SALISBURY NHS FOUNDATION TRUST
TRUST BOARD

MONDAY 3 AUGUST 2015, 1.30PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
1.30pm	**1**	**APOLOGIES FOR ABSENCE**			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES**			
		Meeting held on 8 June 2015			1
	4	**MATTERS ARISING**			
1.35pm	**5**	**CHIEF EXECUTIVE**			
		Chief Executive's Report	PH	SFT 3675	9
1.45pm	**6**	**STAFF**			
		1. Workforce Performance Report to include Safer Staffing and Skill Mix	AK/LW	SFT 3676	13
		2. Annual Equality and Diversity Report	AK	SFT 3677	45
2.10 pm	**7**	**PATIENT CARE**			
		1. Quality Indicator Report to 30 June (Month 3)	CB/LW	SFT 3678	63
		2. Patient Safety Update	LW	SFT 3679	-
		3. Update on Progress of Medical Revalidation	CB	SFT 3680	71
2.40 pm	**8.**	**PERFORMANCE AND PLANNING**			
		1. Finance & Performance Committee Minutes 18 May & 29 June 2015	NM	SFT 3681	79
		2. Finance and Contracting Report 30 June 2015 (Month 3)	MC	SFT 3682	87
		3. Progress against Targets and Performance Indicators to 30 June 2015	AH	SFT 3683	-
		4. Update on Strategic Planning	LA	-	-
		5. Annual Report of the Remuneration Committee	NM	SFT 3684	97
		6. Electronic Patient Record – approval of outline business case	LA	SFT 3685	99

3.20 pm **9** **PAPERS FOR NOTING OR APPROVAL**

1. Minutes from Clinical Governance Committee 28 May and 25 June 2015	LB	SFT 3686	159
2. Minutes from Public Section of Council of Governors 18 May 2015	NM	SFT 3687	181
3. Minutes from Audit Committee 22 May 2015	PK	SFT 3688	185

3.50 pm **10** **ANY OTHER URGENT BUSINESS**

11 **QUESTIONS FROM THE PUBLIC**

12 **NEXT MEETING**

The next ordinary meeting will be held on Monday 5 October 2015, in the Board Room at Salisbury District Hospital starting at 1.30pm.

13 **CONFIDENTIAL ISSUES**

To consider a resolution to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

SALISBURY NHS FOUNDATION TRUST

Minutes of the meeting of Salisbury NHS Foundation Trust Board Held on Monday 8 June 2015

Board Members Present:	Dr N Marsden	Chairman
	Dr C Blanshard	Medical Director
	Mr A Freemantle	Non-Executive Director
	Dr L Brown	Non-Executive Director
	Mr P Hill	Chief Executive
	Mr A Hyett	Chief Operating Officer
	Mr P Kemp	Non-Executive Director
	Mrs A Kingscott	Director of Human Resources and Organisational Development
	Mr S Long	Non-Executive Director
	Revd Dame S Mullally	Non-Executive Director
	Ms L Wilkinson	Director of Nursing
Corporate Directors Present:	Mr M Ace	Associate Executive Director
	Mr L Arnold	Director of Corporate Development
In Attendance:	Mr P Butler	Communications Manager
	Mr M Collis	Deputy Director of Finance
	Mr D Seabrooke	Secretary to the Board
	Mr P Lefever	Wiltshire Health Watch
	Ms S White	Public Governor
	Dr J Lisle	Public Governor
	Mrs J Sanders	Public Governor
	Mr J Parker	Public Governor
	Dr A Lack	Lead Governor
	Sir R Jack	Public Governor
	Cllr J Noeken	Appointed Governor – Wiltshire Council
	Mrs L Taylor	Public Governor
	Mrs L Herklots	Public Governor
	Mr M Wareham	Staff Side
	Mr J Hemming	Consultant for SFT 3662
Apologies:	Mr M Cassells	Director of Finance and Procurement
	Mr I Downie	Non-Executive Director

Organ Donation

Before the meeting started the Chairman called upon Dr Lydia Brown to speak to everyone present in her capacity as the Chair of the Trust's Organ Donation Committee. Dr Brown invited everyone to consider their feelings towards organ donation and to signify this by dropping a token into one of three boxes provided.

2086/00 INTRODUCTION AND WELCOME **ACTION**

The Chairman welcomed the local press and the governors to the meeting.

2087/00 DECLARATIONS OF INTEREST AND FIT AND PROPER/GOOD CHARACTER

Members of the Board were reminded that they have a duty to declare any impairment to Fit and Proper and being of good character as well as to avoid any conflict of interest and to declare any interests arising from the discussion. No member present declared any such interest or impairment.

2088/00 MINUTES

The minutes of the meetings of the Board held on 13 April and 11 May 2015 were accepted as a correct record.

2089/00 CHIEF EXECUTIVE'S REPORT - SFT 3656 – PRESENTED BY PH

The Board received the Chief Executive's Report.

It was noted that the Trust had been named as one of the top hospitals in the country by CHKS, a leading national health care intelligence organisation. The trophy signifying the award was on show at the meeting.

The Trust remained in the best band in the CQC intelligent monitoring system. Work continued towards the joint bid with Great Western and Royal United Hospitals Bath in support of a new model for Adult Community Services across Wiltshire. The next key deadline for shortlisted candidates would be to submit an outline proposal to the Wiltshire Clinical Commissioning Group later in June.

It was noted that Andy Hyett had been designated as accountable officer for emergency planning.

Following elections held earlier in the year for public and staff governors it was noted that Dr Jennifer Lisle, Lucinda Herklots, Isabel McLellan, John Parker, Sharan White, Michael Mounde, Ross Britton, Pearl James, Jonathan Wright and Paul Straughair had been elected to the Council of Governors. Sir Raymond Jack, Dr Beth Robertson, Shaun Fountain, Colette Martindale and Christine White had been re-elected.

The Board noted the Chief Executive's report.

2090/00 STAFF

2090/01 Workforce Performance Report including Safer Staffing and Skill Mix SFT 3657 - Presented by AK & LW

The Board received the Workforce Performance Report including the monthly Skill Mix review and an update on the six monthly Skill Mix review.

In relation to the Workforce Performance Report, AK reminded the Board of the work underway to increase the proportion of staff employed on a permanent basis and through the bank. Actions in relation to agency spend included an updated protocol for the purchasing of agency nursing, a review of the agency that supported the substantive medical post recruitment, ongoing international nurse recruitment during 2015/16 and further work by the nursing and administration bank to bring in more recruits.

Work to address sickness rates continued including special physiotherapy promotional events in June. There was good feedback on the staff Friends and Family test.

Concern was expressed about the appraisal and mandatory training compliance rates reported under workforce compliance. It was noted that a review of the on-line SPIDA system had been undertaken and reported to the Executive Workforce Committee and work was underway to ensure that all completed training was recorded on the managed learning environment (MLE) system.

In relation to the National Quality Board (NQB) report for April 2015 it was noted that figures for maternity were included in the report for the first time. Actual and planned skill mix were closely aligned and fill rates for planned and actual hours were satisfactory. The Board noted the variations shown in the night and day shifts in regard to maternity and neo-natal intensive care unit (NICU). The nationally mandated tool was not able to capture the full range of patient numbers and acuity.

It was noted that the pie chart showing reasons for leaving the Trust showed 20% for the termination of a fixed term contract which included maternity leave cover and staff employed in support of projects particularly in the IT area.

The Trust was avoiding using agencies for nursing cover that charged excessive rates.

The six monthly skill mix had taken place and the Board was reminded of the investments totalling £917,000 that had led to strengthening Band 7 ward sister posts, establishing the 1:8 ratio on day shifts and additional staffing requirements on Durrington and Amesbury wards. The full results would be discussed by the Board and presented at the 3 August meeting. LW

The Board noted the report.

2090/02 Staff Survey 2014- Update on progress – SFT 3658 – Presented by AK

The Board received the update report following consideration of the results at the 13 April meeting. It was noted that the Trust had a Staff Survey Steering Group in place chaired by the Deputy Director of HR and this reported to the Executive Workforce Committee. It was noted that a Staff Support Advisor role was being developed and conflict resolution training across the Trust was continuing. The Trust-based 24 hour security service would be launched in the next few weeks. Consideration was being given to Pulse surveys to help evaluate progress in-between staff survey exercises.

The Board noted the report.

2090/03 Voluntary Services Department Annual Report – SFT 3659 – Presented by AK

The Board received the annual report setting out the range of work undertaken in support of the Trust by its volunteers. The numbers of volunteers registered reflected strong community support for the hospital. Thanks were given to Brian Fisk the volunteer's governor and the service would be welcoming Pearl James as the new volunteer's governor from 1 June. It was noted also that a survey of volunteers had recently been completed.

2091/00 PATIENT CARE

2091/01 Quality Indicator Report to 30 April 2015 (Month 1) – SFT 3640 - Presented by CB and LW

The Board received the Quality Indicator Report and the following principal points were highlighted:

- There had been five new Serious Incident Inquiries.
- Mortality rates were reducing and were in the as expected range.
- There was a reduction in the number of patient spending 90% of their inpatient time on the stroke unit as three patients had been transferred to other wards prior to discharge from the hospital to provide specialist capacity for new stroke patients.
- There had been eight breaches affecting 46 patients for mixed sex accommodation principally arising from the Acute Medical Unit.
- Escalation bed capacity had increased in April and work was underway to look at bed capacity and efficiency.

The Board noted the Quality Report.

2091/02 Customer Care Report – Quarter 4 – SFT 3661 – Presented by LW

The Board received the Quarter 4 Customer Care report and it was noted that complaint numbers remained static. There were 11 complaints reopened in Quarter 4. The Ombudsman had closed two complaints in the quarter of which one had been partially upheld. Concern was expressed that six complaints out of 22 in the Musculo-Skeletal Directorate had been reopened due to inaccuracies in the response further questions, dissatisfaction with the response and further questions arising.

It was also noted that the Trust continued to resolve concerns by discussion wherever possible.

2091/03 Director of Infection Prevention and Control (DIPC) Annual Report 2014/15 – SFT 3662 – Presented by LW

Julian Hemming from the Infection Control Service attended for this item.

The Board received the annual report. It was noted that the Trust had finished 2014/15 with 23 attributed cases of C-Diff against a trajectory target of 18 although CCG reviews of two of these cases had yet to be heard. A number of cases had occurred in February 2015 but ribo typing had not established any connections between these. The Trust had seen a rise in activity in January in patients with influenza and respiratory problems which had been dealt with effectively. The Trust remained vigilant on potential for CPE by using screening on patients transferring from high risk facilities. Microbiologists continued to review patients in conjunction with Pharmacy.

Hand hygiene results continued to be reported to the Matrons Group.

The Board noted the report.

2092/00 PERFORMANCE AND PLANNING

2092/01 Finance & Performance Committee Minutes 30 March and 27 April 2015 – SFT 3663 – Presented by NM

The Board received the confirmed minutes of the Finance and Performance Committee. The Chairman highlighted the Trust's outstanding performance on CQUIN and emphasised that the Committee would continue to focus on the achievement of cost improvement and transformation programmes.

2092/02 Finance and Contracting Report to 30 April 2015 – SFT 3664 – Presented by Mark Collis

The Board received the Month 1 report. It was noted that the Trust had recorded a deficit of £1.1m for the month. This was due to high agency spend, reductions in income and greater spend on resilience. Efforts to continue to reduce high cost agency spend continued.

The Board noted the report.

2092/03 Operational Performance Report – Month 1 – SFT 3665 – presented by AH

The Board received the operational performance report for April. It was noted that the Trust delivered its infection control, referral to treatment, emergency department and seven out of eight cancer standards in April. There were some challenges on admitted pathways for RTT in some areas. It was noted that some of the figures rated as green were close to their threshold to turn to amber. The Trust had failed some of its diagnostics targets in April but a plan was in place to clear a backlog and referrals received by the Trust were back to normal levels.

It had recently been announced nationally that two of the three 18 week targets were to be discontinued but the Trust continued to emphasise that patients would not wait any longer than necessary for their treatments.

Delayed Transfer of Care continued to be an issue which was affecting the length of stay particularly in medicine areas. An operational group was in place seeking improvements to the patient transport service and was working with the contractor in this regard.

The Board noted the the report.

2092/04 Update on Strategic Planning – Presented by LA

LA reported that the Trust had submitted the Annual Plan to Monitor in May and was awaiting feedback.

2092/05 Capital Development Report – SFT 3666 – Presented by LA

The Board received the Capital Development Report. It was noted that planning permission for the Springs entrance project was being sought and tender specifications were being issued. It may however be necessary to take a critical look at which capital schemes could proceed and which would provide value for money. Building work in support of the new Breast Care

Unit was expected to start later in 2015. Work on phase one wards such as Durrington, Post Natal, Surgical Assessment Unit and Radnor was planned to start in late summer with refurbishments completed by mid-December. Design work on the maternity unit expansion was underway.

The Board noted progress with key IT projects including single sign on, POET, Electronic Discharge Summaries and the implementation of an electronic patient record. The outline business case for the latter would be submitted to the 3 August Trust Board. LA

The Board noted the Capital Development Report.

2092/06 National In Patients Survey Results 2014 – analysis of CQC Benchmark Report and local action plans - SFT 3667 – Presented by LW

The Board received an update in relation to the inpatients survey that had been conducted between October 2014 and January 2015. The findings had been considered by the Clinical Governance Committee and with one exception in 60 indicators the results were within the average "about the same as other Trusts". Work was underway to address concerns on food and nutrition, single sex accommodation, noise at night and the Clinical Governance Committee would receive these updates.

The Board noted the report.

2092/07 Informatics Strategy Update – SFT 3668 – Presented by LA

The Board received the report summarising progress on the main work streams of the 2011/16 Informatics Strategy. It was noted that the Trust was developing a new strategy during 2015 with a particular theme to link outwards with the information held by the Trust.

The Board noted the Report.

2093/00 PAPERS FOR NOTING OR APPROVAL

2093/01 Minutes from Clinical Governance Committee 26 March 2015 – SFT 3669 – Presented by LB

The Board received the confirmed minutes of the Clinical Governance Committee. Lydia Brown highlighted the service review for Dementia care and issues arising from this would be followed up by the Committee. It was also noted that the Committee had discussed its quarterly safeguarding adults report.

The Board noted the minutes of the Clinical Governance Committee.

2093/02 Joint Board of Directors Minutes - Review of Assurance Framework and Risk Register – SFT 3670 – Presented by PH

The Board received an extract of the minutes of the Joint Board of Directors indicating the quarterly review of the assurance framework. The minute highlighted the work of Thames Valley and Wessex Leadership Academy in relation to robust governance processes, the introduction of the workforce report and the overall review of the Risk Register.

2094/00 QUESTIONS FROM THE PUBLIC

In response to a question from Alastair Lack concerning compliance rates with staff mandatory training AK stated that there was a process being addressed to ensure that face to face sessions on information governance were recorded in the MLE and similarly with infection control were data was brought together from separate parts of the MLE system.

In relation to a question regarding the split of staffing spend (page 15 of the agenda pack) It was noted that more detailed data was provided to the Executive Workforce Committee but the bar chart would be reviewed to pull out the different categories of spend more clearly. AK

2083/00 DATE OF NEXT MEETING

It was noted that the next public meeting of the Trust Board will be on Monday 3 August 2015, in the Board Room at Salisbury District Hospital starting at 1.30pm.

CHIEF EXECUTIVE REPORT

MAIN ISSUES:

CQC INSPECTION

The Care Quality Commission (CQC) has been carrying out inspections across the country and we have received confirmation that our inspection will now take place between the 1 and 4 December 2015. It is essential that we remain well prepared in both our ability to provide the access and level of input the CQC will require from us during an inspection and to ensure that we give a balanced view of the hospital and the services we provide for our patients. We have already been meeting regularly to discuss our plans and also prepare departments. Over the next few months, we will be putting in place a programme of workshops, communications and other activities, so that our staff have the support and information that they need. The inspection will also be covered in my open autumn presentations to staff.

TRUST PRIORITIES

The Trust Board has set a number of priorities for 2015/2016 that take forward the four key themes of Choice, Care, Our Staff and Value in the Trust's corporate strategy. The priorities also complement our vision of providing an **outstanding experience for every patient**, along with our values and behaviours. These priorities cover a wide area, from quality of care and patient safety to service improvements and initiatives to help with the recruitment, retention and wellbeing of staff. The priorities have been publicised internally and will also be included in my open autumn presentations to staff.

ADULT COMMUNITY SERVICES

Work is progressing on our joint bid with the Great Western Hospital and Royal United Hospitals to create a new model for adult community services across Wiltshire. Clinical engagement is taking place in key areas such as stroke and diabetes and, while there is significant competition to provide this service, we have been successful in reaching the final stage. We are now one of two shortlisted candidates that submitted outline proposals to Wiltshire Clinical Commissioning Group (CCG) on June 22, with completed proposals scheduled for submission in the autumn. The CCG will make a final decision by the end of the year with a view to letting the new five-year contract from July 2016.

CARERS CAFÉ STARTS AT SALISBURY DISTRICT HOSPITAL

We have now launched our new carer's café, where people who have loved ones or friends in hospital will have an opportunity to share their experiences and get advice and support from specialist staff. This is an excellent new initiative developed by our own staff and will run twice a month in Springs Restaurant between 2.30pm and 4. pm every second and fourth Thursday of the month. It is aimed at carers of any age and we have volunteers from the Alzheimer's Society, Age UK and Carers Support Wiltshire who are on hand to answer any questions or to signpost to the appropriate help in the community during these sessions.

TRUST IN TOP 120 HEALTHCARE ORGANISATIONS TO WORK

For the second year running, comments from our staff have placed the Trust among the best healthcare organisations in the country in which to work. The Health Service Journal gathered a range of information from employers and staff and these were then analysed by independent workplace research firm Best Companies Group who used this to benchmark organisations and identify the top 120.There are over 450 healthcare organisations, including general hospital Trusts, community, mental health Trusts and Clinical Commissioning Groups. The publication took into account the results and comments from staff surveys, and a range of information from the quality of leadership and staff communication and engagement, to the working environment and training and development.

STAFF FRIENDS AND FAMILY TEST – QUARTER ONE RESULTS 2015/16

Staff will shortly have another opportunity to give their feedback through the Friend and Family Test (FFT). There are three opportunities each year for staff to carry out the test, which enables us to make improvements that benefit both our staff and patients. The results also help with recruitment and give local people another perspective on the hospital. From a total of 313 responses in June, 95.2% of staff said they were “likely” or “extremely likely” to recommend this organisation to friends and family if they needed care or treatment, placing us in the top 7% of Trusts nationally. Also 81.5% of staff said they were “likely” or “extremely likely” to recommend this organisation to friends and family as a place to work. The next opening for staff to carry out the test will take place in September.

PARENTS, CHILDREN AND YOUNG PEOPLE RATE HOSPITAL EXPERIENCE

Parents, children and young people have rated their experience of care at Salisbury District Hospital highly in the latest national children’s inpatient and day case survey, with safety, friendliness and pain control among the key findings in the report. The survey, carried out by the Care Quality Commission, looked at inpatient and day case care and treatment from admission to discharge for 0 to 15 year olds and captured the views of parents, carers, children and young people. Salisbury was considered better than most hospitals in a number of areas and no ‘worse’ in any area. This is an excellent report which highlights the commitment of our staff and the way in which they look after children and young people in their care. It also reflects, perfectly, our values of providing patient centred safe, care by professional, responsive and friendly staff.

LONG SERVICE AWARDS 2015

It is nice to reflect on the contribution our staff make to the NHS and to local health services and our Chairman, Nick Marsden, and I recently had the pleasure of presenting our Long Service Awards to 41 members of staff. We find these occasions really enjoyable and it is wonderful to see our staff receive their awards in front of family and friends and hear the positive comments from colleagues. It also provides our staff with the recognition they deserve and highlights their tremendous loyalty and commitment to the NHS, our hospital and the local community.

ACTION REQUIRED BY THE BOARD:
To note the report of the Chief Executive.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

n/a

AUTHOR: Peter Hill,
TITLE: Chief Executive

SFT 3676

Trust Board Workforce Performance Report M3 (June) 2015-6

Presented for: Information

Presented by: Alison Kingscott, Director of Human Resources and Organisational Development

Author: Victoria Downing-Burn, Deputy Director of HR (interim) and Mark Geraghty, Head of Workforce Information and Planning

Previous Committees: Executive Workforce Committee (20 July 2015)

Key points
The Trust Board is asked to consider this report, the detail of the metrics and updates, and the return to green actions.

This report satisfies the following three, of four, strategic aims, and each of the Trust Values as outlined below:

Strategic Aims

Care - We will treat our patients with care, kindness and compassion and keep them safe from avoidable harm	✓
Our Staff - We will make SFT a place to work where staff feel valued to develop as individuals and as teams	✓
Value - We will be innovative in the use of our resources to deliver efficient and effective care	✓

Values

We will be Patient Centred and Safe, Professional, Responsive and Friendly	✓

1. Summary
This report describes the key workforce performance metrics for the Trust and the actions undertaken to address those metrics recorded as RED and AMBER, and how the Trust aims to 'Return to Green' at a high level. The report / appendices also provide a brief narrative across all of the presented metrics, with trend analysis for the GREEN rated items.

The report is summarised against four categories:

- Workforce Numbers: numbers and vacancies
- Workforce Quality: temporary workforce and safer staffing
- Workforce Health: absence, starters and turnover and reasons for turnover, Staff FFT
- Workforce Compliance: appraisal, training

2. Performance

Please refer to the charts in the document for monthly data (June 2015) and trends over the previous five months (January – May 2015).

Workforce Numbers

2.2 Vacancies – Green

The overall vacancy rate is 5.3%. This equates to c 156 FTE. When variable staffing (use of temporary agency / bank staff) is included the vacancy rate is -0.3%. This is attributed, largely, to the closure of capacity reducing the demand requirements for nursing staff.

The Nursing and Midwifery (NMW) vacancy rate is higher than the Trust average at 10.6%.

Updates and next steps

Work is being undertaken to understand whether predictor data can inform the impact of vacancies on variable staffing usage.

2.3 Workforce Costs and Quality - AMBER / GREEN

Pay costs for M3 are £10.5m. Workforce costs showed an overspend of £654k against budget after 3 months of the financial year (see Figure 1 below).

Variable staffing costs have decreased in month 3, as a consequence of the scrutiny and close monitoring of usage.

Return to Green and next steps

- On-going monitoring of agency usage for clinical and non-clinical roles is to be managed through the Workforce Vacancy Review panel, overseen by Executives.
- Decreases in non-clinical agency usage is predicted, and will be monitored.
- Medical agency usage is scrutinised at Directorate level, with protocols in place to ensure consistency of approach.
- Further effort is being put into improving the success of the use of an agency to fill medical substantive posts.

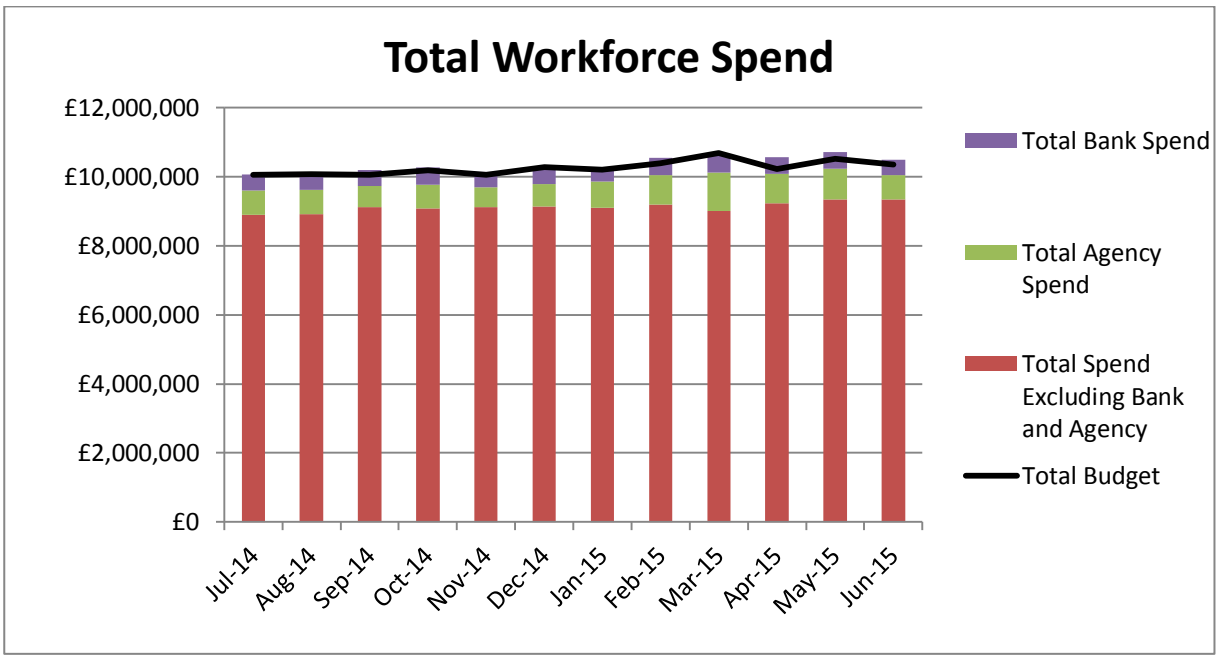


Figure 1

Workforce Quality

2.4 Efficiency of staff deployment

The shift fill rates and shift fill hours for nursing Bank has shown an improvement in the third month of the year (2015-16). The Trust is seeking to move to a position where the uptake of bank shifts is the major proportion of variable staffing where required, with agency usage at a minimum.

Next steps

- Monitoring of use of bank and agency to be continued, in order to maintain the recent reductions in agency usage.
- All non-clinical agency requests to be scrutinised by the Workforce Vacancy Review panel.

2.5 Safer staffing - appendix 1

The expected ratio of 60:40 has remained largely stable since last month, with a slight increase of percentage qualified staff to 61%.

Appended to this report is the 'Safer Staffing NQB Report – June 2015, which provides a further analysis of the nursing staffing levels across the Trust including a full breakdown of the percentage of filled shifts (day and nights). The report also provides an assessment of Red and Amber areas and mitigations.

Workforce Health

2.6 Sickness absence – AMBER

In June the sickness absence rate showed a slight decrease to 3.2%.

Return to Green
Reinforcement of the importance of recording all sickness reasons has been done through OWG. Work between HR and Payroll is underway to review the improvement rates in reporting.

A trial of the self-service function on the Electronic Staff Record (ESR), by managers, is being undertaken allowing for direct system recording and updating to occur.

2.7 Turnover – GREEN / AMBER

Trust turnover (which excludes medical staff on rotation) is 10.5%, against a target of 8.5%.

In the final quarter of 2014-15 the number of starters across the entire Trust was greater than the number of leavers.

Nurse turnover and starters show a negative relationship (with fewer starters than leavers) than in previous months, with active recruitment campaigns aimed at UK and European nurses underway.

Nurse turnover is 8.8%, which is lower than the trust average.

Return to green

- A review of retention rates and reasons for leaving is being undertaken to understand retention opportunities.

2.8 Friends and Family Test – GREEN

Quarter one data shows the Trust to be in a good position, in the top 10% of Trusts nationally.

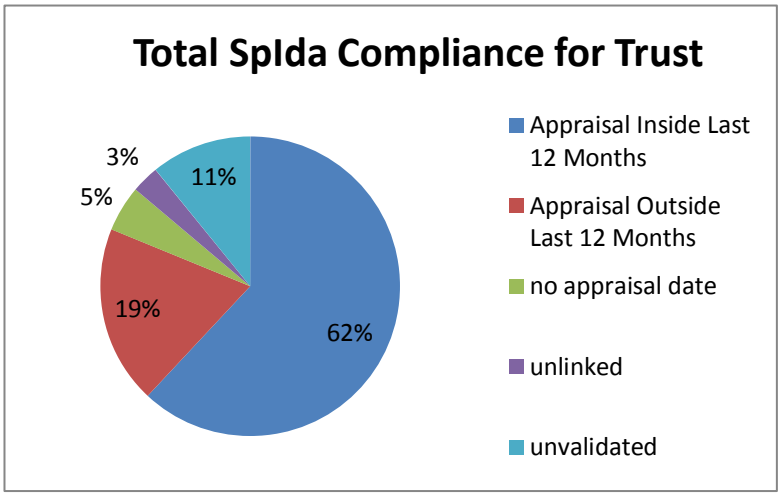
Workforce Compliance

2.9 Appraisal rates –RED / GREEN

Non-medical appraisal rate: 62%. Medical appraisal rate: 90%. Significant work has been undertaken to ensure that all appraisal data is appropriately recorded and 'signed off'.

Next steps
Phase 2 of the development of the appraisal tool (SpIda) is underway with a programme of work for system improvements being updated.

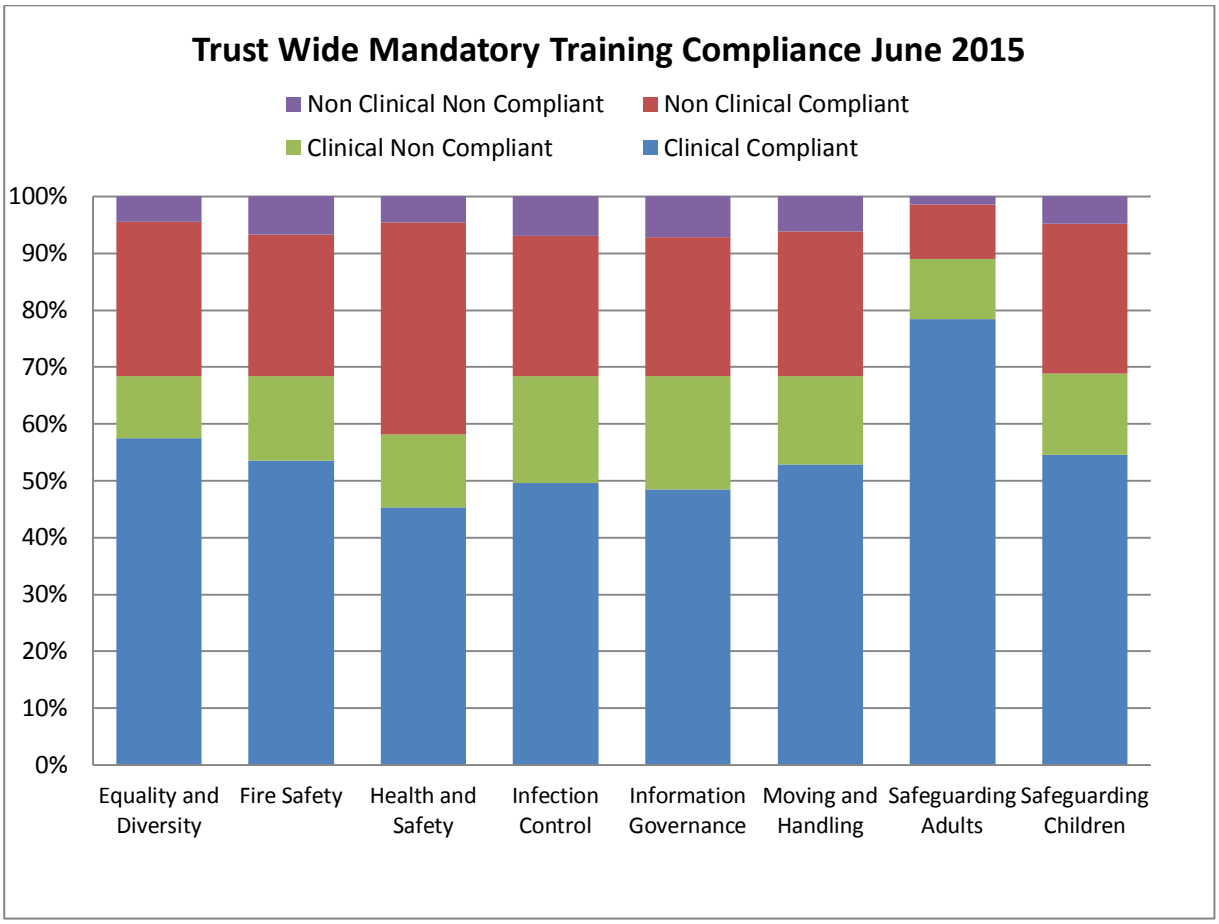
As noted in the chart below, the data from the system identifies a number of staff who sitting in categories other than 'appraisal inside last 12 months'.



Line managers have now received detailed records of appraisals completed and incomplete with names of staff members allowing for targeted support.

2.10 Statutory and Mandatory Training – AMBER/RED

Compliance with training is reported as amber at 81.0% and varies between each of the core topics. *Please note that the figure below provides information on compliance and non-compliance by clinical staff group and then by non-clinical group. Amendments to the chart are in progress to provide 'compliance' and 'non-compliance' broken down by staff group.*



Note: Information Governance
The recorded figure of compliance provided by the IG team and submitted as part of the IG Toolkit is 94.3%.

Return to Green

- Trust staff have been reminded of the requirement to be compliant with statutory and mandatory training.
- Line managers are required to confirm compliance with training for pay progression through the SpIda appraisal system.
- The Trust learning system is being refreshed.

3. Communication and Involvement
The workforce metrics are available for all staff groups, Directorates and wards/departments throughout the Trust. Work continues to integrate qualitative intelligence with the metrics to better inform performance management discussions. Directorates are provided with rankings on key measures, enabling managers to understand how their performance compares with their peers.

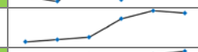
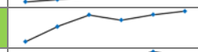
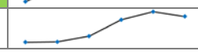
4. Recommendation
The Board is asked to note the current position.

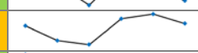
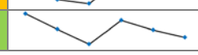
5. Supporting Information
The following documents are attached as appendices:

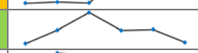
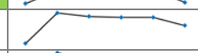
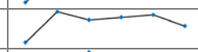
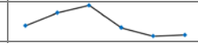
1. Metrics
2. Safer Staffing NQB Report – June 2015.

Alison Kingscott
Director of HR and OD
July 2015

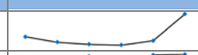
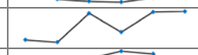
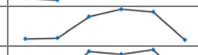
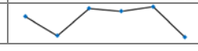
Workforce Numbers

Staff In Post (SiP) numbers	*Target*	Jun-15	Trend	*Plan*
Total substantive Staff in Post (FTE)	= 95% of funded establishment (see vacancy rate RAG rating criteria below)	2,779		2,720
Establishment (FTE)	No target	2,936		2,886
Total substantive SiP - Nurses (FTE)	= 92% of funded establishment (see vacancy rate RAG rating criteria below)	1,097		1,184
Establishment - Nurses (FTE)	No target	1,226		1,193

Vacancies	*Target*	Jun-15	Trend	*Plan*
All Vacancies - excluding variable staffing (%)	<8% = green, 8% to 10% = amber, >10% = red	5.3%		10.9%
All Vacancies - including variable staffing (%)	<=4% = green, 5% to 6% = amber, >6% = red	-0.3%		5.8%
Nursing Vacancies - excluding variable staffing (%)	<10% = green, 10% to 12% = amber, >12% = red	10.6%		8.0%
Nursing Vacancies - including variable staffing (%)	<=4% = green, 5% to 6% = amber, >6% = red	1.3%		0.8%

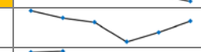
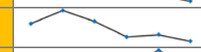
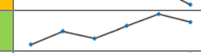
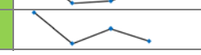
Workforce Costs and Quality	*Target*	Jun-15	Trend	*Plan*
Total Workforce spend vs. plan (YTD % above/below plan)	Plan ±<1% = green, plan ±1 to 5% = amber, plan ±>5% = red	2.1%		£122,465,000
Variable Staffing spend as proportion of total workforce spend (YTD %)	Reduction	11.0%		6.8%
Bank Spend Total	Upward trend	£437,524		
Nursing Bank Spend	Upward trend	£287,733		
Medical Locum Bank Spend	Upward trend	£57,348		
Agency Spend Total	Reduction	£704,934		
Nursing Agency Spend	Reduction	£315,575		
Medical Agency Spend	Reduction	£250,667		

Workforce Quality

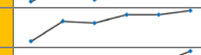
Efficiency of Staff Deployment	*Target*	Jun-15	Trend	*Plan*
Bank Shift Fill Rate % - All Nursing	Upward Trend	67.3%		85.0%
Bank Shift Fill Hours - All Nursing	Upward Trend	15,882		20,062
Agency Shift Fill Rate % - All Nursing	Reducing	28.5%		
Agency Shift Fill Hours - All Nursing	Reducing	6,725		

Safer Staffing	Target	Jun-15	Trend	*Plan*
Actual Staffing Levels - Nursing Assistants % of planned	No target	101.2%		
Actual Staffing Levels - Registered Nurses % of planned	No target	98.5%		
Actual Skill Mix % Qualified	No target	61.0%		

Workforce Health

Sickness Absence	*Target*	Jun-15	Trend	*Plan*
Overall Sickness Absence Rate (12m rolling average %)	<=3.1% = green, 3.1% to 4% = amber, >4% = red (2.87% target).	3.2%		3.0%
Short Term Sickness (12m rolling average %)	No target	1.4%		1.4%
Long Term Sickness (12m rolling average %)	No target	1.8%		1.6%
Average number of working days lost per FTE (in previous 12 months)	<=6.1 = green, 6.2 to 8.6 = amber, >8.6% = red	7.0		7.0%
Financial cost of sickness in last 12 months	<=3.1% = green, 3.1% to 4% = amber, >4% = red	£3,898,954		£3,673,950
% of Sickness Absence with no reason recorded	<=5% = green, 5% to 15% = amber, >15% = red	12.9%		<=5%
Turnover	*Target*	Jun-15	Trend	*Plan*
Staff Turnover rolling 12 months % (Excluding Rotational Medical Staff)	7-10% = green, 10% -12% = amber, >12% = red. (8.5% target)	10.5%		10.8%
Registered Nurse Turnover rolling 12 months %	7-10% = green, 10% -12% = amber, >12% = red. (8.5% target)	8.8%		9.0%
Starters % rolling 12 months (Excluding Rotational Medical Staff)	No target	14.2%		14.0%
Registered Nurse Starters rolling 12 months	No target	6.5%		6.4%
Staff Friends and Family Test	Target	Q1 2015/16	Trend	*Forecast Out Turn*
% of Staff agreeing they would recommend the hospital as a place to receive treatment	Top 20% of Trusts Nationally	95.2%		92.6%
% of Staff agreeing they would recommend the hospital as a place to work	Top 20% of Trusts Nationally	81.5%		80.8%

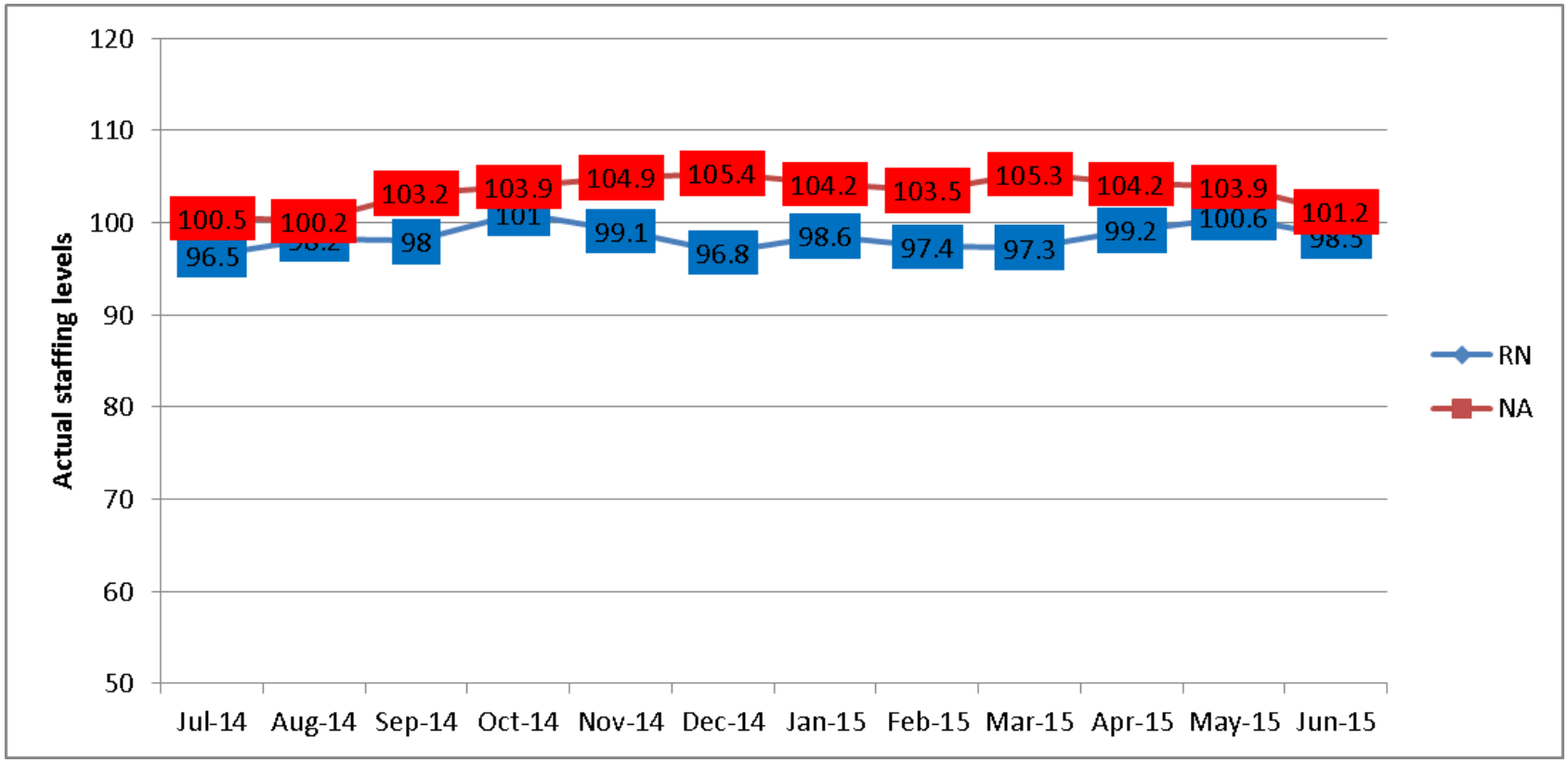
Workforce Compliance

Appraisal rates (excludes Medical Staff)	*Target*	Jun-15	Trend	*Plan*
Appraisal rates for Non Medical Staff	>85% = green, 75% to 85% = amber, <75% = red	62.0%		85.0%
Appraisal rates for Medical Staff	>85% = green, 75% to 85% = amber, <75% = red	90.0%		92.0%
Statutory and Mandatory Training - All Staff	*Target*	Jul-15	Trend	*Plan*
Overall Statutory and Mandatory Training Compliance	>85% = green, 75% to 85% = amber, <75% = red	81.0%		85.0%
Equality and Diversity	>85% = green, 75% to 85% = amber, <75% = red	84.6%		85.0%
Fire Safety	>85% = green, 75% to 85% = amber, <75% = red	78.4%		85.0%
Health and Safety Overview	>85% = green, 75% to 85% = amber, <75% = red	82.6%		85.0%
Infection Prevention and Control (including hand hygiene)	>85% = green, 75% to 85% = amber, <75% = red	74.3%		85.0%
Information Governance	>85% = green, 75% to 85% = amber, <75% = red			
Moving and Handling	>85% = green, 75% to 85% = amber, <75% = red	78.3%		85.0%
Safeguarding Adults	>85% = green, 75% to 85% = amber, <75% = red	88.1%		85.0%
Safeguarding Children Level 1 and 2	>85% = green, 75% to 85% = amber, <75% = red	80.9%		85.0%

Safe Staffing NQB Report - June 2015 (M3)

Monthly Comparisons – Actual Staffing Levels

Registered Nurses			Nursing Assistants			Combined			Actual Skill Mix	
P	A	%	P	A	%	P	A	%		
54543.4	53730	98.5	33814.3	34238.4	101.2	88357.7	87968.4	99.6	61	39



Overview of Nurse Staffing Hours – June 2015

	RN	NA
Total Planned hours (day shift)	32956.42	22711.79
Total Actual hours (day shift)	32556.74	23005.94
Percentage	**98.8**	**101.3**
Total Planned hours (night shift)	21587	11102.52
Total Actual hours (night shift)	21173.17	11232.5
Percentage	**98.1**	**101.2**

The percentage hours are based on actual versus planned and are measured on a shift by shift basis.

Nursing Hours by Day Shifts

Row Labels	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**12863.92**	**13123.84**	**102.0%**	**9931**	**10577.67**	**106.5%**
Durrington Ward	1002	1082.5	108.0%	851	1185.92	139.4%
Emergency Department	345	345	100.0%	345	345	100.0%
Farley Ward	1727.75	1669.25	96.6%	1465	1445.25	98.7%
Hospice	875	869.5	99.4%	629.5	637	101.2%
Pembroke Ward	852	847.75	99.5%	402.5	407	101.1%
Pitton Ward	1426	1439.92	101.0%	1112	1197.5	107.7%
Redlynch Ward	1417.5	1406.5	99.2%	1100	1201	109.2%
Tisbury Ward	1977	1850.75	93.6%	685.5	674	98.3%
Whiteparish Ward	1577.67	1784.67	113.1%	1031	1079.5	104.7%
Winterslow Suite	1664	1828	109.9%	2309.5	2405.5	104.2%
Surgery	**6274.5**	**5961.68**	**95.0%**	**3540.76**	**3178.11**	**89.8%**
Britford Ward	2096.5	2109	100.6%	1215	1191	98.0%
Downton Ward	1304.5	1314.02	100.7%	1486.76	1626.61	109.4%
Radnor	2873.5	2538.66	88.3%	839	360.5	43.0%
Clinical Support	**4443.5**	**4190.25**	**94.3%**	**2098.5**	**1628.75**	**77.6%**
Maternity	2541	2293.25	90.2%	1356	1121.25	82.7%
NICU	1063	1048.25	98.6%	401	166	41.4%
Sarum Ward	839.5	848.75	101.1%	341.5	341.5	100.0%
Musculo-Skeletal	**9374.5**	**9280.97**	**99.0%**	**7141.53**	**7621.41**	**106.7%**
Amesbury Suite	1912.75	1869.89	97.8%	1504.25	1485.6	98.8%
Avon Ward	1428.2	1402.76	98.2%	1483.27	1870.34	126.1%
Burns Unit	1439.25	1418.5	98.6%	554.25	551.75	99.5%
Chilmark Suite	1452.5	1712.97	117.9%	1078.5	1059.86	98.3%
Laverstock Ward	1848	1724.5	93.3%	1034.5	1027.25	99.3%
Tamar Ward	1293.8	1152.35	89.1%	1486.76	1626.61	109.4%
Grand Total	**32956.42**	**32556.74**	**98.8%**	**22711.79**	**23005.94**	**101.3%**

Nursing Hours by Night Shifts

Row Labels	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**9083**	**9225.25**	**101.6%**	**4961.52**	**5501.75**	**110.9%**
Emergency Department	345	345	100.0%	345	345	100.0%
Farley Ward	1025.25	1025.25	100.0%	687.02	680	99.0%
Hospice	494	570	115.4%	481	412.5	85.8%
Pembroke Ward	690	689.5	99.9%	0	55	
Pitton Ward	1032.5	1159	112.3%	690.5	689.25	99.8%
Redlynch Ward	1034.25	1023.5	99.0%	345	586	169.9%
Tisbury Ward	1380	1298	94.1%	345	391	113.3%
Whiteparish Ward	1380	1390	100.7%	343	399.5	116.5%
Winterslow Suite	1035	1035	100.0%	1035	1253.5	121.1%
Durrington Ward	667	690	103.4%	690	690	100.0%
Surgery	**4259.75**	**3969.67**	**93.2%**	**1190**	**1130**	**95.0%**
Britford Ward	900	910	101.1%	590	530	89.8%
Downton Ward	600	600	100.0%	600	600	100.0%
Radnor	2759.75	2459.67	89.1%	0	0	
Clinical Support	**4485**	**4119.5**	**91.9%**	**1426**	**1038.75**	**72.8%**
Maternity	2415	2152.25	89.1%	1035	877.75	84.8%
NICU	1035	954.5	92.2%	345	92	26.7%
Sarum Ward	1035	1012.75	97.9%	46	69	150.0%
Musculo-Skeletal	**3759.25**	**3858.75**	**102.6%**	**3525**	**3562**	**101.0%**
Amesbury Suite	570	560.5	98.3%	855	855	100.0%
Avon Ward	600	679	113.2%	900	880.5	97.8%
Burns Unit	599.25	619.25	103.3%	300	290	96.7%
Chilmark Suite	570	570	100.0%	570	627	110.0%
Laverstock Ward	820	830	101.2%	300	309.5	103.2%
Tamar Ward	600	600	100.0%	600	600	100.0%
Grand Total	**21587**	**21173.17**	**98.1%**	**11102.52**	**11232.5**	**101.2%**

Overview of Areas with Red/Amber

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	**Radnor**	43		√	Day	Small numbers of NA's used to support the team. Not covered each shift which is not always clinically indicated but the data collection model used cannot reflect this flexibility as planned establishment has to be entered into the system as a standard daily amount.
Red	**NICU**	41.4		√	Day	Small number of MA's used to support the team. See Radnor above
Red	**NICU**	26.7		√	Night	Small number of MA's used, see supporting notes above
Amber	**Radnor**	88.3	√		Day	Reduced number of admissions and acuity at the end of June. Active reduction in staff numbers to avoid over staffing.
Amber	**Radnor**	89.1	√		Night	Reduced number of admissions and acuity at the end of June. Active reduction in staff numbers to avoid over staffing.
Amber	**Maternity**	84.8		√	Night	Small number of MAs used
Amber	**Maternity**	89.1	√		Night	Escalation protocol used and each shift assessed. 1:1 care in labour maintained
Amber	**Maternity**	82.7		√	Day	Small number of MAs used
Amber	**Britford**	89.8		√	Night	Night carer flexed to demand depending on whether surgical assessment unit open
Amber	**Hospice**	85.8		√	Night	Small number of NA's used and staffing flexed according to needs of patients, over 100% on RNs
Amber	**Tamar**	89.1	√		Day	High number of vacancies – each shift assessed by DSN

NB: Flags based on green 90% and above, amber 80-90%, red below 80% - no ratings yet agreed by NHS England

Mitigation of Risk

There are fewer wards this month flagging red against our internal measures.

- Specialist areas such as Radnor ICU and NICU flagging where staffing used flexibly according to patient numbers and acuity which cannot be reflected accurately on this tool. Each shift risk assessed for staffing needs by senior nurse and adjusted accordingly. Appropriate 1:1 or 1:2 ratios maintained on all shifts
- All shifts are assessed daily by Directorate Senior Nurses to ensure they are safe.
- NA remains over 100% - this is due to NA's being used on unfilled RN shifts and specials.

Actions taken to mitigate risk

- Patient acuity assessed for staffing levels by individual wards by nurse in charge
- Trust wide staffing levels assessed against patient acuity and staff moved across wards by Directorate Senior Nurses and Clinical Site Team as required
- Staffing levels reduced when beds empty/ procedure lists reduced whilst maintaining appropriate staffing ratios
- If all of the above measures have been taken there may be a requirement that staff on training days are brought back to work clinically as required and / or Sisters on supervisory shifts work clinically.
- Additional NAs rostered to support unfilled RN shifts
- CCOT team support wards where acuity of patients high

Trust Board meeting **SFT**

TITLE OF REPORT Six Monthly Skill Mix Review to Trust Board

Date: August 2015

Report from: Denise Major, Acting Deputy Director of Nursing

Presented by: Lorna Wilkinson, Director of Nursing

Executive Summary:

The third skill mix review has been completed and is being presented to the Trust Board to allow for a discussion on the findings, and to agree a way forward on recommendations.

It is the Director of Nursing's responsibility to oversee a twice yearly skill mix review and present the findings to the Board in an open and transparent manner. The Trust Board have a collective responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability (NQB). It is therefore the role of the Board collectively to receive the skill mix review, consider the findings, and agree a way forward with any recommendations, taking in the wider context of the Trust.

