SALISBURY NHS FOUNDATION TRUST

TRUST BOARD

MONDAY 6 OCTOBER 2014, 1.30PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
1.30pm	**1**	**APOLOGIES FOR ABSENCE –** Steve Long			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES**			1
		Public Board Meeting held on 4 August 2014			
	4	**MATTERS ARISING**			
1.35pm	**5**	**CHIEF EXECUTIVE**			
		1. Chief Executive's Report	PH	SFT 3572	9
1.45pm	**6**	**STAFF**			
		1. Ward Staffing	LW	SFT 3573	13
2.00pm	**7**	**PATIENT CARE**			
		1. Quality Indicator Report to 31 August (month 5)	CB/LW	SFT 3574	21
		2. Complaints Report Q1, 1 April – 30 June 2014	LW	SFT 3575	29
2.30pm	**8**	**PERFORMANCE AND PLANNING**			
		1. Better Care Fund – Update	KH	SFT 3576	Verbal
		2. Skill Mix Review	LW	SFT 3577	39
		2 Finance Committee Draft Minutes and terms of reference 22 September 2014	NM	SFT 3578	45
		3. Financial Performance to 31 August (month 5)	MC	SFT 3579	49
		4. Progress against Targets and Performance Indicators to 31 August (month 5)	KH	SFT 3580	To follow
		5. Update on Planning Process	LA	SFT 3581	Verbal

Time	Item	Title	Lead	Paper	Page
		6. Capital Development Report	LA	SFT 3582	59
		7. Update on Provision of Cleaning Services	KH	SFT 3583	To follow
3.00pm	**9**	**PAPERS FOR NOTING OR APPROVAL**			
		1. JBD Minutes Evidencing Presentation of Assurance Framework and Risk Register	PH	SFT 3584	69
		2. Risk Management Annual Report 2014/15	LW	SFT 3585	71
		3. Risk Management Strategy 2014/15	LW	SFT 3586	105
		4. Clinical Governance Annual Report 2013/14	CB	SFT 3587	129
		5. Maternity and Neonatal Risk Management Strategy and Annual Report	LW	SFT 3588	139
		6. Management Letter for 2013/14	PH	SFT 3589	187
		7. Minutes from Clinical Governance Committee 24th July 2014	LW	SFT 3590	199
		8. Minutes from Public Section of Council of Governors Meeting 21 July 2014	NM	SFT 3591	215
3.45pm	**10**	**ANY OTHER URGENT BUSINESS**			
	11	**QUESTIONS FROM THE PUBLIC**			
	12	**NEXT MEETING**			
		The next ordinary meeting will be held on Monday 8 December 2014, 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 4 August 2014
In the Boardroom, Salisbury District Hospital

Board Members Present:	Dr N Marsden	Chairman
	Mr N Atkinson	Non-Executive Director
	Dr L Brown	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
	Mr I Downie	Non-Executive Director
	Mr A Freemantle	Non-Executive Director
	Mr P Hill	Chief Executive
	Mrs F Hyett	Interim Director of Nursing
	Mrs A Kingscott	Director of Human Resources and Organisational Development
	Mr S Long	Non-Executive Director
	Revd Dame S Mullally	Non-Executive Director
	Mrs L Wilkinson	Director of Nursing
Corporate Directors:	Mr L Arnold	Director of Corporate Development
	Mr M Ace	Associate Executive Director
In Attendance:	Mr P Butler	Communications Manager
	Mr D Seabrooke	Secretary to the Board
	Mr P Lefever	Wiltshire Health Watch
	Mrs C Bishop	Care Quality Commission - Observer
	Mr and Mrs E Gould	Volunteers
	Mr R Polkinghorne	Governor
	Councillor John Noeken	Governor
	Mr B Fisk	Governor
	Mrs J Sanders	Governor
	Mrs C Noonan	Governor
	Dr E Robertson	Governor
	Dr A Lack	Governor
	Mrs L Robson	Observer
	Mrs C Martindale	Lead Governor
Apologies:	Dr C Blanshard	Medical Director
	Ms K Hannam	Chief Operating Officer
	Mr M Wareham	Staff Side

1996/00 DECLARATIONS OF INTERESTS

Members of the Board were reminded that they had a duty to declare any interests arising from the discussion, any impairment to being fit and proper and to avoid any conflicts of interest. No member present declared any such interest.

1997/00 WELCOME

The Chairman welcomed to the meeting Lorna Wilkinson who had taken up her role as Director of Nursing from 4 August 2014.

1998/00 MINUTES – 9 JUNE 2014

The minutes of the Public Board meeting held on 9 June, were approved as a correct record.

