SALISBURY NHS FOUNDATION TRUST
TRUST BOARD

MONDAY 5 OCTOBER 2015, 1.30 PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
1.30pm	**1**	**APOLOGIES FOR ABSENCE –** Peter Hill			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES**			
		Meeting held on 3 August 2015			1
	4	**MATTERS ARISING**			
1.35pm	**5**	**CHIEF EXECUTIVE**			
		Chief Executive's Report	PH	SFT 3696	9
1.45pm	**6**	**STAFF**			
		1. Workforce Performance Report to include Safer Staffing and Skill Mix	AK/LW	SFT 3697	11
2.10 pm	**7**	**PATIENT CARE**			
		1. Quality Indicator Report to 31 August (Month 5)	CB/LW	SFT 3698	27
		2. Customer Care Report	LW	SFT 3699	35
2.40 pm	**8.**	**PERFORMANCE AND PLANNING**			
		1. Finance & Performance Committee Minutes 27 July & 24 August 2015	NM	SFT 3700	49
		2. Finance and Contracting Report 31 August (Month 5)	MC	SFT 3701	55
		3. Progress against Targets and Performance Indicators to 31 August 2015	AH	SFT 3702	-
		4. Update on Strategic Planning	LA	-	-
		5. Capital Development Report	LA	SFT 3703	-

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

1. Minutes from Clinical Governance Committee 23 July 2015	LB	SFT 3704	63
2. Draft minutes from Public Section of Council of Governors 20 July 2015	NM	SFT 3705	77
3. Risk Management Annual Report 2014/15	LW	SFT 3706	83
4. Risk Management Strategy 2015/16	LW	SFT 3707	91
5. Maternity and Neonatal Risk Management Strategy	LW	SFT 3708	119
6. Maternity and Neonatal Risk Management Annual Report	LW	SFT 3709	151
7. Management Letter for 2014/15	MC	SFT 3710	167

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

11 **QUESTIONS FROM THE PUBLIC** NM

12 **NEXT MEETING**

The next ordinary meeting will be held on Monday 7 December 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 3 August 2015

Board Members Present:	Dr N Marsden	Chairman
	Dr C Blanshard	Medical Director
	Dr L Brown	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
	Mr A Freemantle	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
	Right Revd Dame S Mullally	Non-Executive Director
	Ms L Wilkinson	Director of Nursing
Corporate Directors Present:	Mr L Arnold	Director of Corporate Development
In Attendance:	Mr P Butler	Communications Manager
	Mr D Seabrooke	Secretary to the Board
	Mr P Lefever	Wiltshire Health Watch
	Mr M Wareham	Staff Side
	Mrs J Sanders	Public Governor
	Mrs L Taylor	Public Governor
	Sir R Jack	Public Governor
	Dr E Robertson	Public Governor
	Mr M Mounde	Public Governor
	Dr A Lack	Lead Governor
	Dr J Lisle	Public Governor
	Mr J Wright	Staff Governor
Apologies:	Mr I Downie	Non-Executive Director

ACTION

2101/00 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.

2102/00 MINUTES

The minutes of the meeting of the Board held on 8 June 2015 were accepted as a correct record with an amendment to minute 2090/01 on page three to add "as a minimum" to the 3rd line in relation to the 1:8 ratio.

2103/00 CHIEF EXECUTIVE'S REPORT - SFT 3675 – PRESENTED BY PH

The Board received the Chief Executive's Report.

It was noted that the Trust had been notified that as part of the Care Quality Commission's national programme the Trust would be inspected between 1 and 4 December 2015. Work was already underway to prepare for the inspection which would include workshops for staff, communications and a range of activities.

Other issues highlighted included the Trust's priorities for 2015/16 complimenting the vision to provide an outstanding experience for every patient, progress with the Adult Community Services bid and the first sessions of the carer's café. It was noted that the publicity for the Carer's Café would be stepped up in the coming weeks.

The Board received the Chief Executive's report.

2104/00 STAFF

2104/01 Workforce Performance Report including Safer Staffing and Skill Mix SFT 3676 - Presented by AK & LW

The Board received the Month 3 Workforce Report, Safer Staffing and the Skill Mix report.

It was noted that agency spend was reducing as a consequence of the reduced need for escalation beds,increased scrutiny and close monitoring of all variable staff costs including agency. Pay costs were £10.5m for month 3, an overspend of £645,000.

Instances of No Reason Recorded for sickness absence was reducing. There was further analysis on workforce compliance in relation to non-medical appraisal rates, which stood at 62% of staff having had an appraisal completed and recorded on SpIda within the past twelve months although the true figure was thought to be higher than this. A further 19% had an appraisal outside the past twelve months although the true figure was thought to be higher than this. It was noted on mandatory training compliance that compliance for equality and diversity and safeguarding adults were in line with the Trust's targets. Information Governance and Infection Control required further work.

The monthly safer staffing report was received indicating satisfactory fill rates with adequate explanations in relation to areas flagged as red for example Neo-Natal Intensive Care Unit and Radnor where variations in patient activity were reflected in nurse staffing.

The Board received the output from the six monthly Skill Mix Review. The latest review covered the Emergency Department and Maternity Service as well as other inpatient ward areas. The methodology for the reviews including the publication of national guidance was noted.

A minimum ratio of 1:8 was considered to be the bench mark for day time shifts and all the wards at Salisbury Foundation Trust were compliant with this. Night shifts had a higher ratio of registered nurses to patients ranging from 1:5 to 1:16, reflecting the case mix. Registered nurse to nursing assistant ratios varied again according to the patient case mix and in the Spinal Unit there was greater use of nursing assistants with specific competencies. There were also some band 4 roles in relation to elderly

care which counted in the nursing assistant side of the ratio.

In relation to the 2014 investment in nurse staffing there were now senior sister (band 7) ward sisters across the Trust and all wards had two band 6 posts.

The findings of the current skill mix review were indicating that additional planned weekend staffing on Redlynch and Pitton wards which had the potential to reduce the need for use of temporary staff at these times. The recommendation in this case was for a pilot period of additional staffing for Pitton and Redlynch Ward for six months.

It was noted that non-recurring resilience money for 2015/16 had been used to provide additional staffing in the Emergency Department and this arrangement would be fully evaluated in order to inform potential investment for 2016/17 and beyond. Similarly an additional band 5 nurse in majors/resus had been implemented using non-recurring resilience monies. It was noted that in Midwifery five registered midwives had been recruited in support of midwives ratios in Maternity.

The headroom used in rostering was 19% and it was recommended that this should be reviewed on an individual ward basis noting that the requirement varied according to the workforce for example additional study leave for newly qualified and overseas recruited nurses or longer serving staff with a greater annual leave entitlement.

It was also noted that executives were undertaking a bed capacity review which could lead to more efficient configuration arrangements which would affect staffing requirements.

In some instances increasing planned staffing numbers would lead to a reduction in the use of agency staff usage but it was felt further work was required to fully quantify and put into context the proposals where there was a long-term financial impact. LW

It was agreed that a further report would be brought to the 5 October meeting.

2104/02 Annual Equality and Diversity Report – SFT 3677 – Presented by AK

The Board received the Equality and Diversity Annual Report 2015.

It was noted that the Race Equality Scheme required the publication of a range of figures and these requirements would be incorporated into the NHS Contract in future. Data gathered in support of the Race Equality Scheme showed that black and minority ethnic staff were well represented among those receiving job promotions within the Trust. The Stone Wall Health Champions Programme and the improvements to reach 23rd place in this year's index was highlighted and work on mindfulness including support for staff by the Occupational Health Service was noted. Work would continue to identify the causes of the disparity shown in the bar chart "bands by gender" in relation to roles at band 7 and above and bands 5 and 6. The 10% of staff aged over 60 years was in line with national trends.

The Board noted the Equality and Diversity Report.

2105/00 PATIENT CARE

2105/01 Quality Indicator Report to 30 June 2015 – Quarter 1 (Month 3) – SFT 3678 - Presented by CB and LW

The Board received the Quality Indicator Report. It was noted that there had been no new Serious Incident Inquiries opened in June and six so far in the year. Mortality rates were in the As Expected range and reports on the global trigger tool were down. There had been no falls in June resulting in major harm and it was noted that escalation capacity in Breamore Ward had been closed.

There had been three attributed cases of C-Diff in June making a year to date total of four against an annual trajectory of 19. There had been nine single sex breaches mainly in the Acute Medical Unit and this had been the subject of a commissioner visit.

The Board noted the Quality Report.

2105/02 Patient Safety Update – SFT 3679 – Presented by LW

LW gave a brief update on progress with the Sign Up to Safety Campaign and it was noted that four work streams were in place aimed at reducing patient harm and overseen by a Safety Steering Group.

The process was now overseen on the Board's behalf by the Clinical Governance Committee and this would be the reporting route in future.

2105/03 Update on Medical Revalidation – SFT 3680 – Presented by CB

The Board received the Annual Revalidation Report. As the Responsible Officer Christine Blanshard informed the Board that a range of governance and compliance arrangements were in place to oversee the revalidation process. Dr Claire Fuller was appointed as the appraisal lead and was supported by 55 trained appraisers. 143 consultants, 19 SAS doctors and six temporary contract holders completed annual appraisals within the prescribed time. The compliance rate was 92% which compared to a national rate of 84%.

Concerns about the practice of two doctors were identified through the process – both had left the Trust and concerns had been communicated to their current Responsible Officer. No doctors were subject to disciplinary procedures referred by the Responsible Officer to the General Medical Council and four were referred to the GMC by other routes – none was found to have impaired fitness to practise.

It was agreed to share the report with the Second Level Responsible Officer (Medical Director of NHS England South) and to approve the statement of compliance that the Trust as a designated body is in compliance with the regulations.

2106/00 PERFORMANCE AND PLANNING

2106/01 Finance & Performance Committee Minutes 18 May and 29 June 2015 – SFT 3681 – Presented by NM

The Board received for information the confirmed minutes of the Finance and Performance Committee 18 May and 29 June 2015.

It was noted that progress on achieving CQUIN was satisfactory and that considerable focus was on the management of agency spend and achievement of the Cost Improvement Programme.

The Board noted the minutes of the Finance and Performance Committee.

2106/02 Finance and Contracting Report to 30 June 2015 – SFT 3682 – Presented by MC

The Board received the Finance and Contracting Report. It was noted that there was a £2.3m overspend in relation to £2m planned at this stage. Agency spend and progress with the Cost Improvement Programme were the main issues. Elective activity was below contract and out-patient follow ups were down against the previous year. On cost improvement the Trust had achieved savings and income generation of £957,000 against a planned target of £1,444,000 an adverse variance of £487,000. A delay in a payment by a commissioner in June had affected the Trust's cash position temporarily. The Trust was now invoicing Wiltshire CCG on contract values and was receiving the resilience money under the contract.

The Capital Programme was ahead of plan.

The Report highlighted a wide range of major projects with significant implications for senior management time as well as service pressures arising in year.

At present the forecast was for the Trust to be in line with its planned deficit of £6m. This was reliant on achieving the Cost Improvement Programme and CQUIN payments.

2106/03 Progress against Targets and Performance Indicators to 30 June – SFT 3683 – presented by AH

The Targets and Performance Indicators Report was circulated separately. It was noted that the Emergency Department Target had been delivered in Quarter 1 and in the month of July. There had been a review by the Emergency Care Intensive Support Team and an action plan was being delivered. On referral to treatment all reportable specialities were delivered and there was further work on capacity and demand. A peak in Quarter 4 for Endoscopy procedures had meant that the Trust had failed this target but work was underway to address this. There would be a report in September on benchmarking work being undertaken in relation to length of stay. **AH**

2106/04 Update on Strategic Planning – Presented by LA

It was noted that no feedback on the Strategic Plan 2015/16 had been received. Initial steps for 2016/17 planning round had started and this would include the service line reporting information currently under development.

2106/05 Annual Report of the Remuneration Committee – SFT 3684 – Presented by NM

The Board received for the information the Annual Report of the Remuneration Committee which was noted.

2106/06 Electronic Patient Record – approval of outline business case - SFT 3685 – Presented by LA

The Board received the report and it was noted that the current Patient Administration System (PAS) was nearing the end of its useful life. The business case presented to the Board set out a range of benefits including clinical benefits and up to £10m cashable. It was emphasised that this was a major change project in the organisation. It was based on an extensive procurement exercise with the main suppliers and CSC was at this stage the preferred supplier. About £750,000 per year was spent on running the systems that would eventually be replaced and the cost of the new system was £1m per year. There would be further negotiation with the supplier to clarify the benefits to the Trust. Subject to approval of the full business case later in the year it was expected to go live with the system phase one in twelve months. It was noted that software updates and support were included in the operating costs of the system. It would improve the sharing of electronic information with GPs. The phasing of clinical systems within the project would be reviewed.

The Board approved the Outline Business Case and agreed to proceed to full business case including negotiations with the preferred bidder. An implementation team would be established to the point of full business case and contract ready for signature.

2107/00 PAPERS FOR NOTING OR APPROVAL

2107/01 Minutes of Clinical Governance Committee 28 May an 25 June 2015 – SFT 3686 – Presented by LB

The minutes of the Clinical Governance Committee 28 May and 25 June were received for information. It was noted that three core service reviews had been completed across these two meetings. The July meeting had considered a report on the Maternity Service.

2107/02 Minutes from Public Section of Council of Governors 18 May 2015 – SFT 3687 – Presented by NM

The Board received for information the minutes of the Public Section of the Council of Governors meeting on 18 May 2015.

2107/01 Minutes from Audit Committee – 22 May 2015 – SFT 3688 – Presented by PK

The Board received for information the minutes of the Audit Committee on 22 May 2015. It was noted that discussions about the Limited Assurance Audit of the performance indicators in the Quality Account by the KPMG continued to be discussed.

2108/00 QUESTIONS FROM THE PUBLIC

In relation to a question from Raymond Jack PH confirmed there was a meeting scheduled to discuss the proposed capital spend on the Springs entrance.

In relation to a question on Single Sex Compliance on Whiteparish AMU LW emphasised that the ward was not considered to be a mixed sex area.

There was a high turnover of patients in this area and efforts continued to eliminate any breaches.

In relation to a question from Jenny Lisle it was noted that nurse's shifts were a mixture of 7.5 hours and 11.5 hours (with 1 hour break).

In relation to a question about the numbers of patients in the hospital ready for discharge PH reminded the meeting that there were usually around 20 patients who were ready for discharge but were awaiting a package of care etc.

In relation to a question by Alastair Lack in relation to the Fractured Neck of Femur/36 Hours Target CB undertook to send the latest figures indicating what proportion of these patients had breached because they were unfit for surgery. CB

In relation to a question from Alistair Lack regarding weekend cover for consultants PH indicated that there needed to be clarity as to the aims of extending seven day working for the benefit of patients who required a senior medical opinion and diagnostic support. Some planned activity such as out patients and elective procedures would also occur.

2109/00 DATE OF NEXT MEETING

5 October 2015 at 1.30 pm.

CHIEF EXECUTIVE REPORT

MAIN ISSUES:

ADULT COMMUNITY SERVICES

Our joint bid with Great Western Hospital and Royal United Hospital to provide adult community services across the whole of Wiltshire is progressing. An Executive Summary describing how the services would be delivered and the benefits to the health community as a whole was submitted in mid-September. A further dialogue session with Wiltshire Clinical Commissioning Group (CCG) on 1 October 2015, is followed by the submission of the final proposal in November. The CCG are still planning to award the contract by the end of the year.

CLEANLINESS, FOOD AND CARE ENVIRONMENT HIGHLIGHTED IN NATIONAL REPORT

Cleanliness, food quality and patient's overall experience of facilities and support in Salisbury have been rated highly in the latest national report on the Patient Led Assessment of the Care Environment (PLACE). PLACE provides an assessment of how an organisation is performing against a range of non-clinical activities that impact on the patient experience of care. This includes cleanliness, the condition, appearance and maintenance of the hospital. It also covers the environment and how it supports the delivery of care, with privacy and dignity and the quality and availability of food and drink. There is also a new dementia standard that takes into account facilities, decoration and signage. The Trust scored **99.3%** for cleanliness (national average 97.57%), **94.57%** for food (national average 88.93%), **89.47%** for Privacy, Dignity and Wellbeing (national average 86.03%), **95.31%** for Condition, appearance and maintenance (national average 90.11%) and **84.66%** for Dementia standards (national average 74.51%). Each year the standards become more challenging and these are very good results that reflect the commitment of our staff in all aspects of our work.

CQC INSPECTION

Preparations for our CQC inspection in December are progressing well with a range of activities and events set up to provide staff with the information that they need to prepare for the inspection. This includes a number of workshops, ward visits from members of the Executive team and sessions with specific groups in the core services that will be inspected and these have been well received by staff. We will shortly be doing some open sessions for all staff on the key lines of enquiry, which will look at whether services are safe, effective, caring, responsive and well led. We are also working to a deadline of October 5 for providing the CQC with a whole range of corporate information that they need about the hospital and services.

AUTUMN PRESENTATIONS TO STAFF

I have now carried out the first three of five staff open sessions I am doing this year to brief staff on the latest developments around the NHS Five Year Forward View, and our own strategy, priorities, performance and preparations for the CQC inspection. These presentations are designed to help give our staff information on the key strategic issues facing the Trust and an opportunity for them to put questions to me on any issue. This is a key staff engagement exercise which complements a

wide range of staff communication that we do throughout the year and these sessions have been well attended and well received by staff.

SEASONAL FLU CAMPAIGN 2015

This month sees the start of the national NHS staff seasonal flu campaign and vaccines will be available for all Trust staff. It has been proven that comprehensive staff vaccination can help reduce the risk of flu spreading across patient areas and affecting vulnerable patient groups. It can also impact on staff sickness within the Trust and on colleagues and be taken back to the family at home. This year staff will be able to use a walk-in clinic in the Emergency Department or book a vaccination appointment in the Occupational Health Department. This will be promoted through our internal flu vaccination campaign.

VTE AND ANTICOAGULATION AWARD

Congratulations to our VTE service and anticoagulation outreach service who have won a national Quality in Care Programme (QiC) award. These two services cover all aspects of a patient's anticoagulation journey, with the VTE service seeing patients assessed in clinic, and the anticoagulation service operating on hospital wards. QiC recognises good practice in patient care and joint working in key therapy areas. In this award the judges were impressed by the way in which nurses are used in this role. They were also impressed by the streamlined integrated care pathway, collaboration with other departments, the assessment of care and the involvement of people who use the service – all supported by good patient experience and satisfaction levels.

SUCCESSFUL AGM

It was pleasing see a large audience again at the Salisbury Arts Centre for the Trust's AGM, highlighting the tremendous support that we enjoy from the community and the real interest people have in the NHS and our local health services. This year we had special presentations from staff in our Emergency Department (ED), highlighting the day to day work they do, which is well regarded by local people and the Trauma Unit which links in closely with the main centre in Southampton. One of Salisbury's strengths is its high quality burns, plastic surgery, rehabilitation and spinal presence on the Salisbury District Hospital site, which is an addition and advantage when compared with most other trauma units across the country.

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

Trust Board Workforce Performance Report
M5 (August) 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: **none**

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 provides a more detailed assessment of the workforce numbers including vacancies and the actions and intentions to improve the variances.

The metrics is summarised against four categories, with the narrative focusing on key areas for improvement:

- 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 (August 2015) and trends over the previous five months (March – July 2015).

Workforce Numbers

Planned Workforce numbers are based on the Trust's Budget plan position for the year to date.

2.1 Staff in post and Vacancies – RED / AMBER

The Trust is showing staffing levels at 94.3% of plan, with the vacancies of 5.7% over plan (5%); and showing as 'red' within the Registered Nursing workforce at 13.0%, against a plan of 10%.

This would suggest that there is approximately 96 wte vacancies within the Registered Nursing budgeted establishment, however this also includes 19% headroom that is added into ward nursing establishments, which amounts to approximately 29 wte.

The Registered Nursing vacancy rate reduces, when variable staffing is included, to 3.8%

The Trust is responding to the differential in vacancy rates by recruiting to nursing vacancies on a substantive basis, and the actions are reviewed below:

Recent actions have included:

1. The development of a 'Ward Nurse Staffing Tool' to predict the requirements of registered ward staffing to enable forward planning including: newly qualified intake; overseas recruitment activity occurring this autumn; known absences and average sickness.
2. Reduction in nurse agency spend (M5 cost £204,468), and increased use of bank nurses (see the attached Safer Staffing Report, Appendix 1).
3. Close working with Bournemouth University for a pipeline of future nurses.
4. The Trust is actively engaged with the Better Care Plan Workforce Development group which is focusing on overseas nurse recruitment; NA recruitment and retention; and statutory and mandatory training 'passports'
5. Executive Workforce Committee has received an initial paper on the Workforce Governance arrangements for managing the efficiencies and effectiveness of the nursing workforce
6. The Trust is working with the DH Staffing Toolkit to review its action on variable staffing, with an Audit to come to Trust Board
7. As part of the Lord Carter work the Trust is actively undertaking work on the use of electronic rostering systems for the efficient use of resources
8. The Trust is engaging with local Wessex trusts to understand costs of agencies with the aim of levering bargaining power to reduce costs

2.2 Workforce Costs and Quality - AMBER / GREEN

Pay costs for M5 are £10.3m. Workforce costs showed an overspend of £677k against budget after 5 months of the financial year (see Figure 1 below).

Agency staffing costs have decreased in month 5, as a consequence of the scrutiny and close monitoring of usage; supported by an increase in Bank Shift fill rates.

Next steps

- A detailed review of the admin and clerical variable workforce is underway to understand areas for further control.
- On-going monitoring of agency usage for clinical and non-clinical roles is managed through the Workforce Vacancy Review panel, overseen by Executives.
- Medical agency usage is scrutinised at Directorate level, with protocols in place to ensure consistency of approach.
- Implementation of a Master Vend approach to medical locum appointments, during Q2-3.

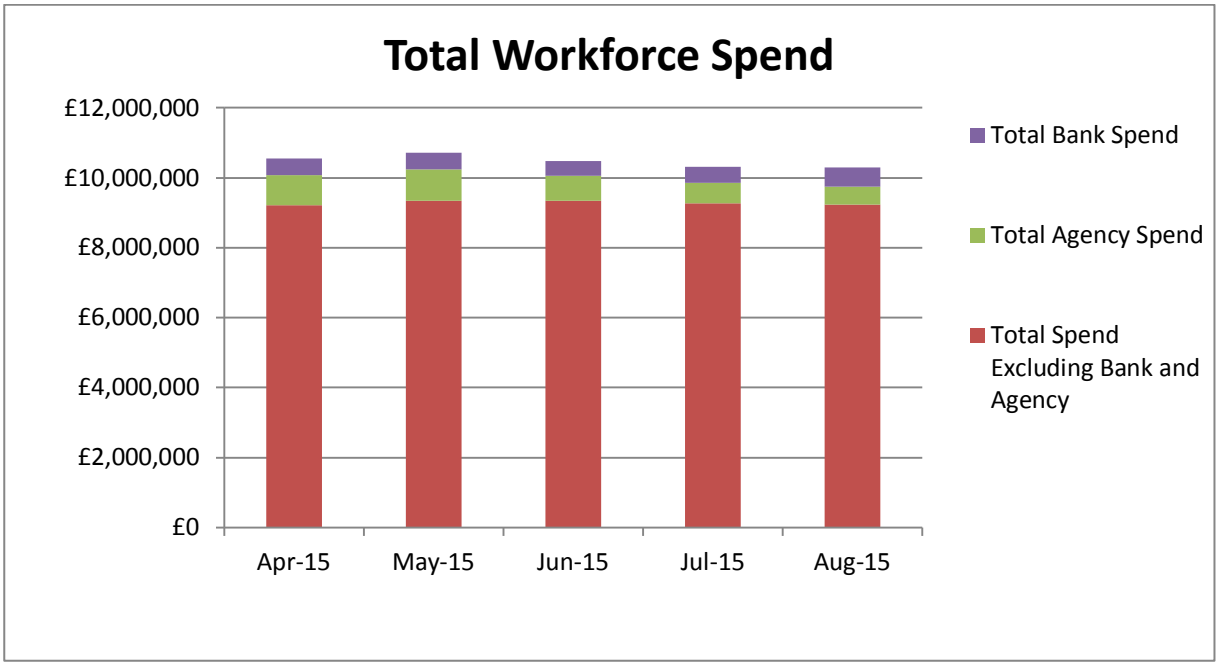


Figure 1

Workforce Quality

2.3 Efficiency of staff deployment

The shift fill rates and shift fill hours for nursing Bank has shown an improvement in the fifth 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

- Continued recruitment to the nurse and admin bank
- 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 are scrutinised by the Workforce Controls Panel.

2.4 Safer staffing - appendix 1

Appended to this report is the 'Safer Staffing NQB Report – August 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

2.5 Sickness absence – GREEN / RED

Sickness is 0.1% above plan, and the percentage of sickness with no reason recorded has decreased this month.

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

2.6 Turnover – GREEN / AMBER

Trust turnover (which excludes medical staff on rotation) is 10.5%, against a target of 8.5%. Registered Nurses: turnover is 8.6%, and starters is 9.7%, showing an improving trend of retention.

Return to green

- A review of retention rates and reasons for leaving has been undertaken to understand retention opportunities for nursing staff.

2.7 Friends and Family Test – GREEN

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

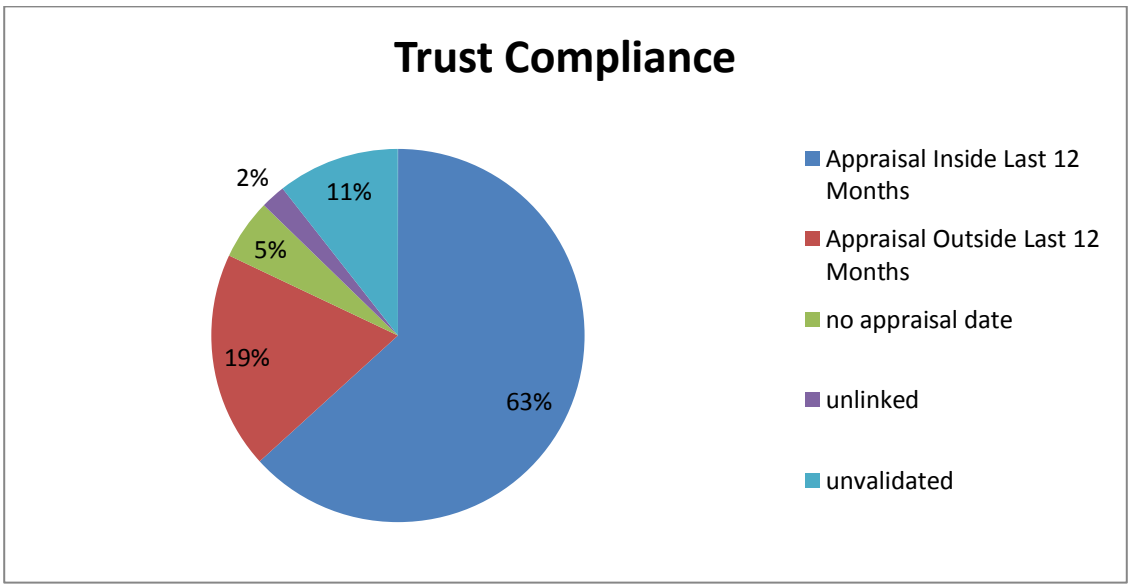
Workforce Compliance

2.8 Appraisal rates –RED / GREEN

Non-medical appraisal rate: 63%. Medical appraisal rate: 88%. Significant work has been undertaken to ensure that all appraisal data is appropriately recorded and 'signed off'.

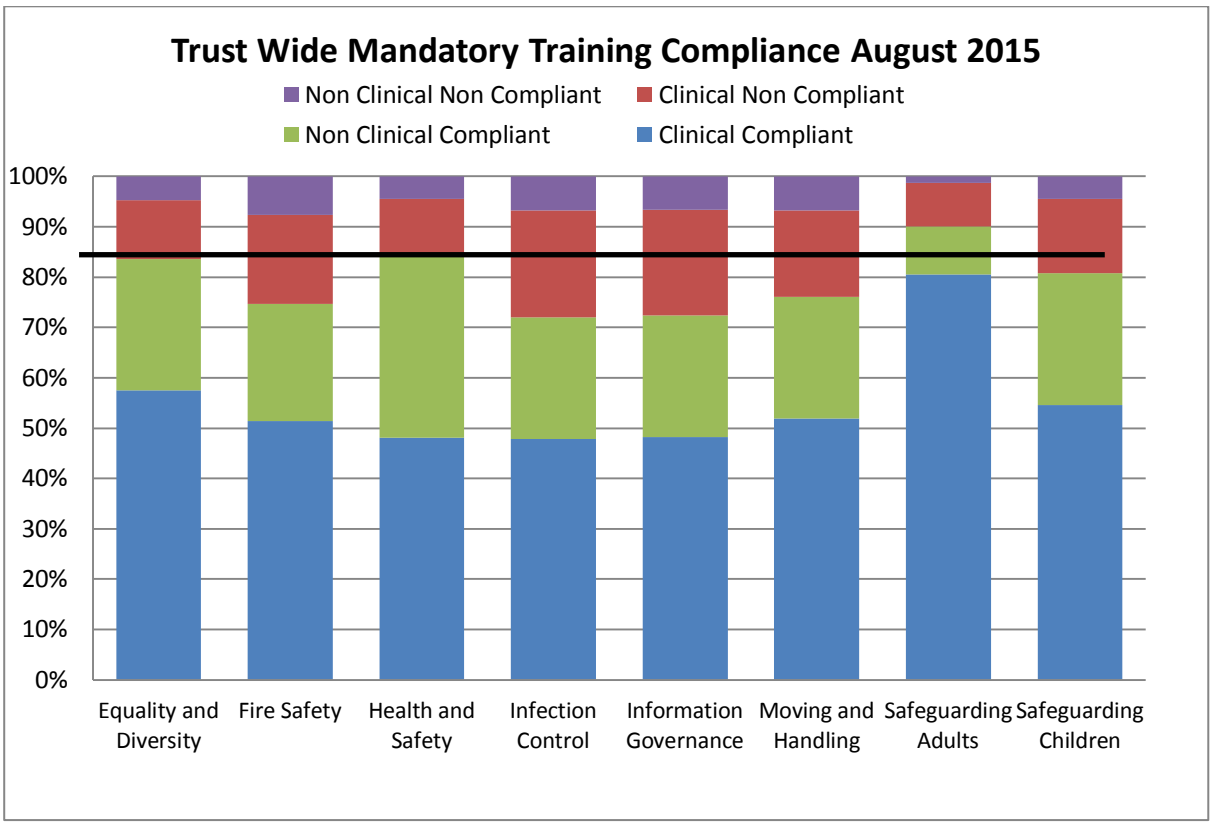
Next steps
Phase 2 of the development of the appraisal tool (SpIda) is underway with implementation due December 2015.

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



2.9 Statutory and Mandatory Training – AMBER/RED

Compliance with training is currently reported as amber at 80.3% which varies between each of the core topics as demonstrated by the table below.



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.

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 – August 2015.

Alison Kingscott
Director of HR and OD
September 2015

Staff In Post (SiP) numbers	Target	Aug-15	Trend	Plan
Total substantive Staff in Post (FTE)	= 95% of funded establishment (see vacancy rate RAG rating criteria below)	2,775		2,942
Total substantive SiP - Registered Nurses (FTE)	= 92% of funded establishment (see vacancy rate RAG rating criteria below)	738		849
Total registered nurses including variable staffing	See plan	816		849

Vacancies	Target	Aug-15	Trend	Plan
All Vacancies - excluding variable staffing (%)	<5% = green, 6% to 10% = amber, >10% = red	5.7%		5.0%
Registered Nursing Vacancies - excluding variable staffing (%)	<10% = green, 10% to 12% = amber, >12% = red	13.0%		10.0%
Registered Nursing Vacancies - including variable staffing (%)	<=4% = green, 5% to 6% = amber, >6% = red	3.8%		0.0%

Workforce Costs and Quality	Target	Aug-15	Trend	Plan
Total Workforce spend vs. plan (YTD % above/below plan)	Plan ±<1% = green, plan ±1 to 5% = amber, plan ±>5% = red	1.3%		£41,392,414
Variable Staffing spend as proportion of total workforce spend	Reduction	10.3%		6.8%
Bank Spend Total	Upward trend	£540,762		
Nursing Bank Spend (All Nursing)	Upward trend	£376,688		
Medical Locum Bank Spend	Upward trend	£78,828		
Agency Spend Total	Reduction	£523,947		
Nursing Agency Spend (All Nursing)	Reduction	£204,468		
Medical Agency Spend	Reduction	£220,823		

Workforce Quality

Efficiency of Staff Deployment	Target	Aug-15	Trend	Plan
Bank Shift Fill Rate % - All Nursing	Upward Trend	67.3%		85.0%
Bank Shift Fill Hours - All Nursing	Upward Trend	16,859		21,313
Agency Shift Fill Rate % - All Nursing	Reducing	24.9%		
Agency Shift Fill Hours - All Nursing	Reducing	6,251		

Safer Staffing	Target	Aug-15	Trend	Plan
Actual Staffing Levels - Nursing Assistants % of planned	No target	100.3%		
Actual Staffing Levels - Registered Nurses % of planned	No target	95.1%		
Actual Skill Mix % Qualified	No target	62.0%		

Workforce Health

Sickness Absence	Target	Aug-15	Trend	Plan
Overall Sickness Absence Rate (12m rolling average %)	<=3.1% = green, 3.2% to 4% = amber, >4% = red (2.87% target).	3.1%		3.0%
Short Term Sickness (12m rolling average %)	No target	1.4%		1.4%
Long Term Sickness (12m rolling average %)	No target	1.7%		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	6.8		6.8%
Financial cost of sickness in last 12 months	<=3.1% = green, 3.1% to 4% = amber, >4% = red	£3,802,086		£3,673,950
% of Sickness Absence with no reason recorded	<=5% = green, 5% to 15% = amber, >15% = red	16.2%		<=5%
Turnover	**Target**	**Aug-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%		10.4%
Registered Nurse Turnover rolling 12 months %	7-10% = green, 10% -12% = amber, >12% = red. (8.5% target)	8.6%		8.5%
Starters % rolling 12 months (Excluding Rotational Medical Staff)	No target	14.3%		14.3%
Registered Nurse Starters rolling 12 months	No target	9.7%		9.6%
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%		92.7%
% of Staff agreeing they would recommend the hospital as a place to work	Top 20% of Trusts Nationally	81.5%		80.8%

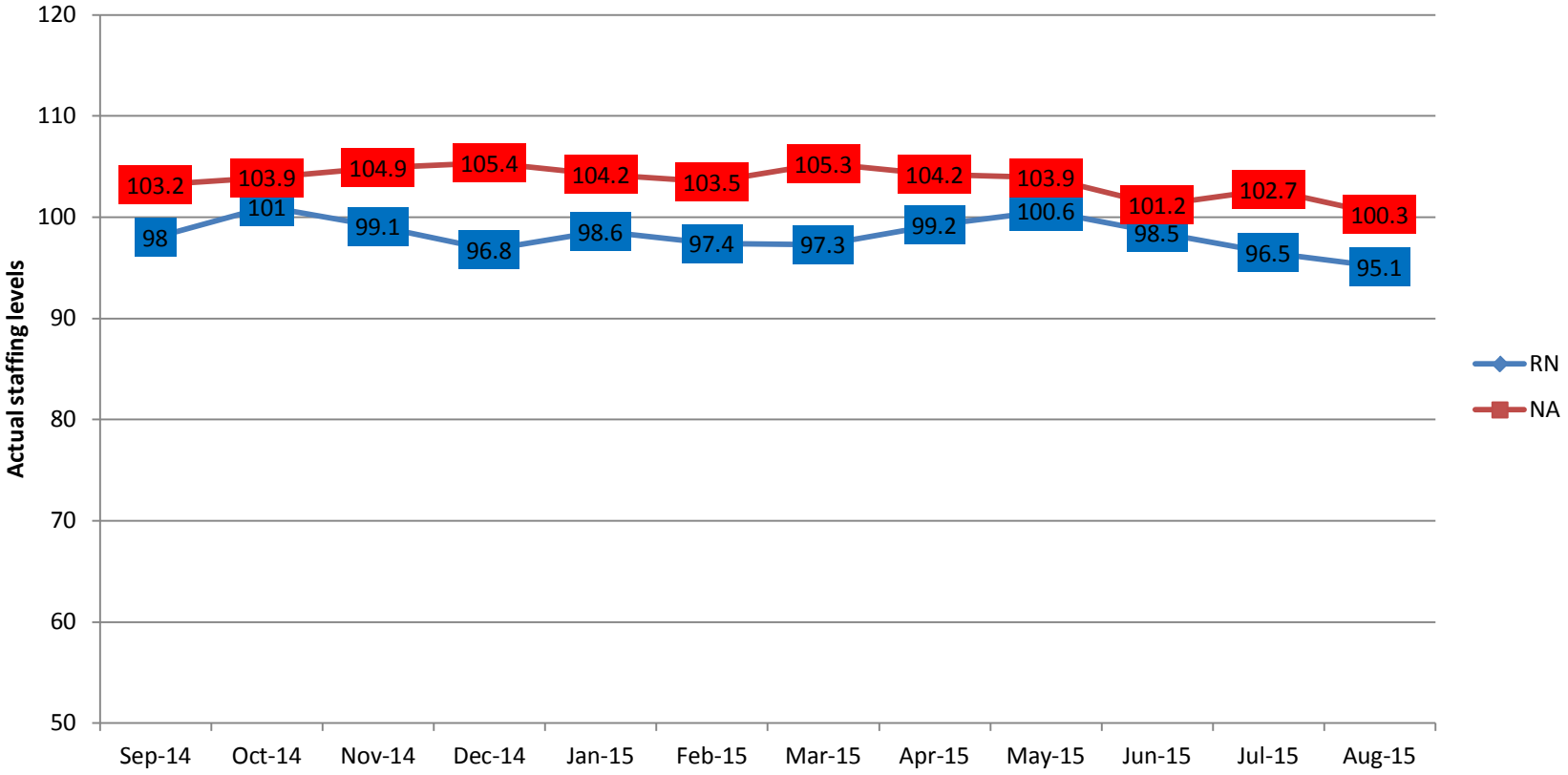
Workforce Compliance

Appraisal rates (excludes Medical Staff)	Target	Aug-15	Trend	Plan
Appraisal rates for Non Medical Staff	>85% = green, 75% to 85% = amber, <75% = red	63.0%		85.0%
Appraisal rates for Medical Staff	>85% = green, 75% to 85% = amber, <75% = red	88.0%		89.7%
Statutory and Mandatory Training - All Staff	**Target**	**Sep-15**	**Trend**	**Plan**
Overall Statutory and Mandatory Training Compliance	>85% = green, 75% to 85% = amber, <75% = red	80.3%		85.0%
Equality and Diversity	>85% = green, 75% to 85% = amber, <75% = red	83.7%		85.0%
Fire Safety	>85% = green, 75% to 85% = amber, <75% = red	74.7%		85.0%
Health and Safety Overview	>85% = green, 75% to 85% = amber, <75% = red	84.6%		85.0%
Infection Prevention and Control (including hand hygiene)	>85% = green, 75% to 85% = amber, <75% = red	72.0%		85.0%
Information Governance	>85% = green, 75% to 85% = amber, <75% = red			
Moving and Handling	>85% = green, 75% to 85% = amber, <75% = red	76.1%		85.0%
Safeguarding Adults	>85% = green, 75% to 85% = amber, <75% = red	90.1%		85.0%
Safeguarding Children Level 1 and 2	>85% = green, 75% to 85% = amber, <75% = red	80.8%		85.0%

Safe Staffing NQB Report – August2015

Monthly Comparisons – Actual Staffing Levels

Registered Nurses			Nursing Assistants			Combined			Actual Skill Mix	
P	A	%	P	A	%	P	A	%		
56014.8	53247.1	95.1%	33892.4	33991.9	100.3%	89907.2	87239	97%	62	38



Overview of Nurse Staffing Hours – August 2015

	RN	NA
Total Planned hours (day shift)	33696.57	22771.92
Total Actual hours (day shift)	31878.38	22645.08
Percentage	**94.6%**	**99.4%**
Total Planned hours (night shift)	22318.25	11120.5
Total Actual hours (night shift)	21368.75	11346.83
Percentage	**95.7%**	**102 %**

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	**13080**	**13056.55**	**99.8%**	**10201.1**	**10636.25**	**104.3%**
Durrington Ward	1089	1097.3	100.8%	882	1044	118.4%
Emergency Department	356.5	356.5	100.0%	356.5	356.5	100.0%
Farley Ward	1716.5	1600.5	93.2%	1439.6	1623.5	112.8%
Hospice	890	913.5	102.6%	616.5	631.5	102.4%
Pembroke Ward	824	826	100.2%	428.5	428	99.9%
Pitton Ward	1408.5	1389.25	98.6%	1133.5	1193	105.2%
Redlynch Ward	1439	1391	96.7%	1125	1346	119.6%
Tisbury Ward	1983.5	1810.5	91.3%	715.5	699.25	97.7%
Whiteparish Ward	1602	1831.5	114.3%	1112	971.5	87.4%
Winterslow Suite	1771	1840.5	103.9%	2392	2343	98.0%
Surgery	**6527**	**5678.25**	**87.0%**	**3138.75**	**2603.75**	**83.0%**
Britford Ward	2163.5	2056.75	95.1%	1254.5	1265	100.8%
Downton Ward	1350.5	1356	100.4%	1025.75	1020.75	99.5%
Radnor	3013	2265.5	75.2%	858.5	318	37.0%
Clinical Support	**4592.5**	**4311.52**	**93.9%**	**2065**	**1388.75**	**67.3%**
Maternity	2628.5	2281.52	86.8%	1275	989.25	77.6%
NICU	1087	1146.5	105.5%	444	69	15.5%
Sarum Ward	877	883.5	100.7%	346	330.5	95.5%
Musculo-Skeletal	**9497.07**	**8832.06**	**93.0%**	**7367.07**	**8016.33**	**108.8%**
Amesbury Suite	1923.98	1861.65	96.8%	1544.5	1520.64	98.5%
Avon Ward	1432.87	1262.46	88.1%	1559.34	2044.05	131.1%
Burns Unit	1475.75	1438.77	97.5%	562	548.42	97.6%
Chilmark Suite	1462	1520.47	104.0%	1114.75	1173.05	105.2%
Laverstock Ward	1870.26	1625.5	86.9%	1079.59	1083.35	100.3%
Tamar Ward	1332.21	1123.21	84.3%	1506.89	1646.82	109.3%
Grand Total	**33696.57**	**31878.38**	**94.6%**	**22771.92**	**22645.08**	**99.4%**

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	**9433.75**	**9398**	**99.6%**	**5086**	**5382.33**	**105.8%**
Emergency Department	356.5	356.5	100.0%	356.5	356.5	100.0%
Farley Ward	1069.5	1057.5	98.9%	713	815.5	114.4%
Hospice	532	589	110.7%	452.5	413.5	91.4%
Pembroke Ward	713	713	100.0%	0	0	
Pitton Ward	1069.5	1070.25	100.1%	713	723.83	101.5%
Redlynch Ward	1069.5	1058	98.9%	356.5	609.5	171.0%
Tisbury Ward	1416.25	1335.75	94.3%	356.5	360.5	101.1%
Whiteparish Ward	1425	1401	98.3%	356.5	379	106.3%
Winterslow Suite	1069.5	1104	103.2%	1068.5	1022.5	95.7%
Durrington Ward	713	713	100.0%	713	701.5	98.4%
Surgery	**4392**	**3885**	**88.5%**	**930**	**1190**	**128.0%**
Britford Ward	920	930	101.1%	620	630	101.6%
Downton Ward	620	620	100.0%	310	560	180.6%
Radnor	2852	2335	81.9%	0	0	
Clinical Support	**4634.5**	**4177**	**90.1%**	**1472**	**955.5**	**64.9%**
Maternity	2495.5	2222	89.0%	1069.5	795.5	74.4%
NICU	1069.5	920	86.0%	356.5	80.5	22.6%
Sarum Ward	1069.5	1035	96.8%	46	79.5	172.8%
Musculo-Skeletal	**3858**	**3908.75**	**101.3%**	**3632.5**	**3819**	**105.1%**
Amesbury Suite	589	589	100.0%	883.5	883.5	100.0%
Avon Ward	610	690	113.1%	920	890	96.7%
Burns Unit	620	619.25	99.9%	310	310	100.0%
Chilmark Suite	589	579.5	98.4%	589	804.5	136.6%
Laverstock Ward	830	830	100.0%	310	311	100.3%
Tamar Ward	620	601	96.9%	620	620	100.0%
Grand Total	**22318.25**	**21368.75**	**95.7%**	**11120.5**	**11346.83**	**102.0%**

Overview of Areas with Red/Amber

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	**Radnor**	37%		√	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	**Radnor**	75%	√		Day	Reduced number of admissions and acuity at the end of June. Active reduction in staff numbers to avoid over staffing.
Red	**NICU**	16%		√	Day	Small number of MA's used
Red	**NICU**	23%		√	Night	Small number of MA's used
Red	**Maternity**	78%		√	Day	As above
Red	**Maternity**	74%		√	Night	Small number of MAs used plus existing vacancies
Amber	**Radnor**	82%	√		Night	Reduced number of admissions and acuity . Active reduction in staff numbers to avoid over staffing.
Amber	**Maternity**	89%	√		Night	Escalation protocol used and each shift assessed against a risk assessment to ensure 1:1 care in labour maintained
Amber	**NICU**	86%	√		Night	As above
Amber	**Laverstock**	86%	√		Day	Reduced RN cover reflects flexibility to cover reduced admissions /acuity
Amber	**Tamar**	84%	√		Day	High number of vacancies & spike in sickness – each shift assessed by DSN
Amber	**Avon**	88%	√		Day	As above

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 is an increase this month flagging red against our internal measures.