This report provides the Board with information on the continuing national guidance being issued around nurse staffing, a progress report on the 2015 skill mix review, and an update on the investment allocated in 2014/15.

The latest review covers the Emergency Department and Maternity for the first time as well as the inpatient ward areas. All of these areas have been subject to a detailed skill mix review before being presented to the Trust Board in August. The reviews were undertaken using a defined approach to ensure consistency for comparison which included a range of information; triangulating the ward staffing levels against nurse sensitive indicators, NICE standards, quality indicator / outcome data, HR indicators, and financial information. Professional judgement was ensured as each review has been undertaken by the Directorate Senior Nurse and Ward Sister with a DSN/Lead Nurse from outside the Directorate to add objectivity and provide initial challenge.

Proposed Action:
The Board are asked to:

- Discuss and agree any areas for investment from this skill mix review paper with full impact analysis to be included in next skill mix review due December 2015
- Support the actions listed in 8.2 with reported outcomes of this work incorporated into next skill mix review due December 2015

- Support the analysis work from the Safecare tool across the ward areas to inform future skill mix requirements
- Support the continuation of recruitment and retention activities

Trust Board August 2015

Title	Six Monthly Skill Mix Review – June 2015
Meeting Date	3rd August 2015
Sponsoring Executive	Lorna Wilkinson – Director of Nursing
Author	Denise Major – Acting Deputy Director of Nursing

1. Background

The government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry 'Hard Truths – The Journey to Putting Patients First' (DH 2013), was published in November 2013. In its executive summary the report highlights the importance of safe staffing and refers to the National Quality Board published guidance *'How to ensure the right people, with the right skills, are in the right place at the right time'* which clarifies the expectation on all NHS bodies to ensure that every ward and every shift have the right number of nursing staff on duty to ensure that patients receive safe care. It requires Boards to take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.

There are 10 expectations within the NQB guidance (see appendix A) with three key reporting elements that each Trust is required to have in place:

- The clear display of information at ward level about the nurses, midwives and care staff present on each ward on each shift.
- The publication of ward level information on staffing requirements and if these are being achieved on a ward by ward, shift by shift basis through the publication of planned versus actual nursing and midwifery staffing levels.
- The completion of a detailed skill mix review which is presented to Board every 6months.

This report serves as the third review of ward based staffing at Salisbury NHS Foundation Trust and follows on from the mid-year review in October 2014. During 2014/15 there was investment into nurse staffing as a result of the 2 skill mix reviews totalling £917 000.

- April 2014 - £800 000 to fund supervisory band 7 ward sisters, establish the minimum 1:8 ratio on day shifts, and support 2 band 6 junior sister posts as a baseline on each ward
- October 2014 - £117 000 to fund extra staffing requirements identified on Durrington and Amesbury wards.

Following the detailed skill mix reviews that have taken place in April 2015, this report provides an assessment of the nurse staffing provision at Salisbury NHS Foundation Trust as assessed locally and against national guidance and validated tools. This results in recommendations where additional investment is identified as well as highlighting early indications of future investment which might be required.

2. Guidance on Safer Staffing:

NICE has produced guidance for safe staffing levels, this programme is currently paused following NHS England announcement in June 2015 but existing publications are still applicable:

- Safe Staffing of Adult Wards in Acute Settings July 2014
- Safe Midwifery Staffing for Maternity Settings Feb 2015
- Safe Staffing for Accident and Emergency Settings was due to be published in May 2015 but currently on hold.

3. General Wards:

3.1 NICE Safe Nurse Staffing of Adult Wards in Acute Settings:

A gap analysis was undertaken against this guidance when it was published with the Trust meeting virtually all of the standards as most were already evident within the NQB guidance. An action plan was developed and is currently being updated following implementation of the Safer Care Module and establishing a process for 'red flag' reporting.

3.2 Ratio of RNs to Patients:

NICE guidance acknowledges that there is no single nursing staff to patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs but work undertaken by the RCN and Safe Staffing Alliance demonstrated that a ratio of more than 1:8 was more likely to lead to poor patient outcomes. There is a recommendation that day shift ratios in general wards should not exceed 1:8. All wards at Salisbury FT are compliant with this ratio on day time shifts during the week but there are some wards (Redlynch and Pitton) who reduce this ratio at weekends.

Night shifts have a higher ratio of RN to patients and range from 1:5-1:16. These ratios reflect the patient case mix on these wards. The one ward with a night time ratio of 1:16 (elective orthopaedics) is currently under review to explore use of twilight shifts. See section 8.2

3.3 Ratio of RN to Nursing Assistant (NA)

The ratios of RN:NA are listed in appendix B. Not surprisingly this differs from ward to ward depending on case mix of patients. The wards range from 80:20 to 50:50, however there are 2 wards that fall below 50% RNs**;** Avon (46:54) and Tamar (45:55).

Both of these wards are within the Spinal Injuries Rehabilitation Unit and have a higher number of band 3 positions than other ward areas. The band 3 nursing assistants have specific competencies and have an important role in supporting patient care. This is exemplified by respiratory competencies where the band 3 can support a registered nurse with acute care needs. An increase in the number of band 3s however, has reduced the ratio of RN:NA.

In areas where we are developing the Band 4 roles (such as elderly care) this can have a negative impact on the ratio even where it adds to the continuity of ward staffing and enhancement of skills. It will be important in the future as this part of the workforce grows to explain where this may be impacting on this ratio.

3.4 Care Contact Time

In November 2014 NHS England published a Guide to Care Contact Time. This compliments the NQB and NICE guidance, in providing an additional way of looking at nurse staffing by assessing time spent involved in direct patient care. The Trust has carried out some initial work on this in evaluating a Band 1 ward assistant role, which demonstrated how much direct care contact time could be reinvested into nursing time. As a result the clinical Directorates are considering where this role may

be appropriate. The Director of Nursing is currently considering how evaluation of care contact time can be used to best effect in other targeted areas. It is also important to note that as part of the Lord Carter programme examining productivity and efficiency within the NHS, the Trust is one of 4 hospitals nationally reviewing in detail the metric of Nursing Hours per Patient Day (NHPPD).

3.5 Skill Mix Review Methodology:
All inpatient wards have been subject to a detailed skill mix review during April. The reviews were undertaken using a defined approach to ensure consistency for comparison which included a range of information; triangulating the ward staffing levels against nurse sensitive indicators, NICE standards, quality indicator / outcome data, HR indicators, and financial information. Professional judgement was ensured as each review has been undertaken by the Directorate Senior Nurse and Ward Sister with a DSN/Lead Nurse from outside the Directorate to add objectivity and provide challenge.

Trust bed capacity modelling and the proposed bed footprint are currently being reviewed by the Chief Operating Officer, Director of Nursing and Medical Director and this report will need to be considered in light of any changes.

3.6 Findings:
The overall assessment is that the majority of wards have satisfactory staffing levels when vacancies are reduced, the hospital is running efficiently and bed capacity is matched to demand. However there are several areas where concerns are still raised

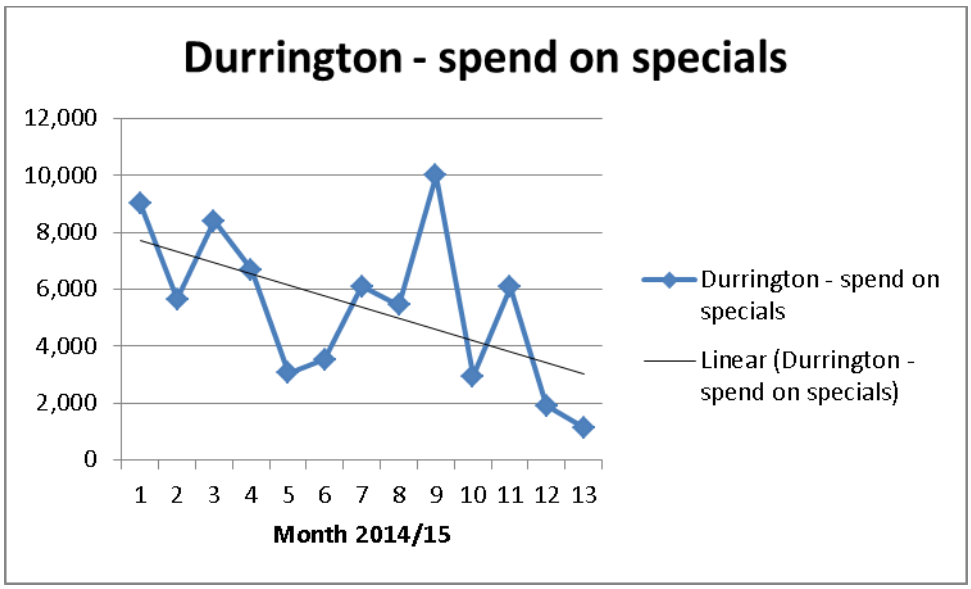
Initial analysis and findings of the skill mix reviews are included in Appendix B. The budgeted RN:Patient staffing ratio is demonstrated by shift alongside the RN:NA ratio. The Supervisory Ward Sister/Charge Nurse role is in addition to these ratios.

All ward staffing levels are assessed daily by the nurse in charge and escalated to the Directorate Senior Nurses where it is felt the staffing levels do not match the acuity/dependency of the patients or where there are concerns around any shortfalls against planned levels. Night staffing levels have been included for review but it is nationally recognised that staffing levels are reduced at night time. Several wards utilise varied shift patterns such as twilights to maximise staffing to peaks in demand.

From the investment in 2014:

- the supervisory ward sister role continues to develop and a development programme was completed for the band 7 ward sisters in 2014/15, with ongoing action learning groups and a ward accreditation process to be developed as part of this concept. As previously reported some wards have not been able to fully introduce the role due to the number of registered nurse vacancies and the requirement for them to be counted within the establishment shift numbers.
- All wards now have 2 band 6 posts, this has been a positive development across the ward areas in succession planning for our future ward leaders and allowing us to flex into increased winter capacity using these band 6s to ensure consistent and strong leadership in our escalation areas. It has also allowed us to introduce senior clinical leadership cover across 7 days.
- Following the October 2014 mid-year review further investment was provided for 2 areas.
  - Amesbury Ward (elective orthopaedics) uplifted the late shift to include an additional registered nurse on the late which reduced the ratio from 1:11 to 1:8 at a busy time of the day when patients are returning from theatre and helping with the management of the workload moving into the night . This has improved safety and quality on the ward, a

concerning theme from complaints on this ward was delays in care, and delays in obtaining pain relief. During Q4 the ward received only 1 complaint.
-Durrington Ward uplifted the night shift to include an additional nursing assistant due to the increasing requirement to provide 1:1 specialling to an increasing number of high risk patients. This resulted in a reduction in the use of specials overnight, which has now been eliminated – the remaining spend below is on day shifts.



3.7 April 2015 Findings:

3.7.1 There are 2 key areas within the general wards where investment is recommended:

- **Redlynch (Gastroenterology) and Pitton (Respiratory) Wards**

Staffing numbers on these 2 acute medical areas (Pitton, Redlynch) was uplifted during 2014 with all other wards but this didn't cover the weekend day shifts. This results in the RN to patient ratio rising above 1:8 (1:9) on Saturday and Sunday. There is no clear rationale for this differential as there is not a decrease in patient numbers, acuity, and dependency at these times. This leads to increased use of temporary staff due to patient acuity.

3.7.2 There are 2 areas that have identified staffing changes since the last skill mix review that are currently managed within the existing budgets and establishments:

- **Laverstock Ward (Plastic Surgery)**

Laverstock Ward are currently piloting an additional band 4 on the late shift 6 days per week. This is to support the activity that occurs later in the day without using an RN. Existing staff have changed their working patterns from short-shifts to long days and this is therefore achieved without impacting upon the budget. Of note – Laverstock is a ward that doesn't have a recruitment problem, uses low levels of temporary staffing and doesn't have an overspend.

- **Sarum ward (Paediatrics)**

The RCN has published guidance (Defining staffing levels for children and young people's services RCN Guidance 2013) for staffing in Paediatrics. During the Mock CQC visit in September 2014 non-compliance to RCN standards for staffing levels was raised by the Paediatric Matron on the group; her recommendation was that this should be reviewed. There is a Day Assessment Unit (DAU) co-

located with the ward which is open Monday to Friday 08.30 to 20.30. On the day shift the ward is staffed with 2 registered nurses and 1 Nursing Assistant and DAU is staffed with 2 registered nurses; these nurses work together flexibly to support the ward and DAU. On the night shift the ward was staffed with 2 registered nurses and 1 Nursing Assistant. DAU is closed at night. There is a 3rd RN at night on Tuesday nights due to an increase in acuity following the cleft list which means high dependency requirements.

Over the winter months due to concerns about the night shift, Sarum ward piloted a trial of 3 registered nurses at night with no nursing assistant. This has been managed within budget (cost per annum 26K) and immediately corrected the staffing concern. Qualitative feedback from the recent winter trial with 3 RNs has been extremely positive. Quantitative data is being analysed however early feedback suggests no ward closures occurred due to staffing levels when there were three RNs on nights and there has been a reduced number of transfers to Southampton PICU as we were able to provide high care to sick children.

3.7.3 There are also other areas to note, where further investment may be required but this is dependent on further analysis

- **Headroom** of 19% does not cover required headroom in all areas – see section 6
- **Downton** – continue to support staffing on Clarendon (private patients unit) without substantive staffing numbers. The provision of private and amenity beds is being reviewed and the outcome of this will identify future staffing requirements.
- **Amesbury** – The late shift was uplifted in the last skill mix review to improve the RN:patient ratio. However, the night shift remains at 1:16 and themes via RTF and Friends and Family identify lateness of medications at night and noise. A pilot is required to trial the use of an RN twilight shift compared to increasing the night shift by an additional RN
- **Avon Ward** - Review of staffing was undertaken in 2012 with no funded changes to establishment. Data from Safecare is currently being analysed by Allocate. Further benchmarking with a similar clinical setting is also in progress. Using professional judgement, an increase of 2.3WTE RN and 5.0WTE Band 3 NA has been proposed to ensure adequate provision for 3 respiratory and 18 acute spinal injury patients. Of note this ward currently has 4 closed beds due number of staff vacancies. The recommendation from this skill mix review is to continue the evaluation and benchmarking exercise for this area in order to inform any increase in capacity.
- **Radnor** – layout of new unit means that when side rooms are all in use there is the need for a 'runner' overnight. Further analysis is required on this regarding occupancy and activity.
- Staffing on **Whiteparish** reduces at the weekend and further analysis of this is required using Safe Care data.
- **Redlynch** – further analysis of the use of specials at night and the requirement for an additional NA. Safecare data to be reviewed
- **Pitton** has become a dedicated respiratory ward with an increasing acuity which requires analysing via Safe Care data and other quality metrics to inform the next skill mix review.

4. **<u>Maternity</u> –** Not previously included in the skill mix review

NICE Safe Midwifery Staffing for Maternity Settings

This recently published guidance is being considered by the Head of Midwifery alongside the Birthrate Plus recommendations. Birthrate Plus is a validated tool used as a framework for workforce planning in maternity units. The Trust commissioned Birthrate Plus to carry out a review of maternity staffing requirements over a 3 month period Oct 2014 – Jan 15. The report was shared with the Trust in March 2015 and is forming the basis of the maternity staffing review in order to

work towards a midwife to birth ratio of 1:32. As an immediate investment the Head of Midwifery is recommending phase 1 of this work to fund 5 Band 6 midwives. The maternity unit ran at an average midwife to birth ratio last year of 1:40, this is much higher than national recommendations.

5. **Emergency Department** – Not previously included in the skill mix review

NICE Safe Staffing for Accident and Emergency Settings:
This guideline had been released in draft format prior to the pause on NICE staffing publications. The Lead Nurse for Emergency Medicine has completed a gap analysis and based her skill mix review on the key recommendations as well as ECIST (Emergency Collaborative Intensive Support Team) feedback. Key recommendations are for:

- additional staffing into Band 6 posts to ensure senior nursing cover across shifts 24/7 (an increase required of 2.76 WTE)
- introduction of a band 5 flexible nurse to cover Majors and Resuscitation areas depending on clinical need, in order to increase the nurse to patient ratios in these areas at times of peak demand

6. **Allocate Electronic-Rostering and Safe Care Module:**

In order to enhance rostering efficiency and understanding of patient acuity and dependency the Trust has been implementing the Allocate E-Rostering system and SafeCare Module, utilising the Shelford tool as endorsed by NICE in guiding a systematic approach.

6.1 Headroom
E-rostering is now in place across all inpatient areas with Maternity the most recent department to 'go live'. Trust data available from the Allocate system is showing that the average headroom requirement is 22% which is 3% over and above the current headroom available of 19%. This impacts on the wards ability to cover the shifts required, which then incur bank/agency costs, and so further review is a key recommendation of this report. Due to the variability in managing within this headroom a targeted approach is advocated in order to assist those areas who cannot manage within a 1% study leave ceiling due to high level of newly qualified and overseas nurses on preceptorship programmes.

6.2 E-Rostering Performance
During 2015/16 the Safer Staffing Steering Group are focussing on efficiency of rostering through the reporting and review of KPIs generated through the Allocate system via Roster Perform. This data has become available from April 2015. The Trust is also one of 22 acute organisations involved in the Lord Carter Programme reviewing productivity and efficiency, with nurse staffing a key workstream of this. The work to date is informing our rostering policies and practices.

6.3 Safe Care Module
SafeCare has been rolled out during Q4 2014/15 to all inpatient wards (except ITU, ED and Paediatrics) and analysis is only now becoming available for the early implementers. The commitment of ward leaders has been excellent and patient acuity/dependency data is being entered for every shift onto the SafeCare module by all the wards. Data entries align with information taken directly from the rosters to provide evidence of either excess levels of staffing or staffing shortfalls and these can be extracted into a reporting format. All information needs to be treated with caution at this stage as the system develops, as wards are only beginning to interpret the tool and at present no account is taken of other nursing tasks which are built in (i.e. patient escorts from the ward, large burns/plastics dressings etc). The output of this module should allow us to monitor where nurse staffing is or isn't matching patient demand (based on acuity and

dependency, and key nursing activities). This data will be reported through the Safer Staffing Steering Group and will inform future planning.

7. Recruitment and Retention:

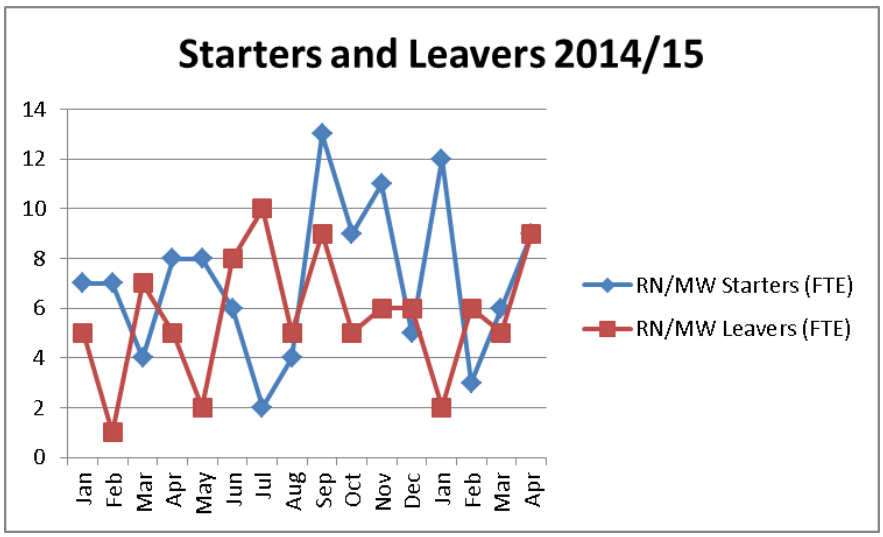
The high number of nursing vacancies within the Trust has continued and there are active recruitment programmes both within the UK and overseas. Unfortunately, despite these efforts some vacancies have still not been recruited to following the nursing uplifts agreed in 2014. There is an ongoing high usage of temporary nursing staff across the Trust with work ongoing to reduce this requirement as successful recruitment takes place.

A total of 32 newly qualified nurses started in the Trust from October 2015 – April 2015. Open days will continue for nursing, midwifery and AHP students who are starting year 3 of their training, in an attempt to showcase the opportunities and benefits in working for the Trust. Many are being recruited up -to 10 months pre-qualification and this will be an opportunity to encourage applications for positions here. Applicants for current band 5 positions are predominantly from student nurses who will qualify in September 2015.

A total of 36 nurses have been recruited from Italy since December 2014 with a further 2 due to start in September 2015.

The Trust has committed to supporting the development of clinical educator posts to support nursing staff in practice – this will include those on the preceptorship programme, overseas recruits, return to practice, and those working towards the Care Certificate. Work is also underway to review and develop Band 4 roles further into areas experiencing a high vacancy factor such as elderly medicine.

The graph below shows the number of starters and leavers. Despite the turnover being relatively low our vacancy levels remain elevated, particularly in some areas (Farley, Winterslow, Amesbury and Spinal). It is imperative that we remain focussed on recruitment programmes. Competition against surrounding Trusts, an increasing number of staff choosing to work for agencies and an ageing workforce will continue to impact the existing vacancy rate. There will be no benefit felt from any national increase in the number of University training places for at least 3 years and attrition from nursing training as well as leavers in the first year are recognised problems nationally.



8. Recommendations:

The Board is asked to note the findings of the report and agree the areas for action:

8.1 Investment

- Support a pilot period of additional staffing for Pitton and Redlynch to have equal RN staffing at the weekends as the weekdays, with full evaluation of cost and quality outcomes. Approximate cost £16, 874 (Pitton) and £16, 874 (Redlynch). Total = £33,748
- Support additional staffing for ED to increase number of band 6 nurses by 2.76WTE in order to provide 24/7 cover, approximate cost £117, 954. This has been implemented using non-recurring Resilience monies for 2015/16 which the Trust received in Q1. Recommend that this is fully evaluated through the year in order to inform 2016/17 investment.
- ED Band 5 resus/flexible nursing resource 1.91 WTE £65,799 to provide nursing resource in majors/resus. This has been implemented using non-recurring Resilience monies for 2015/16 which the Trust received in Q1. Recommend that this is fully evaluated through the year in order to inform 2016/17 investment.
- To work towards a 1:32 ratio requires phase 1 immediate investment of 5 band 6 Registered Midwives at a cost of £187, 000.

Headroom:

- Review the current headroom of 19% to move towards 22% where required and as reported in Allocate. Approximate cost across all clinical areas £685, 979 but a phased approach is advocated targeted at those areas with a high number of newly qualified or overseas nurses with high study leave requirements. It is recommended that 3 areas are identified with example costs in the region of - Pitton £24,851, Redlynch £22,195 and Avon £27,445 giving a total cost of £74,491.

8.2 Further analysis to inform future skill mix reviews:

- Medical Directorate to review and evidence the requirement for an additional NA staffing on Redlynch at night to support reduction in specialling. Analysis of Safecare data required.
- Medical Directorate to explore and analyse the nursing resource requirements put forward in the ED skill mix paper to enhance cover in the Minors and the Paediatric area
- Medical Directorate to review the nurse staffing requirements on Pitton ward now it is a designated respiratory ward using quality indicators and Safe Care data.
- Surgical Directorate to review and evidence the need for a Radnor band 2 (nights) in response to the change to environment
- MSK Directorate to assess the effectiveness of changing a late band 5 to a twilight on Amesbury to improve the timings of drug rounds at night whilst not impacting on the transfers from Recovery later in the day
- MSK to assess the staffing requirements to support 21 beds inclusive of 3 HDU beds on Avon. Fully analyse nurse staffing within the context of on-going full review of spinal services.
- MSK Directorate to assess and evaluate the need for an additional Band 4 on Laverstock late shift 6 days per week, currently being managed within budget. This should then inform the next skill mix review.

- CSFS Directorate to continue the winter pilot of a 3rd RN on Sarum ward at night which is currently being managed within budget and evaluate the impact to inform the next skill mix review
- Clarendon work to be completed so that staffing can be agreed which will remove staffing requirements from Downton
- Work with HR to fully embed the use of exit interviews for all nurse leavers

8.3 Trust Board Actions:

- Agree areas for investment from this skill mix review paper with full impact analysis to be included in next skill mix review due December 2015
- Support the actions listed above in 8.2 with reported outcomes of this work incorporated into next skill mix review due December 2015
- Support the analysis work from the Safecare tool across the ward areas to inform future skill mix requirements
- Support the continuation of recruitment and retention activities

Appendix A

NQB Expectations and Trust Status April 2015

Expectation	Progress	Action
Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery, and care staffing capacity and capability	• The Board receives a number of reports each month which provide information on quality and standards of patient care. Board agrees ward based staffing requirements through the 6 monthly skill mix review and is also informed through the monthly safer staffing reporting and quality indicators report.	
Processes are in place to enable establishments to be met on a shift to shift basis	• Daily staffing levels recorded on a shift by shift basis through allocate e-roster system. • Review of staffing at the twice daily bed meetings to identify any areas of risk and agree action required. This often involves moving staff around if there are gaps. • Ward level capture of 'red flags' as described in NICE guidance 2014.	
Evidence based tools are used to inform nursing, midwifery and care staffing capacity and capability	• During Q4 the allocate safer care module was rolled out which is based on the Safer Nursing Care Tool. This is an evidence based tool that enables nurses to assess patient acuity and dependency. This data will be measured continuously in order to inform future skill mix reviews. • Skill mix reviews do triangulate nurse sensitive indicator data and professional judgement alongside the above. • Allocate roster perform data and safer care module data to be reported into the Safer Staffing Steering Group by each Directorate. This group is chaired by the DoN. • NICE have recommended a ratio of one Registered Nurse (RN) to eight patients 1:8. This is not a mandated requirement and other factors need to be considered e.g. patient acuity and dependency, as well as support roles such as Assistant Practitioners. The 1:8 ratio is reviewed as part of the skill mix review • The Trust commissioned Birthrate Plus to carry out an extensive 3 months review of our midwifery staffing. This report was shared with in March 2015 – recommendations form part of the skill mix review paper. NICE guidance on maternity staffing was also published in February 2015 which will also form part of this review. • The Chief Nursing Officer for England has produced a document Safer Staffing: A Guide to Care Contact Time (Nov 2014) which strongly recommends that Trusts assess care contact time on their wards. It is important to note that there are no validated tools published for the process but suggestions given to using productive ward tools or a system of time and motion clocks. We have used some of this methodology to evaluate the pilot of a band 1 ward assistant in elderly care in showing how direct contact time can be increased through such role development. • The Director of Nursing is working through the Safer Staffing Steering Group on how direct contact	Safer Care data to be used as the basis of future skill mix reviews. Directorate reporting into Safer staffing Steering Group Complete midwifery case and commence monthly reporting through Nursing, Midwifery, Therapy workforce steering group Scope and plan how care contact time will be introduced.

	time can be utilised within the Trust in a way which is meaningful.	
Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns	• Raising Concerns Policy in place for many years • NMC revised code – information has been sent out to all staff and presentations delivered at NMF • NMC revalidation • Nursing and Midwifery and AHP Strategy due for launch June 2015 – very clear on responsibilities of nurses and midwives to put the interest of people in their care first.	Revalidation readiness Strategy launch
A multiprofessional approach is taken when setting nursing, midwifery and care staffing establishments	• Ward leaders are involved in the skill mix reviews and establishment setting • Roles beyond nursing are considered as part of this process e.g. band 1 ward support role on Winterslow, admin support for nursing staff on Britford • Key workforce groups are multi professional • Skill mix review papers are fully worked up with input from executive colleagues	
Nurses, Midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties	• Current headroom is set at 19% to cover sickness, leave and continuous professional development • Through Allocate e-rostering system this has been monitored over the last 6 months which is showing a need for 22% which is the national average allocated. • The impact of this is being explored further by the DoN • Ward leaders were made supervisory in 2014. This has released time for them in their management of the ward, monitoring of quality standards, and most importantly being visible clinical leaders working alongside staff and coordinating care. • A Roster Policy is in place which has been revised since the implementation of Allocate. E-rosters are monitored against the KPIs for managing annual leave etc through the Safer Staffing Steering Group. • Mandatory training and appraisal rates are monitored via the workforce report through the Directorate 3:3s, and has identified a need for improvement through 2015. • Clinical educator posts have been agreed which will allow greater supervision of staff in practice as part of the preceptorship programme, obtaining the Care Certificate, and the introduction of a Return to Practice course during 2015	Headroom to be revisited
Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every 6 months on the basis of a full nursing and midwifery skill mix review	• Safer staffing report is presented to Board each month detailing down toward the planned versus actual nurse staffing • Full workforce report developed 2015 which covers all staff groups • A skill mix review is presented to the Board twice per year. • These are published on the Trust's website	
NHS Providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, dept on each shift	• Displayed on all wards • New information Boards being implemented May 2015	
Providers of NHS services take an active role	• Recruitment plans in place and continuously reviewed.	RTP scheme to be

in securing staff in line with their workforce requirements	• Safer Staffing Steering Group oversees this work. • EU recruitment campaign running through 2015/16 • Recruitment and retention initiatives under constant review – includes rotational posts and return to practice • Close working with local universities and HEW	implemented Recruitment and Retention Plan 2015/16 to be developed

Appendix B
Six Monthly Skill Mix Review June 2015

Ward	RN: Patient Ratio (Early)	RN: Patient Ratio (Late)	RN: Patient Ratio (Night)	% RN : HCA (based on establishment)	Comments / Recommendations
Whiteparish	1:5 (1:6)	1:5 (1:6)	1:5.6 (lower with twilight)	72:28	Review band 5 to give 7 day cover. Consider future review of increasing day shift and 24hr band 6 cover. Analyse safecare data
Tisbury	1:4.5/2.5	1:45/2.5	1:5.75	75:25	Staffing currently appears adequate
Pitton	1:6.75(1:9)	1:6.75(1:9)	1:7.6	59:41	Review band 5 to give 7 day cover. Band 7 vacancy now filled. Vacancies remain since previous staffing uplift and impacting on respiratory skills
Redlynch	1:6.75(1:9)	1:6.75(1:9)	1:7.6	57:43	Review band 5 to give 7 day cover. Consider band 2 at night to reduce use of specials.
Farley	1:6	1:6	1:10	55:45	Staffing currently appears adequate
Durrington	1:7	1:7	1:10.5	55:45	Additional NA on night shift in place. Review use of specials in the day
Winterslow 40	1:8	1:8	1:13.3	49:51	Review roles of band 4 and band 1. For 40 patients consider increasing band 2 on late
Pembroke	1:5	1:5	1:5	81:19	Staffing currently appears adequate
Hospice	1:5	1:5	1:5	60:40	Ensure 2 RN on each shift – review impact on temporary staff usage
Amesbury	1:6.4	1:8	1:16	50: 50	High levels of vacancy continue. Pilot additional RN on night by using a band 3 instead of 5 on late or use of twilight shift. Additional RN alone approximate cost £85k
Chilmark	1:6 (8)	1:8	1:12	55:45	Staffing currently appears adequate
Burns	1:6 (1:3 Paed)	1:6 (1:3 Paed)	1:8.5	80:20	Review need to cover weekends as weekdays with band 2. Approximate cost £14,973. Analyse safecare data
Laverstock	1:5.2	1:8.6	1:8.6	66:34	Using current establishment increase Band 4 on late 6 days per week (by staff undertaking long days)
Avon	1:4.25	1:5.6	1:10.5	46:54	4 beds remain closed. High level of vacancy. Full analysis in progress with comparison to other SIU and safecare data
Tamar	1:7	1:7	1:10.5	45:55	Increase in number of 5 man turns with impact on night shift. Analyse safecare data

Britford	1.5.8	1:5.8	1:10	64:36	Trial of ward admin assistant within budget. Analyse Safecare data for additional RN
Downton	1:7	1:7	1:12	62:38	Review establishment and requirements to support Clarendon
DSU ward	1:7	1:7	N/A	78:22	Staffing currently appears adequate
Sarum	1.8 (5)	1.8	1.5)	73:27	Pilot increasing RN to 3 at night from 2 for 6 nights per week. Currently being managed within budget
ED					Increase number of band 6. Flexible use of band 5 in resus/majors
Radnor	ICS Levels of care 1:1 or 1:2				Consider additional band 2 at night

Numbers in brackets denotes weekends

Equality & Diversity Annual Report 2015

PURPOSE:

This paper provides one of the regular six monthly equality and diversity updates to the board.

The Trust has a statutory obligation under the Equality Act 2010 to publish a range of monitoring information relating to patients and staff. This report is one of the ways in which the Trust fulfils its obligations.

This report provides the board with an update and progress report in relation to the EDS (Equality Delivery System) and contributes to meeting our PSED (Public Sector Equality Duties) and publishing our annual data on the Trusts main functions in relation to equality.

EDS Progress February 2015 to August 2015

As part of our implementation and ongoing commitment to use the EDS process, working with the EDS Leads we have reviewed our performance against the refreshed and newly launched EDS2 criteria and guidance.

The 2015 EDS2 annual review RAG gradings are predominately green coloured which illustrates that the Trust is in the 'achieving' category. In one area we are graded as purple, which is the highest grading colour and illustrates that we are 'excelling' in this particular objective, Outcome 3.2, 'The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations.'

The final 2015 assessment shows positive examples of good practice, including equality becoming mainstreamed within services and processes at the Trust.

The EDSG (Equality and Diversity Steering Group) has developed an Equality and Diversity Service Plan which identifies the Trusts 4 strategic equality objectives with specific actions and outcomes.

The EDS has been integrated into the strategic business of the Trust through both the Quality Account and Annual Strategic Plan.

WRES (Workforce Race Equality Standard)

The evidence of the link between the treatment of staff and patient care is well evidenced for BME staff in the NHS, to this end the NHS have launched the WRES (Workforce Race Equality Standard). We have collated data from April 2014 to March 2015 and will publish this information later in the year.

Our Workforce

This section of the report highlights headline workforce, gender pay & grievances data, refer to Appendix 1 for further detailed data.

Occupations by Ethnicity – At the Trust 9% of the workforce describe themselves as from the BME (Black and Minority Ethnic) communities. The Office for the National Statistics estimates that 4.7% of Wiltshire population identify as BME. Of the 9% BME staff working in the Trust 44% work in roles from band 4 and below, 33% in band 5 to 6 and 19% in band 7 and above.

Age Range of Workforce - The chart shows the proportionality of staff ages across the workforce. Of the staff aged over 60 who work at the Trust, 13% work in band 4 and below positions and 61% aged 40-59 work in band 7 and above positions.

Gender Pay Gap - The average mean salary for women is £27,195 and the average mean salary for men is £35,954 (appendix 2). The total average salary for both men and women is £29,449. This is not unusual as this depicts a trend that is reflected across most sectors whereby a larger proportion of senior roles or higher skilled roles within the organisations are held by male employees. Of the male staff employed at the Trust 34% work in band 7 or above positions, of the female staff working at the Trust 15% work in band 7 or above positions. All staff at the Trust have the same opportunities to work flexibly, with on site child care arrangements, home working options, carers leave and flexible hours which contribute to the opportunities for staff with childcare and carers responsibilities.

The gender balance on the Executive Board with its current gender make up of 3 men and 3 women at Executive Director level and 2 women and 4 men at Non Executive Director level.

Sexual Orientation - In total 84% of our staff describe themselves as heterosexual/straight, 15% either did not want to disclose their sexual orientation or chose to tick the undefined category, 1% of our workforce has identified themselves as LGBT (Lesbian, Gay, Bisexual or Transgender).The Government Equalities Office has stated a reasonable estimate of 5% to 7% of the population consider themselves as LGBT. The Trust will continue progressing with the sexual orientation agenda to develop a culture of fairness and inclusiveness.

The Trust supports the LGBT agenda and has an active LGBT staff network called the RainbowSHED, a dedicated LGBT Staff Champion and a LGBT Staff Buddy Programme. The Trust has been successful with the Stonewall Health Champions Programme and was awarded 23rd place in this year's index.

NHS Jobs – applications, shortlisted and appointed - The Trust has analysed NHS Jobs data from March 2014 to April 2015 which illustrates applications, shortlisted and appointed under ethnic background, gender, disability, age, region and sexual orientation, (refer to Appendix 2). The report continues to identify disproportionality with White applications to appointments in comparison with BME British applications to appointments; this theme also applies to female applications to appointments in comparison to male applications to appointments. The EDSG will plan to revaluate this ongoing theme through our E&D service planning process.

Staff Training on Equality and Diversity - To date approximately 70% of our workforce have undertaken mandatory equality and diversity training, the national average for acute Trusts being 63% and the best acute trust score at 85%.

Staff Survey - Details of the staff survey and action plan can be viewed following this link:www.salisbury.nhs.uk/aboutus/media/pages/salisburyscoreswellonindependentstaffsurvey.aspx 90% of our staff believe that the Trust provides equal opportunities for career progression or promotion. 11% of the staff completing the survey identified

they have experienced discrimination at work in the last 12 months; the national average for Acute Trusts is 11%. We are working with the 'Staff Survey Action Plan' team to resolve some of these issues.

Workforce Data - Further workforce data is available under appendix 3, which also includes equality data on grievances, dismissals and complaints about discrimination. In 2014/15 89.5% of promoted staff were white, 10% were BME. This is roughly the same as the proportion of white to BME staff in the workforce as a whole. Further disaggregated data can be sought from the author of this report.

Occupations by Gender - Of the Trusts female workforce, 39% are full time and 61% are part time. In total 68% of male staff are full time and 32% are working part time. The gender balance varies considerably by occupational group.

Our Patients (Different Protected Characteristics)

Feedback from the National Inpatient Survey 2014 showed that when patients were asked if they felt they were treated with respect and dignity, 83% said "always" and 15% said "sometimes". Patients were asked to score their overall care on a sliding scale between 0 (I had a very poor experience) and 10 (I had a very good experience). 28% rated their overall care as 10 with a further 22% rating it as 9.

Appendix 3 describes the protected characteristics of patients attending outpatients and inpatients from January 2014 to December 2014. The equality data includes, age, ethnicity, disability, religion, gender, transgender, pregnancy and maternity attendances. The Trust currently does not collate sexual orientation data from patients.

In total there were 39,169 female patients and 37,929 male patients. 85% patients described themselves as White. 3% patients described themselves from a BME (Black Minority & Ethnic) community, whilst 12% of patients did not specify or not stated.

The hospital has a varied distribution of age ranges. 21% of our patients are aged 19 or below, 49% of our patients are within the age category of 20 to 60, and 29% of our patients are aged 60 and above.

In total there have been 30 different PPI (Public and Patient Involvement) activities including storytelling, real-time feedback and focus groups, for further information contact the PPI team.

Key Activities 2014/15

We have provided additional support for staff through the publication of accessible E&D handbooks available on the staff intranet pages. The handbooks will be reviewed annually to ensure the information remains relevant and up to date.

The E&D team are supporting the Elevate Project with 'Magna Songs', a music workshop performance by pupils from Exeter House special school, in collaboration with the music company La Folia and the Salisbury Independent Hospital Trust.

The E&D department has continued to engage with staff, patients and the wider community. A quarterly newsletter is published both internally and externally, this has led to EDS members contributing to articles and engaging with our services through its publication.

The E&D team run monthly awareness events for example, in February the team led on the Trust wide LGBT History month that involved members of the local LGBT community and local statutory organisations. The team led an open Q&A session in Springs Restaurant and provided workshops for LGBT Allies. Over 50 people attended this event which received positive feedback.

The Trust is a member of the Equality and Diversity Public Sector Lead Officer Group whose membership includes equality representatives from Wiltshire and Swindon statutory organisations. We are continuing to work towards the collaborative outcomes highlighted in this charter.

The Trust has reapplied for the Mindful Employers Charter, The Charter is a voluntary agreement seeking to support employers in working in the spirit of its positive approach, which is aimed at increasing the awareness of mental health in the workplace and supporting organisations in recruiting and retaining staff.

Equality Analysis (EA)

Highlighted within this report are examples of Equality Analysis (EA) that has been undertaken across the Trust during this period. All policy authors complete an EA for new and updated policies. An example of how the EA has been used to initiate discussion on workforce equality was through Managing Implications of Organisational Change. As a result of completing an EA the policy now stipulates that an EA should be completed for each piece of organisational change.

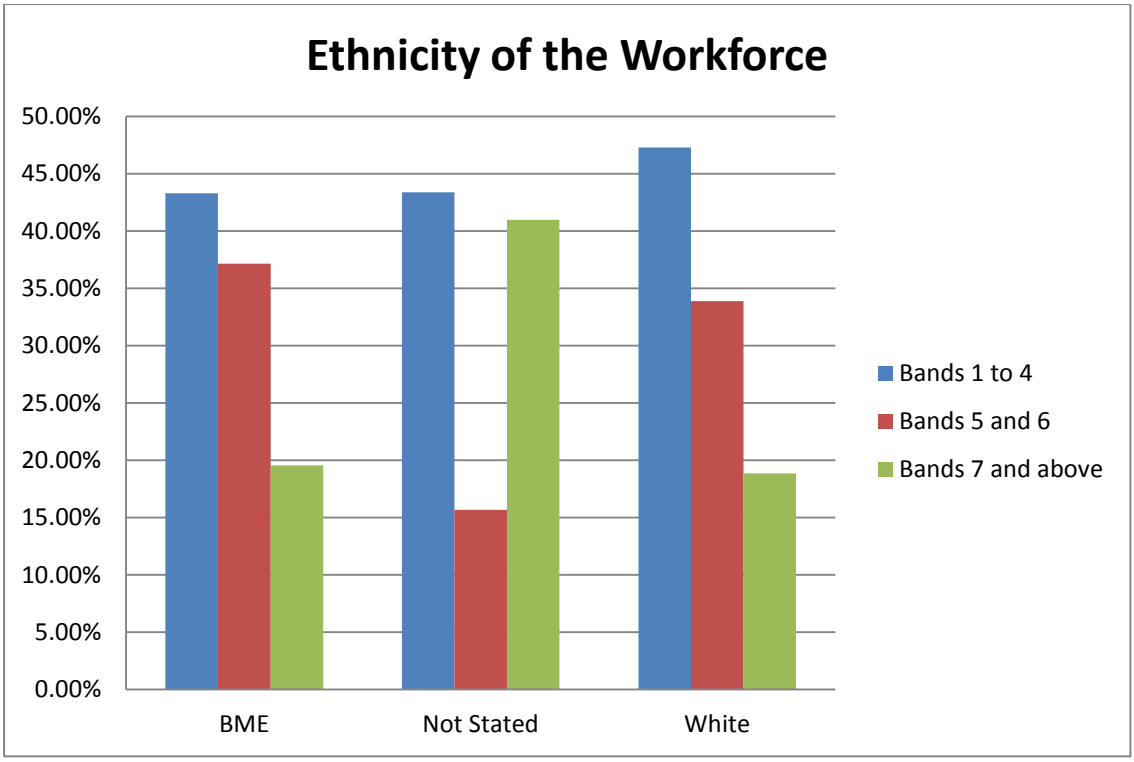
Equality Compliments and Complaints from Patients

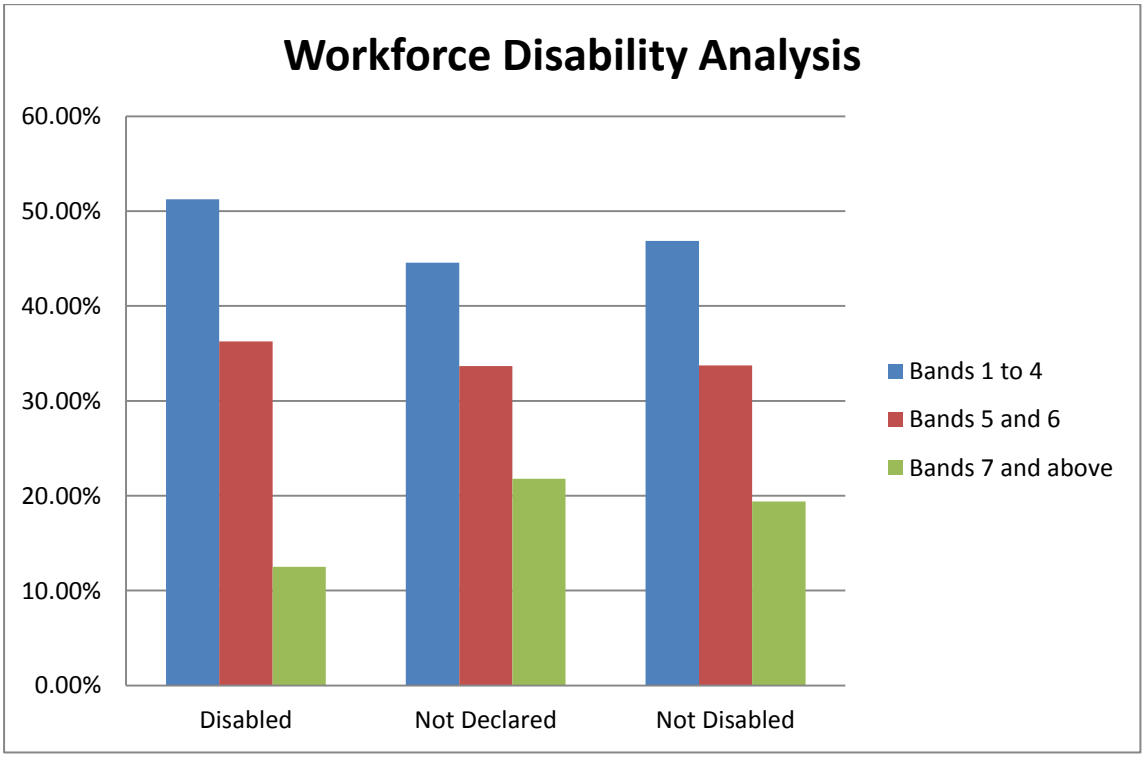
In 2014/15 the Customer Care Team received 2827 compliments from many wards and departments. There were two complaints about discrimination: one where a patient was making racist comments about a member of staff and the other where the patient felt judged by staff for their parenting choices due to their nationality.

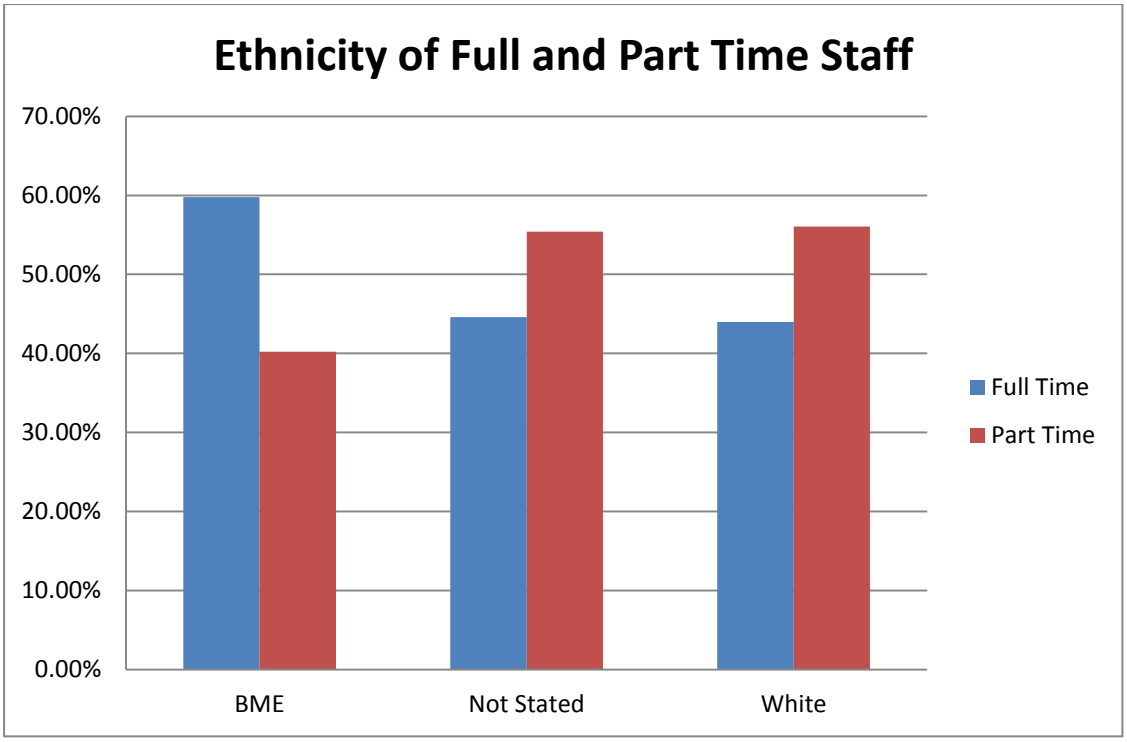
ACTION REQUIRED BY THE BOARD:
Note the report and its contents.