1999/00 CHIEF EXECUTIVE'S REPORT - SFT 3551 - PRESENTED BY PH

Peter Hill highlighted the mock inspection that had been arranged for 3 and 4 September to test the Trust's approach to the re-designed CQC inspection framework.

He reported that the Trust's Quality Account had now been published on NHS Choices together with information on Safer Staffing and other safety information.

The mobile chemotherapy service had recently increased the number of locations the unit was able to visit. The Trust had won a tender for sexual health services in South Wiltshire.

Finally the report set out a number of recent events including the 70th Anniversary of the D-Day Landings, the 30th Anniversary of the Spinal Unit and 60th anniversary of Radio Odstock.

The Board noted the Chief Executive's Report.

2000/00 STAFF

2000/01 Nurse Staffing - SFT 3552 - Presented by FH

The Board received a report setting out nurse staffing levels, actual versus planned for June. The report indicated that the Trust had delivered slightly more hours than planned and that skill mix had been 70% registered nurses and 30% nursing assistants against a planned skill mix of 65%/35%.

The report gave details of the split by day and night shift and a breakdown by individual wards, day shifts and night shifts.

It was noted that the more detailed monitoring would help the Trust to monitor vacancies over time and to target recruitment activity. It was noted that the arrangements on Tisbury Ward meant that some staff carrying out nursing duties had to be recorded in the care assistant column and that the ward had a specification of six qualified nurses but often could work safely with five.

The Allocate e-rostering system continued to be rolled out and was driving the data presented to the Board. It was also noted that the next twice yearly skill mix review was getting underway.

The Board noted the Nurse Staffing Report.

2000/02 Annual Equality and Diversity Report - SFT 3553 Presented by AK

The Board received the half yearly Equality and Diversity Report describing progress with the equality and diversity delivery system, an analysis of existing workforce and figures arsing from job applications, training and staff survey work. The report also highlighted information from the national in-patients survey and the engagement work on equality and diversity being undertaken.

The Executive Workforce Committee had debated the report and had identified a need for more work on sexual orientation issues. It was noted that the Trust had received funding from Stonewall to undertake more engagement work through the Equality and Diversity Steering Group.

There remained a challenge on raising the training compliance rate on equality and diversity. Alison Kingscott undertook to provide further information on the collection of protected characteristics information on governors and service users. AK

The Board noted the Annual Equality and Diversity Report.

2000/03 Friends and Family Test for Staff 1st Quarter – SFT 3554 – Presented by AK

The Board received the report on the new Friends and Family Test for staff. As with the patient Friends and Family Test the Trust asked how likely the respondent would be to recommend the organisation to friends and family who required care and treatment and as a place to work. Under the net promoter score methodology only those respondents responding ‘extremely likely’ counted positively towards the Trust’s score.

AK tabled details of scores provided by other Trusts in the south west. The Trust had achieved a score of 97% in respect of treatment (Net Promoter Score of 80) and 84% in respect of the Trust as a place to work (Net Promoter Score of 42). These scores were noted to be the best in the region. The Trust’s survey had included free text and feedback from this had been given to Directorates. For Quarter Two and going forward the Trust would work to raise the response rate from the Quarter One rate. A further report would be made to the 8 December meeting of the Board and the Board noted the Quarter One Report.

2001/00 PATIENT CARE

2001/01 Quality Indicator Report for Quarter One – SFT 3555 - Presented by CB and FH

The Board received the Quality Indicator Report for Quarter One 2014/15. It was noted that there had been eight attributed cases of C Difficile against the annual ceiling of 18 cases. The Trust would be putting forward up to three of these cases for review by the Wiltshire CCG following receipt of details of their process for this.

There had been five MSSA bacteraemias and six new serious incident enquiries.

The crude mortality rate had declined, HMSR was 99 following March 2014 and was as expected.

It was noted that the hospital had been especially busy during Quarter One with escalation beds open and continuing issues with delayed transfers of care. There had been high attendances in A&E and it appeared that this was the experience across the healthcare community in the locality.

The Board noted the Quality Indicator Report.

2001/02 NHS Safety Update – SFT 3556 – Presented by FH

Fiona Hyett presented a set of slides which described the Sign Up To Safety Campaign taking forward recommendations from the Berwick Advisory Group. The campaign aimed to make lasting changes to improve safety, halving avoidable harm and saving 6,000 lives over three years. Trusts were asked to develop a plan around two or more national safety priorities and two or more local safety priorities and engage the local community and staff in designing these. Among the national support initiatives were patient safety collaboratives led by Academic Health Science Networks, developing 5,000 patient safety fellows and a new SAFE team to provide Trusts with additional clinical and managerial resource.