- Specialist areas such as Radnor (ICU), Maternity, NICU are flagging where staffing is used flexibly according to patient numbers and acuity which cannot be reflected accurately on this tool. Maternity and Spinal have high level vacancies. Each shift risk assessed for staffing needs by senior nurse and adjusted accordingly.
- Appropriate 1:1 or 1:2 ratios maintained on all shifts in critical care areas
- All shifts are assessed daily by Directorate Senior Nurses to ensure they are safe .
- Overall RN shifts are within a 95% cover threshold with night duties at nearly 97% demonstrating a prioritisation of shift cover
- NA remains over 100% at night and at 99% for days 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
- Shifts that are difficult to cover (nights and weekends) are prioritised.
- 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 3698**

Quality indicator report – August 2015

Date: 5 October 2015

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

Executive Summary:

- No MRSA or MSSA bacteraemias for 6 months. The elective MRSA screening rate declined and the Directorates have investigated this with the clinical leads to gain improvement.
- 2 cases of hospital apportioned C Difficile for the month means the Trust remains within trajectory.
- 1 new serious incident inquiry – a never event.
- A decrease in the re-admission rate to July 15.
- A decrease in the crude mortality rate in August 15. SHMI is 102 to December 2014 is as expected. HSMR is 109 to May 15 and is higher than expected. Red flag mortality groups continue to be investigated for evidence of avoidability and learning points are disseminated for improvement actions.
- A decrease in grade 2 pressure ulcers with a downward trend since April. Cluster reviews ongoing.
- Safety Thermometer - an upward trend to 98% of 'new harm free care' and a slight decline to 94% of 'all harm free care' of patients admitted to hospital with a harm.
- There were two falls which resulted in two fractures - a fractured wrist and a fractured elbow, both managed conservatively. RCAs undertaken with a Trust wide falls action plan in place.
- 87% of patients arrived on the stroke unit within 4 hours. One patient had a stroke as an inpatient but the stroke team were not informed and two patients waited for a bed. CT scan within 12 hours sustained at 97%. A slight decrease in patients spending 90% of their time on the stroke unit with 1 patient moved prior to discharge to accommodate a new stroke patient and 1 inpatient that the stroke team were not informed about contributed to the delay
- High risk TIA referrals being seen within 24 hours was sustained at 80% in August. 2 patients were not seen within the time frame as a referral was not sent to the single point of access and the other waited for the completion of investigations, missed by 30 minutes. The CCG have assisted with improvements by raising patient level issues with individual GP practices.
- Escalation bed capacity remained at a low level as did multiple patient ward moves.
- In August there were 7 mixed sex accommodation breaches affecting 39 patients mainly on AMU (38) and 1 patient waiting to be transferred out of Radnor for more than 12 hours. There were no breaches in the last 2 weeks of August. The CCG undertook a second walk round in AMU to advise on improvements, such as more bathroom screens, consent documentation and quick screens in the bays. A recovery plan has been submitted to the CCG and NHSE.
- Real time feedback was as expected. FFT response rates for inpatients dipped and Maternity Services sustained their improvement from July. ED remained below the local target. Day cases and outpatient response rates have improved a little.

Proposed Action:

1. **To note the report**

Links to Assurance Framework/ Strategic Plan:
CQC registration

Appendices:
Trust quality indicator report – August 2015

Supporting Information

Salisbury NHS
NHS Foundation Trust

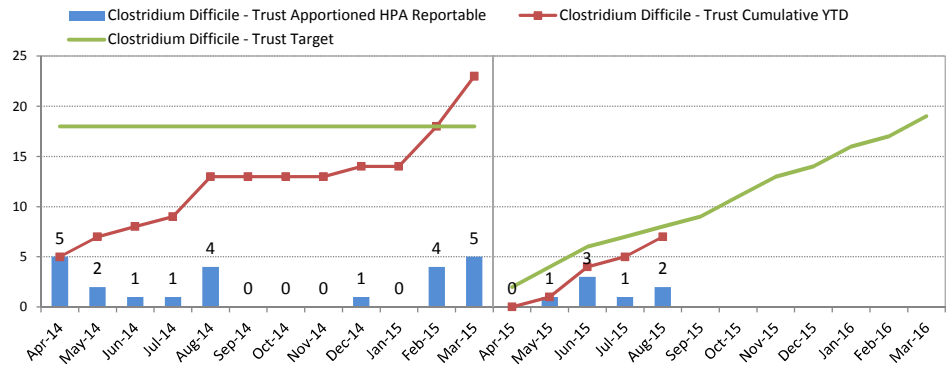
Trust Quality Indicators - August 2015

Quality Measures

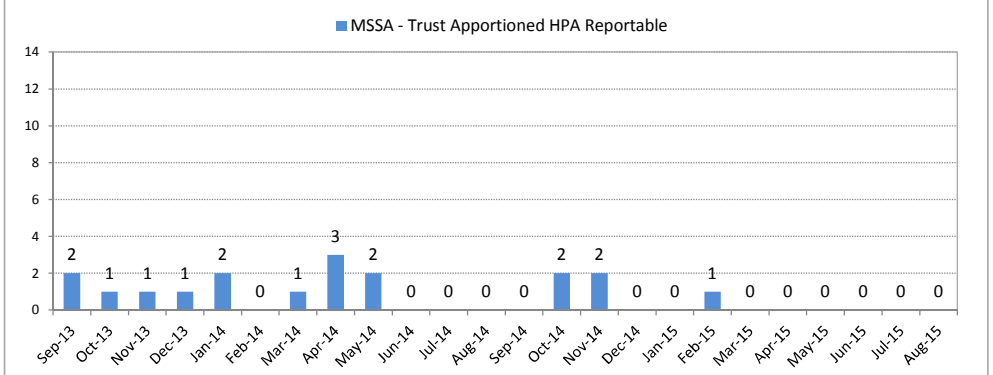
Infection Control	*2014-15*	*2015-16 YTD*
MRSA (Trust Apportioned)	**1 (+1)**	**0**

Trust Incidents	*2014-15*	*2015-16 YTD*
Never Events	**2**	**1**
Serious Incidents Requiring Investigation	**30**	**10**

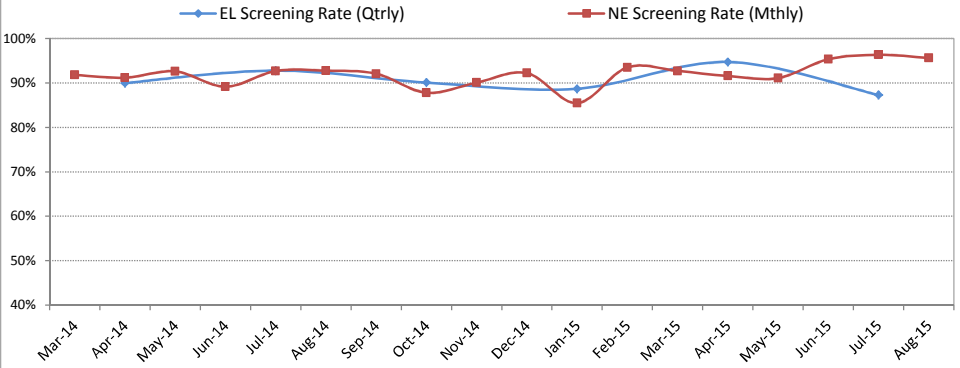
Clostridium Difficile - Trust Apportioned



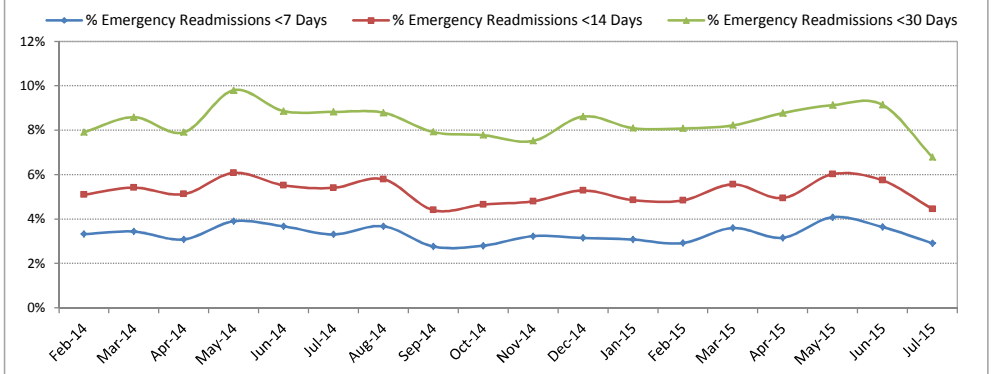
MSSA - Trust Apportioned



MRSA Screening



Emergency Readmissions within 7, 14 & 30 days of Discharge



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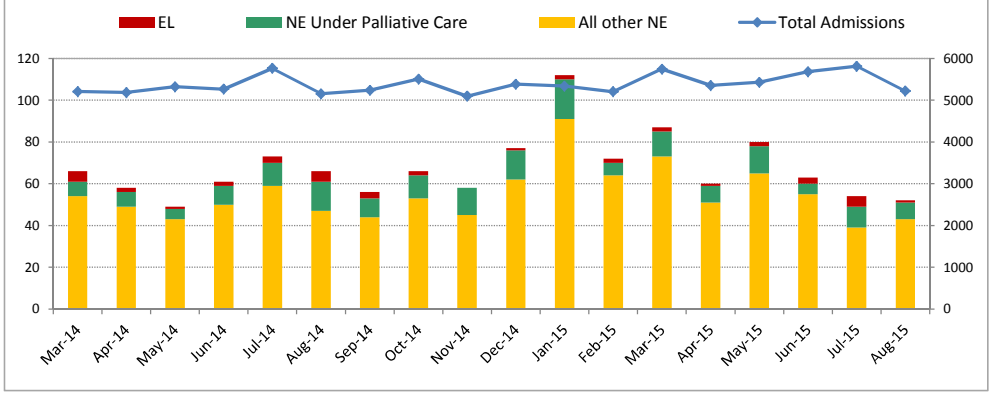
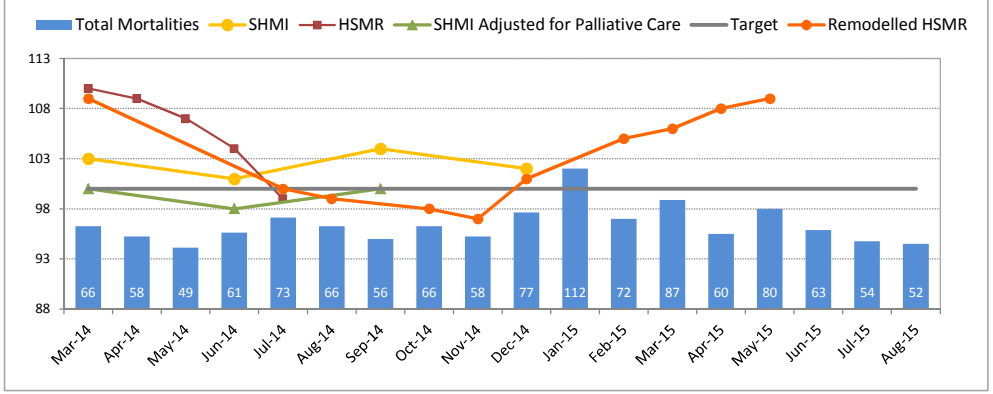
Trust Quality Indicators - August 2015

Quality Measures

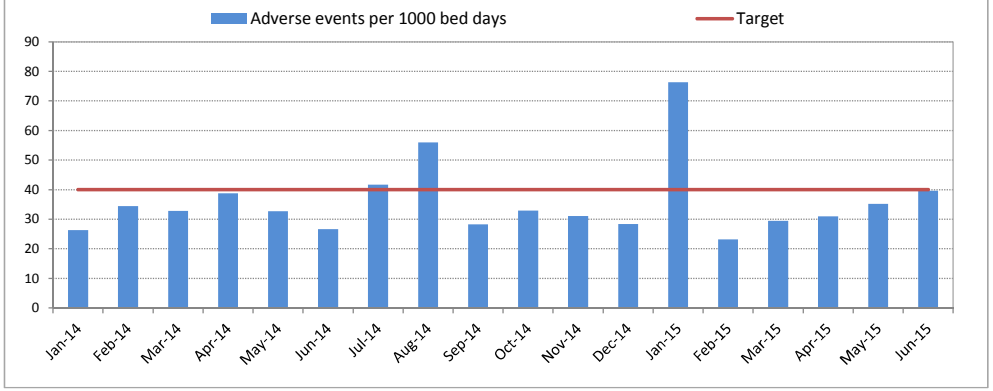
Hospital Mortalities



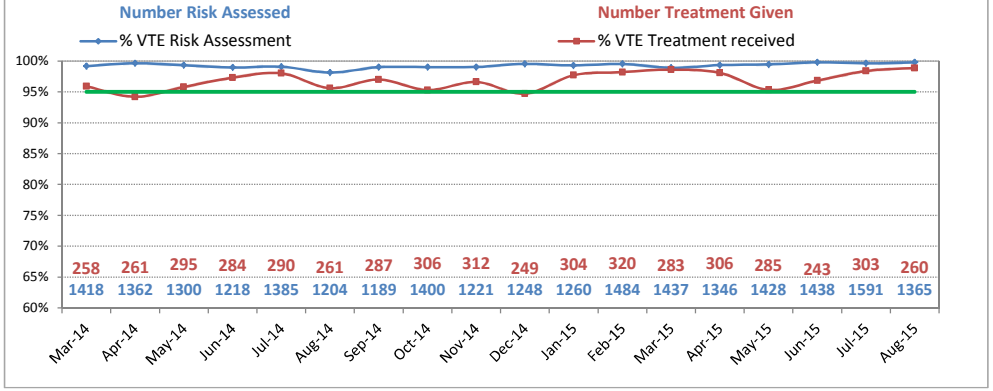
HSMR and SHMI



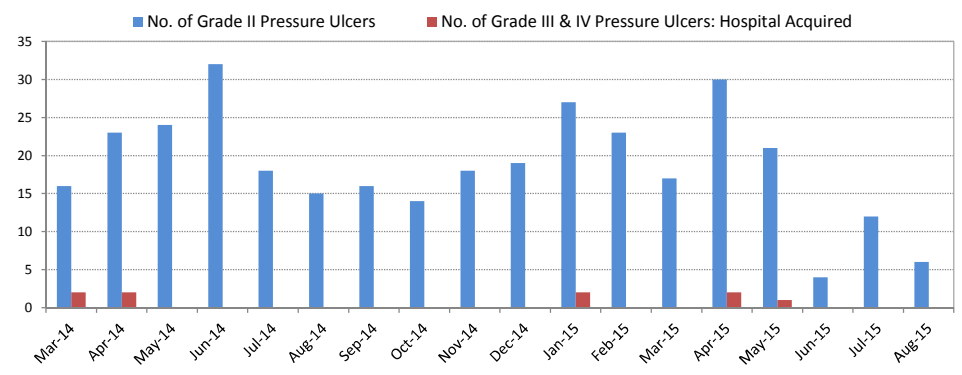
Global Trigger Tool



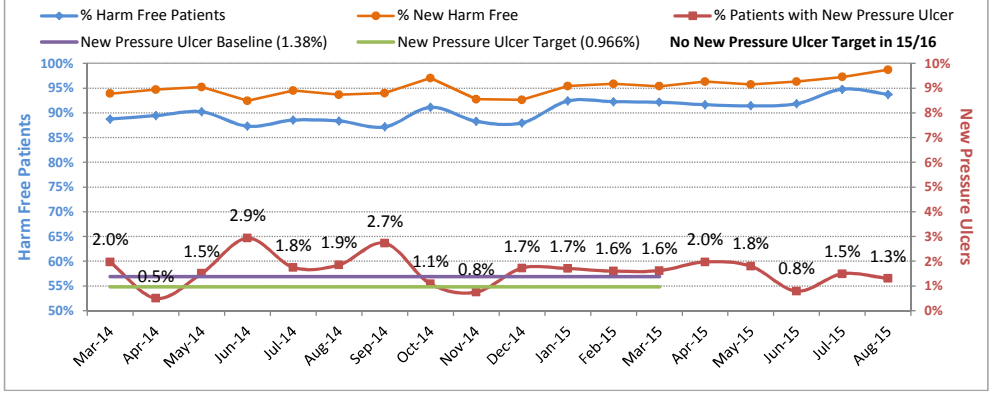
Venous Thrombous Embolism: Risk Assessment & Prophylaxis



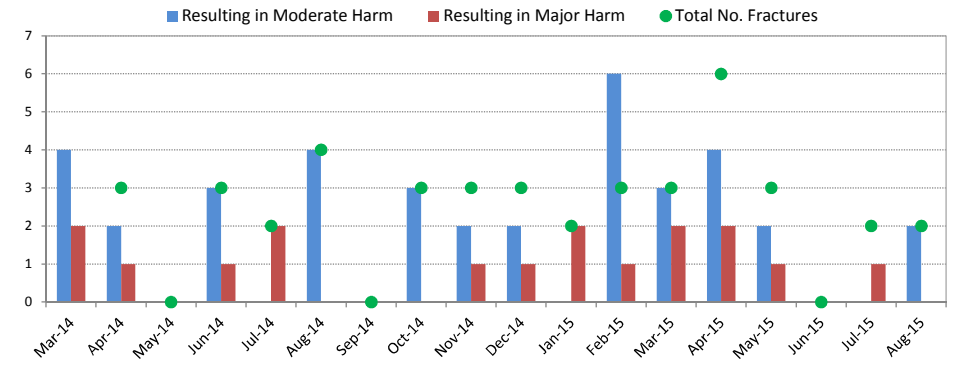
Pressure Ulcers - Total Number per Month



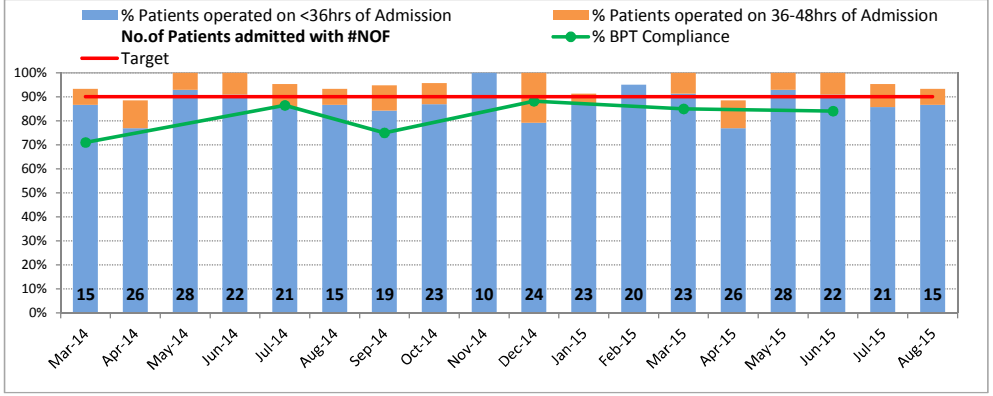
Safety Thermometer - One Day Snapshot per Month



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



Fracture Neck of Femur operated on within 36 hours



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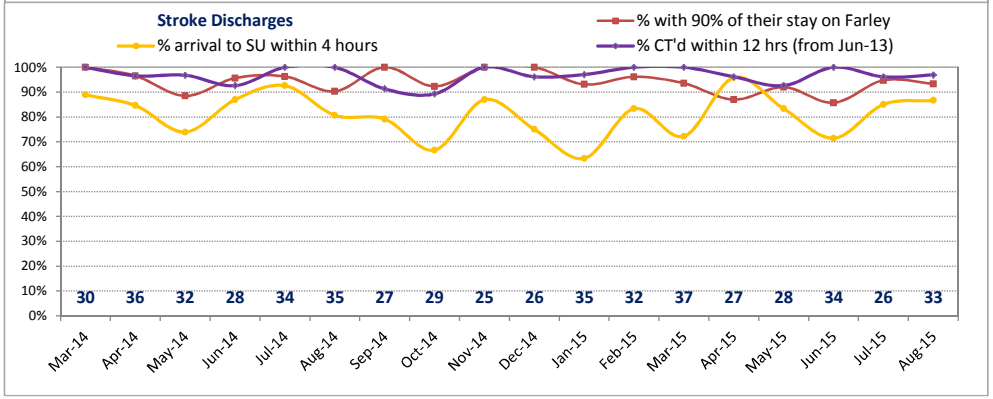
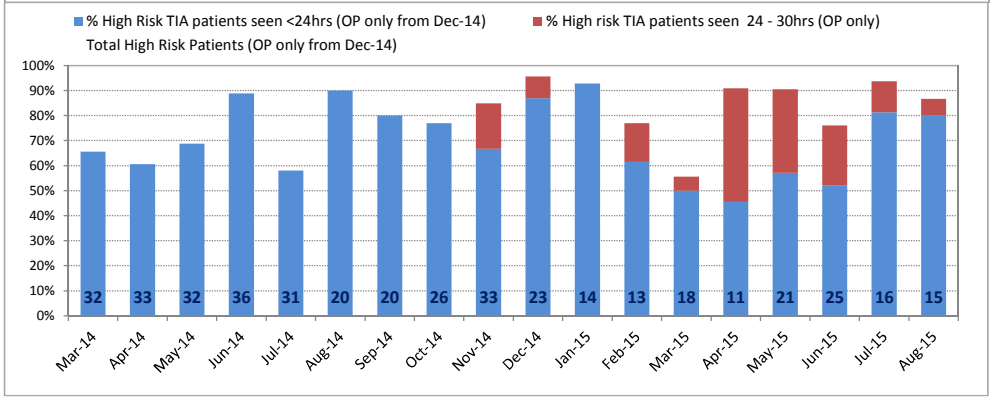
Trust Quality Indicators - August 2015

Quality Measures

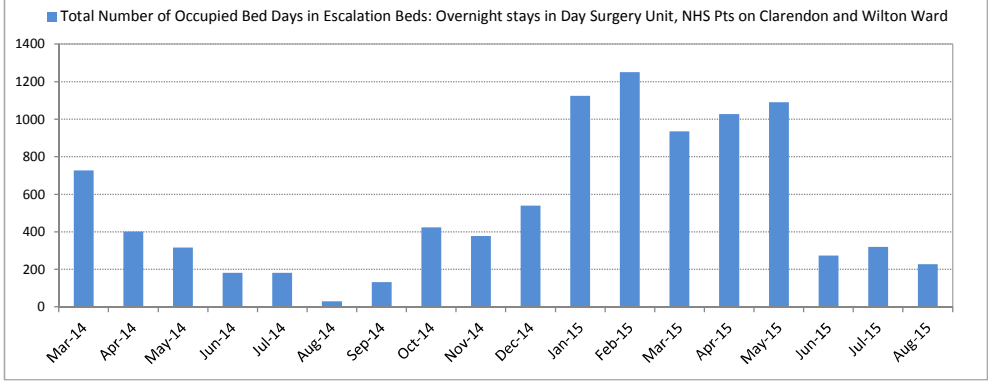
Stroke Care



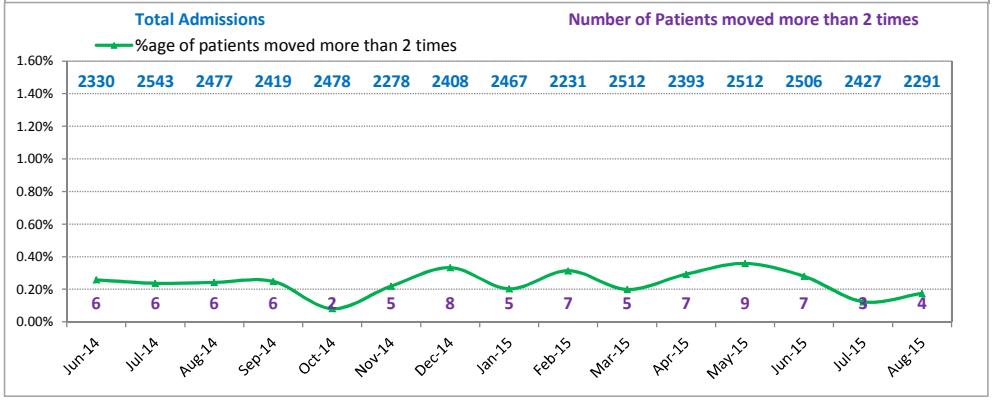
TIA Referrals



Escalation Bed Days

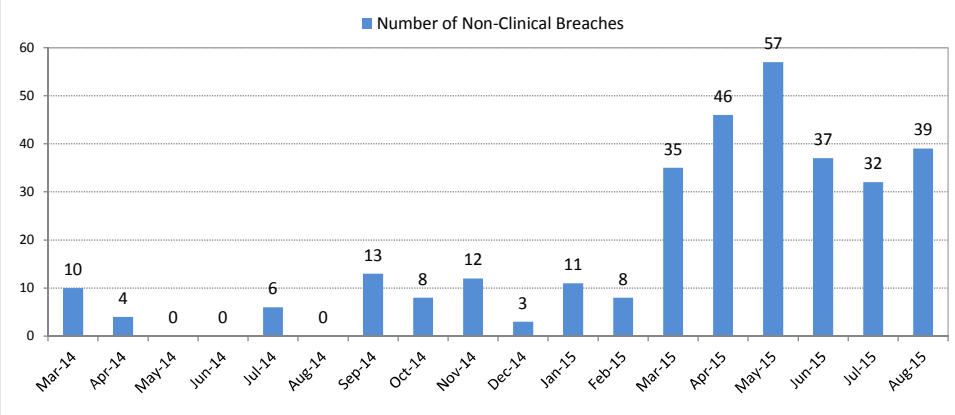


Patients moving multiple times during their Inpatient Stay

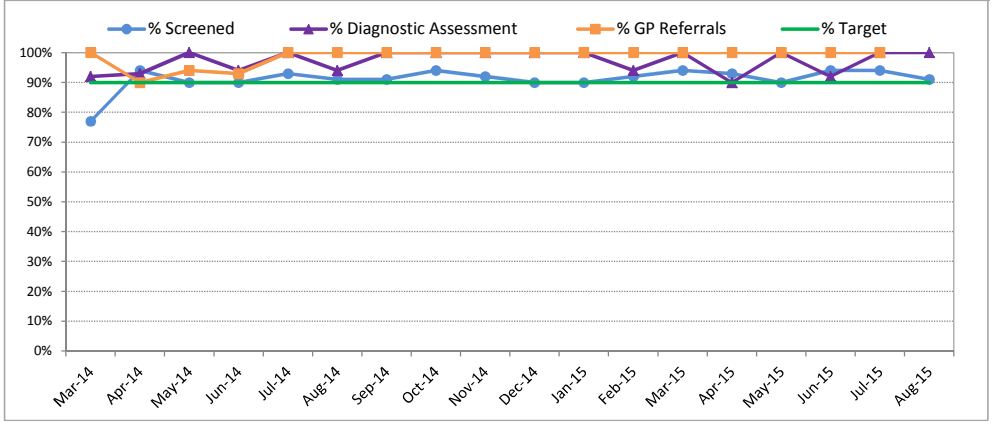


Please note, from Sep-14 escalation bed capactity is Winterslow 8 beds, Wilton 12 beds and DSU if it stays open at night. Breamore ward opened from 1st January 2015 with a further 27 escalation beds and closed on 29th May 2015. From 1st April 2015 Wilton closed for escalation beds.

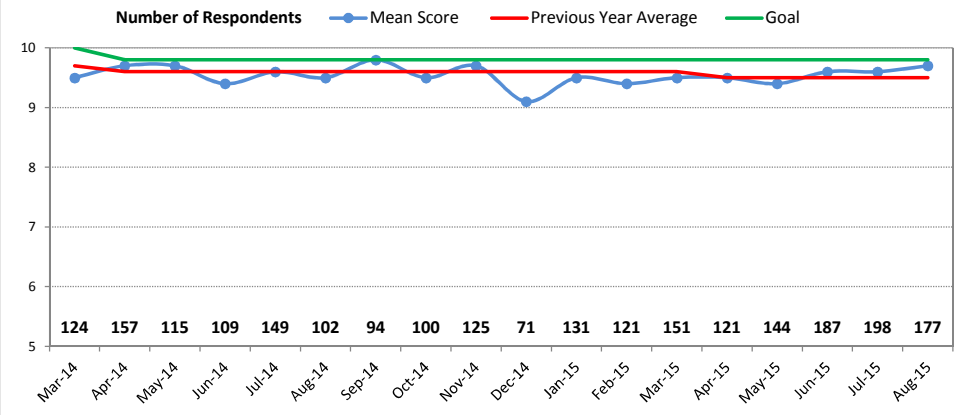
Delivering Same Sex Accommodation



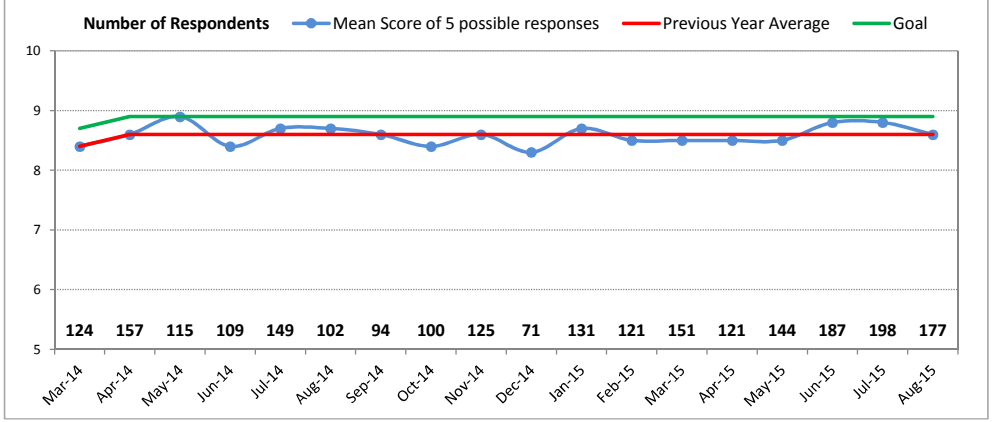
Dementia Audit of Patients Aged 75+



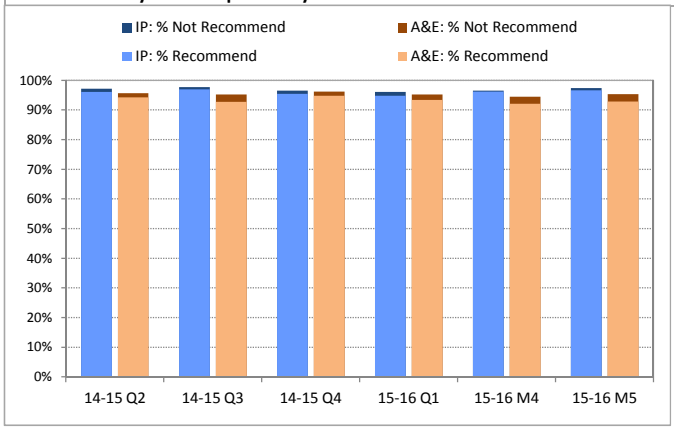
Real Time Feedback: Are you being treated with care and compassion?

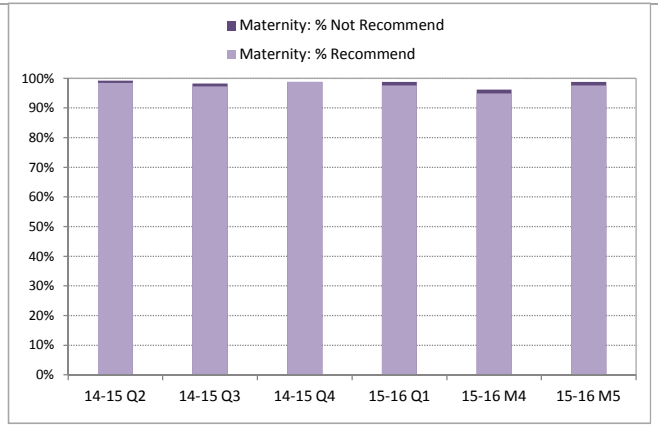


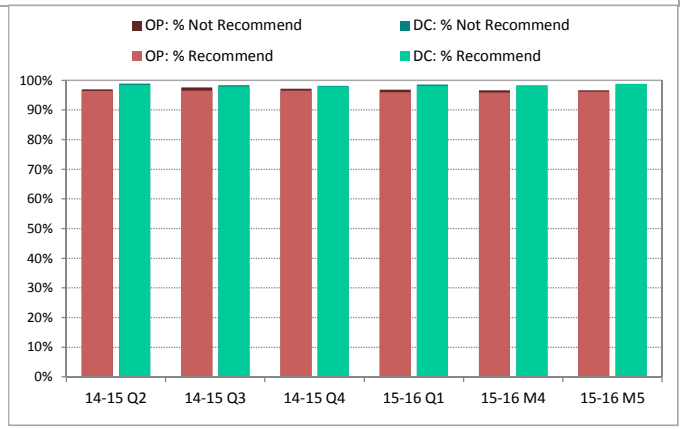
Real Time Feedback: Overall how would you rate the quality of care you received?



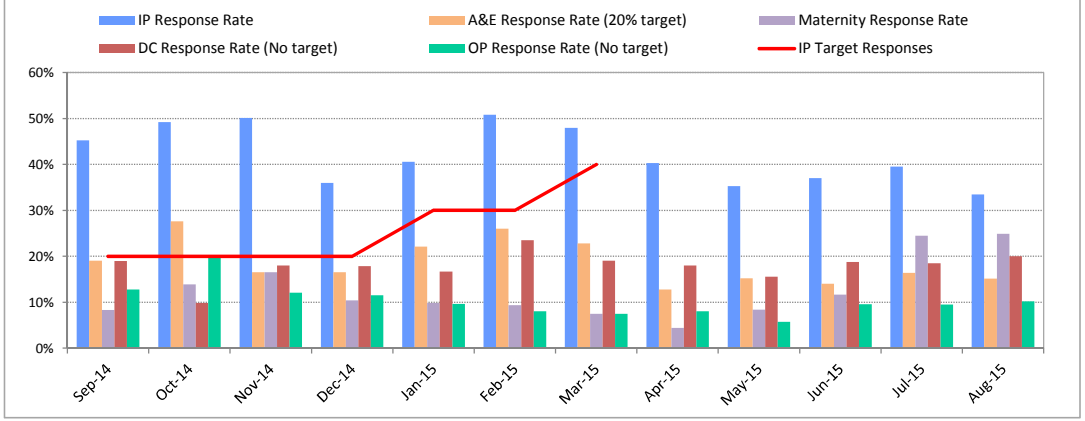
Friends & Family Test: Responses by Area



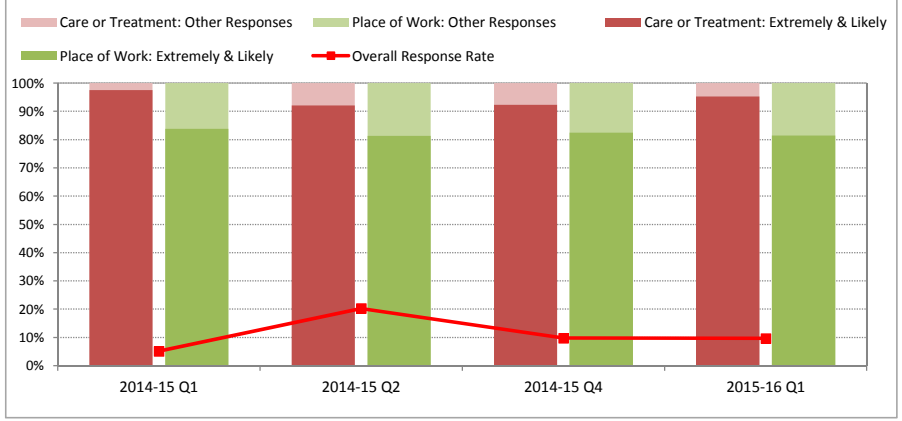




Friends & Family Test: Response Rates (%) by Area



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.

CUSTOMER CARE REPORT - Quarter 1 (1st April – 30th June 2015)

Date: 5th October 2015

Report from: Hazel Hardyman
Head of Customer Care

Presented by: Lorna Wilkinson
Director of Nursing

Executive Summary:
87 complaints were received in quarter 1 compared to 74 complaints in quarter 4 (2014-15) and 79 complaints for the same period in the previous year.

The main issues from complaints are:

- Clinical treatment (29), 2 less than Q4 (31) - sub-themes were 12 unsatisfactory treatment across 9 different specialties, 6 delays in receiving treatment which has decreased this quarter by 2, 3 correct diagnosis not made, 3 further complications, 2 inappropriate treatment, 2 treatment unavailable and 1 lack of communication. The Emergency Department received the highest number of complaints (5) about clinical treatment (2 discharges, 1 staffing levels leading to delays, 1 unsatisfactory treatment and 1 diagnosis not made). There were no themes.
- Appointments (18), 7 more than in Q4 (11) – sub-themes were 5 appointment date cancelled, 4 appointment date required (across 4 different specialties), 4 appointment system delays, 3 appointment procedures, 1 postponed and 1 unsatisfactory outcome.
- Staff attitude (15), 3 more than in Q4 (12) – 11 related to medical staff, 3 nursing staff, and 1 administrative across 15 different areas. There were 12 complaints for the same period last year.

The main issues from real time feedback were:

- noise
- call bells
- cleaning

The main area of concern from the Friends and Family Test was:

- waiting times in the Emergency Department and Outpatients

Proposed Action:
To note the report.

Links to Assurance Framework/ Strategic Plan:
Improving Patient Experience
Patient Feedback – acting on complaints and compliments

Appendices:
None

Supporting Information
None

Customer Care Report - Quarter 1
1st April – 30th June 2015

PURPOSE OF PAPER:

- The purpose of the paper is to update the Board with an analysis of the Quarter 1 patient experience data.

1. COMPLAINTS

The main issues from complaints are:

- Clinical treatment (29), 2 less than Q4 (31) - sub-themes were 12 unsatisfactory treatment across 9 different specialties, 6 delays in receiving treatment which has decreased this quarter by 2, 3 correct diagnosis not made, 3 further complications, 2 inappropriate treatment, 2 treatment unavailable and 1 lack of communication. The Emergency Department received the highest number of complaints (5) about clinical treatment (2 discharges, 1 staffing levels leading to delays, 1 unsatisfactory treatment and 1 diagnosis not made). There were no themes.
- Appointments (18), 7 more than in Q4 (11) – sub-themes were 5 appointment date cancelled, 4 appointment date required (across 4 different specialties), 4 appointment system delays, 3 appointment procedures, 1 postponed and 1 unsatisfactory outcome.
- Staff attitude (15), 3 more than in Q4 (12) – 11 related to medical staff, 3 nursing staff, and 1 administrative across 15 different areas.

87 complaints were received in quarter 1 which is an increase compared to 74 complaints in quarter 4 (2014-15) and 79 complaints for the same period in the previous year. A large increase was seen in appointments across Musculo-Skeletal and Surgery. A breakdown of numbers and themes according to Datix is below:

	Clin Supp & Family Services	Medicine	Musculo-Skeletal	Surgery	Q1 total 2015 -16	Q1 total 2014 -15
Admission	0	0	0	1	1	1
Appointments	0	1	8	9	18	8
Attitude of staff	4	3	2	6	15	12
Capacity issues	0	0	0	0	0	1
Clinical Treatment	5	11	7	6	29	26
Communication	2	4	1	0	7	10
Confidentiality	1	0	0	0	1	0
Delay	0	0	0	0	0	3
Dementia	0	0	1	0	1	0
Discharge arrangements	0	5	1	0	6	3
Equipment, aid and apps	1	1	0	0	2	0
Facilities on site	0	0	0	0	0	1
Falls	0	0	0	0	0	2
Hospital procedures	0	0	0	0	0	1
Infection control	0	0	0	0	0	1
Information	0	0	0	0	0	1
Nursing Care	1	1	0	0	2	1
Operation	0	0	1	0	1	0
Privacy and dignity	0	1	0	0	1	0
Property	0	1	0	0	1	1
Safeguarding	0	1	0	0	1	0
Transport	0	0	0	0	0	1
Waiting time	1	0	0	0	1	6
Totals:	15	29	21	22	**87**	**79**
Patient Activity	9347	27803	18379	16142		

In Quarter 1, the Trust treated 16,477 people as inpatients, day cases and regular day attendees. Another 11,452 were seen in the Emergency Department and 43,742 as outpatients. 87 complaints were received overall which is 0.1% of the number of patients treated, this percentage has remained unchanged. 373 compliments were received across the Trust in Q1, which represents 0.5% of the number of patients treated. There has been quite a drop in compliments in Q1 and wards/departments have been reminded to send their compliments for logging onto Datix. Those sent directly to the Chief Executive or Customer Care Department were acknowledged and shared with the staff/teams named.

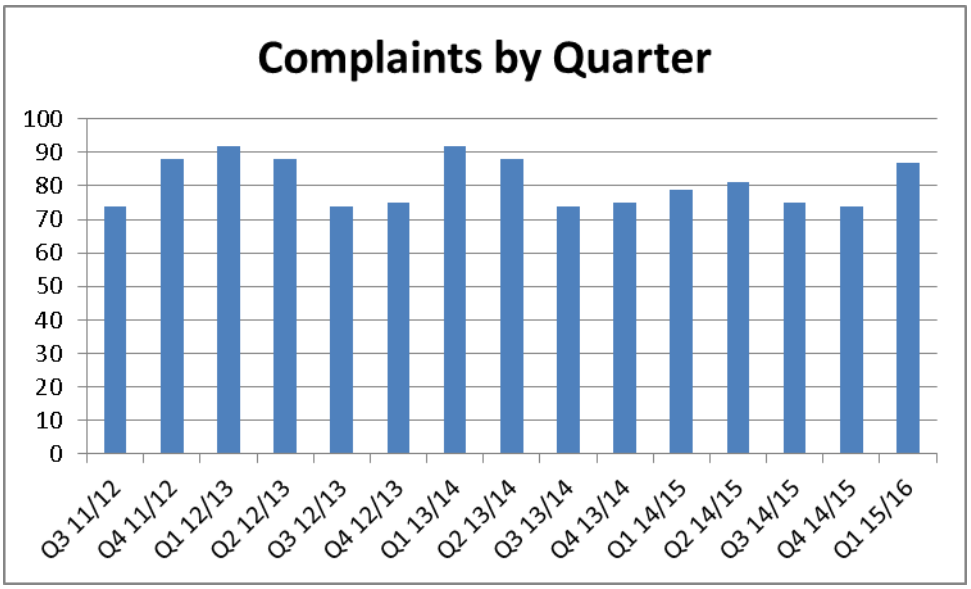
100% of complaints were acknowledged within three working days. 14 complaints were re-opened in Q1 compared to 11 in Q4. The overall number of enquiries, comments, concerns and complaints response times were:

0-10 working days		11-24 working days		25+ working days	
405	73%	87	15%	63	12%

Reasons for some complaints taking more than 25 working days to respond to include: arranging meetings; complexity of the case; and awaiting comments from key members of staff. The 25+ working day response timescale has reduced in compliance in Q1 (12%) compared to Q4 (9%).

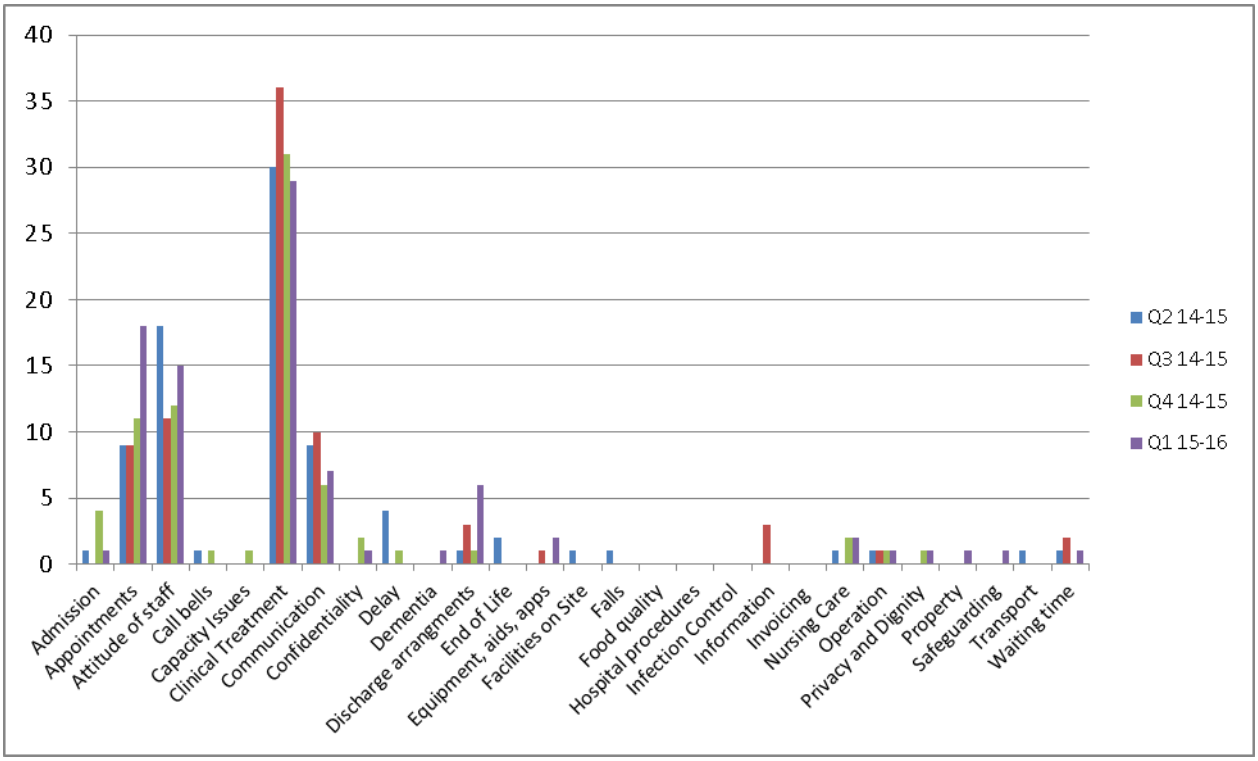
COMPLAINTS BY QUARTER

The following graph shows the trend in complaints received by quarter. There is a pattern of increased complaints in Q1 and Q2 each year. In 2013-14 and 2014-15 the top three subject areas were clinical treatment, staff attitude and communication. The top specialty areas in 2013-14 were the Emergency Department, Adult Medicine and Orthopaedics and in 2014-15 it was Adult Medicine, Orthopaedics and joint third were Ophthalmology and Plastics. The top specialty areas for Q1 were General Surgery, Adult Medicine and Orthopaedics.