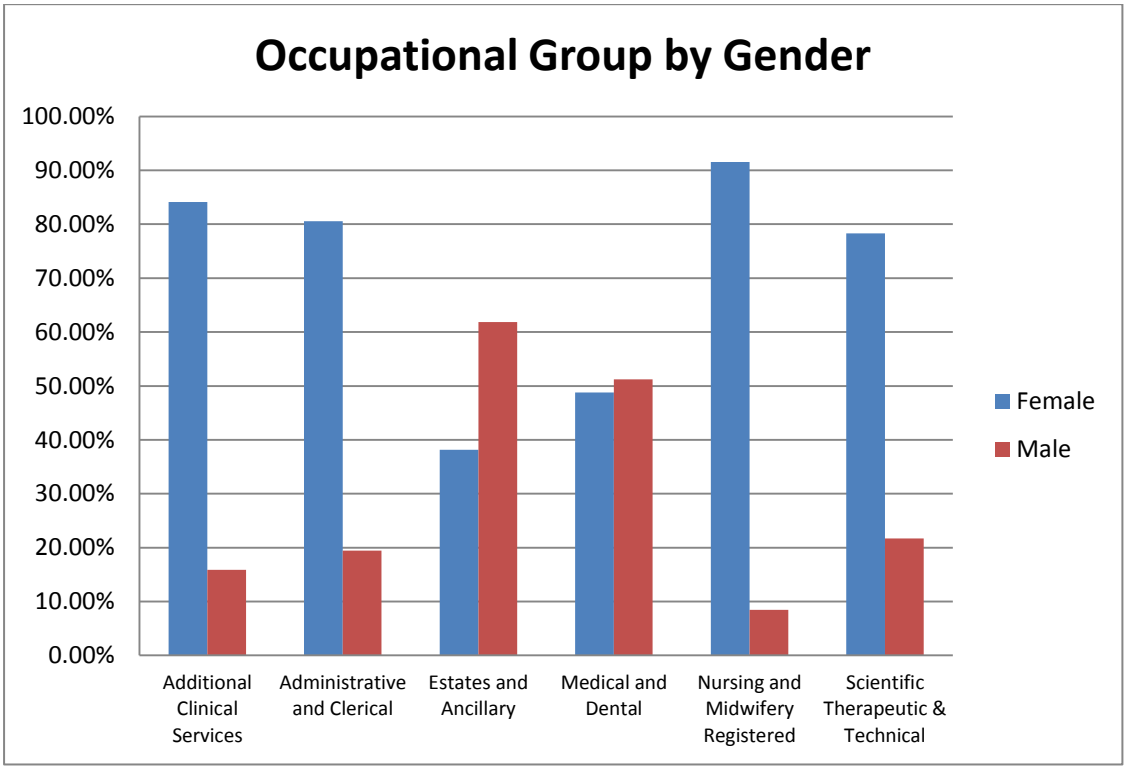
ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:
Appendix 1 – Workforce, Gender Pay Gap & Grievances Data 2014/15
Appendix 2– NHS Job Equality Data (applied, shortlisted & appointed) 2014/15
Appendix 3 – Patient Equality Data Dec 2013 – Jan 2015

AUTHOR: **PAMELA PERMALLOO-BASS**
TITLE: **HEAD OF EQUALITY & DIVERSITY**


Ethnicity of the Workforce
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
BME
Not Stated
White
Bands 1 to 4
Bands 5 and 6
Bands 7 and above


Workforce Disability Analysis
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Disabled
Not Declared
Not Disabled
Bands 1 to 4
Bands 5 and 6
Bands 7 and above


Ethnicity of Full and Part Time Staff
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
BME
Not Stated
White
Full Time
Part Time


Occupational Group by Gender
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Additional Clinical Services
Administrative and Clerical
Estates and Ancillary
Medical and Dental
Nursing and Midwifery Registered
Scientific Therapeutic & Technical
Female
Male

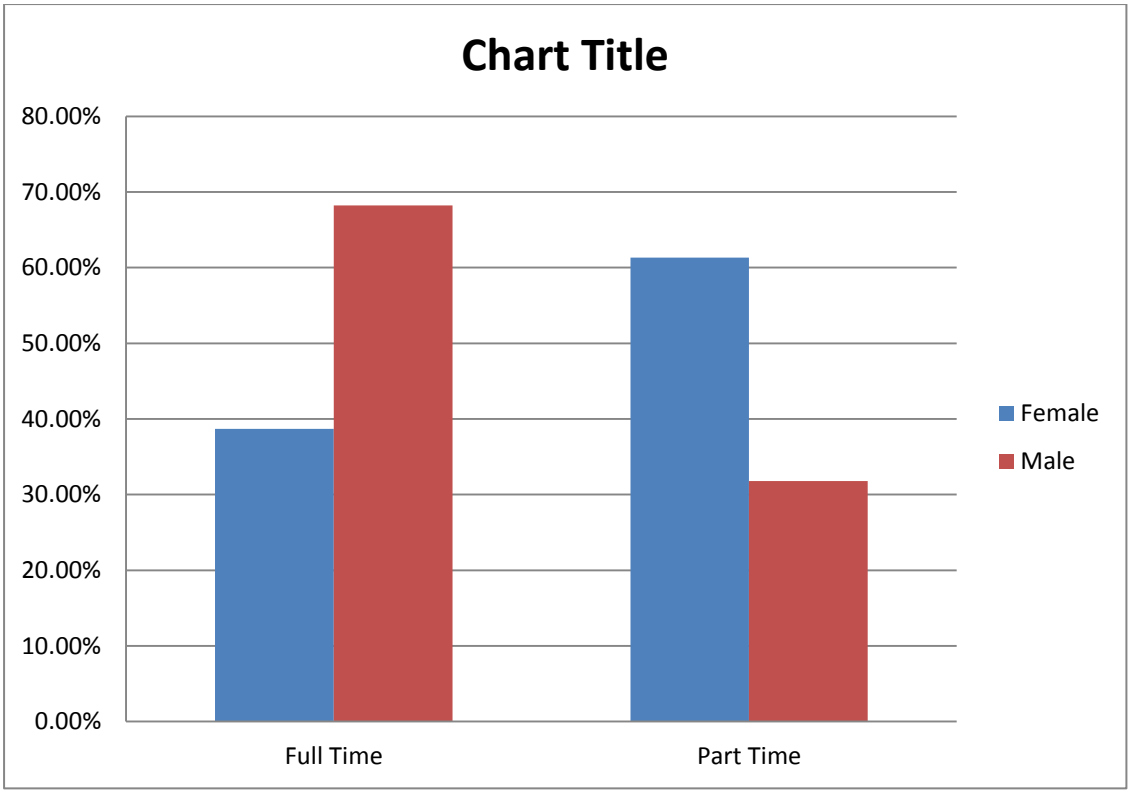
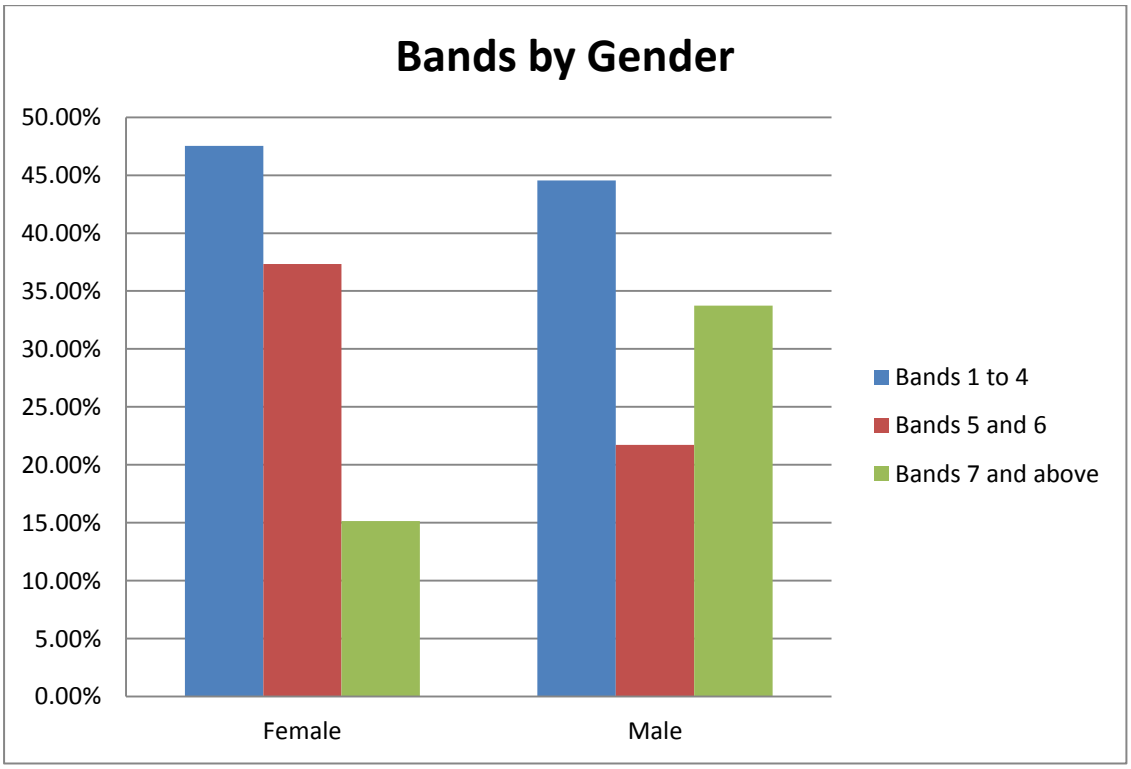
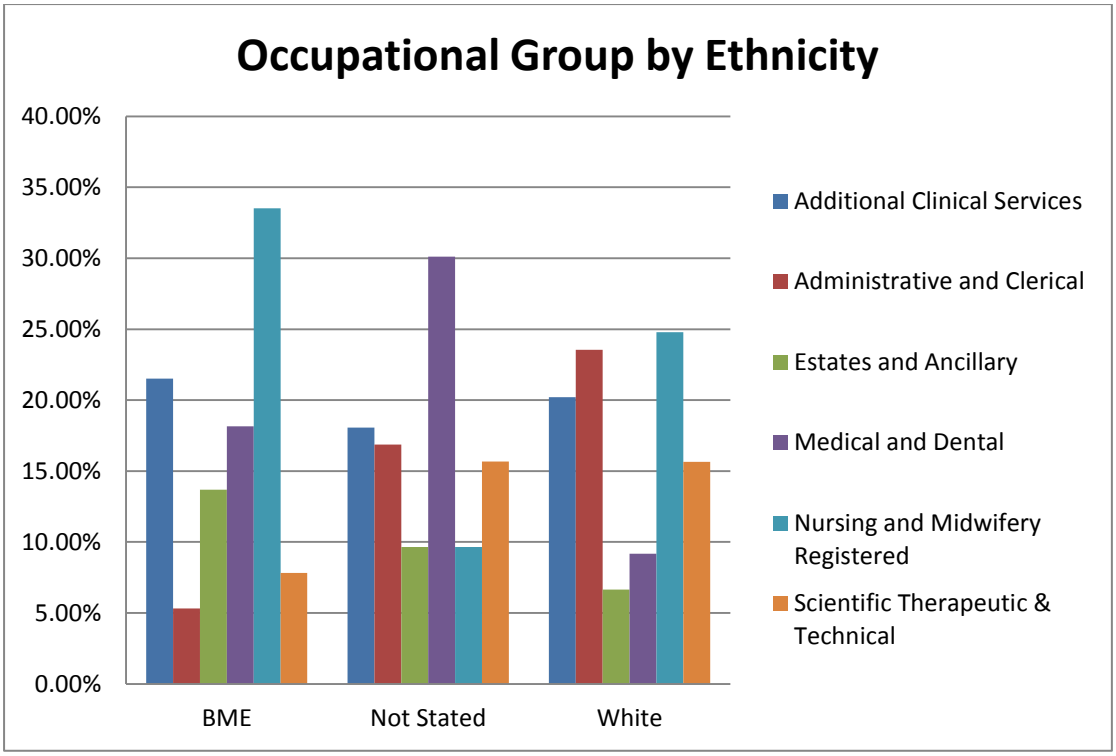
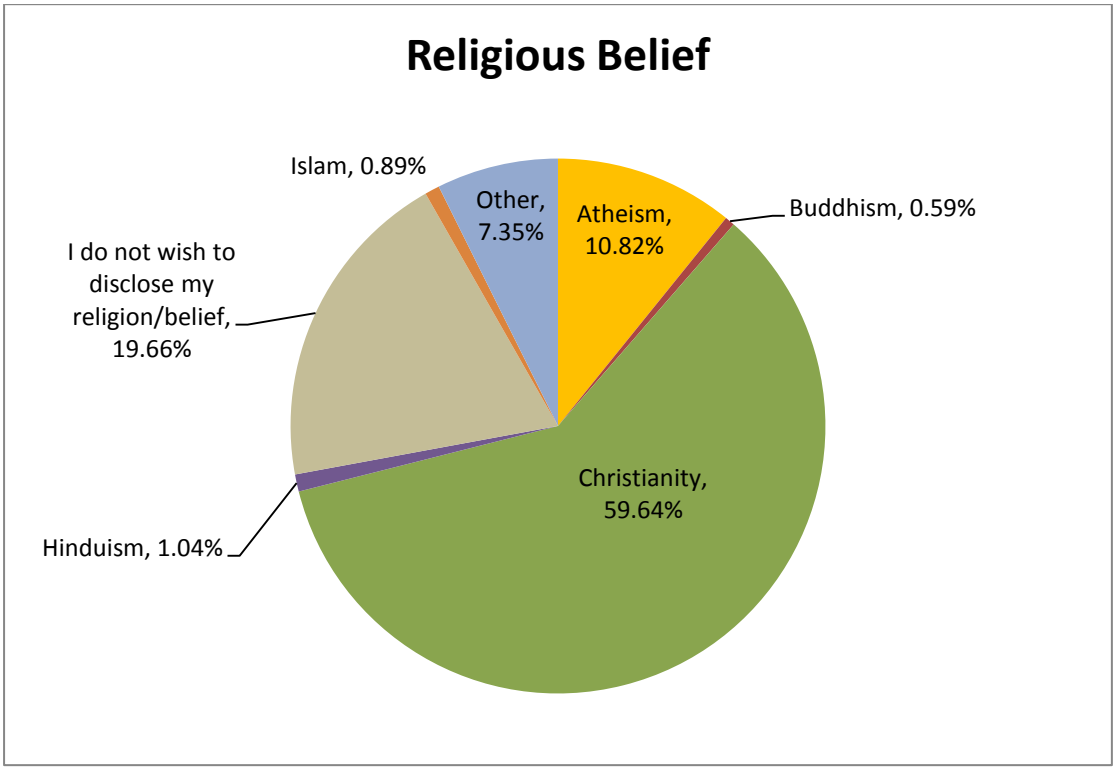
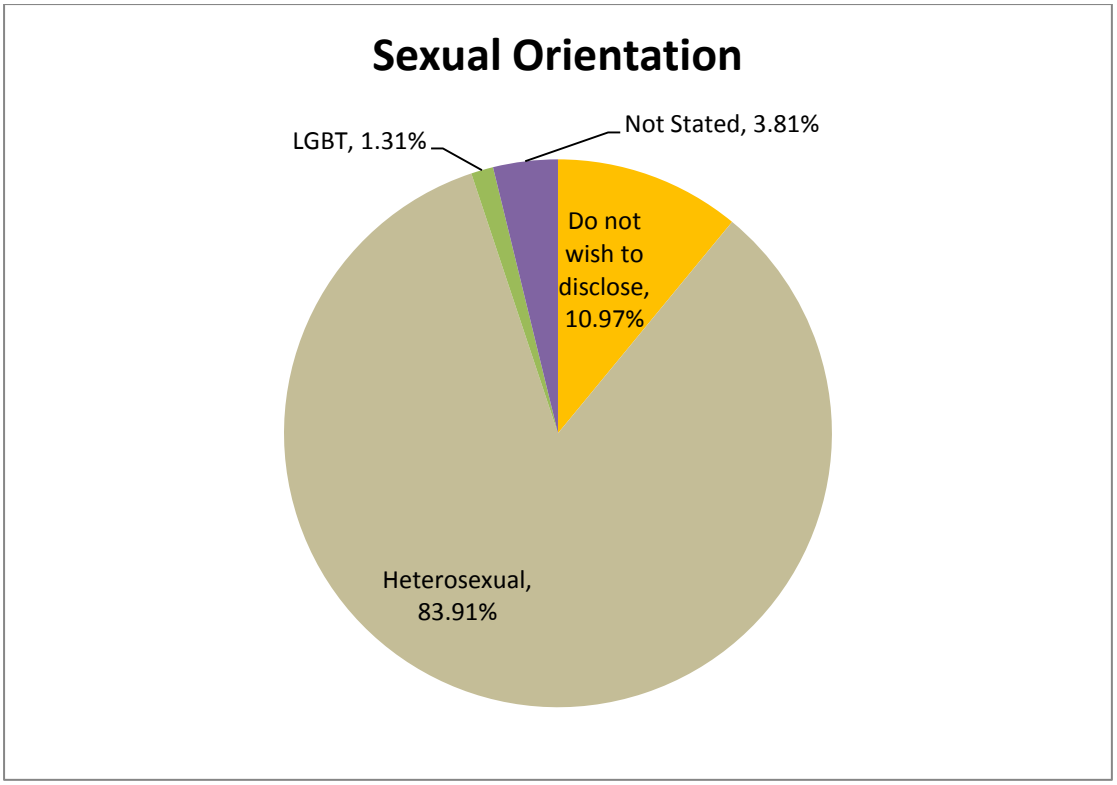


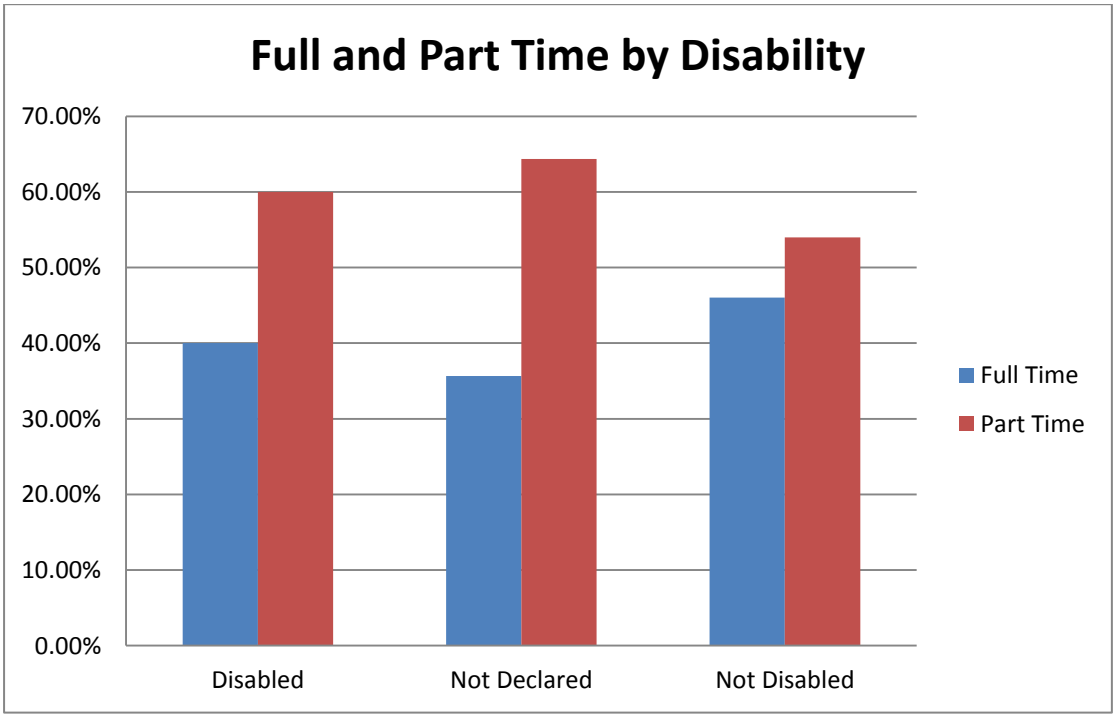
Chart Title
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Full Time
Part Time
Female
Male

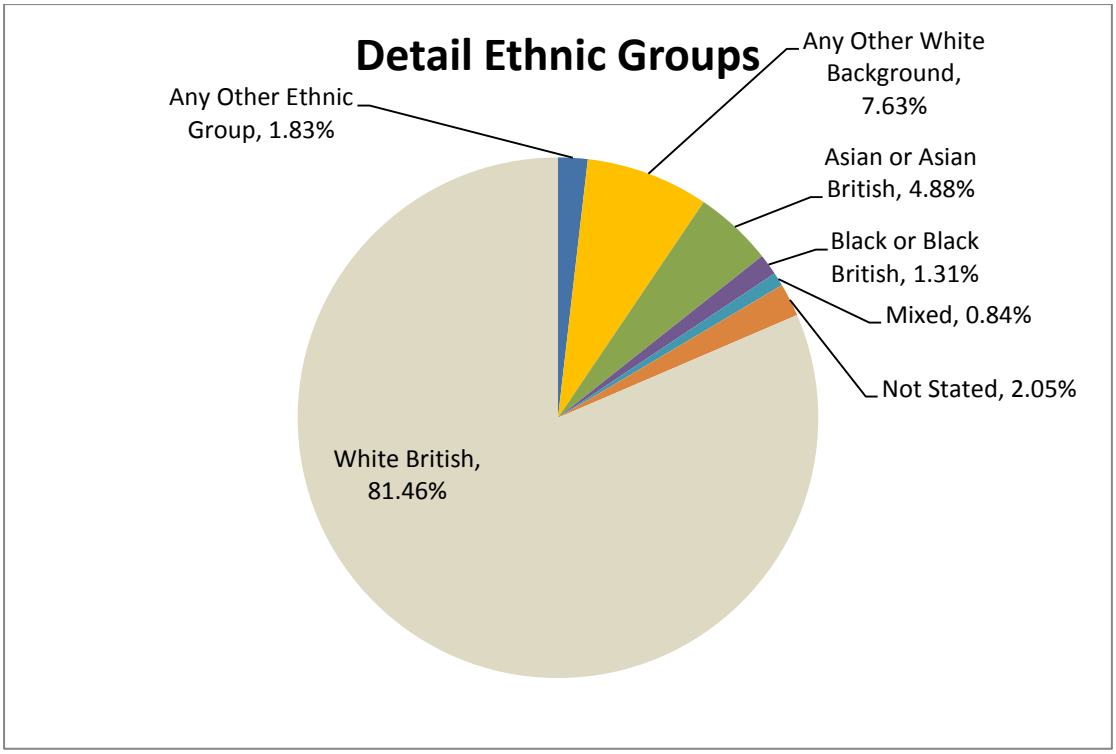

Bands by Gender
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Female
Male
Bands 1 to 4
Bands 5 and 6
Bands 7 and above

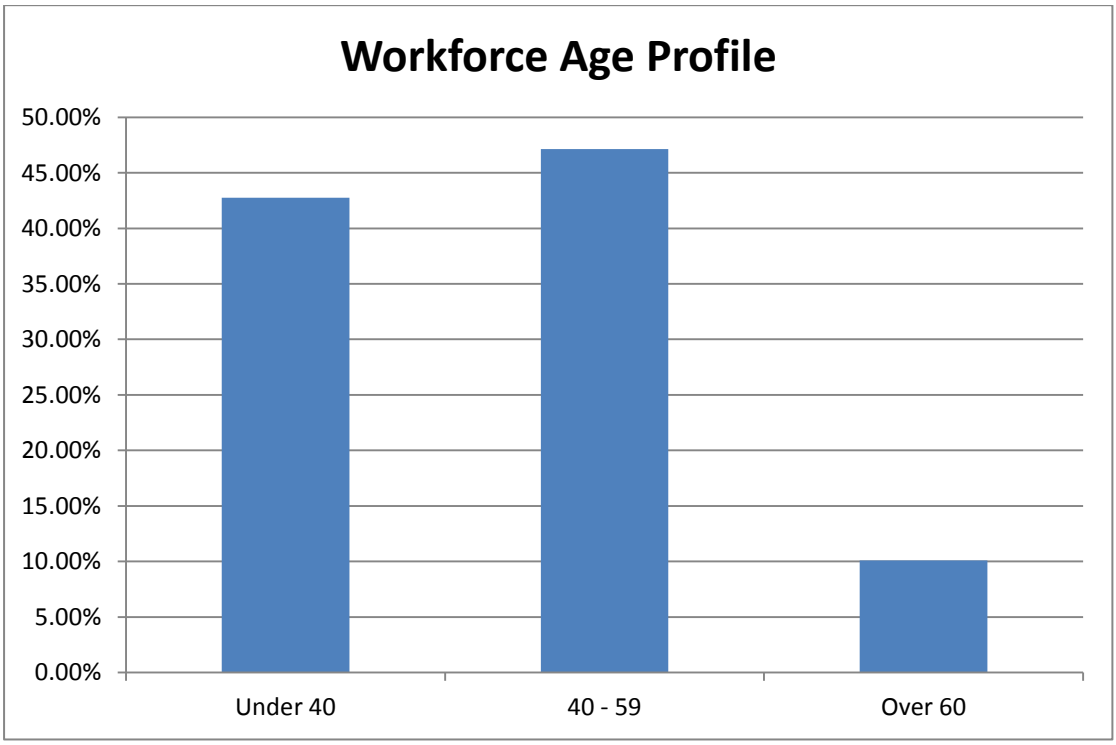

Occupational Group by Ethnicity
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
BME
Not Stated
White
Additional Clinical Services
Administrative and Clerical
Estates and Ancillary
Medical and Dental
Nursing and Midwifery Registered
Scientific Therapeutic & Technical

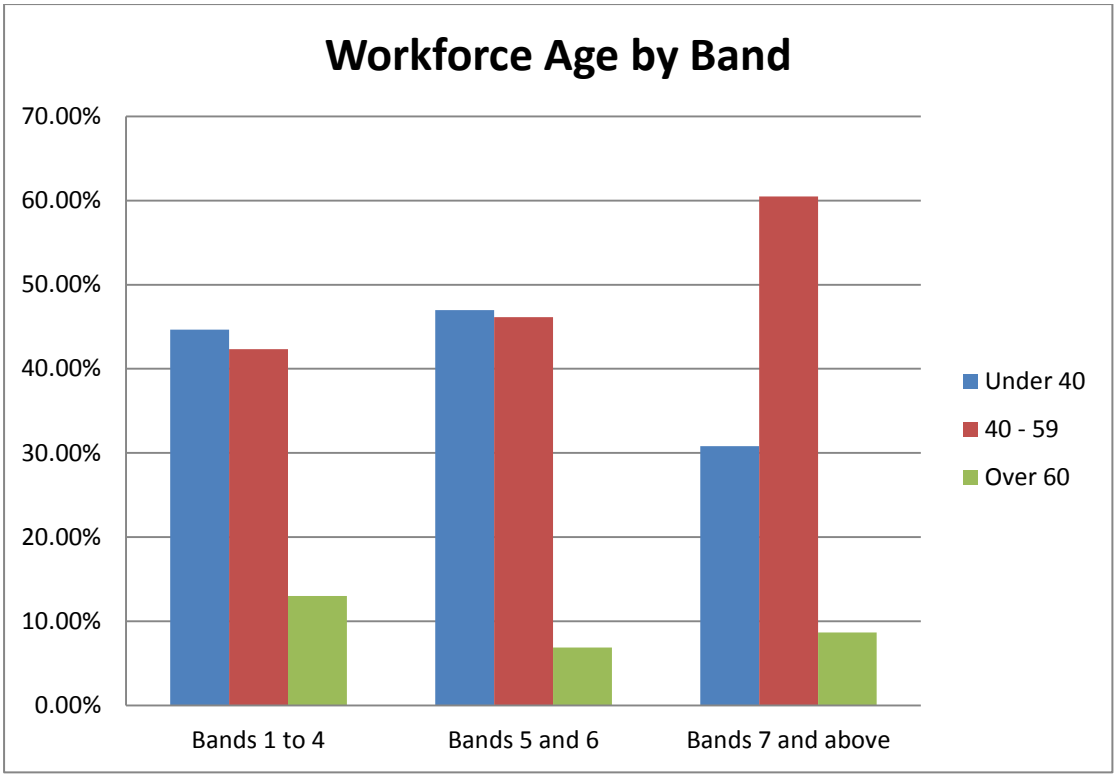

Religious Belief
Islam, 0.89%
Other, 7.35%
Atheism, 10.82%
Buddhism, 0.59%
I do not wish to disclose my religion/belief, 19.66%
Christianity, 59.64%
Hinduism, 1.04%

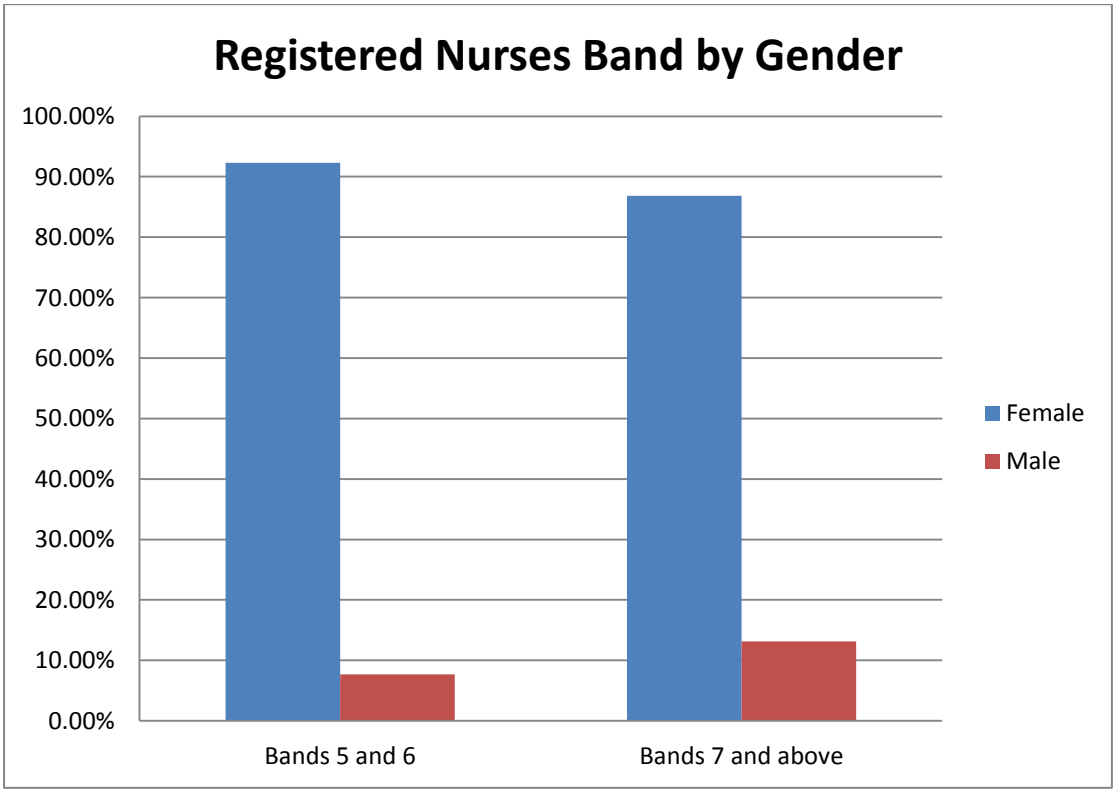

Sexual Orientation
LGBT, 1.31%
Not Stated, 3.81%
Do not wish to disclose, 10.97%
Heterosexual, 83.91%

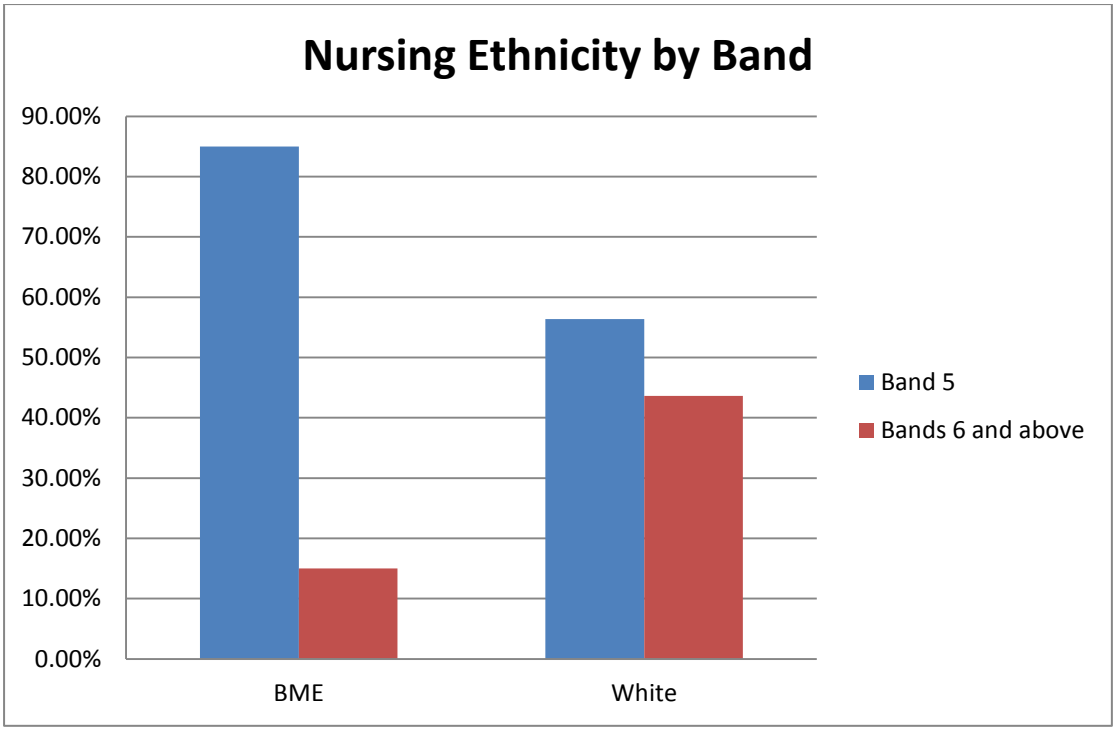

Full and Part Time by Disability
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Disabled
Not Declared
Not Disabled
Full Time
Part Time


Detail Ethnic Groups
Any Other White Background, 7.63%
Asian or Asian British, 4.88%
Black or Black British, 1.31%
Mixed, 0.84%
Not Stated, 2.05%
White British, 81.46%
Any Other Ethnic Group, 1.83%


Workforce Age Profile
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Under 40
40 - 59
Over 60


Workforce Age by Band
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Bands 1 to 4
Bands 5 and 6
Bands 7 and above
Under 40
40 - 59
Over 60


Registered Nurses Band by Gender
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Bands 5 and 6
Bands 7 and above
Female
Male



Grievance and Dismissal Information

In 2014/15 there were a total of 35 grievance, disciplinary and capability cases. 12 of the staff involved were male, 23 were female.

As per EHRC guidance, analysis by any other protected characteristic is not possible due to the small number of staff involved.

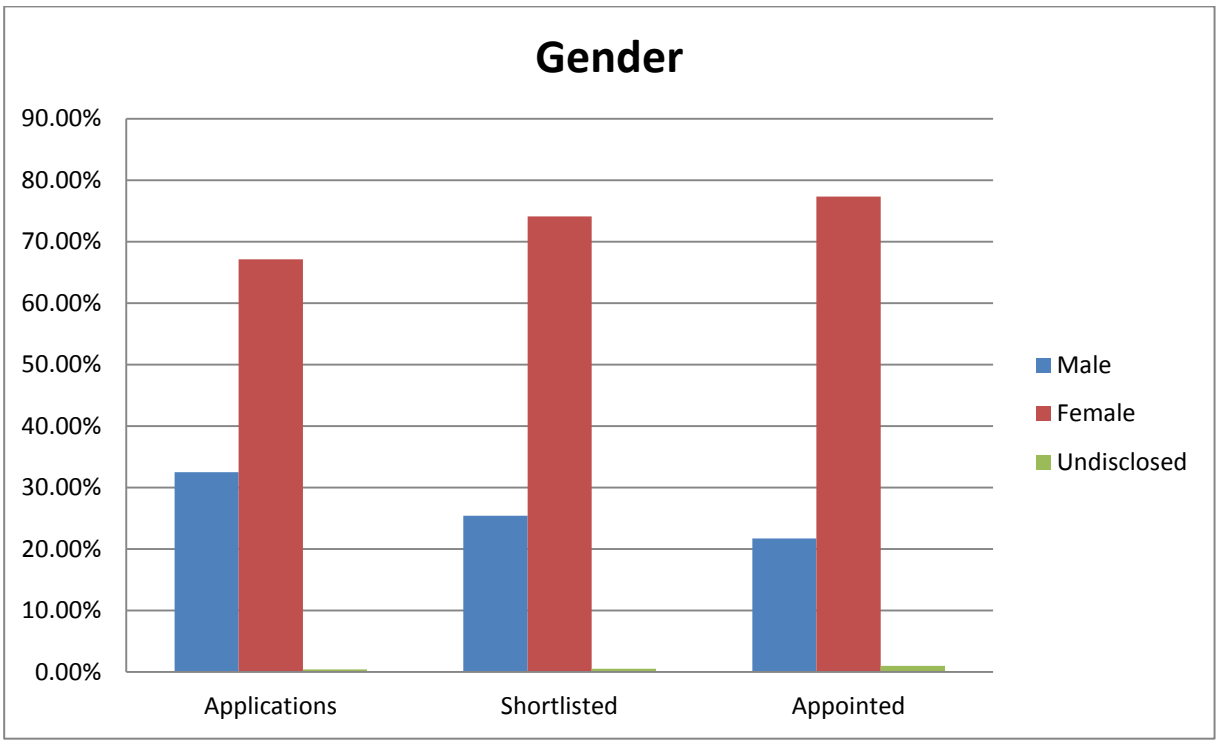
6 staff were dismissed for misconduct or capability reasons. It is not possible to provide further analysis due to the small numbers involved.

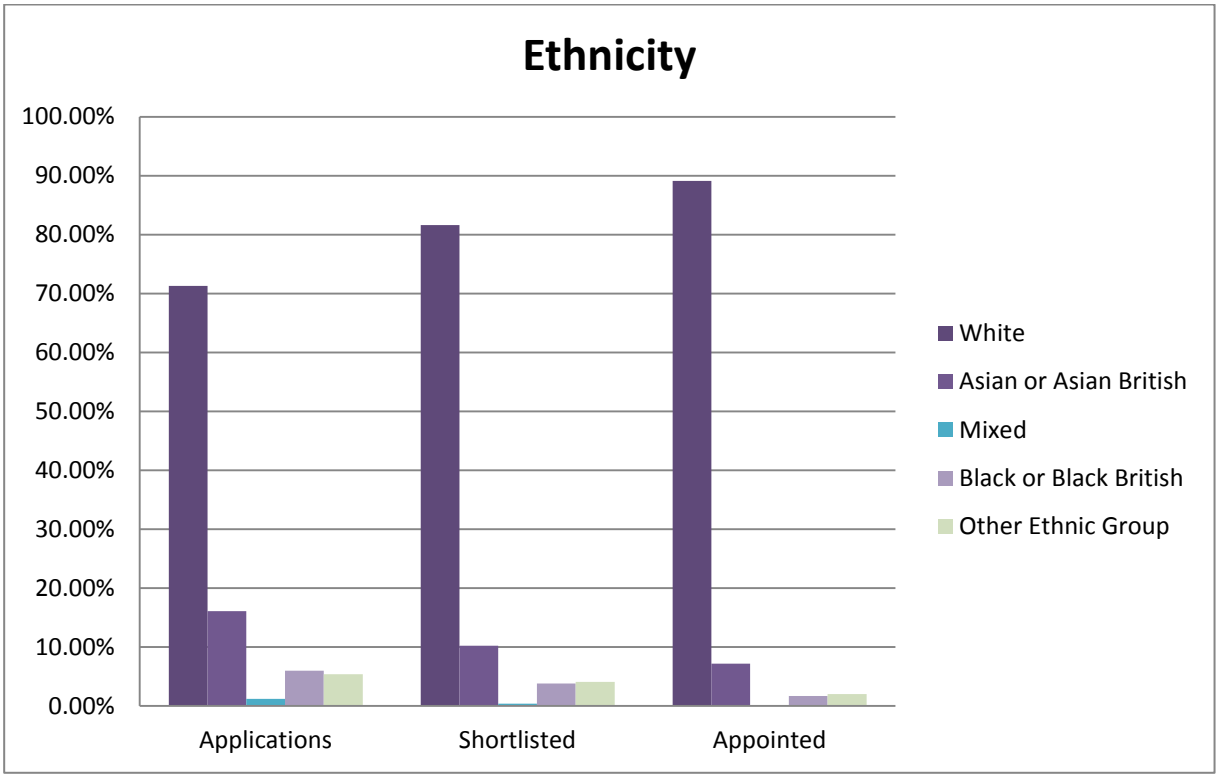
Complaints About Discrimination and Other Prohibited Conduct

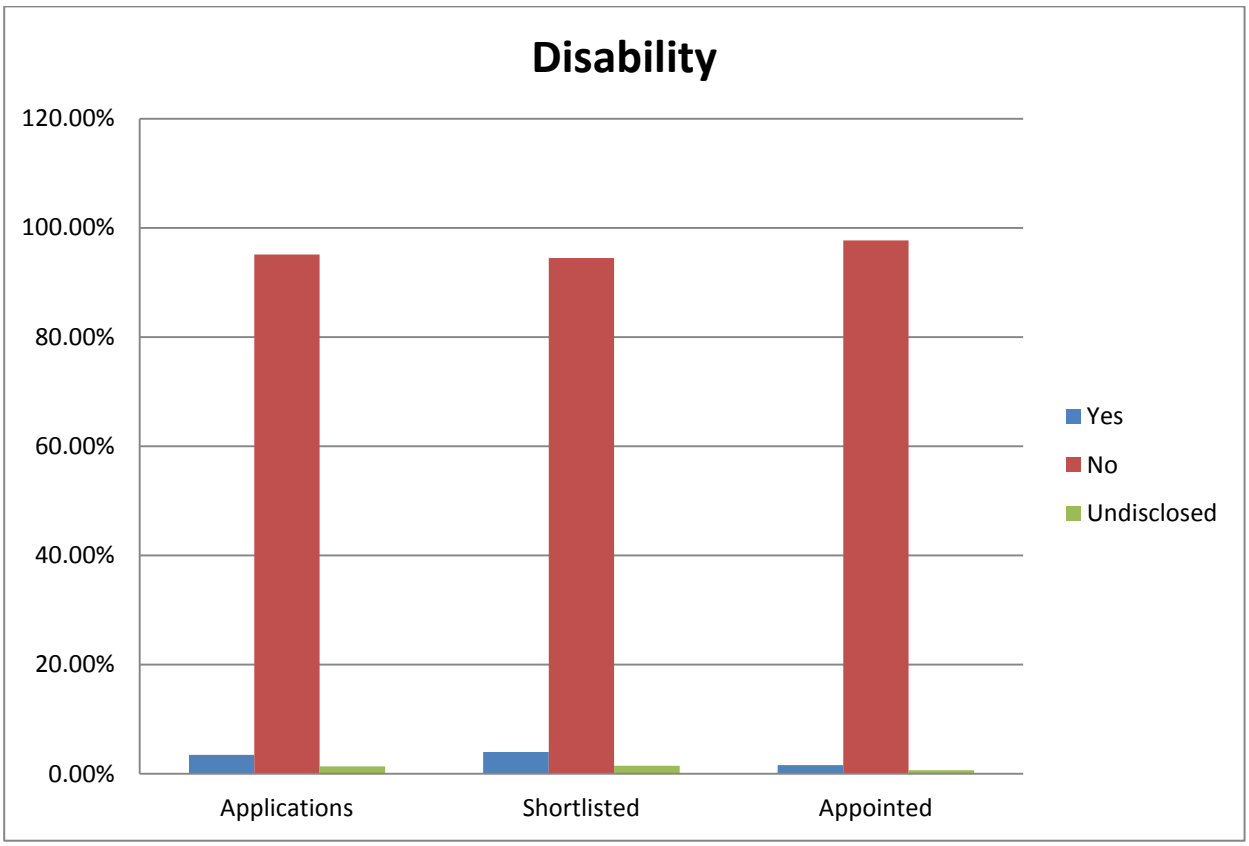
In 2014/15 there were no formal allegations against the Trust of discrimination on the grounds of race, disability, age and religion or belief.

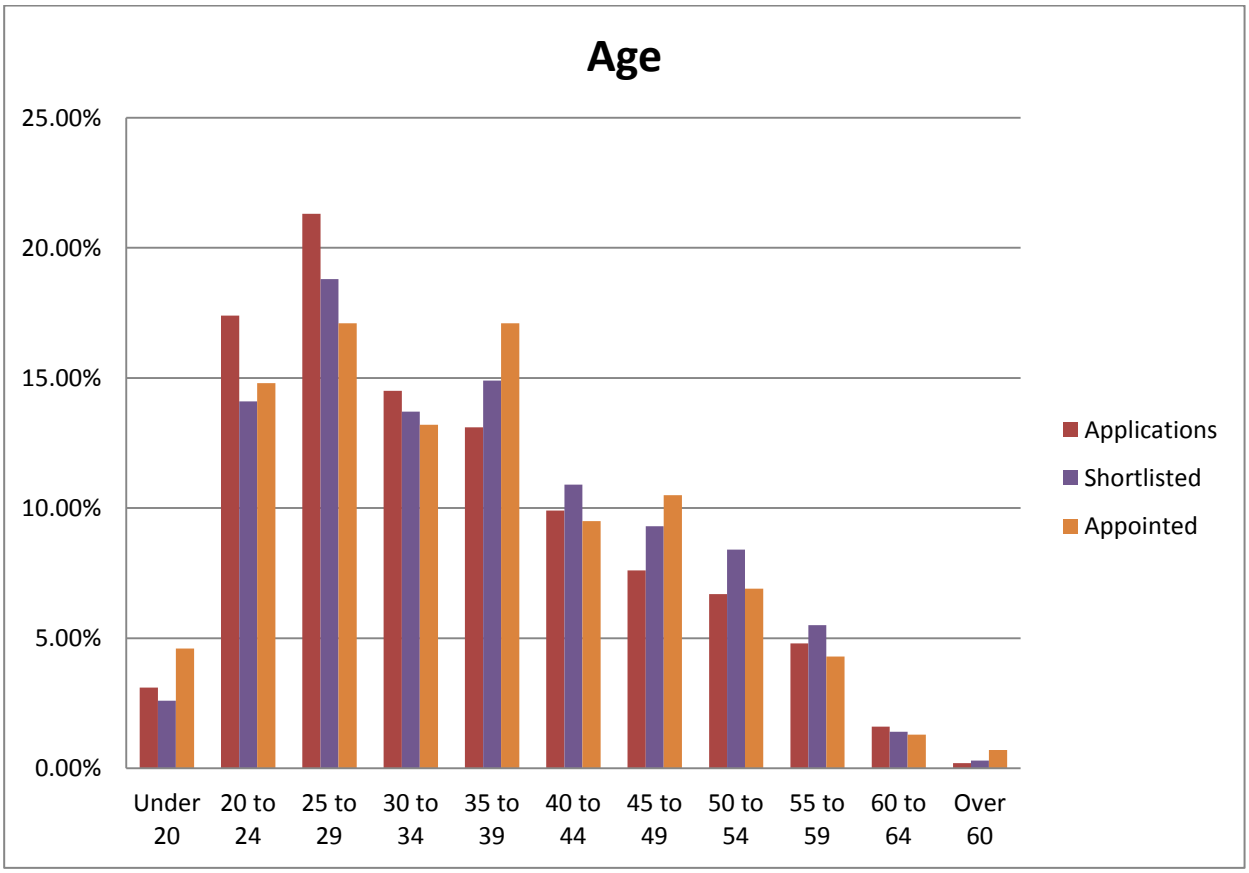
Gender Pay Gap

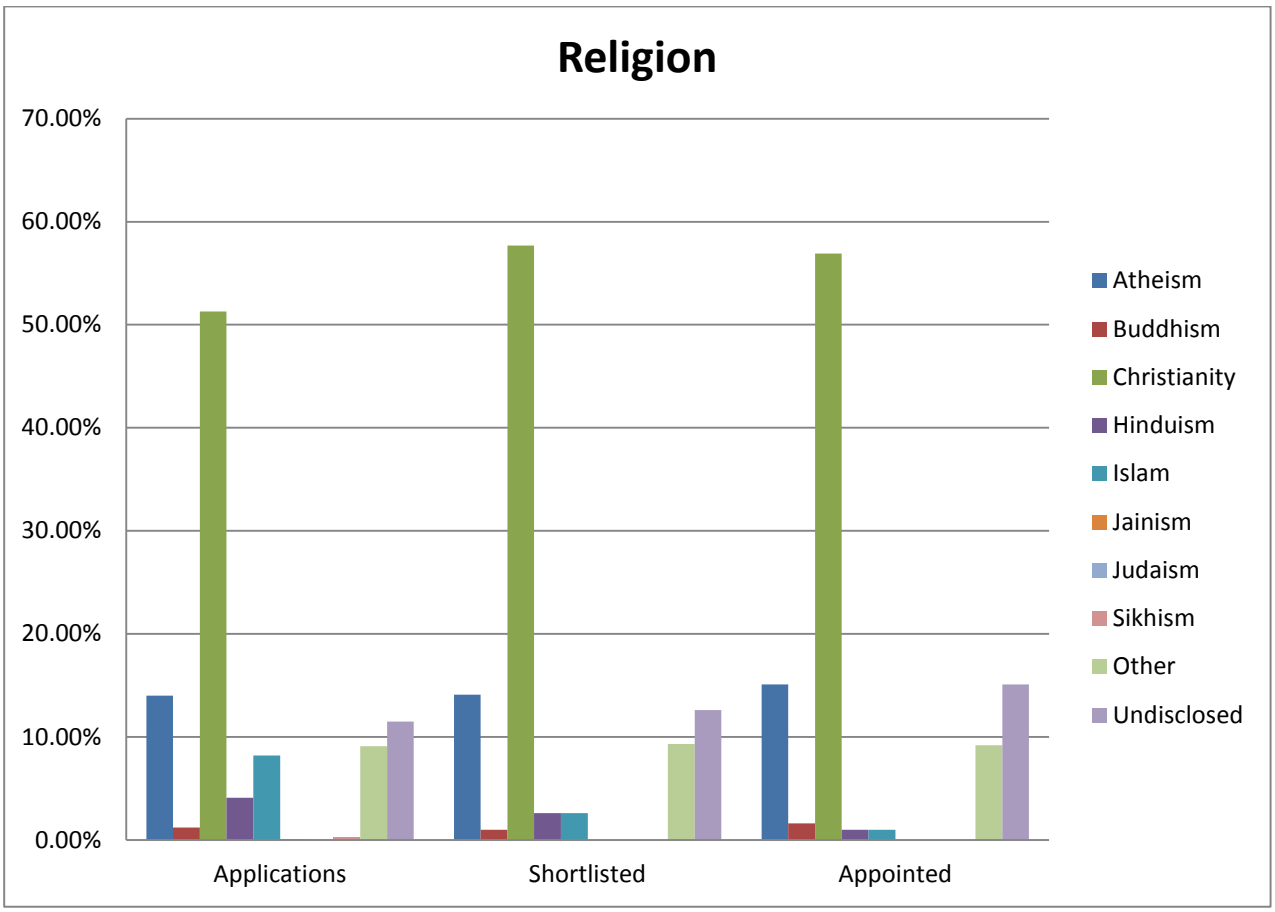
	Total Salary	FTE	Average pay per FTE
Female	£55,557,164	2043	£27,195
Male	£25,450,549	708	£35,954
Total	£81,007,713	2751	£29,449

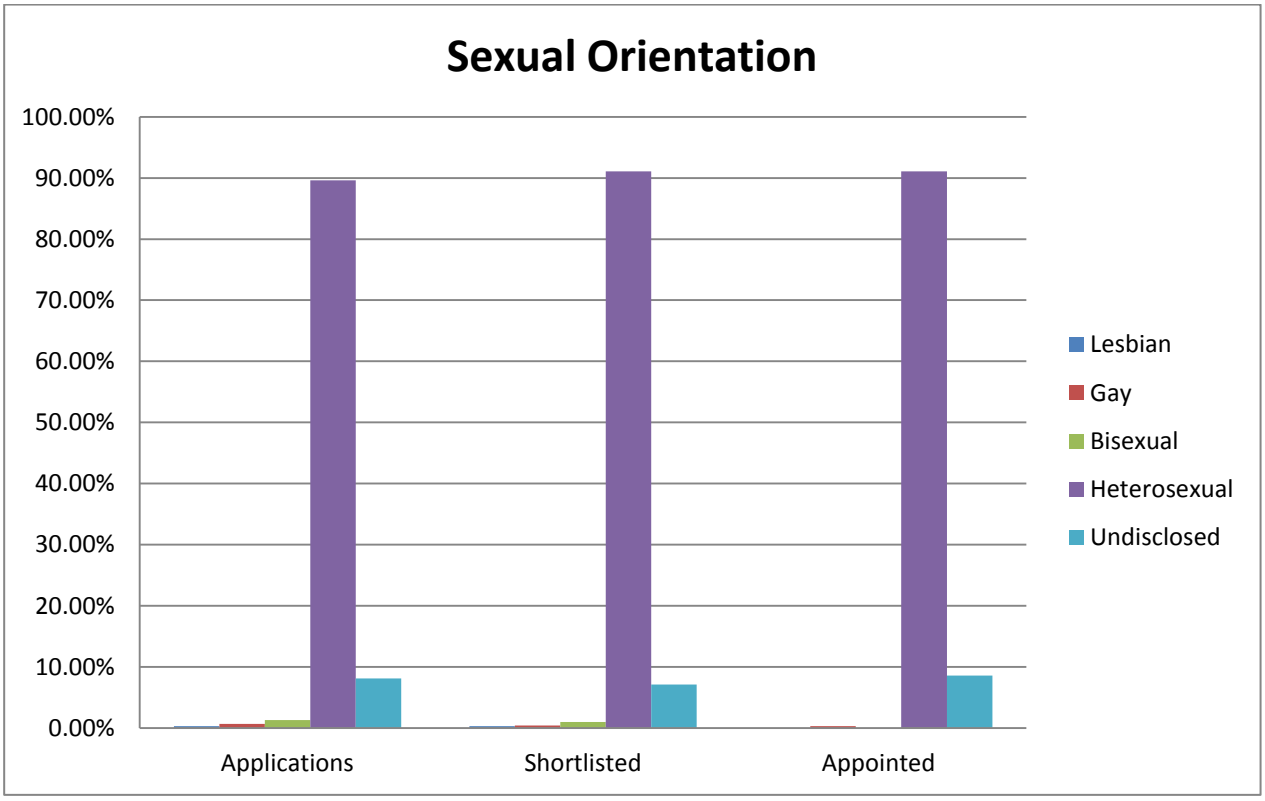

Gender
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Applications
Shortlisted
Appointed
Male
Female
Undisclosed