Lorna Wilkinson would be the Trust's Executive Lead and a number of actions would be agreed to support the pledges of putting safety first, continually learning, honesty, collaboration and support and agreeing the local objectives.

It was noted that the initiative would be incorporated into existing activity and it was believed that the initiative would take about three months to get started.

It was also noted that the Trust had received a 'Red/Among the Worst' rating on NHS Choices based on a mixture of its PLACE score and recent infection control performance.

The Board considered that the tough approach adopted to the 2013 PLACE assessments was the right one as it was based on transparency and honesty and had not resulted in the Trust receiving 100% on any of the self-assessment scores.

The Board supported the Sign Up to Safety campaign.

2002/00 PERFORMANCE AND PLANNING

2002/01 Finance Committee minutes 27 May and 23 June 2014 – SFT 3557 – Presented by NM

The Board received a report summarising the approved minutes of the Finance Committee. The Chairman reported that at this stage in

the financial year the Trust was operating according to plan. The Committee was focusing on monitoring the Trust's transformation schemes. Work continued to develop the appropriate range of information to support this. The Committee had also met with the representatives of the Trust's external companies to discuss performance and progress.

The Board noted the Finance Committee minutes for 27 May and 23 June 2014.

2002/02 Financial Performance to 30 June 2014 – SFT 3558 – Presented by MC

The Board received the Finance Report and MC summarised the main points as follows:-

- A risk assurance Framework rating of Four.
- Cash and working capital were in line with plan.
- The Wiltshire CCG contract was signed.
- There was concern about the use of more expensive staffing agencies.
- The Trust was achieving less than half of straight line cost improvement programme but was delivering against its phased approach.
- The Plan submitted to Monitor may have understated the income that would be received from the Trust's subsidiaries.
- The Trust Capital Programme would need to be re-submitted to Monitor,

The Board noted the Finance Report to 30 June.

2002/03 Progress against Targets and Performance Indicators to 30 June 2014 – SFT 3559 – Presented by LA

The Board received the Performance Report.

It was noted that the Trust had met all the Monitor Assurance measures for Quarter One.

The Four Hour ED target was not achieved in June and was not thought to have been achieved in July. This was due to the increased demand being experienced in the local healthcare system at present. An action plan was being put in place to address these increased attendances.

There had been an increase in the number of Two Week Cancer referrals in July. The referral to treatment patient choice targets had been achieved but it was noted that under a waiting list initiative to be announced by the Secretary of State, recorded performance may go below the 90% standard in Quarter Two.

On staffing it was noted that absence rates were good and that the implementation of electronic appraisals was affecting the reported rate of completed appraisals. Wiltshire Council continued to focus

on delayed transfers of care.

Coding performance was disappointing in terms of time but the quality was demonstrated to be good. The implementation over the next two years of an electronic patient records system would streamline the process.

It was noted that there was less availability from the staff bank to cover shifts in the summer months as many people choose to work through the bank as this enabled them to choose when they worked.

It was also noted that the implementation of the Better Care Fund was being discussed by the Health and Well Being Board and that the local authority was piloting discharge to assess arrangements that enabled a quicker discharge from a hospital to a suitable setting while long term care needs were assessed.

The Board noted the Performance Report.

2002/04 Attendance of Governors at Part II Board Meetings – SFT 3560 – Presented by NM

The Board received a report and a protocol designed to regulate and enable the attendance of a governor at Part II Board Meetings as an observer.

The Chairman reminded the Board that the role of the Council of Governors was to hold the Board to account and although there was minimal business discussed in Part II transparency as to the Board's performance would be enhanced by this mechanism. As noted in the report the governor could discuss issues about the Board's handling of this part of the agenda at the Council of Governors Performance Committee or direct with the Chairman or Senior Independent Director.

The need to recognise the confidentiality of the business discussed in Part II meetings was emphasised. The Lead Governor and Chairman would discuss which governor would be asked to attend Part II Board Meetings. It was noted that the Clinical Governance Committee had at its 25 July meeting approved a similar protocol which would take effect from its 25 September meeting.

The protocol attached to the report was approved.

2003/00 MATTERS FOR NOTING OR APPROVAL

2003/01 Update on Planning Process – SFT 3561 – Presented by LA

Laurence Arnold informed the Board that the Trust expected feedback from Monitor in September. A recent Executive to Executive Board Meeting had taken place with Wiltshire CCG and discussed each organisation's plans. There had not felt to be any dissidence between the approaches adopted.