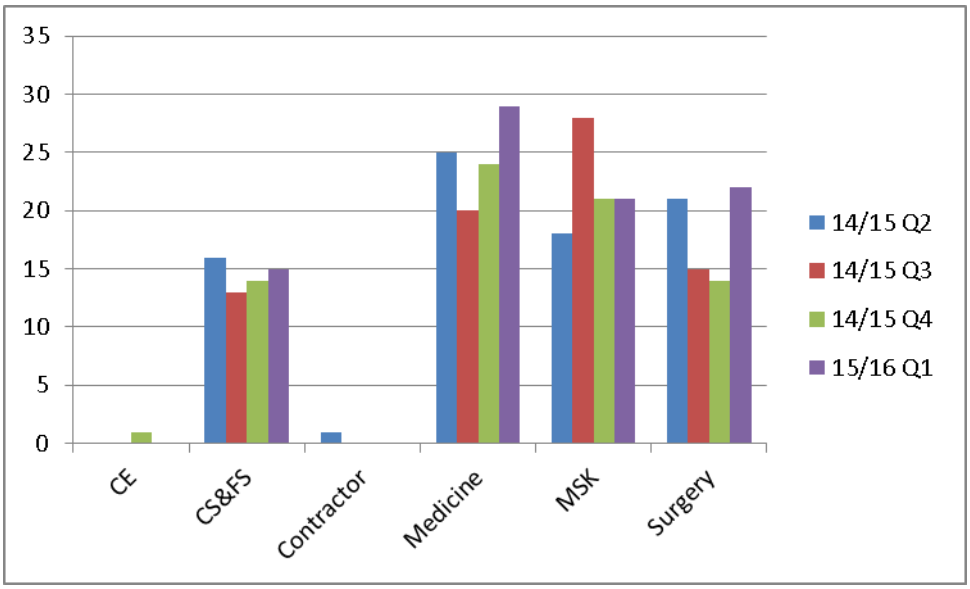
COMPLAINTS BY SUBJECT

The following graph shows the trend in complaints by subject over the last four quarters. Complaints about appointments (18) have increased from Q4 by 7. Discharge arrangements (6) have increased by 5 from Q4 and staff attitude (15) has increased by 3 from Q4. Admission (1) has decreased by 3 from Q4 and clinical treatment (29) has decreased by 2 from Q4 being the second quarter in which there has been a decrease.



COMPLAINTS BY DIRECTORATE

The following graph shows the number of complaints by directorate over the last four quarters with Medicine and Surgery seeing a rise in Q1.



CLINICAL SUPPORT AND FAMILY SERVICES

	Quarter 1 2014-15	Quarter 4 2014-15	Quarter 1 2015-16
Complaints	15	14	15
Concerns	15	17	13
Compliments	140	284	103
Re-opened complaints	2	1	4
% complaints responded to within 25 working days	53%	71%	40%

- Complaints numbers have remained static.
- Three complaints about the Fertility Service, one of which the patient was not eligible for treatment on the NHS due to not meeting the criteria set by the Clinical Commissioning Group (CCG) and another the Trust is awaiting a reply from the CCG in respect of funding.
- Three complaints about care in Maternity with no themes; one of which was dealt with by a meeting. The other two have been offered meetings in the response letter.
- Four complaints about attitude, three concerning medical staff and one nursing staff. Discussions were held with the staff involved.
- There were no particular themes for any one department.
- Nine complaints were not responded to within 25 working days. One was due to a meeting being arranged, one was delayed due to an administrative error in Maternity, one awaiting input from clinicians and the others due to the complexities of the case.
- Four complaints were re-opened within this quarter due to the complainants feeling that not all issues had been resolved. The DMT can find no common link, however re-opened complaints will continue to be monitored at future DMT meetings.

Themes and actions

Department/Ward	Topic	Actions
Fertility	Refusal of fertility treatment on the grounds of eligibility criteria	Although the Directorate have no control over the criteria, they are looking at how this is communicated to patients.

Compliments

In total 103 compliments have been received across the Directorate with the breakdown as:
Sarum = 50, Bowel Screening= 14, Endoscopy = 14, Labour Ward = 9, Pathology = 4, Post-natal Ward = 2, Maternity Administration = 2, Benson Suite = 1, Benson Suite = 1, Bereavement Suite = 1, Radiology = 1, GU Medicine = 1, Histopathology = 1, Hospice = 1 and Lab Medicine = 1

MEDICINE DIRECTORATE

	Quarter 1 2014	Quarter 4 2015	Quarter 1 2015
Complaints	33	24	29
Concerns	36	35	27
Compliments	293	168	121
Re-opened complaints	6	3	6
% complaints responded to within 25 working days	57%	50%	48%

- Complaints have increased from Q4 to Q1, however they have reduced compared to Q1 2014.
- Communication continues to form a large percentage of complaints particularly relating to medical staff.
- The Directorate has tried to arrange meetings with complainants as a first response to their complaint, particularly when it might be complex or involve bereavement. This is in order to try and resolve the complaint in one attempt rather than responding and then having the complaint re-opened.
- On occasions the 25 working day target may be breached when trying to arrange a resolution meeting due to the availability of relevant staff members and the complainant, however the complainant is kept informed of timescales.
- 15 complaints were not responded to within 25 working days. Six of these were due to arranging a meeting to resolve the complaint as a first line of approach, eight due to the complexities of the response and awaiting input from various clinicians and one due to requested amendments being made before signing.
- Six complaints have been re-opened in this quarter: this was due to complainants feeling that their questions had not been answered fully. In view of this, four of the complainants were invited to attend a meeting to discuss their unresolved concerns, one of whom withdrew consent for a meeting to be undertaken. It was deemed inappropriate to offer a meeting to two complainants.

Themes and actions

Department/Ward	Topic	Actions
Lead Clinicians meeting for Medicine	Communication and complaints	Duty of Candour and complaints discussed at Lead Clinicians meeting. Agreed that anonymised complaints would be shared with Consultants to identify themes and learning.
Customer Care	Identifying complaints/concerns	Customer Care Advisor attends weekly walk round with Senior Nurse.
	Increasing visibility of Customer Care Advisor to Ward and Directorate teams	Customer Care Advisor attends DMT meetings monthly to discuss complaints/concerns/themes, RTF, FFT and PPI projects. Work to reach early resolution of concerns/ complaints by involving the DMT as early as possible

Compliments

In total 121 compliments have been received across the Directorate with the breakdown as: Emergency Department= 36, Hospice= 25, Pembroke= 19, Durrington= 15, Whiteparish= 9, Tisbury/CCU= 7, Farley= 5, Redlynch= 2, Nunton Unit=2, Winterslow= 1.

MUSCULOSKELETAL DIRECTORATE

	Quarter 1 2014-15	Quarter 4 2014-15	Quarter 1 2015-16
Complaints	21	22	21
Concerns	33	33	37
Compliments	156	138	81
Re-opened complaints	2	6	2
% Complaints responded to within 25 working days	61%	63.5%	48%

- Number of complaints remains static.
- Response timescales have fallen this quarter. One complaint delayed due to a meeting date required and one following comments of the minutes of a meeting. There has been one less member of the DMT to respond to complaints during this quarter
- Two complaints have been re-opened one of which is now closed. The remaining re-opened complaint has received a second follow-up letter following completion of a meeting.
- Of the complaints, 13 are related to delays and cancellations of operations and appointments in plastics, orthopaedics and spinal. One of the complaints related to a process issue within bookings with the remaining 12 due to operational issues. There is also a similar theme within the concerns.
- Orthopaedics continues with the highest numbers, receiving eight complaints and 14 concerns. Of these, six concerns related to appointments. Amesbury and Chilmark wards received one complaint each.
- There were two complaints and four concerns regarding the attitude of staff across the departments of Rheumatology and Orthopaedic inpatient and outpatient areas.

General actions

- Risk of delays and cancellations remains on the Directorate Risk Register – consultant appointments and outpatient transformation work linked to these actions.
- The DMT has been tasked with looking at ways in which to reduce the number of complaints overall and have met with the Customer Care Advisor (CCA) who will now be working with the DMT. The CCA will undertake walkrounds within the Directorate and attend the regular DMT meeting. The DMT

want to work more pro-actively in identifying issues that they are already aware of that can be shared with patients as exemplified by a waiting list issue in a particular area.

Themes and actions

Department/Ward	Topic	Actions
Orthopaedics	Delays and cancellations	Discussion with patients regarding realistic timeframes for treatment raised at Specialty Meetings. Expedite patients where required. Review of job plans continues.
Plastics	Delays and cancellations	Review of the bookings process within Plastics Trauma clinics. Ongoing daily review of operating delays for plastics trauma.
Directorate responses	Prediction of issues	Consider information or prepared letter for patients in specialties where delays are predicted due to operational or staffing issues.

Compliments

In total 81 compliments have been received across the Directorate with the breakdown as: Amesbury =28, Wessex Rehab = 13, Chilmark = 9, Tamar = 6, Laverstock = 6, Plastics = 4, Burns Unit = 3, Orthopaedics = 5, Dermatology = 3, Spinal Therapy = 1 and Spinal Unit = 1.

SURGICAL DIRECTORATE

	Quarter 1 2014	Quarter 4 2015	Quarter 1 2015
Complaints	10	13	22
Concerns	27	22	34
Compliments	430	111	53
Re-opened complaints	5	1	1
% complaints responded to within 25 working days	80%	92%	68%

- A significant increase in complaints received for the Directorate.
- A reduction in response rate compliance across the Directorate was partially due to an increased number having multiple department/directorate involvement.
- Ophthalmology saw a significant increase in concerns and complaints in Q1 receiving 13 concerns and six complaints. 10 of the concerns and one of the complaints were due to appointment booking issues.
- There was an increase in concerns and complaints due to the administrative management of appointments. Issues relate to not receiving follow-up appointments within the required timescale, cancellations and changes of appointments. Issues are predominantly due to the availability of appointments in Ophthalmology.
- No complaints were graded as high risk in Q1.

Themes and actions

Department/Ward	Topic	Actions
Ophthalmology	Clinic delays and clinic management	The Ophthalmology service is under severe pressure, particularly as a result of recruitment difficulties at senior

		and junior medical staff grades. The DMT is working to resolve these issues. Clinical and nursing staff have been appointed and a review of the service undertaken which has led to putting a co-ordinator in place. The DMT, and in particular the Clinical Director, is working very closely with the Head of Service and will continue to do so to support the department.
Central Booking	Management of appointments	Central Booking have had to deal with many clinic changes and cancellations of patients as well as an increase in wait times due to lack of capacity and issues beyond their control. The DMT are working very closely with specialities, in particular with ophthalmology, setting up a weekly rota meeting with booking, management and nurses all working together. The workload of the Booking Co-ordinators has also been looked at and recognised that this may be too large in certain specialities. Work is ongoing to support the teams, but also how the workload can be reconfigured to spread the workload more evenly.

Compliments
In total 53 compliments have been received across the Directorate with the breakdown as:
Britford = 29, Radnor = 11, DSU = 4, Downton = 2, Central Registration =1, ENT = 1, Medical/Surgical O/P = 1, Ophthalmology =1 , Surgical Admissions Lounge = 1, General Surgery = 1 and Urology = 1.

2. TRUSTWIDE FEEDBACK – INCLUDING REAL TIME FEEDBACK AND THE FRIENDS AND FAMILY TEST

The top negative themes from inpatient real time feedback, the Friends and Family Test and complaints are:

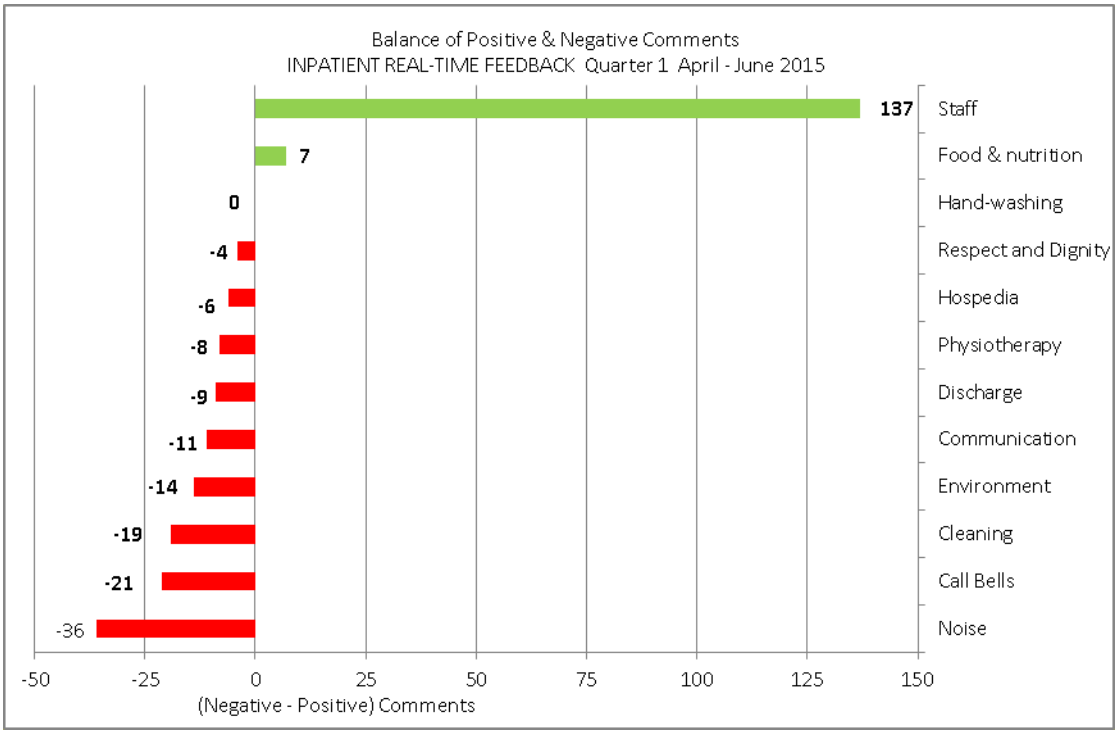
Feedback area	Theme	Actions
Complaints	Clinical treatment	• The highest area was the Emergency Department (5), with no particular theme. • No themes across a number of areas.
	Staff attitude	• Complaints against a member of staff are dealt with by a face-to-face discussion and individual action is taken as appropriate.
	Appointments	• Booking Team manager is reviewing processes.
Inpatient RTF	Noise	• A Trust-wide 'Noise at Night' campaign is to be undertaken between August and October 2015.
	Call bells	• Call bell audits have been included in ward action plans following the National Inpatient Survey 2014.

	Cleaning	• New toilet paper dispensers will be introduced to prevent paper falling on the floor.
FFT Emergency Department and Outpatients Inpatients	Waiting times Staff attitude	• ED publishes details of any breaches in waiting times on their staff notice board. In other areas staff endeavour to keep patients informed of delays. • As above.

PICKER REAL TIME FEEDBACK (AFTER FRANCIS PROJECT)
The Trust is the top recruiter for the six pilot sites across the country for the first three months of this project. This provides the Trust with valuable feedback on the relational aspects of the services we provide and helps with the Trust research recruitment targets.

Picker will be meeting with staff from the three areas in October 2015 to discuss the results from the real time patient data collection, identify what they mean for the trust and make simple, concrete and actionable plans to drive improvements.

INPATIENT REAL TIME FEEDBACK
A total of 472 inpatients were surveyed in the quarter. They made 380 positive and 374 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below.



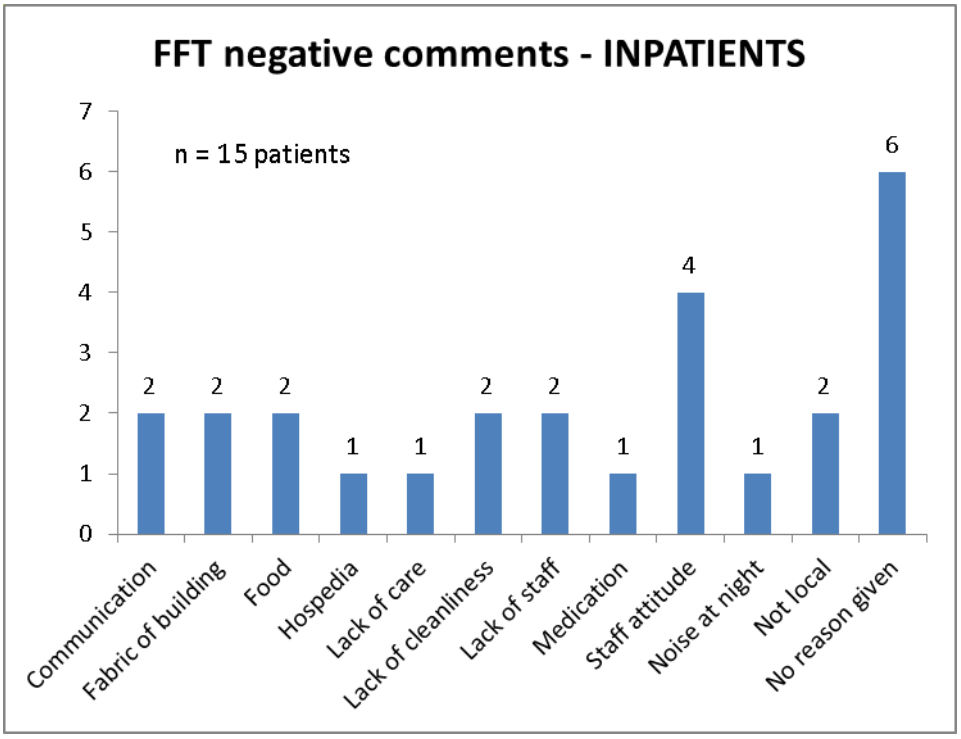
The three main areas of concern were noise, call bells and cleaning.

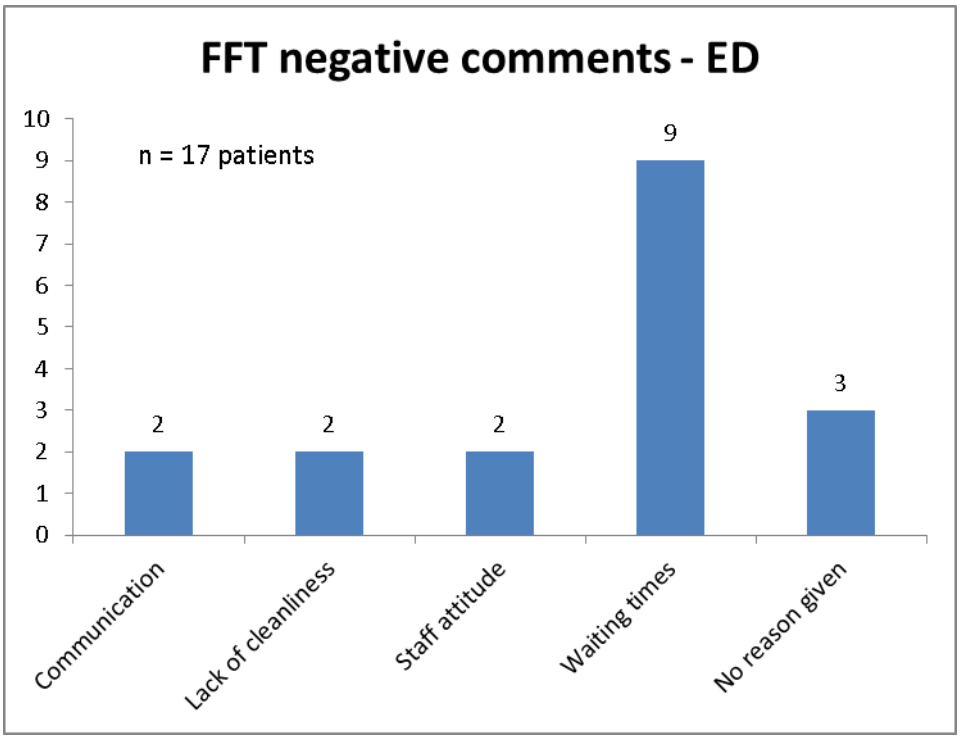
A Trust-wide 'Noise at Night' campaign is being led by the Director of Nursing. Call bell audits have been included in ward action plans following the National Inpatient Survey 2014. Regular monitoring is carried out on all wards for cleaning and extra audits are undertaken as required. Housekeeping is looking at increasing cleaning times at weekends on wards. New toilet paper dispensers will be introduced to prevent paper falling on the floor.

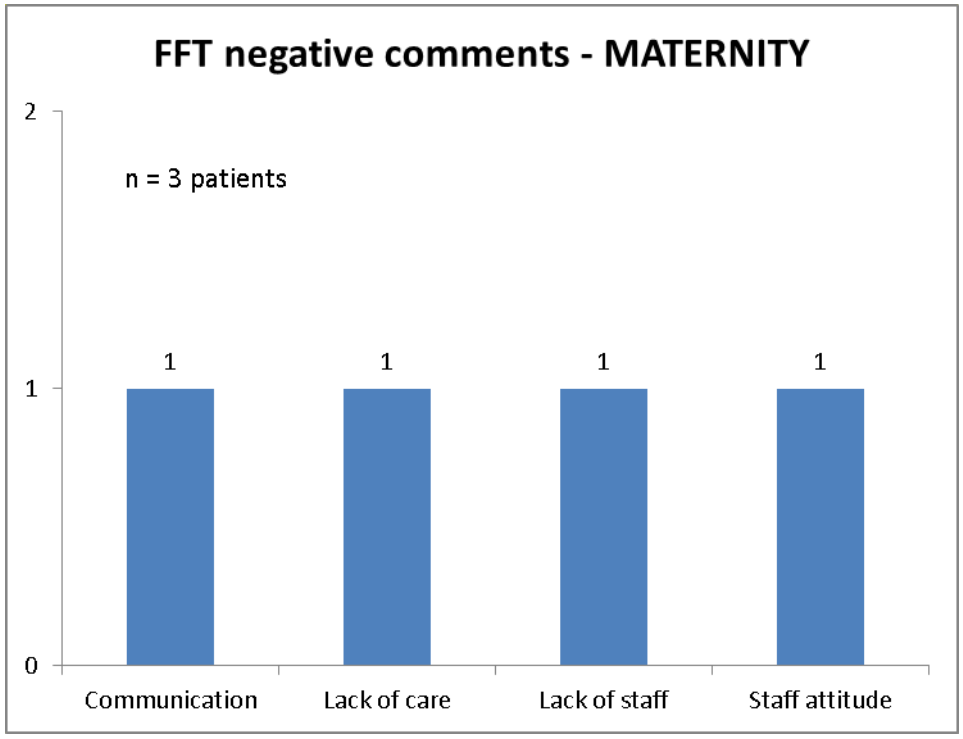
FRIENDS AND FAMILY TEST
Responses for the period were as follows:

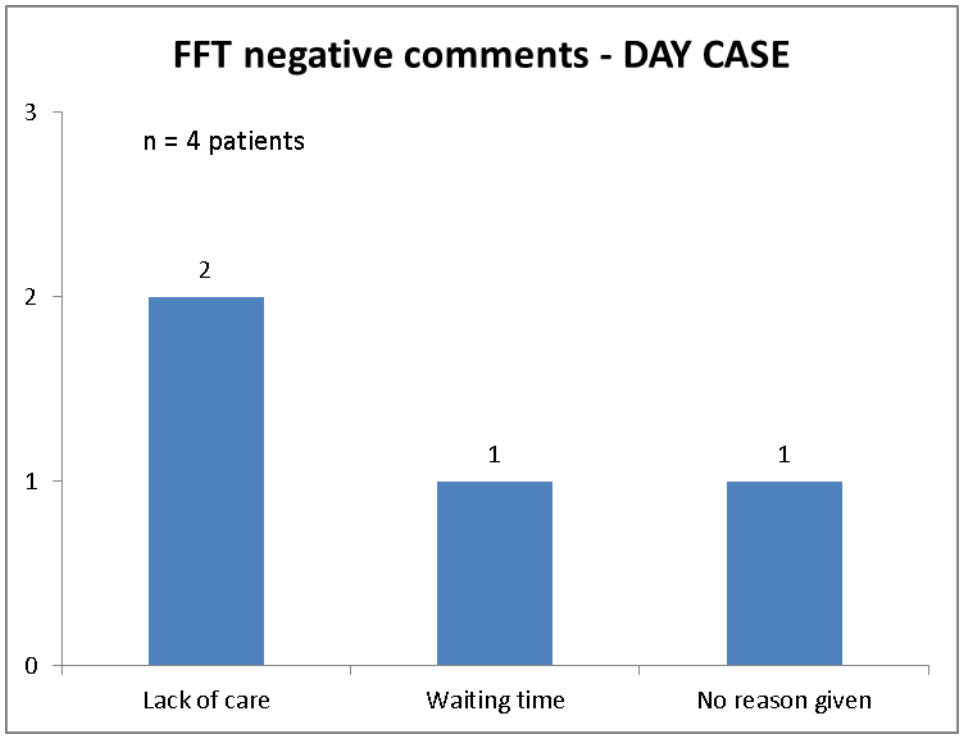
		Rating		
	Total Responses Received	Extremely Likely	Unlikely	Extremely Unlikely
Inpatients	1496	1178	9	9
Emergency Department	1323	1025	9	16
Maternity	202	167	3	0
Outpatients	4326	3539	22	16
Day Case	1366	1184	2	3

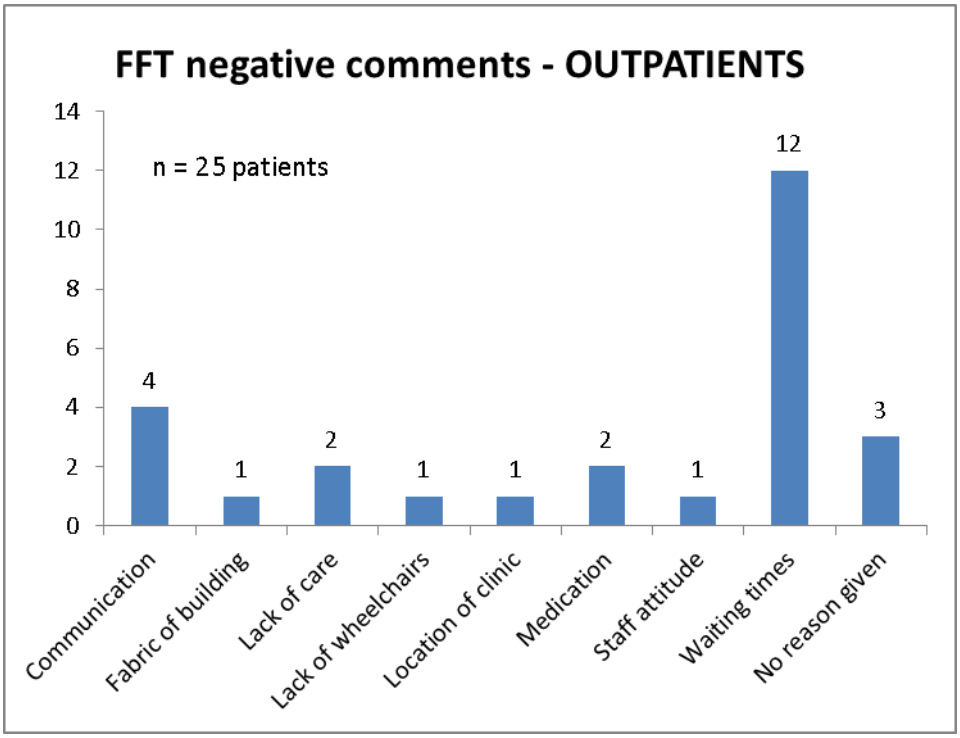
Comments made by those patients who stated they would be unlikely or extremely unlikely to recommend the hospital have been categorised as set out in the graphs below.






FFT negative comments - MATERNITY
n = 3 patients
2
1
0
1
1
1
1
Communication
Lack of care
Lack of staff
Staff attitude


FFT negative comments - DAY CASE
n = 4 patients
3
2
1
0
2
1
1
Lack of care
Waiting time
No reason given



The main areas of concern are waiting times in the Emergency Department and Outpatients. The Emergency Department publishes details of any breaches in waiting times on their staff notice board.

Although the receptionists in the Pre-Operative Assessment Unit inform patients of waiting times, there has been a problem whereby the Unit was unable to provide patient information on the waiting room TV. It is likely that this will soon be resolved.

Endoscopy use a management tool called 'a timer, stop watch' to try to assist the nursing team to keep the patient flow through the department as efficient as it possibly can be. Delays sometimes occur when a procedure takes longer than expected or an emergency patient arrives from the ward. In these circumstances, staff endeavour to keep all patients and relatives informed of delays.

3. PATIENT AND PUBLIC INVOLVEMENT

In Q1there were six new project requests to the Patient and Public Involvement Group:

- Medicine – to improve the amount of time it takes from when patients are admitted to hospital to when they have access to their glasses and hearing aids.
- Maternity – National Maternity Survey 2015 response.
- Fertility Service – to improve the patient's experience by reducing the number of hospital appointments and waiting time for diagnosis.
- Anticoagulation Service – to evaluate patient satisfaction with the Anticoagulation Service. Establish the difference between the two different treatment modalities used and to use the feedback from the British Society for Haematology conference and facilitate any further development in this field.
- Chaplaincy – to ascertain the understanding of patients in regards to the Chaplaincy Service in the hospital and if it meets their needs.

4. PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

In Q1 there were no new requests for independent review.

The Plastic Surgery case reported last quarter has been closed with the conclusion from the PHSO "having considered all the evidence and the clinical advice we have obtained, we do not uphold the complaint".

5. NHS CHOICES WEBSITE

In Q1 there were 16 comments posted on the NHS Choices website relating to 11 different areas. Of the 12 positive comments, one person said of the Breast Service “I have had the best of care here. Many people mention the bad treatment they have received on the NHS; well this time I'm flying the flag for SDH. Well done guys and keep up the good work”. Of the 4 negative comments, one person said of Radiology “They did not acknowledge me when I entered the room, didn't introduce themself, the staff didn't even know the doctor's name! At no point did the doctor explain what they were doing or what was going to happen and in the end said they found nothing but would send a report to my GP but no reference to how long that would take. Very poor show!” All the feedback was shared with the departments.

AUTHOR: Hazel Hardyman
TITLE: Head of Customer Care
DATE: September 2015

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance and Performance Committee
Held on 27 July 2015

Present:	Dr N Marsden	Chairman
	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
	Rt 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 L Wilkinson	Director of Nursing (for item 2)
	Mrs F Hill	Head of Risk Management (for item 9)
Apologies	Mr L Arnold	Director of Corporate Development

1. MINUTES – 29 JUNE 2015

The minutes of the meeting of the committee held on 29 June 2015 were accepted as a correct record.

2. MATTERS ARISING

Community Services Bid

An update on the 23 July summit meeting would be given under any other business.

Finance and Contracting Report

It was agreed that a paper on the Trust's cash position including arrangements for the drawdown of the FTFF loan in relation to approved capital schemes would be given at the August meeting.

Market Share Information

It was noted that work was underway to consider how orthopaedic work could be won back for the Trust.

3. CQUIN REPORT

The Committee received the Month 3 CQUIN report and it was noted that all matters were on track. Agreement was close to being reached on CQUIN seven and had been reached in relation to West Hampshire's delayed transfers of care scheme. The next step would be to agree quarter 2 targets for CQUINs one and two.

It was agreed to have CQUINs at the Finance and Performance Committee on a quarterly basis subject to early escalation of any issues of concern.

The Committee noted the report.

4. FINANCE AND CONTRACTING REPORT TO 30 JUNE 2015

The Committee received the report which indicated a year to date deficit of £2.3m not including the donated income of £157,000. This rate was an improvement over months one and two but agency spend was still high although there were still positive signs of this being better controlled. The achievement of planned cost improvement programmes remained a challenge. There had been a reduction in outpatient follow ups which was thought to be due to changes in Maternity.

There had been a delay in a June payment from a commissioner of £2.3m which had temporarily affected the Trust's cash position.

In terms of the forecast outcome for 2015/16 if there was some limited impact of the Better Care Fund on activity that helped reduce length of stay that would see a contribution to cost pressures and cost improvements of £1.5m, this would bring the Trust in line with its planned deficit for the year of £6m.

The Committee noted the report.

5. APPROVAL OF MONITOR Q1 RETURN

The draft targets and indicators Monitor return was received. This indicated a fully compliant position for the relevant performance indicators.

The return was approved for submission to Monitor. DS

It was noted that formal feedback for Quarter 4 had not yet been received.

6. TRANSFORMATION AND COST IMPROVEMENT

The Transformation and Cost Improvement PMO Report was received. AH highlighted good practice and sharing activities taking place in support of the Cost Improvement Programme. There was also involvement from the Intensive Support Team on capacity and demand modelling which would begin initially with Endoscopy MRI but could be rolled out into other areas. Twelve schemes had been drafted for 2016/17. Schemes were being continually reviewed and where necessary substituted. At present there was £267,000 that was unidentified and currently unallocated. Unidentified schemes totalled £1.87m. It was noted in relation to Surgery that schemes hosted by this directorate involving theatre efficiency were very challenging to deliver.

PH highlighted the 9 July visit by Lord Carter and his team who viewed Salisbury as a good example of a well-run organisation.

The Committee noted the report.

7. OPERATIONAL PERFORMANCE – MONTH 3

The Committee received the month 3 report and AH highlighted activity to clear the Endoscopy backlog. There was an increased focus on cancer waits and the Committee was reminded that it could be just one patient that made the difference between complying with a target and not. Ambulance handover breaches were discussed at COO level with the Ambulance Trust.

The Committee noted the report.

8 REPLICA 3D

The position of the company was discussed. Staff had agreed to a short week to control costs and it was not currently thought that existing principal investors wished to invest further. A letter would be circulated to all shareholders setting out the current position. A decision would be made at the end of August as to the next steps.

The Committee would continue to review the company's position at its monthly meetings. DS

9 ASSURANCE FRAMEWORK/RISK REGISTER QUARTERLY REVIEW

The Committee received the Quarterly Review report.

Fenella Hill attended for this item. Risk owners were being asked to address entries on the Risk Register that had been graded as "catastrophic" and the service was working to remove some duplicate entries. A revised protocol to control the adding of new risks had been agreed so that DMT approval was required.

The need to include strategic risks was highlighted.

The risk register reviews would continue and would be considered at the 7 September Annual Risk Register Review session held by the Board.

10. COMMUNITY SERVICES BID

PH reflected on the 23 July summit and it was noted that the August meeting of the Board and the September Board day would be discussing the bid further.

The Chairman requested an update on My Trusty at the next meeting. MC

10 DATE OF NEXT MEETING

Monday 24 August at 9.30 am

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance and Performance Committee
Held on 24 August 2015

Present:	Dr N Marsden	Chairman
	Dr L Brown	Non-Executive Director
	Mr I Downie	Non-Executive Director
	Mr P Hill	Chief Executive
	Mr M Cassells	Director of Finance and Procurement
	Mr L Arnold	Director of Corporate Development
In Attendance:	Mr P Kemp	Non-Executive Director
	Mr D Seabrooke	Head of Corporate Governance
Apologies	Mr A Freemantle	Non-Executive Director
	Rt Rev S Mullally	Non-Executive Director
	Mr A Hyett	Chief Operating Officer

1. MINUTES – 27 JULY 2015

The minutes of the meeting of the committee held on 27 July 2015 were agreed as a correct record.

2. MATTERS ARISING

It was noted that a report on the Trust's cash position would be included in future monthly reports. **MC**

QIPP

Noted that the total value was £2.7m was principally residing with the CCG and showing in the figures as £209,000.

Winter Planning would be added to the agenda for the Board Seminar day on 7 September.

Workforce Report

It was agreed that this would be presented to the committee for information.

3. FINANCE AND CONTRACTING REPORT TO 31 JULY (MONTH 4)

The committee received the report. It was noted that in the introduction section the figure in the second bullet point should be £647,000 not £695,000. July had been an improvement on previous months and assuming that cost improvement programmes continued as planned the Trust would be on target to end the year with the planned £6m deficit. There were generally good signs on income and a welcome reduction in temporary staffing spend. Concern continued to be expressed that A&E attendances were above plan suggesting that the full effects of the Better Care Fund had yet to be felt.

On Cost Improvement Programmes there was commitment across the Trust to achieve the required £8m savings in support of the planned position.

It was noted that contract documents had been signed and the associated schedules were being worked through. There had been good outcomes for the Trust on CCG contracts and specialist commissioners.

Work would continue to review whether the Trust was earning all best practice tariffs.

It was noted that the Department of Health was consulting on changes to the Tariff Objection Mechanism which at present was triggered on the basis of provider volume against the Tariff. The consultation suggested that the volume element was now distorted by a small but growing number of larger providers. However it was felt that raising the threshold from 51% to 66% or 75% as was proposed was inappropriate. The matter was summarised in a on the day briefing from NHS Providers which MC undertook to circulate. It was noted that there were two outline consultations from Monitor on the 2016/17 Tariff published by Monitor.

The Committee noted the Finance Report and recommended that the Trust's response to the Tariff Objection Mechanism Consultation be discussed at the Trust Board Seminar day.

4. TRANSFORMATION AND COST IMPROVEMENT PROGRAMME

The Committee received the PMO Report for Month 4. It was noted that leadership of the Outpatient Productivity Programme would be strengthened in September and that as a result of improvements to theatre productivity some capacity could be made available to other providers.

The committee noted the PMO report.

5. OPERATIONAL PERFORMANCE

The Committee received the Operational Performance Report for Month 4. PH highlighted the increased interest in cancer performance and the outturn on 62 Day Screening for July which indicated the Trust had missed the target but the figure continued to be subject to validation. There had been a 50% increase in patient volume on the 2 week pathway and substantial increases in patient numbers in Endoscopy.

Finally it was noted that the Trust continued to report incidents on the patient transport contract to the CCG.

6. REPLICA 3D

It was noted that short working for staff continued and that information to shareholders had been circulated and a board meeting was scheduled for the following week.

7. MT TRUSTY

The Committee received a report from the Director of Finance and Procurement setting out the current activities to develop and promote the My Trusty brand. Work continued to promote the product range with a leading retail chain.

It was agreed that the issue would come back to the November meeting of the Committee.

8 DATE OF NEXT MEETING

28 September at 9.30 am

TRUST BOARD

FINANCE & CONTRACTING REPORT TO 31st AUGUST 2015

1. Introduction (Appendix 1)

This paper outlines the main drivers behind the SFT Group consolidated financial position for the period ending 31st August 2015.

The Income & Expenditure (I&E) position was a Year-to-Date (YTD) deficit of £3,906k (before adjusting for donated income of £157k), a favourable variance against the plan of £72k due to phasing, but nevertheless an in-month deficit of £968k.

The main reasons for the YTD position were:

- Expenditure on agency, although there has been a continuation of the reduction in nursing agency spend in August.
- CIPs savings being less than planned by £747k (32%).
- This has been offset by over-performance on income of £925k mainly on CCG contracts due to reductions in activity for QIPP schemes not being delivered.

The over-performance income from CCG contracts is mitigating the overspending. However, this need to be treated with some caution as to its sustainability and therefore it is important CIP projects deliver.

Summary of Key Financial Information	YTD (Cumulative to August)			
	Plan £000s	Actual £000s	Var £000s	Var %
Income	82,883	83,485	602	0.7%
Expenditure	80,513	80,940	(427)	(0.5%)
EBITDA	**2,370**	**2,545**	**175**	**7.4%**
Finance Costs	6,348	6,451	(103)	(1.6%)
I+E Surplus /(Deficit) excl donated asset income	**-3,978**	**-3,906**	**72**	**1.8%**
Donated Asset Income Adjustment	100	157	**57**	57.0%
I+E position including donated asset income	**-3,878**	**-3,749**	**129**	**3.3%**
Adverse variance in brackets				

In month favourable variance of £213k can be explained as follows:-

- Improved income over-performance by £77k mainly on CCG contracts as a result of activity being delivered above plan.
- A reduction in spend on temporary staff of £67k when compared to last month due to closure of escalation beds and new management controls.
- The monthly run rate of CIP savings has increased by £89k in the month due to recognition of Best Practice Tariff income relating to the previous month.

2. Sales

NHS activity revenue was £71,688k which was £925k greater than plan. Excluded pass-through drugs under-performance was £189k and was offset by a similar underspend on expenditure. The over performance against the Plan was mainly driven by QIPP schemes, which were to deliver a reduction of activity, not being achieved. The performance on NHS clinical activity can be summarised as follows:-

- Day Cases were ahead of plan by 414 spells when compared to the previous year. The actual income value of the over-performance was not significant in comparison due to the case mix being predominately low value investigation work. The areas of over-performance were: Plastics, General Medicine, Gastroenterology and Rheumatology. This was offset by under-performance in: Colorectal Surgery, Ophthalmology, Oral Surgery and Gynaecology.

- Elective spells were down by 247 when compared to last year and 304 down against plan. Oral Surgery and Paediatrics have over-performed but Urology, T&O, Plastic Surgery, and Paediatric ENT were down.

- Non-Elective activity has over-performed by 97 spells against last year and 729 over plan. The plan includes significant reductions in activity for QIPP schemes which have not yet delivered. This was the main reason for the overall YTD over-performance against the Plan.

- Outpatient activity was up against plan for new (434) but down for follow-ups (-929) and up on procedures (552).

- A&E activity was up against the 2015-16 plan by 963 (Plan includes a reduction in activity for QIPP schemes) but was down by 398 attendance when compared to last year.

Contract Activity Performance 2015/16 (August 2015)	Actual 2014-15	Actual 2015-16	Plan 2015-16	Year on Year Variance	Plan Variance
Elective inpatients	2,522	2,275	2,579	-247	-304
Elective PSDs/day attenders	8,921	9,335	9,886	414	-551
Regular Day Attenders	2,943	3,247	2,949	304	298
Non Elective Inpatient	10,673	10,770	10,041	97	729
Outpatient initial attendances	27,318	27,459	27,025	141	434
Outpatient follow-up attendances	48,282	44,793	45,722	-3,489	-929
Outpatient procedures	15,124	14,927	14,375	-197	552
A&E attendances	19,493	19,095	18,132	-398	963
Favourable Variances are shown as +ve					

Other non-clinical income was behind plan by £323k. The adverse variance is mainly to do with the following:

- Income Generation schemes relating to CIPs included in the Finance Plan of £128k not yet achieved;
- Recharges to other NHS organisations was down by £46k;
- Advance income of £263k deferred from the previous year not released as expenditure has not been incurred.

3. Cost of Sales including indirect costs

The total for all Directorates was an overspend position of £2,039k.

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.

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	3,222	3,225	(3)	16,291	16,946	(655)
Musculo Skeletal	2,302	2,336	(34)	11,764	12,199	(435)
Surgery	2,746	2,884	(138)	13,846	14,558	(712)
CSFS	3,062	3,073	(11)	15,137	15,367	(230)
Facilities	368	357	11	1,768	1,735	33
Corporate	1,800	1,897	(97)	9,223	9,263	(40)
TOTAL	**13,500**	**13,772**	**(272)**	**68,029**	**70,068**	**(2,039)**
Adverse variance in brackets						

There has been good progress in reducing nursing agency expenditure as shown in the following table although nursing budgets overall are overspent by £483k:

Directorate	APR 15-16 (£)	MAY 15-16 (£)	JUN 15-16 (£)	JUL 15-16 (£)	AUG 15-16 (£)	YTD 15-16 (£)
CSFS	2,217	2,681	8,056	- 1,198	219	11,975
MEDICINE	273,482	277,403	163,367	112,412	99,714	926,379
MUSCULO-SKELETAL	96,146	99,473	61,684	81,349	48,644	387,295
OTHER	-	1,849	- 225	545	17,205	19,373
SURGERY	71,681	139,730	82,693	49,361	30,054	373,520
Grand Total	**443,526**	**521,136**	**315,574**	**242,469**	**195,836**	**1,718,541**

Medicine

The Year to Date (YTD) overspend of £655k was mainly attributable to the cost of agency staff due to the high level of nursing vacancies on wards. This will continue to be monitored very closely by the Directorate Management Team. The run rate of overspending reduced significantly in month due to retrospective funding for Best Practice Tariff income.

Musculo-Skeletal

The YTD overspend of £435k was mainly due to charges of £175k for LLP (private contractor), the high use of temporary staff due to vacancies and the shortfall in CIPs of £254k resulting from a delay in the start-up of savings schemes. The Directorate over the coming months will be maintaining a lower level of agency spend, analysing opportunities for savings and identifying ways in which elective Orthopaedic activity can be increased without further recourse to LLP.

Surgery

The YTD overspend of £712k was due to a shortfall on CIPs of £574k mainly relating to unidentified schemes and the additional cost of agency staff due to nursing vacancies. There has been a decrease in bed days against the baseline, which has meant that no additional income has been earned to offset the financial position. Actions are being developed to manage agency spend and close the gap on unidentified schemes.

Clinical Support & Family Services

The YTD overspend of £230k was due to underperformance on CIPs as a result of unidentified schemes and work is on-going to close the gap.

Facilities

Facilities YTD underspend was £33k and the directorate has over-achieved its savings target.

Corporate services

The YTD overspend of £40k represents an in-month deterioration of £97k mainly due to the treatment of education income and also additional spend in Medical Records. In addition expenditure on My Trusty products has not been classed as stock and this will be reviewed.

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 £1,818k against a plan target of £2,565k an adverse variance of £747k. It is recognised the CIP programme is back loaded and therefore on a straight line basis the Trust is £1,515k (45%) below where it should be.

At the time of preparing this report, unidentified schemes amounts to £1,187k (14.8%) (last month £1,188k). Against this will be offset £400k being the reduction in the CNST increase. 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 especially in order to make inroads into the planned deficit of £6m.

The COO will report separately about the CIP progress and the discussions which have taken place as part of the Carter review.

5. Statement of Financial Position

5.1 Working Capital including Cash

Overall the working capital position (current asset less liabilities) was behind plan by £641k. The cash balance at 31st August 2015 was £13,736, which is also behind plan by £1,133k due to:

i) The Trust has made a number of prepayments and bulk purchases of stock (the latter to secure improved prices).

ii) The plan assumes a higher level of drawdown of loans and public dividend capital than has happened to date, which is a phasing issue. The next loan drawdown is scheduled for 21st September 2015.

The cash plan over the year shows the impact of the £6m loan. It can be seen that excluding the loan the SFT planned cash position drops from £14.8m to £5.2m as a result of the deficit and capital schemes. It is intended to improve on the planned position by driving down capital expenditure.

6. Capital Expenditure (Appendix 2)

Expenditure was £2,869k which was ahead of plan by £45k and efforts are on-going to reduce capital expenditure where possible.

7. 2015-16 Contracts

Wiltshire CCG has issued its month 4 challenge letter which continues to challenge activities undertaken by the Trust. A meeting will be held shortly to resolve ongoing issues around the Interventions Not Normally Funded (INNF) challenges. It has been agreed that any new challenges should be raised firstly at the joint monthly Finance and Information Group meeting to agree the methodology and basis of the challenge before they are published within the challenge letter. This will hopefully make the challenge process more robust.

Wiltshire and West Hampshire CCGs have both agreed to re-invest the mixed sex breach penalties for the first six months. The number of breaches in the month has reduced dramatically. The C-Diff breaches remain within the YTD threshold. Ambulance hand-over breaches continue to be an issue and are being reviewed.