Ethnicity
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Applications
Shortlisted
Appointed
White
Asian or Asian British
Mixed
Black or Black British
Other Ethnic Group


Disability
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Applications
Shortlisted
Appointed
Yes
No
Undisclosed


Age
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Under 20
20 to 24
25 to 29
30 to 34
35 to 39
40 to 44
45 to 49
50 to 54
55 to 59
60 to 64
Over 60
Applications
Shortlisted
Appointed

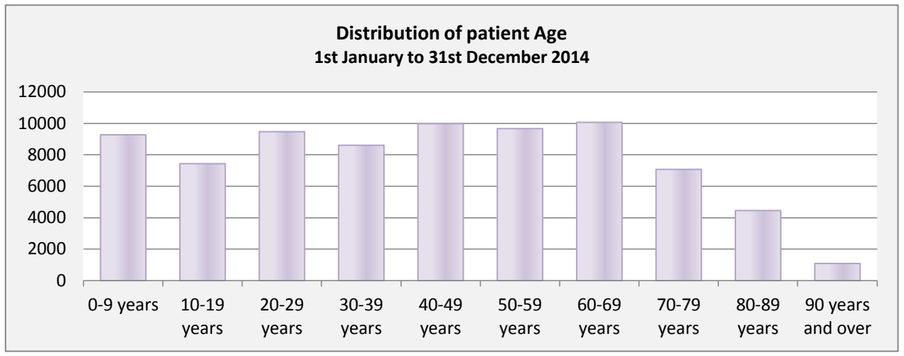

Religion
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Applications
Shortlisted
Appointed
Atheism
Buddhism
Christianity
Hinduism
Islam
Jainism
Judaism
Sikhism
Other
Undisclosed


Sexual Orientation
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Applications
Shortlisted
Appointed
Lesbian
Gay
Bisexual
Heterosexual
Undisclosed

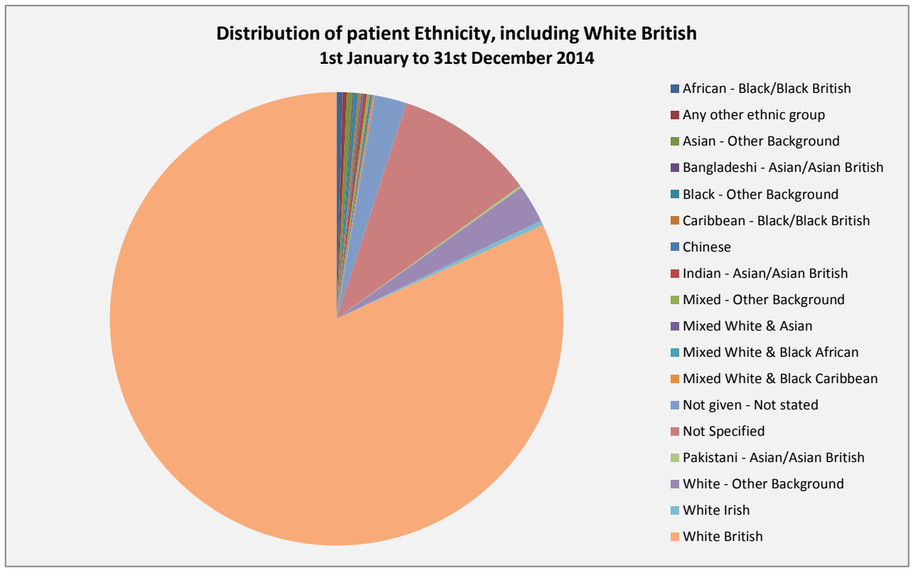
Equality & Diversity Data

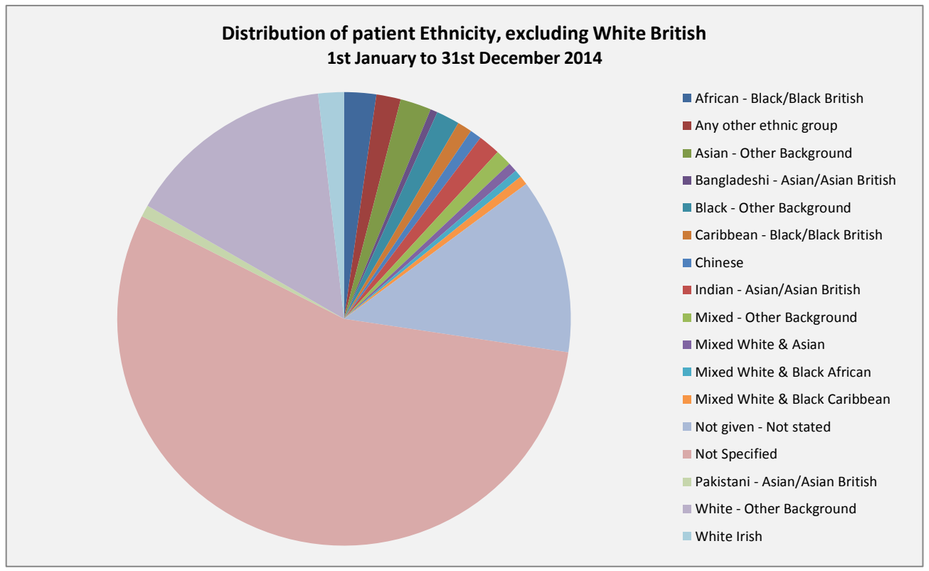
1st January to 31st December 2014

Age Group	Total
0-9 years	9270
10-19 years	7436
20-29 years	9469
30-39 years	8605
40-49 years	9976
50-59 years	9663
60-69 years	10062
70-79 years	7073
80-89 years	4455
90 years and over	1089
Grand Total	**77098**



Ethnicity	Total
African - Black/Black British	321
Any other ethnic group	244
Asian - Other Background	311
Bangladeshi - Asian/Asian British	72
Black - Other Background	233
Caribbean - Black/Black British	147
Chinese	115
Indian - Asian/Asian British	220
Mixed - Other Background	164
Mixed White & Asian	93
Mixed White & Black African	75
Mixed White & Black Caribbean	91
Not given - Not stated	1756
Not Specified	7738
Pakistani - Asian/Asian British	118
White - Other Background	2086
White Irish	257
White British	63057
Grand Total	**77098**



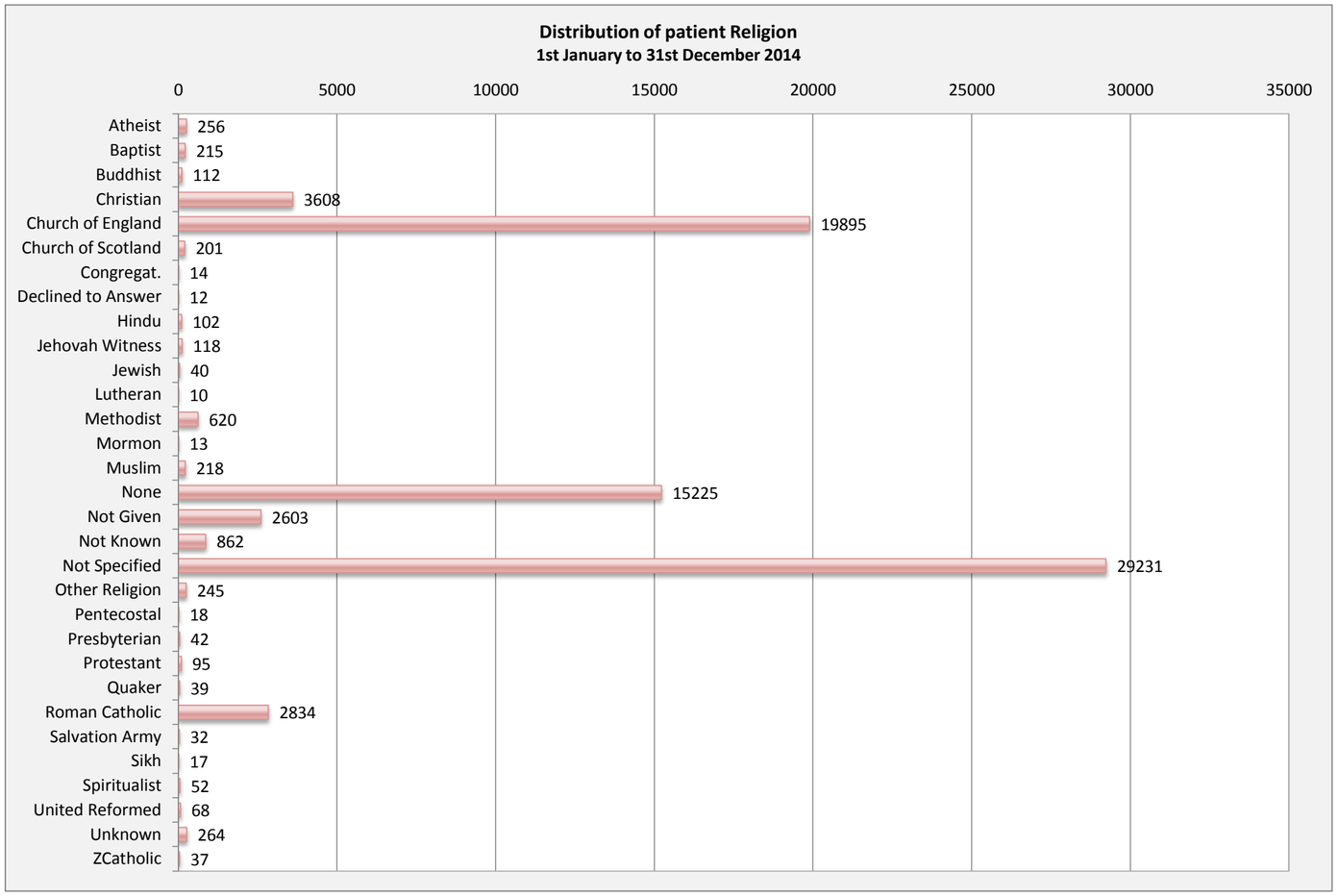


Disability	Total
N	77097
Y	1
Grand Total	**77098**

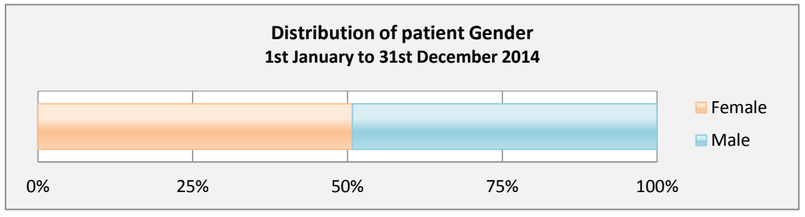
Equality & Diversity Data

1st January to 31st December 2014

Religion	Total
Atheist	256
Baptist	215
Buddhist	112
Christian	3608
Church of England	19895
Church of Scotland	201
Congregat.	14
Declined to Answer	12
Hindu	102
Jehovah Witness	118
Jewish	40
Lutheran	10
Methodist	620
Mormon	13
Muslim	218
None	15225
Not Given	2603
Not Known	862
Not Specified	29231
Other Religion	245
Pentecostal	18
Presbyterian	42
Protestant	95
Quaker	39
Roman Catholic	2834
Salvation Army	32
Sikh	17
Spiritualist	52
United Reformed	68
Unknown	264
ZCatholic	37
Grand Total	**77098**



Gender	Total
Female	39169
Male	37929
Grand Total	**77098**



Equality & Diversity Data

1st January to 31st December 2014

Gender Reassignment

12 patients have been coded with a Diagnosis of F649 or F640, as defined below, during an Inpatient Spell

F649: Gender identity disorder, unspecified
F640: Transsexualism

Please let me know if you would like this figure to be broken down in any way

Sexuality

A patients sexuality is not a field that is recorded within iPM
This is a field that can be recorded within the GUM system Lillie, however this only covers those patients that attend a GUM Clinic

Pregnancy

The figures below are taken from the VSMR web reports that extract from the Maternity E3 Database

Number of Deliveries by Location	Total
Home	88
Hospital	2279
Grand Total	**2367**

Number of Bookings Recorded on E3 (Attendances to Maternity)	2981

Attendances to Maternity include all Pre- and Post-Natal appointments

Trust Board meeting **SFT 3678**

Quality indicator report – June 2015 and Q1 15/16

Date: 17 July 2015

Report from: Dr Christine Blanshard, Medical Director
Presented by: Dr Christine Blanshard, Medical Director

Executive Summary:

- No MRSA or MSSA bacteraemias in Q1.
- 3 cases of C Difficile in June. Total of 4 in Q1 against a Q1 trajectory of 6. Full year target no greater than 19.
- No new serious incident inquiries in June. 6 in total in Q1.
- A decrease in the crude mortality rate in June 15 and in Q1 compared to Q4. SHMI is 104 and when adjusted for palliative care is 100 to September 2014 is as expected. HSMR is 105 to March 15 and is as expected.
- A sustained decrease in the adverse event rate to April 15 as measured by the Global Trigger tool. Detail reported at the Clinical Risk Group.
- A significant decrease in grade 2 pressure ulcers in June. A total of 55 grade 2 pressure ulcers in Q1 a reduction from 79 in Q1 in 14/15. Two grade 3 and one grade 4 pressure ulcers in Q1. Cluster reviews ongoing.
- Safety Thermometer – consistently 96% 'new harm free care' and 92% of 'all harm free care' of patients admitted to hospital with a harm in Q1.
- There were no falls in June resulting in fracture or major harm. In Q1 there were 9 falls, 3 resulting in major harm (all fractured hips requiring surgery), 6 resulting in moderate harm all were managed conservatively. RCAs undertaken with a Trust wide falls action plan now in place.
- In June all patients with a fractured neck of femur had their operation within 36 hours. Q1 best practice tariff achieved 84%.
- A decrease in patients arriving on the stroke unit within 4 hours in Q1 with several patients arriving minutes after the 4 hours but other patients waited for a bed. CT scan within 12 hours was sustained in Q1. A decrease in patients spending 90% of their time on the stroke unit in June with 2 patients receiving critical care and cardiology care on speciality wards and one patient with a short length of stay. The Stroke Strategy Group monitor performance and lead improvements.
- High risk TIA referrals being seen within 24 hours has remained below target in Q1. Most are due to a wrong referral route used by GPs at weekends or delay in sending the referral. The CCG are assisting with improvement by raising patient level issues with individual GP practices.
- Escalation bed capacity peaked in May but significantly declined in June with the closure of Breamore ward.
- In June there was a decrease in mixed sex accommodation breaches to 9 breaches affecting 37 patients mainly on AMU (34) and 3 patients waiting to be transferred out of Radnor who waited more than 12 hours. In total in Q1 there were 29 breaches affecting 139 patients on AMU (132) and 7 patients ready to be transferred out of Radnor. The Director of Nursing and Chief Operating Officer continue daily reviews on AMU. The CCG have undertaken a walk round in these areas to assist with improvements.
- Real time feedback was as expected. In Q1 the Friends and Family test response rate for inpatients and ED remained below the local target. Maternity Services improved response rates in Q1 but remain below local target. Day cases and outpatient response rates remain variable.

Proposed Action:

1. **To note the report**

Links to Assurance Framework/ Strategic Plan:
CQC registration

Appendices:
Trust quality indicator report – June 2015
Supporting Information

Salisbury NHS
NHS Foundation Trust

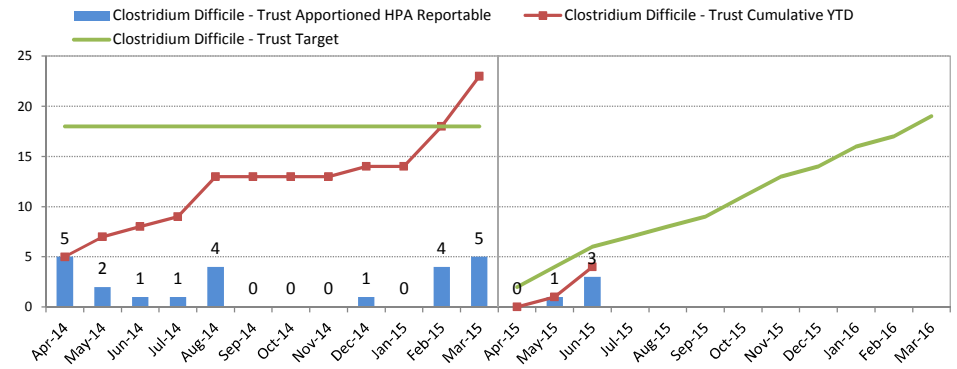
Trust Quality Indicators - June 2015

Quality Measures

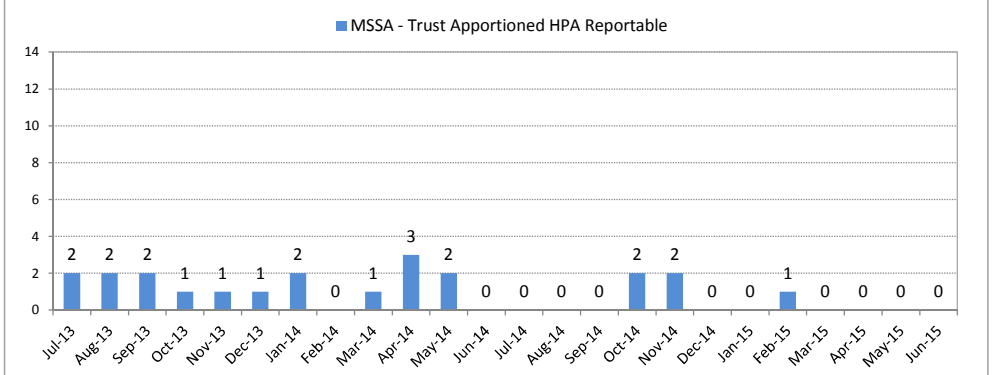
Infection Control	2014-15 YTD	2015-16 YTD
MRSA (Trust Apportioned)	1 (+1)	0

Trust Incidents	2014-15 YTD	2015-16 YTD
Never Events	2	0
Serious Incidents Requiring Investigation	30	6

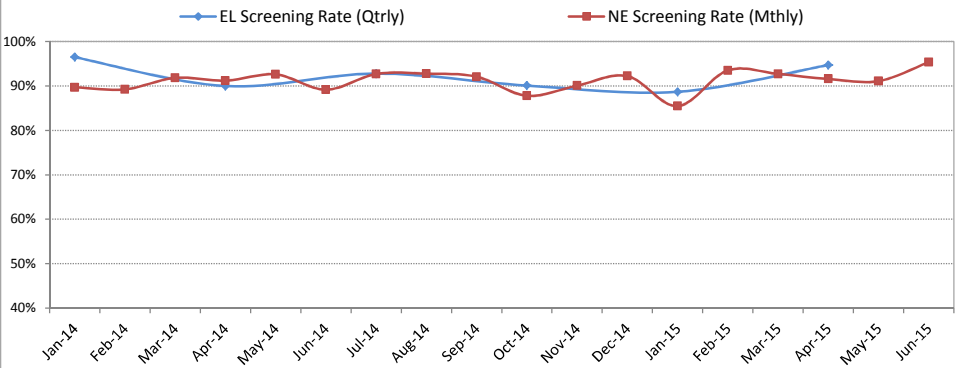
Clostridium Difficile - Trust Apportioned



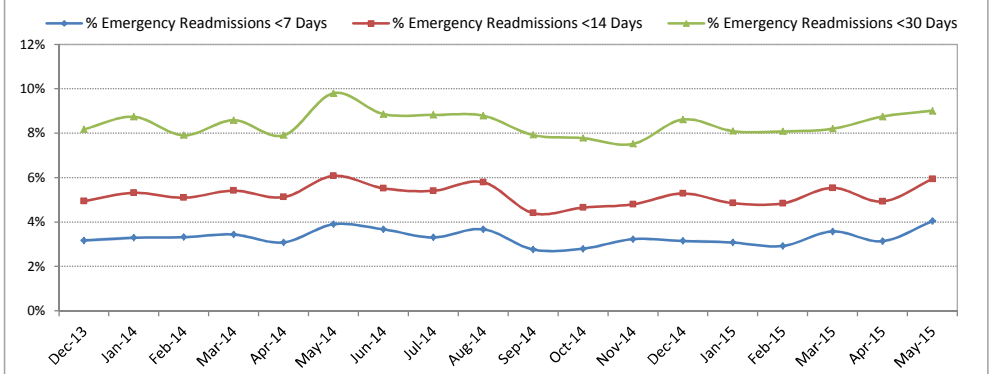
MSSA - Trust Apportioned



MRSA Screening



Emergency Readmissions within 7, 14 & 30 days of Discharge

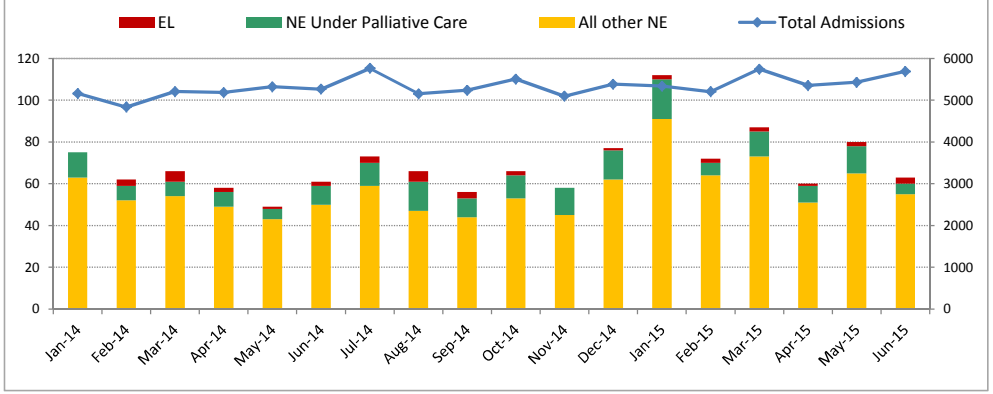


Salisbury NHS
NHS Foundation Trust

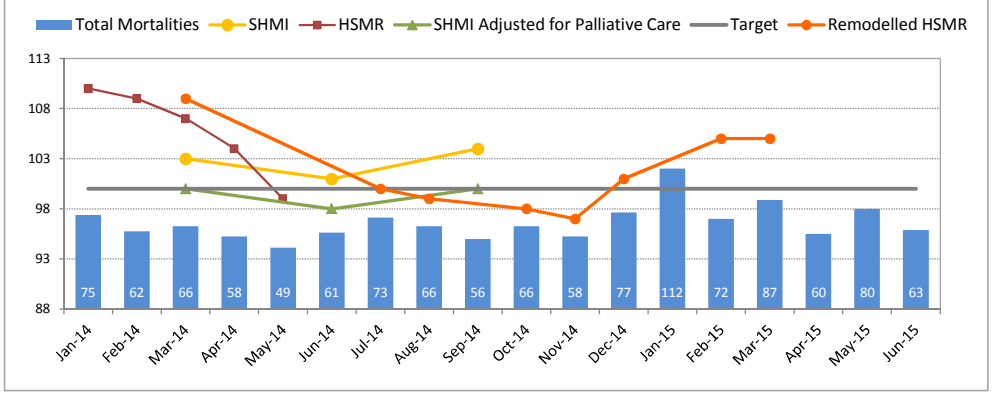
Trust Quality Indicators - June 2015

Quality Measures

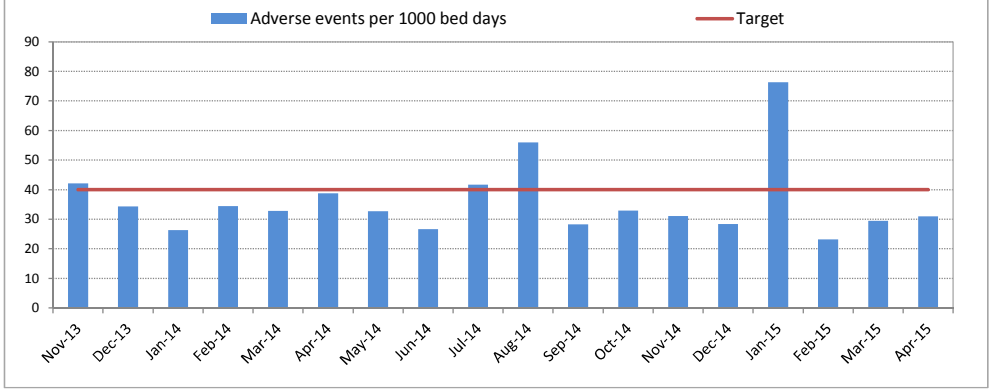
Hospital Mortalities



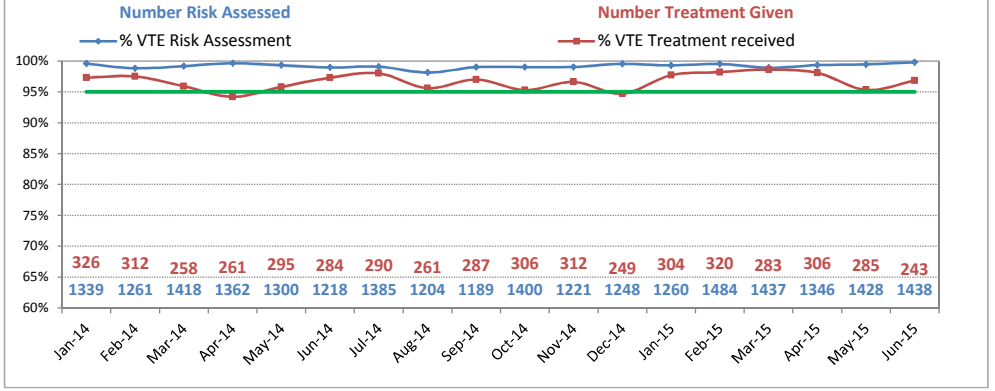
HSMR and SHMI



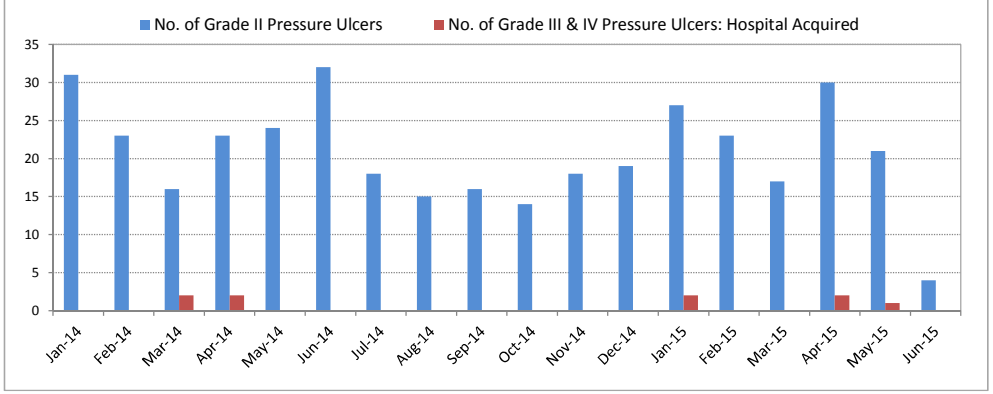
Global Trigger Tool



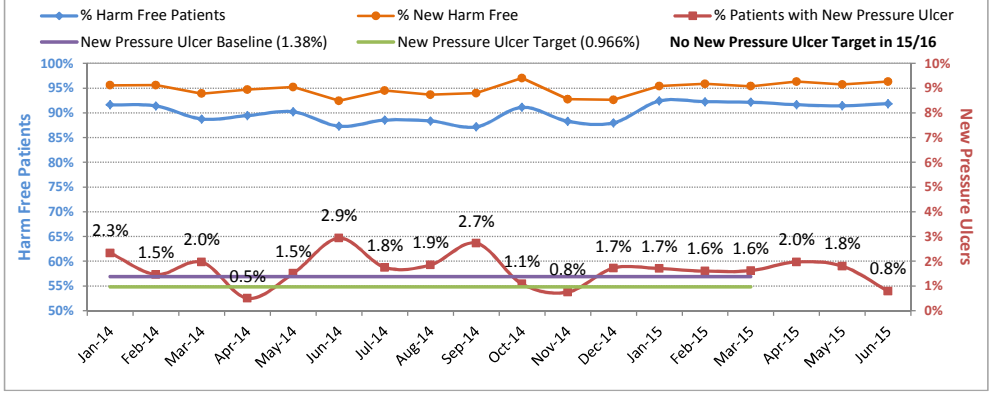
Venous Thrombous Embolism: Risk Assessment & Prophylaxis



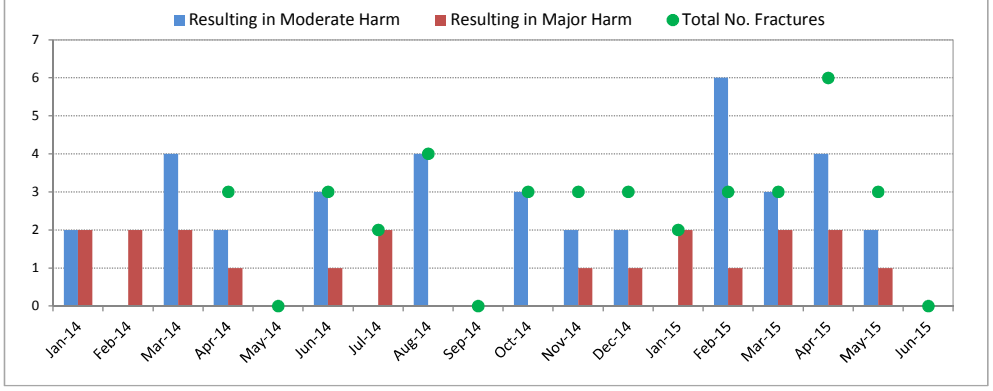
Pressure Ulcers - Total Number per Month



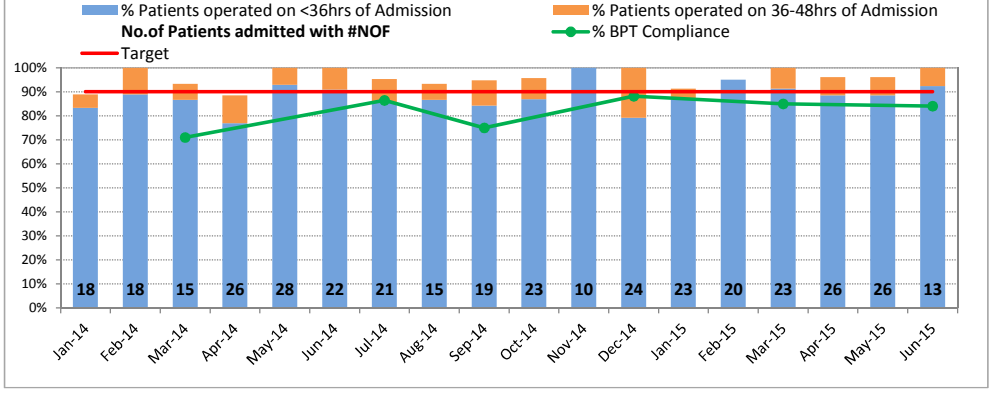
Safety Thermometer - One Day Snapshot per Month



Patient Falls in Hospital Resulting in Moderate Harm or Fracture / Major Harm



Fracture Neck of Femur operated on within 36 hours



Salisbury NHS
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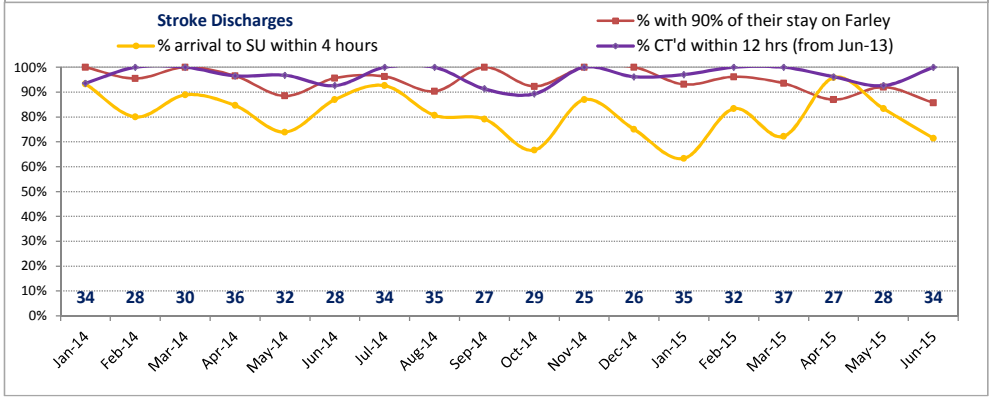
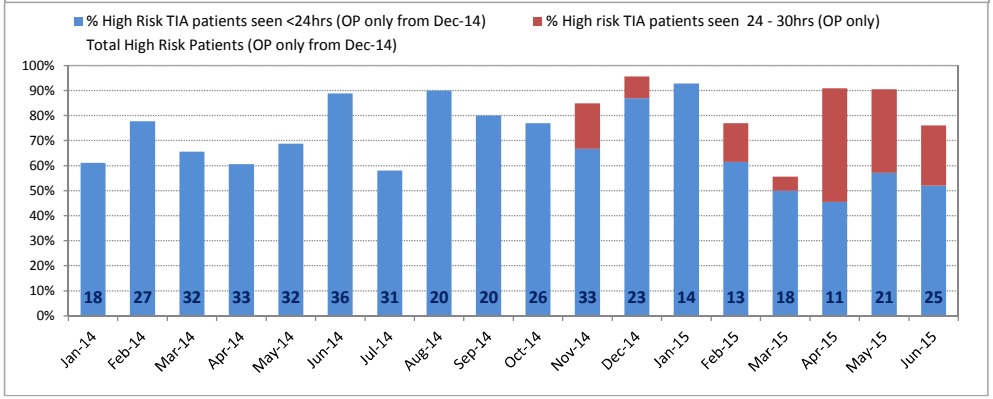
Trust Quality Indicators - June 2015

Quality Measures

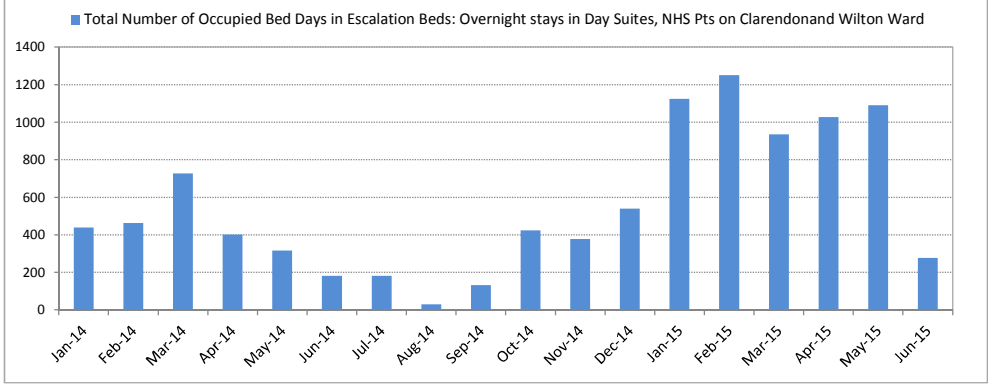
Stroke Care



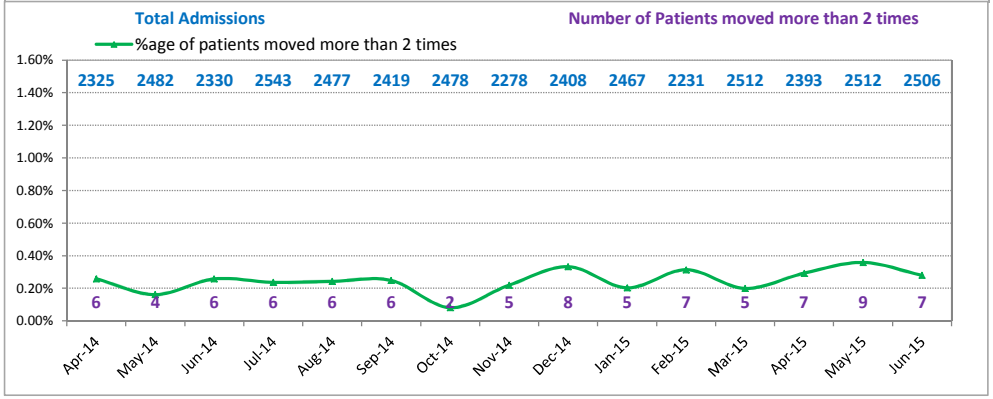
TIA Referrals



Escalation Bed Days



Patients moving multiple times during their Inpatient Stay



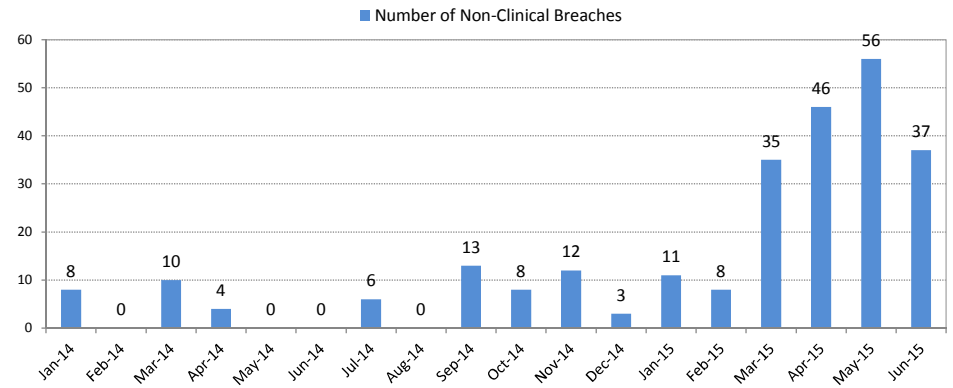
Please note, from Sep-14 escalation bed capactity is Winterslow 8 beds, Wilton 12 beds and DSU if it stays open at night. Breamore ward opened from 1st January 2015 with a further 27 escalation beds and closed on 29th May 2015. From 1st April 2015 Wilton closed for escalation beds.

Salisbury NHS
NHS Foundation Trust

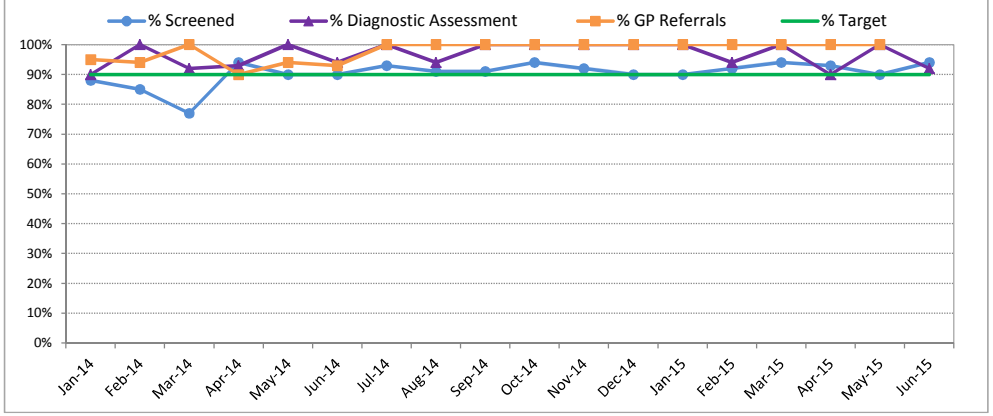
Trust Quality Indicators - June 2015

Quality Measures

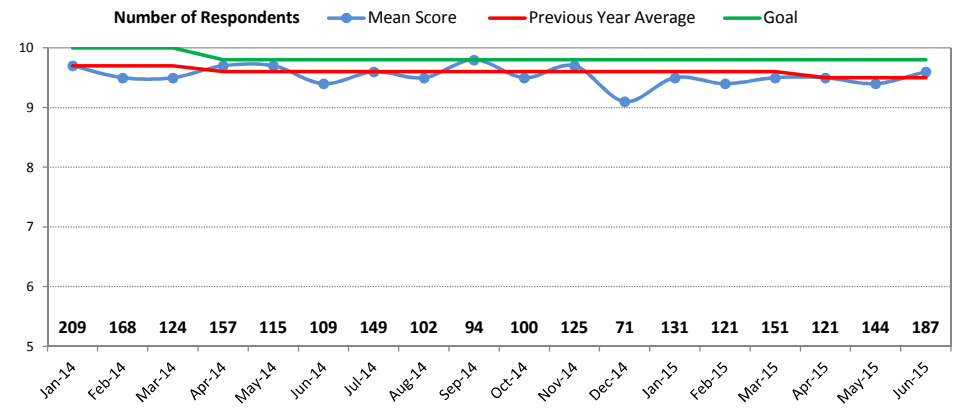
Delivering Same Sex Accommodation



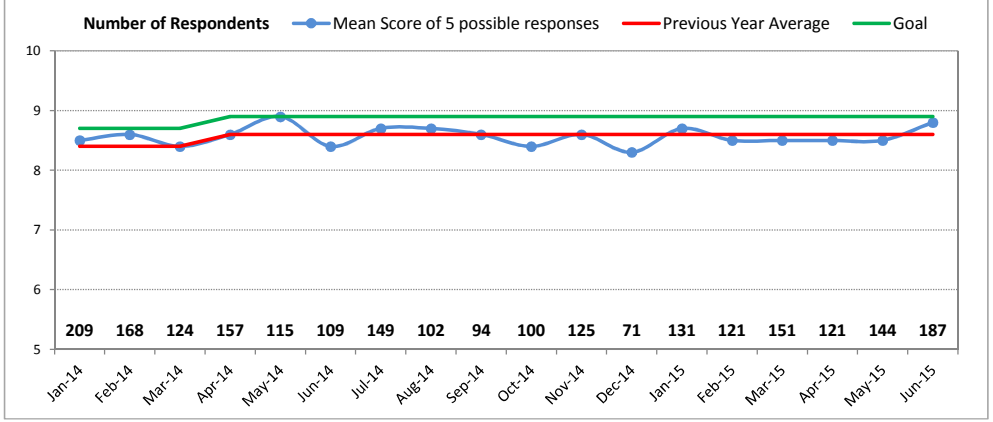
Dementia Audit of Patients Aged 75+



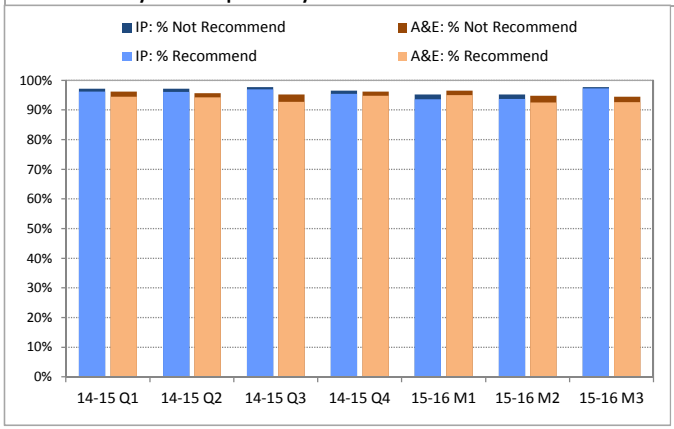
Real Time Feedback: Are you being treated with care and compassion?

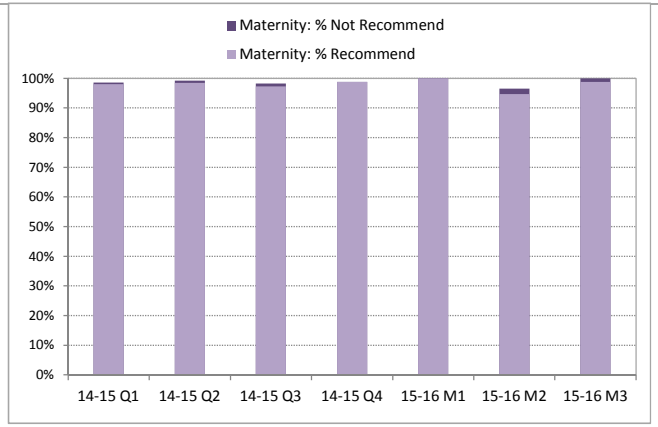


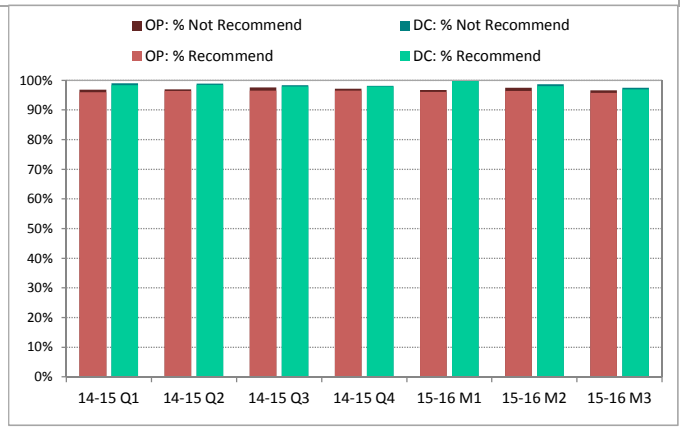
Real Time Feedback: Overall how would you rate the quality of care you received?



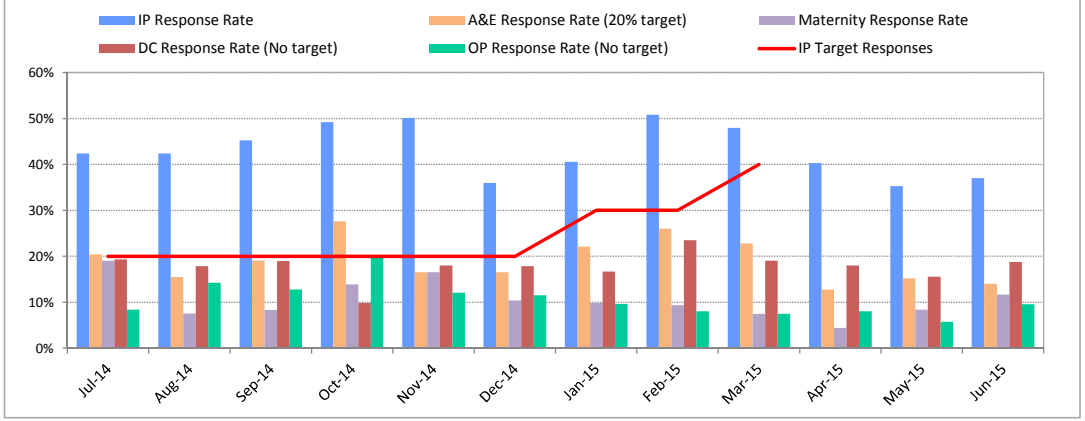
Friends & Family Test: Responses by Area



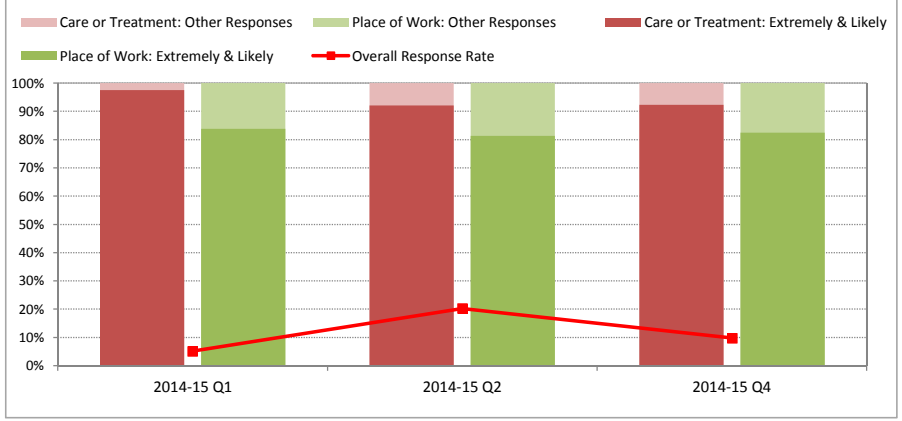




Friends & Family Test: Response Rates (%) by Area



Friends & Family Test: Staff (% Responses)



From October 2014 the Net Promoter Score (NPS) is no longer being used as a headline score.
The new score measures the % Recommended (Likely + Extremely Likely) and the % Not Recommended (Unlikely + Extremely Unlikely) to show the pecentage of responses that would or wouldn't recommend the Trust.
Don't Know and Neither Likely or Unlikely responses are excluded from this measure.

PAPER: SFT 3680

PAPER TITLE: Annual Revalidation Report

PURPOSE: This paper serves to give assurance to the Board of the Designated Body that the revalidation process is being carried out in accordance with the regulatory framework.

MAIN ISSUES:

- The Trust has sufficient trained appraisers supported by an appraisal lead, regular workshops and peer support
- Appraisal compliance rate 92%
- Eighty-three doctors were revalidated
- In nine cases revalidation was deferred due to ill health, maternity leave or delayed appraisal
- No cases of non-engagement notified to GMC
- No fitness to practice referrals made by the RO
- Policies for appraisal, remediation and handling concerns require updating
- Quality assurance for appraisal is in place

ACTION REQUIRED BY THE BOARD:

To note this report and agree for it to be shared with the Second Level Responsible Officer.

To approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations

AUTHOR: Dr Christine Blanshard

TITLE: Medical Director and Responsible Officer

Revalidation - Annual Board Report

1. Executive summary

In April 2014 NHS England published a framework for quality assurance for revalidation which requires Responsible Officers to produce their annual report on revalidation for the Board of their Designated Body in a prescribed format, and the chairman or chief executive to sign a statement of compliance to be submitted to the level 2 RO. This report describes the number of doctors with a prescribed connection to the Trust, the number of completed appraisals within the appraisal year 2014-15, the appraisal quality assurance process and any issues with the revalidation process and an action plan.

2. Purpose of the Paper

This paper serves to give assurance to the Board of the Designated Body that the revalidation process is being carried out in accordance with the regulatory framework.

3. Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical profession.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

The Medical Director is the Trust's Responsible Officer and has a statutory duty to ensure that doctors participate in an annual appraisal process which meets the requirements for revalidation. Where there is a potential conflict of interest or

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

appearance of bias in acting as an RO for any of the doctors linked to the designated body, the Trust is required to appoint an alternative RO. This has not been necessary for Salisbury foundation Trust since the advent of revalidation in 2012.

The Responsible Officer must ensure that appraisals involve obtaining and taking account of all available information relating to the medical practitioner's fitness to practise in the work carried out by the practitioner for the designated body, and for any other body, during the appraisal period.

She is also required to:

- Maintain records of practitioners' fitness to practise evaluations, including appraisals and any other investigations or assessments.
- Ensure that doctors are appropriately qualified for their proposed duties, including ensuring that appropriate references are obtained and checked and the identity of the doctor is verified
- Ensure that medical practitioners have sufficient knowledge of English language necessary for the work to be performed in a safe and competent manner
- Review regularly the general performance information held by the designated body, including clinical indicators relating to outcomes for patients
- Identify any issues arising from that information relating to medical practitioners, such as variations in individual performance
- Ensure that the designated body takes steps to address any such issues.
- Ensure that appropriate action is taken in response to concerns about medical practitioners' conduct or performance and where appropriate
    a) take any steps necessary to protect patients;
    b) recommend to the medical practitioner's employer that the practitioner should be suspended or have conditions or restrictions placed on their practice
    c) maintain accurate records of all steps taken
- Establish and implement procedures to investigate concerns about a medical practitioner's fitness to practise raised by patients or staff of the designated body or arising from any other source
    a) initiate investigations with appropriately qualified investigators;
    b) ensure that procedures are in place to address concerns raised by patients or staff of the designated body or arising from any other source;
    c) ensure that any investigation into the conduct or performance of a medical practitioner takes into account any other relevant matters within the designated body;
    d) consider the need for further monitoring of the practitioner's conduct and performance and ensure that this takes place where appropriate;
    e) ensure that a medical practitioner who is subject to procedures under this paragraph is kept informed about the progress of the investigation
    f) ensure that procedures under this paragraph include provision for the medical practitioner's comments to be sought and taken into account where appropriate

- Where appropriate refer concerns about the medical practitioner to the General Medical Council
- Where a medical practitioner is subject to conditions imposed by, or undertakings agreed with, the General Medical Council, to monitor compliance with those conditions or undertakings
- Make recommendations to the General Medical Council about medical practitioners' fitness to practise

She is line managed in this respect by her "second level responsible officer" who is currently the Medical Director of NHS England South, and appraised with regard not only to her performance as an RO, but on the whole of her practice, by an NHSE appointed appraiser. Her annual appraisal was completed in March 2015.

The RO is supported by an appraisal lead, who is responsible for ensuring that:

- The trust has enough appraisers
- Appraisers are properly trained and supported in their work
- They carry out sufficient appraisals each year to maintain skills
- Appraisees are helped to identify a suitable appraiser
- The appraisal policy for medical staff is kept up-to date and complies with national guidance

Administrative support to the RO and appraisal lead is by a part time administrator who is responsible for:

- Ensuring that the list of doctors with a prescribed connection to the designated body is up-to-date and correct by cross-referencing it with the electronic staff record (ESR)
- Dealing with queries about the appraisal and revalidation process
- Training and supporting doctors in the use of their e-portfolio
- Reminding doctors when their appraisal is due and supporting them to complete it in a timely manner

Appraisers are responsible for:

- Ensuring they are trained and keep up-to-date with the appraisal requirements for revalidation. This includes completing at least five appraisals per year in order to maintain their skills.
- Ensuring that the doctor's appraisal meets the requirements for revalidation and providing assurance to the RO that this is the case by completing an appraisal output form which confirms compliance.

Appraisees are responsible for ensuring that they have an annual appraisal which meets the requirements for revalidation and feeding back to the appraiser and appraisal lead on the quality and value of the appraisal.

Progress with appraisals is monitored by the RO and administrator at a monthly meeting, and any doctors who have not completed their appraisal by the anniversary of their previous appraisal are sent a reminder. If there is no further progress they are offered a face-to-face appointment with the administrator to support them in completing their portfolio; if this fails the appraisal lead will contact the doctor and offer more intensive support, and the RO will remind the doctor that participation in

an annual appraisal process is a requirement to retain a licence to practice medicine. As a last resort the GMC can be informed of non-engagement with the appraisal process.

a. Policy and Guidance

Our appraisal policy for medical staff, remediation policy and handling concerns policy all require updating and this has been delayed due to lack of resource in medical HR.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

For the appraisal year 2014-2015:

192 doctors had a prescribed connection to the Trust (increased form 177 in the previous year) comprising 156 consultants, 28 SAS doctors and 8 temporary or short-term contract holders (trust locums and junior doctors not in a training post)

143 consultants, 19 SAS doctors and 6 temporary contract holders completed their annual appraisal within the prescribed time. Nine doctors were exempt due starting in-year, maternity leave or long-term sickness absence. Fifteen doctors did not complete their appraisal within the year despite repeated reminders, including two temporary contract holders who left before completing their appraisal, eight consultants, one of whom retired without completing his appraisal, and five SAS doctors. Thus the overall compliance rate for appraisal for revalidation is **92%**. This year there has disappointingly been a reduction in the compliance rate for SAS doctors to 79%, which whilst similar to the national rate is less than we have achieved previously. At the time of writing the most overdue appraisals are for two consultants whose last appraisal was in July and August 2013 respectively. Their previous appraisals have been satisfactory and I have no concerns about their fitness to practice.

Eighty-three doctors were due for revalidation during the course of the year and a revalidation recommendation was made by the due date in 79 cases. In 72 cases a positive recommendation was made; nine doctors had their revalidation deferred, in two on two occasions. Three of the deferrals were due to maternity leave, three due to long term sick leave and five due to insufficient evidence being produced as a consequence of delayed or incomplete appraisals. All of these doctors were eventually successfully revalidated. The revalidation recommendation was delayed by up to 48 hours in four cases, three of which were due to late sign-off of the appraisal output form.

No doctors were involved in a remediation process as a result of issues identified at appraisal. However some concerns about the practice of two doctors were identified by our governance processes; both have now left the Trust and the concerns have been communicated to their current RO.

No doctors were subject to disciplinary procedures or referred by the RO to the GMC. Four doctors were referred to the GMC by other routes, none of whom were found to have impaired fitness to practice, but one received a punitive suspension of his licence to practice for two months. Three doctors have removed themselves from the medical register with the agreement of the RO following retirement from clinical practice.

b. Appraisers

The trust has 55 trained appraisers of whom all attended at least one appraiser support group meeting or training session and completed at least two appraisals over the course of the year. All directorates are represented and the pool of appraisers includes SAS doctors.
We held four appraiser support group meetings, and a half day workshop for appraisers, facilitated by the appraisal lead. Topics for discussion were selected by the RO, the appraisal lead and appraisers to ensure they met their needs and included:

- Trust values and behaviours and their link to GMP
- Dealing with health concerns
- Challenging conversations
- Confidentiality
- Raising concerns

The appraisal lead attends NHS England (South) appraisal leads network meetings.

The Head of Learning and Development and the appraisal lead have completed training-the-trainers for appraisal and we are able to offer in-house training to prospective new appraisers.

c. Quality Assurance

Prior to the appraisal meeting the customer care and clinical risk departments supply appraisees and their appraiser information on complaints, concerns and compliments and any incidents they have been named in during the year. However this is reliant on the quality of the indexing on datix and may not always be complete.

We have an appraisal quality assurance board chaired by a non-executive director which has met twice, in September 2014 and June 2015. The board reviews the number, training and engagement of appraisers, the feedback given by appraisees to appraisers and independently reviews a random selection of 10% of completed appraisals using a validated quality assurance scoring tool called PROGESS. The tool allows a score of 0-10 to be allocated where 0-3 is inadequate and 10 is excellent.

At the September meeting a small number of output forms were of poor quality but following further training of appraisers there was a marked improvement in quality by June. The comments were more focussed, reflecting a good appraisal discussion and it was clear that the appraiser had thought about the appraisal beforehand; some of the comments were very personal and insightful. The forms were reflective and included the whole scope of work. Areas for improvement included ensuring that the objectives included in the PDPs were SMART, bringing sufficient challenge to the discussion and identifying gaps in skills or development.

Following the appraisal each appraisee completes a feedback form which is sent to the appraiser and copied to the appraisal lead. Feedback is used to determine the content of the appraisers support group meetings. Over the last year feedback has been overwhelmingly positive including when the doctor has been appraised from outside their own specialty, with the only negative comments being about the e-portfolio system.

d. Access, security and confidentiality

Access to data in appraisal portfolios is limited to the appraiser, responsible officer and appraisal quality assurance board. Doctors are reminded that no patient-identifiable data should be included in the portfolio.
The data is "owned" by the appraisee and can be downloaded to a suitable storage device if the doctor leaves the Trust.

e. Clinical Governance

The Quality Directorate and information services support doctors in gathering evidence for their appraisal, including supplying details of audited clinical outcomes, complaints, compliments and significant events.

6. Recruitment and engagement background checks

Prior to recruitment the medical personnel department carry out relevant background checks including confirmation of the doctor's identity, qualifications and professional registration. Out of hours this is the responsibility of the senior clinician on site.

7. Risk and Issues

The success of the medical appraisal and revalidation process is dependent upon the expertise of a small number of individuals with limited back-up support.

There is a lack of senior expertise in medical personnel at present, risking failure of recruitment checks, limiting the support available for remediation or disciplinary processes, and making it difficult to ensure policies and procedures are kept up-to-date. There is a tension between the Responsible Officer having a statutory responsibility for ensuring that appropriate recruitment checks are carried out including ensuring that doctors are adequately qualified and trained for their proposed duties and have a sufficient grasp of English, with not having line management of medical HR. For consultants this is resolved by the medical director sitting on all recruitment panels but non-consultant level appointments are made at directorate level.

The trust has only three doctors trained as case investigators and one has recently retired.

A small number of doctors are struggling to engage with the process and there is a risk that they will lose their licence to practice; however this is unlikely as compliance increases markedly as the revalidation date draws close. The difficulty will be keeping these doctors engaged in appraisal once they have been revalidated.

8. Next Steps

Although much progress has been made over the last year we need to further strengthen the appraisal process. In particular we want to broaden the focus of the appraisal from merely complying with the GMC regulations to using appraisal to align individuals' values and objectives with those of the Trust. We need to fully exploit the potential of a robust and challenging appraisal to enable medical staff to reach their full potential.

There remain a small number of doctors who are struggling to engage with the appraisal process and they are likely to need intensive support. If this fails the GMC will be notified of their non-engagement.

Our appraisal policy, remediation policy and handling concerns policy all need to be updated.

The necessary legislation to permit English language testing of EU as well as non-EU doctors has recently been passed, and guidance from the GMC in how this will work in practice is expected soon. It is clear that having conversational English at interview will not be regarded as sufficient evidence and doctors may be expected to have their "medical" English formally tested.

9. Recommendations

Board is asked to note this report and agree for it to be shared with the Second Level Responsible Officer. Board is further requested to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance and Performance Committee
Held on 18 May 2015

Present:	Dr N Marsden	Chairman
	Mr L Arnold	Director of Corporate Development
	Mr I Downie	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
	Dr L Brown	Non-Executive Director
	Rev S Mullally	Non-Executive Director
	Mr A Freemantle	Non-Executive Director
	Mr A Hyett	Chief Operating Officer
	Mr P Hill	Chief Executive
In Attendance:	Mr P Kemp	Non-Executive Director
	Mr M Ace	Associate Executive Director
	Mr D Seabrooke	Head of Corporate Governance
	Mrs C Gorzanski	Head of Clinical Effectiveness (for item 2)
	Mrs L Wilkinson	Director of Nursing (for item 2)
	Mr R Webb	Associate Director of Procurement (for item 5)
	Mr P Casson	OML Managing Director (for item 6)

1. MINUTES – 27 APRIL 2015

The minutes of the meeting held on 27 April 2015 were approved as a correct record subject to amendment to item 6 in relation to the submission of the quarterly return to Monitor to indicate that the Trust would revisit the board declaration in relation to the delivery of targets in the coming twelve months, in the next quarterly review.

2. CQUIN REPORT

The Committee received the CQUIN Report for month one.

The target in relation to Sepsis Screening was concerning due to the small number of patients involved. The trajectory for this target continued to be discussed with commissioners. CQUIN seven in relation to ambulatory care could not be agreed until baseline data had been clarified with the commissioners.

In relation to West Hampshire, the scheme for outpatient reform was on track. For Delayed Transfers of Care the requirement was to deliver an acute patient Alert IT system by the end of Quarter 2 and this proposal continued to be discussed.

In relation to the contract a recent proposal from commissioners was being considered but it was clear that there remained a significant financial gap to be covered. The Committee agreed that the Trust should not sign up to targets that were unclear but it was not believed that it could deliver on.

The committee noted the CQUIN Report.

3. FINANCE REPORT TO 30 APRIL

The Committee received the Finance and Contracting Report to 30 April. The Committee noted that work was continuing to confirm the positions set out in the report.

The income and expenditure position was deficit of £1.1m which was a variance against the Monitor plan of £193,000 surplus. Cost improvement programmes were underway, but delivery of savings was behind plan at this stage. Variances for the Medicine and Surgery Directorates were noted and this was attributed mainly to non-pay factors. Nursing budgets were £187,000 overspent in month with agency spend at £443,000 which was higher than in 2014/15. It was noted that work was continuing to manage agency spend appropriately in terms of the management information and authorisation processes as well as efforts to increase the numbers of nurses registered with the nurse bank.

There had been challenging discussions with senior managers about the need to balance quality and financial considerations. Sizeable savings needed to be identified to meet the Trust's savings requirements.

The Committee noted the Finance Report to 30 April.

4. CAPITAL DEVELOPMENT REPORT

The Committee received the Capital Development Report. It was noted that work towards the Springs main entrance redevelopment was continuing with tender specifications being issued and planning permission sought. Work towards the new Breast Care Unit was underway and subject to the success of the charitable fundraising building work was expected to start later in 2015. Improvements to wards on SDH North were being planned and would include the Surgical Assessment Unit. Building work on the expanded Maternity Unit was expected to start in early 2016 to complete in spring 2017.

Benefits realisation was a focus of the work towards an Electronic Patient Record.

It was suggested progress of the Laundry Dispatch Unit for which the Trust had provided loan finance should be included in the report.

The Committee noted the Capital Development Report.

5. HEAD OF PROCUREMENT

The Committee received the Annual Report and overview objectives for 2015/16 for the Trust's Procurement and Commercial Services Department.

Rob Webb highlighted the following principal points –

- The service had reduced Single Tender Actions in the Trust.
- The Bravo Health System would enable more analysis on non-pay spend to drive out further value in this area.
- The Trust was engaging via the Southern Procurement Partnership with a number of other larger Trust's in the locality.

- The Service had a £800,000 cash releasing efficiency savings target.
- A revised procurement strategy was under development.

It was noted that there were further potential savings in clinical areas but these would require careful handling and would need to undergo a Quality Impact Assessment. It was noted that issues in the Supply Chain had affected the Pharmacy Homecare Initiative.

The Chairman thanked the Head of Procurement and team for their work in this area.

6. ODSTOCK MEDICAL LIMITED

The Committee received the profit and loss account to March 2015 for Odstock Medical Ltd and further information about the company's activities was provided at the meeting. It was noted that a profit of £43,000 had been made in 2015/16. The company had purchased Orderwise to improve its stock control and had invested in further marketing materials. It had seen an increase in referrals as a result of advertising and there had been an increase in outreach centres. Growth in the business was expected. The product portfolio was developing so that more premium products were available.

The Chairman of OML reflected on a challenging past two to three years and on the developing product range.

The Committee noted the report.

7. TRANSFORMATION AND COST IMPROVEMENT

The Committee received the Transformation Plan Tracker. It was noted that against the planned savings requirement just over £5m worth of savings schemes had been identified. The monthly target for April was £526,000, of which £204,000 had been achieved although this was subject to confirmation because of unconfirmed income schemes. Work continued to fill the plan gap of £3m.

It was noted that much of the schemes identified were rated as red or amber.

Non-Executive Directors were prepared to offer assistance in terms of their experience and expertise in delivering this although there needed to be clarity as to how this would work in practice.

The Committee noted the Transformation Plan Tracker Report.

8 OPERATIONAL PERFORMANCE

The Committee received the Operational Performance Report for Month One. It was noted that in April the Trust had missed the Symptomatic Breast Cancer Two Week Wait target by a small margin. There had been peaks in demand for diagnostic tests and the Trust had failed on the Four Week and Six Week targets.

Delayed Transfers of Care were reported as being 14.

It was noted that in relation to the Two Week Wait extra clinics were being provided to address the backlog.

It was noted that many of the performance indicators were close to this threshold.

9 STERILE SERVICES PROPOSAL

The Committee received a confidential report from the Director of Finance describing a proposal for a commercial partnership for the provision of Sterile Services. The company concerned was a market leader in this area and was proposing a joint venture with the Trust which it was believed had the potential to improve on costs in this area.

The company's expertise would increase the opportunity to bring in extra work and profit into the arrangement.

The Committee was of the view that the Trust should only consider the proposal further on the basis of a 50/50 share of the venture, but with the company having operational control.

It was agreed that discussions could continue on this basis.

10 DATE OF NEXT MEETING

Monday 29 June 2015 at 9.30am

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance and Performance Committee
Held on 29 June 2015

Present:	Dr N Marsden	Chairman
	Mr L Arnold	Director of Corporate Development
	Mr I Downie	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
	Dr L Brown	Non-Executive Director
	Mr A Freemantle	Non-Executive Director
	Mr A Hyett	Chief Operating Officer
	Mr P Hill	Chief Executive
	Rev S Mullally	Non-Executive Director
In Attendance:	Mr P Kemp	Non-Executive Director
	Mr M Ace	Associate Executive Director
	Mr D Seabrooke	Head of Corporate Governance
	Mrs C Gorzanski	Head of Clinical Effectiveness (for item 2)
	Mrs L Wilkinson	Director of Nursing (for item 2)
	Mrs K Stovin-Bradford	Business Relations Manager (item 9)

1. MINUTES – 18 MAY 2015

The minutes of the meeting held on 18 May 2015 were approved as a correct record subject to an amendment to minute 3 (second paragraph, first sentence as follows – "The actual income and expenditure position was a deficit of £1.1m whereas the plan submitted to Monitor was for a £900,000 deficit i.e. an adverse variance of £193,000."

2. MATTERS ARISING

Sterile Services Proposal

It was noted that following the Committee's discussion further negotiations had taken place and had progressed to a heads of terms agreement, which would see a substantial reduction in costs and could be taken into other related areas of activity.

3. CQUIN REPORT MONTH 2

The Committee received a revised CQUIN Report for Month 2. The financial value of Wiltshire and Dorset CQUIN 6 was still being worked on and the target in relation to Sepsis was still under negotiation. It was also noted that the West Hampshire scheme on Delayed Transfers of Care had not been agreed. In relation to Wiltshire and Dorset CQUIN 7 this may need to be escalated to the Chairman for resolution.

4. FINANCE AND CONTRACTING REPORT FOR MONTH 2

The Committee received the Finance and Contracting Report. The income and expenditure position was a year to date deficit of £1,826,000 which represented an adverse variation against the plan of £406,000. This was attributed principally to high spend on agency staffing and cost improvement programmes being less than planned by £440,000. It was noted that actions had been taken to improve management controls in relation to authorising agency spend and that a number of winter escalation beds had been closed at the end of May.

The following principal points were made:

- Some selective use of enhanced rates of hard to fill areas had been offered but the most beneficial improvement was the introduction of weekly pay for nursing staff on the Trust's bank.
- Although the case mix had changed over the time reducing average length of stay was crucial to protecting income.
- Improvements to the Trust's capacity and demand planning for beds were being progressed.

It was noted that the Trust would be begin to draw down on the previously agreed FTFF loan.

It was noted that Monitor were consulting on changes to the continuity of service risk rating through the proposed introduction of two new components to the risk assurance framework.

Forecast outturns would be included from the month 3 report onwards. MCa

5. COMMUNITY SERVICES BID UPDATE

LA reported that the 130,000 word submission had been completed and submitted which would lead onto dialogue days in July. Work was underway to model the impact of the contract and this would be discussed at the forthcoming Board Seminar Day. There was a meeting of the three Directors of Finance and a summit of Chief Executives and Chairs planned for 23 July.

The contract was not thought to constitute a significant transaction for the Trust in accordance with the Monitor definition. It was noted that the contract as specified and currently delivered did not make a surplus.

6. TRANSFORMATION AND COST IMPROVEMENT UPDATE

The Committee received the Programme Management Office Report for Month 2, plus return to green reports for patient flow and nursing workforce. It was noted that in-depth meetings with directorates were continuing and that three quarters of the required savings had been identified at this stage. However the remainder, £1.9m requirement was not it was thought capable of being completely closed by individual directorate actions. It was also noted that some schemes had been refused as not viable or on quality grounds.

It was noted that the work led by Lord Carter would be the subject of a meeting hosted by the Trust on 9 July.

7. ANNUAL REVIEW OF TERMS OF REFERENCE AND EFFECTIVENESS

The Head of Corporate Governance put forward some discussion points to the Committee as follows:

- All members of the Committee could expect to be interviewed by the Care Quality Commission in the forthcoming inspection around the Well Led agenda.
- How good was the Committee's reporting to the Trust Board?
- How effective were its relationships with other components of the Trust's system of governance?
- How effective were the proceedings and information it received and was the composition appropriate?

The Committee reflected as follows:

- The committee was felt to be appropriately sized.
- It was thought that relationships, particularly with Clinical Governance Committee and Audit Committee were good and effective.
- The reporting of the Committee's proceedings to the rest of the Board was an area to consider.
- The Committee provided a valuable forum to discuss the business of the Trust in an open and honest way.

The Chairman undertook to consider these points in relation to the review work that had been led by Thames Valley & Wessex Leadership Academy.

8 OPERATIONAL PERFORMANCE MONTH 2

The Committee received the Operational Performance Report for Month 2. It was noted that performance on diagnostics was currently shown as red but a recovery programme for this was underway. The rate of cancelled operations should improve in June. The Committee was reminded that single patients could make a difference to the Trust's performance on the Cancer targets.

AH undertook to review the benchmarks for length of stay. AH

9 MARKET SHARE INFORMATION

The Committee received the market share analysis.

Market share was broadly static and there was concern about greater use of New Hall and the Devizes ISTC particularly for orthopaedic procedures driven by differences in waiting times. It was suggested that there could be a business plan aimed at increasing the Trust's market share in this area which would be helpful to the Trust's income. Work continued with GPs through education sessions.

The Committee thanked Kate Stovin-Bradford for the report.

10. REFERENCE COST COLLECTION EXERCISE 2014/15

The Committee received the report of the Director of Finance providing assurance as to the Trust's system for the collection of Reference Costs for 2014/15 in accordance with Department of Health guidance.

The Committee confirmed that is was satisfied with the Trust's costing processes and systems and that the cost return would be provided in accordance with the guidance.

10 DATE OF NEXT MEETING

Monday 27 July at 9.30 am

TRUST BOARD

FINANCE & CONTRACTING REPORT TO 30th JUNE 2015

1. Introduction

This paper outlines the main drivers behind the SFT Group consolidated financial position for the period ending 30th June 2015.

The Income & Expenditure (I&E) position was a Year-to-Date (YTD) deficit of £2,494k (before adjusting for donated income of £157k), an adverse variance against the plan of £398k. (Appendix 1)

The main reasons for the YTD adverse variance were:

- High expenditure on agency. Action has been taken to reduce the number of escalation beds and new management controls have been introduced to strengthen the agency approval process. There has been a notable reduction in nursing agency spend this month.
- CIPs savings being less than planned by £487k (34%).

Summary of Key Financial Information	YTD (Cumulative to June)			
	Plan £000s	Actual £000s	Var £000s	Var %
Income	49,886	49,461	(425)	(0.9%)
Expenditure	48,171	48,090	81	0.2%
EBITDA	**1,715**	**1,371**	**(344)**	**(20.1%)**
Finance Costs	3,811	3,865	(54)	(1.4%)
I+E Surplus /(Deficit) excl donated asset income	**-2,096**	**-2,494**	**(398)**	**(19.0%)**
Donated Asset Income Adjustment	100	157	**57**	57.0%
I+E position including donated asset income	**-1,996**	**-2,337**	**(341)**	**(17.1)%**
Adverse variance in brackets				

In month there was a reduction in the monthly deficit run rate as a result of:-

- A reduction in spend on temporary staff of £230k when compared to last month due to closure of escalation beds and new management controls.
- Income improvements mainly reflecting additional activity in most areas.
- Additional stock adjustment of £70k for bulk purchasing.

2. Sales

NHS activity revenue was £42,595k which was circa £5k less than plan. Excluded pass-through drugs under-performance was £339k and was offset by a similar underspend on expenditure. The balance of the over-performance can be summarised as follows:-

- Elective Inpatients underperformance was (£188k) mainly in General Surgery and Trauma & Orthopaedics.
- Day Case underperformance was (£290k) and this was an improvement in month. Activity has increased when compared to the previous period last year however the planning target was for average increase of 7% on outturn for 2014/15. The key areas of under-performance were: Colorectal Surgery, Ophthalmology and Cardiology.

Referrals have increased substantially and more day case capacity is planned to meet demand.

- Non-Elective Inpatients over-performance was £678k and is now reimbursed at 70% of tariff. This was sufficient to offset the shortfall on elective and day case activity. The favourable variance is partly due to the way that we report the maternity activity and this has been agreed after the Monitor plan submission.
- Outpatient attendances and procedures underperformance was (£20k), a significant improvement in month. Overall activity was above plan by 100 attendances.

Contract Activity Performance 2015/16 (June 2015)	Actual 2014-15	Actual 2015-16	Plan 2015-16	Year on Year Variance	Plan Variance
Elective inpatients	1,448	1,423	1,527	-25	-104
Elective PSDs/day attenders	5,240	5,487	5,979	247	-492
Regular Day Attenders	1,767	1,854	1,661	87	193
Non Elective Inpatient	6,370	6,571	6,095	201	476
Outpatient initial attendances	16,275	16,336	16,106	61	230
Outpatient follow-up attendances	29,314	27,018	27,247	-2,296	-229
Outpatient procedures	8,904	8,896	8,567	-8	329
A&E attendances	11,614	11,453	10,779	-161	674
Favourable Variances are shown as +ve					

Other income was behind plan by £420k and this relates to clinical and non-clinical activity including: services provided to other NHS organisations, Road Traffic Accident (RTA) and overseas patient income.

3. Cost of Sales including indirect costs

The total for all Directorates was an overspend position of £1,287k. The position is summarised below:

Directorates	In Month			Year to Date (Cumulative)		
	Plan	Actual	Var	Plan	Actual	Var
	£000s	£000s	£000s	£000s	£000s	£000s
Medicine	3,251	3,286	(35)	9,895	10,313	(418)
Musculo Skeletal	2,392	2,478	(86)	7,041	7,308	(267)
Surgery	2,745	2,875	(130)	8,299	8,757	(458)
CSFS	3,081	3,115	(34)	8,996	9,101	(105)
Facilities	363	353	10	1,037	1,024	13
Corporate	1,880	1,702	178	5,621	5,673	(52)
TOTAL	**13,712**	**13,809**	**(97)**	**40,889**	**42,176**	**(1,287)**
Adverse variance in brackets						

All pay and non-pay costs and provisions have been fully accrued, and inflation and other reserves, including agreed cost pressures, have been added to budgets as appropriate.

Medicine

The Year to Date (YTD) overspend of £418k was mainly attributable to the cost of agency staff due to the high level of nursing vacancies on wards. Action has been taken to strengthen the controls on use of agency and reduce the number of escalation beds and medical outliers. This has resulted in a significant reduction in agency costs and the adverse variance in month was significantly less than the previous months.

Musculo-Skeletal

The YTD overspend of £267k was mainly due to charges of £126k for LLP (private contractor), the high use of temporary staff due to vacancies and the shortfall in CIPs of £167k resulting from a delay in the start-up of savings schemes. The gap on the savings target has been closed and the focus is now on the delivery of saving schemes.

Surgery

The YTD overspend of £458k was due to a shortfall on CIPs of £245k mainly relating to unidentified schemes and the additional cost of agency staff due to nursing vacancies. Action has been taken to manage agency spend and close the gap on unidentified schemes.

Clinical Support & Family Services

The YTD overspend of £105k was due to underperformance on CIPs as a result of unidentified schemes. Work to close the gap is on-going and progress has been made to find the additional savings.

Facilities

Facilities services were marginally under-spent and on target to achieve savings target.

Corporate services

In total corporate services were overspent YTD by £52k due to unmet savings. Further work is taking place to address this.

4. Cost Improvement Plan

The total cost improvement savings target for the year is £8.0m which includes revenue Income Generation (IG) schemes of £2.1m.

The Trust has achieved savings and income generation of £957k against a plan target of £1,444k an adverse variance of £487k. It is recognised the CIP programme is back loaded and therefore on a straight line basis the Trust is £1,043k (48%) below where it should be.

At the time of preparing this report, unidentified schemes amounts to £1,869k (23%) (last month £2,489k); Red and Amber rated schemes of £2,909k (last month £2,883k) and Green rated schemes of £3,222k (last month £2,628k). Clinical Directorates & Corporate Services continue to work on developing schemes and finalising the deliverability of key project milestones and the monthly phasing of savings. Considerable work is required to identify sizable change projects that will release significant savings.

5. Statement of Financial Position

5.1 Working Capital including Cash

Overall the working capital position (Current Asset less liabilities) was behind plan by £521k due to the deficit being greater than planned.

The cash balance at 30th June 2015 was £10,392k, which was £6,030k behind plan. This was caused by a number of reasons.

i) NHS England (mainly specialist commissioning) failed to make any payment in June (monthly payment was due on 15 June), with funds eventually being received on 1 July 2015. Total amount was £2.3m. This matter has been raised with NHS England and the July payment was received on time.
ii) Wiltshire CCG was invoiced, and paid, the first 3 months based on an annual value of £86m. The plan is now based on a value of £88m. The CCG have accepted this higher value for invoicing purposes. Future invoices and payments will be based on this amount. The invoice for July reflects this sum and includes the shortfall for the period to 30 June 2015.
iii) The Trust has made a number of prepayments and bulk purchases of stock (the latter to secure improved prices).
iv) The remainder primarily relates to the deficit exceeding plan, the capital programme being slightly in advance of plan and a five week month for payments to suppliers where the plan assumes an average monthly payment for the year.

6. Capital Expenditure (Appendix 2)

Expenditure was £1,410k which was ahead of plan by £360k and efforts are on-going to reduce capital expenditure where possible.

7. 2015-16 Contracts

There continues to be on-going discussions with Wiltshire CCG to finalise the contract and supporting schedules for the end of July. An overall financial and activity envelope has been agreed and considerable progress has been made to agree the CQUIN targets. Wiltshire CCG continues to challenge activity which they believe requires prior approval. Discussions are being held at senior level to clarify the challenge process and understand more fully the CCGs expectations around this policy.

Wiltshire CCG has indicated that they will be issuing details of information breaches and there are financial penalties attached to this if the Trust does not address these issues. However, they have indicated a willingness to reinvest the fines that are to be applied in relation to mixed sex breaches as long as robust plans are put in place to resolve the on-going breaches, other fines will not be reinvested. The CCG has acknowledged that QIPP plans are not delivering and this risk lies with the CCG.

Although Heads of Terms have been signed with Dorset CCG and the Hampshire CCGs (SHIP) Consortia, work continues in relation to the agreement of the various contract schedules before the contracts can be formally signed. Contracts with both Dorset and SHIP will be signed once the CQUIN schedules with Wiltshire CCG have been finalised.

The Trust has received an initial draft contract from NHS England for specialist services. The activity and finance envelopes for specialist services, offender health, dental, screening and military contracts have been agreed. CQUIN schemes have been agreed for rehabilitation post critical care discharge; two year outcomes for infants born less than 30 weeks; prevention of hyperthermia in pre-term babies and to reduce separation of mothers and babies by improved learning from avoiding admissions into NICU.

8. Risks and Forecast Outcome for 2015/16

The Trust's key financial risks can be summarised as follows:

- Deliver the CIP target of £8m; this is the greatest financial challenge;
- Developing CIPs for future years;
- Contractual challenges from CCGs;

- Meet contractual obligations and avoid penalties;
- Delivery of CQUIN targets;
- Unplanned growth of non-elective activity which has a detrimental impact on elective work;
- Match capacity to demand in the most cost effective way in order to avoid losing work to local competitors.

The agenda currently being faced is huge and is in addition to the work necessary to drive forward savings. Particular examples include: Wiltshire CHS tender, Genomics, Dorset pathology work, SDU changes, and the EPR project. All these have costs associated with them, much of which will be capitalised, but all have significant implications for senior management time.

The Trust is also facing a continual growth in cost pressures and demand for funds that it simply does not have. Examples include: nursing and midwifery staffing, a growing number of services are requesting more doctor time, recruitment problems driving agency usage, growth in services such as cardiology and endoscopy, bed pressures, etc. Generally speaking we are not seeing a level of income growth which supports the requests.

Forecasting the year end is obviously dependent on our response to much of the above. As things stand we can expect some level of growth in income and given that QIPP is not really effective at present the growth could be up to £3m, albeit some paid at 70% of tariff. If we assume we receive all CQUIN payments at 100%, and there is limited impact of BCF on activity whilst helping us to reduce length of stay then it is possible to see a contribution to cost pressures and CIPs of say £1.5m. This would bring us roughly in line with our planned deficit of £6m. Clearly delivery of CIPs is top of the list in supporting this position.

As we move forward during the year we will refine the forecasting and also have better SLR information which will help us to have greater clarity.

9. Other Issues

Given the significant financial challenges and the deteriorating performance of acute providers, Monitor is proposing changes to the risk assessment framework and the accounting officer memorandum. These changes will enable Monitor to take regulatory action earlier if a Trust is in deficit, failing to deliver its financial plan, or not providing value for money. The consultation closed on 1st July and the Trust's response can be summarised as follows:-

- The scores for the rating categories are too narrow and therefore too sensitive to any change in performance.
- Duplication of the financial criteria used in some of the metrics
- I&E surplus & deficit can be significantly distorted by donations under their plans
- Under the proposals there are likely to be more than a hundred Trusts that Monitor would need to be heavily involved with and the question is whether this makes sense or is realistic.

Using the new risk rating matrix the Trust would score an overall rating of 2, which is described as a material risk, subject to a likely investigation and potential improvement support. As the Trust's planned deficit is greater than 2% which rated as 1, the Trust's overall risking is therefore capped at 2. It is highly likely that the majority of acute providers would either score a 1 or 2

10. Conclusions

After three months of the financial year the Trust is showing a deficit of £2,494k (before donation of £157k), an adverse variance against plan of £398k. It is important that the Trust continues to achieve savings, manage budgets tightly and undertake more profitable elective work.

The Trust has achieved a Monitor Continuity of Services Risk Rating of 3.

11. Recommendation

The Trust Board is asked to note the report and consider any further actions necessary.

Malcolm Cassells
Director of Finance and Procurement
20th July 2015

Appendix 1 - SUMMARY STATEMENT OF COMPREHENSIVE INCOME

	In month			YTD (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Operating Income						
NHS Clinical Income	12,947	13,429	482	38,907	39,241	334
High cost drugs income	1,211	1,184	(27)	3,693	3,354	(339)
Other Clinical Income	892	547	(345)	2,000	1,644	(356)
Research & Development & Education	502	539	37	1,623	1,587	(36)
Other (Excluding Donated Asset income)	1,243	1,043	(200)	3,663	3,635	(28)
TOTAL INCOME	**16,795**	**16,742**	**(53)**	**49,886**	**49,461**	**(425)**
Operating Expenditure						
Pay - In post	9,883	9,919	(36)	29,649	29,752	(103)
Pay- Agency & Locums	705	915	(210)	2,115	2,834	(719)
Drugs	1,465	1,400	65	4,559	4,211	348
Clinical Supplies	1,767	1,610	157	4,848	4,726	122
Non-Clinical Supplies	977	1,111	(134)	2,786	2,668	118
Other (incl PFI unitary charge)	1,404	1,144	260	4,214	3,899	315
TOTAL EXPENDITURE	**16,201**	**16,099**	**102**	**48,171**	**48,090**	**81**
EBITDA (Earnings Before Interest, Tax, Depreciation & Amortisation)	**594**	**643**	**49**	**1,715**	**1,371**	**(344)**
Financing Costs	1,270	1,311	(41)	3,811	3,865	(54)
SURPLUS / (DEFICIT) excluding DONATED ASSET INCOME	**(676)**	**(668)**	**8**	**(2,096)**	**(2,494)**	**(398)**
Donated Asset Income	100	146	46	100	157	57
SURPLUS / (DEFICIT)	**(576)**	**(522)**	**54**	**(1,996)**	**(2,337)**	**(341)**

Appendix 2 - CAPITAL EXPENDITURE

Project Name	15/16 Board Approved + 14/15 final slippage - 14/15 b/fwd £	Adjustments to final Plan £	Revised Plan £	Spend to 30th June 2015 £	Under/(Over) spent on Project £
Donated Assets					
Bariatric Bed	11,140	0	11,140	0	
Clinical Radiology 2 x Ultrasound	137,008	0	137,008	0	
Dermatology UV Light	15,300	0	15,300	0	
O&G Bladderscanner	6,985	0	6,985	0	
Orthodontics & Oral Surgery Cone Beam CT Scanner	110,000	0	110,000	0	
Small Donated Additions	0	145,825	145,825	145,825	
Spinal Refurb ADL Bathroom (LoF contribution)	10,792	0	10,792	0	
Spinal Unit Ultrasound	35,542	0	35,542	0	
Vascular Unit Ultrasound Machine	65,475	0	65,475	0	
Donated Assets - Totals	**392,241**	**145,825**	**538,066**	**145,825**	**0**
Phase 3 Building Schemes					
Breast Unit enabling	50,000	0	50,000	0	
CT Scanner Building and Enabling	11,822	0	11,822	1,000	
Decant Ward	500,000	330,000	830,000	260	
Helter Skelter Storage	150,000	-149,350	650	650	
Maternity development 1st (2015/16)year of 2	500,000	0	500,000	0	
Radnor Ward Development	164,191	0	164,191	24,687	
SDU Development	0	50,000	50,000	0	
Springs entrance development	1,310,252	0	1,310,252	42,362	
Ward changes - Dementia Patient Care	10,112	-6,000	4,112	0	
Building Schemes - Totals	**2,696,378**	**224,650**	**2,921,028**	**68,959**	**0**
Building and Works					
Accommodation - Langley House Kitchen Upgrade	3,461	-3,461	0	0	
Accommodation key security	7,000	0	7,000	0	
Accommodation replacement of kitchens and bathrooms	150,000	-16,539	133,461	348	
AHU replacement yr 3 (2014/15) of 7	352,559	8,600	361,159	3,918	
Asbestos management	18,222	0	18,222	450	
Avon House Boiler Replacement	0	20,000	20,000	0	
BMS upgrade 3rd year of 3 - invest to save	42,642	0	42,642	59	
Boiler house demolition	0	0	0	0	
Car park 8 machinery replacement - [? Part insurance claim]	96,000	0	96,000	0	
Catering Dishwasher	126,000	0	126,000	0	
Catering oven	17,000	0	17,000	0	
Catering refrigeration upgrade	9,560	0	9,560	0	
Catering thaw cabinet	8,000	0	8,000	0	
Catheter Suite - Rebalance of Heating System	18,400	0	18,400	0	
Central booking relocation - block 79 (Wilton ward)	100,000	0	100,000	0	
Central Clinical Notes Preparation	617	0	617	4,429	(3,812)
DSU Replacement Insulation to Air Handling System	8,600	-8,600	0	0	
DSU Roof Repairs	58,856	0	58,856	19,340	
DSU Theatres - Flooring	1,882	0	1,882	0	
Ductwork & Fire Damper Cleaning Whole Site Year 3 of 3	188,865	0	188,865	44,308	
ED Data Centre Ventilation	78,999	40,000	118,999	0	
Electricity at Work Regulations Compliance	82,744	0	82,744	3,515	
Estates health and safety	10,000	0	10,000	0	
Eye clinic expansion	4,292	0	4,292	0	
Finance fire alarm system upgrade	21,600	0	21,600	0	
Fire alarms - detection & prevention equip - various	4,487	0	4,487	0	
Fire compartmentation SDH north - remedial works	28,407	0	28,407	0	
Flooring Replacement (including Stairwells)	67,744	0	67,744	0	
General laboratory replacement autoclave	60,000	0	60,000	0	
Genetics Modular cold room	26,000	0	26,000	0	
Glanville Roof	0	7,200	7,200	0	
Hospice fire alarm	30,000	0	30,000	0	
Lab Medicine Cold Room	36,000	0	36,000	0	
Level 4 Bedspace Power Sockets	61,610	0	61,610	0	
Lightning Conductor	0	12,000	12,000	0	
LIfts overhaul - year 3 (2014/15) of 3	66,379	0	66,379	0	
Main boiler burners	60,000	0	60,000	0	
Main Entrance L3 Upgrade	10,076	0	10,076	721	
Main operating theatres recovery area	56,000	0	56,000	0	
Main Theatres 4th Laminar Flow System	185,000	0	185,000	0	
Maternity Obstetric Theatre Refurbishment	78,000	-19,000	59,000	0	
Maternity Post Natal Upgrade	121,550	0	121,550	2,413	
Maternity Relocation - Enabling	1,622	0	1,622	218	
Mattress Laundering	2,521	0	2,521	0	
Medical Gas Hoses 2nd year of 2 (2015/16)	147,000	0	147,000	0	
Microbiology - Category 3 Room	2,025	0	2,025	0	
Mortuary washer disinfector	10,000	0	10,000	0	
Noise Reduction & Facilities Equipment	26,368	0	26,368	0	
Nurse Call System Upgrade - SDH North & Maternity - 2nd year of 2	133,167	0	133,167	0	
OHSS replacement windows	27,000	0	27,000	0	
Old GUM Clinic Demolition	13,998	0	13,998	8,614	
Orthotics Move and Radiology Bowel Screening Relocation	33,315	0	33,315	29,720	
Owlswood houses x2 blocked cavities	30,000	0	30,000	0	
Pathology - air tube upgrade	36,000	0	36,000	0	
Pathology - conversion of computer room to office	12,000	0	12,000	0	
Pathology Reception	44,000	0	44,000	6,868	
Pedestrian crossings	66,000	-66,000	0	0	
Portering bed movers	23,000	0	23,000	0	
Powered Door Curtains Level 2	30,000	0	30,000	0	
Productive Operating Theatres	18,542	0	18,542	0	
Public & Staff WCs L5,L4,L3	86,598	0	86,598	0	
Public Spaces Fund	13,425	0	13,425	984	
Radiology Recovery Area Improvements	603	0	603	0	
Roads and paving repairs	160,169	66,000	226,169	0	
Sarum Ward Playdeck	0	0	0	0	
SDH North Drain Survey	15,000	0	15,000	7,200	
SDU Washers	148,605	0	148,605	15,870	
Security Improvements	48,921	0	48,921	3,817	
Server Rooms - Air Conditioning	16,890	0	16,890	0	
Shower Cubicle Drainage Improvements	30,000	0	30,000	0	
Site Signage	2,462	0	2,462	43	
Spinal treatment centre refurbishment	169,286	52,000	221,286	144,799	
Spinal Unit Doors and Locks	0	35,000	35,000	0	
Spinal Unit Double Glazing 2nd year of 2 (2015/16)	60,000	-60,000	0	0	
Spinal Unit Fire Escape	27,000	-27,000	0	0	
Springs servery upgrade - floor and freezers only	75,000	0	75,000	0	
Taps & IPS panels - sitewide	60,000	911	60,911	5,185	
Theatres 1 - 10 Replacement Taps	911	-911	0	0	
Walls - repairs to failing walls	8,000	0	8,000	0	
Water tanks access - main tanks only	30,000	0	30,000	0	
Wessex Rehab Windows and Cladding	11,466	0	11,466	0	
Wilton Ward Winter Pressures 13/14 (Block 79)	10,000	0	10,000	0	
Building Projects/Building and Works Totals	**3,927,447**	**40,200**	**3,967,647**	**302,819**	**(3,812)**

Appendix 2 - CAPITAL EXPENDITURE

Project Name	15/16 Board Approved + 14/15 final slippage - 14/15 b/fwd	Adjustments to final Plan	Revised Plan	Spend to 30th June 2015	Under/(Over) spent on Project
Information Technology					
Alternative to Microsoft products - review	50,000	0	50,000	0	
Aruba expansion	34,000	0	34,000	0	
Baby Tagging - RFID	66,000	0	66,000	0	
Backup Tape Library Replacement	470	0	470	3,309	(2,838)
Bighand 2015 AMS Renewal	0	0	0	0	
Blood Tracking	8,891	0	8,891	0	
Blood Tracking Phases 1 - 3	225,439	0	225,439	0	
BMS Network Upgrade	16,596	0	16,596	3,134	
Brocade Switch Replacement	5,004	0	5,004	0	
Clikview Reporting System	80,000	0	80,000	0	
Clinical Coding Encoder	13,168	0	13,168	0	
Cohort system - Occupational Health	44,000	0	44,000	18,240	
Community Midwifery system trial	35,748	0	35,748	0	
Connectivity Upgrade for Warminster & Shaftesbury	42,000	0	42,000	0	
EDCR-Changes to improve air flow and balance	3,468	0	3,468	0	
Edge Security replacement	651	-651	0	0	
Electronic Letters	20,148	0	20,148	3,759	
EPMA (Yr 2 (2014/15) of 7)	47,011	-47,011	0	30,740	(30,740)
Estates - Oracle software interface	24,000	0	24,000	0	
Exchange 2010 Upgrade	1,949	0	1,949	0	
Genetics - software upgrade	101,000	0	101,000	0	
Genetics High Spec Analysis Equipment & Software	57,691	0	57,691	0	
Histopathology Hardware	13,384	0	13,384	1,973	
IBD register	10,000	0	10,000	0	
Inhouse development team - applications, databases and Dashboards (subject to bus case)	92,176	0	92,176	15,133	
iPad Security	160	0	160	0	
Maintenance renewal - estimate	650,000	0	650,000	0	
Microsoft Licensing - being challenged	500,000	0	500,000	503,720	
Mobile Computing	19,151	0	19,151	957	
Mortuary module	52,000	0	52,000	0	
Network - unsupportable equipment	52,000	0	52,000	0	
Network Load Balancers	12,690	0	12,690	0	
Network Upgrade Consultancy	68,910	0	68,910	2,880	
Neurophysiology Project	726	-726	0	0	
Nexus 5 Expansion	7,809	0	7,809	2,337	
Open eyes phase II	153,938	0	153,938	5,812	
Order Comms – additional development	41,000	47,011	88,011	0	
Order Comms (includes System Admin Bid & Sexual Health Bid)	15,265	0	15,265	0	
PACS Reprocurement	68,308	0	68,308	274	
Palliative Care EPR	39,437	0	39,437	0	
Paperless Real-time Patient Status	200,000	0	200,000	0	
PAS 2016 Replacement - Consultancy Costs	7,606	1,970	9,576	8,205	
Patient Observations Monitoring and Decision Support/Early Warning System/POET	32,029	0	32,029	35,405	
Patient Tracking	238	-238	0	0	
Radiology - OrderComms	46,602	0	46,602	742	
Radiology Replacement PC's	522	-306	216	216	
RAM Asset Maintenance Module	2,999	0	2,999	1,361	
Replace 6509x3 network hubs	350,000	0	350,000	0	
Results System in GP Practices 'Review' System	19,678	0	19,678	0	
SBAR for PAS	38,447	0	38,447	7,129	
SBAR re NACS Update to ED Symphony	7,500	0	7,500	0	
SBAR re UPS Replacement (formerly UPS Replacement - Room based for Computer Rooms)	21,150	0	21,150	0	
Scanned Health Rtecords	2,292	0	2,292	0	
Scriptlogic licenses and upgrade	67,000	0	67,000	0	
SDU Quality System	1,727	0	1,727	2,399	(671)
SLAM	805	0	805	0	
Telecomms Voice Over IP - invest to save (non clinical areas - subject to a telephony strategy)	167,000	0	167,000	0	
Telepath enhancements	8,245	0	8,245	0	
Telepath to CSCLims (Phase 3 / Year 3 of 4 2015/16)	75,000	0	75,000	0	
Therapy information system	45,000	0	45,000	0	
Tray Tracking	71,000	0	71,000	41,744	
Upgrade of low spec equipment (680 machines)	265	-49	216	216	
UPS Replacement Programme	24,202	0	24,202	0	
VMWare Upgrade	20,000	0	20,000	0	
Wireless Expansion and Coverage	122,582	0	122,582	0	
Information Technology Totals	**4,006,077**	**0**	**4,006,077**	**689,683**	**(34,249)**
Medical Devices					
Anaesthetic Machines	1,931	0	1,931	0	
Anaesthetic monitors x2 - DSU	26,000	0	26,000	0	
Arthroscopy telescope/sheath replacement - DSU	58,000	0	58,000	0	
Bariatric Equipment	1,054	0	1,054	11,640	(10,586)
B-Braun Review of Theatre Instruments	704,237	0	704,237	10,606	
BED replacement programme - 3rd (2015/16) yr of 4	158,047	0	158,047	31,071	
Bowel Scope Programme	-29,000	41,000	12,000	0	
DSU Operating Theatre Lights	40,755	0	40,755	0	
ED Trolleys x 20	15,726	0	15,726	0	
Fluoroscopy x-ray machine - radiology room 8	330,000	-282,500	47,500	0	
Foetal Heart Monitors X 6	7,531	0	7,531	0	
General x-ray machine - Westbury - radiology	99,000	0	99,000	0	
Grouped Items 2014/15	6,543	0	6,543	0	
Grouped Items 2015/16	100,000	11,800	111,800	35,752	
Maternity Theatre Equipment	7,014	19,000	26,014	0	
Medical Equipment < £50k 13/14	21,433	-21,433	0	0	
Medical Equipment <£50k 14/15	152,429	-26,067	126,362	5,886	
Medical Equipment <£50k 15/16	384,262	-80,800	303,462	86,814	
O&G Ultrasound	11,734	0	11,734	0	
Patient monitoring and stations 2nd phase of 2	9,267	0	9,267	0	
Patient trolleys x 14 + 1 Radiology	2,483	0	2,483	0	
Pitton Monitoring	0	16,500	16,500	0	
Power tools replacement/upgrade - theatres/DSU/oral surgery	200,000	0	200,000	0	
Replacement Mattresses (x 15)	557	0	557	0	
Rigid hysteroscopes x 4 plus stack	4,115	0	4,115	554	
Scopes x7 endoscopy	150,000	0	150,000	0	
Static and Pressure Relieving Mattresses	0	69,000	69,000	0	
Thermometery Data Loggers	29,958	0	29,958	0	
Urology Laser Scope	-11,928	28,000	16,072	15,487	
Ventillators Programme - 1st year of 5 (2014/15)	2,400	0	2,400	0	
Videoscopes x2 - main theatres	50,000	0	50,000	0	
Medical Equipment Totals	**2,533,547**	**-225,500**	**2,308,047**	**197,810**	**(10,586)**
Other					
Bed Stacking	98,200	0	98,200	0	
Car Park White Lining Site Wide	0	23,072	23,072	0	
Catering Trolley Replacement x20	3,902	0	3,902	0	
Demand Response Generator Conversion	360,000	-180,000	180,000	0	
Drinking Water Stations	700	0	700	0	
DSU Truck	434	0	434	0	
Efficiency schemes	160,570	-20,000	140,570	0	
Endoscope Vacuum Pack System	1,120	0	1,120	0	
Finance systems 2011/2012	40,000	0	40,000	0	
Fire Safety Training Equipment	820	0	820	0	
LED Lighting	52,555	0	52,555	5,050	
Lightening Repairs	0	0	0	0	
Mortuary Temporary Storage	230	0	230	0	
Outpatient Kiosks	74,338	0	74,338	0	
Phhotovoltaic's / Solarthermal PV	23,744	0	23,744	0	
Project costs 2013/14	14,029	0	14,029	0	
Staff Accommodation Fire Door Closers	315	0	315	0	
Telecoms Trunk Lines	10,000	0	10,000	0	
Ward Waste Bins	60,643	0	60,643	0	
Other Totals	**901,599**	**-176,928**	**724,671**	**5,050**	**0**
Trust Totals	**14,457,289**	**8,247**	**14,465,536**	**1,410,146**	**(48,647)**
Likely slippage on Trusts schemes 2015/16	0	-1,471,674	-1,471,674		
Trust Totals	**14,457,289**	**-1,463,427**	**12,993,862**	**1,410,146**	**(48,647)**

REMUNERATION COMMITTEE

Annual Report 2014-15

INTRODUCTION

This is the 19th annual report on the work of the Remuneration Committee and covers the period 1 July 2014 to 31 July 2015. During this time the Committee met on three occasions and a summary of the business is given below.

8 December 2014 Meeting

- The Committee heard the outcome of the mid-year reviews held with each of the Executive Directors.
- It noted the interim arrangements being put in place for the role of Chief Operating Officer

13 April 2015 Meeting

- The committee reviewed a national benchmark of executive pay and concluded that levels were in line with other similar employers
- it reviewed an updated framework for directors' objectives
- It discussed factors that would be included in the Remuneration Report included in the Trust's Annual Report 2014/15

8 June Meeting

- The committee received an update on 2015/16 objectives for the executives
- It reviewed the achievement of the 2014/15 objectives for the executives
- It determined the annual review of executive pay in the light of the national pay award and national comparisons
- It discussed the Trust's response to a letter from the Secretary of State regarding levels of executive pay
- The terms of reference for the committee were reviewed

SFT3685

Salisbury EPR Project

Public Board Paper

Foreword by the Medical Director

Our patient administration system is coming to the end of its life, and this gives us a fantastic opportunity to replace it not like-for-like, but with a comprehensive electronic patient record which promises to bring huge benefits to patients and the Trust. This business case necessarily focuses on the financial benefits, but I would like to illustrate by some brief case studies the improvements in patient care that this investment would bring.