QIPP plans across all commissioners do not appear to be delivering the expected savings and the risk remains with the commissioners.

The draft tariff proposals for 2016-17 have been published and one of the major changes to will be the move to the HRG 4+ grouper which will provide granularity to the tariffs and will be based on the 2013-14 reference costs submission. New best practice tariffs for myocardial infarction and heart failure are being proposed.

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.

In terms of the forecast outturn the assumptions are being made in arriving at the planned deficit of £6m: minimum escalation over the next three months, nursing agency costs continuing to reduce compared with last financial year (assume £1m reduction), agreed CIPs being delivered to plan and the CIP gap being reduced by at least half, QIPP not delivering, and the growth in activity continuing to the year end, and the cost of the large projects which are under way being contained within planned levels, contain aspirations for investment to that which is absolutely unavoidable. Work is taking place to model the scenarios. At this stage there remains a wide range of variables but with tight control achieving plan or better is possible.

9. Other Issues

Following discussion at the Trust Board a response was made to the DoH consultation on changes to the tariff objection mechanism reflecting those discussions.

10. Conclusions

After five months of the financial year the Trust is showing a deficit of £3,906k (before adjusting for donated income of £157k), a favourable variance against the plan of £72k. It is important that the Trust continues to achieve savings, manage budgets tightly and undertake more profitable elective work.

The Trust has achieved Continuity of Services Risk Rating of 3. Using the new risk rating, introduced by Monitor this month, the Trust score is 2. The score of 2 is the maximum the Trust can achieve due to a rating of 1 for the I&E deficit position and capital servicing capacity.

11. Recommendation

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

Malcolm Cassells
Director of Finance and Procurement
17 September 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	12,439	12,906	467	64,725	65,839	1,114
High cost drugs income	1,569	1,182	(387)	6,038	5,849	(189)
Other Clinical Income	656	534	(122)	3,384	2,859	(525)
Research & Development & Education	511	549	38	2,677	2,699	22
Other (Excluding Donated Asset income)	1,173	1,670	497	6,059	6,239	180
TOTAL INCOME	**16,348**	**16,841**	**493**	**82,883**	**83,485**	**602**
Operating Expenditure						
Pay - In post	9,854	9,730	124	49,357	49,505	(148)
Pay- Agency & Locums	699	914	(215)	3,513	4,218	(705)
Drugs	1,670	1,488	182	7,635	7,394	241
Clinical Supplies	1,550	1,483	67	8,303	8,116	187
Non-Clinical Supplies	913	1,573	(660)	4,601	4,697	(96)
Other (incl PFI unitary charge)	1,417	1,170	247	7,104	7,010	94
TOTAL EXPENDITURE	**16,103**	**16,358**	**(255)**	**80,513**	**80,940**	**(427)**
EBITDA (Earnings Before Interest, Tax, Depreciation & Amortisation)	**245**	**483**	**238**	**2,370**	**2,545**	**175**
Financing Costs	1,269	1,295	(26)	6,348	6,451	(103)
SURPLUS / (DEFICIT) excluding DONATED ASSET INCOME	**(1,024)**	**(812)**	**212**	**(3,978)**	**(3,906)**	**72**
Donated Asset Income	0	0	0	100	157	57
SURPLUS / (DEFICIT)	**(1,024)**	**(812)**	**212**	**(3,878)**	**(3,749)**	**129**

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 31st August 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	
Durrington Upgrade (Charitable Contribution to Decant Ward Project)					
Fluoroscopy Room 8 - Charitable Contribution	0	330,000	330,000	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	10,792	
Spinal Unit Ultrasound	35,542	0	35,542	0	
Vascular Unit Ultrasound Machine	65,475	0	65,475	0	
Donated Assets - Totals	**392,241**	**475,825**	**868,066**	**156,617**	**0**
Phase 3 Building Schemes					
Breast Unit enabling	50,000	0	50,000	2,035	
CT Scanner Building and Enabling	11,822	0	11,822	1,746	
Laverstock Ward (Decant Ward Project)	500,000	50,000	550,000	260	
SAU Refurb (Decant Ward Project)	0	280,000	280,000	472	
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	48,680	
SDU Development	0	50,000	50,000	2,000	
Springs entrance development	1,310,252	0	1,310,252	62,017	
Ward changes - Dementia Patient Care	10,112	-6,000	4,112	0	
Building Schemes - Totals	**2,696,378**	**224,650**	**2,921,028**	**117,860**	**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	8,703	
AHU replacement yr 3 (2014/15) of 7	352,559	800	353,359	85,253	
Asbestos management	18,222	0	18,222	5,451	
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	9,560
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	5,497	-4,881
DSU Replacement Insulation to Air Handling System	8,600	-8,600	0	0	
DSU Roof Repairs	58,856	-20,000	38,856	19,340	
DSU Theatres - Flooring	1,882	0	1,882	0	1,882
Ductwork & Fire Damper Cleaning Whole Site Year 3 of 3	188,865	0	188,865	45,355	
ED Data Centre Ventilation	78,999	40,000	118,999	0	
Electricity at Work Regulations Compliance	82,744	0	82,744	5,859	
Estates health and safety	10,000	0	10,000	1,004	
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	50	
Genetics Modular cold room	26,000	0	26,000	175	
Glanville Roof	0	7,200	7,200	0	
Grovely Roof Repairs	30,000	0	30,000	0	
Hillcote Sale Costs	0	0	0	0	
Hospice fire alarm	30,000	0	30,000	0	
Lab Medicine Cold Room	36,000	0	36,000	13,834	
Level 4 Bedspace Power Sockets	61,610	0	61,610	0	
Lightning Conductor	0	12,000	12,000	0	
Llfts 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	4,090	
Main operating theatres recovery area	56,000	0	56,000	15,221	
Main Theatres 4th Laminar Flow System	185,000	0	185,000	2,353	
Maternity Obstetric Theatre Refurbishment	78,000	-19,000	59,000	0	
Maternity Post Natal Upgrade	121,550	15,000	136,550	48,100	
Maternity Relocation - Enabling	1,622	0	1,622	1,349	
Mattress Laundering	2,521	0	2,521	0	
Medical Gas Hoses 2nd year of 2 (2015/16)	147,000	0	30,000	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	1,558	
Orthotics Move and Radiology Bowel Screening Relocation	33,315	0	33,315	35,658	-2,343
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	225	
Roads and paving repairs	160,169	66,000	226,169	0	
Sarum Kitchen Ventilation	0	7,800	7,800	0	
Sarum Ward Playdeck	0	0	0	9,682	-9,682
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	22,720	
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 Boiler Replacement & Associated Pipework	0	37,400	37,400	0	
Spinal treatment centre refurbishment	169,286	52,000	221,286	148,329	
Spinal Unit Doors and Locks	0	35,000	35,000	1,372	
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	6,597	
Theatres 1 - 10 Replacement Taps	911	-911	0	0	
Theatres - Male Changing Facilities	0	25,000	25,000	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	**3,927,446**	**97,600**	**3,908,046**	**518,800**	**-5,464**
Information Technology					
Alternative to Microsoft products - review	50,000	0	50,000	0	
Aruba expansion	34,000	10,000	44,000	51,003	-7,003
Baby Tagging - RFID	66,000	0	66,000	1,337	
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	67,239	0	
BMS Network Upgrade	16,596	0	16,596	3,134	
Brocade Switch Replacement	5,004	0	5,004	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	

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 31st August 2015	Under/(Over) spent on Project
Edge Security replacement	651	-651	0	0	
Electronic Letters	20,148	0	20,148	5,241	
EPMA (Yr 2 (2014/15) of 7)	47,011	-47,011	0	73,989	-73,989
EPR	0	350,000	350,000	11,176	
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	15,473	
Genetics High Spec Analysis Equipment & Software	57,691	0	27,691	0	
Histopathology Hardware	13,384	0	13,384	2,611	
IBD register	10,000	0	10,000	0	
Inhouse development team - applications, databases and Dashboards (subject to bus case)	92,176	0	92,176	31,147	
iPad Security	160	0	160	0	
Maintenance renewal - estimate	650,000	0	650,000	499,000	
Microsoft Licensing - being challenged	500,000	0	500,000	503,720	-3,720
Mobile Computing	19,151	0	19,151	2,343	
Mortuary module	52,000	0	52,000	0	
Network - unsupportable equipment	52,000	0	52,000	0	
Network Load Balancers	12,690	-10,000	2,690	0	
Network Upgrade Consultancy	68,910	0	68,910	2,400	
Neurophysiology Project	726	-726	0	0	
Nexus 5 Expansion	7,809	0	7,809	3,740	
Open eyes phase II	153,938	0	153,938	7,687	
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	1,067	
Palliative Care EPR	39,437	0	39,437	0	
PAS 2016 Replacement - Consultancy Costs	7,606	1,970	9,576	19,216	-9,640
Patient Observations Monitoring and Decision Support/Early Warning System/POET	32,029	0	32,029	29,963	
Patient Tracking	238	-238	0	0	
Radiology - OrderComms	46,602	0	46,602	0	
Radiology Replacement PC's	522	-306	216	286	-70
RAM Asset Maintenance Module	2,999	0	2,999	1,361	
Replace 6509x3 network hubs	350,000	0	350,000	84	
Reporting System	80,000	0	80,000	68,910	
Results System in GP Practices 'Review' System	19,678	0	19,678	0	
SBAR Cardiology DICOM Migration	0	47,000	47,000	0	
SBAR for PAS	38,447	0	38,447	11,881	
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	-67,000	0	0	
SDU Quality System	1,727	0	1,727	2,917	-1,189
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	17,552	
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	67,590	
Upgrade of low spec equipment (680 machines)	265	-49	216	251	-35
UPS Replacement Programme	24,202	0	24,202	1,027	
VMWare Upgrade	20,000	0	20,000	0	
Whiteboards	200,000	0	200,000	6,063	
Wireless Expansion and Coverage	122,582	0	122,582	0	
Information Technology Totals	**4,006,077**	**330,000**	**4,147,877**	**1,463,717**	**-98,484**
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 Bed (2016/17 bfwd)	0	0	12,654	0	
Bariatric Equipment	1,054	0	1,054	11,640	-10,586
B-Braun Review of Theatre Instruments	704,237	0	704,237	19,771	
BED replacement programme - 3rd (2015/16) yr of 4	158,047	0	158,047	62,142	
Biologics Service		60,000	60,000	60,000	
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	-15,726	0	0	
Fluoroscopy x-ray machine - radiology room 8	330,000	-282,500	47,500	0	
Foetal Heart Monitors X 6	7,531	-7,531	0	0	
General x-ray machine - Westbury - radiology	99,000	0	99,000	0	
Grouped Items 2014/15	6,543	-6,300	243	0	
Grouped Items 2015/16	100,000	21,814	121,814	61,053	
Histpathology Kit	0	39,026	39,026	0	
Maquet Repairs Table/Lights	0	6,730	6,730	0	
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	127,366	
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	-2,483	0	0	
Pitton Monitoring	0	16,500	16,500	16,485	
Power tools replacement/upgrade - theatres/DSU/oral surgery	200,000	0	200,000	190,995	
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	-17,000	12,958	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**	**-158,770**	**2,387,431**	**571,379**	**-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	-138,400	22,170	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	14,586	
Lightning Repairs	0	0	0	19,513	-19,513
Mortuary Temporary Storage	230	0	230	0	
Outpatient Kiosks	74,338	0	74,338	1,675	
Phhotovoltaic's / Solarthermal PV	23,744	0	23,744	0	
Procurement Storage Raching Investment	0	11,400	11,400	2,718	
Procurement Tug 2015/16	0	9,940	9,940	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	1,720	
Theatres Storage and Trolleys	0	51,420	51,420	0	
Ward Waste Bins	60,643	0	60,643	0	
Other Totals	**901,599**	**-222,568**	**679,031**	**40,213**	**-19,513**
Trust Totals	**14,457,289**	**746,737**	**14,911,480**	**2,868,586**	**-134,047**
Likely slippage on Trusts schemes 2015/16	0	-1,917,618	-1,917,618		
Trust Totals	**14,457,289**	**-1,170,881**	**12,993,862**	**2,868,586**	**-134,047**

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 23rd July 2015, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

SFT 3704

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair), Christine Blanshard, Claire Gorzanski, Hazel Hardyman, Laurence Arnold, Malcolm Ace, Paul Kemp, Peter Hill, Steve Long, Jan Sanders.

In attendance:

	Item
Kate Williams	Minute taker
Victoria Downing-Burn	CGC0704
Denise Major	CGC0712/ CGC0723/ CGC0724
Ian Robinson	CGC0708
Alison Montgomery, Kate Johnson	CGC0710
Katrina Glaister	CGC0720
Fenella Hill	CGC0721/ CGC0722

CGC0701 Apologies:

Fiona Hyett, Andy Hyett, Lorna Wilkinson, Sarah Mullally, Angela Clarke, Hollie Foreman, Sally Tomlin.

CGC0702 – Minutes of the meeting held on 23rd July 2015

An amendment was made to an item under 'Any other urgent business' and Steve Long's name was added to the list of attendees after which the minutes of the last meeting were agreed as an accurate record.

CGC0703 – Action Tracker

No comments.

CGC0704 – Matters arising – Local Response to the Challenges SFT Faces in Recruiting Medical Practitioners – Christine Blanshard, Victoria Downing-Burn (verbal update)

CB reported on the hospital's existing agency usage with regard to doctors. We have a high locum expenditure. There are concerns regarding both expenditure and quality, but overall the level is 10.5% down from the same time last year.

There has been a huge rise in using agency doctors to work in the Endoscopy department owing to demand for the service which is likely to increase – it will be a challenge to meet the staffing levels required. We have been looking to recruit for some time, positions have been advertised several times but these have not been filled.

There has been a high level of agency staff used in Geriatrics, due to escalation bed capacity. We have successfully recruited a consultant in July to work in this department. Many other departments have needed agency staff / locum doctors for reasons of vacant posts or holiday/other cover. CB stated that since the last report to the committee we have recruited in many areas, but are struggling in others – for example, vacant posts in Radiology - which is following a national trend. We have concerns with Opthalmology/Radiology as we now have two retirees who have returned to work, with another member of staff planning to retire in the near future. We are networking with another Trust to try and resolve this issue.

We have a strong response to advertisements for Trauma and Orthopaedic posts but need to improve recruitment in other areas – to this end we are building on advertising, promotions, press, conferences, trade stands and fairs. In relation to our Research department we are above our

targets and show that we positively attract people to this area. We also actively nurture our registrars by supporting their training and education, building their confidence and encouraging team work. PH commented that he had recently met with five local GP's and our nurturing is something that has been noticed. CB commented that regionally, within other Trusts, existing consultants have been used to successfully recruit new staff.

SL noted that we appear to be doing well with what is a national problem and asked if these difficulties are being recognised. CB responded that all Trusts are struggling with recruitment. SL stated that this is worrying – there needs to be a long-term strategy. There needs to be research into this to see how the NHS is going to move in the future. CB reported that 'Monitor' has commissioned a report into workforce planning but that even if increases were made to medical school places it would be ten years before problems were resolved.

VD-B then reported that we have used the 'Total Assist' agency to try to recruit substantively without any real success. We may abandon this process if no real improvements are made in the next four weeks. We may be able to try to recruit substantively through a different agency, 'South West Consortium' but it will not be a quick fix.

LB noted that this is a long-standing issue and commented that she felt reassured by the work being done. JS agreed and stated that she was encouraged by the efforts being made in this area.

CGC0705 – Matters arising – National Inpatient Survey – Trust wide action plan 2014 – Hazel Hardyman

HH reported that following concerns raised at the Clinical Governance Committee meeting held on 28 May 2015 the action plans for the national inpatient survey 2014 were returned to the relevant directorate senior nurses with a request that they review and amend where necessary to ensure accuracy and robustness. This work has now been undertaken.

In addition, the Committee asked that an over-arching Trust-wide action plan be developed to cover communication, noise at night, discharge, single-sex accommodation and food. This, too, has now been developed.

LB stated that there was still work to be done in this area, but progress is being shown. PK commented that he was pleased to see the progress being made but he had some concerns regarding those items shown as 'ongoing' and suggested that it would be helpful if the next milestones could be recorded. Some items need to be refreshed but these are minor refinements. PH asked how the procedure works and HH responded that Gill Sheppard chases up the departments and then the results are reported to the Directorate.

This item will return before the Committee at a later date.

CGC0706 – Matters arising - Complaints Dip Sampling Report – Hazel Hardyman (verbal update)

HH reported that there has been an increase in action plans. The information is reported on DATIX and is followed up. SL has met with an investigating manager and commented that the process of investigations is good but could be improved. SL is arranging to see the Police Complaints System to compare this with our own system.

HH and FHi are beginning to streamline some of the complaints material. FHi is updating the risk matrix.

SL reported that good progress is being made.

CGC0707 – Matters arising – National Children and Young People Survey 14 CQC Benchmark Report and Local Action Plans – Hazel Hardyman

HH reported that SFT participated in the second national children's survey between October 2014 and February 2015. Three questionnaires were used:-

0 - 7 year olds for completion by the parent or carer of the child
8 - 11 year olds consisting of two sections – the first for completion by the child and the second for completion by the parent or carer
12 – 15 year olds consisting of two sections – the first for completion by the young person and the second for completion by the parent or carer

The benchmark report was published on 1 July 2014 and is available on the NHS Surveys website.

In addition, a child-friendly leaflet explaining the results was also produced.

SFT scored 'better' than most other Trusts in 14 (26%) of the 53 questions, as follows:-

All Parents and Carers said:

THE HOSPITAL WARD
- The hospital room or ward their child stayed on was clean

HOSPITAL STAFF
- Staff knew how to care for the child's individual or special needs
- Staff were available when their child needed attention
- Members of staff caring for their child worked well together

SPEAKING WITH PATIENTS AND PROVIDING INFORMATION
- Hospital staff kept them informed about what was happening whilst the child was in hospital
- Staff asked if they had any questions about their child's care

FACILITIES FOR PARENTS AND CARERS
- The facilities for staying overnight for parents and carers were good

PAIN
- Hospital staff did everything they could to ease the child's pain

BEING PREPARED TO LEAVE HOSPITAL
- They were given advice on how to care for the child when home

Parents and Carers of 0-7 year olds said:

HOSPITAL STAFF
- Their child was well looked after by hospital staff

SPEAKING WITH PATIENTS AND PROVIDING INFORMATION
- Members of staff communicated with the child in a way they could understand
- They were not told different things by different people, which left them feeling confused

BEING PREPARED TO LEAVE HOSPITAL
- They were told what to do or who to talk to, if worried about their child when home

Children and Young People said:

SPEAKING WITH PATIENTS AND PROVIDING INFORMATION
- The people looking after them were friendly

SFT scored 'about the same' as most other Trusts for all the other 39 questions; 26 of which were towards the top end of the middle range.

There were no 'worse' scores for this Trust.

COMPARISONS WITH OTHER TRUSTS

When compared with Trusts in Bath, Dorchester, Poole, Southampton, Swindon, Winchester and Yeovil, Salisbury had the highest or joint highest score for 18 of the 53 questions and the lowest or joint lowest for one question (access to hot drinks facilities). Details of the comparisons are contained in Appendix A.

LOCAL RESULTS ANALYSIS

A total of 107 comments were received on things that went well and 70 on things that could be improved. Children aged between 8 to 11 years were invited to draw a picture depicting their experience but due to the relatively small number of children providing drawings nationally, and the non-specific nature of the question asked, no formal analysis of the pictures was undertaken. Locally, only five pictures were received. All five demonstrated positive feedback although one respondent did say they were cold at night.

THE NEXT STEPS

Action plans have been drawn up for Sarum Ward, Day Surgery, Emergency Department and food and nutrition (Appendices B to E). Progress on these plans will be reported to the Clinical Governance Committee in January 2016.

HH reported that very comprehensive action plans are being developed. SL questioned the frequency of the survey to which CGz responded that it was every other year.

The committee noted the report.

CGC0708 – Matters arising – Annual Food and Nutrition Report – Ian Robinson

IR reported that the Food and Nutrition Group develops and monitors its own work plan for the year, considers nutritional issues in their entirety and is responsible for monitoring the Trust's compliance against national standards. The groups work plan is developed against 5 core topics – ensuring personalised care, ensuring support needs are met, promotion of patient's rights and choices, workforce capability and national standards. The work plan was also mapped to CQC Outcome 5, Food and Nutrition Quality Standards, the Malnutrition Task Force Principles and BAPEN Principles of Good Nutritional Care.

The group receives regular reports from task and finish groups and reviews patient feedback using RTF, compliments, concerns and complaints and regular feedback from the Patient Food Forum.

The National Patient surveys undertaken in 2014 indicate areas for improvement in food services and provisional results from the Patient Led Assessment of the Care Environment (PLACE) audit (April 2015) suggest improvements have been made.

The Group have developed an action plan for 2015/16 and agreed task and finish groups for key priorities to ensure improvements and service development are maintained.

IR stated that this is a large, multi-disciplinary and evolving group. It has been a very busy year. A highlight has been the positive audit which showed a significant improvement form 83-94% in food scores. The action plans are reported to and signed off by the Board. Caroline Lecko, who is the Patient Safety lead for NHS England, visited and met dieticians, speech & language therapists, catering staff, and people from our patient food forum group.

Complaints reduced from 10 to 5 during 14/15, 3 of which were to do with assistance with eating.

Previously we received complaints regarding cold food / poor temperature control which led to investments into new trollies – this appears to have made a significant positive impact in this area.

IR reported that there are two main challenges : -

1. To increase the percentage of patients who are weighed within 6 hours of admission. We have received funding to gain extra weighing equipment.
2. To provide training for patients with NG tubes. This is not yet in place. The current level of knowledge is deteriorating due to staff movements.

We are launching an MLE module in food safety. Everyone who has contact with food will need to complete this, approximately 2000 staff.

LB stated that she sits in on the Food and Nutrition Group and confirm that lots of work is being done in this area.

PH noted that there was a link to the Children's Survey to which IR responded that had proved a challenge as the children / parents were reporting on food which had not been delivered by our services. However, constructive efforts were made to meet with staff to try and resolve issues. We have developed a bedside booklet for children and parents regarding allergies and the food being offered. There is a bespoke paediatric menu – this can be altered and is reviewed regularly. PH commented that this is helpful as we do need to listen to children and their parents - Bath RUH are doing well in this – could we take some positives from them? IR responded that we do have close networks with other Trusts and we can take positive aspects from them.

CB queried whether water is now independently accessible throughout the wards. IR responded that during this week the tenders will be evaluated for this service with the order to be placed soon – possibly within the next week. Locations have been agreed with the ward leaders. CB asked if this would be completed before the end of the summer to which IR responded that we would probably

struggle with that deadline, but it is possible.

SL noted that this was a good report and was well presented.

CGC0709 – Matters arising – Annual CLIP update – Hazel Hardyman

HH reported on the aggregate analysis and learning report from complaints, incidents and claims. The purpose of the report is to demonstrate aggregate analysis and identification of common themes across patient safety, patient experience and claims. To ensure organisational learning is in place in response to these themes or to recommend actions to be taken. The reporting period was between 1st April 2014 to 31st March 2015.

Top themes:

1. Falls (Incidents)
2. Medication (Incidents)
3. Clinical Treatment (Complaints)
4. Attitude of staff (Complaints and Concerns)
5. Orthopaedics (Claims) – high numbers of Orthopaedic claims

Organisational learning from top themes: work in progress to**:**

- ☐ Learning from medication incidents
- ☐ Learning from fracture root cause analysis, where the fracture was sustained as a result of patient fall which is now part of the Patient Safety Programme.
- ☐ Appropriate escalation and management of staff behaviour

HH reported that Julie Austin and Fenella Hill were working closely to find gaps. LB queried the number of incidents not reported to which the response was 31. Most claims arose from Orthopaedics, work is being done to see how this can be reduced.

SL asked who the 'none' patients are to which HH responded that these would have been visitors or due to low staff levels etc.

The committee noted the report.

STRATEGY

CGC0710 – Core Service presentation – Diagnostic Imaging – Alison Montgomery, Kate Johnson

AM reported that a significant problem for the team lies with the recruitment and the retention of staff due to a national shortage in this area.

The achievements of the team include: -

- A multi-disciplinary approach to governance
- Service development – we have a second CT scanner
- A change in practice from barium enema to CT colonography
- A transformative GP walk-in service for plain film x-ray. External (GP's) and internal (MSK, Surgery, Medical) stakeholder workshops. Overall this service has been well received by GP's and patients.
- Tertiary support for services – for example, the Paediatric Hip Service. Key Performance Indicators are used to help monitor our performance.
- 'Growing our own' Sonographers through university and in-house training programmes; challenging recruitment processes and thinking differently which has led to recruitment of some foreign Radiographers – actively tackling the issue of a national shortage of Sonographers

The challenges faced by the team include: -

- Support for non-clinical time for Band 7 modality leads to develop and support their teams
- Moving forward with Imaging Services Accreditation Scheme without resources
- Balancing staffing levels against service needs – Radiographer shortages as well

as Sonographers
- Managing demand and capacity, particularly 'Be Clear on Cancer' campaigns
- Developing 7 day services in line with national and Trust requirements
- Maintaining Interventional Radiology Services. We have authority for locum cover if there is a gap

The aims of the team are :-

- To provide a service which is safe, effective, caring, responsive and well-led
- To live by the Trust's values and behaviours

PH stated that this was an important presentation as in recent years there had been concerns with this service. It now feels as if the leadership is better with a key 'can – do' attitude from the lead staff. It is a well managed service, well done.

CB commented that the leadership of the team had been understated in this presentation and report. The provision of 7 days / out of hours services is being recognised and presented nationally. We have an opportunity now to make a more robust service with regards to interventional radiology. It is essential to provide an interventional service from now on and the links with the Tertiary Centre will improve this.

PK asked if the report was showing the full list of KPI's and use of KPI's, to which AM responded that this was the full clinical list. Other lists are available. PK asked if we had received feedback from the patients and AM replied that quarterly feedback is given at DMT meetings.

PK asked what our targets are in respect of continued development as he felt that some are unclear ie TIA records – if 24 hours is our target, how is this being addressed? KJ responded that there are two targets – an image within 24 hours or 1 week depending on the patient.

CB stated that the KPI's are ongoing and developing and queried the DNA result for ultrasound. KJ replied that there are a huge number of requests from GP's but many patients do not then turn up. LB noted that we could try to improve the DNA's over time.

SL commented that this was an excellent presentation and report, and is very helpful with the sense that the department is being lead well

KJ stated that the demand for Radiology services has increased over the last 6 months and will continue to increase – we need to plan for this trend.

PH commented that we need good quality referrals from GPs and meetings need to take place with GP's to try to avoid DNA's.

JS noted that constituents have reported that the service is a good one, and very efficient.

LB thanked AM and KJ for their report and presentation and asked that they pass on the committee's thanks to the team.

CGC0711 – Hot Topic – Customer Care process – Hazel Hardyman (verbal update)

See item CGC0716 below.

CGC012 – Spinal Unit Leadership – Christine Blanshard, Denise Major (verbal update)

DM reported that the Spinal leadership and DMT team had a very successful away day which will be completed again with other staff.

CB stated that the meeting to discuss programme was taking place later that day, so the item was deferred until the next Clinical Governance Committee meeting. **CB**

CGC0713 – Nursing, Midwifery and AJP Strategy update

LW

This item was deferred until October 2015.

LW

CGC0714 – Nursing Revalidation

This item was deferred until September 2015

ASSURING A QUALITY PATIENT EXPERIENCE

CGC0715 – Friends and Family Test – Hazel Hardyman

HH reported on the results of the Friends and Family Test :-

Volume
A total of 17,230 people responded to FFT between December 2014 and May 2015. The main source of data collection is still via cards given to patients as they leave the hospital. 261 patients who were 16 years old or younger responded to FFT between April and May 2015. Plans are still in place to introduce iPads for children to complete FFT.

Targets
Target response rates were in place for inpatients, ED and maternity until 31 March 2015 but no targets have been set nationally for 2015/16(these may be re-instated for 2016/17). The target for inpatients and ED was achieved with the exception of ED in December 2014. The target for Maternity was not achieved in any month between December 2014 and March 2015. This fact was noted by the Commissioners who suggested that we may wish to contact the Royal United Hospital at Bath who have a maternity response rate of 60% to see if any lessons may be learnt. Staff from the Maternity Service are liaising with RUH.

Incentives
Cake was awarded to Laser OPD in December 2014 for consistently high returns. As there are currently no targets in place, the incentive scheme has been suspended.

SFT score
The average percentage of patients who would recommend a ward or department during the reporting period is as follows:-

Wards	95%
ED	94%
Maternity	98%
Outpatients	96%
Day Case	98%
Children and young people	94%

Negative Comments and Improvement Actions
Of the 17,230 people who completed FFT, only 74 (0.4%) gave negative comments. All comments are fed back to the relevant areas on a weekly basis and improvements are made where possible. Actions taken include:-

- a notice board in the Emergency Department showing results and other relevant information such as details of any breaches in waiting times which were shown to be an issue from the free-text comments;
- ward action plans for the national inpatient survey 2014 include any issues arising through FFT;
- Trust participation in a nationwide campaign called '#Hello my name is…' planed for September 2015;
- keeping patients informed of waiting times in outpatients.

THE NEXT STEPS

- Work will continue to improve and maintain response rates in all areas.
- iPads will be introduced for children to provide FFT feedback as soon as IT are able to implement this.

LB asked if we had considered using an automated telephone Friends and Family Test as in other places – we would have to ensure anonymity. This is not something currently offered at this hospital.

LB thanked HH for her report.

CGC0716 – Customer Care Report – Hazel Hardyman

HH reported to the committee that the Customer Care annual report focuses on the lessons learnt and changing practice as a result of comments, concerns, complaints, patient and public involvement (PPI), national patient surveys (NPS), real time feedback (RTF), the Friends and Family Test (FFT) and NHS Choices.

The report also complies with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, which requires each NHS Trust to produce regular reports about complaints received, including an annual report. It also fulfils the requirement of our commissioners.

The total number of complaints received for this year was 309, a decrease on 21 complaints in 2013-14. There were also 424 concerns, 221 comments, 777 general enquiries and 2827 compliments received.

HH stated that it will be difficult to pull information for Quarter 1 and Quarter 2 reports for the Health and Social Care Information Centre because Datix has not been updated.

We are aiming to lower costs in respect of interpreting by using telephone interpretation rather than face to face. With that in mind a lot of work has been done with Hospedia and the use of Skype as a way to move forward.

There were 30 PPI projects this year and we are encouraging people to come forward for service awards this year.

Real-time feedback is showing improvements.

We have delivered a lot of training in Customer Care – we will get feedback from this and make adjustments as necessary. The Customer Care team has been restructured and is performing well, we are back on track with dealing with complaints. "I" statements are taken into account in questions or complaints and we are strengthening the dip sampling process.

SL commented that the real-time feedback is showing overwhelming positive feedback in respect of staff but queried the negative result relating to respect and dignity. CB responded that it was very likely that this result was due to only negative comments being captured.

LB asked HH to expand on the Hot Topic element – the committee is seeking assurance that the Customer Care process is working. HH responded that we have now recruited in Customer Care and achieved 100% staffing. We try to respond before the 25 day target. LB asked if people are telephoned once a complaint has been received to which HH replied that if the complaint is not clear then we will, or if it is complex or following a bereavement. If the complaint is made by someone other than the patient then the patient is written to in order to gain their consent.

SL commented that the Helpdesk do a good job and this is not reflected in the report.

PH stated that 18 months ago the system was broken and now massive improvements have been made. There is still some way to go but the recruitment of staff has made improvements to the service.

LB thanked HH for her report.

ASSURING CLINICAL EFFECTIVENESS
CGC717 – Quality Indicator Report – Christine Blanshard, Claire Gorzanski

CB presented the report to the committee : -

- 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.

CB noted that we are below our trajectory for the year in respect of C Difficile. It was disappointing that we had a Grade 4 pressure ulcer, this was due to a non-compliant spinal patient. In some instances we are missing our 4 hour target for patients arriving on the stroke unit by minutes and we are trying to make improvements to pick those up. We are maintaining constant vigilance in the area of mixed sex sleeping arrangements and Action Plans are in place.

CB reported that the CCG have visited Whiteparish ward and we had quite positive results. We did, however, receive a warning letter – CGz noted that this was fairly apologetic as they could see all the efforts being made. DM reported that the CCG were very impressed with their visit to Radnor ward.

PK asked what happened if we cannot provide an escalation bed to which CB responded that we always provide an escalation bed. Our core capacity is very high, almost 100% - to avoid escalation beds we would need to run beds at about 92%. We have good data to predict bed demand and this is being worked on with LW. DM added that if we are veering towards escalation then an extra bed meeting is scheduled to deal with this.

The report was noted.

CGC718 – Major Issues Report – Christine Blanshard, Claire Gorzanski

CB reported to the committee about important clinical governance events affecting safety, effectiveness and the patient experience that have occurred since the end of March 2015 both within the Trust and externally. These were : -

1. NHSE published a Heatwave Plan.
2. NICE published guidelines for GPs on suspected cancer: recognition and referral.
3. The Government published its response to the consultation on updating the NHS Constitution.

4. NCEPOD 'Time to Get Control?' published a review of the care received by patients who had a severe GI haemorrhage.
5. The DH announces a review of the Human Embryology Fertilisation Authority (HEFA).
6. NHSE published a report Transforming Care for People with Learning Disabilities progress report.
7. NMC nurse revalidation is a new system which will come into effect on 1/4/16.
8. SFT presented an outline bid as a joint tender for adult community services with GWH and RUH to Wilts CCG.
9. SDH in top 100 health care organisations to work for second year.
10. SFT were named as one of the top hospitals in the country by national healthcare intelligence organisation, CHKS.
11. The CQC announce a planned inspection of the Trust from 1 to 4 December 2015.
12. New Carers Café to be launched on 16 July in Springs Restaurant.
13. Men who need treatment for an enlarged prostate can now have the latest laser surgery called Holmium Laser Resection of the Prostate (HoLEP)

CB stated that the NCEPOD report contained 26 recommendations, 4 of which were organisational recommendations.

LW will report soon regarding nurse revalidations, but this is work in progress. We are looking at how we will build into existing processes.

The CQC will take place from 1st – 4th December 2015.

The Carer's Café was a good event. CGz reported that this was collaborative with various agencies and will be taking place every 2 weeks - it is a great initiative.

The committee noted the report.

CGC0719 - New Procedures Report – Christine Blanshard, Claire Gorzanski

CB reported to the committee on the implementation of new procedures within SFT between July 2014 and June 2015.

The New Procedures policy is next due for review in May 2018.

<u>New Procedure Approved</u>
No new procedures were approved within the reporting period.

<u>Procedures under Development</u>
Two new procedure applications are being developed; one of which commenced prior to going through the new procedures process.

<u>Audits</u>
- Two procedures are currently being audited (balloon sinoplasty and fallopian tube cannulation). A third is complete and will be re-audited in August 2015 (hycosy).
- Six audits were outstanding from the previous reporting period:
    - one is part of a five-year research trial (anal fistula plug);
    - two are complete and compliant (cardiac rhythm and UAE);
    - one required an action plan which is now complete and a re-audit is being arranged (conscious sedation);
    - one has data being analysed (blue light cystoscopy);
    - one has been audited in Southampton and is now being audited locally (MRI arthrography).

<u>Other New Procedures</u>
Two procedures previously approved are currently 'on hold' due to operational issues (sentinel node biopsy and wireless capsule endoscopy). A third was 'on hold' but it is hoped to re-start the service shortly (sacral nerve stimulation).

<u>NICE Interventional Procedure Guidance (IPGs)</u>
There have been no IPGs published in this reporting period which need to go through the New Procedures process at this stage.

CB stated that the process for monitoring new procedures here is very good.

The committee noted the report.

ASSURING SAFETY

CGC0720 – Patient Safety Programme Progress Report – Katrina Glaister

KG reported to the committee as follows:-

Patient Safety Priorities:

Our aim is to reduce avoidable harm by 50% and to reduce our HSMR further by 10% by 2018; this will be achieved through the following workstreams:

Workstream One – Reducing Harm in Frailty

1a) Reducing falls resulting in injury
1b) Reducing harm from pressure ulcers
1c) Reducing harm from catheter associated urinary tract infections (CAUTIs)
1d) Transfers of care (Collaboration with Wessex Academic Health Science Network)
These are safety specific themes that have been identified through local safety data, global trigger tool reviews, safety thermometer, and incident data. Progress has already been seen in reducing our rates of pressure ulcers but we are committed to making further improvements in these areas as a common cause of harm.

Workstream Two – Deteriorating Patient

1a) Reducing harm from sepsis
1b) Reducing harm from acute kidney injury
These are disease specific themes that have been identified through local safety data as well as national reviews. Our global trigger adverse events, mortality reviews, serious incidents/clinical reviews and clinical audits indicate that these are areas for safety improvement.

Workstream Three – Perioperative Safety

This is a cross cutting theme identified through our historical claims data where intraoperative/surgical problems (which is a wide range of issues) is our highest volume of claims category. The underlying issues are varied and so as a cross cutting theme we have identified a broad project to address the culture as well as practice within surgery from end to end.

Workstream Four – Maternity Safety

This is a safety specific theme, identified through our serious incident and adverse event data. Learning from these events has indicated a need to improve CTG interpretation as well as recognition of growth issues in the unborn. Although we haven't had a strong history of claims in this area we believe that there is potential for future cases and this is a priority area for safety improvement.

KG stated that we had completed a second learning event with Wessex Academic Health Services network on the previous day.

LB asked when we would receive results to which KG responded that it would be quarterly in terms of data.

SL asked how our efforts were being communicated to which KG responded that we have a new public facing website, an internal website and we are able to tweet.

GC0721 – Assurance framework – Fenella Hill

FH reported that The Assurance Framework has undergone review and significant change / update by the Board since it was last presented to the assuring committees.

New Risks Identified for Inclusion onto Assurance Framework

3912 – Failure to reduce HCAI rates to minimum level.

3913 – Failure to achieve single sex compliance in ITU and AMU

3939 – Risk of patients slipping and falling whilst in our care and sustaining harm

Newly Identified Gaps in Control / Assurance

Risk 2.1 (Compliance with infection prevention practice and policy)

- **Gap in control**: Variability in practice and evidence of learning across clinical areas
- **Remedial action**: Observational rounds in place across all directorates and led by DSN's

Risk 2.2 (Failure to comply with internal and external expectations on quality of care)

- **Gap in control**: Reliable assessment and application of preventative measures for patients who are at risk of falls, particularly those becoming more mobile and 'medically fit' for discharge
  Remedial action: Renewed focus on falls as part of Safety Programme with linked KPIs
  - Compliance with intentional rounding
  - Review of falls risk assessment
  - Review of physiotherapist terminology

- **Gap in control**: Proactive management of single sex within a capacity challenged environment such as AMU
  Remedial action: Daily review by COO/DoN with clinical teams to 'unblock' downstream capacity issues
  - Visit and review other hospitals who have worked on this challenge in AMU
  - Exploration of longer term plan to meet AMU capacity requirements

- **Gap in control**: Variation in perioperative practices regarding briefings and stop moment
  Remedial action: Review of perioperative safety and gain assurance around embedding recommendations from never event reports

Newly Identified Positive Assurances

Risk 2.1 (Compliance with infection prevention practice and policy)

- 6 monthly DIPC report to Board (June 2015)
- Early investigation and ribotyping showing so far that the majority of Q4 cases were unlinked cases in place and time

Risk Register – Newly Identified Risks

3869 - Stereo machine used to take mammogram guided biopsies and place wires within the breast under mammogram guidance broken (patients required to travel to Southampton on morning of surgery)

3914 - Recruitment of substantive nursing staff

3912 - Failure to reduce HCAI rates to minimum level

3913 - Failure to achieve single sex compliance in ITU and AMU

3937 - Balancing financial risks with those relating to quality

3939 - Risk of patient's slipping and falling whilst in our care and sustaining harm

3977 - DAU closure at weekends with paediatrics

PK stated that there was an execution risk, and we need to look at strategic risk. He asked if this would come back before the Committee or the Board to which PH and FHi confirmed it would be before the Board.

LB and PK both expressed a wish to discuss some items which are transitioning from high to lower after the meeting. FHi noted that there was a need to show how we are doing this and our actions.

The committee noted the report.

CGC0722 – SII/CR Report Q1 – Fenella Hill

Fenella Hill reported on The Serious Incident Inquiry/Clinical Review Outstanding Actions Compliance Report which provides progress on actions taken on recommendations.

EXECUTIVE SUMMARY

Updates to outstanding recommendations:

- SII 148
- SII 150
- SII 151
- SII 152
- SII 155
- SII 157
- SII 161
- SII 164
- SII 165

Reviews with outstanding recommendations:

- SII 161

New Recommendations since May 2015 CGC

- SII 157
- SII 158
- SII 161
- SII 164
- SII 165

Serious Incident Inquiry/Clinical Review for Closure

- SII 148
- SII 150
- SII 151
- SII 152
- SII 155
- SII 157
- SII 164
- SII 165

- NHSLA – Investigation, analysis and Improvement
- CQC – Outcome 16

LB commented that she was encouraged by the number of completed items.

The report was noted.

CGC0723 –Safeguarding Children – Denise Major

Denise Major reported that here has been an audit regarding our DNA policy. Template letters are available for follow-ups. The numbers of people needing level 3 training will increase. The Education department has been involved in respect of MLE and reports, and who has Safeguarding levels 1, 2 and 3 in their learning tree. Managers need to be responsible for ensuring that their staff obtain the correct level of training.

There were no serious incidents for Quarter 1. Quarter 4 has been signed off.
Jane Murray has been looking at training staff regarding supervision when working with children and also at safer recruitment processes.

The annual report to be heard at a future CGC meeting.

CGC0724 – Safeguarding Adults – Denise Major

DM updated the committee on the Safeguarding Adults, MCA and DoLS agenda.

Included in the Q1 report is information around referrals, activity & themes in relation to the Adult Safeguarding/ MCA/ DoLS agenda, which continues to be a Trust priority. We have a very ambitious Safeguarding Adult Schedule, especially training requirements.

The Care Act came into force in April, and creates a legal framework for key organisations and individuals with responsibilities for adult safeguarding and replaces ‘No Secrets’ (2000).

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. The Education Department are still working to find a solution. Training has been provided for Managers to help them identify the correct role specific training their teams require.

PK asked how we are pursuing missing assessments to which DM responded that they are followed up by Gill Cobham, Jo Jones and Becky Benson. They are escalated and documented.

DM stated that training at appropriate levels is a big issue. In the next 3 months there will be huge numbers undertaking the training process. SL asked if we are content that training is addressing any issues or challenges to which DM responded that Karen Littlewood will be joining us soon in her position as Deputy Director of Nursing, she will have lots of experience in this area.

With regard to the Jimmy Savile investigation, GC has spoken with all original witnesses and we will action anything necessary following the results.

CGC0725 – Learning disabilities work plans 14/15 – Katrina Glaister
This report was noted.

PAPERS FOR NOTING

CGC0726	Clinical Management Board meeting minutes (June 2015)	Noted
CGC0727	Clinical Risk Group meeting minutes (May 2015)	Noted
CGC0728	Infection Prevention & Control meeting minutes (April 2015)	Noted
CGC0729	Children & Young People's Quality and Safety Board meeting (March 2015)	Noted
CGC0730	CQC Inspection Steering Group meeting minutes (June 2015)	Noted

CGC0731 - ANY OTHER BUSINESS

The proposed dates for the CGC meetings in 2016 were agreed.

NEXT MEETING
2015 dates will be Thursdays, 10am-12pm in the Boardroom - 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 20 July 2015

Governors Present:	Nick Marsden (Chairman) Colette Martindale Alastair Lack (Lead Governor) Chris Horwood Shaun Fountain Mary Monnington Raymond Jack James Denny John Noeken Lucinda Herklots Pearl James John Parker Paul Straughair Jan Sanders Sharan White Ross Britton Michael Mounde Lynn Taylor Beth Robertson Jenny Lisle	**Apologies:**	Jonathan Wright Rob Polkinghorne Christine White

In Attendance:
Peter Hill (Chief Executive)
Malcolm Cassells (Director of Finance and Procurement)
Denise Major (Acting Deputy Director of Nursing)
David Seabrooke (Head of Corporate Governance)
Isabel Cardoso (Membership Manager)
Patrick Butler (Communications Manager)
Lydia Brown (Non-Executive Director)
Ian Downie (Non-Executive Director)
Paul Kemp (Non-Executive Director)
Jon Brown (KPMG)
John Oldroyd (KPMG)
Alison Kingscott (Director of Human Recourses and Organisation Development)

ACTION

1. INTRODUCTION AND WELCOME

The Chairman gave a special welcome to the governors elected on 1 June 2015.

2. MINUTES 18 MAY 2015

The minutes of the meeting of the Council of Governors held on 18 May were accepted as a correct record.

3. MATTER ARISING – ELECTRONIC PATIENT RECORD

The Council received a briefing note providing an update on progress with the procurement of an Electronic Patient Record system. It was

noted that the outline business case was due to be considered by the Trust Board at its meeting on 3 August. It was emphasised that this was not an IT project but a major service delivery change project.

The Chairman summarised the benefits of an electronic system capturing a range of patient information on their journey through the hospital. Implementation, if the full business case was approved would take two years to complete.

The Council of Governors noted the report.

4. CUSTOMER CARE REPORT – QUARTER 4

The Council received the Quarter 4 Customer Care Report and the Chairman welcomed Denise Major who summarised the main points in the report;

- Clinical treatment, attitudes and difficulties with appointments continued to be the main themes.
- There had been six re-opened complaints in the quarter and the Director of Nursing was viewing the individual files for any learning points that may arise.

It was noted that complainants were required to exhaust the local complaints procedure before raising their points with the Parliamentary and Health Service Ombudsman. In Quarter 4 the Ombudsman had rejected one such complaint and partially upheld one and did not uphold another. Complaints where clinical negligence was considered to be a factor were additionally reviewed by the Head of Litigation. In practice most complainants stated that they were taking legal advice were applicable.

With regard to infection control and cleanliness there had been four attributed C-Diff cases in Quarter 1 and no MRSAs or MSSA cases the Trust's deep clean programme for ward areas was continuing.

The Council noted the Quarter 4 Complaints Report.

5. TRUST PERFORMANCE – MONTH 3

The Council received the Month 3 Performance Report for Governors. The Chief Executive reminded the Council that the Board of Directors monitored over 100 indicators of quality and performance on a monthly basis. All the targets highlighted in the report had been met in June. There continued to be a healthy rate of friends and family tests inpatient questionnaires returned and a good rate of recommendation as a place to receive treatment.

The Council noted the Performance Report.