The record will be instantly visible on any computer within the trust

Mrs A's GP telephones her consultant to ask whether it is safe to prescribe a new blood pressure lowering drug in the light of her liver condition. Her consultant opens her record, refreshes his memory of the patient from his last clinic letter, reviews her blood test results and liver scan and assures the GP the drug is safe to prescribe. He adds the new drug to her medication record.

A radiologist is reporting a chest x-ray and notices an abnormality. He opens the electronic patient record and finds that the patient had TB thirty years ago, concludes that this is likely to be the cause of the abnormality and completes his report. His colleague in a neighbouring Trust without an EPR, in the same situation spends an hour trying to contact the patient's doctor without success and advises a CT scan to further evaluate the abnormality.

The record can be viewed by more than one person at the same time, allowing shared decision making

A consultant gastroenterologist asks her surgical colleague to see a patient with a view to operating on his bowel. The surgeon sees the patient on the ward but has a question about the findings on a CT scan and telephones the gastroenterologist who is in a distant clinic. They look at the scan together and agree that the patient needs an operation later that day.

Communication becomes near instantaneous

Mr B is being discharged from hospital. The prescription for his discharge medicines is viewed as soon as it is completed by pharmacy and the drugs dispensed whilst he phones for his wife to collect him. The electronic discharge summary has reached his GP before he has walked to the car park.

Mr X sees a patient in clinic who needs an urgent operation. He knows he has an operating list next week which his booking clerk was trying to fit some patients into. He opens the list and finds that it is not yet full so schedules the patient for his operation. The system then generates a pre-admission clinic appointment to see the anaesthetist the day before. The patient leaves clinic with his appointments already booked so he can arrange time off work.

Patient safety is improved

Miss C is being prescribed amoxycilllin for a urinary tract infection. The system alerts the doctor that she has had a previous allergic reaction to penicillin so she chooses a different antibiotic.

Dr Y is in his office when he receives an electronic alert that one of his patients on the ward has developed some abnormal blood tests. He goes straight to the ward and prescribes fluids which prevent the patient developing kidney failure and allow her to get better and go home days quicker than she would have done.

Clinical staff can be prompted to provide safer better quality care

Staff nurse Z completes a care plan for Mrs D indicating that she is at high risk of falling. The system reminds the nurse to check on the patient every hour to offer to walk with her if she needs to visit the kitchen or lavatory.

Dr W prescribes a new drug for a patient's arthritis. The system prompts him to ask the patient if she has stomach problems and if so prescribe an additional drug to prevent ulcers and gastric bleeding.

Unnecessary duplication and waste is avoided.

It is easy to see whether tests have been ordered and are in the pipeline, and results are available instantly. Once clinical information is entered it can be seen and shared by everyone involved in the

patient's care without it needing to be entered more than once. Letters, forms and referrals can't get lost.

Patients can access their records via a patient portal
In an era of internet banking and on-line shopping, why shouldn't patients be able to change their hospital appointments or GP details without telephoning or writing to an administrator? Why shouldn't they be able to upload their blood pressure readings before their clinic appointment? Shouldn't they be able to see their medical records and check the information is correct? As well as improving patient safety the administrative burden for the hospital will be vastly reduced by allowing patients access .

Records are easily transferrable from one provider to another
Mrs D gets a great new job and moves to Swansea. She has a complicated medical history with three long term conditions and six regular medications. Her hospital record is downloaded in PDF format onto a memory stick which she takes with her to her new GP so that her regular drugs can be prescribed and she can be referred to a specialist in her local hospital for ongoing care. The last time she moved house it took six weeks for a bundle of photocopied barely legible paper notes to arrive at the practice to be re-photocopied and forwarded on to her new consultant.

Electronic systems offering all of these benefits are widely used in the United States and are being introduced here, but implementation has been slow and patchy. If we have the courage to implement a fully comprehensive electronic patient record system we will create a platform for the future of the Trust which will transform the way we deliver an outstanding experience for every patient.

Dr Christine Blanshard MA MD FRCP
Medical Director
Salisbury NHS Foundation Trust

Strategic Case

In order to achieve the Trust's vision of "An outstanding experience for every patient", high quality information is required at the point of healthcare delivery to support decision making and improve outcomes. The availability, quality and speed of this information are currently limited by the Trust's existing IT systems and this could adversely affect the achievement of the Trust's vision.

The Trust's current approach to documenting patient care and managing patient operations are centred on:

- Older systems - e.g. the Trust's current Patient Administration System has been in use at Salisbury for 20 years
- Only a basic level of integration between electronic systems - e.g. If a patient in the Emergency Department is to be admitted to the main hospital inpatient wards it is not possible to electronically transfer the information generated in ED so that it is available to inpatient teams.
- Details of patient diagnoses and treatment are recorded mainly on paper case notes
- Information recorded on paper has issues of legibility, security, the potential for misplacement/loss, and can only be physically in one place – thus denied to others.
- Business processes that work because people strive to make them work, not because the IT was designed to support them properly

Integrated Electronic Patient Records bring the ability to share health information securely leading to higher quality and safer care for patients by:

- Providing accurate, up-to-date, and complete information about patients at the point of care
- Enabling quick access to patient records for more coordinated, efficient care
- Securely sharing electronic information such as care plans with patients and other clinicians
- Allowing access to patient information from any physical location, including using wireless devices
- Helping care providers reduce medical errors, and provide safer care
- Improving communication between patient and care provider
- Improving choice and convenience for the patient
- Enabling safer, more reliable prescribing through positive patient identification, clinical decision support and automated warnings
- Ensuring documentation is legible, complete, and presented in a standard format
- Providing a detailed audit trail of all access and updates to patient records
- Reducing costs through decreased paperwork, improved patient safety, better productivity and more efficient service delivery

The Outline Business Case shows a positive benefit to cost ratio. More than 75% of the financial benefits are cash releasing and the remainder are productivity improvements. However it is important to recognise that whilst we must drive these financial benefits to delivery, many of the benefits are about patient safety and the provision of a future platform for recording and supporting patient care efficiently and effectively.

Solution Procurement

In accordance with government procurement guidelines, the recommended approach for procurements of this size is to procure via the Official Journal of the European Union (OJEU). In October 2014 the Trust posted an OJEU notification for an EPR service. The Pre-Qualification Questionnaire process (PQQ) yielded 18 bids. Evaluation of the PQQ responses resulted in 6 bidders being selected for the subsequent Invitation To Tender (ITT).

Of the six bidders, one withdrew prior to submitting a tender. Of the remaining five bidders, two were disqualified because their tenders failed to meet the criteria we required in the ITT documentation.

Of the 3 remaining qualifying bids, Bidder B was the clear winner based on our evaluation process.

Bidder	Financial (40%)	Specification (40%)	Visits & Demos (20%)	Overall
Bidder A	12.5	26.2	11.7	50.3
Bidder B	33.5	30.8	10.6	74.9
Bidder C	29.1	27.3	10.1	66.5

Bidder B has advanced to “preferred bidder” status. The OJEU procurement ITT stage has now completed without challenge from any of the unsuccessful bidders. The Trust is now in a position finalise the Full Business Case (FCB) with input from the bidder and to negotiate a contract for signature. Project work has begun with a plan to deliver this by end September 2015.

Since procurement has completed without challenge we can identify now Bidder B as CSC (Computer Science Corporation) and the proposed EPR product is Lorenzo.

CSC and Lorenzo

CSC is a global technology company working in many industry sectors, including defence, healthcare and IT outsourcing.

Salisbury has been a customer of CSC since 2007 and has a strong working relationship around the i.PM PAS which is currently supplied and hosted by CSC.

The Lorenzo solution was developed specifically to meet the needs of the NHS in England. It is now live in 12 English NHS hospital sites of which 8 were deployed in the last 18 months. Projects are currently under way at:

- Warrington & Halton
- Sheffield
- North Bristol
- Coventry and Warwickshire
- Royal Brompton & Harefield

The Trust intends to implement Lorenzo across a 2 year period with different aspects of the solution going live in two main phases.

Module	Phase 1	Phase 2
PAS	⚑	
Order comms & results reporting	⚑+	
ED	⚑	
Maternity		⚑
Theatres		⚑
Clinical documentation	⚑	
Electronic prescribing		⚑
Data warehouse	⚑	
Internal clinical portal		⚑
Mobile device support		TBC
Patient portal		3rd party
Electronic document management	WinDip	

Programme Costs and Financial Benefits

The Trust will negotiate with the preferred bidder and therefore the figures mentioned here may change when the Full Business Case is produced. The Trust aims to negotiate a 10 year service contract with CSC in which the last two years will be optional.

The Trust is considering a "Software as a Service" (SaaS) contract in which the solution is hosted and delivered to the Trust by CSC from their remote high-security, highly resilient, highly available data centres, with 24/7 support services. In a SaaS contract the vendor's implementation services, hosting, and support costs are all rolled into a single annual charge.

Exact figures cannot be used in this paper as the suppliers' pricing is Commercial in Confidence, however the approximate SaaS costs is around £1m per annum. These costs are offset by approximately £700k per annum due to a reduction in costs for other systems (the EPR will replace several existing systems which also have a significant cost).

The Outline Business Case identifies cash releasing benefits of almost £12m over 10 years and non-cash releasing benefits of circa £5.7m over 10 years.

A major element of the FBC will be to validate that these benefits are achievable with the CSC solution and to determine if further benefits can be identified.

The deployment project will build in a focus on benefit delivery from the outset, ensuring that the benefits identified in the business case can be managed and tracked completely across the term of the contract to ensure they are delivered.

Risks

The project team will create a complete risk analysis for the project and present this in a format compatible with Salisbury's formal risk assessment processes. Some items from the project risk assessment may be included on the Trust's risk register under the guidance of the Information Strategy Steering Group (ISSG). The main risks identified so far are as follows:

Risk	Mitigation
Failure to deliver desired benefits	Strong focus on benefits realisation from outset. To include PMO input and expertise
Resistance to change	Undertake project as business change project rather than an IT project. Strong leadership.
Ability to resource the project appropriately, including release of clinical staff for training	Plan the project implementation using experienced resources to deliver realistic timescales. Senior level support to ensure release of staff for training. Identify internal champions to promote key messages to their peer groups.

Risk	Mitigation
Management of inter-dependent projects	Strong programme management approach to ensure that interdependencies are clearly understood and planned for
Impact on activity reporting and therefore on income	Early work on data warehouse replacement. Close liaison with commissioners. Careful testing prior to decision to go live.
Ensuring that contractual deadlines are achieved	Rigorous project management with escalation as appropriate should timescales become at risk
Local technical infrastructure may be inadequate or underperform	Perform a review of current infrastructure against future requirements. Budget to enhance where necessary as part of the program plan. Meet with other Trusts using the product to discuss their experiences and lessons learned.
Pressure from within the Trust to request software development from the vendor can lead to significant delays and significant development costs	Trust's Information Strategy Steering Group (ISSG) to filter all such requests for change and ensure costs are contained.

Board Approval

The following items are submitted for approval at this Board:

- The Outline Business Case
- Decision to proceed to Full Business Case, including negotiations with CSC as preferred bidder
- Agreement to establish an implementation team to deliver the above to the point of FBC and contract ready for signature.

Outline Business Case: Integrated EPR

Version No: 08cR
Issue Date: 10th June 2015

Purpose of this document

This Outline Business Case provides justification for the business change in terms of its strategic fit, value for money, affordability and achievability. It also provides the basis for managing the delivery of the project on time, within budget and to agreed quality standards.

VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
Draft v0	00.00.00	First Draft Version	
Draft v1	24.03.15	Draft for discussion at EPR PMB	L Campbell
Draft v2	Not issued	Comments from EPR PMB	L Campbell
Draft v3	Not issued	Addition of newly identified risks	L Campbell
Draft v4	Not issued	Further comments from EPR PMB	L Campbell
Draft v5	Not issued	Addition of Benefits Realisation	L Campbell
Draft v6	Not Issued	Addition of Finance Case	L Campbell
Draft v7	Not issued	Further comments from internal reviewers	L Campbell
Issued v8a	05.06.15	Final Amends prior to ISSG	L Campbell
Issued v8b	10.06.15	Final additions to benefit case	L Campbell
Issued v8c	24.06.15	Addendum to reflect procurement progress	L Campbell
Issued v8cR	10.07.15	With redactions for Public Trust Board	L Campbell

Contents

1. FOREWORD BY THE MEDICAL DIRECTOR

Our patient administration system is coming to the end of its life, and this gives us a fantastic opportunity to replace it not like-for-like, but with a comprehensive electronic patient record which promises to bring huge benefits to patients and the Trust. This business case necessarily focuses on the financial benefits, but I would like to illustrate by some brief case studies the improvements in patient care that this investment would bring.

The record will be instantly visible on any computer within the trust
Mrs A's GP telephones her consultant to ask whether it is safe to prescribe a new blood pressure lowering drug in the light of her liver condition. Her consultant opens her record, refreshes his memory of the patient from his last clinic letter, reviews her blood test results and liver scan and assures the GP the drug is safe to prescribe. He adds the new drug to her medication record.
A radiologist is reporting a chest x-ray and notices an abnormality. He opens the electronic patient record and finds that the patient had TB thirty years ago, concludes that this is likely to be the cause of the abnormality and completes his report. His colleague in a neighbouring Trust without an EPR, in the same situation spends an hour trying to contact the patient's doctor without success and advises a CT scan to further evaluate the abnormality.

The record can be viewed by more than one person at the same time, allowing shared decision making
A consultant gastroenterologist asks her surgical colleague to see a patient with a view to operating on his bowel. The surgeon sees the patient on the ward but has a question about the findings on a CT scan and telephones the gastroenterologist who is in a distant clinic. They look at the scan together and agree that the patient needs an operation later that day.

Communication becomes near instantaneous
Mr B is being discharged from hospital. The prescription for his discharge medicines is viewed as soon as it is completed by pharmacy and the drugs dispensed whilst he phones for his wife to collect him. The electronic discharge summary has reached his GP before he has walked to the car park.
Mr X sees a patient in clinic who needs an urgent operation. He knows he has an operating list next week which his booking clerk was trying to fit some patients into. He opens the list and finds that it is not yet full so schedules the patient for his operation. The system then generates a pre-admission clinic appointment to see the anaesthetist the day before. The patient leaves clinic with his appointments already booked so he can arrange time off work.

Patient safety is improved
Miss C is being prescribed amoxycilllin for a urinary tract infection. The system alerts the doctor that she has had a previous allergic reaction to penicillin so she chooses a different antibiotic.
Dr Y is in his office when he receives an electronic alert that one of his patients on the ward has developed some abnormal blood tests. He goes straight to the ward and prescribes fluids which prevent the patient developing kidney failure and allow her to get better and go home days quicker than she would have done.

Clinical staff can be prompted to provide safer better quality care
Staff nurse Z completes a care plan for Mrs D indicating that she is at high risk of falling. The system reminds the nurse to check on the patient every hour to offer to walk with her if she needs to visit the kitchen or lavatory.
Dr W prescribes a new drug for a patient's arthritis. The system prompts him to ask the patient if she has stomach problems and if so prescribe an additional drug to prevent ulcers and gastric bleeding.

Unnecessary duplication and waste is avoided.

It is easy to see whether tests have been ordered and are in the pipeline, and results are available instantly. Once clinical information is entered it can be seen and shared by everyone involved in the patient's care without it needing to be entered more than once. Letters, forms and referrals can't get lost.

Patients can access their records via a patient portal
In an era of internet banking and on-line shopping, why shouldn't patients be able to change their hospital appointments or GP details without telephoning or writing to an administrator? Why shouldn't they be able to upload their blood pressure readings before their clinic appointment? Shouldn't they be able to see their medical records and check the information is correct? As well as improving patient safety the administrative burden for the hospital will be vastly reduced by allowing patients access .

Records are easily transferrable from one provider to another
Mrs D gets a great new job and moves to Swansea. She has a complicated medical history with three long term conditions and six regular medications. Her hospital record is downloaded in PDF format onto a memory stick which she takes with her to her new GP so that her regular drugs can be prescribed and she can be referred to a specialist in her local hospital for ongoing care. The last time she moved house it took six weeks for a bundle of photocopied barely legible paper notes to arrive at the practice to be re-photocopied and forwarded on to her new consultant.

Electronic systems offering all of these benefits are widely used in the United States and are being introduced here, but implementation has been slow and patchy. If we have the courage to implement a fully comprehensive electronic patient record system we will create a platform for the future of the Trust which will transform the way we deliver an outstanding experience for every patient.

Dr Christine Blanshard MA MD FRCP
Medical Director
Salisbury NHS Foundation Trust

2. ADDENDUM – UPDATE ON PROCUREMENT STATUS

2.1. Procurement Update

The Information Strategy Steering Group (ISSG) meeting on 12th June discussed the analysis of scoring in the EPR procurement. The EPR Programme Management Board had previously recommended that two bidders be dismissed under the rules set by the Trust at the beginning of the ITT. The scoring mechanism called for each bidder to self-score against our specifications, and for the Trust to review and moderate that self-scoring. The rule stated that if the Trust was obliged to moderate more than 30% (253 items) of a bidder's self-scoring, the Trust could dismiss the bidder. The recommendation to dismiss two bidders under this rule was approved by ISSG (subject to Trust Board approval). Of the remaining three bidders the highest scoring company was BIDDER 3. ISSG confirmed BIDDER 3 as the preferred bidder in the procurement process (subject to Trust Board approval). The Trust has started initial engagement with the company. All bidders were notified on Thursday 18th June and the procurement "standstill period" for legal challenges expires on Sunday 28th June. The procurement process can be halted at any stage up to contract signature without risk.
The scoring analysis is shown below. The NPV pricing of all bidders is detailed in the Financial Case section of this OBC.

Bidder Name	Financial (out of 40)	Specification (out of 40)	Moderated responses	Visits and Demos (out of 20	Overall Score
BIDDER 1	0	0 (23.22)	298	0 (8.2)	0
BIDDER 2	12.5	26.16	183	11.7	50.34
BIDDER 3	33.5	30.84	154	10.6	74.98
BIDDER 4	29.1	27.34	176	10.1	66.46
BIDDER 5	0	0 (23.62)	266	0 (9.4)	0

2.2. Full Business Case

Since beginning its initial engagement with the preferred bidder the Trust has been working to develop a Full Business Case (FBC). The FBC is due to be completed by August 2015 and will:

- Confirm that benefit case is achievable
- Confirm the project scope and implementation phasing
- Confirm the resources required for project delivery and establish a plan
- Confirm the overall project budgets
- Provide the information necessary for approval to proceed with contract signature and to proceed to project governance Gateway 1

3. EXECUTIVE SUMMARY

3.1. Introduction and Background

This section summarises the Outline Business Case (OBC) for investment in an Electronic Patient Record system (EPR). The purpose of the document is to provide sufficient information for the Trust Board, to make a reasoned decision to approve the proposed investment and authorise the move to the next step of procurement: identification of preferred bidder

The OBC follows the format and approach recommended by Monitor. It provides an audit trail to demonstrate that the appropriate steps have been undertaken to reach the conclusions.

Both the main body of the OBC and this executive summary are structured according to the "five-case model":

- The Strategic Case, establishing the need for the investment
- The Economic Case, identifying the options available to meet that need; evaluating those options in terms of costs, benefits and risks; and identifying the preferred option
- The Financial Case, demonstrating that the preferred option is affordable and how it will be funded
- The Commercial Case, identifying how the solution will be procured
- The Management Case, defining how the solution will be delivered – in terms of the implementation plan, management/governance structures, risk management, training, communications, and benefits realisation.
- Finally, the conclusions and recommendations section sets out what the Trust Board are asked to consider and approve.

3.2. Strategic Case

The Strategic Case explains how the proposed investment fits within the existing business strategies of the Trust and establishes a compelling case for change to the existing methods for supporting the delivery of patient care.

The Trust has:

- Developed a clear vision in its Strategic Plan 2014-19
- Undertaken a review of its Informatics Strategy
- Defined a range of measureable strategic performance objectives.

Taken together these strategic reviews and programmes have clearly identified the need for improved systems to support patient care and to support the delivery of the Trust's strategy for improving healthcare services.

In order to achieve the Trust's vision of "An outstanding experience for every patient", high quality information is required at the point of healthcare delivery to support decision making and improve outcomes. The availability, quality and speed of this information are currently limited by the Trust's existing systems and this could adversely affect the achievement of the Trust's vision.

Integrated EPR offers an opportunity to advance the pace at which this support can be delivered. The goal is to create a strong platform for clinical safety and service improvement for the foreseeable future. Consequently the Trust believes it is essential to progress with this EPR investment in order to facilitate the secure and timely delivery of its Strategic Plan.

3.3. Economic Case

This section of the business case explores and assesses a series of options for delivering the investment objectives, resulting in identification of the best value for money option that is subsequently carried forward into the affordability analysis within the Financial Case.

A “long-list” of options has been identified and these have been evaluated against the investment objectives noted above in order to reject any that do not support them. This left a short list of three options which support the Trust’s objectives and which have been taken forward for further action. Further details of the long and short list evaluation can be found in the main body of this document below. All of the short listed options had a common denominator which was to procure an Integrated EPR solution.

The benefits case shows a positive return on investment over 10 years of at least 2:1. This will be further refined and confirmed in the Full Business Case.

3.3.1. The Preferred Option

It was decided to initiate procurement for an integrated EPR solution using a range of pre-qualification requirements as a filter. It was also decided that the Trust would conclude a decision on the main differentiator between the shortlisted items, namely the licensing model, during the procurement and business case development.

3.4. Financial Case

The Financial Case demonstrates that the “preferred option” will result in a fundable and affordable deal. This section of the business case sets out the capital and revenue requirement for the spending proposal over the expected life span of the service, together with an assessment of how the Deal will impact upon the Trust.

3.5. Commercial Case

The Commercial Case demonstrates that the “preferred option” will result in a viable procurement and well-structured deal. This section of the business case includes the planning and management of the procurement. It requires the spending authority to set how the “preferred option” will be procured competitively, in accordance with European Union (EU) and Word Trade Organisation (WTO) rules and the current regulations for the public sector procurements.

3.5.1. Procurement Strategy

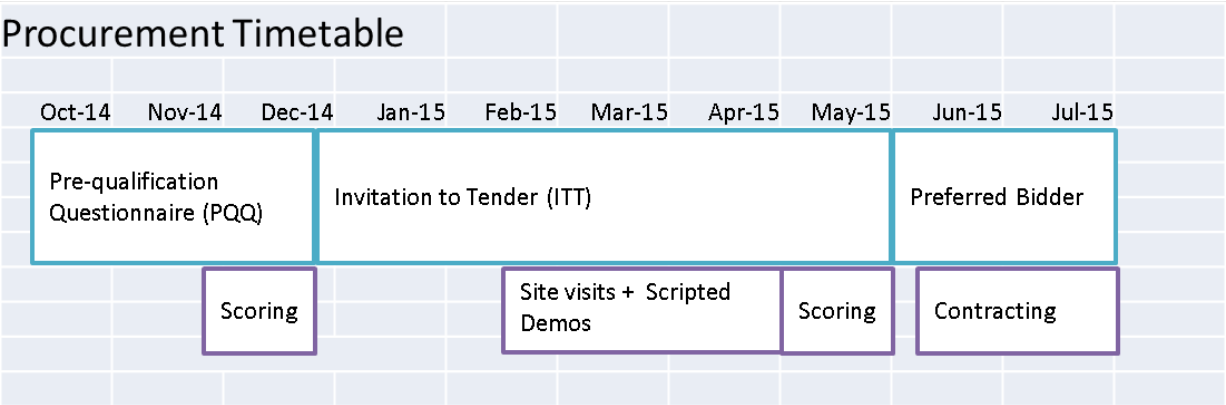
In accordance with procurement guidelines, the recommended approach for procurements of this size is to procure via the Official Journal of the European Union (OJEU). In October 2014 the Trust posted an OJEU notification for an EPR service. The Pre-Qualification Questionnaire process (PQQ) yielded 18 bids. Evaluation of the PQQ responses resulted in 6 bidders being selected for the subsequent Invitation To Tender (ITT).

Six bidders were approved by ISSG in late November 2014, and the ITT was issued on 23rd December 2014.

The short-listed bidders and products were as follows:

Company	Product
Bidder 0 (names redacted)	Redacted
Bidder 1 (names redacted)	Redacted
Bidder 2 (names redacted)	Redacted
Bidder 3 (names redacted)	Redacted
Bidder 4 (names redacted)	Redacted
Bidder 5 (names redacted)	Redacted

The graphic below shows the high-level procurement timetable.



3.5.2. The scope of required services

Broadly speaking the scope is as follows:

- PAS – all aspects of patient administration
- Clinical comprising: order communications, results reporting, electronic prescribing and medicines administration, clinical documentation, nursing documentation and observations
- Departmental modules including: emergency department, maternity department, theatres
- Information governance
- Information technology requirements for: hosting, service delivery, support
- Non-functional requirements covering: deployment of the solution and business change
- Contract term – 8 years plus two optional years
- Implementation period: 2 years, 2 Phases

The Trust has developed a requirements specification for its EPR procurement based on example requirements from other NHS Trusts, enhanced by local knowledge and local needs. The requirements were reviewed by a multi-disciplinary team and have been approved for issue to bidders. Further details of the scope and requirements can be found in the main body of this document.

3.5.3. Evaluation Criteria

The preferred bidder will be selected on the basis of most economically advantageous tender. To assess this evaluation is split into three broad areas:

- Quality of response to specifications; 40%
- Evaluation of reference site visits and scripted product demonstrations; 20%
- Evaluation of Financial Model (cost and credibility); 40%

The bidder with the best score will advance to preferred bidder status and be offered the opportunity to enter into a contract. If the Trust is unable to successfully achieve a negotiated contract with the preferred bidder it may choose to withdraw that offer and move to the bidder with next-highest score and advance them to preferred bidder status instead.

3.5.4. Licensing Mechanisms

The Trust has required bidders to prepare a Financial Model as part of their Invitation To Tender (ITT) response that covers the two approaches to payment described above, namely Traditional Licensing and SaaS. The choice of Traditional .vs. Software as a Service will be determined according to the Trusts preferred investment profile and any borrowing requirements.

3.5.5. Potential for Risk Transfer

The Trust seeks to share risk by requiring fixed prices for implementation that guarantee the bidders pricing as long as the Trust is able to guarantee its deliverables and resources in line with the project plan. Any changes or delays introduced by the Trust may cause extra charges to be incurred, but any delays caused by the bidder will grant the Trust an opportunity to either withhold payment or to reduce amount due to be paid.

3.6. Management Case

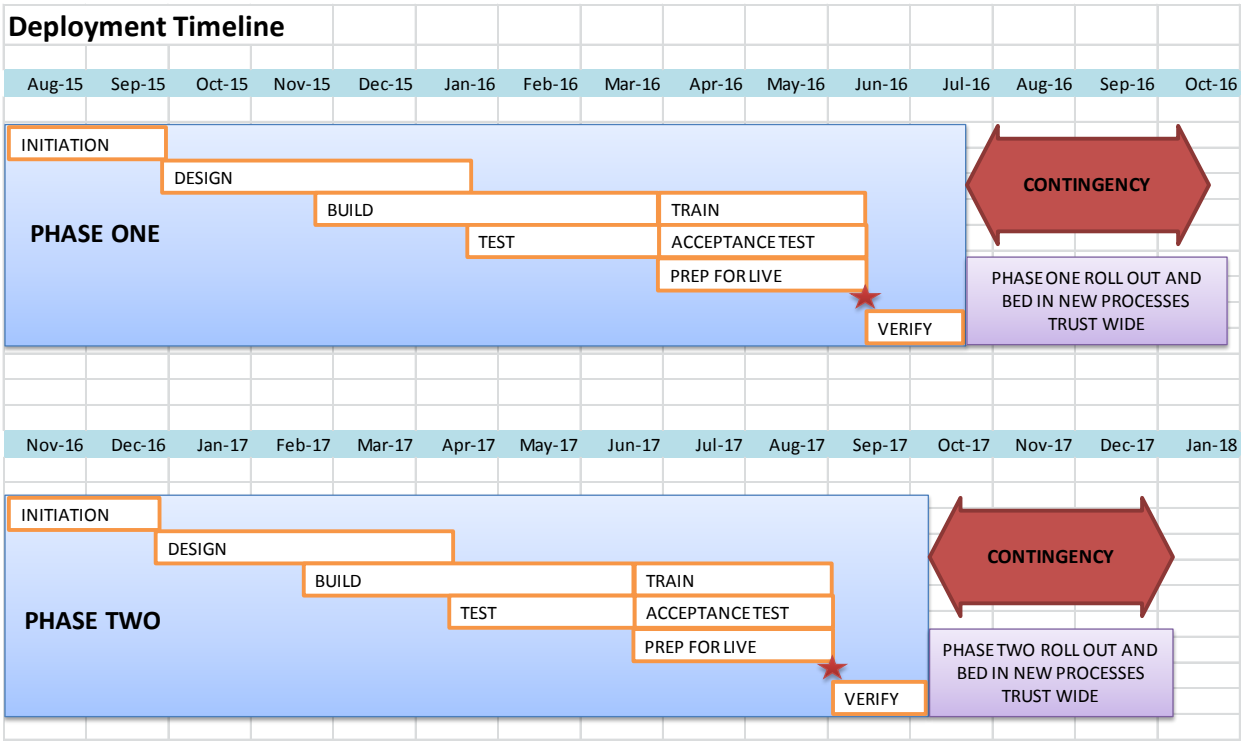
The Management Case demonstrates that the “preferred option” is capable of being delivered successfully, in accordance with recognised best practice.

3.6.1. Project Management Arrangements

EPR forms a programme of projects within the Informatics team. However it is important that EPR is not seen as an IT project. It is essentially a business change project and requires strong governance from Clinical, Operational and IT executive management. A Senior Responsible Officer at Board level will be appointed for the project. The current EPR Project Management Board will ensure that scarce resources are allocated to projects in line with their relative priorities.

3.6.2. Outline Plan

The image below shows the proposed deployment phasing that is recommended for this project. Essentially this is two phases in two years to implement the vendor’s full EPR solution.



3.6.3. Resource Requirements

The following resource profile is estimated for the scope and phasing of the proposed project

Teams	Phase 1 FTE	Phase 1 Man Days	Phase 2 FTE	Phase 2 Man Days
Project Management	3.0	945	3.0	825
Change Management	2.3	715	2.3	625
Functional Team	7.7	2,418	4.6	1,255
Training Team	10.3	3,245	10.2	2,805
Data Migration	2.0	630	0.7	205
Testing	3.1	965	2.6	705
Interfaces	1.5	480	1.3	370
Business Information	1.3	413	1.3	353
Technical	1.0	323	0.8	208
Whole Project	32.2	10,133	26.7	7,350

3.7. Conclusions and Recommendations

At this stage the Integrated EPR project is within its Pre-Procurement stage and is proceeding on target.

The Strategic Case shows a clear link between implementing an EPR and the delivery of Trust strategies and objectives.

The Economic Case shows a range of options has been considered and that the Trust is continuing to investigate the preferred option, which demonstrated the best fit to strategic goals. The significant

cash-releasing benefits and non-cash releasing benefits in excess of £24.5million have been calculated using a very conservative methodology. These need to be more fully developed based on the preferred bidder's product offering. This will be provided in the Full Business Case.

The Commercial Case shows that a solution can be procured, and that procurement is being conducted fairly and according to local and national guidance. The evaluation criteria have been constructed to ensure the Trust selects the most economically advantageous tender that meets its requirements.

The Financial Case shows that the Trust is seeking to ensure that the project is affordable. This case needs further development in the Full Business Case based on the costs and benefits available from the preferred bidder's tender.

The Management Case shows that the project will be delivered according to agreed standards, with adequate governance and a reliable approach to risk management.

The EPR Project Management Board recommends the approval of this Outline Business Case.

The Trust Board is requested to approve this Outline Business Case and instruct the development of the Full Business Case in parallel with continued procurement activity, leading to the confirmation of a preferred bidder, and signature of a contract.

4. THE STRATEGIC CASE

4.1. The Strategic Context

The Strategic Case explains how the proposed investment fits within the existing business strategies of the Trust and establishes a compelling case for change to the existing methods for supporting the delivery of patient care.

Salisbury has been dependent on paper based clinical notes since the hospital first opened. Over time the Trust has made a number of improvements by using technology to record some aspects of care in some departments, but the paper notes have remained a constant element. Moving to a Trust-wide integrated electronic patient record will provide a step-change how the Trust records patient care information. It will deliver clinical decision support, improve patient safety, and remove problems associated with the legibility, storage, handling, and transportation of patient records. The goal is to provide a modern, secure, reliable and pervasive platform to support the clinical care of patients, allowing services to grow and improve.

The Trust has:

- Developed a clear vision in its Strategic Plan 2014-19
- Undertaken a review of its Informatics Strategy
- Defined a range of measureable strategic performance objectives
- Established a transformation programme focused on cost and quality improvement
- Established a quality programme focused on improving clinical outcomes

Each of these documents and programmes identifies a range of drivers for change and activities to enact change. The introduction of an EPR supports many of these drivers and delivers tools to help achieve a step-change in benefit from the projects already in place by automating data capture and providing tools for audit and performance management.

In addition to the local Trust drivers, a number of national drivers and publications are relevant, including:

- Personalised Health and Care 2020 – published Nov 2014
- DoH Review of the potential benefits from the better use of information and technology in health and social care – published Jan 2013
- The NHS Five Year Forward View – published Oct 2014

Common themes from these publications revolve around the personalisation of care, new models of care, integration of services, improved management of service access, and reshaping the workforce. These are expressed at the Informatics level with examples including: driving the rollout of e-prescribing in secondary care, achieving better sharing of information to aid care of post-operative patients, provision of better operational performance information to help shape services and drive savings.

These national drivers tie in with the Trust's four Strategic Goals within its five year plan:

- Choice - To be the hospital of choice, we will provide a comprehensive range of high quality local services enhanced by our specialist centres
- Care - We will treat our patients with care, kindness and compassion and keep them safe from avoidable harm
- Our Staff - We will make SFT a place to work where staff feel valued to develop as individuals and as teams
- Value - We will be innovative in the use of our resources to deliver efficient and effective care

Taken together these strategic reviews and programmes have clearly identified the need for improved systems to support patient care and to support the delivery of the Trust's strategy for improving healthcare services.

In order to achieve the Trust's vision of "An outstanding experience for every patient", high quality information is required at the point of healthcare delivery to support decision making and improve outcomes. Many healthcare processes are still paper based or paper form dependant.
The availability, quality and speed of information exchange are currently major limiting factors. These limitations adversely affect the rate of achievement of the Trust's vision.

4.2. The Case for Change

Integrated Electronic Patient Records bring the ability to share health information securely leading to higher quality and safer care for patients by:

- Providing accurate, up-to-date, and complete information about patients at the point of care
- Enabling quick access to patient records for more coordinated, efficient care
- Securely sharing electronic information such as care plans with patients and other clinicians
- Allowing access to patient information from any physical location, including using wireless devices
- Helping care providers reduce medical errors, and provide safer care
- Improving communication between patient and care provider
- Improving choice and convenience for the patient
- Enabling safer, more reliable prescribing through positive patient identification, clinical decision support and automated warnings
- Ensuring documentation is legible, complete, and presented in a standard format
- Providing a detailed audit trail of all access and updates to patient records
- Reducing costs through decreased paperwork, improved patient safety, better productivity and more efficient service delivery

A further component of the Strategic Context is the support for existing systems. The Trust's PAS must be replaced as its contract will expire in March 2016. An Options Appraisal was conducted in July 2014 which identified replacing PAS with an EPR as the most desirable option.

One year's extension is permitted under the current PAS contract, and in November 2014 ISSG approved a decision to use this extension to facilitate the replacement of PAS with an integrated EPR. The vendors are currently in discussion with all members of the iSOFT7 to discuss terms for a short contract extension of between 1 and 3 years, but this is not yet finalised. Salisbury has indicated it would consider taking a single year extension under the revised contract if more-favourable terms can be agreed. This is still in negotiation.

The existing situation is as follows:

- The Trust seeks to move away from its paper based patient notes system to a more-modern and efficient means of recording patient care electronically.
- Our current contract will allow us to operate our existing i.PM PAS until 31st March 2017 including the permitted one year service contract extension. Successful negations with the supplier may permit a further 2 years support which the Trust hopes not to require.
- A number of other key departmental systems are also nearing end of contract and will need to be replaced or extended soon.
- The interfaces between existing systems are sub-optimal leading to significant data quality issues and many labour-intensive workarounds.

Moving to an integrated EPR solution will resolve many of these issues.

4.2.1. Strategy Considerations of Moving to an Integrated EPR

Historically, the Trust has followed a "Best of Breed" applications strategy, using a large number of applications to deliver service and functionality for each specialist area of the hospital. The Trust has attempted to integrate these applications using interfaces and database connections. It has developed in-house applications to fill particular gaps and meet very specific needs. Through this strategy it has started to deliver components of an Electronic Patient Record and has achieved a level of integration that allows services to function. However, many problems exist with the current integration:

- Data is trapped in many different databases
- Not all applications receive all the required HL7 integration messages needed to improve communication and many are incapable of so doing
- Problems persist with duplicate registrations
- Many short term workarounds have remained in place too long and have since become a way of life

A few examples of the problems arising from current systems integration at SFT are (this list is not exhaustive):

- The pharmacy system is interfaced to PAS for patient demographics, but does not receive any information about inpatient spells, outpatient appointments, or emergency attendances. This data must be manually entered or omitted from the record.
- Interface does not pass merged patient data to TheatreMan leading to duplicate demographics in TheatreMan
- When any surgery is rescheduled in TheatreMan a complex manual workaround in PAS is required to "fix" the associated bookings and waiting list entries.
- Bed states are incorrect – BATS and PAS always disagree (this may improve soon via POET)
- When electronic discharge summaries are produced the details of care given and drugs administered/given as TTOs must be manually transcribed from a variety of other sources.
- Departmental systems interfaces for demographics are usually one-way forcing users to log into PAS to change patient demographics and then wait for the interfaces to propagate the changes back to their departmental systems.
- Symphony users in ED need to manually re-enter data too often - e.g. must record presenting problems and reasons for ordering tests in Symphony, then re-type the same data into the pathology order in tQuest, and retype it again into the radiology order also in tQuest
- Consultant's list does not match PAS (this may improve via POET)
- Lack of spine integration means Choose and Book introduces duplicate patients onto PAS
- Registrations and demographic details changes take 24 hrs to get from PAS to CVIS (TOMCAT) (batch file interface overnight)

Moving to an integrated EPR removes much of this complexity and challenge by replacing many of the applications and thus their interfaces. In essence a "Best of Breed" strategy places the burden and risk of integrating applications and data on the Trust. Moving to an integrated EPR allows the Trust to reduce the local integration burden, reduce local risk, and provides many opportunities to improve service delivery and benefit to patients.

The following table contrasts several aspects of Best of Breed against an Integrated EPR approach.

	Best of Breed approach	Integrated EPR approach
Characteristics	Integration of point solutions for all services and applications	Integrated EPR solution with small number of integrated

		point solutions
Examples	Current SFT Architecture	Current EPR systems
Ability to unify IT estate as a Strategic Platform	Low	High
Ability to manage key clinical risks	Low	High
Ability to maintain/synchronise key data	Low	High
Ability to flex to local departmental needs	High	Medium
Organisational change impact	Low	Medium
Benefits available to be taken	Medium	High
Ability to maximise existing application investments	High	Medium

It can be seen that the Integrated EPR approach is more sustainable than Best of Breed.

4.2.2.EPR Gap Analysis

In recent years, the Trust has invested in Informatics to deliver services which already provide some of the required functionality outlined above.

- A Picture Archiving and Communications System (PACS) in place which is expected to provide reliable service until at least 2020.
- The Emergency Department has a well-liked IT system.
- Other departmental systems are in place including Pathology, Radiology, Cardiology, Pharmacy (stock control management) and Theatres.
- Basic order communications and results reporting is already in place though not widely liked by clinicians
- Digital dictation is being rolled out to support clinical letter production

The elements of a comprehensive integrated EPR which are either not present or at risk include:

- The Patient Administration System (PAS). This system must be replaced when its contract expires (including a one year contract extension) the deadline for replacing this component is March 2017. It cannot be further extended beyond this date.
- Fully integrated departmental systems. At present the systems in ED, Theatres, and Maternity are not integrated – these systems stand-alone with very basic interfaces to PAS and create silos of clinical information that are not shared with other systems or clinicians involved in the care a patient.
- Orders and results for investigations are managed via another stand-alone system. It is not currently possible to view this data alongside other elements of the patient's clinical record.
- e-Prescribing is not available at present.
- Clinical documentation is not recorded electronically at present.
- Clinical decision support is limited by the information silos that exist in disparate systems – e.g. the ED system may record a patient's allergies but this information is not available to inpatient prescribers and must be collected again and recorded on paper.
- Integrated Care pathways which define the Trust's preferred treatment protocols currently only exist on paper and cannot be used dynamically throughout a patient's journey to offer clinical decision support.

- Electronic Records Management (scanned past medical history) has not yet been rolled out across the Trust.

These gaps constrain the pace at which the Trust can deliver its vision of an outstanding experience for every patient.

4.2.3. Potential Benefits

The primary factor in the case for change is that the Trust must have a replacement PAS to continue operating as a service. However the benefits in terms of patient safety, improved security and audit, improved decision support, and increased efficiency are all positive factors over and above this basic need for a PAS.

A wide range of benefits have been identified and are detailed in Appendix A. Section 5 discusses the Financial case which includes discussion of benefits versus costs.

The benefits identified cover issues such as:

- Reduction in costs for purchase, movement, and storage of paper records and forms
- Reduced avoidable emergency re-admissions
- Reduced avoidable patient harms
- Reduced delays to discharge
- Improved capacity management
- Improved efficiency in nursing processes
- A variety of benefits from electronic prescribing and medicines administration including enhanced patient safety via positive patient identification and medication cross checking, removal of drug chart costs, more efficient clinical and pharmacy review processes

Please see section 5.4.1 and appendix A for more details.

4.2.4. Risks, Constraints, Dependencies

There are a number of factors to be considered concerning the strategic case for Integrated EPR. In terms of risks the following should be considered:

RISK	IMPACT	LIKELIHOOD	MITIGATION
The EPR may fail to deliver the desired level of benefits.	Expenditure without delivery of savings.	Medium	Strong focus on benefits delivery from inception through to the end of the EPR's contractual term
Staff may be resistant to change causing delays to the implementation of the EPR.	Delays to benefit delivery, extended project timescales, overspend on project implementation budgets	Medium	Strong focus on Business Change Management and Clinical change. Strong executive support for change.
The Trust may not have sufficient resources with the right skills to implement the EPR.	Delays to project implementation timescales. Poor quality implementation.	Medium	Ensure the project is adequately resourced. Use external resources to fill resource peaks and skill gaps.

RISK	IMPACT	LIKELIHOOD	MITIGATION
The Trust may not be able to release appropriately skilled staff (especially clinical staff) from their duties to provide sufficient input to the project due to work pressures.	Delays to project implementation timescales. Poor quality implementation.	High	Ensure budget exists to allow staff to be back-filled so they can be released for project work. Ensure senior management understand the need to release high quality staff to work on EPR.
There may be delays to Payment By Results (PBR) reporting around the time of implementation.	Trust could lose a percentage of income until we do report.	High	Inform the CCGs of the project. During testing phase, ensure that data can be extracted.
New Data warehouse may not built in time for go-live	Unable to carry out any reporting including Monitor, CCGs and internally	High	Commence Business Analysis and create a project specifically for Data warehouse replacement or re-write depending on supplier.
Pathology project	Trust unable to use order comms functionality. This could impact on both internal and external Order Comms	Medium	Ensure that good comms between Pathology and EPR projects and that any new solution implemented by Pathology can handle the order comms HL7 message set.

One project constraint is that the project needs to deliver a replacement for the existing PAS which is nearing the end of its contract. The aim is to reduce expenditure on further potential contract extensions. This has already been discussed above, and there is sufficient time to procure and implement a replacement for this functionality within EPR.

In terms of dependencies, the goal of achieving a paper-light or paper-free electronic patient record has a number of dependencies on other projects. The most obvious example is the WinDip electronic document management system. A new EPR will reduce the volume of paper being generated per patient episode, but the EDMS must be used to digitise the past medical history and any “new” paper records not capable of being replaced by EPR functionality. At present the EDMS project is still in pilot with a limited scope, so this dependency could also be classed as a risk. Other dependencies do exist, such as the ability for the new EPR to integrate with other information systems that are not being replaced by it. These other dependencies are more easily managed by the EPR project.

Dependencies on major projects such as WinDip EDMS must be managed through the Programme Management Board.

5. THE ECONOMIC CASE

5.1. Critical Success Factors

These are the investment objectives against which the various options must be assessed to determine their inclusion in the Short List.

- Must provide a comprehensive set of patient administration functionality
- Must allow at least the patient administration functionality to be live 6 months before expiration of the current PAS support contract
- Must provide a stable platform to support Trust operations for at least 8 years
- Must reduce problems associated with the current systems integration approach
- Must improve patient safety
- Must provide additional clinical and operational benefits above the status quo
- Must provide better information to improve service performance

5.2. The Long List

The PAS Replacement Options Appraisal produced in July 2014 by an independent external consultant analysed seven options:

1. Continue to extend support for the existing iPM PAS
2. Replace PAS with a range of best-of-breed and in-house developed applications
3. Implement and develop an Open Source PAS/EPR
4. Procure and implement a commercially available PAS without EPR
5. Upgrade from CSS i.PM PAS to CSC Lorenzo EPR Solution
6. Procure and implement a full EPR solution with a traditional licensing model
7. Procure and implement a full EPR solution with a Software as a Service (SaaS) model

The seven options are summarised in the following table. All options are discussed in greater detail in the PAS Replacement Options Appraisal document.

Options	Advantages	Disadvantages
1. Continue to extend support for the existing iPM PAS	• No business change or associated costs • One year extension guaranteed in the contract	• At this stage no additional contract extensions have been confirmed by the provider, though this is under discussion • No business benefits to be gained • The Trust would need to negotiate further extensions and would still need to procure a new long-term solution very soon • PAS is currently perceived as poor value for money, only use 30% of it
2. Replace PAS with a range of small components and in-house applications	• Close fit to current best-of-breed IT strategy	• Trust assumes integration risk • Trust assumes risk and burden of developing something widely available externally • Costs need much more analysis and ratification • Heavy dependence on in-house

Options	Advantages	Disadvantages
		development • Would require in-house infrastructure support • It may take too long to develop
3. Implement and develop an Open Source PAS or modular PAS/EPR	• Ability to tailor the solution to local needs • Zero license costs	• The Open Source solution lacks key components – EPMA, Maternity • Local extensions would be unsupported • Source code is available to all – including hackers • Local extensions could inadvertently introduce security risks • Zero cost licensing is offset by higher implementation and support costs • Need to expand the Trusts development team • Requires in-house infrastructure support
4. Procure and implement a commercially available PAS	• Some products still exist on the market • Close fit to current best-of-breed IT strategy • Less business change to implement • Lower risk than EPR	• Little or no new benefits to be achieved • Up-front licensing and implementation payments • Suppliers often slow to deliver requested changes
5. Upgrade from CSC i.PM PAS to CSC Lorenzo EPR Solution	• A single integrated electronic patient record offers the best benefits to the Trust and its Patients • The software has recently been proven fit for purpose • Remotely hosted infrastructure architecture	• Funding may not be granted as the iSOFT 7 Trusts are not currently an explicit part of CSC's agreement
6. Procure and implement a full EPR solution with a traditional license model	• A single integrated electronic patient record offers the best benefits to the Trust and its Patients • Many products available • Vendor assumes integration risks • Fully supported solution • Replaces several systems • Remotely hosted infrastructure architecture	• Up-front licensing and implementation payments • Suppliers often slow to deliver requested changes
7. Procure and implement a full EPR solution with a SaaS license model	• License and implementation costs spread across the term of the contract – no up-front costs • Ability to reclaim VAT on all invoices • A single integrated electronic patient record offers the best benefits to the Trust and its Patients • Vendor assumes integration risks	• Suppliers often slow to deliver requested changes

Options	Advantages	Disadvantages
	• Fully supported solution • Replaces several systems • Remotely hosted infrastructure architecture	

5.3. The Short List

The long list of options was considered at EPR PMB, and a paper was taken to Trust Board during September 2014. The Trust came to the following conclusions:

1. Continue to extend support for the existing iPM PAS
    - The current contract does not provide for further extensions beyond March 2017 and the supplier has indicated that only short term extensions may granted beyond that date, therefore this option was excluded.
2. Replace PAS with a range of best-of-breed and in-house developed applications
    - This option transfers too much risk to the Trust, and it is unlikely that such a proposal could deliver successful results in the timeframe needed; therefore this option was excluded.
3. Implement and develop an Open Source PAS
    - This option was explored by the Trust and offers some advantages in terms of developing a solution that closely fits the needs of the Trust. Unfortunately changes in central funding made this option less attractive to the Trust financially, and no Open Source suppliers were successful in qualifying at the PQQ stage of our procurement activities.
4. Procure and implement a commercially available PAS
    - This option, if successfully implemented, would incur costs but bring no additional benefits, merely replacing the status quo. Furthermore such systems are fewer than in previous years as most vendors have moved to EPR solutions. Their PAS offerings are now seen as “legacy” systems due to be retired; therefore this option was excluded.
5. Upgrade from CSC i.PM PAS to CSC Lorenzo EPR Solution
    - This option is a natural progression for the Trust, but was excluded for two reasons:
        - i) Procurement regulations dictate that a full and fair competitive procurement must be conducted for contracts at this value level;
        - ii) Following legal advice the Trust was denied entry to the Lorenzo RPA agreement for Trusts in the North Midlands and East which would have provided full central funding and avoided the procurement issues.
6. Procure and implement a full EPR solution with a traditional licensing model
    - This approach offers significant benefits and is being further explored
7. Procure and implement a full EPR solution with a Software as a Service (SaaS) model
    - This approach offers significant benefits and is being further explored

Options 3, 6, and 7 above were shortlisted as being compatible with the Trust’s investment objectives. All short listed options feature the procurement and implementation of an EPR solution.

The Trust Board approved further work to determine the requirements for an EPR solution and to initiate market sounding activity. These were used to develop a set of pre-qualification requirements for EPR at Salisbury and initiate a procurement exercise.

5.3.1. Economic appraisal of costs and benefits

The Trust wants to achieve a 2.4:1 return on investment at a basic level. The benefits data presented in detail in appendix A is still a work in progress, but already shows benefits at the level

of £24.5million pounds over 10 years. Further details are provided in section 5.4.1 Benefits Case. This needs to be completed and finalised in the Full Business Case.

The costs provided by bidders are now also available and are still being analysed by the Finance department. The bidder's prices range from £5million to £15million pounds. In addition to this, the Trust should budget approximately £3million pounds to cover the local cost of deployment.

All the above financial information is subject to confirmation in the Full Business case.

5.4. The Preferred Option

It was decided to initiate procurement for an integrated EPR solution using the pre-qualification requirements as a filter. It was also decided that the Trust would conclude a decision on the licensing model during the procurement and business case development.

A procurement notice was posted in the Official Journal of the European Union (OJEU) in October 2014 for an EPR service. The Pre-Qualification Questionnaire process (PQQ) yielded 18 bids. Evaluation of the PQQ responses resulted in 6 bidders being selected for the subsequent Invitation To Tender (ITT).

The pre-qualification requirements focused on four main issues:

- Methodology and approach to deploying the EPR
- Full compliance with the NHS Spine for patient demographics, "Choose and Book", security and role based access, access to "Summary Care Record"
- The bidders ability to provide a fully managed service from a remote, secure, and highly resilient data centre with 99.9% availability
- A functionally rich electronic prescribing and medicines administration system (EPMA) and the ability to deploy a 3rd party EPMA instead of their own (as the Trust was still in procurement for an external EPMA).

Six bidders were approved by ISSG in late November 2014, and the ITT was issued on 23rd December 2014.

The short-listed bidders and products are as follows:

Company	Product	Status
Bidder 0	redacted	WITHDRAWN
Bidder 1	redacted	Active
Bidder 2	redacted	Active
Bidder 3	redacted	Active
Bidder 4	redacted	Active
Bidder 5	redacted	Active

6. THE COMMERCIAL CASE

The Commercial Case demonstrates that the “preferred option” will result in a viable procurement and well-structured deal. This section of the business case includes the planning and management of the procurement. It requires the spending authority to set how the “preferred option” will be procured competitively, in accordance with European Union (EU) and Word Trade Organisation (WTO) rules and the current regulations for the public sector procurements.

EPR solutions are readily available from a wide range of commercial vendors as “off the shelf” packages. Their implementation and configuration to the needs of the Trust are normally part of the purchase, as these systems must be configured with the professional services of the vendor organisation.

The objective of this OBC is to provide sufficient information to gain approval to proceed to the development of a Full Business Case so that the organisation can make an informed decision based on the following investment objectives:

- To procure the most economically viable solution that best meets the administrative, clinical and management information needs of the organisation.
- To minimise any financial risk to the Trust.
- To transition to the replacement supplier with minimum disruption to the organisation.
- To procure a system that enables the implementation of the Trust’s business objectives.

6.1. Procurement Strategy

The Trust has initiated procurement using an OJEU Restricted Procurement process, and at the time of writing this OBC, we are evaluating and scoring the ITT submissions from the bidders identified earlier.

The procurement process is under the control of the Trust’s Procurement Department with assistance and advice from an external consultant with a proven track record procuring similar services for other NHS hospitals.

6.2. The Required Services

The required services in relation to Trust’s preferred option of procuring an integrated EPR service are broadly as follows.

- To procure an integrated EPR that meets the Trust’s requirements in the following areas:
    - PAS
        - Master Patient Index
        - Fully Spine Compliant
        - Referral and Waiting List Management
        - Outpatient Scheduling
        - Outpatient Clinic Management
        - Inpatient Management
        - Full Bed Management
        - RTT Status Management
        - Payment By Results
        - Coding Integration

        - Patient Document Tracking
        - Management Reporting and Business Information
    - Clinical
        - Order Communications
        - Results Reporting
        - Electronic Prescribing and Medicines Administration
        - Clinical Documentation
        - Nursing Documentation and Observations
    - Departmental
        - Emergency Department
        - Maternity Department
        - Theatres
    - Information Governance
        - Consent
        - Security
        - Confidentiality
        - Audit
    - Information Technology
        - Hosting
        - Infrastructure
        - Availability and Resilience
        - Backup and Failover
        - Business Continuity
        - Local Infrastructure
        - Systems Integration
        - Data Migration
        - Upgrades and Patches
    - Non-Functional Requirements
        - Project Management
        - Testing
        - Training
        - Deployment
        - Business Change Management
        - Benefits Management
    - Support
        - Service Levels
        - Service Management
- Contract Term – Initially 8 years
- Implementation period
    - 2 Years
    - 2 Phases

6.3. Potential for Risk Transfer and Payment Mechanisms

The Trust has required bidders to prepare a Financial Model as part of their ITT response that covers the two approaches to payment described above, namely Traditional Licensing and SaaS.

The Trust seeks to share risk in both these approaches by requiring fixed prices for implementation that guarantee costs as long as the Trust is able to deliver its deliverables and resources in line with the project plan.

The intention is to compare the actual models produced by the vendors and contract using the preferred bidder's quotations. The choice of Traditional .vs. SaaS will be determined according to

the Trust's preferred investment profile and any borrowing requirements. This decision will be flushed out during the development of the FBC. Contract will be awarded on the basis of "Most Economically Advantageous Tender". The evaluation criteria are more fully defined in the ITT Documentation, and break down as follows:

- Quality of response to specifications; 40%
- Evaluation of reference site visits and scripted product demonstrations; 20%
- Evaluation of Financial Model (cost and credibility); 40%

Details of the payment mechanisms need to be fully defined, but the Trust will apply the principle of payment for results. This will either be achieved by milestone payments, or by a system of service credits for delivery delays, or a combination of the two. This needs to be more fully defined in the FBC.

7. THE FINANCIAL CASE

7.1. NPV (Net Present Value) Calculations.

NPVs have been prepared using a discount rate of 3.5% in line with treasury guidance and have been prepared over 8 years. At Full Business Case stage we will also provide 10 year figures for the preferred bidder in order that the Trust can decide whether it is more beneficial to enter into a 10 year rather than 8 year contract although the preferred bidder must be chosen using the 8 year figures requested in the tender process to comply with EU procurement rules.

The actual NPV information is redacted as the bidder's pricing is Commercial in Confidence.

7.2. NPV including Project and Financing costs, VAT and Benefits

The calculations have been prepared taking account of VAT where applicable in line with current advice from the Trust VAT advisors. This advice will be refined further and subject to greater analysis at the preferred bidder stage. NPVs have taken account of all other cash movements including Public Dividend Capital (PDC) interest payments and cash delivering savings.

The actual NPV information is redacted as the bidder's pricing is Commercial in Confidence.

7.3. Potential Impact on Revenue.

For 4 of the 5 suppliers, revenue savings can be achieved over an 8 time frame whichever the payment option, one supplier is unaffordable. It is expected that savings would increase if a 10 year option is chosen and this will be dealt with at Full Business Case stage.

These savings are achieved as a result of the business change benefits detailed within the benefits case and associated Appendix A. However no analysis has yet been carried out to ascertain if all suppliers can deliver this level of benefit and so the benefits assumption should still be treated with caution at this stage particularly given that some of the suppliers still have considerable development needed to make their product near fit for purpose.

The exact impact will be determined at Full Business Case stage when negotiations are completed with the preferred supplier.

7.4. Potential impact on Capital.

If at Full Business Case stage the Trust enters into a SaaS arrangement, the whole cost would be expected to be charged to revenue over the life of the contract. If however the Trust decides upon a traditional financing approach then Capital of between £3.3m and £4.9m is likely to be required depending on the preferred supplier (the unaffordable option is excluded from this range).

Should the traditional capital approach be adopted, the recommended financing option would be to approach the Independent Trust Financing Facility for a loan with which to fund the capital development.

7.5. Overall Funding and Affordability

The most significant affordability issues are faced in the early years of the project no matter which option is chosen with positive cash flows being delivered in the middle and late years of the project, for all but one supplier, mainly as a result of the forecast efficiencies being delivered.

There are risks associated with the proposed efficiencies and so the Trust will need to put in place robust governance and delivery arrangements to make sure the savings are realised.

7.6. Benefits Case

Evidence from other Trusts has shown that the implementation of an Electronic Patient Record can bring with it significant benefits in terms of return on investment. In order to see the largest return on investment, the EPR would need to be fully implemented and embraced across all areas of the organisation. Looking at our internal processes and data, the benefits we have initially identified fall into three categories:

- Quantified cash-releasing savings, relating to the reduction in staff costs, the reduction in costs relating to the maintenance of existing software solutions and the ability to move from paper to electronic communications.
- Efficiency benefits through a reduction in the number of processes which require wasted or duplicated effort.
- And qualitative benefits that focus on improvements to patient experience, reductions in errors and avoidable harm and safety improvements.

The three most significant areas in which we see cash releasing savings are:

- The reduction in the number of application software and systems we manage. This will enable both hardware and software savings in terms of supplier support and upgrade costs as well as time savings as the need for Trust staff to support multiple systems reduces.

- The ability to move from paper to electronic methods of communication to both our referrers with regard to outpatient attendance letters and general clinical correspondence and to patients in terms of appointment letter/TCI notifications.

- Reduction in the cost of administrative staff across the Trust as the reliance on paper reduces.

Appendix A gives a more detailed breakdown of the currently identified benefits. These will be added to and further refined as more data becomes available regarding current costs and processes and the procurement process continues. Once the preferred supplier has been engaged, these benefits will be reviewed jointly with the vendor to ensure that they are realistic when measured against what is to be delivered. If additional benefits are identified by the vendor, these will also be included.

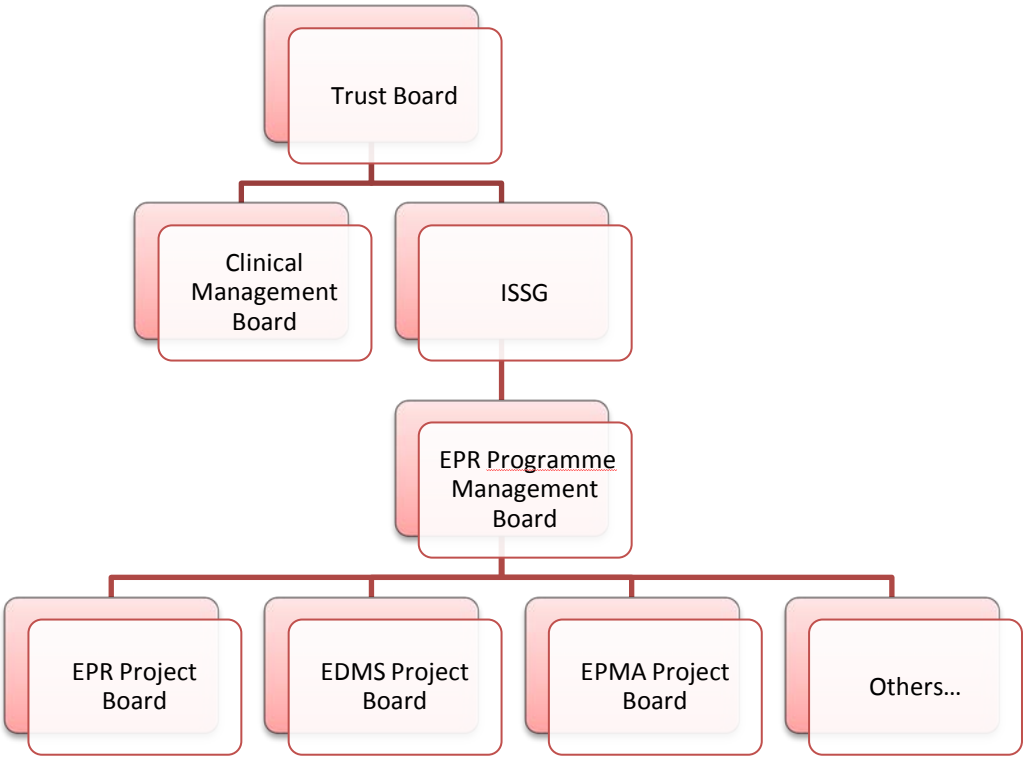
Appendix B gives a more detailed breakdown of the options and costs per vendor.

8. THE MANAGEMENT CASE

The Management Case demonstrates that the “preferred option” is capable of being delivered successfully, in accordance with recognised best practice.

8.1. Project Governance Arrangements

EPR forms a programme of projects within the Informatics team. However it is important that EPR is not seen as an IT project. It is essentially a business change project and requires strong governance from Clinical, Operational and IT executive management. An SRO will be appointed for the project. The following governance structure is strongly recommended. The current EPR Project Management Board will be reconstituted into a programme board to ensure that scarce resources are allocated to projects in line with their relative priorities.



8.2. Programme and Project Management Methodology

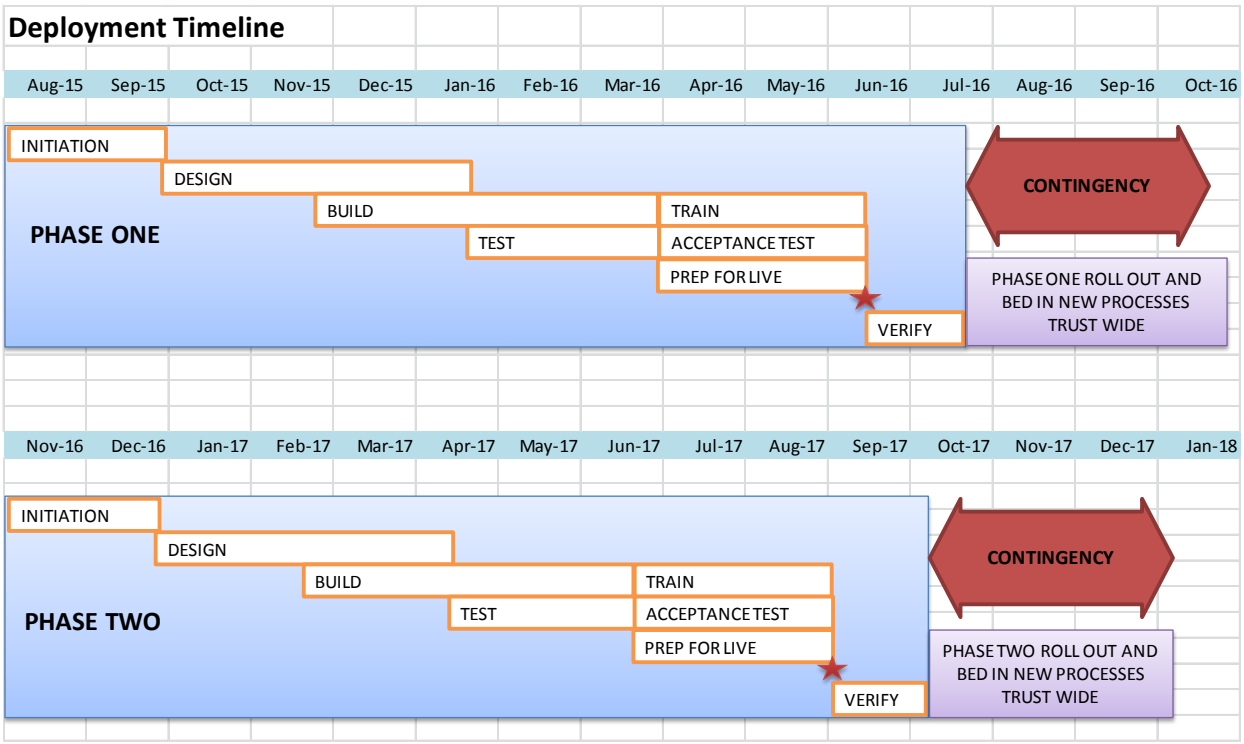
The project will be managed and controlled according to the PRINCE II project management methodology, which is an accepted standard approach for projects in the NHS.

A Project Brief will be produced in parallel with this OBC and deliver greater detail on the project management approach. A series of project gateways will be established to manage the progress of the project and control spending on each Phase and Stage.

8.3. Programme Plan

The image below shows the proposed deployment phasing that is recommended for this project. Essentially this is two phases in two years to implement the vendor’s full EPR solution.

The i.PM PAS support contract (with 12 months extension) will end in March 2017, giving a significant safety margin for replacing this component.



8.3.1. Resource Requirements

The following resource profile is estimated for the scope and phasing of the proposed project.

Teams	Phase 1 FTE	Phase 1 Man Days	Phase 2 FTE	Phase 2 Man Days
Project Management	3.0	945	3.0	825
Change Management	2.3	715	2.3	625
Functional Team	7.7	2,418	4.6	1,255
Training Team	10.3	3,245	10.2	2,805
Data Migration	2.0	630	0.7	205
Testing	3.1	965	2.6	705
Interfaces	1.5	480	1.3	370
Business Information	1.3	413	1.3	353
Technical	1.0	323	0.8	208
Whole Project	32.2	10,133	26.7	7,350

A more detailed breakdown of required Trust resources can be found in Appendix C. The final recommended resource profile will be confirmed with the preferred bidder and included in the Full Business Case.

8.3.2.Space Requirements

The following space requirements have been identified and submitted to the Facilities Department:

- Co-location in open plan office space for 30 people
- 2 dedicated meeting rooms for up to 12 people at a time
- 10 training rooms with PC's for 10 users + trainer

8.4. Change and Contract Management Arrangements

Contractual scope change management will be defined within the contract with the selected vendor, and will be managed through the project governance structure. The Trust will actively negotiate the contractual clauses associated with change management to ensure the Trust has effective control over scope change. More detail will be included in the FBC when the contracts are available for reference.

Business Change Management will be controlled on the project within a dedicated work stream, led by a Business Change Manager. As the project is essentially an IT supported business change project, this role is vital. The Business Change Management work stream encompasses the following major elements:

- Business process redesign – including clinical process changes which may need further clinical governance approval
- End user training
- Cutover management at Go-Lives
- Rollout of functionality across the Trust

8.5. Benefits Realisation

The project recognises that a significant investment is required and that investment is justified by a benefits case for implementing the EPR. In order to ensure that benefits are delivered as fully as possible, the Trust should appoint a Benefits Manager for the project to:

- Establish a benefits management strategy
- Identify the benefits needed for the investment case in the OBC and FBC
- Define and implement the mechanisms by which benefits will be tracked, owned and delivered
- Operate delivery of benefits during the project and beyond into normal operations

Benefit recovery should be managed across the full term of the EPR contract. Benefits Manager is a role that should continue to exist after the implementation project itself has been closed.

8.6. Risk Management

The project will collate and manage Risks, Issues, Assumptions, Dependencies, and Constraints at Project Board Level. Where appropriate these will be escalated to Programme Board, and ISSG.

A project level risk log will be maintained using Microsoft Excel. Risks will be clearly defined, assessed for likelihood and impact, and a risk score allocated. Risks will be managed by a RAG (Red, Amber and Green) rating. Each risk will have an owner whose job it is to report on the risk and mitigate the risk. Every risk will have a mitigation strategy.

Further details on the approach to risks, issues, assumptions, dependencies and constraints can be found in the “Integrated EPR: Project Brief” document. (The Project Brief is a standard project management document required by the PRINCE 2 project management methodology to ensure projects are governed effectively. A Project Brief document was produced for the Integrated EPR project to guide its earliest stages and has been approved at EPR PMB.)

A list of high-level risks was included in section 2.2.4 above.

9. RECOMMENDATION

At this stage Integrated EPR project is within its Pre-Procurement stage and is proceeding on target.

The Strategic Case shows a clear link between implementing and EPR and the delivery of Trust strategies and objectives.

The Economic Case shows a range of options has been considered and that the Trust is continuing to investigate the preferred option, which demonstrated the best fit to strategic goals. The benefits of the project have been validated by the finance department as realistic and are based on verified Trust data. Additional potential benefits are still being analysed. These need to be more fully developed based on the preferred bidder's product offering. This will be achieved in the Full Business Case.

The Commercial Case shows that a solution can be procured, and that procurement is being conducted fairly and according to local and national guidance. The evaluation criteria have been constructed to ensure the Trust selects the most economically advantageous tender that meets its requirements.

The Financial Case shows that the Trust is seeking to ensure that the project is affordable. This case needs significant further development in the Full Business Case based on the costs and benefits available from the preferred bidder's tender.

The Management Case shows that the project will be delivered according agreed standards, with adequate governance and a reliable approach to risk management.

The EPR Project Management Board recommends the approval of this Outline Business Case.

The Trust Board is requested to approve this Outline Business Case and instruct the development of the Full Business Case in parallel with continued procurement activity, leading to the confirmation of a preferred bidder, and signature of a contract.

10. APPROVALS

EPR PMB: Graham Branagan (Chairman EPR PMB)..... Date:……..

ISSG: Peter Hill (Chairman ISSG)..... Date:……..

Trust Board: ……..... Date:……..

SRO: ……..... Date:……..

11. APPENDIX A – POTENTIAL BENEFITS

These potential benefits are based on the introduction EPR at other hospital trusts. The benefits listed have been used in their business cases and were approved by NHS England and Monitor. As such they are widely recognised with proven causal relationships based on documented research.

The numbers are based on SFT data, using our known patient volumes and known process costs with estimated future state costs that need to be verified in the Full Business Case when the preferred bidder's exact functionality is confirmed. Potential benefits have been adjusted or removed where SFT have already delivered the benefit through other means – e.g. reducing drug costs.

These potential benefits need to be developed and agreed as achievable by the business during preparation of the FBC. The Trust may already be pursuing some of these benefits via other projects, but the introduction of the EPR will accelerate/enhance benefit delivery.

Where delivery of a particular benefit will increase over time as adoption of the future state process improves, the value of that benefit is scaled up over time according to the projected rate of adoption.

Where accrual of a particular benefit can be assigned to multiple projects, the value attributable to EPR is estimated as a proportion of the overall benefit value and only this portion is claimed as an EPR benefit.

Benefit delivery has been scaled over 10 years. This is consistent with an 8 year initial term plus two annual contract support extensions.

EPR Benefits Summary

Description	Details	How calculated	Type	10 year value
Reduce storage cost for medical records - internally	As more information is recorded electronically, the requirement to put paper in folders is reduced. This reduces the rate of expansion of paper notes volumes. As time passes and paper notes can be destroyed, the overall volume of storage space required reduces. Used in conjunction with an EDMS and the scanning of historic records this can be accelerated, but will not count that aspect of this benefit here. When it is planned to scan all remaining paper notes on discharge and shred the originals, this benefit shows as a reduced requirement to produce additional paper, scan additional paper, and shred additional paper. (see below for recording of this aspect of the benefit)	Shelf space is saved. Paper is saved Average growth rate of folders (pages) Cost per page - paper and pre-printing Estimated reductions in number of papers per attendance. Number of attendances: Linear meters of storage space: Cost per linear metre: Need to think about how costs have grown over time so that we can show how they will fall over time too.	Cash releasing	£ 210,000
Letters move from paper to e-mail or other electronic delivery	Letters not printed, Letters not posted. Letters are produced electronically and emailed to patients instead of printing and posting. This covers appointment letters, Outcome letters, Waiting List letters, TCI letters and general clinic letter.	Current cost of sending a letter is: 85p Letters per year approx. 742000 in 2014. Currently 20% of letters from i.PM go via Synertec, the rest go via Royal mail.	Cash releasing	£ 2,258,400

Description	Details	How calculated	Type	10 year value
Letters normally typed by Audio Typists and Medical Secretaries will be reduced to auto generated letters in most cases with minimal (direct) clinician input. It should be possible to reduce headcount in Audio Typists by 80% making this benefit Cash Releasing. There will also be a non-cash releasing benefit for Med Secs, but this has not been included.	Time saved dictating letters, time saved typing letters. Assume 80% of letter volume can be moved to automatically generated. More information being gathered on actual WTE numbers. Need to ascertain how much audiotyping is done as initial scoping shows that audio typists do other things as well. Cathy to shadow audio typist in Medicine (on-going)	19 Audio typists reduced to 4. Reduction in Medical Secretaries has not been counted as these staff perform other tasks.	Cash releasing	£ 2,343,500
Reduce missing notes and temporary notes	As we move to an electronic record dependence on paper notes is reduced. When paper notes are "missing" a temp folder must be created and then merged with the original notes.	Stationery cost of folders, labels, sheets, time spent searching for paper, time spent making temp notes, time spent merging notes. Stationery costs Time searching Time per temp folder Time per merge Number of attendances requiring notes: Number of temp folders PA estimated as 1.5% of all attendances requiring notes:	Cash releasing	£ 275,000

Description	Details	How calculated	Type	10 year value
Reduce health records administration and staffing	As more information is recorded electronically, the requirement to pull, move and file paper notes is reduced. In combination with EDMS, this can be realised more quickly. Savings in this area should be attributed part to EDMS, part to EPR. As time more information is recorded at point of care electronically the need to scan new paper and file electronically is reduced.	Health records staff WTE reductions Need to be clear what would be attributed to EDMS and what could be attributed to EPR. Will be a figure but need to think about when. And will be less than if we scanned.	Cash releasing	£ 1,891,400
Reduce cost of medical records stationery	The combination of EPR and EDMS (WinDip) will remove the need to create new folders for medical records. Co-dependency on WinDip - EPR contribution 50%	Cost of folders and associated labels	Cash releasing	£ 109,000
Forms move from paper to electronic reducing cost of purchasing pre-printed stationery	SFT form purchase costs have been analysed. Forms targeted for replacement with e-forms have been identified. Costs calculated based on ordering patterns.	Cost of pre-printed stationery. Many forms, many prices, many volumes - so a total value is used for calculations - see associated spreadsheet for details	Cash releasing	£ 314,000
Elimination of stationery costs for drug charts by moving to e-prescribing	As drugs no longer need to be recorded on paper drugs charts this avoids the purchase cost of the charts.	Cost per chart Number of charts per year	Cash releasing	£ 116,500

Description	Details	How calculated	Type	10 year value
Application Software and systems retired through introduction of EPR – saved costs on software, equipment, support and staffing	As more information is recorded in the EPR it will be possible to retire other applications, particularly some of the departmental systems. There will no longer be a need to pay for the hardware, or supplier support of these systems. Trust staff that support these systems may no longer be needed.	Software costs of departmental systems Hardware costs to host departmental systems Supplier Support costs System administrator WTE reductions PAS – i.PM Replaced Contract expires 03/16 A&E - Symphony Replaced Upgrade due 2014 Theatres – TheatreMan Replaced Contract expires 09/17 Maternity - E3 ViewPoint Replaced Contract expires 07/14 Order communications and results reporting- tQuest/Review Replaced Contract expires 03/17	Cash releasing	£ 7,050,000
Elimination of Coloured paper use - we print a lot of information leaflets especially in DSU for patients on coloured paper, if there is a patients portal surely they can view all this information on line. Also coloured paper is being used for outcome forms which are disposed after the information is inputted onto the computer. **NEW FOR V8b BENEFIT CASE**	As we use different forms of communication such as email / patient portal less printing will need to be done especially on coloured paper which is over twice as expensive as white paper. Various forms are photo copied on coloured paper Various Leaflets are printed onto coloured paper This covers all areas of the Trust	Cost of coloured paper ordered and used throughout the Trust	Cash releasing	£ 42,595

Description	Details	How calculated	Type	10 year value
If EPR creates a paperless environment no prepping will be needed to be done by reception staff – less staff would be needed. **NEW FOR V8b BENEFIT CASE**	Reception currently prep paper notes ready for clinic and in some cases have no delivery service.	We have identified a cost saving of 7.5 WTE who currently prep notes and once paperless will no longer be required for that role.	Cash releasing	£ 1,016,925
Courier Services – If paperless no need for courier services. **NEW FOR V8b BENEFIT CASE**	Couriers currently deliver to various peripheral locations for Plastic Surgery clinics. Plastics pay facilities for this service. As this is an in house payment from plastics to facilities costings will be based on ferry costs and petrol money = £2,000.00 per year	Notes currently couriered to peripheral locations CP has costings	Cash Releasing	£ 18,000
Restore currently store patients records and other records in an offsite location for Maternity Medical Records Child & Adolescent psychiatry Customer Care Chief Exec Departments Nurse Management Nurse Management admin **NEW FOR V8b BENEFIT CASE**	Reducing the number of Medical Records being held on site could give us the space to bring the offsite records back to SDH These could also be scanned electronically so no need for storage	Cost of storage over the various departments	Cash Releasing	£ 245,130

Description	Details	How calculated	Type	10 year value
Faxes will be no longer required if emailing or (using a patient portal) **NEW FOR V8b BENEFIT CASE**	Reducing he use of faxes – sending communication electronically	Costing of line rental for 160 faxes	Cash Releasing	£ 212,722
Reduction in printer / fax machine support – possible down grading of printers required **NEW FOR V8b BENEFIT CASE**	Reduction in support costs for faxes and printers if more communication is sent electronically	Cost of current support costs reduced by 80%	Cash Releasing	£ 1,926,849
Replacement of our Teletracking system **NEW FOR V8b BENEFIT CASE**	Solution within the EPR system to manage porting	Costing from yearly Licence / Maintenance agreements	Cash Releasing	£ 270,650
Reduction in the number of System Administrators required (depending on chosen product) **NEW FOR V8b BENEFIT CASE**	Systems administrators cover : i.PM Symphony PACS Tman E3 Tquest and review	Saving of 2x band 5 system administrators identified by reducing the amount of systems that will need support	Cash Releasing	£ 527,310

Description	Details	How calculated	Type	10 year value
Reduction in avoidable hospital acquired infections through consistent and timely event notification and more proactive preventative management through better quality information. EPR 50% contribution	Consistent and timely reporting of patient safety events will lead to fewer hospital acquired infections that need to be treated. Ability to record and share infection status flags; Use of Risk Assessments to identify and communicate infection risks; Use of Care Plans to manage and monitor care; Use of Dynamic Lists to track at-risk or infected patients; Access to integrated EPR to proactively identify potential infection risks, This will mean that the number of deep cleans required because of such infections will be reduced and the number of days of delayed discharge will be reduced, thus freeing up beds. DoH and NICE data suggest the cost per case is £7000. Research suggests that 20-40% reductions can be achieved with reliable and consistent information from EPR. We have assumed 30% with a 50% contribution from new EPR.	April 2014 to December 2014 • MRSA bacteraemia - Trust apportioned reportable cases = 2 • MSSA bacteraemia - Trust apportioned reportable cases = 10 • E.coli bacteraemia - Trust apportioned reportable cases = 20 • C.difficile - Trust apportioned reportable cases = 23 The cost of drugs to treat the hospital acquired infection. The number of deep cleans that have to be carried out is reduced, saving time and cost. The number of days of delayed discharge is reduced. Actual cases April to Dec 14 = 45, scaled up to full year = 57 cases	Non cash releasing	£ 100,000

Description	Details	How calculated	Type	10 year value
Increased nursing staff productivity through reduction in time spent finding notes, chasing notes, writing in notes, seeking information from other systems etc.	As we move to an electronic record dependence on paper notes is reduced, more information about the patient will be available electronically in one system and viewable by as many staff as need to have access, even at the same time. Staff will not need to log onto several systems to find information, to make requests, view results, and make notes etc. thus freeing them up to carry out other duties. Need to get a better understanding of this. Possibly shadow nursing staff to see how much time they spend on these duties.	0	Non cash releasing	£ -
Clearer and more reliable bed states improve capacity management and reduce wasted management and administration time	Real time bed management at bed level provides a single view of the truth of bed states. This improves productivity of admin teams.	Management time spent searching for accurate bed state information.	Non cash releasing	£ 2,000,000
Reduction in Information Governance incidents due to improved data security	44% reduction in IG reported incidences recorded on Datix.	TBC	Non cash releasing	£ 75,000
Elimination of clinician rewriting drug charts	Source SAcP - Clinicians no longer need to re-write drug charts	40 hours per week, at £40 per hour	Non cash releasing	£ 670,000

Description	Details	How calculated	Type	10 year value
Reduction in pharmacy checking drug charts	Pharmacy save time by using electronic record to check drug charts	40 hours per week at B5	Non cash releasing	£ 230,000
Drug-related Incident management costs (1200 pa @ £40 / incident)	Incident management costs (1200 pa @ £40 / incident)	Saved incident management costs	Non cash releasing	£ 386,000
Letters move from paper to e-mail or other electronic delivery	Letters not printed, Letters not posted. Letters are produced electronically and emailed to patients instead of printing and posting. This covers appointment letters, Outcome letters, Waiting List letters, TCI letters and general clinic letter.	Consultants time saving	Non-cash Releasing	£ 2,056,000
Typing medical secretaries	Audio typing completed by medical secretaries - time saved	Further investigation needed	Non-cash Releasing	£ -
Improved productivity from health care workers not having to log into multiple systems and find the patient context in each	As more information is recorded in the EPR it will be possible to retire other applications, particularly some of the departmental and in-house developed systems. This will lead to staff needing access to fewer systems and being able to have one view of the patient.	TBC	Non cash releasing	£ -
Porters time – if no notes need to be delivered when we go electronic **NEW FOR V8b BENEFIT CASE**	Porters currently deliver Medical Records / and collect Medical Records across the Trust This need should disappear due to medical records going electronic	0.8 Efficiency saving identified connected to notes delivery	Non cash releasing	£ 108,572

Description	Details	How calculated	Type	10 year value
Reduce time collecting outcome forms / booking forms / referral collection and delivery **NEW FOR V8b BENEFIT CASE**	Currently use 2.5 hours per day on this task – band 3 12.5 per week 150.0 hours a year	Costing from 0.33 band 3 time	Non cash releasing	£ 61,675
TOTAL BENEFITS				£ 24,517,260
TOTAL CASH RELEASING BENEFITS				£ 11,780,013
TOTAL SAVINGS BENEFITS FROM EXISTING SYSTEMS				£ 7,050,000
TOTAL NON-CASH RELEASING BENEFITS				£ 5,687,247

12. APPENDIX B – OPTIONS AND COSTS PER VENDOR

Appendix redacted as the supplier’s pricing is Commercial in Confidence.

13. APPENDIX C: RESOURCE PROFILE

	Phase One							Totals
	Initiation	Design & Build	Test	Prep	GL	Verify	Rollout	Man Days
Man Days per stage	40	80	40	50	5	30	70	
Project Roles and FTE								
Programme Manager	1	1	1	1	1	1	1	315
Project Manager	1	1	1	1	1	1	1	315
PMO	1	1	1	1	1	1	1	315
Business Change Manager	1	1	1	1	1	1	1	315
Business Change Analyst	1	1	1	1	1	1	1	315
Cutover Manager				1	1	1		85
System Administrator	1	1	1	1	1	1	1	315
Design/Config Leader	1	1	1	1	1	1	1	315
Functional Lead O/P		1	1	1	1	1	1	275
Functional Lead Med Recs		0.5	0.5	0.5	0.5	0.5	0.5	138
Functional Lead Waiting Lists		1	1	1	1	1	1	275
Functional Lead Bed Management		1	1	1	1	1	1	275
Functional Lead A&E		1	1	1	1	1	1	275

	Phase One							Totals
	Initiation	Design & Build	Test	Prep	GL	Verify	Rollout	Man Days
Functional Lead Maternity								-
Functional Lead Theatres								-
Functional Lead E-prescribing								-
Functional Lead Order Comms		1	1	1	1	1	1	275
Functional Lead I/P		1	1	1	1	1	1	275
Training Manager			1	1	1	1	1	195
Trainer			2	10	5	5	4	1,035
Trust Training Admin			1	1	1	1	1	195
Trust Floorwalkers/support		2	4	20	40	10		1,820
Data Migration	1	1	1	1	1	1	1	315
Data Quality/Assurance lead	1	1	1	1	1	1	1	315
Testing Manager		1	1	1	1	1	1	275
Testing Staff (Build/Data Entry / Validation - UAT)		4	4	4	2			690
Interface Manager		1	1	1	1	1		205

	Phase One							Totals
	Initiation	Design & Build	Test	Prep	GL	Verify	Rollout	Man Days
Trust Interface Analyst		1	1	1	1	1	1	275
Business Information Manager		0.5	0.5	0.5	0.5	0.5	0.5	138
Senior Information Analyst		1	1	1	1	1	1	275
Infrastructure Analyst	0.5	0.5	0.5	1	1	0.5	0.5	185
SQL Developer		0.5	0.5	0.5	0.5	0.5	0.5	138
TOTAL Phase 1								10,133

	Phase 2							Totals
	Initiation	Design & Build	Test	Prep	GL	Verify	Rollout	Man Days
Man Days per stage	40	60	30	40	5	30	70	
Project Roles and FTE								
Programme Manager	1	1	1	1	1	1	1	275
Project Manager	1	1	1	1	1	1	1	275
PMO	1	1	1	1	1	1	1	275
Business Change Manager	1.0	1.0	1.0	1.0	1.0	1.0	1.0	275
Business Change Analyst	1.0	1.0	1.0	1.0	1.0	1.0	1.0	275
Cutover Manager				1.0	1.0	1.0		75

	Phase 2							Totals
	Initiation	Design & Build	Test	Prep	GL	Verify	Rollout	Man Days
System Administrator	1.0	1.0	1.0	1.0	1.0	1.0	1.0	275
Design/Config Leader	1.0	1.0	1.0	1.0	1.0	1.0	1.0	275
Functional Lead O/P								-
Functional Lead Med Recs								-
Functional Lead Waiting Lists								-
Functional Lead Bed Management								-
Functional Lead A&E								-
Functional Lead Maternity		1.0	1.0	1.0	1.0	1.0	1.0	235
Functional Lead Theatres		1.0	1.0	1.0	1.0	1.0	1.0	235
Functional Lead E-prescribing		1.0	1.0	1.0	1.0	1.0	1.0	235
Functional Lead Order Comms								-
Functional Lead I/P								-
Training Manager			1.0	1.0	1.0	1.0	1.0	175
Trainer			2.0	10.0	5.0	5.0	4.0	915
Trust Training Admin			1.0	1.0	1.0	1.0	1.0	175

	Phase 2							Totals
	Initiation	Design & Build	Test	Prep	GL	Verify	Rollout	Man Days
Trust Floorwalkers/support		2.0	4.0	20.0	40.0	10.0		1,540
Data Migration								-
Data Quality/Assurance lead	1.0	1.0	1.0	1.0	1.0	1.0		205
Testing Manager	1.0	1.0	1.0	1.0	1.0			175
Testing Staff (Build/Data Entry / Validation - UAT)		4.0	4.0	4.0	2.0			530
Interface Manager		1.0	1.0	1.0	1.0			135
Trust Interface Analyst		1.0	1.0	1.0	1.0	1.0	1.0	235
Business Information Manager		0.5	0.5	0.5	0.5	0.5	0.5	118
Senior Information Analyst		1.0	1.0	1.0	1.0	1.0	1.0	235
Infrastructure Analyst		0.5	0.5	1.0	1.0	0.5	0.5	140
SQL Developer		0.5	0.5	0.5	0.5			68
TOTAL Phase 2								7,350

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 28th May 2015, 10am-12pm
Boardroom, Salisbury District Hospital

SFT 3686

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair), Christine Blanshard, Lorna Wilkinson, Claire Gorzanski, Hazel Hardyman, Hollie Foreman, Laurence Arnold, Malcolm Ace, Paul Kemp, Peter Hill, Sally Tomlin, Angela Clarke, Jan Sanders, Sarah Mullally.

In attendance:

	Item
Kate Williams	Minute taker
Judy Cronan, Sarah Paterson, Debra Sweeny, Carol Daniels	CGC0504

Observing:

Nick Hayter, Deputy Lead Nurse, Radnor ITU/HDU

CGC0501 Apologies:

Steve Long, Mark Stabb, Maria Ford, Fiona Hyett

CGC0502 – Minutes of the meeting held on 26th March 2015

The minutes of the last meeting were agreed as an accurate record.

CGC0503 – Matters Arising/Action Tracker

There were no matters arising due this month.

STRATEGY

CGC0504 – Core Service presentation – Stroke Medicine. Judy Cronan, Sarah Pattison, Debra Sweeny, Carol Daniels.

JC delivered a Powerpoint presentation on Stroke Medicine.

JC highlighted the ethos of Farley Stroke Unit; described how and why the Farley Stroke Unit works; explained the Sentinel Stroke National Audit Programme and described how the Rapid Access TIA clinic service is provided 7 days a week. The following achievements have been made: -

- Direct admission to the Unit <4 hours.
- Urgent CT head scans <1 hour.
- Increased therapy input and weekend therapy service to Unit.
- Rapid access TIA clinics and weekend TIA clinics.

The current concerns being : -

- Poor staffing levels, at present, for nursing and therapy staff and the need to recruit a 3rd Consultant
- Ongoing low staffing establishment to the Unit for Speech and Language therapy and Dietetics
- Delayed patient discharges whilst awaiting care packages or transfer to an Early Supported Discharge team.
- Possible Unit move and the split of Acute and Rehabilitation services.

PH confirmed that the proposal for the possible unit move had not yet been forthcoming – this needs to be done so that proper consideration can be made.

SM asked if there were any plans to change the treatment for stroke patients – ie within different hospitals.

PH stated that the commissioners have expressed some interest in this – depending on the outcomes of SSNAP. JC confirmed that the audit reporting was very robust.

PK asked for further clarification of the weekend TIA network service. JC explained that there is a 1 in 3 rota between Salisbury, Bournemouth and Poole. There are 6 slots in the clinic which is completely staffed for all scans and consultations. Details are sent to the patient's local hospital for follow up. The clinic was audited regarding patient satisfaction – there were no complaints about travel or parking and patients were impressed with the 1:1 service they received. Hospital transport is provided by the hospital on call.

PK asked how well it worked when we receive paperwork from the other hospitals to which JC responded that it works very well.

PK asked if this could be used as a model for other departments.

CGz gave an example of a patient story where they were treated at Bournemouth hospital under the network service and were very satisfied with the care they received.

PH stated that this was effective networking. The Salisbury team led the initiative, which was difficult to set up. It shows brilliance and determination that such an effective network has been created.

JC reported that Dr Black meets with members from the other hospitals every three months to discuss any problems and confirmed that it is possible to filter patients if their treatment at Salisbury is deemed inappropriate.

PK raised concerns regarding tracking patients progress if there is not enough staff cover to which DS responded that patients are prioritised so that they are seen at the earliest opportunity.

AC reported that there were issues regarding visits from dieticians which could be only once a week. It is important to ensure that patients are getting adequate nutrition to aid recovery and this is difficult to ensure with so few visits. CB responded that the dieticians are provided under an SLA and are commissioned by community service.

LB thanked JC, SP, DS and CD for their report and presentation.

CGC0505 – Hot Topic – Nursing Documentation – Maria Ford

This item was deferred to October 2015.

CGC0506 – Spinal Unit Strategy (verbal update) – Christine Blanshard/Denise Major

CB reported that there are three pieces of work in progress : -

- To embed work and sustain it and move from current progress, to a future improved state.
- Operational work regarding backlog and referrals. Plans are in place to reduce the current backlog.
- Thames Valley and Leadership Academy are supporting the spinal team. They recently had an awayday to work on development of the leadership of the whole team.

There are concerns regarding the pace and sustainability of change. LW, CB and AH will be working with the team to aid further improvements. There needs to be a more standardised patient pathway, delivered consistently.

LB asked if patients that have been on the ward for a long time have seen any difference to which CB responded it was difficult to analyse, but there have been less complaints. There are lots of different issues and lots of small incremental changes which may not be obvious to all patients. There was a need to get a shared vision for staff and that is in place now. Some changes are still in the process of evolving.

LB requested that she have an informal walkaround with LW and CB. CB confirmed that she was happy for this to take place.

SM suggested that it may be helpful to have some Quality Indicators in order to see improvements being made.

CGC0506A – Nursing Strategy – Lorna Wilkinson

LW reported that the revised nursing strategy is to be relaunched. There was positive feedback leading to Pride in Practice. Staff felt that strategy needed to be refreshed and made more snappy, focused and less wordy. They wanted to keep the three key objectives and pick out key bulletpoints thereafter. Staff also found it helpful in terms of how the strategy translates for members of staff. The document is showing priorities for Year 1. It is monitored by Nursing, Midwifery and AHP Forum and is before the committee for comments.

PK stated that he felt they were extremely effective documents but he noted that the word 'develop' starts a lot of the bulletpoints, suggesting that these items have not yet been attended to. PK suggested a change of wording to show that we have attended to these items but wish to improve them. It would be good to see how patients will see our improvements on each page. LW was in agreement with these suggestions.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC0507 – National Inpatient Survey 2014 – CQC Benchmark report and Local Action Plans – Lorna Wilkinson, Hazel Hardyman

EXECUTIVE SUMMARY:
Salisbury NHS Foundation Trust (SFT) participated in the 12th national inpatient survey between October 2014 and January 2015. The survey contained 60 core questions which could be analysed, grouped into 11 sections.

Comparisons with other Trusts

- SFT scored 'about the same' as all other Trusts in all sections and 'about the same' for 59 of the individual questions.
- For the remaining question (Did you every share a sleeping area with patients of the opposite sex?) SFT scored 'worse'.

Comparisons with its own 2013 benchmark results

- SFT scored significantly higher for one question:
    - Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?
- It scored significantly lower for two questions:
    - Did you ever share a sleeping area with patients of the opposite sex?
    - Did nurses talk in front of you as if you were not there?

Local Results Analysis

- 290 comments were received on things that were good
- 239 comments were received on things that could be improved
- The main area where more negative than positive comments were received related to food.

The Next Steps

- A sub-group of the Food and Nutrition Group has recently carried out work to try to identify the reasons for negative comments and the real-time feedback questionnaire for 2015/16 has been adapted to capture patients' views on what could be done to improve in this area.
- There are two main areas of concern regarding patients sharing a sleeping area with patients of the opposite sex:-
    - our Commissioners have been invited into the Trust to review the issues on Radnor since the unit was refurbished, and AMU;
    - daily review of any breaches or capacity issues on AMU being led by the Chief Operating Officer and Director of Nursing with the clinical teams. Longer term piece of work looking at a proposal to relocate the AMU into a larger footprint to be considered by Executive Directors.
- Individual ward action plans have been developed

HH reported the results of the survey and noted the particular concerns regarding mixed sex sleeping areas and negative comments relating to food. Action plans have been drawn up.

LW noted that this had been discussed at the CMB and that every year we obtain average results overall although we do well in specific areas. There are some inconsistencies between ward targets in the action plans. There should be a Trustwide response to the issues raised – this will go back to the CMB in two months. **HH**

AC stated that a main area of concern relates to delays in the discharge of patients which is not helped by waiting times for services from Hampshire, Dorset, and others.

LW noted that it would be beneficial to have improved communication with patients.

CGz suggested that GP's would like to be contacted about their patients – this could aid progress as they give good feedback. AC responded that she was in agreement with this as the GP's prove to be very helpful and she would like to see more encouragement of junior doctors to contact GP's. AC suggested that this could be part of the induction process.

HH stated that she will be meeting with Gill Sheppard in June to create a Trust Action Plan.

CB noted that there needs to be a consistency between the wards on matters such as the response time for answering a call bell.

PK stated that, having looked through the documents, some actions are not new but are things that we should already be doing. Where it is written that a target is to 'ensure' there needs to be clarification as to how this is being done.

CGC0508 – Q4 Customer Care Report – Lorna Wilkinson, Hazel Hardyman

The main issues from complaints are:

- Clinical treatment (31) - sub-themes were 10 unsatisfactory treatment across 10 different specialties, 8 delays in receiving treatment which has increased this quarter by 2, 6 correct diagnosis not made, 2 further complications, 2 inappropriate treatment, 1 treatment unavailable, 1 ward moves and 1 pain management. Obstetrics and Gynaecology received the highest number of complaints (4) about clinical treatment but there were no themes.
- Staff attitude (12) – 9 related to medical staff, 2 nursing staff and 1 therapist across 11 different areas. There were 10 complaints for the same period last year.
- Appointments (11) – sub-themes were 5 appointment date required (across 5 different specialties), 4 appointment system delays, 1 cancelled and 1 appointment procedures.

74 complaints were received in quarter 4. This compares to 76 complaints in quarter 3 (2014-15) and 75 complaints for the same period in the previous year.

HH reported that the timescale for response to complaints has improved but it needs to be better, particularly in some areas. The case referred to the Ombudsman has not been upheld.

CGC0508A – Complaints Dip Sampling Report – Lorna Wilkinson, Hazel Hardyman

HH has discussed the report with SL and the need to do more work to investigate discrepancies between actions to be taken and actions recorded in action plans. LB has concerns that we are not showing that we are demonstrating that we are 'learning lessons'. HH responded that it proves difficult to get the action plans back and get them recorded, this appears to be due to pressure of work.

LW noted that once a letter has been sent out, it appears to close the matter, but we need to complete actions. SM suggested that there needs to be some streamlining of the procedure to which LW noted that the matters could be presented at staff meetings as part of an action plan. AC stated that it was really important to get feedback in these matters. PK suggested that simple process mapping may assist and asked if the Committee could have a verbal update at the next meeting. **HH**

ASSURING CLINICAL EFFECTIVENESS
CGC0509 – Quality Indicator Report - Christine Blanshard

- 5 new serious incident inquiries.
- A decrease in the crude mortality rate in April 15. SHMI is 104 and SHMI adjusted for palliative care is 100 to September 2014 is as expected. HSMR increased to 101 in December 14 is as expected.
- An increase in the adverse event rate in January 15 as measured by the Global Trigger tool with a decline in February 15. Detail reported at the Clinical Risk Group.
- An increase in grade 2 pressure ulcers. Two grade 3 pressure ulcers.
- Safety Thermometer – 96% 'new harm free care'. A decrease to 92% of 'all harm free care' of patients admitted to hospital with a harm.
- There were 6 falls, 2 resulting in major harm (fractured hips requiring surgery), 4 resulting in moderate harm; 1 fractured impacted hip, 2 fractured wrists and 1 neck fracture all managed conservatively. RCAs undertaken and ongoing aggregated learning reported at the Falls Working Group.
- An improvement in patients arriving on the stroke unit within 4 hours. A reduction in patients spending 90% of their time on the stroke unit as three patients were transferred to other wards prior to discharge to provide capacity for new stroke patients.
- There was a decrease in high risk TIA referrals being seen within 24 hours. This affected 5 patients who were seen between 45 minutes and 6 hours over the target time.
- Escalation bed capacity increased in April. Ward moves of patients moved more than twice remains at a low level.
- There were 8 breaches affecting 46 patients in mixed sex accommodation mainly on AMU (44) and the remainder were 2 patients ready to be transferred out of Radnor who waited more than 12 hours. The Director of Nursing and Chief Operating Officer are undertaking daily reviews on AMU.

Real time feedback was as expected. The Friends and Family test response rate for inpatients was at target but the ED response rate fell below target and the Maternity Services response rate remains well below target. Day cases and outpatient response rates remain variable. Overall, there was a 36.3% response rate for the staff FFT in 14/15 with over 90% of staff recommending the hospital as a place to receive care and treatment.

CB reported improved admissions to the Stroke Unit but we are struggling with capacity. There are concerns regarding the Stroke Unit's plans to move and reduce beds. PH responded that information received suggests that whilst approximately 50% of patients on Farley Ward are stroke patients, that at any given time a significant number are not. AC and CB responded that the information must have contained an error as 50% seems very low – AC reported that it would be more usual for 3 / 4 patients who are not stroke patients out of approximately 31. CB has previously reported to the committee that we have had more stroke patients than beds. Patients are exceeding target times due to referrals.

LB asked about the graph showing that C Difficile had risen last year above 19. CB responded that the line is not helpful as the numbers may be above or below that line. PK noted that it was however helpful to see the trajectory to see where we are.
CB reported that pressure ulcers are generally reduced and there are investigations regarding Grade 3 pressure ulcers on the Spinal Unit. With regard to falls, the information is showing that the majority are in patients who are medically fit for discharge. LW noted that the profiles have significantly changed.

SM asked if it would be possible to give information to the patients regarding falls before they leave the hospital. AC confirmed that this is already done and most have been seen by physiotherapists.

LW asked if it was a question of taking our eye off the ball as the patients are fit for discharge

although their falls risk has not decreased. Work needs to be done on this.

PK asked if there was anything to be drawn from the April fracture results to which LW responded no, all were moderates / majors which resulted in fractures. This matter will continue to be reported to the committee. CB noted that there will be a fracture liaison service for patients who have suffered falls / fractures but that this will take a long time to demonstrate effectiveness. PK requested that there be a specific falls report to come back to the committee. It was agreed that this would occur after the next quarterly report. **CB / LW**

LW reported that incidents of mixed sex sleeping accommodation were happening less on Radnor Ward, most concerns are within MAU Whiteparish where the take can be between 35/40 but the ratio of male / female patients cannot fit into the allocated single sex bays. Breaches are reported 3 times a day. LW and Andy Hyett visit each morning to try and unblock beds. Our team will be visiting RUH and Dorchester who had similar difficulties but have resolved them. AC noted that problems with mixed sex sleeping accommodation happen each day although staff work very hard to avoid this and within this it is important to remember that patient safety is paramount.

PH stated that it is very positive that this issue is being worked on and that staff are being spoken to about the difficulties. It is good that we are reporting honestly in this matter. PK asked if the matter of refurbishments are being given enough weighting.

SM asked why the Global Trigger Tool showed a peak in January. LW responded that this was due to the pressure ulcers and to three prescribing issues relating to opiates and insulin. There has been a change in prescribing practice and there is an education issue regarding opiates and insulin. Insulin is now very complex and it is easy to make an error. Lots of insulin have very similar names.