6. FINANCE AND CONTRACTING REPORT TO 31 MAY

The Council received the Finance and Contracting Report and Malcolm Cassells highlighted the following principal points;

The first two months of the year had resulted in a deficit of £1.8m in relation to an annual deficit target of £6m. The rate of loss had in June reduced to £0.5m. This earlier performance was due to the delivery of the Cost Improvement Programme and agency costs relating to nurses,

doctors and other staff categories. He highlighted the recent visit by the Lord Carter Team looking at hospital efficiencies which had broad terms had found the Trust to be a well-run and efficient organisation. The Trust continued to work to ensure there was capacity available for elective patients at busy times. Work around savings targets was continuing. Heads of agreements with the main contractors had been signed at this stage.

In relation to a question from Raymond Jack it was noted that the Trust had in June closed a number of escalation beds and had been able to reduce the excess workforce. Agency staffing requests were the exception following the implementation of stricter controls on authorisation. However it was planned that the Trust would probably need escalation capacity for Quarter 4.

MC added that Trusts needed to approach ward staffing levels based on local risk assessment and return on investment.

In relation to seven day working the Trust was working on a plan to implement low cost interventions at a greater range of times of the week. Anything approaching universal implementation of seven day working would result in a percentage increase in costs. The Trust continued to work to repatriate activity from the private sector.

The Finance and Contracting Report was noted.

7. COMMUNITY SERVICES UPDATE

The Council received a note setting out progress with the bidding process for the Adult Community Services contract. The contract for the whole of Wiltshire was worth around £38m per year and was expected to last five years and was due to start in July 2016. Work was underway on due diligence and the expectation is that the combined bid would be submitted by mid-October.

The Council of Governors noted the report.

8. REPORT BY EXTERNAL AUDIT

The Chairman welcomed representatives of KPMG the Trust's appointed auditors to the meeting and the Council received the Independent Auditor's Report to the Council of Governors on the Quality Report, the 2014/15; External Assurance Aannual Quality Report, the Independent Auditors Report to the Council of Governors relating to the Annual Report and Accounts and the ISA 260 Audit Highlights Memorandum.

It was noted that KPMG had given a clean (unqualified) opinion on the Trust's financial statements, on use of resources and on the content of the Quality Account. A very good first draft of accounts was available for audit when due, new remuneration requirements were met in full and new policies put in place in good time, a range of other annual reporting requirements had been met and there had been good scrutiny and challenge at the Audit Committee.

In relation to the performance indicators included in the Quality Report a "limited assurance" review of information supporting the management of 62 day cancer waits and referral to treatment (incomplete) had been undertaken. Through the process of agreeing data to evidence no

opinion had been provided in relation to these two indicators.

This had been discussed in full by the Audit Committee. There were concerns about the methodology and sampling used and the consistency of approaches adopted by auditors nationally.

The Audit Committee had discussed the issues with the Executive and actions were underway to improve training and compliance with the rules governing these performance indicators.

The Council received the reports of the external auditors.

9. VOLUNTARY SERVICES

The Council received a copy of the Voluntary Services Department Annual Report, previously considered at the Trust Board. It was noted that there were over 700 volunteers overseen by the Voluntary Services Manager and an assistant. Volunteers were engaged in a wide range of activities and a key aim was to improve the volunteer's experience of the Trust. Uniforms were being introduced for new governors and more training and buddying was being introduced. Volunteer gardeners were being considered. Pearl James had been elected as the Volunteer's Governor and was working with volunteers to further develop and promote the role. Although volunteers could not provide care to patients the role of "sitting services" to support patients with dementia was being considered.

The Council noted the report.

10. STAFF SICKNESS

Alison Kingscott gave a presentation on the management of sickness and highlighted the Trust's below average sickness rates. Targets for different departments varied slightly. There was review by the HR team of sickness trends and the issue was monitored by an internal Health and Wellbeing Board.

A range of initiatives to reduce stress related absences had been started and measures to improve the physical health of the workforce were also being taken.

11. GOVERNORS DUTIES – ROLES AND RESPONSIBILITIES

The Council received for adoption an updated statement required under the Code of Governance setting out the roles and responsibilities of the Council of Governors.

The statement was approved.

12. COMMITTEES AND TRUST LED GROUPS

The Council of Governors received a schedule of committees of the Council of Governors and of governor representation on a range of internal working groups. It was noted that the committees of the Council reflected its key functions such as promoting membership, appointing and appraising the Non-Executive Directors and being consulted on the Trust's strategic developments. All of the Committees were advisory and the composition and membership were locally determined.

Over recent years governors had taken a special interest in a number of internal issues and had by negotiation with the Trust joined a number of internal working groups to represent the public's interest in the issue and to keep the Council of Governors informed of developments.

In both cases governors had been asked to state their preferences for the committees and working groups they would be interested in serving on having regard to the total time commitment. The document had been discussed extensively and with minor amendments the composition of the committees and representation on internal working groups was approved.

13. DATES OF COUNCIL OF GOVERNORS MEETING IN 2015

The Council noted the meetings of the Trust Board, informal meetings, Medicine for Members development sessions and the 23 November Council of Governors meeting.

SFT 3706

Trust Board meeting
Risk Management Annual Report

Date: 5th October 2015

Report from: Fenella Hill, Head of Risk Management Presented by: Lorna Wilkinson

Executive Summary:

The Risk Management Annual Report focuses on the progress that has been made against the strategic goals as set out in the Risk Management Strategy (2014), the lessons that have been learnt as a result of incident reviews undertaken, changes within the risk (particularly incident reporting) processes over the 2014/15 year and ongoing progress against agreed key performance indicators.

The report also confirms that accountability and responsibility arrangements are in place within the organisation and monitored on a regular basis and compliance is maintained with national standards and requirements including CQC regulations, NHS England Patient Safety Alerts and reporting to the National Reporting and Learning System.

The report concludes with the future developments that will be driven forward in 2015/16 to ensure the implementation of the Risk Management Strategy.

Proposed Action:

The Committee members are asked to note the achievements within the Annual Report and Annual Risk Management Plan

Links to Assurance Framework/ Strategic Plan:

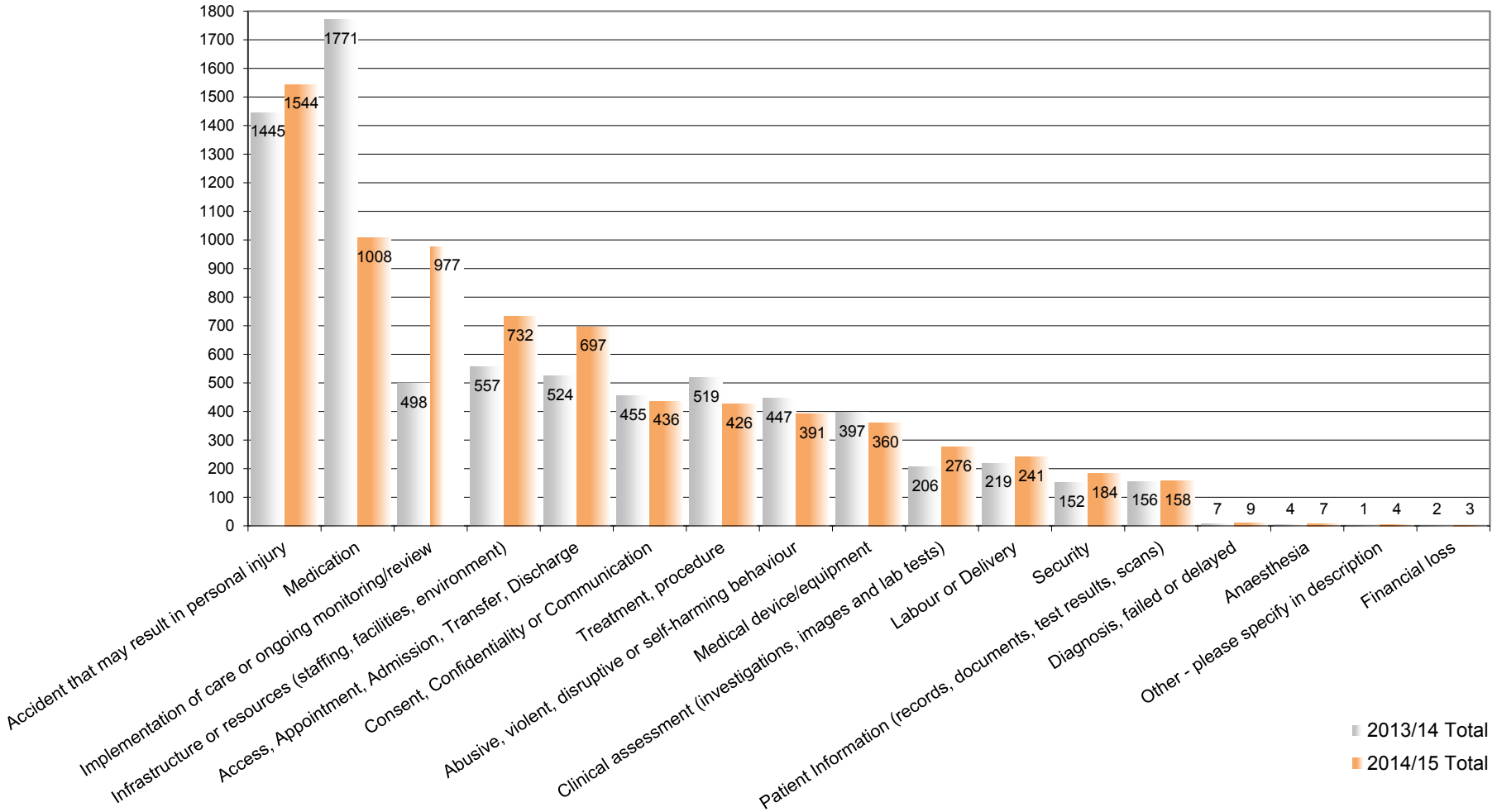
Care - We will treat our patients with care, kindness and compassion and keep them safe from avoidable harm
Choice - To be the hospital of choice, we will provide a comprehensive range of high quality local services enhanced by our specialist centres
BAF – 1.3 and 2.2

Appendices: None

Risk Management Report Card

Reported Period: 1st April 2013 to 31st March 2014

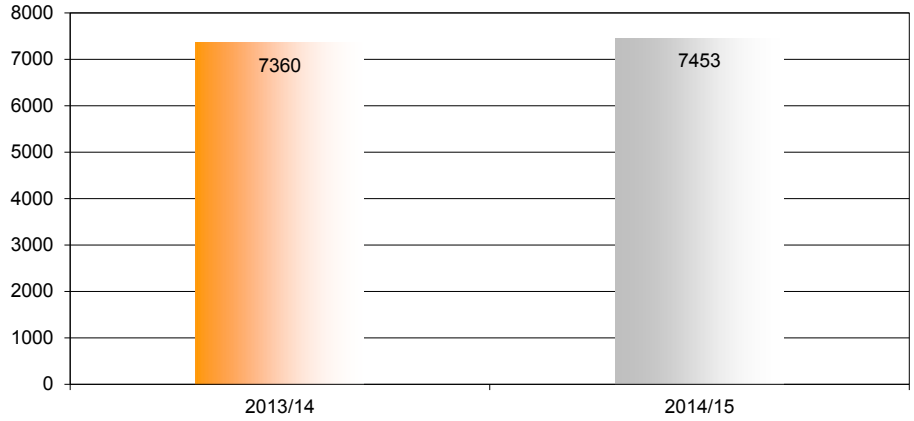
Incidents reported by Stage of Care



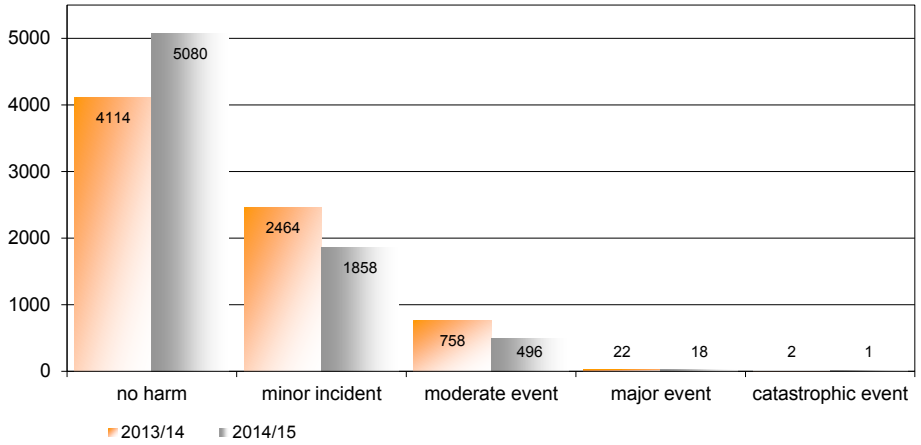
Risk Management Report Card

Reported Period: 1st April 2013 to 31st March 2014

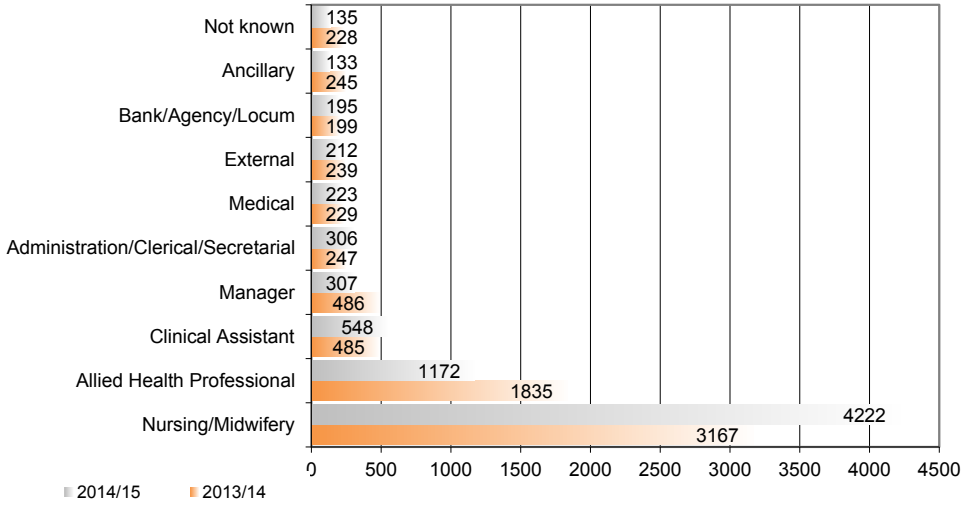
Total Incidents Reported



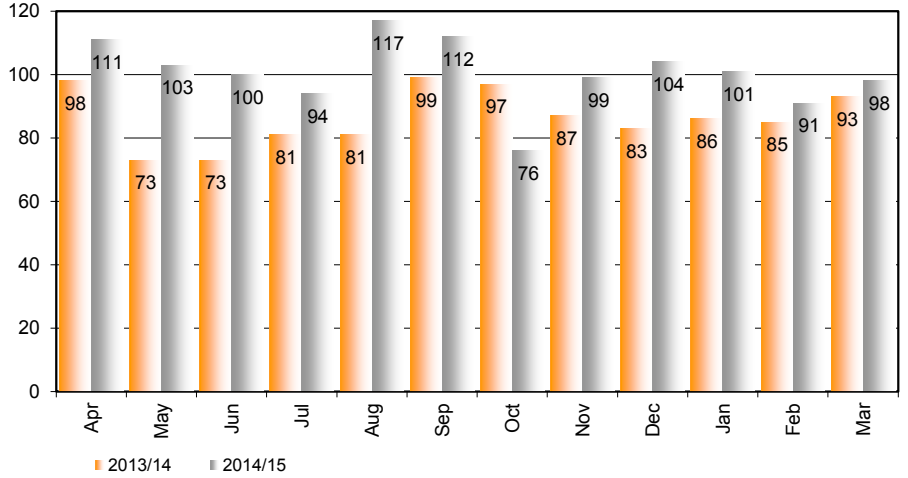
Incidents Reported by Severity



Staff Types reporting incidents



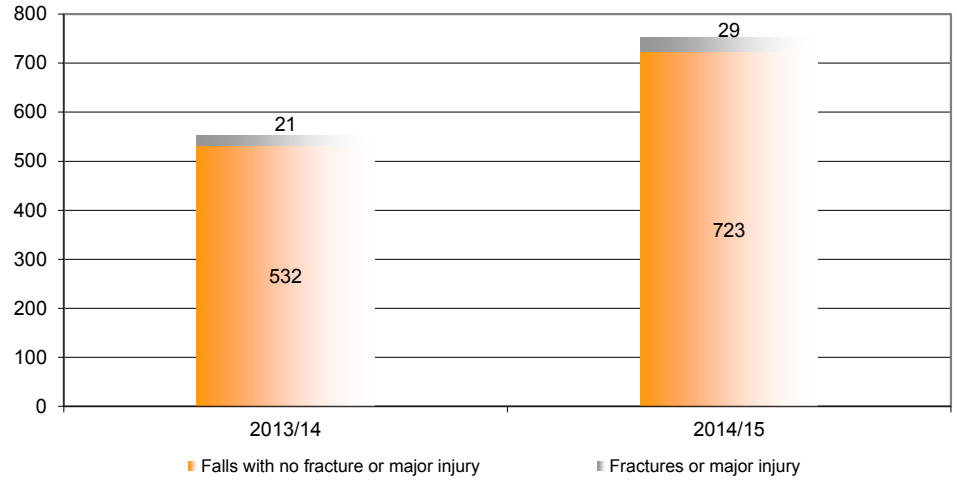
Slips, Trips, Falls and Collisions



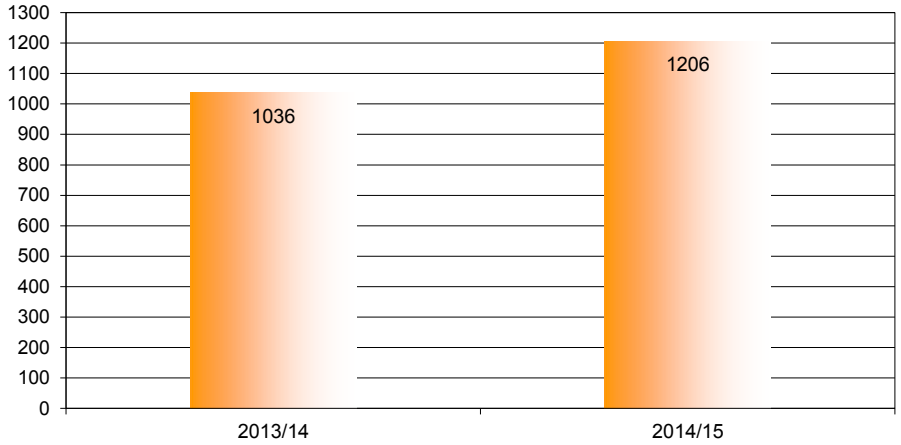
Risk Management Report Card

Reported Period: 1st April 2013 to 31st March 2014

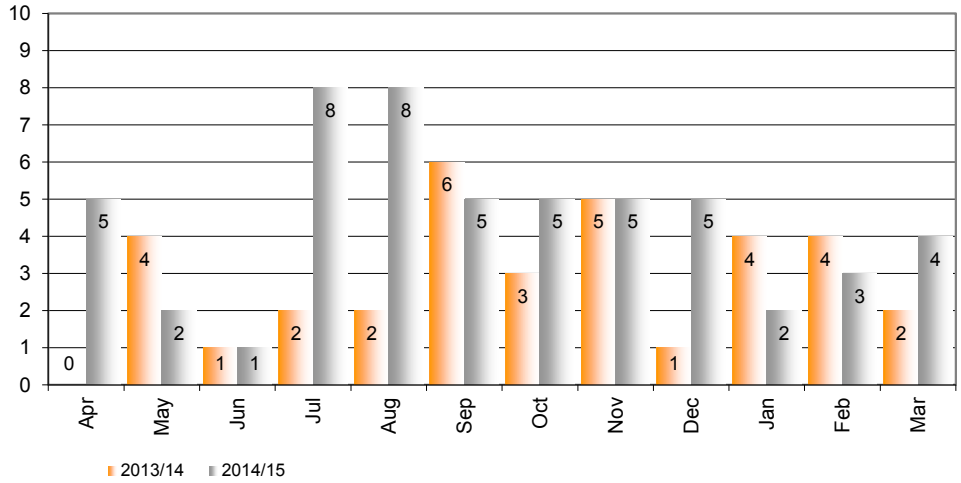
Falls resulting in Fractures or major injury



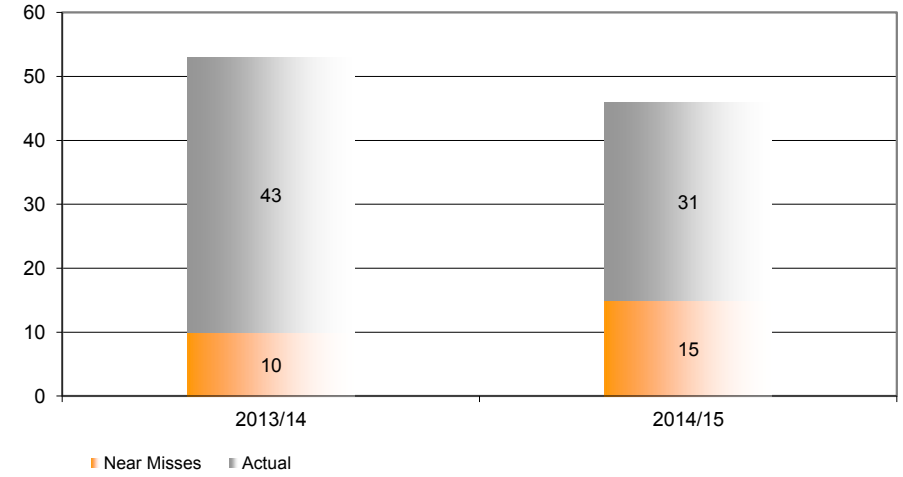
Slips, Trips, Falls and Collisions Total



Needlestick Injuries (includes near misses)



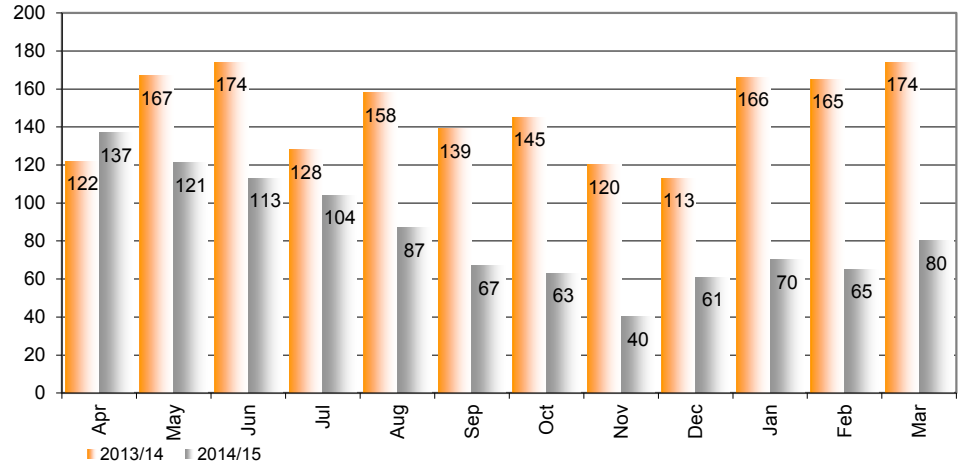
Needlestick Injuries Total (includes near misses)



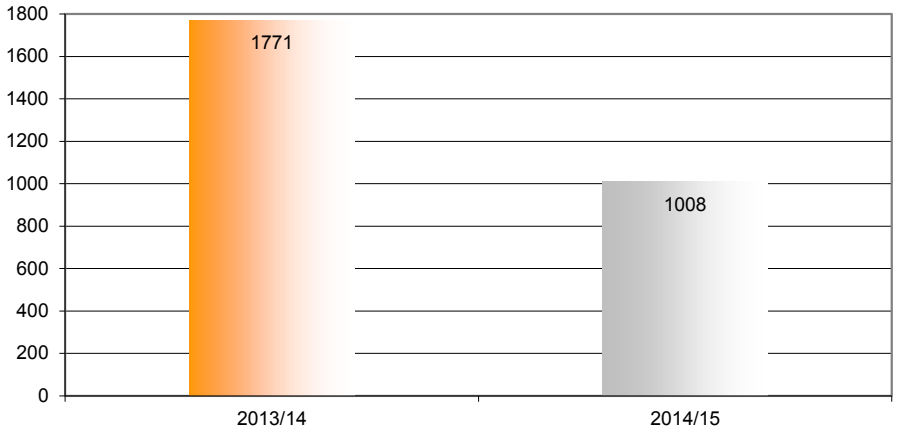
Risk Management Report Card

Reported Period: 1st April 2013 to 31st March 2014

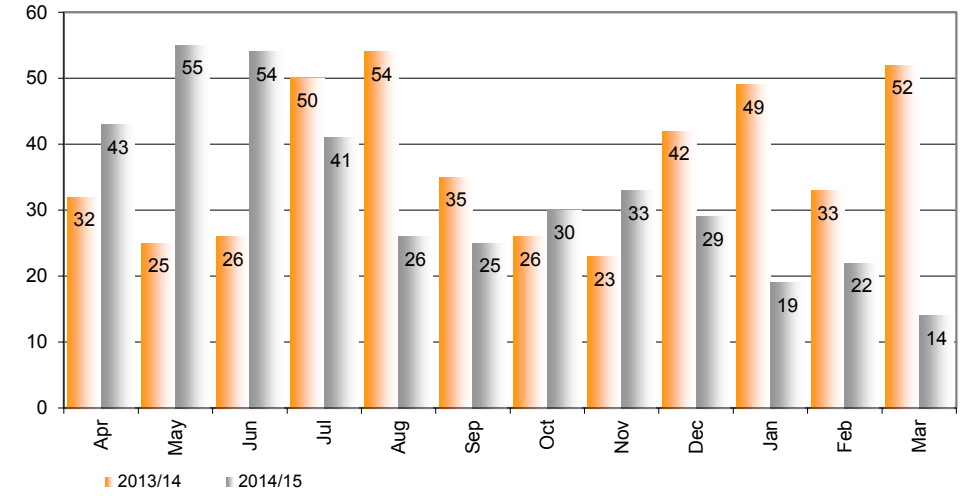
Medication Errors



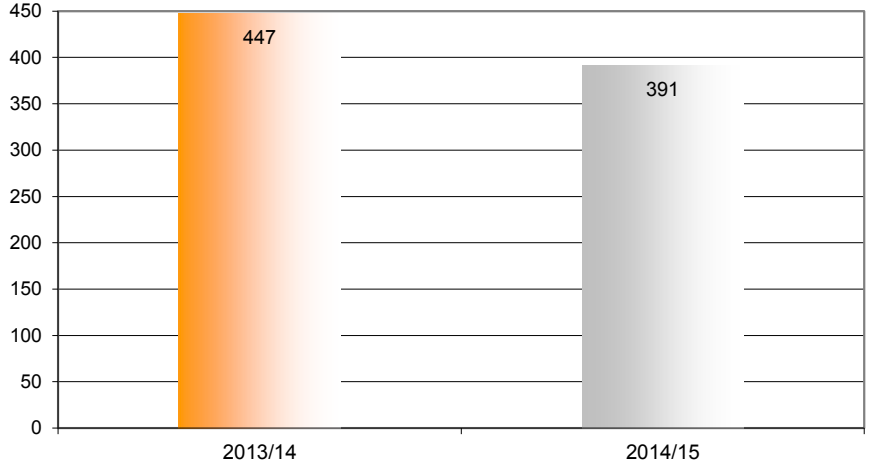
Medication Errors Total



Verbal/Physical Violence



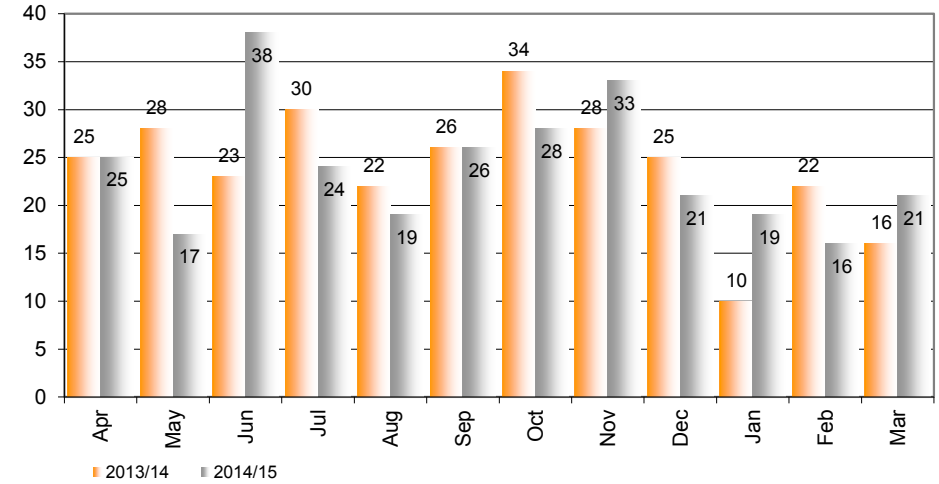
Verbal/Physical Violence Total



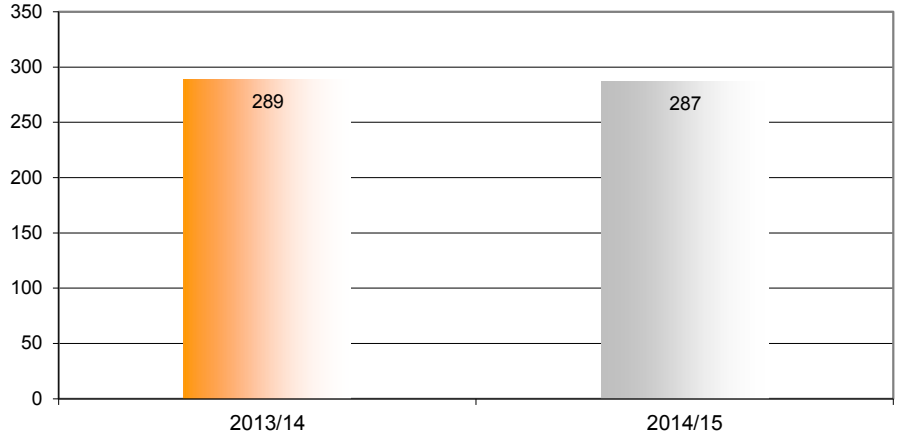
Risk Management Report Card

Reported Period: 1st April 2013 to 31st March 2014

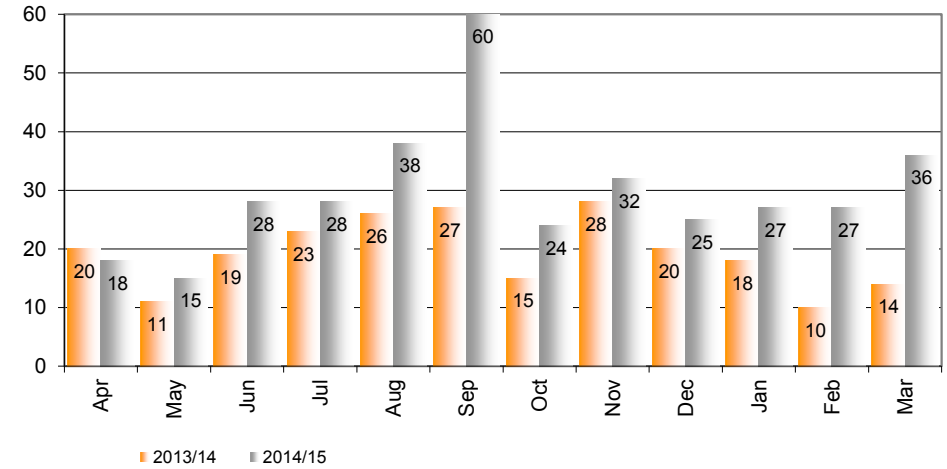
Communication



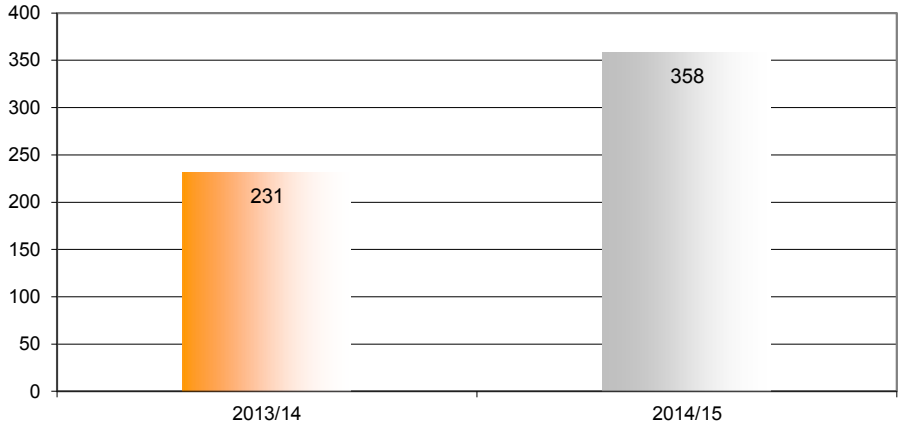
Communication Total



Staffing



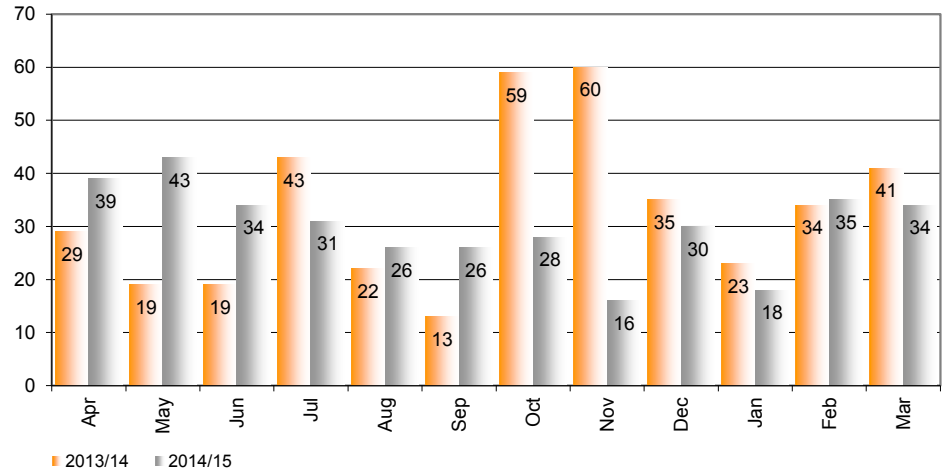
Staffing Total



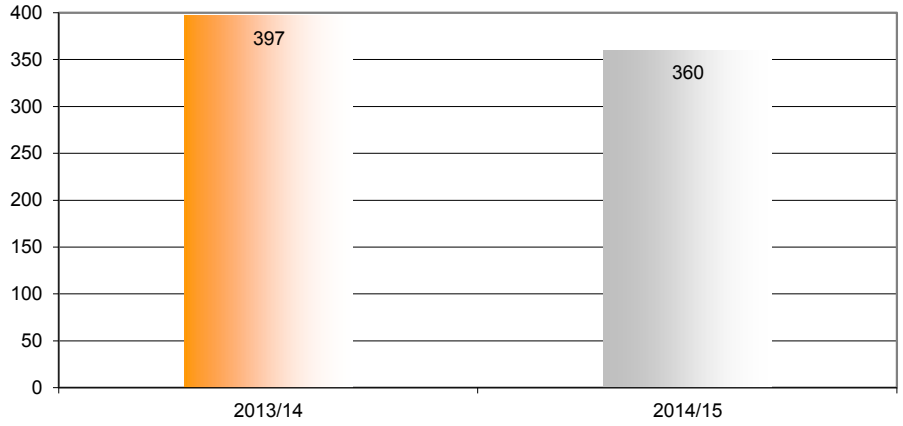
Risk Management Report Card

Reported Period: 1st April 2013 to 31st March 2014

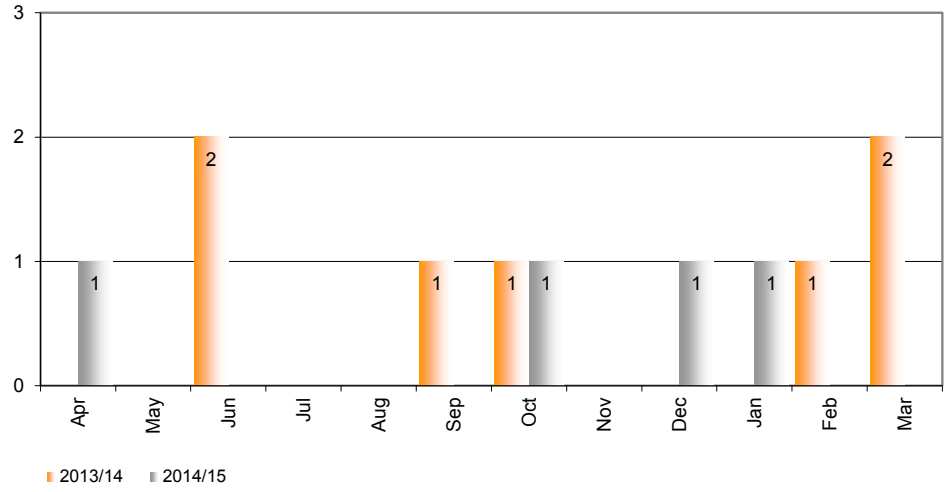
Equipment



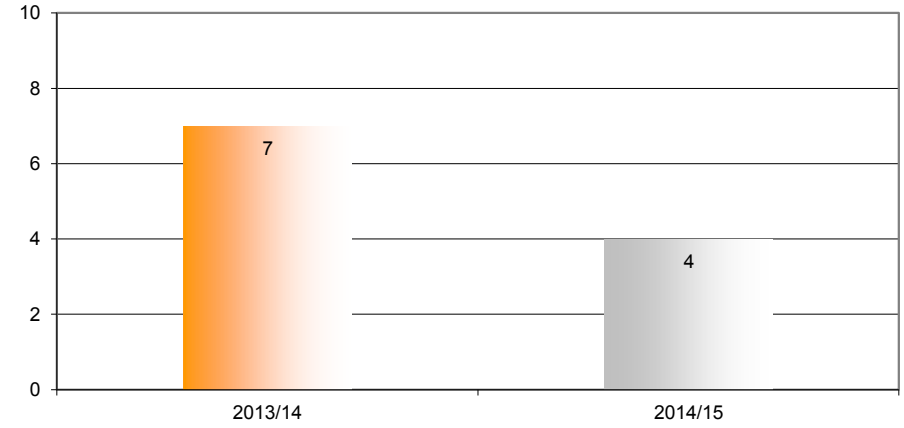
Equipment Total



Hospital Acquired Grade III/IV Pressure Ulcers



Hospital Acquired Grade III/IV Pressure Ulcers Total



SFT 3707

Trust Board meeting
Risk Management Strategy 2015

Date: 5th October 2015

Report from: Fenella Hill, Head of Risk Management Presented by: Lorna Wilkinson

Executive Summary:

The Risk Management Strategy sets out the strategic direction for Risk Management. It provides a framework for the Trust, specifying the direction of travel with clear objectives, responsibilities and monitoring mechanisms.

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place which will assure the Trust

Board that as a Foundation Trust it is discharging its responsibilities as set out by the Department of Health and Monitor.

The Risk Management Strategy has been updated to reflect the ongoing promotion of a fair and open culture, participation in patient safety initiatives and the requirement for a robust and dynamic risk register.

The Strategic Objectives and Key Performance Indicators (KPIs) have been updated for 2014/5 and include:

- Embedding risk management at all levels of the organisation – creating a safety culture.
- Theming of incidents to highlight trends and areas requiring further investigation/action.
- Leading and supporting staff and promoting reporting
- Ensuring there is appropriate provision of training
- Ensuring compliance with 'Duty of Candour' requirements.

The following KPI's are also in place:

- Achieve an overall Monitor financial risk rating of 3 or above;
- Maintain full registration with the Care Quality Commission;
- To be above average reporters of incidents when benchmarked against Trusts of a similar size (NRLS Report);
- Participation in the 'Sign up to Safety' campaign and patient safety collaborative;
- 100% completion of a full root cause analysis for all fractures, resulting in moderate or greater harm, following a fall, ensuring themes and actions fed into the Trust action plan for falls;
- Evidence of a decreasing trend in grade 3 and 4 pressure ulcers acquired during hospital admission;
- Maintain a culture where staff feel risk management processes are fair and

responsive, evidenced through the annual Staff Survey;

- Ongoing participation in the Safety Thermometer to allow monitoring of our work in reducing patient harm;
- Compliance with contractual requirements associated with the reporting and management of SI's;
- Cascade and Timely response to NHS England Patient Safety Alerts.

Proposed Action:

The Trust Board is asked to consider and approve the revised Risk Management Strategy 2015/6.

Links to Assurance Framework/ Strategic Plan:

Care - We will treat our patients with care, kindness and compassion and keep them safe from avoidable harm
Choice - To be the hospital of choice, we will provide a comprehensive range of high quality local services enhanced by our specialist centres
BAF – 1.3 and 2.2

Appendices: Risk Management Strategy 2015/16

Salisbury NHS
NHS Foundation Trust

Risk Management Strategy

Directorate Responsible for Strategy:	Quality Directorate
Name of responsible board/committee:	Trust Board
Post Holder Responsible for Strategy:	Head of Risk Management
Contact Details:	Risk Management 01722 336262 x2496
Date Written:	September 2006
Approved and Ratified by:	Trust Board
Date ratified:	October 2015
Date Strategy Becomes Live:	October 2015
Next Due for Review:	October 2016

VERSION INFORMATION

Version No.	Updated By	Updated On	Description of Changes
1.0	Lorna Wilkinson	September 2006	• New Policy
2.0	Lorna Wilkinson	September 2007	Minor amendments: • Section 9.2 Executive roles • Section 9.5 Departmental Managers/Clinical Lead roles
2.1	Lorna Wilkinson	September 2008	Minor amendments: • Section 3 Reference to OD Strategy in Strategic Goals • Section 3 Strengthen links with project risks as part of Strategic Goals • Section 9.3 additional responsibility to report risk information to commissioners as per contract
2.2	Lorna Wilkinson	September 2009	Minor amendments: • KPIs, Section 7, p9 – added CQC registration requirements • p.15 - increased monitoring requirements added as per NHSLA standards • Appendix B – Committee structure updated
2.3	Denise Heming	September 2010	Minor amendments • Updated change to Head of Risk • KPIs, section 7, p9 and p10– added new KPIs for pressure ulcers and VTE compliance • Head of Risk Management, section 9.3, p12 – amended role in attending Clinical Quality Review Group • Updated terms of reference for the Assurance Committees, Appendix A, pages 16-20 • Change of name for Maternity labour Forum to Maternity Governance Forum, Appendix B, p21

Version No.	Updated By	Updated On	Description of Changes
2.4	Denise Major	September 2011	• Section 1 updated reference to DoH,11/12 Operating Framework. DoH,'Liberating the NHS', 2010. • Monitor, Compliance Framework 2011. • The National Quality Board: Maintaining and improving quality during the transition: safety, effectiveness, experience. 2011. • KPIs, section 7, p9 and 10 • Updated Head of Risk working with CEO and Head of Clinical Effectiveness, section 11.2, p14 • Updated terms of reference for the Assurance Committees, Appendix A, p16-24 • Updated references, p26
2.5	Fenella Hill	September 2012	Section 1, p5 updated reference to DoH 12/13 Operating Framework 'Liberating the NHS' (November 2011) and Monitor Compliance Framework 12/13 (March 2012). Section 4, p8 Statement of Internal Control changed to Annual Governance Statement. Section 7, p10 KPIs updated
2.6	Fenella Hill	September 2013	Section 1, p5 updated NHS Outcomes Framework 2013/14. Monitor Compliance Framework. P6 updated Monitor requirements and licensing. Section 7, p10 updated KPI's
2.7	Fenella Hill	September 2014	Section 1, p5 Re-written Section 2, p6 Re-written Section 3, p6 new addition All other sections amended and updated.
2.8	Fenella Hill	October 2015	Addition of Section 3, p6 Responsibility for Risk Management Section 9, p9 Re-written to reflect strategic objectives for 2015/16 Appendix E, p22 updated. All sections minor updates to reflect correct processes.

Table of Contents

Salisbury NHS Foundation Trust

Risk Management Strategy

1) Introduction

1.1 An understanding of the risks that face NHS Trusts is crucial to the delivery of healthcare services moving forward. The business of healthcare is by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing Salisbury NHS Foundation Trust (SFT) Board with assurance on the framework for clinical quality and corporate governance.

1.2 The stated vision for Salisbury NHS Foundation Trust is to provide and outstanding experience for every patient, delivering health care services to the local community and those referred from further afield into specialist services. To ensure that the care provided at SFT is safe, effective, caring and responsive for patients, the board must be founded on and supported by a strong governance structure.

1.3 SFT is committed to developing and implementing a risk management strategy that will identify, analyse, evaluate and control the risks that threaten the delivery of its critical success factors. The board assurance framework (BAF) will be used by the Assuring Committees and Board to identify, monitor and evaluate risks to the achievement of the strategic objectives. It will be used alongside other key management tools, such as performance and quality dashboards, and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

1.4 The management of risk underpins the achievement of the Trust's objectives. SFT believes that effective risk management is imperative to not only provide a safe environment and improved quality of care for service users and staff, it is also significant in the financial and business planning process where a successful and competitive edge and public accountability in delivering health services is required. This illustrates that risk management is the responsibility of all staff.

1.5 The risk management process involves the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the Trust and individuals reduce the incidence and impacts of risks that they face. Risk management is therefore a fundamental part of both the operational and strategic thinking of every part of the service delivery within the organisation. This includes clinical, non clinical, corporate, business and financial risks.

1.6 The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. The risk management strategy represents a developing and improving approach to risk management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective performance management and accountability for organisational learning in order to continuously improve the quality of services.

1.7 The Trust Board recognises that complete risk control and/or avoidance is impossible, but the risks can be minimised by making sound judgments from a range of fully identified options and having a common understanding at Board level on risk appetite.

1.8 As part of the Annual Governance Statement, SFT will make a public declaration of compliance against meeting risk management standards. The Trust currently has

good systems and process for risk management in place as evidenced by internal and external audit opinion.

1.9 The strategy is subject to annual review and approval by the Trust Board.

2) Purpose of the Risk Management Strategy

2.1 The purpose of the Risk Management Strategy is to detail the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, Monitor Terms of Authorisation, key regulatory requirements such as Care Quality Commission, and its strategic objectives. The risk management strategy underpins the Trust's performance and reputation, and is fully endorsed by the Trust Board.

3) Responsibility for Risk Management

The success of the risk management programme is dependent on the defined and demonstrated support and leadership offered by the Trust Board as a whole.

However, the day-to-day management of risk is the responsibility of everyone in our organisation at every level, and the identification and management of risks requires the active engagement and involvement of staff at all levels. Our staff are best placed to understand the risks relevant to their areas of work and must be enabled to manage these risks, within a structured risk management framework.

4) Promoting a Fair and Open Culture

4.1 All members of staff have an important role to play in identifying, assessing and managing risk. To support staff the Trust provides a fair, open and consistent environment which does not seek to apportion blame. In turn, this will encourage a culture and willingness to be open and honest to report any situation where things have, or could go wrong. Exceptional cases may arise where this is clear evidence of wilful or gross neglect contravening the Trust's policies and procedures and/or gross breaches of professional codes of conduct which will be managed and referred accordingly.

5) Strategic Goals

5.1 To ensure that the Trust remains within its licensing authorisation as defined by Monitor and to deliver a risk management framework which highlights to the Executive Team and Trust Board any risks which may prevent the Trust from complying with its provider licence.

5.2 Continued development of the Assurance Framework as the vehicle for informing the Annual Governance Statement.

5.3 To ensure that Risk Management policies are implemented ensuring that:

- All risks, including principal risks, service development risks, and project risks, are being identified through a comprehensive and informed Risk Register and risk assessment process.
- The open reporting of adverse events is encouraged and learning is shared throughout the organisation

5.4 To monitor the effectiveness of Risk Management Policies and procedures via the monitoring of agreed Key Performance Indicators.

5.5 To further develop the organisational safety culture and its effectiveness through implementation of Sign up to Safety and Patient Safety Collaborative interventions.

5.6 To develop an Annual Risk Management Plan.

5.7 To ensure that all individuals within the organisation are aware of their role, responsibilities and accountability with regard to Risk Management.

5.8 To ensure that the structure and process for managing risk across the organisation is reviewed and monitored annually.

5.9 To ensure compliance with Monitor, Care Quality Commission registration requirements, and Health and Safety Standards.

6) Compliance and Assurance

6.1 Monitor has a very clear compliance framework which ensures that all NHSFTs are able to demonstrate that they are remaining within their agreed provider licence. It is therefore imperative that the Trust is aware of any risks (e.g. associated with new business or service changes) which may impact on its ability to adhere to this framework.

6.2 The Assurance Framework provides the Trust Board with a vehicle for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being met to satisfy internal and external requirements. In turn it will inform the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. This allows the organisation to respond rapidly.

6.3 All NHS bodies are required to sign a full Annual Governance Statement (AGS) and must have the evidence to support this Statement. The Assurance Framework brings together this evidence.

6.4 In order to identify the risks against delivery of principal objectives and gaps in control/assurance the Trust Board must have a comprehensive Performance Management Reporting framework. The Trust Board must agree its own indicators for Performance Reports which will act as assurance on service delivery and quality. Any significant gaps in assurance or control within the Performance reports must be identified, translated onto the Assurance Framework and remedial action agreed.

6.5 The whole Assurance Framework is reviewed bi-annually by the Trust Board. The Framework identifies the principal risks facing the Trust and informs the Trust Board how each of these risks is being managed and monitored effectively. Each principal risk has an identified local risk manager, normally an Executive Director, who is responsible for managing and reporting on the overall risk. An Assurance Committee is also identified for each principal risk to assure the Trust Board that it is being monitored, gaps in controls identified, and processes put into to place to minimise the risk to the organisation.

6.6 The designated Assurance Committees of the Trust Board are the Clinical Governance Committee (Clinical Risk), the Finance Committee (Financial Risk), and the Joint Board of Directors (Organisational Risk including workforce, Health and Safety, IT) (Appendix A). The Audit Committee monitors the Assurance Framework process overall on an annual basis.

6.7 It is the responsibility of the Assurance Committees to report to the Trust Board, on a quarterly basis any new risks identified, gaps in assurance/control, as well as

positive assurance on an exception basis. If a significant risk to the Trust's service delivery or gap in control/assurance is identified then this should be reported immediately via the Executive Directors (see Appendix D).

6.8 It is important for the Trust Board to be able to evaluate the quality and robustness of the Assurance Framework and to have arrangements in place to keep it updated in light of evidence from reviews and actual achievements. For consistency, the Head of Risk Management attends the Assurance Committees quarterly to review and update the Assurance Framework along with the high level Risk Register consisting of those risks scoring 12 and above. The Trust Board and Audit Committee formally review the Assurance Framework biannually.

6.9 The Head of Risk Management shall continue to work closely with the Executive Lead for Risk, Deputy Director of Finance, Director of Corporate Development and Head of Corporate Governance to ensure that the document remains dynamic and is integral to the Business Planning cycle.

6.10 If at any time performance reporting and risk management processes indicate that the Trust will not meet a current or future regulatory requirement/target then the Board must notify Monitor via an Exception Report.

7) The Trust Risk Register

7.1 Each Department will continue to carry out Risk Assessments which feed into the Directorate Risk Registers. A single framework for the assessment, rating, and management of risk is to be used throughout the Trust; this process is described in detail within the Risk Management Policy and Procedure (intranet).

7.2 Each Directorate will continue to maintain a comprehensive risk register, which will be formally reviewed at four monthly intervals through the Directorate Performance Meetings. At these meetings the directorates will be expected to report on their risk register (risks scoring 12 or above), highlight any new or emerging risks to service delivery and present action plans for minimising and managing these risks. The performance meeting should identify those departmental risks which also pose a corporate threat and so require inclusion on the Trust Risk Register. The risk register should be seen as a dynamic process as ranking/prioritisation of risks will change as risk reduction practices take place. The DMT has responsibility for ensuring that all risks within the Directorate are appropriately graded and have sufficient actions in plan to mitigate/reduce the risk.

7.3 The departmental and directorate risks identified at the performance meetings which impact on the corporate objectives are combined with the corporate risks on the Trust Risk Register, thus allowing for a bottom up top down approach to identifying the Trust's principal risks and informing the Assurance Framework. This proactive approach to risk management should be holistic and identify all risks to the organisation, including clinical, organisational, health and safety, business, marketing and financial.

7.4 The Assurance Committees shall receive their extract of the Risk Register quarterly along with the Assurance framework. The Trust Risk Register extract will contain risks scoring 12 and above.

7.5 The Assurance Committees must exception report any new risk scoring 15 or above to the Trust Board for monitoring or action.

8) Risk Management Policy

8.1 Risk assessments carried out across the Trust must utilise the format as set out in the Risk Management Policy and Procedure (available on the intranet). This process for submission and review must be adhered to.

8.2 This strategy should also be read in conjunction with the following Risk Management Policies which are all available on the intranet:

- Risk Management Policy and Procedure
- Adverse Events Reporting Policy
- Serious Incidents Requiring Investigation Policy
- Duty of Candour and Being Open Policy

9) Strategic Objectives 2015/16

9.1 To monitor the effectiveness of the Risk Management processes and policies the following a strategic objectives have been set and will be monitored via the Clinical Risk Group, Directorate performance meetings and Assurance Committees.

- Embedding risk management at all levels of the organisation – creating a safety culture
    - Greater ownership of risks at a local level
    - Enhance the use of risk registers at Departmental and Directorate level.
    - Ensuring the transfer of all risks to a centrally held database – Datixweb
    - Evidence that dynamic risk registers are held within all departments covering key risks
    - Ensuring a transparent system for aggregation and escalation between departmental and DMT risk registers with the Corporate Risk Register and Assurance Framework.
    - Undertake review of Datix functionality with view to enhance reporting of risk, analysis of reporting trends and culture.

- Theming of incidents to highlight trends and areas requiring further investigation/action
    - Monthly theming of incidents at Clinical Risk Group.
    - Feedback themes to Departments/Directorate for further action and learning.
    - Support Departments and Directorates in recording themes and change as evidence of learning and action.
    - Linking with complaints and Litigation team to look at broader themes and learning.

- Leading and supporting staff and promoting reporting
    - Ensure all staff are aware of their responsibility for reporting incidents through relaunch of the updated adverse Events Reporting Policy.
    - Utilise both formal and informal opportunities with staff for teaching.
    - Participation in local meetings, M&M meetings, Clinical Governance Sessions.
    - Monitor reporting patterns to identify areas/groups of staff who may not be reporting and investigate whether reporting patterns are reflective of risk activity.

- Ensuring there is appropriate provision of training
    - Review existing in-house training provision in relation to risk management to identify gaps in training provision.
    - Review current availability of training opportunities both internal and external

- Evaluation of Board risk management session
- Delivery of Department/Directorate specific training to enhance the use of Datix functionality.

- Ensuring compliance with 'Duty of Candour' requirements
  - Ensure all staff are aware of their responsibilities through cascade of the Duty of Candour and Being Open Policy.
  - Appropriate and responsive training as required in liaison with the Head of Litigation.
  - Review of all incidents to ensure that graded appropriately
  - Where Duty of Candour triggered monitor that correct notification and follow up procedures are completed and recorded.

The following KPI's are also in place:

- Achieve an overall Monitor financial risk rating of 3 or above;
- Maintain full registration with the Care Quality Commission;
- To be above average reporters of incidents when benchmarked against Trusts of a similar size (NRLS Report);
- Participation in the 'Sign up to Safety' campaign and patient safety collaborative;
- 100% completion of a full root cause analysis for all fractures, resulting in moderate or greater harm, following a fall, ensuring themes and actions fed into the Trust action plan for falls;
- Evidence of a decreasing trend in grade 3 and 4 pressure ulcers acquired during hospital admission;
- Maintain a culture where staff feel risk management processes are fair and responsive, evidenced through the annual Staff Survey;
- Ongoing participation in the Safety Thermometer to allow monitoring of our work in reducing patient harm;
- Compliance with contractual requirements associated with the reporting and management of SI's;
- Cascade and Timely response to NHS England Patient Safety Alerts.

10) The Annual Risk Management Plan

10.1 The Annual Risk Management Plan will be developed by the Head of Risk Management.

10.2 The Annual Plan will include objectives to address key risk issues in order to ensure continuity and progression in the Trust's strategic direction for risk management. This includes issues relating to business, financial, clinical and non-clinical risks.

11) Accountability and Responsibility Arrangements

11.1 The Chief Executive

The Chief Executive is the Accountable Officer and has overall responsibility for Risk Management. The Chief Executive has delegated this responsibility to an Executive Lead for Risk (Director of Nursing). The Executive Lead for Risk is responsible for reporting to the Trust Board on the development and progress of Risk Management, and for ensuring that the Risk Management Strategy is implemented and evaluated effectively.

11.2 Executive and Non Executive Directors

The Executive and Non Executive Directors have a collective responsibility as a Trust Board to ensure that the Risk Management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives.

The Executive and Non Executive Directors are responsible for ensuring that they are adequately equipped with the knowledge and skills to fulfil this role. Risk Management training sessions can be accessed via the Risk Department but as a minimum the Risk Manager and Executive Lead for Risk will co-ordinate an annual workshop and update for the Trust Board members.

The Executive Directors are accountable and responsible for ensuring that the Corporate Directorates are implementing the Risk Management Strategy and related policies. They also have specific responsibility for managing the Trust's principal risks, which relate to their Directorates. For example:

- The Director of Finance for managing the Trust's principal risks relating to ensuring financial balance,
- Director of Nursing for managing the principal risks relating to risk and infection control as DIPC.
- Director of HR is responsible for managing the Trust's principal risks relating to Health and Safety and Workforce planning.
- The Medical Director is responsible for managing risks associated with Medical Workforce planning.

These designated Directors sit on the appropriate Assurance Committees which cover their area of risk.

The Non-Executive Directors have a responsibility to scrutinise and, where necessary, challenge the robustness of systems and processes in place for the management of risk.

11.3 Head of Risk Management

The Head of Risk Management is responsible for:

- Maintaining and updating appropriate and compliant Risk Management Policies and procedures;
- Co-ordinating and updating the Assurance Framework as well as presenting the document at the Assurance Committees;
- Ensuring the Trust has a comprehensive and dynamic Risk Register and working with Directorate Management Teams to ensure that they understand their accountability and responsibilities for managing risks in their areas;
- For ensuring information is provided on incident data to Directorate Management Teams, the Clinical Governance Committee, and Trust Board;
- Ensuring risk reports are available for the Clinical Quality Review Meeting (CQRM) in line with contract requirements;
- Producing and coordinating Risk Management training programmes in conjunction with the Patient Safety Facilitator
- Collaborating with external stakeholders' key to Risk Management e.g. Commissioners, links with CQC and other Trusts.
- Being a point of contact for patients and families during the review process.

11.4 Specialist Areas

The Facilities Director has delegated responsibility for ensuring that safe systems of work are in place for the management of catering, transport, decontamination, security, and waste management risks.

11.5 Directorate Management Teams

Directorate Management Teams are accountable and have authority to ensure appropriate risk management processes are implemented within their respective directorates and areas of authority. Each member of the DMT should be aware of their clear lines of accountability for risk. Each Directorate Management Team is required to:

- Work proactively to achieve the Trusts Key Performance Indicators for Risk Management.
- Understand and implement the Risk Management Strategy and related policies.
- Ensure that appropriate and effective risk management processes are in place within their delegated areas.
- Ensure Directorate activity is compliant with national risk management standards and safe practices, alerts etc.
- Develop specific objectives within their service plans which reflect their own risk profile and the management of risk.
- Risk assesses all business plans/service developments including changes to service delivery.
- Ensure that risk assessments, both clinical and non-clinical, are undertaken throughout their areas of responsibility. The risks identified will be prioritised and action plans formulated. These action plans will be monitored through the performance meetings.
- Maintain a directorate risk register (clinical, non-clinical and financial). Formally reporting high and extreme risks via the performance meetings.
- Report all incidents, including near misses, in accordance with the Adverse Events Reporting Policy and identify action taken to reduce or eliminate further incidents.
- Undertake investigation into all serious incidents, in accordance with the Adverse Event Reporting policy providing evidence of local resolution and learning.
- Disseminate learning and recommendations made as a result of incident investigations, clinical reviews, and serious incident inquiries within their areas of responsibility, ensuring recommendation outcomes are fed back to the Head of Risk Management.
- Monitor and report on the implementation and progress of any recommendations made which fall within their area of responsibility i.e. within the Directorate
- Ensure that all staff are made aware of risks within their working environment and their personal responsibilities within the risk management framework.
- Identify own training needs to fulfil the function of managing risk as a senior manager. As a minimum 'Risk' updates will be provided via the Directorate performance meetings. Further training can be accessed via the Risk Department

11.6 Departmental Managers/ Clinical Leads

Departmental Managers/Clinical Leads are accountable and have authority for the following:

- Ensuring that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility as per this Strategy and related Risk Management Policies.
- Adverse Events are reported and investigated thoroughly
- Disseminating learning and implementing recommendations made as a result of incident investigations, clinical reviews, and serious incident inquiries within their area of responsibility.
- Monitor and report on the implementation and progress of any recommendations made which fall directly within their area of responsibility i.e. within the Department.
- Maintaining a dynamic departmental risk register
- Ensuring that where high or extreme risks are identified these are brought to the attention of the Directorate Management Team for inclusion onto the Risk Register.
- Ensuring that all staff are made aware of these risks within their work environment and area aware of their individual responsibilities.
- Ensuring that all staff have appropriate information, instruction, and training to enable them to work safely.
- Ensuring that all new staff attend Trust Induction, receive a departmental induction and are released for mandatory training.

11.7 All Staff

All Staff are required to:

- Be conversant with the Risk Management Strategy and have a working knowledge of all related risk polices.
- Comply with Trust policies, procedures and guidelines to protect the health, safety, and welfare of any individuals affected by Trust activity
- Acknowledge that risk management is integral to their working practice within the Trust.
- Report all incidents and near misses in accordance with the Adverse Events Reporting Policy and take action to reduce or eliminate further incidents.
- Report any risk issues to their line manager
- Participate in the investigation of any adverse events as requested.
- Attend mandatory training appropriate to role.

12) Organisational Arrangements and Risk Management Structure

12.1 A diagram illustrating the committee structure is given in Appendix B. A summary of the Assurance Committee's terms of reference can be found in Appendix A.

12.2 The Risk Management Team supports and co-ordinates risk management activity; the Risk Management Team structure is detailed in Appendix C.

13) Ensuring Compliance with National Standards

13.1 The Risk Team is responsible for facilitating and ensuring compliance with core risk standards. The Risk Management Annual Plan identifies how compliance will be assured and its progress monitored by the Clinical Governance Committee.

13.2 The Head of Risk Management works in collaboration with the Head of Clinical Effectiveness and the Chief Executive's Offices to ensure compliance with the Care Quality Commission outcomes, and formulates and monitors action plans pertinent to risk

13.3 The Head of Risk Management works in collaboration with the Health and Safety Committee to ensure compliance with Health and Safety Standards

14) Monitoring and Review

This strategy shall be reviewed annually by the Trust Board.
The organisational risk management structure shall be reviewed annually at the Trust Board risk workshop
The Head of Risk shall monitor that the process for managing risk locally is being complied with as per this Strategy and the Risk Management Policy and Procedure, this shall be reported at the Directorate performance meetings and within the annual report.
The overall implementation of this strategy shall be monitored through the annual internal audit review.

APPENDIX A

The Trust's Assurance Committees

The Trust Board has three Assurance Committees comprising the Finance Committee, the Clinical Governance Committee, and the Joint Board of Directors. Each of these committees has terms of reference, which have been agreed by the Trust Board. The terms of reference can be found in the Trust Standing Orders and Standing Financial Instructions, which are available on the Intranet. The following provides a summary of the purpose of each of these committees and illustrates how risk management is monitored, and the Assurance Framework tested, to ensure that the organisation's principal risks are being minimised or resolved. The Audit Committee oversees the Assurance Framework process in its entirety.

The Audit Committee

The Audit Committee provides the Trust Board with a means of independent and objective review of financial and operational systems and compliance with law, guidance, and codes of conduct.

The Committee undertakes a number of duties, which are clearly described in their terms of reference. They include the following:

a) Review the Internal Audit Strategy and Plan ensuring sufficient time is being allocated to verify that suitable and effective systems for Risk Management and controls assurance are in place.

b) Review the relevant elements of the Assurance Framework and the Risk Registers on a half yearly basis.

c) Receive a report at each meeting from the Chief Internal Auditor on audit reports completed and management's response. Unless there are significant issues this will not normally include full copies of audit reports, but these will be available to any member on request.

d) Agree the annual work plan for the Local Counter Fraud Specialist (LCFS) and receive a progress report at each meeting.

e) Review the annual report of the Chief Internal Auditor and ensure the content satisfies the requirements of the Trust's Annual Governance Statement signed annually by the Chief Executive as the Trust's Accountable Officer.

f) Discuss the external audit plan with the External Auditor before the audit commences and the extent of the reliance to be placed on internal audit.

g) Discuss with the External Auditor problems and reservations arising from work undertaken and any matters the External Auditor may wish to raise (in the absence of the Chairman of the Trust other Non-Executive and Executive Directors should be approached as the Committee deems necessary).

h) Review the External Auditor's annual management letter and the Trust's response.

i) Support the Governors with the appointment of the External Auditor

j) Review the annual financial statements before submission to the Trust Board, focusing in particular on:

- Any changes in accounting policies and practices
- Major judgmental areas
- Significant adjustments arising from the audit
- The going concern basis
- Compliance with accounting standards
- Compliance with NHS guidelines and limits

k) Consider the contents of any report issued by the External Auditor and review management's proposed response, before presentation to the Trust Board for agreement.

l) Consider the contents of any report involving the Trust issued by the Public Accounts Committee or the Comptroller and Auditor General and review management's proposed response before presentation to the Trust Board for agreement.

m) Review the scope of internal control arrangements while recognising that the responsibility for such control remains an Executive duty.

n) Review proposed changes to the Standing Orders and the Standing Financial Instructions.

o) Examine the circumstances associated with each occasion when Standing Orders are formally waived.

p) Review the schedules of losses and compensations and make recommendations to the Trust Board as necessary.

q) Review accounting policies.

r) Monitor the policies for ensuring compliance with relevant regulatory, legal and Code of Conduct requirements.

s) Refer all appropriate matters to other sub-committees of the Trust Board.

The Finance Committee

The overall purpose of the committee is to provide assurance to the Board that key financial issues have had adequate scrutiny.

Committee will examine all financial issues as requested by the Board and in particular will routinely:

a) Agree detailed revenue and capital financial plans, budgets, income generation programmes and financial monitoring reports.
b) Monitor the financial performances of the Trust against the detailed plans taking such remedial action as considered necessary.
c) Approve the Quarterly returns to the Independent Regulator of Foundation Trusts known as Monitor.
d) Approve any other financial information prior to submission to any other accountable authority.
e) Approve the development of financial reporting in line with the NHS Foundation Trust Financial Regime including key ratio reporting.
f) Oversee the development and implementation of the financial information systems strategy.

g) Act as an Assurance Committee of the Trust's business and finance risks via the Assurance Framework and Risk Registers which will be presented to the Committee quarterly.
h) Consider any new financial initiatives/formation of companies to assist with the business development of the Trust and, where appropriate, make recommendations to the Trust Board.
i) Review any financial activity which impact on the financial performance or reputation of the Trust.
j) Take any legal or other professional advice with regard to the financial performance of the Trust as necessary.

The Clinical Governance Committee

The Committee has the power to act on behalf of the Trust Board. Its purpose is to assure the Trust Board and the Chief Executive that high quality care is provided throughout the Trust.

The key objectives are to ensure the Trust delivers and drives the key principles of quality it should assure safe, clinically effective, patient centred care, identifying where improvements may be required. This includes:

To have overview responsibility for the following outcomes as described by the Care Quality Commission

- Outcome 1 – respecting and involving people who use the services
- Outcome 7 – safeguarding people who use the services from abuse

Patient Safety:

- Agree the annual safety plan and monitor progress

- Ensure risks to patients are minimised through application of a comprehensive risk management system. Including:
  - To identify areas of significant risk, set priorities and place actions using the Assurance Framework
  - To maintain and monitor the Trust's Risk Management Policy

- To assure that there are processes in place that safeguard children and adults within the Trust.

Clinical Effectiveness / Clinical Outcomes:

- Agree the annual quality plan and monitor progress

- Ensure that care is based on evidence of best practice/ national guidance

- Assure that procedures stipulated by professional regulators of chartered practice (i.e. GMC and NMC) are in place and performed to a satisfactory standard

- Assure the implementation of all new procedures and technologies according to Trust policies

- Monitor the development of quality indicators throughout the Trust and assure the quality accounts for teams and the Trust meet the requirement of commissioners and other external regulators.

- Identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties

- Ensure the research program and governance framework is implemented and monitored

Patient Experience:

- Agree the annual patient experience plan and monitor progress

- Assure that the Trust has reliable, real time, up to date information about what it is like being a patient experiencing care in this hospital, to identify areas for improvement and ensure that these improvements are made. This will be provided through a comprehensive patient experience framework .

Learning From Others:

- Ensure the Trust is outward looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery

The Joint Board of Directors

The overall purpose of JBD is to provide a decision making forum for key issues discussed and developed by the Clinical Management Board, Drugs and Therapeutic Committee, Education and Workforce Development Strategic Committee, Health Records Committee, Health and Safety Committee, Medical Appointments Committee, Medical Devices Committee and Operational Management Board

The Joint Board of Directors undertakes a number of duties, which are clearly described in their terms of reference. They include the following:

a) To allow the Chief Executive, supported by the Executive Directors and Clinical Directors, to set the strategic direction both for the Trust and the Trust's involvement in the wider health economy.

b) Each year to approve the financial, operational and quality plans for the Trust and establish the priorities that will lead to the delivery of these plans ahead of sign-off by the Trust Board.

c) To provide a decision making forum for key issues discussed and developed by the Clinical Management Board, Drugs and Therapeutic Committee, Education and Workforce Development Strategic Committee, Health Records Committee, Health and Safety Committee, Medical Appointments Committee, Medical Devices Committee and the Operational Management Board.

d) On behalf of the Trust Board to monitor and review the principal risks and accompanying action plans of the Assurance Framework with specific reference to Estates, Facilities, Human Resources, Operational Management, Information Management and Technology, Business Planning and External Stakeholders. The Assurance Framework is to be reviewed quarterly with these minutes made available to the Trust Board for reporting purposes.

e) To agree policy and procedural change as required.

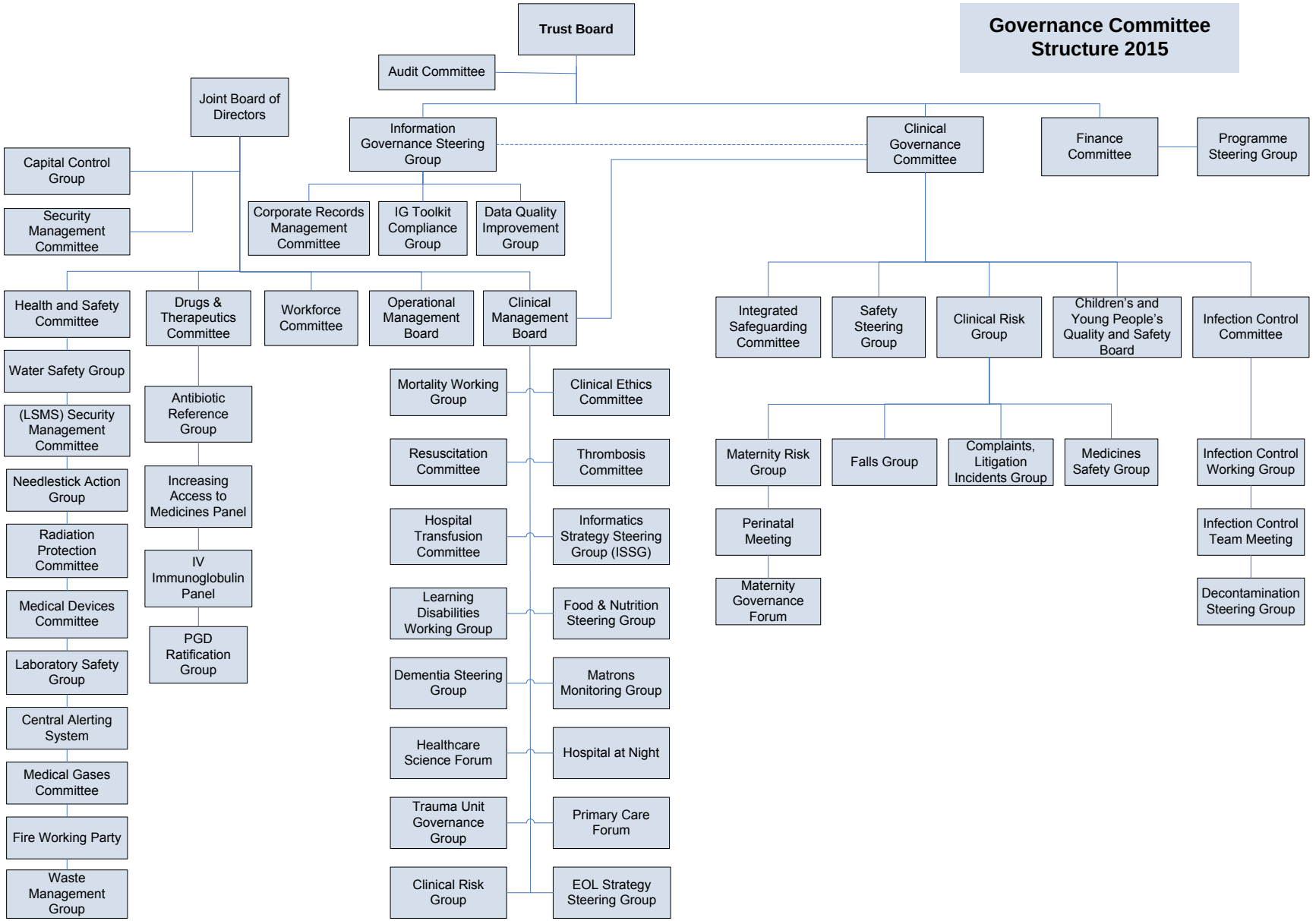
f) To review financial, clinical or operational performance as required.

g) To provide a decision making forum for future service development, including discussion and agreement ahead of establishing all new Consultant positions.

h) To sign off all 'new clinical procedures'.

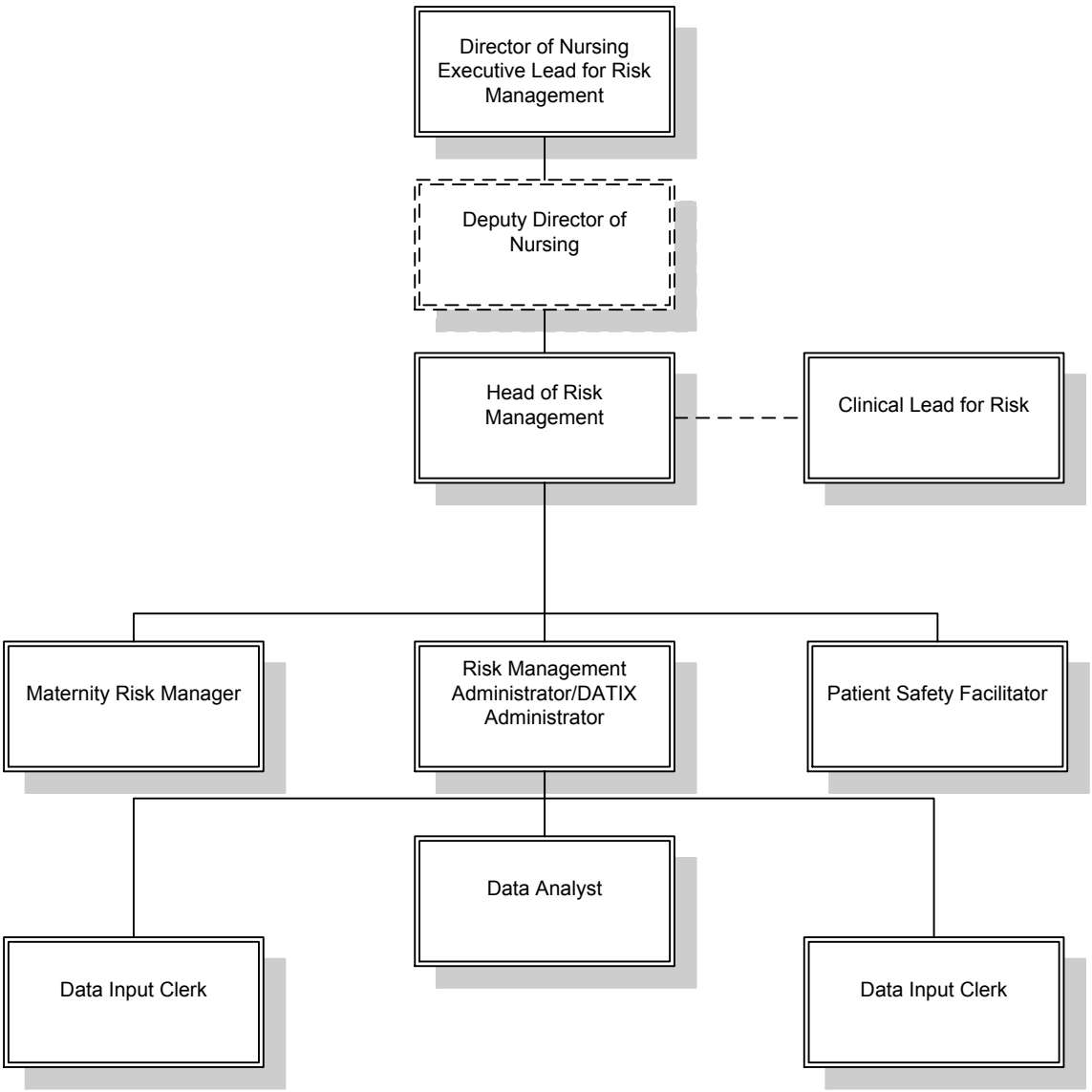
APPENDIX B

Governance Committee Structure 2015



APPENDIX C

Organisation Chart for Risk Management Team



APPENDIX D

Assurance Framework Report to Trust Board

1. Date of Assurance Committee	
2. Name of Assurance Committee	

3. New Risks Identified for Inclusion onto Assurance Framework

Risk: Executive Lead:

4. Newly Identified Gaps in Control/Assurance

Details of gap: Remedial Actions agreed:

5. Newly Identified Positive Assurances

Please detail the assurance and the linked risk:

6. Risk Register – Newly Identified Extreme Risks

Please detail the nature of the risk and action being taken to control risk

APPENDIX E

Other Reading

Department of Health Guidance
Department of Health, 2013. *The NHS Outcomes Framework 2013/14*
Department of Health, 2010. *Equity and Excellence: Liberating the NHS.*
Department of Health, 2010. *The NHS Outcomes Framework 2011/12.*
Department of Health, 2008. *High Quality Care for All.*
Department of Health, 2006. *Safety First: A Report For Patients, Clinicians, and Health Care Managers*
Department of Health, 2004. *National Standards, Local Action: Health and Social Care Standards and Planning Framework.*
Health Care Commission, 2004. *Assessment for Improvement – Our Approach*
Department of Health, 2002. *Assurance: The Board Agenda.*
Department of Health, 2002. *Governance in the NHS: Statement on Internal Control for 2001/2002 and Beyond.*
Department of Health, (National Patient Safety Agency) 2001. *Doing Less Harm.*
Department of Health, 2001. *Building a Safer NHS for Patients.*
Department of Health, 2000. *An Organisation with a Memory.*
Other Guidance
NHS England (2015) Serious Incident Framework: Supporting learning to prevent recurrence. Patient Safety Domain. London.
NHS England, *Revised Never Events Policy and Framework,* 2015
Monitor, 2014, *The NHS Foundation Trust Code of Governance, updated July 2014*
Monitor, 2013. *Compliance Framework 2013/14*
National Quality Board, 2011. *Maintaining and improving quality during the transition: safety, effectiveness, experience Part one 2011-12.*
Care Quality Commission, 2010*. Essential Standards of Quality and Safety.*
Monitor. 2006. *Clinical Quality and Service Performance.*
National Audit Office 2000. *Supporting Innovation: Managing Risk in Government Departments. HC 864.*
HM Treasury 2000. *Management of Risk: A Strategic Overview.*
Standards Australia 1999. *Risk Management Standard.* AS/NZS 4360.

APPENDIX F

RISK MANAGEMENT STRATEGY

THE IMPLEMENTATION PLAN

INTRODUCTION

Fundamentals:

The Risk Management Strategy requires that the following fundamentals be present in order to embed the strategy into the standard operating function of Salisbury NHS Foundation Trust

- An endorsement of the Risk Management Strategy by the Trust Board
- Dissemination of the Risk Management Strategy to all staff levels
- The definition of roles and responsibilities within the Trust
- A framework for supporting appropriate standards, procedures and guidelines
- Regular review of the Risk Management Strategy

Frequency of Review

The Risk Management Strategy has been reviewed in line with changes and amendments to Trust procedures and NHS national standards. The frequency of review will be 1 year intervals.

IMPLEMENTATION PLAN

Task	Activity	Responsible	Start	End	Status
1	Consultation (with whom)	N/A			
2	Policy Approval	Trust Board			
3	Policy Ratification	Trust Board			
4	Uploaded to Policies Section of Intranet	Information Governance Department			
5	Notification to staff via Intranet Home Page Notice.	Information Governance Department			
6	Upload to Trust Website for publication	Information Governance Department			
7	Cascade Brief	Risk Management Department			
8	Inclusion in other audience targeted publication	N/A			
9	Other bespoke publication method	N/A			
10	Audit compliance	Clinical Risk Group / Clinical Governance Committee			

APPENDIX G

Equality Analysis (EA's) Template

1.Title of policy, programme, framework or organisational change being analysed. Risk Management Strategy
2. Please state the aims and objectives of this work and the intended equality outcomes. How does this proposal link to the organisation's business plan or Values and Beliefs? To ensure that national requirements for identifying, reporting and investigating serious incidents are met. Closely links with Trust's values and beliefs i.e patient centred, safe, responsive, caring.
3. Who is likely to be affected? Eg: staff, patients, service users (please refer to appendix 1) All staff and also impact on patients and families
4. Using the 'Equality Definitions' template - What evidence do you have of the potential impact (positive or negative)? Include any supporting evidence eg: research, data or feedback from engagement activities
4.1 Disability No impact
4.2 Sex (Male or Female) No impact
4.3 Race No impact
4.4 Age No impact
4.5 Transgender No impact
4.6 Sexual Orientation (this will include lesbian, gay and bi sexual as well as heterosexual people) No impact

4.7 Religion or belief (includes religion, beliefs or no religion or belief) No impact
4.8 Marriage and civil partnership No impact
4.9 Pregnancy and maternity (this can include impact on working arrangements and infant caring responsibilities) No impact

5.0 This table should be completed with all actions identified to mitigate any negative effects **List of Actions:**	**Action Plan**	**Target Date**	**Review Date**	**Person Responsible**
n/a				

6.0 Sign off
Name and signature of person who carried out this analysis: Fenella Hill
Date analysis completed: 09.09.2015
Name and signature of line manager:
Date analysis approved by line manager:
Copy forwarded to Equality and Diversity Department:

PAPER: 3708

MATERNITY RISK MANAGEMENT STRATEGY 2015/16

PURPOSE:

To present the Trust Board with the revised Maternity Risk Management Strategy for approval.

MAIN ISSUES:

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place within the Maternity and Neonatal unit which will assure the Trust Board.

Key items to note:

Additional text has been added to section 8.2.6 detailing the role of Antenatal Manger

Apprendix 2:Updated departmental structure.

ACTION REQUIRED BY THE BOARD:

The Trust Board is asked to consider and approve the revised Maternity and Neonatal Risk Management Strategy 2015.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

Maternity and Neonatal Risk Management Strategy, 2015.

AUTHOR: **Louise Jones**

TITLE: **Maternity Risk and Governance Manager**

Salisbury NHS
NHS Foundation Trust

MATERNITY AND NEONATAL SERVICES RISK MANAGEMENT STRATEGY

Post holder responsible for Policy:	Midwife Risk and Governance Manager
Directorate responsible for Policy:	Clinical Support and Family Services
Contact details:	Louise Jones Midwife Risk and Governance Manager Maternity Administration (Beatrice 5) SDH
Date written:	September 2010
Approved by:	Maternity and Neonatal Risk Management Group
Date approved:	
Ratified by:	Trust Board
Date Ratified:	October 2015
Next due for revision:	October 2016
Date policy becomes live:	October 2015

VERSION INFORMATION

Version No.	Updated by	Updated On	Description of Changes
1.0	Midwife Risk Manager	September 2010	• Revised version to reflect Trust Risk Management Strategy and NHSLA requirements
2.0	Midwife Risk Manager	December 2011	• Name change
3.0	Midwife risk and Governance manager	September 2012	• 1:Additional text • 3: Additional text • 6: Additional text • 8.2.1**:** Additional text • 8.2.2: Additional text • 8.2.3 & 8.2.4 text merged • 8.2.10 :Additional text

			• 10: Additional text • 11.1 Additional text • 11.1.3: Additional text • 11.1.7: Additional text • 12: Additional text • Appendix 2 deleted and new departmental structure inserted • Appendix 3 :deleted and terms of references inserted • Appendix 4: added TOR Maternity Governance Forum. • Appendix 5: added TOR Supervisors of Midwives Forum. • Appendix 6: added TOR perinatal Forum • Appendix 7: added TOR Maternity and Neonatal Risk Forum • Appendix 8: added escalation of incidents. • Appendix 9: added Unexpected admission to Neonatal Unit.
4.0	Midwife Risk and Governance Manager	October 2013	• 8.2.2 Additional text • 8.2.7 Change to labour ward manager. • 8.2.10 Added role of duty manger • 8.2.11 added text to Supervisors of Midwives • 8.2.12 Added role of contact Supervisor. • 11.1.2 added text • 11.1.3 added text • Appendix 3 Maternity Governance Monitoring structure
5.0	Midwife Risk and Governance Manager	October 2014	• 8.2.6 Added role of Community and Safeguarding Managers • 12: Additional text re Datix web • Appendix 11: SOM Trusts Assurance meetings.
6.0	Midwife Risk and Governance Manager	September 2015	• Apprendix 2:Updated departmental structure. • 8.2.6 Added role of Antenatal Services Manager

1. INTRODUCTION

The purpose of the Maternity and Neonatal Services Risk Management Strategy is to underpin and support the Trust's Risk Management Strategy by setting out the systems and processes to be used to manage risk within the Maternity and Neonatal Services**.**
This Risk Management Strategy should be read in conjunction with the Trusts Risk Management Strategy.

Risk management is a systematic method of identifying, analysing and evaluating risk associated with service activity. Risks have to be analysed, treated and monitored. In one sense, incident reporting is on the reactive side of risk management. More emphasis needs to be placed on the proactive side, as risk management is more effective when resources are used to minimise the occurrence of patient safety incidents instead of responding when things have gone wrong.

The Maternity and Neonatal Services at Salisbury NHS Foundation Trust are committed to providing a high standard of woman and infant centered care. The complex nature of healthcare provided by the service and the high cost in terms of personal, financial, and reputational loss if unexpected outcomes occur is well recognised.

The Trust is committed to providing a Maternity and Neonatal Service that is focused on patient safety, professional and public accountability, whilst acting responsibly within the financial and resource constraints imposed upon it. The service accepts that 'honest failures' will occur and believes that risk management can and will inform and improve practice. When things go wrong it is important that the response is one of openness and learning with a drive to reduce future risk for patients, as well as supporting patients, staff, and anyone who may suffer as a consequence. Every incident reported presents a learning opportunity enabling improved delivery of future services.

The Maternity and Neonatal Service is thus committed to the challenge of minimising risk and improving patient safety through a comprehensive, pro-active, multidisciplinary approach to risk management.

This Maternity and Neonatal Services Risk Management Strategy details the risk structures and processes within the Maternity and Neonatal Services and how these feed into Salisbury NHS Foundation Trusts risk framework. This strategy should be read in conjunction with the following Risk Management Policies which are all available on the intranet:

- Risk Management Policy and Procedure
- Adverse Events Reporting Policy
- Serious Incidents Requiring Investigation Policy
- Duty of Candour and Being Open Policy

2. DEFINITIONS

Throughout this Strategy the term 'Maternity and Neonatal Service' is used. This term includes the following services, whether provided in an acute, primary or community setting by Trust staff:

- Antenatal Services – The provision of healthcare monitoring during pregnancy for example screening, which assist in the assessment and monitoring of the current state of the pregnancy and its possible ongoing pregnancy effects on the woman.
- Intrapartum Services - The provision of healthcare from the onset of labour to the end of the third stage of labour.

- Postnatal Services - The provision of health care provided to a woman and her baby following the birth.
- Midwifery led care - Midwife led model of care based on the premise that pregnancy and birth are normal life events.
- Neonatal unit - The Neonatal Unit provides care for premature or sick newborn infants.
- Obstetric anaesthetics - The provision of anaesthetic services specifically for pregnant women.
- Obstetric theatre services - The provision of theatre services specifically for pregnant women.

3. Aim of the Maternity and Neonatal Services Risk Management Strategy

The aim of the Maternity and Neonatal Services Risk Management Strategy is to ensure that women and their families experience safe, high quality, clinically effective care at all times, to ensure a positive birth experience and a healthy outcome for mother and baby. Through a proactive approach to risk management, systems of care can be improved as deemed necessary to maintain high standards of care. Poor management of care is identified and immediately escalated.

The Maternity and Neonatal Services Risk Management strategy and the Trusts Risk Management Strategy, aim to achieve a culture where proactive risk management and safety is everyone's business, there is an open and honest reporting of incidents, a culture which encourages organisational learning, and risks are continuously identified, assessed and minimised. This is achieved through robust risk management processes within the department which will assure the Trust Board that it is discharging its responsibilities in relation to the management of risk in Maternity and Neonatal services.

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4. Scope

This policy applies to **all** employees (including temporary staff and contractors) within the Maternity and Neonatal Service and requires an active lead from managers at all levels.

5. Outcomes

By putting the strategy into operation the Maternity and Neonatal Services aim to achieve**:**

- A culture where risk management and patient safety is everyone's business by ensuring clear understanding of roles and responsibilities related to risk.
- Building on the high standard of care already being provided through improvements and the prevention, control and containment of risk.
- Maintenance of a safe environment for patients, employees and visitors.
- A robust and proactive system for reporting and analysis of adverse incidents (including near misses) with subsequent learning for all staff.
- The adoption of an open and fair approach to incident investigation which will include a culture of Being Open with patients and their families when incidents have occurred.
- Compliance with the Care Quality Commissions Essential Standards of Quality and Safety.
- Compliance with the NHS England's (South) SI Trigger List.

6. Measurable Objectives For Managing Risk via the Maternity and Neonatal Services Risk Management Strategy

The following key objectives are considered essential for the successful implementation of the Maternity and Neonatal Services Risk Management Strategy. These objectives are also steered by the Clinical Support and Family Services Directorate and the recommendations

from National reports.

- An annual report must be produced and presented to the Trust Board to show clear direction of travel against the aims and objectives of this strategy within the Maternity and Neonatal Service.
- Incident reporting rates should continue to rise as the open reporting of incidents is encouraged within an open and fair culture.
- All staff groups across Maternity and Neonatal Services must report incidents as per the Adverse Events Reporting Policy and in compliance with the Maternity and Neonatal services Trigger List (appendix 1).
- Where necessary incidents will be reported to other agencies, for example: NPSA, Director of Public Health, MBRACE, UKOSS, NHS Litigation Authority and Local Supervising Authority.
- There should be evidence that the learning arising from adverse events, root cause analysis, claims, complaints and supervisory reviews is acted on and shared throughout the Maternity and Neonatal Service, and as necessary through the organisation.
- Maternity and Neonatal Risk Group is to meet as a minimum 10 times annually with an attendance list and documented minutes of actions being taken.
- The Maternity and Neonatal Risk Group must report to the Trust Clinical Risk Group as a standing agenda item.
- There must be attendance at the Directorate Governance performance meetings by the Head of Midwifery (or nominated deputy) to ensure that maternity and neonatal incidents and risks are discussed as part of the Directorate Risk Register and Incident Report Card with the executives present and the Head of Risk Management
- Annual review of staffing of clinical areas and review skill mix to ensure leadership and safe clinical practice is maintained, for all disciplines of staff.
- There should be evidence that National Guidance i.e. NSF / NICE / National Confidential Enquiries have been reviewed and recommendations implemented where appropriate.
- Ensure risk and patient safety awareness is an integral part of everyone's role within Maternity and Neonatal Services.
- The Maternity and Neonatal Service must have a dynamic risk register which shows depth and breadth of risks identified. Risks should be reviewed as a standing agenda item at the Maternity and Neonatal Risk Group meeting. As a result there should be evidence that all risks are appropriate, in date, and subject to review.