CGC0510 - Intelligent Monitoring Report - Christine Blanshard, Claire Gorzanski

- The overall risk score of 1 has remained the same since the last report in December 2014.
- There are no elevated risks.
- There is one indicator rated as a risk.
  - Mortality associated with musculoskeletal conditions – the mortality working group have reviewed all these deaths and disseminated learning points.
- SFT continues with a risk banding of 6 which puts us in the lowest risk cohort.

CB reported that this result was good. The one risk has been reviewed and has been reported to the mortality group and the Clinical Management Board.

CGC0511 – Update of the mock CQC inspection action plan - Christine Blanshard, Claire Gorzanski

- Progress has been made in the Trust wide improvement actions particularly related to end of life care and staffing levels within the wards. However, ongoing work is required to ensure corridors are kept clear, drug fridges are managed effectively and securely and patient flow and transport experience is monitored.
- Four speciality/clinical teams have presented to the CGC since November 2014. The areas of concerns raised by each team are tracked and many have been addressed or led to improvements.
- A CQC preparedness steering group was set up in March 14 chaired by the Director of Nursing. These include preparation of information requirements, a communication plan, service level presentations at CGC and JBD, Executive walk rounds and mini inspections.

CB reported that progress is being made, particularly in end of life care. Corridors are occasionally still blocked. Drug fridges are being managed and locked. Areas of concern are being tracked and reported. There are a number of workstreams – there is preparation of information for the CQC inspection. Walk rounds are taking place, JBD had a presentation from Gastroenterology and the

next day they were visited – all was as they had reported which was good news.

GC0512 – Final Quality Account - Christine Blanshard, Claire Gorzanski

- Overall, the Trust has made good progress in improving the quality of care in 14/15 but there is still work to do.

- Five quality priorities have been selected for 15/16 following a wide consultation. The five

  priorities are: Priority 1 Strive to keep patients safe from avoidable harm

  Priority 2 Ensure patients have a positive experience of care

  Priority 3 Actively work with our community partners and patients to prevent ill health

  Priority 4 Provide patients with high quality care seven days a week

  Priority 5 Provide co-ordinated care across the whole health community.

- The final quality account has been reviewed by the Readership panel and their suggested amendments incorporated in the text. Overall comments included 'I looked through the document and thought it looked fine. I think including direct quotes from people is very helpful'. 'I have not included pages on which I did not have comments' (20 pages commented on).

- Statements from Dorset CCG Healthwatch, the governors and Wiltshire Council are supportive of our progress in 14/15 and our priorities in 15/16. The response from Wiltshire CCG was tabled at the meeting and was very positive.

- KPMG have completed a review of the account which included 2 mandated indicators and 1 indicator selected by the governors.

- Progress of the quality priorities will be monitored and reported through a mid year report and final report in May 2016.

CB reported that there were very positive comments from Wiltshire Clinical Commissioning Group. Due to an accident of timing this went to the Board on previous Friday. LB responded that it was approved post-board approval.

ASSURING SAFETY

CGC0513 – Sign up to Safety Programme – Lorna Wilkinson

The paper sets out our refreshed patient safety priorities. This work has been informed by internal information, the outgoing South West Collaborative, Sign up to Safety commitment, and also the Wessex AHSN hosted regional Patient Safety Collaborative.

Current Situation:

- Priorities identified
- Teams and team leads identified
- Safety Steering Group established to monitor progress on an ongoing basis
- Programme Manager in place
- First Wessex AHSN learning event attended in May 2015

LW reported that there are various campaigns and safety programmes for which we now have teams and team leaders. The Wessex Healthtrust Learning Event was attended. LW suggested that we need to report to the committee on a quarterly basis which was agreed.

LB asked if we had heard back as to why we had not received a grant to which LW responded that we had not but that she would be having a conversation about this soon.

CGC0514 – SII/CR Report Q4 – Lorna Wilkinson, Fenella Hill

Updates to outstanding recommendations:

- SII 140 All recommendations completed
- SII 147 No recommendations from review
- SII 148 Recommendations 1, 2, 4-6 completed
- SII 150 Recommendation 2 completed
- SII 151 Recommendations 1-4, 6 and completed
- SII 152 Recommendations 1, 2 and 5 completed
- SII 153 All recommendations completed
- SII 155 Recommendations 1, 3. 4 and 5 completed
- SII 159 All recommendations completed

Reviews with outstanding recommendations:

- SII 148
- SII 150
- SII 151
- SII 152
- SII 155
- SII 159

New Recommendations since February 2015 CGC

- SII 147 (Medicine)
- SII 148 (Surgery)
- SII 150 (Medicine)
- SII 151 (Medicine)
- SII 152 (Surgery)
- SII 153 (HR&OD)
- SII 155 (CS&FS)
- SII 156 (Surgery)
- SII 159 (Medicine)

Serious Incident Inquiry/Clinical Review for Closure

- SII 140
- SII 147
- SII 153 All recommendations completed
- SII 159 All recommendations completed

FHi reported that the staff are doing a huge amount of work to complete recommendations. Good work is being done by the ward staff. PH stated that we needed to connect to complaints made, there are lessons to be learned as to our response.

PK asked why actions relating to falls in January and February were not completed to which FHi responded that the ward had the Action Plan and confirmation had not yet been received that it is complete. LW noted that regarding the trialling of boards it was proving difficult trying to work with the location of beds. CB stated that the possibility had been explored so therefore the action is completed but a good alternative had not yet been found.

CGC0515 – Safeguarding Children Q4 Report – Lorna Wilkinson

LW reported that audits have taken place and that staff awareness is good. The staff DNA policy is also good but the team were not using the template letters. The key challenges are training and the need to now upgrade the level of training for many staff. For Level 3 there will be a phased approach next year, this is a 3 year programme.

LB asked if they would need an annual update to which LW responded that it was similar to continuous professional development in that staff would need to do a certain number of hours throughout the year. There is also a need to commission training for new supervisors in respect of safeguarding children.

CGC0516 – Safeguarding Adults Q4 Report – Lorna Wilkinson

Included in the Q4 report is information around referrals, activity & themes in relation to the Adult Safeguarding/ MCA/ DoLS agenda, which continues to be active, and a Trust priority

The Safeguarding Adults & MCA Lead has returned to work from the beginning of April.

The DoLS workload continues to increase significantly following the Supreme Court ruling in March 2014. The Local Authorities are mostly unable to complete the Best Interest & Mental Health Assessments within the 7 day Urgent Authorization period. This is a national picture, but it leaves the Trust with the risk of depriving these patients of their liberty without a legal framework in which to hold them.

Concerns continue around the accuracy of the MLE reports for both Safeguarding Adults & MCA, particularly in regard to capturing all the relevant staff

LW reported that standards were maintained whilst GC was away. The main concern is DoLS workload and slow response from WCC.

PK asked if our paperwork is robust enough whilst we're waiting for an assessment to which LW and AC responded that it is always open to criticism. LW stated that we have to decide what level of risk is acceptable as an organisation.

PK asked if this could be escalated as a monthly tracking / reporting item. LB noted that quarterly reports are already made and LW responded that she would see how feasible that would be.

LW further reported that with regard to the Jimmy Savile investigation, this had been completed but is now re-opened as an additional patient has come forward. There are no allegations, but investigations are continuing to ascertain Jimmy Savile's attendances here at the hospital.

CGC0517 – NPSA NRLS Organisation Patient Safety Incident Report – Lorna Wilkinson, Fenella Hill

- The number and type of Trusts that SFT are bench marked against has changed since the last report was produced. SFT are now benchmarked against 140 Acute (non specialist) Organisations previously this was 28 Small (non acute) Trusts.

- Previously reporting rates were measured per 100 admissions. This has been changed to per 1000 bed days. Reporting rate of 28.94 incidents per 1000 bed days admissions shows the Trust to be in the lowest 25% of reporters (median reporting rate for this cluster 35.1 per 1000 bed days)

- Medication incident reporting continues to be positively high demonstrating reporting at 11.6% higher than other Acute (non specialist) Organisations.

- 73.7% of incidents reported in Acute (non specialist) Organisations resulted in no harm; we reported 89.2% of incidents as resulting in no harm. Nationally 70% of incidents are reported as no harm.

- Incidents reported in 6 of the 6 months April 2014 – September 2014

- Work to be undertaken to understand reporting triggers in other trusts and promote incident reporting (positive culture recognised through staff survey results).

FHi reported that the benchmarks have changed which now shows a different result. Using the old benchmarks our reporting has not changed at all.

PK asked if he could get assurance from this. FHi responded that it was open to

interpretation to some degree, but our reporting has not changed.

ST asked if figure 3 gives assurance. LB said that it was reassuring that you are talking to other people in the region. PK asked if the report is seen by anyone else.

ST stated that the reporting changed on the Carter Review, we are coming out at 4 which is not the best. We report very well (harm resulting low) but because we report a lot, our results look worse than they should. The reporting seems to be 'upside down'.

LB commented that the paper seems to be unsatisfactory for all.

PAPERS FOR NOTING

CGC0518	Clinical Risk Group Minutes (March 2015)	Noted
CGC0519	CMB Minutes (March and April 2015)	Noted
CGC0520	Information Governance Group (February 2015)	Noted
CGC0521	Infection Prevention & Control Committee (January 2015)	Noted
CGC0522	Integrated Safeguarding Committee (December 2014)	Noted
CGC0523	CQC Inspection Steering Group Minutes (March 2015)	Noted
CGC0524	CQC Preparedness Steering Group Minutes (April 2015)	Noted

CGC0525 - ANY OTHER BUSINESS

The NEDs were still experiencing difficulties in opening their documents. LB reported that this is in hand and David Seabrooke will be attending to this during the summer.

CB reported that she had obtained advice from the formal advisory committee that (as discussed in the last meeting) if consultant positions were offered to junior doctors whilst they were still training, it would still be necessary to openly advertise the position. If a position were to be offered it could not be enforced on either side. SM commented that we need to be more imaginative in the way we recruit. CB agreed that trainees need to be encouraged to see that Salisbury is their place of choice.

NEXT MEETING

2015 dates will be Thursdays, 10am-12pm in the Boardroom - 25th June, 23rd July, 24th September, 22nd October, 26th November. No meetings in April, August or December.

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 25th June 2015, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair), Christine Blanshard, Lorna Wilkinson, Claire Gorzanski, Hazel Hardyman, Hollie Foreman, Laurence Arnold, Malcolm Ace, Paul Kemp, Peter Hill, Sally Tomlin, Angela Clarke, Sarah Mullally, Steve Long.

In attendance:

	Item
Kate Williams	Minute taker
Richard Smith, Sarah Bartram, Sam Carvalho, Emma Rayfield, Stacey Kemp (Rheumatology)	CGC0604
Clare Hunter, Gill Hibberd (Orthopaedics)	CGC0604
Katrina Glaister, Nigel (Patient)	CGC0605

CGC0601 Apologies:

Fiona Hyett, Jan Sanders, Katie Ransby, Fenella Hill, Ian Robinson, Andy Hyett, Alison Kent, Victoria Downing-Burn

CGC0602 – Minutes of the meeting held on 28th May 2015

An amendment was made to item CGC0516 after which the minutes of the last meeting were agreed as an accurate record.

CGC0603 – Matters Arising/Action Tracker

No comments.

STRATEGY

CGC0604 – Core Service presentation – Rhuematology, Richard Smith, Sarah Bartram, Sam Carvalho, Emma Rayfield, Stacey Kemp

RS delivered a Powerpoint presentation on the Rhuematology service.

The Rheumatology department is located in a good position which enables co-ordination with other departments. RS reported that the team benefits from in-house training and that there is a low turnover of staff. There are regular departmental meetings and the fundamental principle in Rheumatology is that 'everyone in the department has an equal voice and are encouraged to contribute to the benefit of the department'.

RS reported on the development of a Biologics Database which was set up to monitor patients receiving this treatment. They were able to show that biologics aid patients to remain in employment and improves their overall function.

SC reported that all nurses delivering the service in the Early Inflammatory Arthritis clinic were given training. A large amount of documentation regarding the safe monitoring of patients was produced in relation to this which needed to be ratified and audited. The nurses need to be assessed in relation to the competencies each year and all nurses have passed to date. It is a good piece of work which can be rolled out to other departments and potentially to Rheumatology departments in other hospitals.

RS stated that they had worked closely with the audit department to ensure that there was good quality data collection – Julie Higgins has been very helpful and was instrumental in developing this

service. We have the most complete clinical coding for any NHS Rhuematology department in the UK.

The department have piloted a manned telephone line which operates for two hours per day – this has proved to be much more successful with patients than the previous system. A patient group exists and as a result of collaboration with the group a leaflet has been produced to help new patients.

RS reported that the Biologics Service is an innovative service to improve patient care and ensure the cost effective use of effective medications. There is joint research with Southampton General Hospital.

Challenges being faced by the department included increasing numbers of referrals, staff shortages and sewage leaks.

SL asked if the problem of the sewage leaks was being resolved to which LW responded that it was a problem with a bathroom which is in the process of investigation by various departments.

LW reflected on the positivity of RS and in his description of the team from everyone from the cleaners to the consultants. This is a very important and welcome attitude which benefits the patients. CGz stated that the effectiveness of this team is clear and felt that they had achieved a great deal. CGz asked how patients were being followed up to which RS replied that they were able to use a list of patients 12 months after admission.

LB thanked RS, SB, SC, ER and SK for their report and presentation.

CGC0604 – Core Service presentation – Clare Hunter, Gill Hibberd

CH delivered a PowerPoint presentation on the Orthopaedics inpatient and outpatient service.

Successes include: -

- Orthogeriatrician service and the positive impact on the care of patients with a fractured neck of femur and orthopaedic trauma / elective patients with complex medical needs.
- Excellent Friends & Family and 'Real Time' feedback from patients across the unit.
- Excellent MDT work across professions
- Responsive to negative feedback and the changing pressures on the service – listening to our patients and learning from mistakes.
- Good audit outcomes.

The ward staff work hard to get patients well and back home.

Challenges facing the team are to fill high levels of vacancies by recruiting and retaining staff, which has proved difficult.

The team also need to improve timely discharges by improving throughput on the wards; improving the management of patients from other specialities in the orthopaedic setting; MDT work to improve processes locally; effectively use white board meetings and early discharge planning and improve effectiveness of collaborative working with primary care providers and social services.

A further challenge is to improve Outpatients Services with :

- Increased flexibility to meet the needs of the public – more evening and weekend clinics
- Improve management of clinic 'over – runs'
- Job Planning reviews
- Reduced amount of follow – ups to reduce need for overbooking
- Possibly increasing the use of community hospitals for more local follow up.

PH asked how the team had risen to the challenges they face, particularly with regard to the turnover of staff and vacancies. CH responded that as senior staff have left, other members of the team have been developed skills-wise who may not otherwise have had a chance, which is positive. CH has also encouraged junior staff to step up and deal with things under her supervision.

PH asked if enough support was received from the Trust to which CH replied that further support may be needed.

GH stated that there was a gap when people are going into Band 6 roles to which LW responded that this was the case historically; the leadership course needs to be completed earlier. LW asked how the department was sharing their report. CH confirmed that the report has been emailed to all Band 6's and from there it will be sent to all other members of staff. LW suggested that some bite-sized information would be useful.

SL asked how the challenges of staff vacancies was being met to which CH responded that temporary / agency staff are taken on and monitored by the team. SL noted that it is a broad, transient team and asked how they are engaged to come together to find solutions to the problems faced. CH reported that her door is always open and the team are supported so that they feel able to come forward with any suggestions.

GH stated that it is easier to recruit and keep therapy staff who all work together and find the white boards very effective.

CB asked how doctors, surgeons and junior staff are managed. CH reported that the junior staff are very good, they prioritise on-call or surgeons doing rounds. They are good at reporting back.

PH reported that historically the Orthopaedic department receives a high level of complaints. CH has achieved a whole year with no complaints being made. AC stated that the ward is well run and CH is a fantastic nurse.

LB thanked CH and GH for their report and presentation.

CGC0605 – Patient Story – Katrina Glaister, NT

NT reported to the committee on his experiences as a patient diagnosed with rheumatoid arthritis in June / July 2013. He had found the diagnosis to be frightening as he had no real knowledge of the condition and was scared he would be incapacitated.

NT was referred to Dr Smith in the Rheumatology department at Salisbury District Hospital – his initial appointment was at 7.45pm and he was not sure what to expect. His first contact was with Sister Vera who set the tone for the department as she was able to put him at ease with her warmth and banter. NT found Dr Smith to be enthusiastic and interested in him. Dr Smith was able to reassure NT that they would be able to control his symptoms, with a clear explanation of what would happen and the process that they would go through in order to find the best treatment for him.

NT had a reaction to the initial drug he was given, but was able to see Dr Smith very quickly in order to get started on a different one. NT remarked that it was reassuring that Dr Smith would always see him in the same room, it was good to have consistency. The team members as a whole treat patients wonderfully, from the receptionist onwards, even with a full waiting room.

After approximately one year the treatment wasn't proving effective and NT was unable to drive for several months, although he continued to work during this time. Dr Smith talked to NT about using biological drugs and was very positive and confident about the benefits of this. NT now receives biological drugs by way of an infusion and he stated that the staff on the ward are all very caring and professional. NT received his first infusion in August 2014 and within three weeks he was completely pain-free. When he was unable to attend due to a tooth infection, symptoms began to return and he was slotted in at short notice for a steroid injection which helped him until he could continue with his treatment.

NT wanted to report that he has found that every member of the team is as good as the others and that they always put the patient first. He has every confidence in Dr Smith and the Rheumatology team which has made a massive difference to him and to his wife.

LB thanked NT for taking the time to talk to the committee.

AC reported that the Rheumatology team are always very helpful when they are called onto the wards, and GH stated that when she worked with patients with ankolysing spondylitis, they would always remark on how great the team were.

CGC0606 – Morecambe Bay Report and self-assessment – Fiona Coker

Fiona Coker delivered a PowerPoint presentation on a distressing chain of events that began with serious failures of clinical care in the maternity unit at Furness General Hospital, part of what became the University Hospitals of Morecambe Bay NHS Foundation Trust.

Investigation Findings

Dysfunctional maternity unit with five principle problem areas which *'constituted a lethal mix'* and 'led *to the unnecessary deaths of mothers and babies'*.

i. **Clinical competence of staff** fell significantly below the standard required for a safe effective service

   - essential knowledge was lacking
   - guidelines were inconsistently followed
   - clear instances of substandard practice amongst midwives, obstetricians and paediatricians
   - failure to recognise or act on warning signals

ii. **Poor working relationships**
   - failure to communicate important clinical information
   - 'them and us' culture
   - poor record keeping often written in retrospect
   - MDT meetings took place infrequently and were poorly attended
   - breakdown of personal and interprofessional relationships jeopardised care

iii. **Midwifery care was dominated by a small number of dominant individuals**
   - overzealous pursuit of natural childbirth
   - inappropriate classification of women as low risk
   - middle grade obstetricians strongly discouraged from being involved in care even when problems had developed
   - obstetricians lacked the determination to challenge lapses from proper standards by the midwifery staff

iv. **Failure to assess the risk of delivery in FGH**
   - restricted range of NNU care provided at FGH yet high risk mothers were allowed to deliver there
   - FGH paediatricians often adopted a 'wait and see' approach when babies were clearly likely to need a higher level of neonatal care resulting in difficult emergency transfers

v. **Grossly deficient response to serious incidents by the unit clinicians**
   - investigations were often uni-disciplinary and carried out by the same senior person
   - reports were brief, failed to identify key failures in care and demonstrated protective approach to midwives
   - blame shifting predominated
   - little visible dissemination of lessons learned
   - investigations were largely rudimentary and flawed

233 pregnancies were systematically reviewed including all of the still births, neonatal and maternal deaths.
63 showed features of concern prompting a full clinical review which found 20 instances of failures of care that were significant or major, associated with three maternal deaths, ten stillbirths and six neonatal deaths. In 13 of these there was *'suboptimal care in which different management would reasonably have been expected to make a difference to the outcome'* including one maternal death, five stillbirths and six neonatal deaths.

Delayed Problem Recognition
The FGH did not become unsafe overnight. The safety of maternity units depends on their level of vigilance to detect risk and deviation from the norm and on their taking effective action when it is found.

Had an effective MDT investigation been carried out following the death of a full term baby in 2004 then it is likely that the early stages of dysfunctional relationships and inappropriate risk assessment would have been identified and could have been addressed as several features of this case e.g. inappropriate risk assessment and failure to monitor adequately, became familiar features of later incidents; this was seen as a missed opportunity.

Had five SIs between 2006-7, including a stillbirth and neonatal death, been examined in any detail

it would have become apparent that there were further signals that all was not well with the unit including fractured relationships between midwives, obstetricians and paediatricians. Experienced clinicians must have known the problems yet no systematic attempt was made to warn those in more senior positions in the Trust e.g. managers, nurses or doctors and there is no documentary evidence that concerns were raised.

Five serious incidents in 2008 including two maternal deaths (following which the baby also died), an intrapartum stillbirth, a neonatal death from sepsis and a brain damaged baby, demonstrated:

- deficient clinical skills
- dysfunctional relationships
- failure to appreciate the significance of incidents involving disastrous outcomes for mothers and babies

The care in each case was seriously deficient. The failure to discover the problems or to enquire into the poor interpersonal relationships that afflicted the unit raises serious questions about the diligence and conduct of clinicians involved in those cases and the professional leads who knew of the cases.

Recommendations

- 221 page report culminating in 44 recommendations
- 18 were for UHMBT
- All involve supervision of midwives
- 26 pertain to the wider NHS and partners

Actions for Salisbury NHS Foundation Trust

- Disseminate the information to entire multiprofessional workforce.
- Ask questions of all
- Supervisors to complete GAP analysis
- Multiprofessional GAP analysis on first 18
- HOM and senior Trust manager complete GAP analysis on remaining 26
- Disseminate strengths and weaknesses
- Draw up action plan

LB thanked FC for her presentation and commented on the huge amount of learning that had come from this.

PK asked for clarification of our action plan. Interpersonal relationships need looking at – how are we doing that for ourselves? FC responded that we have good, respectful mulit-disciplinary relationships which are mutually challenging. CB stated that it is clear when relationships are not good. We talk to staff, talk to patients for feedback and also have multi-disciplinary and departmental discussions. LW confirmed that we have a large number of teams, governance meetings and clinical reviews.

PH agreed that it was a good question to ask – Barrow-in-Furness and Salisbury have some corresponding attributes. We have been assessed by an external agency and found to have good practices.

LW reported that one area of risk is supervision. An internal meeting is needed to look long and hard at this area. SM noted that there is supervision of midwives and this would pick up any of the cultural issues. Supervision is likely to change and there are concerns around this. We need to ask ourselves is there any risk Trust wide, particularly with the spinal unit, as Salisbury is isolated in the same way as Morecambe Bay.

FC reported that there was a good system here at Salisbury where concerns can be discussed and staff are equally supported and challenged.

AC asked how often the perinatal meeting takes place as this is a very useful forum for junior members of staff to which FC responded that they take place once a month.

SM noted the work done by FC in this area over the last few years.

LB thanked FC for her report and presentation.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC0607 – National Children and Young People Survey 14 CQC Benchmark Report and Local Action Plans

This report was unavailable and has been deferred to July 2015.

CGC0608 – Annual Food and Nutrition report

This report has been deferred to July 2015.

CGC0609 – Learning Disabilities report and work plan 15/16 – Lorna Wilkinson

This report was considered and it was requested that the work plan for 15/16 is brought back before the committee in September 2015. **GC**

CGC0610 – National Staff Survey results 2014

This report was considered and noted by the committee.

ASSURING CLINICAL EFFECTIVENESS
CGC0611 – Quality Indicator Report (for information)

This report was considered and noted by the committee.

CGC0612 - Annual Clinical Governance Report

This report was considered and noted by the committee.

CGC0613 – Annual Clinical Audit Report 14/15 (including proposed audit programme 15/16) – Christine Blanshard, Claire Gorzanski

Clinical audit is a requirement of CQC outcome 16 ' Assessing and monitoring the quality of service provision'.

The annual report provides assurance to the CGC and Trust board that clinical audits at SFT are:

- Prioritised to focus on key areas
- Professionally undertaken and completed
- Produce results that are shared and acted upon
- Followed by improvements that are made and sustained

And that they meet the statutory and mandatory requirements imposed on healthcare providers who work in the NHS in England.

A number of notable highlights are presented along with areas for improvement.

CGz reported that there has been lots of progress. CB and MS will produce a plan for the internal audit to come before the committee. LB noted that there is a gap, we need some recommendations.

CB stated that we should be proud of the high participation in national audits, we make best use with what we have.

The cost to participate in the National Audits is approximately £25,000.00 per year.

GC0614 – Annual NICE Report - Christine Blanshard, Claire Gorzanski

In January 2015 NICE started to move to a new way of numbering guidelines (NG1, NG2, etc.) whether they are clinical, public health, social care, safe staffing or medicines practice guidelines. Other guidance (technical appraisals, interventional procedures, medical technologies, diagnostic guidance and quality standards) will remain unaffected by the change. Within the Trust baseline assessments are still required on all NGs (NICE guidelines) that would previously have been known as clinical guidelines. Audits on other sets of guidelines are dependent upon the nature of that

guideline but assurance of compliance is still sought from the relevant area.

NICE have introduced 'highly specialised technologies' (HSTs) relating to new and existing highly specialised medicines and treatments within the NHS in England. The highly specialised technologies programme only considers drugs for very rare conditions.

NICE guidance published between 1 April 2014 and 31 March 2015

A total of 131 sets of guidance have been published. The current status is as follows:-

Compliant	40
Working towards compliance	35
Awaiting feedback	4
Non-applicable to SFT	52

Progress towards compliance with guidance outstanding more than 12 months

A total of 37 sets of guidance have been outstanding for more than 12 months. There are no areas for concern.

PK noted his concerns that where we are not compliant we are showing compliance dates a considerable time in the future. CGz responded that we have a three year time limit for these under the NICE guidelines. Most 'high risk' are moving towards our target of 'moderate'.

SM asked if some are heading towards the three year mark to which CGz responded that we have made significant progress. SM asked what the consequences would be if we did not achieve compliance after three years. CGz stated that we are at a low risk and gave an example regarding Acute Kidney Injury in which we had 40 recommendations, of which we had 80% compliance after six months. The outstanding matters relate to the education of staff and electronic prescribing.

PK asked if there needed to be a risk assessment with regard to possible publicity surrounding non-compliance. CB responded that we are tough on ourselves as we maintain that we are non-compliant until all items are completed, even if most are. SL commented that this was a matter of guidance and we need to ensure that we are completing the process. PK asked if we have to be compliant if it is simply guidance to which CB responded that it is recommended and the CQC would take a dim view if we did not complete this. PK suggested that we show active management and document items that we choose not to comply.

CB stated that with any relevant items we try to comply as far as we can. CGz added that a great deal of rigour and effort is put in to ensure that we are compliant. CB stated that the right philosophy is to be compliant and if, at the end of three years, we are not, we need a reassessment. LW reported that we show a clear audit trail and GAP analysis which would justify our decisions. SD commented that some NICE guidelines are vague and woolly so it is difficult to ascertain if there has been compliance.

CGC0615 - Annual R & D Report – Christine Blanshard, Stef Scott

Clinical research is a vital part of the work of the NHS, and a commitment to conduct, promote and use clinical research to improve patient care is part of the NHS England Constitution. Dr Jonathan Sheffield, the chief executive of the National Institute of Health Research Clinical Research Network (NIHR CRN) has a vision "for participation in a clinical research study to be a treatment option for all patients, no matter where they are treated or what condition they have". The Annual Report describes the contribution that the Trust has made towards the NIHR CRN high level objectives. We are pleased to report another successful year for Trust research. Highlights for the Trust during 2014/15 include:

- Meeting the following targets on time or ahead of schedule:
    - increased percentage of Trust projects that are eligible for the NIHR CRN portfolio (this is a marker of quality) to 98%
    - more than quadrupled recruitment into NIHR CRN portfolio studies over the last 5 years;
    - Increased recruitment into commercial contract portfolio research;
    - Reduced the median time taken issue NHS permission to proceed through CSP for NIHR studies to 8 days, with 94% of projects approved within 30 days;
    - Recruitment of the first study participant within 70 days for 81% of interventional studies

- The targets to recruitment to time and target for commercial studies were not met. This is largely for reasons beyond the Trust's control, but remain a key areas for development;
- Targets have been set for 2015/16 relating to consolidation of the above, and to meet the revised NIHR targets.

SS reported that we are expanding and initiating portfolios into departments not previously done. Recruitment is difficult as often funding is stopped and studies are closed with very little notice. We need to look at funding as we go forward. SS asked the committee to note the report and approve the action plan.

The committee noted the report and approved the action plan.

CGC0616 – Research Support Service Framework – Christine Blanshard, Stef Scott

The National Institute of Health Research (NIHR) published the Research Support Service (RSS) Framework in January 2001. In March 2011, CMB and CGC approved and ratified an R&D Operational Capability Statement (RDOCS) version 1.0 for the Trust and agreed that CGC would review updated RDOCS on an annual basis. The RDOCS has been updated for 2015/16.

The committee noted and ratified the framework.

CGC0617 – Dr Foster Report and Mortality Reviews – Christine Blanshard, Claire Gorzanski

Mortality:

- SHMI is 104 and SHMI adjusted for palliative care is 100 to September 2014 and is as expected. HSMR is 105 to February 15 and is as expected.

Quality investigator mortality dashboard:

- **Composite indicator of musculo-skeletal conditions** - initially red flagged from 1/5/13 to 1/4/14 and again from 1/6/13 to 1/5/14. There were 27 deaths versus an expected 13 with a relative risk of 206. There was a CUSUM alert in January 2014 and April 14. The mortality working group has reviewed 23 of these deaths. The learning points are**:**

> Pre-hospital - optimal management with prophylaxis against osteoporosis may have prevented the osteoporotic vertebral fracture leading to the patient's admission

> In hospital - optimal management with laxative prophylaxis may have prevented the constipation which resulted from the patient's analgesic requirement.

> Ensuring that patients fully understand the risks and benefits of a procedure and that it is documented in the health care records.

> Embedding practice related to reducing catheter acquired urinary tract infection.

> Roll out of the Sepsis Six care bundle across the Trust. A severe sepsis screening tool has been introduced as part of the Sepsis screening CQUIN in 15/16. This is aimed at early identification of patients who are likely to deteriorate and will benefit from early intervention with IV antibiotics. Work progressed as part of the Sign up to Safety programme work.

Diagnosis groups:

Composite indicator of genito-urinary conditions (1/11/13 – 31/10/14) – According to the December 14 Dr Fosters Care Quality Tracker, Salisbury NHS Foundation Trust has a red flag as an 'elevated risk' for the composite indicator of Genito-urinary conditions (Sept 13 to August 14).

Close inspection of the CUSUM charts indicates that there were mortality spikes in November 2013 and January – February 2014.

We have reviewed 23 of the 27 deaths which occurred in these months.

1. We found no definitely avoidable deaths.

2. We found one death where the reviewer was unsure as to whether the death was avoidable. This 79 year old patient was admitted with urosepsis to the acute medical unit and acute on chronic renal failure.
On second review of these notes I would categorise the death as having only 'slight evidence of

avoidability'.
The sepsis 6 pathway was not used, the first dose of antibiotics were given more than 2 hours post admission and no blood cultures were taken.
However it was agreed early that ward based care should be the ceiling of care and palliation was instituted in a timely fashion once it became clear that the patient was deteriorating further.

3. We noted one iatrogenic event which occurred which contributed to harm to the patient:
Opioid narcosis in a patient with Acute Kidney Injury requiring naloxone reversal.

4. We noted 4 elements of care which we feel should have happened but did not during the patients stay in hospital.

3 of these 4 involved not using the sepsis 6 pathway and delays in first dose of antibiotics.
In 1 case, the reviewer felt that there could have been an earlier and clearer decision made to stop active treatment. Some active management had stopped such as iv fluids and access but blood tests were still being done.

5. There was one learning point for the Trust to consider with regard to the early treatment of urinary tract infection prior to knowledge of renal function. A patient was given a treatment dose of Gentamicin when suffering from urosepsis and acute on chronic renal failure.

6. There was one case where admission to hospital could have been avoided had there been an advanced care plan for 'in the event of a deterioration' of an elderly demented patient who lived in a nursing home.
This situation should become less common with the recent GP initiative for advanced care plans and plans with regard to escalation in community care facilities.

Spondylosis, intervertebral disc disorder, other back problems (1/9/13 – 30/8/14) – there were 9 observed deaths vs 3 expected with a relative risk of 282. All the deaths in this group were reviewed. All were unavoidable apart from one which was previously reviewed under the musculo-skeletal conditions composite indicator.
The death that was possibly avoidable occurred in an orthopaedic patient following a dural tear. The patient died of E Coli meningitis.
The learning points were as follows:

- The Sepsis six proforma was not used.
- The standard sepsis antibiotics would however not have worked in this case due to the need for CNS penetration.
- If central nervous system infection was suspected, Ceftriaxone 2 g bd should be given as standard treatment for Urinary Tract Infection does not penetrate CNS.
- If you make a diagnosis of sepsis - give the first dose of antibiotics yourself as soon as possible.

Pathological fractures (1/9/13 – 30/8/14) – there were 7 deaths versus 1 expected giving us a relative risk of 300. WG reported that Mr Rauh and Dirian Padiachy were reviewing these deaths. Only one of the deaths was a neoplastic pathological fracture – what the clinicians would call a 'pathological fracture'.
The five other deaths all occurred as a result of falls in patients who suffered from osteoporosis and were coded as osteoporotic pathological fractures for this reason.

1. Our Dr Foster data for fractured neck of femur patients for this period shows that we had the following outcomes:
268 spells
12 observed deaths against 18 expected deaths.
This gives us a relative risk of 65.89
This confirms that the quality of our fractured neck of femur care is good.

2. Clinicians need to be clear in their documentation in the notes with regard to the whether the fracture was due to osteoporosis or due to a fall.
If a clinician documents that the fracture was due to osteoporosis, this will be coded as a pathological fracture.
If a clinician documents that a patient with osteoporosis has a fall resulting in a fracture and the fracture is not stated to be due to osteoporosis, the fracture is coded as a traumatic fracture, with osteoporosis coded in addition.

- **Intestinal obstruction without hernia (1/3/14 – 28/2/15)** 20 observed vs 10.2 expected with relative risk 197. No CUSUM alert.
- **Peripheral and visceral artherosclerosis (1/3/14 – 28/2/15)** – 10 observed vs 3.0 expected with a relative risk 329. No CUSUM alert.

Procedure groups:

Rest of heart (1/9/13 – 30/8/14) – procedural category - 4 observed vs 0.8 expected with a relative risk of 407.
The cardiologists have reviewed all of the deaths.
One of the deaths was thought to be potentially avoidable as follows:
'As the death occurred as a result of a procedural complication then the death should be classified as avoidable. However, both a Serious Incident Inquiry and Coroner's inquest have come to the conclusion that death followed a recognised complication of the procedure being undertaken and that all treatment was appropriate and no change in the service was recommended'

There was one learning point for the Trust whereby acute heart failure patients should always be referred to cardiology at first presentation.
In this case, a patient was admitted with acute heart failure and treated with iv furosemide. The patient was then discharged for outpatient review.
The patient was then readmitted four days later.

- **Urethral catheterisation of the bladder (1/11/13 – 31/10/14)** 44 observed vs 30.9 expected with a relative risk 142 - the mortality working group will review these cases with the clinical teams concerned – **Outcome awaited**

CB reported that mortality reviews found that there were two deaths which may have had elements where care may have impacted and both related to the management of sepsis. We find that we gain valuable learning from patient pathways.

LB asked who participated in the Mortality Working Group to which CB responded that people from a range of professions and specialities form the group.

ASSURING SAFETY
CGC0618 – Annual Report for Professional Registration – Lorna Wilkinson

All registered staff are checked at appropriate intervals to ensure their registration is maintained and current. If registration should lapse they are not able to work in a registered capacity and may be dismissed. All medical and dental staff registrations are also checked to ensure they are registered and licenced and the Trust is working to implement all the requirements of revalidation. All new recruits who require professional registration have their registration status checked via the regulators web site, GMC, HPC and NMC by the HR administrative team.

The Trust employs approximately 2,000 clinical staff who are required to be professionally registered to perform their roles. These include Medical, Dental, Pharmaceutical, Nursing, Scientific and Therapy staff from a wide range of departments and specialisms.

Medical Staff are in addition required to be licensed to practice medicine.

The Trust's Professional Registration Policy states :

It is the responsibility of all staff, employed **in posts subject to registration/licensing with a Professional Body**, to ensure that their registration/license with the relevant Professional Body is maintained up to date at all times and that they comply with the relevant professional codes of practice.

It is the responsibility of the Personnel Department to ensure checks are carried out directly with the appropriate professional body both at employment and ongoing. It is the responsibility of Professional Leads, Heads of Service and Directorate Management Teams to work with the Personnel Department in ensuring that this policy is complied with to ensure that staff whose registration/license has lapsed are prevented from working in a registered capacity.

Failure to maintain Professional Registration/License to Practise could have potentially serious implications for both the member of staff and the Trust as a whole. If there are any changes to an individual's registration status, HR notify the individual, the relevant Heads of Service, professional leads and senior Trust management as appropriate. As well as making routine checks with professional body websites, HR receive notifications of changes to registration status are via ESR, which is directly linked to the professional bodies registration databases.

Registration checking flowcharts for medical and non-medical staff are attached for information.

Lapses in Registration 2014/15

In the period from June 2014 to May 2015, the following staff members registration lapsed. None was allowed to work un-registered, in a registered capacity.

- 5 Staff Nurses with substantive contracts, all subsequently renewed their registration, and returned to work in a registered capacity after a few days.

- 2 Bank Staff Nurses, whose names were removed from the bank shift booking system on the dates of expiry of their registration, and blocked from working until they had re-registered.

- 3 Bank Locum Medical Staff's licence to practice medicine expired. The contracts of all three were terminated as they had retired, and were not intending to return to work. None worked after their licences had expired.

No other staff who were required to be registered to perform their duties (including Medical, Scientific Technical and Therapeutic staff) experienced a lapse in professional registration in the period in question.

LW reported that revalidation will be a challenge, she will report on this in July 2015 **LW**

CGC0619 – Risk Report card Q4

This report was noted.

CGC0520 – Annual CLIP Report

This item has been deferred to July 2015.

PAPERS FOR NOTING

CGC0621	Clinical Management Board meeting minutes (May 2015)	Noted
CGC0622	Information Governance Group meeting minutes (March 2015)	Noted
CGC0623	Clinical Risk Group meeting minutes (April 2015)	Noted
CGC0624	CQC Inspection Steering Group meeting minutes (April / May 2015)	Noted
CGC0624	CQC Preparedness Steering Group meeting minutes (May 2015	Noted

CGC0625 - ANY OTHER BUSINESS

The dates for the CGC meetings in 2016 have been sent to all members of the committee – please let LB know if these are acceptable so that they can be confirmed. **ALL**

LW reported that OFSTED are reviewing child services in Wiltshire and will probably follow cases through. This may touch on our services in ED / Paediatrics.

NEXT MEETING

2015 dates will be Thursdays, 10am-12pm in the Boardroom - 23rd July, 24th September, 22nd October, 26th

November. No meetings in April, August or December.

SALISBURY NHS FOUNDATION TRUST

Minutes of the Council of Governors Meeting – Part 1
At Salisbury District Hospital
Held on Monday 18 May 2015

Governors Present:	Nick Marsden (Chairman) Sarah Bealey John Carvell Mandy Cripps Col James Denny Brian Fisk Shaun Fountain June Griffin Chris Horwood Raymond Jack Alastair Lack John Markwell Colette Martindale (Lead Governor) John Noeken Carole Noonan Rob Polkinghorne Janice Sanders Nick Sherman Lynn Taylor Christine White	**Apologies:**	Mary Monnington Beth Robertson Chris Wain Lynda Viney

In Attendance:
Peter Hill (Chief Executive)
Malcolm Cassells (Director of Finance and Procurement)
Lorna Wilkinson (Director of Nursing)
Andy Hyett (Chief Operating Officer)
David Seabrooke (Head of Corporate Governance)
Isabel Cardoso (Membership Manager)
Patrick Butler (Communications Manager)
Sarah Mullally (Non-Executive Director)
Lydia Brown (Non-Executive Director)
Ian Downie (Non-Executive Director)
Paul Kemp (Non-Executive Director)
Andrew Freemantle (Non-Executive Director)
Steve Long (Non-Executive Director)

ACTION

1. INTRODUCTION AND WELCOME

The Chairman welcomed Colonel James Denny to his first meeting of the Council of Governors since his appointment in February as military governor. He also welcomed Andy Hyett, Chief Operating Officer.

In an earlier meeting those governors who were retiring had reflected on their time with the Trust as a governor and the Chairman thanked all concerned for their contribution to the work of the Trust which in some cases was from when the Trust was first authorised.

It was noted that the results of the elections were expected at the end of the week and would be on general issue early the following week.

The Council also thanked Colette Martindale for her work as Lead Governor as she was standing down on 31 May having completed her term of office.

2. MINUTES 16 FEBRUARY 2015

The minutes of the meeting of the Council of Governors on 16 February were accepted as a correct record with an addition to Minute 6 to the effect that the purpose of the committee protocol was also to provide a structure for appointing and regulating the membership of committees of the Council.

The minutes of the joint meeting with the Board of Directors held on 23 February 2015 were accepted as a correct record.

3. TRUST PERFORMANCE TO 31 MARCH 2015 (MONTH 12)

The Council received the Performance Report for Month 12.

It was noted that the Month 12 figures were generally healthy but behind them was considerable effort by the staff. Referrals for cancer and diagnosis were up as a result of public health campaigns. There were 23 attributed cases of C-Diff in excess of the target of 18 and it was noted that these were not considered to be an outbreak. There was no associated change in clinical practice and the cases occurred in different locations in the hospital.

The Council noted the Performance Report for March.

4. TRANSFORMATION PROJECT

The Council received a report on the Transformation and Cost Improvement Plan for 2015/16. The figures shown in the report were considered to be robust and derived from clear calculations but achievement of these in relation to red/amber/green ratings was considered to be challenging. In some cases work was spread over more than one year with a great deal of enabling work in for instance outpatients, to drive out savings in the second year. The Trust would need to address cultural resistance to change but also listen carefully to staff feedback. Work continued to strengthen the role of the Programme Management Office to support major projects.

Efforts would be made to maintain staff morale in the event that it was affected by the deficit situation.

The Council noted the Transformation Project Report.

Governors had requested further updates on capacity planning in Orthopaedics and the recent PLACE audit.

In relation to command and capacity planning, this was active looking at capacity in Trauma, Fracture and other areas to increase the service available and to reduce waits.

In relation to the PLACE audit local scores were up against the national averages from 2014 and national comparative feedback would be published later on in August. The Trust continued to undertake a rigorous and honest assessment in line with the guidance. Thanks were given to all governors who had taken part in the PLACE audit.

5. CUSTOMER CARE REPORT – QUARTER 3

The Council received the Customer Care Report and it was noted that although overall complaint numbers were static, issues around staff attitude had improved on the previous year. Work continued to standardise appointment processes the Medicine Customer Care Facilitator had had a positive impact on the figures from that area. It was emphasised that complaints were an important source of learning for the Trust. Compliments were not analysed by subject. The complaints workshop had led to less re-opened complaints and improvements to the rate of three day acknowledgement of new complaints. Some people mentioned issues to governors but did not consent to these being raised formally with the hospital. Although complaints could be taken over the phone, this remains a frustration for individual governors.

The Council noted the Quarter 3 Customer Care Report.

6. FINANCE AND CONRACTING REPORT TO 31 MARCH

The Council received the Finance Report. The Trust had ended the year with a £1.9 deficit against a planned surplus of £800,000. This was a comparatively small deficit – cost improvement programmes, agency spend and the displacement of elective work in the winter months had all been factors.

The Report indicated that outpatient initial attendances had been increased and that follow ups had been reduced. The 2014/15 savings plan had achieved £6.2m and 2015/16 represented a major challenge for the Trust. The finance costs shown included the PFI payments, public dividend capital payments and depreciation charges.

It was noted that the provision of the maternity services was a contributor to overheads but was not an area that of itself generated a major surplus for the Trust.

The Council noted the Finance Report.

7. FEEDBACK FROM RECENT MEETINGS

The Council received notes from the constituency meetings held in March for South Wiltshire Rural and for Salisbury City, the 11 March meeting of the South West Governor Engagement Network and notes provided by Brian Fisk who attended the NHS Providers Governor Focus event in April.

8. COMMITTEE/WORKING GROUPS MINUTES AND NOTES

The Council received the minutes of the Strategy Committee of 27 April 2015. The minutes of the Membership and Communications Group of 24 February were received. In its most recent meeting the committee had worked on material for the induction of the new governors including acronyms and suggestions around shadowing and mentoring. A productive meeting had taken place with the principal of the Avon Valley College. It was also noted that Christine White had spoken to the principal of the new Salisbury UTC.

Notes were received for the Patient Experience Group and Trust led sub groups.

10. DATES OF FUTURE MEETINGS IN 2015

It was noted that the next meeting of the Council of Governors was on 21 July 2015.

SALISBURY NHS FOUNDATION TRUST
Minutes of the Audit Committee
Held on: 22 May 2015

Present: Mr P Kemp (Chairman and Non-Executive Director)
Dr L Brown (Non-Executive Director)
Mr I Downie (Non-Executive Director)
Mr A Freemantle (Non-Executive Director)

In Attendance: Mr J Brown (KPMG)
Mr M Stabb (TIAA)
Mr D Seabrooke (Head of Corporate Governance)
Mr A Hyett (Chief Operating Officer) for item 3
Mr G Holmes (Director of Informatics) for item 3
Mr M Cassells (Director of Finance and Procurement)
Mr A James (Financial Controller)

ACTION

1. MINUTES

The minutes of the meeting of the committee held on 22 January 2015 were agreed as a correct record.

2. MATTERS ARISING

The Committee would revisit the Losses and Compensation Register (minute 6) at the July meeting. It would also further discuss any potential requirements for training and development of committee members at a future meeting.

3. SUMMARY INTERNAL PROGRESS REPORT

The Committee received the report from TIAA. The report summarised the findings of audit reviews of cost improvement, financial accounting, payroll, Facilities Management Services, Odstock Medical, ward rostering, consultant job planning, laundry – financial controls, information governance toolkit, board assurance framework and risk management, regulatory compliance, 18 week RTT feedback, procurement and ward visits.

It was noted that the Trust continued to remind managers about the need to notify staffing changes to Payroll promptly to avoid overpayments arising. On invoice processing it was noted that improvements through the new Workflow system were being made that would strengthen compliance with payment rules. On ward visits the Audit had highlighted the need to ensure that staff were fully aware of the need to monitor and record drug fridge temperatures and a simple flow chart had been provided in this connection.

The Chairman invited Glen Holmes, the Director of Informatics to give an update on the issues arising from the IT Change Control Audit. A management response and action plan was received.

Glen Holmes made the following principal points:

- Upgrade to Windows 7 for PCs in the Trust had progressed and there were now around 300 PCs that ran Windows XP and could not be

immediately upgraded because of specific applications that they were required to run. Work would continue to improve the security of these machines for example using Citrix software.

- Two people had been trained to carry out clinical risk assessments in relation to ISB Standards to improve the Trust's in-house software development capability and processes.
- Glen Holmes agreed to provide a note to the Audit Committee on the range of risks identified in the department's Risk Register. **GH**
- He provided an update on recurring serious IT problems over recent months and the measures taken to address this.

In relation to the limited assurance findings of the audit on the cost improvement programme the Chairman invited the Chief Operating Officer, Andy Hyett to comment on the Management Response that had been circulated to the Committee.

The following principal points were made:

- Actions included redefining the role of the Programme Management Office to focus on a single major project at a time and move most of their attention from monitoring to delivery.
- Communications with staff at all levels in the organisation were essential to the process and a variety of methods of achieving this were being deployed.
- The Trust should be planning for 2016/17 well advance of the year end.

The Committee thanked Andy Hyett for the presentation and noted the Management Response.

The Internal Audit Progress Report was noted.

4. ANNUAL REPORT AND HEAD OF INTERNAL AUDIT OPINION

The Committee received the report of the Head of Internal Audit and it was noted that reasonable assurance was given in relation to the Trust's internal control processes.

It was noted that the actions, marked as 'outstanding' in the report were not at this stage overdue for delivery. To improve the assurance opinion there would need to be less limited assurance audit reports in the year and less Important recommendations arising from audits.

The Committee noted the report.

5. ISA 260 – AUDIT HIGHLIGHTS MEMORANDUM

The Committee received the report of the appointed auditor KPMG.

Jon Brown reminded the Committee of the requirements of the international standard on accounting including the new duty to report on whether the annual report was fair, balanced and understandable.

An unqualified audit opinion on the accounts was to be provided. In general there was positive feedback about the Annual Report in that it was easy to read, gave a good interpretation of the guidance and the year-end process of

completing draft material for review had proceeded very smoothly.

The Audit was required to identify routine areas of significant risks and these included the valuation of property, plant and equipment, management override of controls and revenue recognition. The Trust had instructed the District Valuer to undertake a full revaluation exercise on its land, buildings and dwellings at the year end. The assumptions in the instructions to the District Valuer were considered to be appropriate and it was agreed that a brief report to the Finance and Performance Committee of the Trust should be made in this regard in the future.

There were no matters of concern in the 'use of resources' to report. There were minor and immaterial differences in the statements to be provided to the National Audit Office in connection with the Whole of Government Accounts.

The Committee noted two Priority 3 recommendations in respect of payroll leavers and the reporting of bank hours worked in whole time equivalent. There were no major issues to report in the follow up of prior year recommendations.

The report included a draft of the management representation letter and the committee recommended to the Board that the letter as set out in the report should be signed by the Chief Executive.

6. DRAFT CONSOLIDATED FINANCIAL STATEMENTS FOR THE YEAR TO 31 MARCH 2015

The Committee received the Draft Financial Statements as set out in the Agenda for the Trust Board 22 May 2015 and also received the Draft Annual Governance Statement. The Chairman of the Committee had reviewed the Financial Statements and notes to the accounts in detail and provided feedback to the Financial Controller.

The Committee recommended that the Board approved and adopt the Financial Statements as set out in its agenda. In doing so, it recorded its appreciation to the Director of Finance and team for the production of the accounts and for achieving a clean audit.

7. EXTERNAL ASSURANCE ON THE TRUST'S QUIALITY REPORT 2013/14

The Draft Quality Report had been circulated to all members of the Trust Board in the agenda for the Trust Board Meeting. The completed text of the opinion on the Quality Report was not available at the meeting, but was reflected in the overall opinion included with the Draft Financial Statements.

In accordance with the Monitor guidance on the Limited Assurance Audit on the content of the Quality Account, KPMG had sampled a number of patient records that supported the 18 Week Referral to Treatment and 62 Day Cancer Wait indicators set out in the quality account.

This testing had found an error rate that was above the pre-set 2% tolerance level and so assurance on this aspect of the audit could not be provided. On this basis, the Board would need to amend the Annual Governance Statement 2014/15 and the declarations in relation to the Quality Report.

There were no issues to raise in relation to the content of the Quality Report in

relation to the criteria set out by Monitor or the consistency with sources as specified in that guidance.

It was noted that no response had been yet received from Wiltshire CCG in this regard.

It was noted that the Trust was responding to the issues raised by the audit for example organising further training for staff undertaking bookings and strengthening the validation of data. There was concern however that these measures would not be sufficient to reduce the error rate to the level applied in this instance which was considered very arbitrary and it was noted that the vast majority of Trusts in the experience of KMPG could not achieve this standard.

8. AUDIT CHARTER

The Committee received the Draft Audit Charter that reflected existing practices and this was approved.

9. INTERNAL AUDIT REVISED DRAFT PLAN 2015/16

The committee received the revised Audit Plan for 2015/16 which provided for a total of 310 planned days which was felt to give satisfactory coverage for the Trust. The Audit Programme included work on data quality, detailed work around duty of candour and temporary staffing arrangements.

The Committee noted the report.

9. DATE OF NEXT MEETING

Monday 13 July 2015, at 10am