7. Maternity and Neonatal Services Risk Management Structure

See appendix 2 for diagram showing all committees/sub committees/groups which have responsibility for risk.

8 Roles and Responsibilities:

8.1 Trust Level

8.1.1 The Chief Executive has the overall responsibility for risk management within Salisbury NHS Foundation Trust. This responsibility has been delegated to the Director of Nursing who is the Executive Lead for Risk.

8.1.2 The Director of Nursing has responsibility for the strategic management of risk across the whole Trust including Maternity and Neonatal services. The Director of Nursing has a lead role in liaising with the executive team to ensure risk has a high profile at Trust Board level and ensuring that there is a robust risk management framework in place across

the organisation resulting in the achievement of the objectives within the Trust Risk Management Strategy.

Specific duties include:

- Presenting the annual Risk Management Report to the Trust Board.
- Coordinating an annual Trust Board workshop along with the Head of Risk Management for both executive and non executive directors.
- Attending Trust Board meetings in capacity as Executive Lead for Risk (or nominated deputy).
- Attending Clinical Risk Group as Executive Lead for Risk (or nominated deputy).
- Commissioning of Serious Incident Inquiries and Clinical Reviews.
- Attending the Directorate performance meetings where risk registers and incident report cards are reviewed at Directorate level
- Monthly 1:1s with the Head of Maternity and Neonatal Service.

The Board Lead executive (Director of Nursing) communicates with and obtains assurance from the Maternity and Neonatal Service through:

- Attendance of both the Executive Lead (or nominated deputy) and Head of Maternity and Neonatal Services (or nominated deputy) at the Directorate performance meetings where risk issues are discussed through presentation of the Directorate Risk Register and Incident Report Card.
- Monthly 1:1s with the Head of Maternity and Neonatal Service.
- Attendance at the Clinical Risk Group (or nominated deputy) where maternity is a standing agenda item with reporting from the Maternity and Neonatal Risk Management Group.

8.1.3 Head of Risk Management

- The Head of Risk Management is responsible for maintaining and updating appropriate and compliant Risk Management Policies and procedures.
- The Head of Risk Management is responsible for co-ordinating and updating the Assurance Framework as well as presenting the document at the Assurance Committees.
- The Head of Risk Management is responsible for ensuring the Trust has a comprehensive and dynamic Risk Register and working with Directorate Management Teams to ensure that they understand their accountability and responsibilities for managing risks in their areas.
- The Head of Risk Management is responsible for ensuring information is provided on incident data to Directorate Management Teams, the Clinical Governance Committee, and Trust Board.

8.1.4 Directorate Management Team:

Directorate Management Teams are accountable and have authority to ensure appropriate risk management processes are implemented within their respective directorates and areas of authority. Each Directorate Management Team is required to:

- Work proactively to achieve the Trusts Key Performance Indicators for Risk Management.

- Understand and implement the Trust's Risk Management Strategy and related policies.
- Ensure that appropriate and effective Risk Management processes are in place within their delegated areas.
- Ensure Directorate activity is compliant with national risk management standards and safe practices, alerts etc
- Develop specific objectives within their service plans which reflect their own risk profile and the management of risk.
- Risk assess all business plans/service developments including changes to service delivery.
- Ensure that risk assessments, both clinical and non-clinical, are undertaken throughout their areas of responsibility. The risks identified will be prioritized and action plans formulated. These action plans will be monitored through the 3:3 meetings.
- Maintain a directorate risk register (clinical, non-clinical and financial). Formally reporting high and extreme risks via the 3:3.
- Report all incidents in accordance with the Adverse Events and Near Misses Policy and identify action taken to reduce or eliminate further incidents.
- Undertake investigation into all serious incidents, in accordance with the Adverse Event Reporting Policy providing evidence of local resolution and learning.
- Disseminate learning and recommendations made as a result of incident investigations, clinical reviews, and serious incident inquiries within their areas of responsibility.
- Monitor and report on the implementation and progress of any recommendations made which fall within their area of responsibility i.e. within the Directorate.
- Ensure that all staff are made aware of risks within their working environment and their personal responsibilities within the risk management framework.
- Identify own training needs to fulfill the function of managing risk as a senior manager. As a minimum 'Risk' updates will be provided via the Directorate 3:3s. Further training can be accessed via the Risk Department.

8.2 Maternity and Neonatal Service Level

8.2.1 The Head of Midwifery and Neonatal Services is responsible for providing professional and managerial leadership for Midwives and Nurses within the service and is responsible for developing the strategic direction for the Maternity and Neonatal Services. The Head of Midwifery and Neonatal Services has overall responsibility for ensuring Risk Management Policies and procedures are in place within the Maternity and Neonatal Service. The Maternity Risk Manager is responsible for the day to day management of risk related activity and reports directly to the HOM.

Specific risk related duties include:

- Attending the Maternity and Neonatal Risk Management Group (or nominated deputy)
- Attending regular (at least quarterly) 1:1s with the Executive lead for Risk - the Director of Nursing at least quarterly.
- Attending Directorate 3:3s (or nominated deputy) where the Directorate Risk Register and Incident report card are discussed to ensure that the Maternity and Neonatal Service risks are discussed with the executive team.

8.2.2 Maternity Risk and Governance Manager

Operationally, the Maternity Risk and Governance Manager works collaboratively with the Head of Risk Management and the Head of Maternity and Neonatal Services. The Maternity Risk and Governance Manager works with the lead Obstetrician for Clinical Risk. Lead Obstetric Anaesthetist, lead Paediatrician, Labour ward Managers, Antenatal Manager and Community Manager to coordinate Risk management issues for the Maternity , Neonatal and Community setting.

Specific duties include:

- Co Chair of the Maternity and Neonatal Risk Management Group.
- Coordination of the Maternity and Neonatal Services Risk Register.
- Coordination of incident reporting processes within the department to ensure that all incidents are investigated to an appropriate level presenting findings from individual incidents or themes/trends across incident groups to the Maternity and Neonatal Risk Management Group.
- Share learning across the department as a result of incident investigations.
- Attend the Clinical Risk Group (or nominated deputy) to report on Maternity and Neonatal Risk activity on behalf of the Department and to report back any Trust issues at the Maternity and Neonatal Risk Management Group..
- Author of the Maternity and Neonatal Services Annual Report to the Trust Board.
- Act as a panel member on any Serious Incident Inquiries as nominated by the Executive Lead for Risk.
- Lead Midwife for Clinical Governance. Coordinates the audit programme and ensures learning from risk reviews are cascaded to all maternity and neonatal staff are incorporated into clinical policies and practices.

8.2.3 Consultant Lead for Labour Ward and Obstetric Risk Management works with the Midwife Risk Manager to ensure implementation of the Risk Management Strategy and framework. Specific duties include:

- Co chairs the Maternity and Neonatal Risk Management Group.
- Attend the Clinical Risk Group (or nominated deputy) to report on Maternity and Neonatal Risk activity on behalf of the Department and to report back any Trust issues at the Maternity and Neonatal Risk Management Group.
- Act as a panel member on any Serious Incident Inquiries as nominated by the Executive Lead for Risk.
- Is responsible for providing clinical leadership for all medical staff working in the labour ward and ensures good inter-professional relationships are maintained. Specific duties include:
- Involved in incident investigations and recommendations for improving practice.
- Involved in Obstetric investigations and recommendations for improving practice as nominated.
- Raises obstetric issues within the Maternity and Neonatal Risk Management Meeting and provides feedback on Risk Management issues to obstetric staff as appropriate.

8.2.4 Consultant Lead Obstetric Anaesthetist is responsible for providing clinical leadership and organisation for all anaesthetic medical staff working in the unit and ensures good inter-professional relationships are maintained. Specific duties include:

- Involved in incident investigations and recommendations for improving practice.
- Attends the Maternity and Neonatal Risk Management Group (or nominated deputy).
- Raises anaesthetic issues within the Maternity and Neonatal Risk Management Meeting and provides feedback on Risk Management issues to anaesthetic staff as appropriate.

8.2.5 Consultant Lead for Neonatology is responsible for providing clinical leadership for all paediatric medical staff working in the unit and ensures good inter-professional relationships are maintained. specific duties include:

- Involved in incident investigations and recommendations for improving practice.
- Attends the Maternity and Neonatal Risk Management Group (or nominated deputy).
- Involved in Obstetric/paediatric panel investigations and recommendations as nominated.
- Raises paediatric issues within the Maternity and Neonatal Risk Management Meeting and provides feedback on Risk Management issues to paediatric staff as appropriate.

8.2.6 Antenatal Services Manager

- Involved in incident investigations and recommendations for improving practice.
- Attends the Maternity and Neonatal Risk Management Group (or nominated deputy).
- Provides feedback to Antenatal Unit staff on any recommended changes to clinical practice arising out of incidents, complaints and claims.
- Work collaboratively with risk management team to ensure co-ordination, monitoring, investigation and learning from adverse events is managed appropriately.

8.2.7 Community Services Manager and Named Midwife for safeguarding children

- Ability to make judgements on a range of complex midwifery problems which require investigation, analysis and assessment
- Involved in incident investigations and recommendations for improving practice.
- Provides feedback to individuals and implement any recommended changes to clinical practice arising out of incidents, complaints and claims.
- Attends the Maternity and Neonatal Risk Management Group
- Working in partnership with Head of Maternity and Neonatal Services the post holder will lead and participate in the implementation of the Maternity Services Risk Management Strategy with a focus on the achievement of NHSLA Standards, NSF for Maternity Services,CQC expectations within safeguarding and ensuring compliance with appropriate Governance frameworks
- Work collaboratively with risk management team to ensure co-ordination, monitoring, investigation and learning from adverse events is managed appropriately.
- Development and delivery of safeguarding systems whilst ensuring the quality of safeguarding practices within maternity and neonatal services will be a priority.

8.2.8 Labour Ward Manager

- Involved in incident investigations and recommendations for improving practice.
- Attends the Maternity and Neonatal Risk Management Group (or nominated deputy).
- Provides feedback to individuals and implements any recommended changes to clinical practice as a result of incidents, complaints and claims.
- Work collaboratively with risk management team to ensure co-ordination, monitoring, investigation and learning from adverse events is managed appropriately.

8.2.9 Neonatal and Postnatal Services Manager

- Involved in incident investigations and recommendations for improving practice.
- Attends the Maternity and Neonatal Risk Management Group (or nominated deputy).
- Provides feedback to Postnatal and Neonatal Unit staff on any recommended changes to clinical practice arising out of incidents, complaints and claims.
- Involved in the coordination and running of Perinatal Morbidity and Mortality Forum.

8.2.10 Practice Development Midwife

- Attends the Maternity and Neonatal Risk Management Group (or nominated deputy).
- Co-ordinates and implements any recommended training schedules or changes to current training (TNA).
- Provides expert midwifery advice especially concerning training issues.
- Ensures the clinical guidelines used by the service are current and evidence based, where the evidence exists, to reflect best practice.

8.2.11 Duty Manager

- A senior midwife is rostered daily Monday to Friday to take the role of Duty manager.
- Management of off duty to ensure staffing levels and skill mix meet the needs of the service on a day to day basis.
- Assess the unit capacity, bed occupancy and anticipated requirements on the day shift and consider the need in the community if issues have been escalated from there.
- Co-ordinate unit breaks. Arrange with leads in each area that breaks are arranged early in the shift and taken.
- Co-ordinate escalation for increasing activity as required.
- Co-ordinate bed management and increasing capacity.

8.2.12 Supervisors of Midwives

Supervision is a statutory responsibility which provides a mechanism for support and guidance to every midwife. The purpose of supervision of midwives is to protect women and babies by actively promoting a safe standard of midwifery practice.
Supervision is a means of promoting excellence in midwifery care, by supporting midwives to practise with confidence, therefore preventing poor practice. (NMC 2009). Supervision of midwives sit externally to the Trust and are appointed by the local supervising authority midwifery officer.

- Supervisors utilise NMC rules/standard/code when contributing to risk management reports.
- A Supervisor of Midwives (SoM) attends all risk and governance forums to ensure that the statutory rules and standards relating to supervision of midwives and midwifery practice are met. (NMC 2009).
- A supervisor of midwives must be present on all risk review panels to provide assurance of the safety of women and babies. The SOM then acts as a link between risk management and the SOMs forum.
- Supervisors investigate any complaints or incidents involving midwifery practice. These reports are given directly to the LSAMO who makes the decision regarding the midwife's fitness to practice. (This could be a local action plan, an LSA action plan or a referral to the NMC).
- The recommendations of the Supervisor of Midwives investigation may form part of the action plan for the Maternity Service in terms of practice development for the service or individual practitioners.
- Every midwife employed within the trust has a named SoM
- All midwives will have an annual supervisory review undertaken by their allocated supervisor of Midwives. On receipt of the annual LSA report
- Supervisors of midwives (SoM) will produce an action plan which along with the report will be presented and reviewed at the Maternity Clinical Governance Forum.
- All supervisors of midwives ensure that all practicing midwives submit their intention to practice annually by the 1st April and that this is entered onto both the LSA and NMC database to enable midwives to continue on the register.

- The team of supervisors of midwives at Salisbury Foundation Trust provide 24hour on call cover for any practice issues or complex care planning. They are available for women, their families and midwives.
- The LSA Officer carries out an annual audit of supervisory activity within the unit and produces a report and a work plan which is sent to all supervisors of midwives, Head of Midwifery and the Director of Nursing.

8.2.12 Contact Supervisor of Midwives

- This is a named supervisor of midwives who is nominated by her peers to act as a conduit between the LSA and the supervisors of midwives and also between the supervisors, the head of midwifery and the wider Trust.
- Meets quarterly with all other contact supervisors of midwives and the LSAMO to discuss practice issues across the South West LSA region.
- Coordinates supervisory activity within the unit.
- Oversees all supervisor of midwives investigations locally.
- Provides a quarterly briefing paper and meets quarterly with the HOM and the DON to discuss supervisory activity including themes and feed back of any learning to the department. Provides assurance that midwives are safe to practice and any that concerns are investigated.
- To monitor completion of any LSA or local action plans for midwives.
- To monitor progress against the annual work plan.

8.2.13 All Maternity and Neonatal Services Staff

For risk management to be effective it must actively involve staff at all levels within the organisation (i.e. 'Board to Ward'), it must be seen as everyone's responsibility and not just that of any one individual or department.

All Staff are required to:

- Be conversant with the Maternity and Neonatal Services Risk Management Strategy and have a working knowledge of all related risk polices.
- Comply with Trust policies, procedures and guidelines to protect the health, safety, and welfare of any individuals affected by Trust activity.
- Acknowledge that risk management is integral to their working practice within the Trust.
- Report all incidents,near misses and be familiar with the reporting of trigger list, in accordance with the Adverse Events Policy and take action to reduce or eliminate further incidents.
- Report any risk issues to their line manager.
- Participate in the investigation of any adverse events as requested.
- Attend mandatory training appropriate to role.
- Staff must comply with professional guidelines (as applicable to their role and profession) and act in accordance with such guidelines and codes of practice.

9. Maternity and Neonatal Services Risk Register

The Maternity and Neonatal Risk Register is developed and managed in accordance with the Trust's Risk Management Policy and Procedure.

9.1 Departmental Level

Departmental risks are identified through adverse events/near misses, complaints, claims, clinical risk assessments, health and safety inspections and audit and should incorporate all risks associated with delivery of care.

Risk assessments carried out within the Maternity and Neonatal Unit must utilise the format as set out in the Risk Management Policy and Procedure (available on the intranet). This process for submission and review must be adhered to.
The risk assessment proforma and risk rating matrix must be applied to all risk assessments

Once a risk assessment is completed it must be submitted to the Maternity Risk and Governance Manager who will ensure its input onto Datix (risk software used across the Trust). This then provides the departmental risk register.

The Maternity Risk and Governance Manager will present any new, rising risks, or those requiring review at the monthly Maternity and Neonatal Risk Management Group meeting. The risk register should be seen as a dynamic process as ranking/prioritisation of risks will change as risk reduction practices take place.

9.2 Directorate Level

Each Directorate will continue to maintain a comprehensive risk register, which will be formally reviewed at four monthly intervals through the Directorate Performance Meetings. At these meetings the directorates will be expected to report on their risk register (risks scoring 12 or above), highlight any new or emerging risks to service delivery and present action plans for minimising and managing these risks. The performance meeting should identify those departmental risks which also pose a corporate threat and so require inclusion on the Trust Risk Register. The risk register should be seen as a dynamic process as ranking/prioritisation of risks will change as risk reduction practices take place. The DMT has responsibility for ensuring that all risks within the Directorate are appropriately graded and have sufficient actions in plan to mitigate/reduce the risk.

9.3 Trust Risk Register

The Trust Risk Register is a combination of risks identified at corporate level and those at departmental and Directorate level which have followed the process as set out above. On a quarterly basis the Head of Risk Management presents the Trust Risk Register to the Assurance Committees (Clinical Governance Committee - clinical risks; Joint Board of Directors - organisational, HR, IT risks; Finance Committee – financial risks) along with the Assurance Framework.

The Assurance Committee Chairs provide an exception report and minutes to the Trust Board following these quarterly reviews. The appropriate Assurance Committee or the Trust Board can recommend whether an extreme risk should be transferred onto the Assurance Framework.

10. Immediate Escalation Of Risk Management Issues To Trust Board Level

Where issues are such that immediate escalation to Trust Board is required e.g. maternal death, the following process is initiated:-

The Head of Midwifery and Neonatal Services or Midwife Risk Manager will inform the Executive Lead for Risk (Director of Nursing), the Head of Risk Management, and also a Directorate Management team member.

In normal working hours a phone call between the Head of Midwifery/Head of Risk/ Director (or her deputy) of Nursing to inform them of the incident that has occurred.
Out of hours this phone call will be between a senior midwife/ supervisor of midwives on call, to the on call Trust Director.
The phone call is then followed up with an email of confirmation to the Head of Risk/ Director (or her deputy) of Nursing .E-mails will also be sent to the Head of Midwifery/ Deputy).

The incident should be inputted onto datixweb , where appropriate.
Serious incidents are managed in accordance with the Trust Serious Incident Policy (available on the intranet) .

11. Learning as a Result of Incidents, Complaints, and Claims

11.1 Incidents

All reported incidents are reviewed by the Midwife Risk Manager and where necessary delegated to appropriate clinical experts to review further. When serious concerns are identified, these concerns are highlighted and acted upon immediately.

All staff should be aware of the Trust Adverse Event Reporting Policy (available on the intranet) and the requirements for the immediate reporting of serious events as set out in the Serious Incident Policy. (available on the intranet). All incidents should be reported onto datix web. (refer to how to report an incident appendix A, on the intranet). The Maternity and Neonatal Services have an established trigger list (appendix 1) which informs staff on the types of clinical events which must be reported via this route, although this is not exhaustive.

The level of investigation required is informed by the grading of the incident. All incidents are reported monthly at the Maternity and Neonatal Risk Management Meeting where trends and themes are identified across the incident categories. Any event graded as major or catastrophic is discussed individually and a full investigation commissioned with resulting findings and recommendations reported back into the group.

The maternity and neonatal incidents are also reported monthly at the Trust's Clinical Risk Group as a standing agenda item. The Head of Risk Management produces a monthly report card which covers themes and trends across incident categories but also identifies any major or catastrophic events individually with narrative, this would also include any Maternity and Neonatal Services incidents of this severity. These individual incidents are discussed and the level of investigation agreed. Any Serious Incident Investigations should have been escalated immediately to the Head of Risk Management and Executive Lead for Risk as per the Serious Incident Policy and full investigation commissioned as a result of this. The Clinical Risk Group acts as a safety net and reflective forum to ensure that all serious events have been communicated and the appropriate level of investigation commenced.

11.1.2 Serious Incident Inquiries/Clinical Reviews

As a minimum any serious incident requiring Serious Incident Investigation or Clinical Review must undergo full investigation utilising root cause analysis methodology. Serious Incident Inquiries and Clinical Reviews are commissioned by the Executive Lead for Risk and coordinated by the Risk Management Department. A panel appropriate for the investigation will be nominated, this may include where required external panel membership. In all cases where a review has been commissioned a supervisory review is undertaken by 2 SOMs to assess if there are any practice issues relating to an individual midwife. If this is found to be the case the LSA midwifery Officer is informed and a supervisory investigation may be recommended and be conducted alongside the risk investigation. All SII should be uploaded onto the LSA database.

The final report and recommendations of any Clinical Review or Serious Incident Inquiry will be presented at the Clinical Risk Group for ratification to ensure that appropriate methodology has been used and the recommendations are valid. The final report is then signed off by the Chief Executive before being shared with the family.

11.1.3 Recommendations and Learning

Recommendations and learning from incidents are disseminated via the Clinical Governance

Meetings, Maternity and Neonatal Risk Management Group meetings, Perinatal meetings and/or Maternity Governance Forum and Supervisors Forum. Maternity and neonatal incidents will be shared with all staff and changes/recommendations fed back through notice boards, emails ,various forums and the minutes of these shared to reach the wider workforce staff.

11.1.4 Trust Board Assurance

The Trust Board are made aware of all commissioned clinical reviews and Serious Incident Inquiries through a report produced by the Head of Risk Management which is presented to the Trust Board as a minimum three times per year. This report can be requested more frequently by the Trust Board if there are particular issues arising.

The Head of Risk Management monitors progress against recommendations from all Clinical Reviews and Serious Incident Inquiries. Assurance is provided through a quarterly report produced for the Clinical Management Board which is also presented to the Clinical Governance Committee on an annual basis. The Annual Risk Management Report and Annual Maternity and Neonatal Risk Management Report also discuss changes to practice as a result of serious incidents.

11.1.5 Learning from Experience – Case Reviews

The Maternity and Neonatal Services are also committed to learning via the use of case reviews which are prepared and presented at the Perinatal Meetings.

11.1.6 Comments, Concerns and Complaints.

Comments, Concerns and complaints are coordinated by the Customer Care Department and managed within the Maternity and Neonatal Services as per the Customer Care Policy. Comments, concerns, and complaints data is recorded using Datixweb Risk Management software.

Comments and concerns raised with senior staff within the Maternity and Neonatal Services are addressed immediately, taking corrective action where appropriate. The Trust Customer Care Department can be called upon to assist staff in the resolution of issues in real time.

Complaints may be made in writing, via e-mail or verbally. Where practice issues or concerns relating to an individual midwife, the complainant will be offered an early face-to-face meeting to discuss their concerns with a Supervisor of Midwives. On these occasions, the minutes / outcome of the meeting will often be used to formulate a follow-up formal written response.

A report of new complaints received, response times for closed complaints and lessons learnt is presented at the Directorate 3:3 meeting quarterly. Patient surveys and PPI project results will also be received and analysed at this forum.

11.1.7 Unexpected admission to Neonatal Unit (see appendix 9)

All babies over 37 weeks gestation that are admitted to the neonatal unit, will have an incident form generated and case reviewed by an obstetrician, if the admission is straight from labour ward, or a paediatrician if the admission is via the postnatal ward. All cases will be entered onto the unexpected admissions to neonatal unit database and graded once the management of care has been reviewed. Lessons learnt will be circulated through direct feedback to individuals involved, communication groups, SOM meetings and community meetings.

11.2 Claims

The Maternity and Neonatal Service liaises closely with the legal department to deal with claims and potential claims arising out of complaints and incidents promptly and transparently.

12. Dissemination Of Lessons Learnt Within Maternity and Neonatal Services

Communicating the learning and recommendations from internal incidents, claims, and complaints is an important factor in the Maternity and Neonatal units approach to managing risk. Learning will be identified and disseminated through the Clinical Governance, Perinatal Mortality and maternity and neonatal Risk forums where practice change will be implemented.

Action plans resulting from Serious Incidents, case reviews, internal incidents, complaints and claims will be cascaded via

- communication groups.
- Notice Boards with information on current audits results and topics.
- Theme of the month
- File with all SII reports in clinical areas for clinicians to read.

13. Monitoring

The Maternity and Neonatal Services Risk Management Group will undertake an annual audit to ensure that the spirit of the Maternity and Neonatal Risk Management Strategy is met. This will be reported to the Maternity and Neonatal Risk Forum with an action plan if required.

Auditable standards:

	Standard	**Evidence**	**Review/monitoring**
M&NRM meeting	9 out of 12 meetings take place	Minutes .	Maternity Risk Annual audit
M&NRM meeting	Meetings are quorate	Sign in sheets	Maternity Risk Annual audit
Departmental Risk Register	Risks are reviewed quarterly unless “ongoing” which may be annually	M&NRM minutes, 3:3 minutes	3:3 - action plan if required
Departmental Risk Register	All risk are logged on Datix	Datix audit annually	Maternity Risk
Complaints/claims	All complaints are logged on Datix	Datix audit annually	3:3
Dissemination of lessons learnt	Relevant clinical changes/actions will be cascaded to staff groups as appropriate	Theme of the month board. Minutes of meeting. Daily safety briefings.	M&NRM group - action plan if required
Staffing levels review	Staffing levels for midwives, obstetricians & anaesthetists are	Annual audit Quarterly dashboard review	M&NRM group M&NRM group - action plan if required

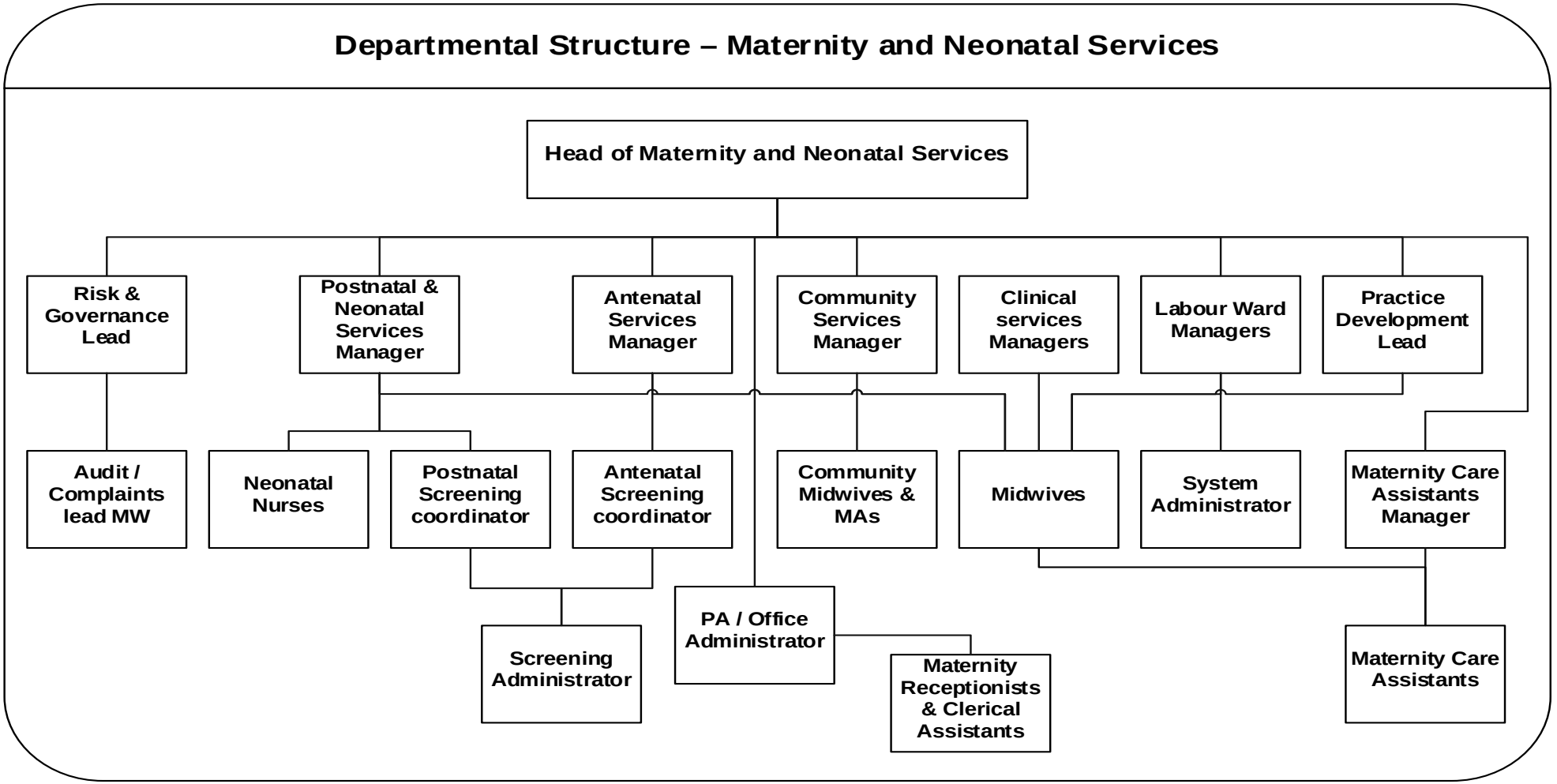
	reviewed	at M&NRM	
TNA review	All staff groups will be complaint with their training needs	Quarterly database review/report	M&NRM group - action plan if required

Maternity and Neonatal Services Trigger List Appendix 1

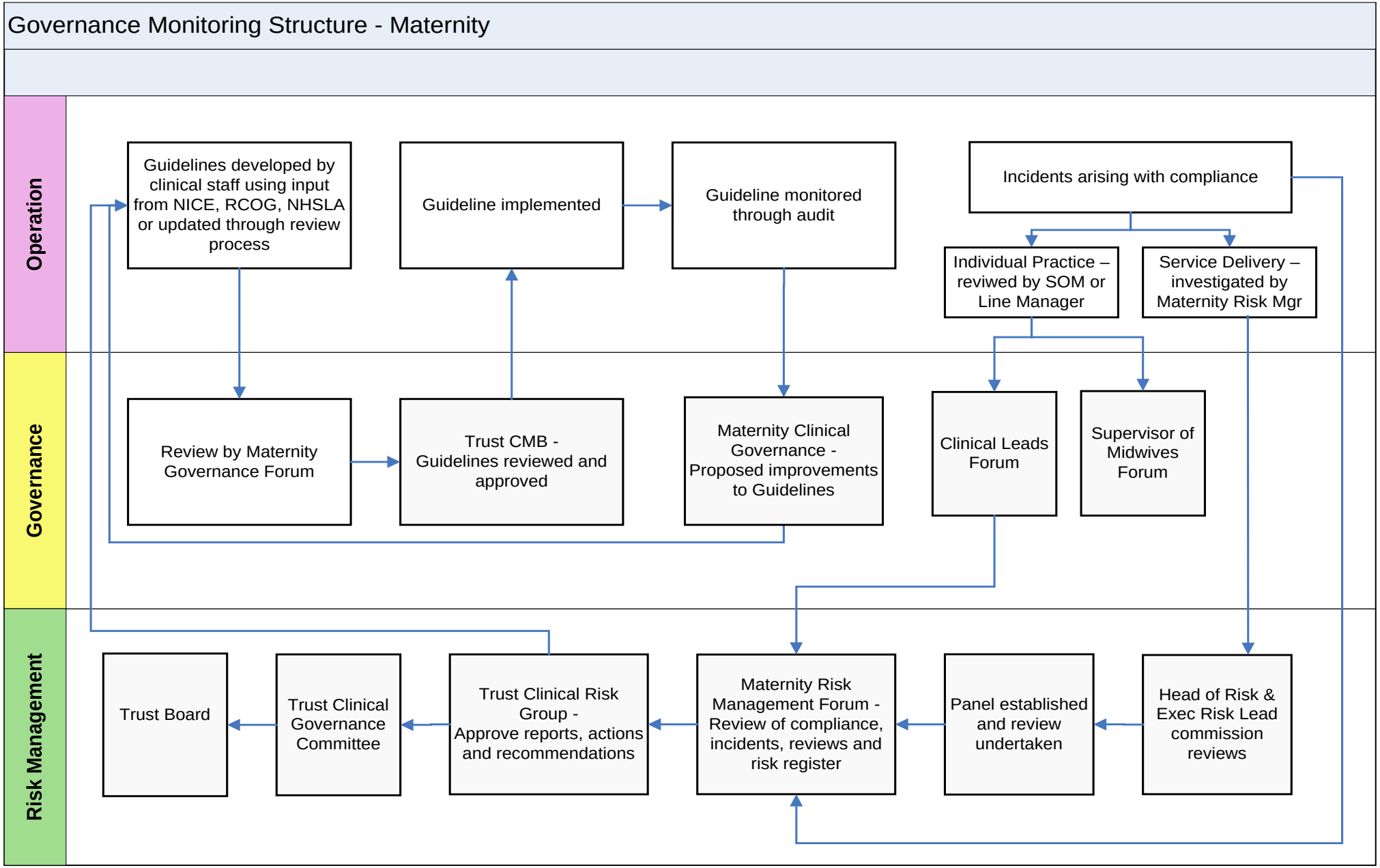
Maternal incident / near miss	Fetal / neonatal incident / near miss
Maternal death Maternal resuscitation Unexplained maternal collapse Undiagnosed breech Shoulder dystocia Blood loss >1000mls Return to theatre Eclampsia Hysterectomy/Laparotomy Venous thromboembolism Pulmonary embolism 3rd and 4th degree tear Uterine rupture Readmission of mother 2222 LSCS - failure to meet time standard Cord prolapse Trauma to bladder or other organs Blood transfusion reaction Loss of clinical materials i.e. swabs Significant infection Pressure ulcer (also report to hotline 4062) CCOT involvement in care	Stillbirth > 500g Neonatal death Apgar score < 7 at 5 minutes Birth trauma Erbs Palsy/Brachial plexus injury Fetal laceration at LSCS Cord pH < 7.05 arterial or < 7.1 venous Neonatal seizures Term baby or unexpected admission to NICU Undiagnosed fetal anomaly Incorrect plotting of SBR or SBR above transfusion threshold Significant infection Pressure necrosis/NCAP related incidents Readmission of baby Hypoxic ischemic encephalopathy (HIE) Necrotising enterocolitis (NEC) Gestation less than 28 weeks (or 30 week twins) Hypothermia Transported without heated cot or transport incubator Neonatal abstinence requiring admission Procedure / intervention complication (e.g. extravasation injury) Any child transferred for tertiary care Ventilation > 24 hours Pneumothorax
Anaesthetic incident / near miss	Organisational incident / near miss
Dural tap Failed intubation Anaphylaxis (medication error and needlestick injury as per organisational incident list) Unplanned admission to Intensive Care Neuropraxia	Unavailability of health record Unplanned home birth or transfer in from home birth Issues related to equipment Issues related to staffing Medication error or adverse drug reaction Needlestick injury Unavailability of facility or equipment failure Incidents relating to data protection/security Unavailability of bed/ neonatal cot Child protection Injury to staff, patient or visitor Communication issues Violence and aggression Miscellaneous

Reporting structure : Band 2 - to Head of Midwifery

Appendix 2



Governance Monitoring Structure - Maternity



TERMS OF REFERENCE

Maternity and Neonatal Risk Management Forum

AIMS.

To ensure systems are in place so that women and their families experience safe, high quality, clinically effective care at all times. The overriding commitment of the Maternity and Neonatal Risk Management forum is to encourage safe effective clinical practice. In addition to this, the group is committed to implementing activities designed to identify and decrease the risk of patient injury associated with clinical care.

The main functions of the group are:

- To encourage safe, effective clinical practice.
- To feedback through the workforce via; communication groups, Supervisors meetings, Community midwives meetings, directly to staff involved .
- To monitor and review the departmental risk register.
- Monitor and review the maternity and Datix monthly report card
- To review monthly incidents, identify trends/themes in reporting and cascade these out to staff groups through quarterly newsletter.
- Keep minutes of meetings with recommendations and responsibility for action. These should be cascaded out to staff groups.
- Monitor clinical audit plans and ensure that lessons learned/ feedback is given to staff.
- Act as a central pool of expertise to supplement and support risk management work across the service and encourage a systematic approach to the management of clinical risk.

MEETINGS AND AGENDAS

- Meetings will be held monthly (a minimum of 9 meetings should take place throughout the 12 months)
- The quorum for the group is 4 members (either Maternity Risk Manager, or consultant lead to chair meeting)
- Members are expected to attend 5 out of 10 meetings annually.
- Obstetric Lead for Risk or Head Of Midwifery must be present to ensure information is disseminated fully.
- Agenda items should be notified to the chair 7 days prior to the meeting.
- An agenda should be issued 3 days prior to the meeting.
- Minutes should be available 7 days from the meeting.
- Records of Meetings will be maintained

Membership

Consultant Obstetrician lead for risk
Maternity Risk and Governance Manager (Chair)
Head of Maternity and Neonatal Services
Consultant Anaesthetist
Postnatal and Neonatal Services Manager
Labour ward lead
Consultant Paediatrician
Antenatal lead
Supervisor of Midwives
Minimum attendance being 50%

(This forum is open to all clinical staff within the maternity and Gynaecology department).

TERMS OF REFERENCE

APPENDIX 5

Maternity Governance Forum

Aim:

- The Maternity Governance Forum will meet every two months to ensure that there is a clearly documented system and process for management and communication throughout the key stages of maternity care.

- It is imperative that there is good inter-professional communication and teamwork, especially during the intra-partum period. This is considered by the NHS Litigation Authority to be best achieved by having a multi-disciplinary forum comprising:

1. Membership

Lead Obstetrician*
Midwifery lead in risk management*
Clinical Midwife Manager*
Obstetric Anaesthetist*
Neonatal Paediatrician*
Consultant Obstetricians
Obstetric SpR*
Supervisor of Midwives*
Obstetric and Paediatric SHO
Midwifery Staff
Consumer Representative

There will be a quorum of 6

*If the nominated person is unable to attend a representative should attend in their place

2. The purpose of the group:

- To meet to review **all** aspects of maternity services activity including:
- To review professional (clinical) issues.
- To review organisational issues.
- To review broader subjects which incorporate staffing and skill mix; education and training; monitoring of the environment in relation to the safety of mothers and babies.
- To review any issues related to other areas within maternity and neonatal services.
- Evidence based guideline development, encompassing all areas of the maternity services.
- To follow the guiding principles within the document 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.' (RCOG, October 2007)
- To ensure that the Maternity Governance Forum develops and participates in the monitoring of standards as outlined in the above document.
- Any issues raised at the Maternity Risk Group meetings that are relevant to the Maternity Governance Forum will be raised by the Midwifery Risk Manager.

3. Frequency of meetings

Meetings are held every two months

There will be a published agenda, detailed minutes and a register maintained of membership, grade and role.

The dates of the Maternity Governance Forum will be published 12 months in advance.

Distribution of the Maternity Governance Forum minutes will include:
Forum Membership
Clinical areas on e-mail

4. Reporting Structure

The Maternity Governance Forum will report to the Maternity Services Risk Management Group. Information will then be escalated as required via the Trust Risk Management Group. The Maternity Governance Forum will report within maternity services through the Midwifery Group Practices and clinical areas and Supervisors of Midwives meetings.

TERMS OF REFERENCE

APPENDIX 6

Supervisor of Midwives Forum

Midwifery supervision is a statutory function for maternity services. It is proactive and facilitates good standards of practice and individual development of midwives. Every practicing midwife will have a named Supervisor of Midwives. Midwifery supervision is responsible for safe guarding the safety of mothers and babies and is therefore an integral part of the Clinical Governance and the risk management process (Ref. NHSLA standard 1.2)

The main functions of the group are:

Specific duties:

- Represented at the Maternity and Neonatal Risk Management Group, Clinical Governance forum, Maternity Governance and Perinatal forum.
- Assist in incident and complaint investigations as appropriate.
- A supervisor of midwives will be involved in the investigation of all Serious Incidents (SI). All Serious Incidents will be reported to the Local Supervising Authority (LSA). This occurs in collaboration with the LSA and following national Supervisory Guidelines.
- Incidents occurring which involve midwifery practice issues will also require a supervisory investigation.
- Supervisors of midwives will support the implementation and monitoring of any action plans and lessons learned from any internal or external incidents/risk issues
- Provide professional advice to other midwives on a 24 hour basis through an on call system.
- The SoM team provides an Annual Report to the LSA and has a written Supervision of Midwifery Strategy.
- Recommendations from NICE, MBRACE and Government reports are incorporated into supervisory activities.
- The SoM Team meets monthly.
- The minutes of the meeting will be circulated to all members within 2 weeks of the meeting
- The agenda will be circulated 7-10 days before the meeting
- Agenda items should be forwarded to the chair at least 14 days before the meeting
- On receipt of the annual LSA report Supervision of midwives will produce and action plan which along with the report will be presented and reviewed at Maternity and Gynaecology Clinical Governance Group

Membership
All Supervisors of midwives
All student supervisors of midwives

TERMS OF REFERENCE

APPENDIX 7

Perinatal Mortality & Morbidity Meeting

The Maternity and Neonatal Services recognise the need to review any cases that have resulted in poor or unexpected outcomes for either mother or baby related to the antenatal period and through the postnatal / neonatal period.

It requires close co-ordination between midwives, obstetricians, neonatologists, neonatal nurses and ultrasonographers.

This is achieved through regular multi-disciplinary review meetings to discuss Perinatal morbidity and pathology.

Aims

- To review recent cases focusing on those, which resulted in Perinatal mortality or morbidity including near misses (see Maternity Risk Management Reporting Trigger List)
- To provide a forum for multi-disciplinary discussion and learning
- To provide a forum to discuss the recommendations of MBRACE, other National Confidential Enquiries and relevant national or local documents.
- To develop an increased knowledge and understanding of high risk obstetric and neonatal complications.
- To provide a forum to recognise the need for changes to practice and to forward learning points to the relevant maternity and Neonatal Governance groups for action.
- To serve as the forum to inform completion of both Stillbirth (MBRACE)and RCOG 'Each baby counts' and Child Death (CPOD) review paperwork.

Membership

Meetings are multi-disciplinary and open to all interested health care professionals. The meetings will uphold an environment of mutual respect for personal and professional opinions expressed with the aim of interprofessional learning. They are held monthly and representatives from the following disciplines are expected at every meeting.

- Obstetricians
- Paediatricians
- Midwives
- Neonatal Nurses
- Ultra-sonographers (as appropriate to the individual cases)

- Anaesthetists (as appropriate to the individual cases)

A record of attendance will be kept and members will be required to sign the attendance sheet at each meeting.

The meeting with be jointly chaired by a Consultant for both Obstetrics and Paediatrics. The meeting will be considered Quorate when a minimum of 2 consultant obstetricians and 2 Consultant Paediatricians are present.

It is expected that the consultants will send apologies direct to the chair person when they are unable to attend the meeting.

Meeting format
Meetings will consist of:

(1) Case Reviews
(2) Informal Discussions
(3) Presentations of topics related to Perinatal mortality and/or morbidity
(4) Guest presentations as appropriate
(5) Follow up of cases from previous meetings subsequent to Paediatric or obstetric reviews and assessments

An anonymised record of cases presented and multiprofessional discussions will be kept along with any relevant presentations. Recommendations for changes in practice or guidelines may be presented to the Maternity Governance Forum for ratification.

Unresolved cases
In the rare case where those present cannot reach a clear agreement of appropriateness of care delivery, the case will be reviewed outside the meeting by a panel that includes as a minimum:
Consultant Paediatrician - lead for neonates
Consultant Obstetrician - labour ward lead
PN and neonatal services manager
Labour ward co-coordinator
Maternity Risk and Governance Manager

This panel will again review the presentations of the case, if at this stage they cannot agree the appropriateness of care then escalation to the Trusts Risk Manager and the Executive Lead for Risk should be undertaken by the Head of Midwifery or the Maternity Risk Manager.

References

1. RCOG – Green top Guideline Late intra uterine deaths and still birth October 2010
2. Working together to safeguard children" document march 2010 - chapter 7

TERMS OF REFERENCE APPENDIX 8

Maternity and Gynaecology Clinical Governance

The Maternity and Gynaecology Clinical Governance meeting is 6 times per year. These sessions are split throughout the year so that Maternity Clinical Governance is the main focus for 3 of the sessions and Gynaecology for the other 3 sessions. This forum provides an opportunity to: discuss lessons learnt following serious incidents, to feedback themes from complaints, to present any audits undertaken within the service and discuss the findings in relation to changes required to practice. All grades of staff are encouraged to attend this meeting.

Aims

- To encourage multidisciplinary review and analysis of critical incidents (including serious untoward) and risks
- Encourage multidisciplinary participation in clinical audit across the Division, present and discuss findings and make recommendations for further audit.
- Dissemination and review of current research, Government reports and Confidential Enquiries.
- Disseminate any information as required by the Trust.

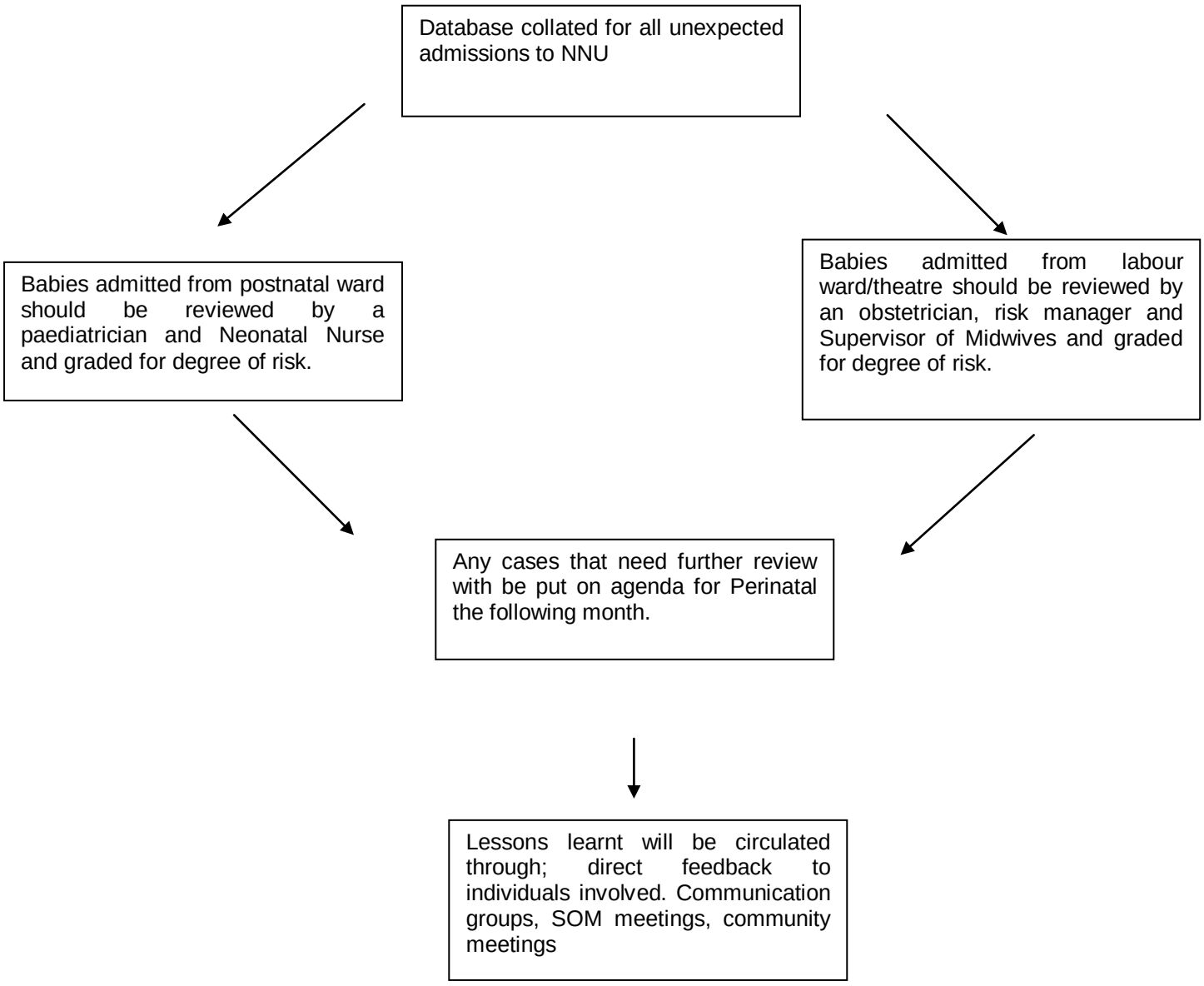
Membership

Open to all clinical staff within the maternity and Gynaecology department and where necessary to include members of relevant multi-disciplinary teams from outside the department.

Objectives of the Group

- To present anonymised cases including serious untoward incidents identifying lessons that have been learnt and need to be shared including any action plans to be implemented.
- Present audit that has been undertaken within the Maternity and Gynaecological services and discuss implications of the findings and agree further actions and audit if required.
- Present findings and recommendations form all relevant confidential enquiries such as MBRACE, NICE and any other directives form such organisations as NPSA, HCC and NHSLA.
- Discuss policy decisions and changes.
- Include as standing agenda items such as infection control and feedback on any directives from the Trust.

Unexpected admissions to Neonatal Unit (37+ gestation)



SALISBURY NHS FOUNDATION TRUST
SUPERVISION OF MIDWIVES TRUST ASSURANCE MEETINGS
TERMS OF REFERENCE

Purpose

To provide assurance to the Executive team that the quality and safety of care for mothers and babies is consistent with expected standards of care.

To report on statutory activities of Supervisors of Midwives.

To report on findings from audits, investigations and reviews to the Clinical Governance Committee.

To ensure progress against the annual work plan and statutory activity is completed.

To raise the profile of the statutory Supervision of Midwives within the Trust.

Membership

Director of Nursing, Midwifery and Allied Health Professionals - Chair
Deputy Director of Nursing, Midwifery and Allied Health Professionals – Deputy Chair
Head of Midwifery
Contact Supervisor of Midwives
Head of Clinical Effectiveness
Non-Executive Director

Frequency of attendance

The members are expected to attend all meetings or send a nominated deputy in their absence. Attendance will be monitored and managed where appropriate.

Quorum

The Chair or Deputy Chair must be in attendance with the Head of Midwifery or Deputy Head of Midwifery and the Contact Supervisor of Midwives or another Supervisor of Midwives.

Frequency of meetings

The group will meet at the end of each quarter in July, October, January and April.

Accountability/reporting arrangements

The minutes of each meeting will be presented to the Clinical Governance Committee.

Monitoring Arrangements

The terms of reference, reporting process, membership and attendance will be reviewed annually and amended accordingly.

1. Healthcare Commission. (2008). *Learning from Investigations.* London: Commission for Healthcare Audit and Inspection. Available at: http://www.healthcarecommission.org.uk/
2. NHS Litigation Authority. (2009). *Risk Management Standards for Acute Trusts, Primary Care Trusts and Independent Sector Providers of NHS Care*. London: NHSLA. Available at: http://www.nhsla.com/
3. Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press. Available at: http://www.rcog.org.uk/
4. Department of Health. (2007). *Maternity Matters: Choice, access and continuity of care in a safe service*. London: COI. Available at: http://www.dh.gov.uk/
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6. King's Fund. (2008). *Safe Births: Everybody's business - Independent Inquiry into the Safety of Maternity Services in England*. London: King's Fund. Available at: http://www.kingsfund.org.uk/
7. Confidential Enquiry into Maternity and Child Health. (2004). *Why Mothers Die 2000-2002.* London: RCOG Press. Available at: http://www.cemach.org.uk/
8. Confidential Enquiry into Stillbirths and Deaths in Infancy. (1998). *5th Annual Report*. London: Maternal and Child Health Research Consortium. Available at: www.cemach.org.uk
9. Department of Health. (2000). An *Organisation with a Memory: Report of an expert group on learning from adverse events in the NHS. Chaired by the Chief Medical Officer*. London: The Stationery Office. Available at: http://www.dh.gov.uk/
10. Royal College of Obstetricians and Gynaecologists. (2005). *Improving Patient Safety: Risk Management for Maternity and Gynaecology*. London: RCOG Press. Available at: www.rcog.org.uk
11. **LSA Standards for the Statutory Supervision of Midwives** (2007) LSA Midwifery Officers, Orbital design, Lancashire
12. Nursing & Midwifery Council (2004) **Midwives rules and standards**. NMC, London

THE MATERNITY & NEONATAL RISK MANAGEMENT ANNUAL REPORT

PURPOSE:

This paper covers the period 1st April 2014 to 31st March 2015 with the aim of assuring the board members that the Maternity and Neonatal Services are committed to minimising risk, and improving patient safety. This is achieved through a comprehensive, pro-active, multidisciplinary approach to risk management.

The purpose of the Maternity and Neonatal Services Risk Management Strategy is to reinforce the underlying sentiment of the Trusts Risk Management Strategy, which is: To ensure that a culture is maintained where proactive risk management and safety is everyone's business, ensuring an open and transparent approach to reporting that promotes learning and prevents future adverse outcomes.

MAIN ISSUES:

There should be evidence that the learning arising from adverse events, root cause analysis, claims, complaints and supervisory reviews are shared throughout the Maternity and Neonatal Service and as necessary through the organisation.

Some of the recommendations, changes to practice, and learning arising from incidents.

2.5.1 Fetal surveillance and the correct plotting of fundal height on the growth chart: Continual training and reviews of fetal surveillance is ongoing to ensure the profile is constantly high.

Work continues to implement the GROW programme (Perinatal Institute's Growth Assessment Protocol ,GAP). (Training for Midwives and Obstetricians is underway but there is a shortage of Sonographers. 1 midwife will complete this training by the end of September 2015, and 2 Midwives will be trained by the end of the year. The radiology department are supporting their clinical practice hours).

2.5.2 New guidance on antenatal interpretation of CTG's Computerised CTG's or Dawes Redman monitors are used on all antenatal women to aid interpretation of fetal surveillance. Guidance around this analysis is to be written to enhance clinicians interpretation and understanding.

2.5.3 Telephone triage. Work has been done to improve the telephone triage proforma that is completed when women telephone the labour ward. Additional questions have been added which will prompt the question around previous telephone calls in. Staff are then encouraged to invite women in for a review if they have made contact on 2 occasions previously within a limited timeframe with the same concern.

2.5.4 3rd and 4th degree tears. Discussion continues regarding the number of reported births that have resulted in the complication of 3rd and 4th degree perineal tears. Salisbury's current rate of 3rd and 4th degree tears (which are measured together) has decreased from 3.9% to 3.4%. A continuous review of each case is undertaken but there remains no clear contributing factors apart from women are larger today (which is a known risk factor) according to a recent local audit and report. All incidences of 3rd and 4th degree tears are reviewed individually and any practice concerns investigated and reported back to clinicians and if necessary to their line managers.

The number of 4th degree tears have decreased – 3 incidents were reported during the period of 2014/15 compared to 4 the previous year and 8 in 2012/13.

2.5.5 Commissioning arrangements for the Newborn hearing screening programme are now in place. The national recommendation that a local manager oversees this screening has now been agreed and commissioned within the Maternity tariff.

2.5.6 Investigation into the maternal death is currently under review and learnings are still to be agreed.

Summary of 2014/15 achievements

- Positive progress in all of the Risk Management Strategy measurable objectives
- Friends and Family testing has been consistently positive since its implementation in October 2013. Friends and Family responses have increased within Maternity services. There has been a real drive to emphasise the importance of this initiative and all staff have embraced this. It will take time for this to become truly embedded in everday practice, but the increase in rates has been encouraging. New systems are in place within the Labour Ward to ensure all staff are aware of the need to promote the forms. In the Postnatal area, the forms are discussed and given out at the point of discharge and women and their partners are encouraged to complete the form prior to leaving. We hope to see our rates increase further over the coming months.
- The real time feedback for the Maternity Service has been consistently positive.
- The ongoing development of a rag rated clinical dashboard enabling benchmarking against other trusts in the South West.
- A huge amount of ongoing multidisciplinary teamwork with updating clinical guidelines and joint collaborative working with the quality team to improve how clinical guidelines are accessed on ICID.
- Work force review looking at activity and planning for the next 3 years alongside projected birth numbers and activity in the community has been undertaken.
- The undertaking of Birthrate plus audits to provide the specific data required to accurately measure staffing against acuity.
- Maintaining the quarterly 'quality of midwifery supervision' meeting occurs with the Director of Nursing, Head of Midwifery, Head of Governance and the Contact Supervisor of Midwives to feedback outcome of supervisory investigation and completion of any recommendations to provide additional assurance to the Trust.
- Restructure of the departments PROMPT training. To incorporate CTG training and sepsis into the PROMPT day so that all doctors and midwives receive the same training.
- The leadership team to drive robust appraisals using the new SPIDA tool.
- The successful introduction and training to implement Datix web reporting of incidents within maternity and neonatal unit. This can be evidenced by an 11% increase in the reporting of incidents.
- The completion of the obstetric theatre provision .
- The uptake of staff GROW training in preparation for the implementation of customised fetal growth charts. The GROW project forms part of the Trusts 'Sign up to safety'.
- Scanning capacity has been stretched to over capacity which has hampered the delay in implementing GROW. 3 midwife sonographers will be qualified by September 2015 which will enable this implementation to go ahead.
- A scoping exercise has been conducted looking at the capacity and demand as the current antenatal template is severely overbooked and has not been reviewed for 10 years. A further consultant clinic is to be introduced later this year.
- The number of non- labouring admissions has again marginally risen provoking a review of the antenatal DAU service.
- The implementation of Allocate for electronic off duty rosters.
- Baby steps was implemented within the public health agenda. It is an intensive programme of education delivered to vulnerable families and has a strong evidence

base suggesting that the programme directly impacts upon health and social outcomes for babies and children.

- PIMS (Positive image motivation service) is a new initiative that is supported by the Wiltshire public health team. This is a concentrated care package for women with raised BMIs to support them to manage weight gain in pregnancy and to make life changing choices that enable them to be healthier in the long term.
- Maternity is participating with the RCOG national audit 'Each baby counts'.
- On going development with Duty of Candour to maintain open and transparent culture within the department.

Future Plans

- Continue to promote an open and supportive approach towards risk which continues to reflect an environment in which staff feel able to report so that reporting rates increase.
- New Midwifery- led unit is to be built to increase birth choices for women.
- A 24/7 operational Obstetric theatre.
- The recruitment and appointment of a local manager and an administrator for NHSP.
- The refurbishment of the postnatal ward.
- To include bank staff into the Allocate rostering system.
- To continue participation into the National audit Each Baby Counts the lead by RCOG's
- Completion of the stillbirth review.
- Completion of OASIS review.
- Salisbury has signed up to be an early implementer for the NHS England 'Reducing stillbirths care bundle'.

The maternity unit had a visit from the NMC as part of an overall audit of the LSA of the South West Region. They undertook two site visits as part of their audit and Salisbury was chosen by the LSA midwifery officer as she felt the function of supervision of midwifery is undertaken well. The audit was successful and there were no actions related to the part that Maternity played in the audit. The maternity unit received positive feedback on the day and were informed that the NMC found the Maternity Unit to be welcoming and friendly, and the environment was clean and bright. Feedback from women they spoke to on the day was very positive.
The Local Supervising Authority (LSA) carried out their annual audit of supervision of midwives in Salisbury three weeks after the NMC visit. The day began with a presentation, to an invited audience, by the supervisory team on achievements of the 2014 action plan. The LSA examined health care records, patient information, specific care plans written for women with complex care needs. They toured the unit taking note of the security of records throughout and the environment.

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ATTACHMENT AVAILABLE TO VIEW ON WEBSITE: The Maternity and Neonatal Risk Management Annual Report (full paper).

ACTION REQUIRED BY THE BOARD: To note and ratify report.

Author: **Louise Jones**
Title: **Maternity Risk and Governance Manager**
Date: **September 2015**

SALISBURY NHS FOUNDATION TRUST

Maternity and Neonatal Risk Management Annual Report 2014/15

1. Introduction

This paper covers the period 1st April 2014 to 31st March 2015 with the aim of assuring the board members that the Maternity and Neonatal Services are committed to minimising risk, and improving patient safety. This is achieved through a comprehensive, pro-active, multidisciplinary approach to risk management.

The purpose of the Maternity and Neonatal Services Risk Management Strategy is to reinforce the underlying sentiment of the Trusts Risk Management Strategy, which is: To ensure that a culture is maintained where proactive risk management and safety is everyone's business, ensuring an open and transparent approach to reporting that promotes learning and prevents future adverse outcomes.

To achieve this the following outcomes are set out within the Risk Management Strategy:

- A culture where risk management and patient safety is everyone's business by ensuring clear understanding of roles and responsibilities related to risk.
- Building on the high standard of care already being provided through improvements, and the prevention, control and containment of risk.
- Maintenance of a safe environment for patients, employees and visitors.
- A robust and proactive system for reporting and analysis of adverse incidents (including near misses) with subsequent learning for all staff.
- The adoption of an open and fair approach to incident investigation which will include a culture of Being Open with patients and their families when incidents have occurred.
- Compliance with the Care Quality Commissions Essential Standards of Quality and Safety.
- Compliance with the South of England's SI Trigger List 2014.

2. Measurable Objectives for Managing Risk via the Maternity and Neonatal Services Risk Management Strategy.

Achievement of the following key objectives are considered essential for the successful implementation of the Maternity and Neonatal Services Risk Management Strategy. These objectives are also steered by the Clinical Support and Family Services Directorate and recommendations from national reports.

2.1 An annual report must be produced and presented to the Trust Board to show clear direction of travel against the aims and objectives of this strategy within the Maternity and Neonatal Service. *Achieved by way of this document*

***2.2 Incident reporting rates should continue to rise as the open reporting of incidents is encouraged within an open and fair culture*.**

Year	Total number of incidents reported for year
2012/13	**446**
2013/14	**477**
2014/15	**530**

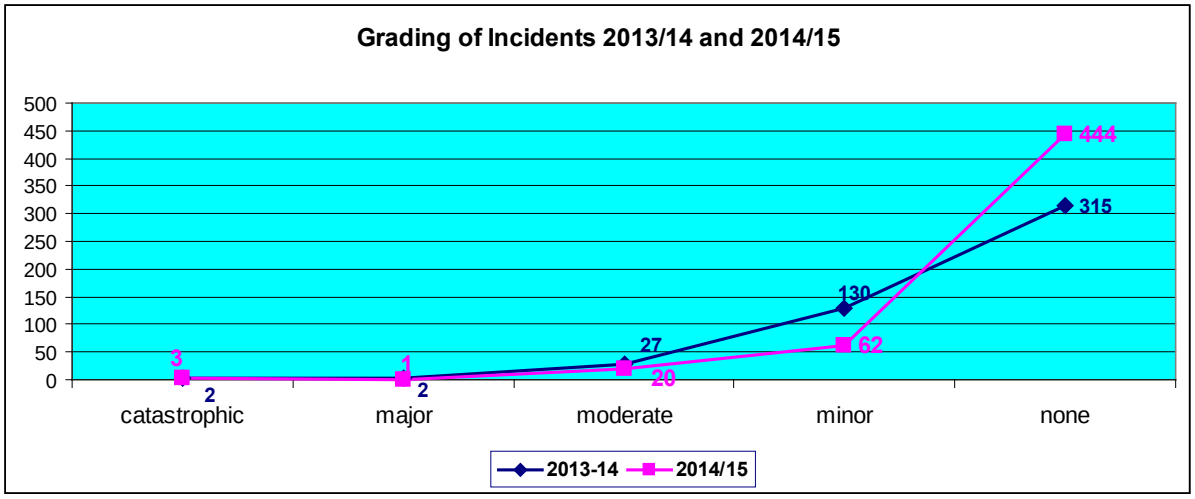
The total number of incidents reported has increased by 53 (11.11%) on the previous year. An open and supportive approach towards risk continues, which reflects an environment in which staff should feel able to report. The monthly incident report summary continues to be cascaded to all staff outlining all incidents reported, agreed outcomes thus creating an opportunity for discussion, but fundamentally for learning to be enhanced, this ensures that there is transparency surrounding activity, that there is a robust process for reviewing and investigating incidents and that the outcomes and any learning achieved can be fed back to the workplace.

All reviews/investigations are shared in full with families and staff members who have been directly involved in the care. When an incident is identified that requires a review the Maternity Risk and Governance Manager contacts the family in writing to inform them that there will be a review into their care. At that time the family are invited to ask questions they feel they would like included in the review. Families are given regular updates on the progress and a meeting is offered in person to the family to share the findings of the review when it is completed.

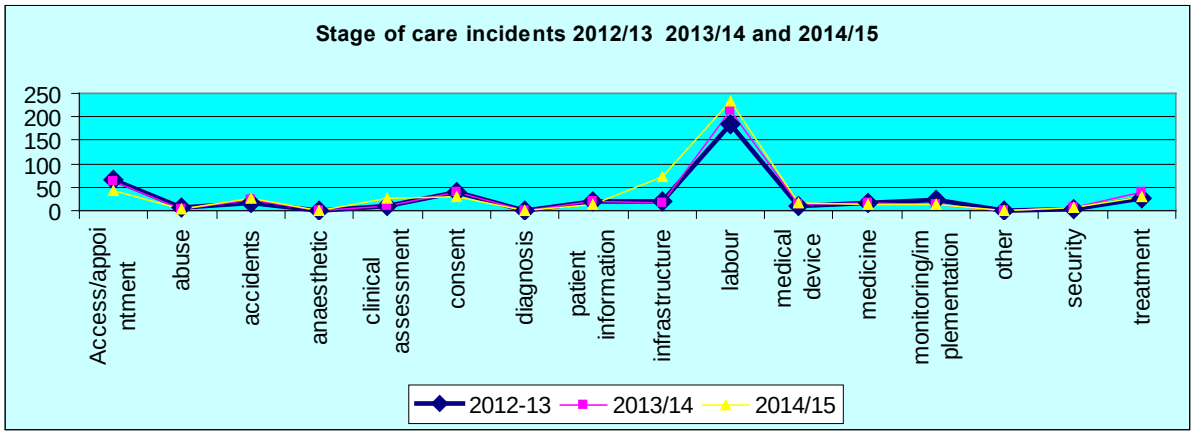
The Maternity Risk and Governance Manager and the Obstetric Consultant lead for risk work collaboratively to ensure all risks and incidents are considered, and that the duty of candour is extended and upheld for all moderate incidents.

The reports, with the recommendations raised from incident reviews and investigations, are cascaded and shared throughout the department and discussed in the multidisciplinary Clinical Governance Forum. A paper copy of all reviews is then kept within the clinical areas for staff to access to promote ongoing learning.

The table below shows the breakdown of incidents by severity. There has been an increase in the number of catastrophic incidents reported from 2 to 3 since previous year. The number of majors have reduced from 2 to 1 incident over the year (all subject to SIIs or Clinical Reviews), with a reduction in moderate and minor events and a significant increase in the number of no harm events reported.



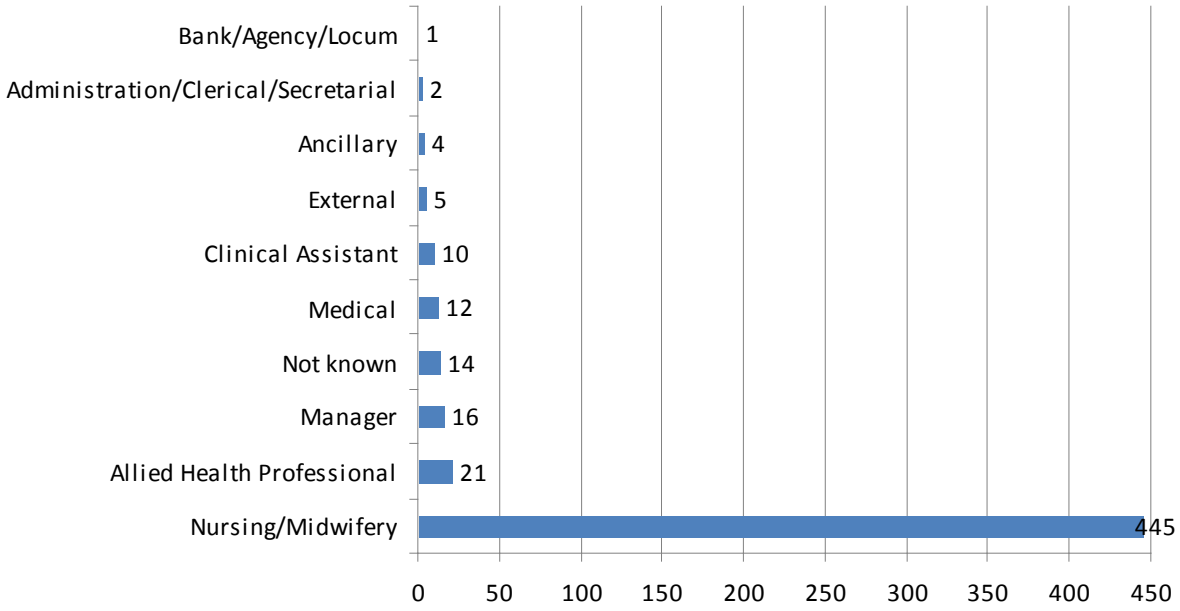
The largest number of reported incidents 234, (43.3%), were clinical incidents within the labour and delivery stage of care (Intrapartum), this is unchanged from the previous year. The majority of these are trigger events which are known potential complications of labour that all maternity units should be reporting against. This allows us to monitor whether complication rates are rising and therefore where further investigation should be focussed.



2.3 All staff groups across Maternity and Neonatal Services must report incidents as per the Adverse Events Reporting Policy and in compliance with the Maternity and Neonatal services Trigger List (appendix 1).

The graph below demonstrates the reporting rates amongst non midwife groups. The number of midwives reporting incidents has increased however the other groups have either stayed the same or reduced. This is likely to be due to the implementation of Datix web and staff in these groups are being encouraged to sign up to the training.

Staff types reporting incidents Period: 1st April 2014 - 31st March 2015



2.4 Where necessary incidents will be reported to other agencies, for example: NPSA, Director of Public Health, MBRACE, UKOSS, NHS Litigation Authority and Local Supervising Authority, RCOG (each baby counts).

In September 2014, the web reporting of incidents to the electronic database (Datix) was implemented in Maternity. All adverse incidents and near misses are now inputted onto the Trusts electronic database (DatixWeb).

Once inputted Datix web automatically notifies the Maternity Risk and Governance Manager, the Labour Ward Manager and the Contact Supervisor of Midwife of the incident. The Maternity risk and Governance manager considers whether there are any fitness to practice issues. This would necessitate escalation to the Head of Maternity and Neonatal services in the first instance. This may lead to a Supervisory review conducted by a Supervisor of Midwives (SOM) and inputted onto the LSA database.

Via Datix web clinical ward leads are notified of the incidents through email and are then able to investigate the incident within their area of expert knowledge and can complete the investigation. Once completed the grading is confirmed by the Maternity Risk and Governance manager and are then moved onto to the risk department for review and closure of the incident. Datix reporting system is used for the logging of all incidents which are reported and these are then monitored at the monthly Maternity Risk Management forum and the Trusts Clinical Risk Group. The Risk and Governance Manager reports all serious incident inquiries (SII's) to the head of Risk Management and they are then reported through STEISS.

Maternity services ensure that any external reporting requirements are met in collaboration with the Head of Risk.

Each Baby Counts is the RCOG's national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. The maternity and neonatal services signed up to this initiative when it launched in January 2015.

2.5 There should be evidence that the learning arising from adverse events, root cause analysis, claims, complaints and supervisory reviews are shared throughout the Maternity and Neonatal Service and as necessary through the organisation.

Feedback and learning from reviews are discussed at the department's Clinical Governance sessions. This is a multidisciplinary forum where lessons learnt can be cascaded . All Clinical Reviews/Serious Incident Inquiries are reported to Clinical Risk Group, and Trust Board, detailing the nature of the incident, the key findings and subsequent recommendations. The Head of Risk Management also provides the Clinical Governance Committee with a quarterly report on compliance with the recommendations from the reviews.
Some of the recommendations, changes to practice, and learning arising from incidents.

2.5.1 Fetal surveillance and the correct plotting of fundal height on the growth chart: Continual training and reviews of fetal surveillance is ongoing to ensure the profile is constantly high.
Work continues to implement the GROW programme (Perinatal Institute's Growth Assessment Protocol ,GAP). (Training for Midwives and Obstetricians is underway but there is a shortage of Sonographers. 1 midwife will complete this training by the end of September 2015, and 2 Midwives will be trained by the end of the year. The radiology department are supporting their clinical practice hours).

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2.5.3 Telephone triage. Work has been done to improve the telephone triage proforma that is completed when women telephone the labour ward. Additional questions have been added which will prompt the question around previous telephone calls in. Staff are then encouraged to invite women in for a review if they have made contact on 2 occasions previously within a limited timeframe with the same concern.

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The number of 4th degree tears have decreased – 3 incidents were reported during the period of 2014/15 compared to 4 the previous year and 8 in 2012/13.

2.5.5 Commissioning arrangements for the Newborn hearing screening programme are now in place. The national recommendation that a local manager oversees this screening has now been agreed and commissioned within the Maternity tariff.

2.5.6 Investigation into the maternal death is currently under review and learnings are still to be agreed.

2.6 Maternity and Neonatal Risk Group is to meet at least 10 times annually with an attendance list and documented minutes of actions being taken

The Maternity and Neonatal Risk Management group has met on 10 occasions throughout this period. The forum is jointly chaired by the Maternity Risk and Governance Manager and the Lead Obstetric Consultant for risk. Attendance from the Head of Maternity, the Lead anaesthetic Consultant for Obstetrics and the Paediatric Consultant for risk is mandatory. This forum is supported by the Trust Lead for risk and any concerns she has are escalated to the Executive lead for risk.

The attendance at maternity risk forum is encouraged for all staff, to promote openness and for learning. All meetings are minuted, actions identified and a copy disseminated to all staff through the communication folders and a quarterly report is circulated in the form of a newsletter updating staff on key areas to raise awareness and promote learning. The minutes provide an audit trail which provides a link to the other forums when issues need to be discussed with a wider group of staff. (see appendix 1 for Terms of reference). Staff are keen to learn about outcomes of incidents that they have reported, and this continues to be acknowledged as a positive change.

2.7 The Maternity and Neonatal Risk Group must report to the Trust Clinical Risk Group as a standing agenda item.

The Maternity Risk and Governance Manager and/or the Obstetric Consultant lead for Risk and Governance have attended the Trusts Clinical Risk Group monthly where Maternity and Neonatal risk items are a standing agenda item, and the maternity dashboard is presented for scrutiny. The development of a regional dashboard is underway and the department intends to use this toll for further benchmarking by the end of 2015

A robust review into stillbirths was undertaken and shared with the clinical risk group and with the commissioners.

2.8 There must be attendance at the Directorate Governance 3:3 by the Head of Midwifery (or nominated deputy) to ensure that maternity and neonatal incidents and risks are discussed as part of the Directorate Risk Register and Incident Report Card with the executives present and the Head of Risk Management.

The Head of Midwifery attends the Directorate 3:3s to ensure a seamless and open reporting structure of relevant information relating to risk and governance.

2.9 Annual review of staffing of clinical areas and review skill mix to ensure leadership and safe clinical practice is maintained, for all disciplines of staff.

A work force review has been undertaken and was presented at the October 2014 Trust Board. There was acknowledgment that the midwife to birth ratio was not at an acceptable level. Although 1:1 care in labour is maintained this requires frequent use of the escalation process which pulls on the community teams. These discussions initiated Birth Rate Plus to be commissioned in undertaking work within the department during November 2014 to January 2015 to provide further detail around staffing and the units activity. The final report from the birth rate plus assessment was circulated and a business case put forward to the Director of Nursing and the Chief Operating Officer prior to being discussed within the project board. An immediate appointment of 5 band 6s was agreed increasing our WTE from 73 to 78. Ongoing recruitment of staff continues.

***2.10 There should be evidence that National Guidance i.e. NSF / NICE / National Confidential Enquiries have been reviewed and recommendations implemented where appropriate*.**

All Trust clinical guidelines are based on relevant national guidance and are formally approved through the Trust process. Within maternity and the neonatal service new guidance that is released nationally is reviewed within the Governance forums. The findings are then presented and discussed at the Maternity/Neonatal Clinical Governance Forum. A baseline audit assessment is then undertaken by a nominated clinician to ensure that recommended quality standards are included within the local guidance as applicable. The audit results are returned to the clinical governance session for review, and adjustments to practice are made following discussion.

2.11 Risk and patient safety awareness is everyone's business and is included in all staff's job description. *Achieved*

2.12 The Maternity and Neonatal Service must have a dynamic risk register which shows depth and breadth of risks identified. Risks should be reviewed as a standing agenda item (as a minimum quarterly) at the Maternity and Neonatal Risk Group meeting. As a result all risks should be in date.

The Risk Register is maintained and discussed as a set agenda at the monthly Maternity and Neonatal Risk Management meeting within a multidisciplinary forum. All risks due for review are assessed and the risk escalated or reduced as the risk changes. A number of risks have been closed on the register due to successful capital bids such as, the Maternity call bell system – The old system was no longer able to meet the needs of the service with many points of call beyond repair. The new call bell system in the NNU was not able to link to the rest of the maternity system and in parts of the NNU the system wasn't working at all. Money was agreed and the system was replaced.

Departmental risks are identified through adverse events/near misses, complaints, claims, clinical risk assessments, health and safety inspections and audit and incorporate all risks associated with delivery of care.

The current top 2 risks on the departmental risk register are:

Maternity staffing which is reviewed monthly. The complexity of this involves balancing a static number of staff with an inability to exactly predict when women will labour. National guidance is available to support midwifery staffing numbers which the department considers alongside the local skill mix review process. As previously stated in 2.9 a work force review has been undertaken which initiated the commissioning of Birth Rate Plus to review the departments staffing and acuity. This work is ongoing as part of the Maternity Services Review
Day to day a robust escalation plan is utilised to ensure 1:1 care in labour and the safety of women. This is led by the supervisors of midwives out of hours and a duty manager during office hours. There is a National Maternity review underway and this is expected to have an impact on traditional working patterns. The full review is expected to be published in early 2016

The dedicated obstetric theatre has been an emergency provision open between 8am to 5pm on weekdays for the last 15 years. This risk is reviewed 3 monthly on the risk register. Agreement is now in place that the theatre will function 24 hours 7 days a week. Plans are underway for this to be implemented by October 2015.

3. Serious Incident Inquiries(SII)/Clinical Reviews.

The department has undertaken 7 reviews during the 2014/15 period compared to 8 in 2013/14.

1 review was completed using the local review format, and 6 were reported as SII's. (This compared to 5 SII's that were reported during 2013/14). The number of incidents that required formal escalation within the Trust was expected to increase due to the change to the South of England reporting structure which has extended the definition of SII's.

All reviews had engagement from staff involved in all aspects of care, and involvement with each of the families was sought. As a result of these reviews a number of recommendations were made and implemented. The recommendations are reviewed prior to implementation and are then monitored by the clinical governance committee.

The number of still births in 2011/12 had risen to 14 (0.5%) prompting a thorough, multidisciplinary review .The number of stillbirths in 2012/13 decreased to 8 (0.3%) and in the year 2014/15 that number increased to 10 (0.4%). Of these 10, 2 had known abnormalities but had chosen to continue with their pregnancies. Each case continues to be reviewed individually at the monthly Perinatal meeting and when necessary, are commissioned as a clinical review/SII. (2 of these were investigated as SII's this year). A repeated stillbirth review (2012-2014) is underway following on from the previous years (2010-2012) investigation.

4. User Feedback

Overall complaints and concerns have been reduced by half from the previous year.This is partly due to the provision of face to face meetings with families providing them with an opportunity to air their concerns at the earliest opportunity. This can also be attributed to the workforce embracing the need to have robust communication.

All complaints, concerns and comments are examined for trends and themes. During this period there have been 14 complaints and 10 concerns

4.1 Complaints

It would seem that there was an emerging theme during this period where staff behaviour, in particular, their attitude was raised in 4 complaints. These were involving different members of staff and a variety of situations within the maternity unit. When examining each incident further, it would appear that there was some miscommunication and a feeling that the complainant's were unhappy with the advice or management plans offered rather than the way in which these were communicated.

3 complainants identified, clinical management decision made in the intrapartum period as their main concern.

2 complaints were related to incidents which occurred several years ago. One in relation to an incorrect diagnoses of a DVT and the other regarding the management of a case were an incorrect HIV result was shared with the family.

The remainder of the complaints on analysis do not share common themes:

- The provision of Paediatric Services on the postnatal ward

- Management of ' prolonged rupture of membranes (PROM)' , in particular Group B strep and the late onset of neonatal sepsis.
- Safeguarding issue, requiring the removal of the baby at birth, Mother felt this management was unjust.
- Information governance concern surrounding the sharing of patient's information amongst other staff members.
- Waiting time in the Day Assessment Unit.

4.2 Concerns

2 concerns were raised regarding staff attitude. Again these were isolated incidents.

- Difficulties accessing a community midwife.
- Standard of amenity rooms. More than one family commented on the poor standards of these rooms. These have recenly been upgraded during the postnatal refurbishment.
- Anomaly scan appointment time was changed and no apparent apology offered.
- During transfer to theatre, a woman's jewellery was removed. The woman's earrings was thought to be placed in the midwife's scrub pocket and unfortunately was misplaced. All jewellery is given to family members for safe keeping. Community midwives encourage women not to bring in valuables with them to the hospital.
- A woman received an anomaly scan appointment when sadly she had lost her baby at 15 weeks gestation. Changes to the bereavement paperwork has been made to prevent a recurrence of this. Antenatal clinic staff are now responsible in cancelling all antenatal apointments in the event of a misscarriage.
- Lack of fetal medicine support when sadly a fetal abnormality was detected. Poor management decision following the TOP.

5. Summary of 2014/15 achievements

- Positive progress in all of the Risk Management Strategy measurable objectives
- Friends and Family testing has been consistently positive since its implementation in October 2013. Friends and Family responses have increased within Maternity services. There has been a real drive to emphasise the importance of this initiative and all staff have embraced this. It will take time for this to become truly embedded in everday practice, but the increase in rates has been encouraging. New systems are in place within the Labour Ward to ensure all staff are aware of the need to promote the forms. In the Postnatal area, the forms are discussed and given out at the point of discharge and women and their partners are encouraged to complete the form prior to leaving.
  We hope to see our rates increase further over the coming months.

- The real time feedback for the Maternity Service has been consistently positive.
- The ongoing development of a rag rated clinical dashboard enabling benchmarking against other trusts in the South West.
- A huge amount of ongoing multidisciplinary teamwork with updating clinical guidelines and joint collaborative working with the quality team to improve how clinical guidelines are accessed on ICID.
- Work force review looking at activity and planning for the next 3 years alongside projected birth numbers and activity in the community has been undertaken.
- The undertaking of Birthrate plus audits to provide the specific data required to accurately measure staffing against acuity.

- Maintaining the quarterly 'quality of midwifery supervision' meeting occurs with the Director of Nursing, Head of Midwifery, Head of Governance and the Contact Supervisor of Midwives to feedback outcome of supervisory investigation and completion of any recommendations to provide additional assurance to the Trust.
- Restructure of the departments PROMPT training. To incorporate CTG training and sepsis into the PROMPT day so that all doctors and midwives receive the same training.
- The leadership team to drive robust appraisals using the new SPIDA tool.
- The successful introduction and training to implement Datix web reporting of incidents within maternity and neonatal unit. This can be evidenced by an 11% increase in the reporting of incidents.
- The completion of the obstetric theatre provision .
- The uptake of staff GROW training in preparation for the implementation of customised fetal growth charts. The GROW project forms part of the Trusts 'Sign up to safety'.
- Scanning capacity has been stretched to over capacity which has hampered the delay in implementing GROW. 3 midwife sonographers will be qualified by September 2015 which will enable this implementation to go ahead.
- A scoping exercise has been conducted looking at the capacity and demand as the current antenatal template is severely overbooked and has not been reviewed for 10 years. A further consultant clinic is to be introduced later this year.
- The number of non- labouring admissions has again marginally risen provoking a review of the antenatal DAU service.
- The implementation of Allocate for electronic off duty rosters.
- Baby steps was implemented within the public health agenda. It is an intensive programme of education delivered to vulnerable families and has a strong evidence base suggesting that the programme directly impacts upon health and social outcomes for babies and children.
- PIMS (Positive image motivation service) is a new initiative that is supported by the Wiltshire public health team. This is a concentrated care package for women with raised BMIs to support them to manage weight gain in pregnancy and to make life changing choices that enable them to be healthier in the long term.
- Maternity is participating with the RCOG national audit 'Each baby counts'.
- On going development with Duty of Candour to maintain open and transparent culture within the department.

6. Future Plans

- Continue to promote an open and supportive approach towards risk which continues to reflect an environment in which staff feel able to report so that reporting rates increase.
- New Midwifery- led unit is to be built to increase birth choices for women.
- A 24/7 operational Obstetric theatre.
- The recruitment and appointment of a local manager and an administrator for NHSP.
- The refurbishment of the postnatal ward.
- To include bank staff into the Allocate rostering system.
- To continue participation into the National audit Each Baby Counts the lead by RCOG's
- Completion of the stillbirth review.
- Completion of OASIS review.
- Salisbury has signed up to be an early implementer for the NHS England 'Reducing stillbirths care bundle'.

The maternity unit had a visit from the NMC as part of an overall audit of the LSA of the South West Region. They undertook two site visits as part of their audit and Salisbury was chosen by the LSA midwifery officer as she felt the function of supervision of midwifery is undertaken well. The audit was successful and there were no actions related to the part that Maternity played in the audit. The maternity unit received positive feedback on the day and were informed that the NMC found the Maternity Unit to be welcoming and friendly, and the environment was clean and bright. Feedback from women they spoke to on the day was very positive.

The Local Supervising Authority (LSA) carried out their annual audit of supervision of midwives in Salisbury three weeks after the NMC visit. The day began with a presentation, to an invited audience, by the supervisory team on achievements of the 2014 action plan. The LSA examined health care records, patient information, specific care plans written for women with complex care needs. They toured the unit taking note of the security of records throughout and the environment.

TERMS OF REFERENCE
Maternity and Neonatal Risk Management Form

- ***AIMS.***

To ensure systems are in place so that women and their families experience safe, high quality, clinically effective care at all times. The overriding commitment of the Maternity and Neonatal Risk Management forum is to encourage safe effective clinical practice. In addition to this, the group is committed to implementing activities designed to identify and decrease the risk of patient injury associated with clinical care.

The main functions of the group are:

- To encourage safe, effective clinical practice.
- To feedback through the workforce via; communication groups, Supervisors meetings, Community midwives meetings, directly to staff involved .
- To monitor and review the departmental risk register.
- Monitor and review the maternity and Datix monthly report card
- To review monthly incidents, identify trends/themes in reporting and cascade these out to staff groups through quarterly newsletter.
- Keep minutes of meetings with recommendations and responsibility for action. These should be cascaded out to staff groups.
- Monitor clinical audit plans and ensure that lessons learned/ feedback is given to staff.
- Act as a central pool of expertise to supplement and support risk management work across the service and encourage a systematic approach to the management of clinical risk.

MEETINGS AND AGENDAS

- Meetings will be held monthly (a minimum of 9 meetings should take place throughout the 12 months)
- The quorum for the group is 4 members (either Maternity Risk Manager, or consultant lead to chair meeting)
- Members are expected to attend 5 out of 10 meetings annually.
- Obstetric Lead for Risk or Head Of Midwifery must be present to ensure information is disseminated fully.
- Agenda items should be notified to the chair 7 days prior to the meeting.
- An agenda should be issued 3 days prior to the meeting.
- Minutes should be available 7 days from the meeting.
- Records of Meetings will be maintained

Membership

Consultant Obstetrician lead for risk (Chair)
Maternity Risk and Governance Manager
Head of Maternity and Neonatal Services
Consultant Anaesthetist
Postnatal and Neonatal Services Manager
Labour ward lead
Community Manager and Named Midwife for Safeguarding children.
Consultant Paediatrician
Antenatal lead
Supervisor of Midwives

Minimum attendance being 50%
(This forum is open to all clinical staff within the Maternity and Neonatal department).

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SALISBURY NHS FOUNDATION TRUST ONLY

Opinions and conclusions arising from our audit

1 Our opinion on the financial statements is unmodified

We have audited the financial statements of Salisbury NHS Foundation Trust (FT) for the year ended 31 March 2015 set out on pages 1 to 43. In our opinion:

- the financial statements give a true and fair view of the state of the Group's and the Trust's affairs as at 31 March 2015 and of the Group's and the Trust's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

2 Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows:

Valuation of land, buildings and dwellings - £109.6 million

Refer to the Annual Report page 51 (Audit Committee Report) and the Financial Statements page 8 (accounting policy) and pages 27 to 30 (financial disclosures).

The risk*:* Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (MEAV).

There is significant judgment involved in determining the appropriate basis (EUV or MEAV) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation and the condition of the asset. In particular the MEAV basis requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site, with a potentially significant effect on the valuation.

In 2014/15 the Group commissioned a full revaluation exercise of all land, buildings and dwellings from an external valuer, District Valuer Services.

Our Response*:* In this area our audit procedures included:

- Assessing the competence, capability, objectivity and independence of the District Valuer Services, considering the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the NHS Foundation Trust Annual Reporting Manual;
- Considering those assets acquired or constructed during the year which were not subject to a full valuation to assess whether it was reasonable for the Group to conclude that the fair value of these assets was not significantly different from their initial cost by reference to appropriate indices;
- Challenging the appropriateness of the valuation bases and assumptions applied to individual assets by reference to property records held by the Group, including reconciliation of details provided for revalued assets to the historical revaluations and indices applied to the revaluation with reference to third party data. We used our own valuation specialist to support our assessment of the revaluation;
- Undertaking work to understand the basis upon which any revaluations to land and buildings have been recognised in the financial statements and determining whether they complied with the requirements of the FT Annual Reporting Manual; and We considered

the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities.

NHS Income Recognition - £174.8 million

Refer to the Annual Report page 51 (Audit Committee Report) and the Financial Statements page 6 (accounting policy) and pages 19 to 20 (financial disclosures).

The risk: The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners, which make up (96%) of income from activities. The Trust participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource accounts. The AoB exercise identifies mismatches between receivable and payable balances recognised by the Trust and its commissioners, which will be resolved after the date of approval of these financial statements. For these financial statements the Trust identifies the specific cause, and accounts for the expected future resolution, of each individual difference. Mis-matches can occur for a number of reasons, but the most significant arise where:

- the Trust and commissioners record different accruals for completed periods of healthcare which have not yet been invoiced;
- income relating to partially completed period of healthcare is apportioned across the financial years and the commissioners and the Trust make different apportionment assumptions;
- there is a lack of agreement over proposed contract penalties for sub-standard performance.

Where there is a lack of agreement, mis-matches can also be classified as formal disputes and referred to NHS England Area Teams for resolution.

We do not consider NHS income to be at high risk of significant misstatement, or to be subject to a significant level of judgement. However, due to its materiality in the context of the financial statements as a whole NHS income is considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit.

Our response*:* In this area our audit procedures included:

- Reconciling the income recorded in the financial statements to signed contracts with material commissioners and reviewing material variations agreed throughout the year to supporting activity, supported by explanations from the Trust;
- Assessing whether the Trust was in formal dispute or arbitration in relation to any material income balances and examining the supporting correspondence, including - if appropriate - any legal advice, for consistency with the treatment of these balances within the financial statements;
- Inspecting third party confirmations from commissioners, including the results of the AoB exercise with other NHS organisations and comparing the values disclosed within their financial statements to the values recorded in the Trust's financial statements;
- Carrying out testing of a sample of invoices raised pre and post year end to determine whether income had been recognised in the appropriate period.

3 Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £4.0m, determined with reference to a benchmark of income from operations (of which it represents 2%). We consider income from operations to be more stable than a surplus-related benchmark.

We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.2, in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group has four reporting components and all of them were subject to audits for group reporting purposes performed by the Group audit team at one location in Salisbury. These audits covered 100% of group income, surplus for the year and total assets. The audits performed for group reporting purposes were all performed to Group materiality levels.

4 Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15; and
- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5 We have nothing to report in respect of the matters on which we are required to report by exception

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the annual report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the annual report and accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Group's performance, business model and strategy; or
- the Annual Report which includes the section on "The Audit Committee" on page 51 does not appropriately address matters communicated by us to the audit committee.

Under the Audit Code for NHS Foundation Trusts we are required to report to you if in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.
- the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of the above responsibilities.

Certificate of audit completion

We certify that we have completed the audit of the accounts of Salisbury NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

As detailed further in our separate opinion on the Trust's quality report, we have not issued a limited assurance opinion in relation to the Trust's mandated indicators (62 day Cancer Waits and 18 week Referral to Treatment target).

Respective responsibilities of the accounting officer and auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page (ii) the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Jonathan Brown

for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
100 Temple Street, Bristol, BS1 6AG
28 May 2015