The Trust's adopted plan was being issued to Directorates as the

basis for their planning.

2003/02 Remuneration Committee 18th Annual Report – SFT 3562 – Presented by NM

The Board received a brief summary of the main items determined by the Remuneration Committee in 2013/14.

The report was noted.

2003/03 Clinical Governance Committee minutes from meeting held on 26 June 2014 – SFT 3563 – Presented by LB

The Board received the approved minutes of the Clinical Governance Committee for 26 June. It was noted that the incident in Quarter Four that had been categorised initially as catastrophic had since been re-classified following the conclusion of the investigation.

Lydia Brown informed the Board that the Committee discussed C Diff on a regular basis. In response to the cases experienced in Quarter One the Trust had had a critical friend review by Wiltshire and West Hampshire Infection Control Leads and this had resulted in an action plan detailed in the next board agenda item.

It was noted that the Trust had started ribotyping recently and had introduced Glosair machines for cleaning areas occupied by patients with C Diff. The PLACE style audits conducted by the Trust were being extended to include areas not usually visited by patients. There had been positive feedback from the CCG leads showing good practice and there had been an opportunity to share policy documents.

It was also noted that the Wiltshire CCG had now confirmed their process for the review of attributed C Diff cases.

The Board noted the minutes of the Clinical Governance Committee.

2003/04 Update on C Diff - SFT 3564 – Presented by FH

The Board received details of an action plan for the prevention of C Diff based around the themes of Policies and Procedures, Isolation of Symptomatic Patients, Anti Microbial Prescribing, Assurance, Clinical Practice/Cleaning and the Environment and Education and Training. It was noted that the Trust was reviewing housekeeping arrangements in particular the cleaning agents and tools used and would be promoting more face to face learning in addition to e learning.

The Board noted the C Diff action plan

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2003/5 Minutes from Audit Committee meetings held on 23 May 2014 and 14 July 2014 – SFT 3565 – Presented by NA

The Board received the confirmed minutes of the 23 May meeting

and the draft minutes of the 14 July meeting.

NA reported that the 23 May meeting had been concerned with the scrutiny of the annual accounts and the 14 July with the routine review of the reports of the internal and external auditors. The external auditor had presented to the Council of Governors meeting on 21 July. Counter Fraud continued to progress and it was noted that through national networks issues arising in other Trusts such as bank fraud were picked up and were reflected in local practices. The July meeting had received an update from the Director of IT on the progress with patching Windows software.

The Board noted the minutes of the Audit Committee 23 May and 14 July 2014.

2003/06 Annual Review of Committee Terms of Reference – SFT 3566 – Presented by NM

The Board received the recently reviewed Terms of Reference for the Clinical Governance Committee, Audit Committee, Finance Committee and Remuneration Committee.

It was noted that the Finance Committee would be considering its Terms of Reference with a view to taking greater responsibility for scrutinising operational performance.

The Board noted the report.

2004/00 QUESTIONS FROM THE PUBLIC

Alastair Lack asked about data relating to surgery cancelled the day before the appointment and LA undertook to provide information about this to him. LA

2005/00 INTERIM DIRECTOR OF NURSING

The Board joined the Chairman in thanking Fiona Hyett for her work as Interim Director of Nursing since 1 April 2014 and she was presented with a spray of flowers.

2006/00 DATE OF NEXT MEETING

It was noted that the next public meeting of the Trust Board will be on Monday 6 October 2014, in the Board Room at 1.30pm.

CONFIDENTIAL ISSUES

The Board resolved to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reasons of confidential nature of the business to be conducted.

SFT 3572

CHIEF EXECUTIVE REPORT

MAIN ISSUES:

SEASONAL FLU CAMPAIGN 2014

In early October we will be starting 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. We will be taking a flexible approach to vaccinating staff this year and will offer a walk-in clinic in the Emergency department, a booked vaccine clinic in the Occupational Health Department, and a number of pop-up clinics at various locations throughout the Trust. This will be promoted through our internal flu vaccination campaign.

SALISBURY IN TOP 100 HEALTHCARE ORGANISATIONS TO WORK

We are pleased to report that comments from our staff have placed the Trust in the top 100 best healthcare organisations in the country to work. The Health Service Journal gathered a range of information from employers and staff and these were then analysed by independent workplace research firm Best Companies Group who used these to benchmark organisations and identify the top 100. The publication, which was supported by NHS employers, covered all general, community and mental health Trusts, as well as Clinical Commissioning Groups. It took into account the results and comments from staff surveys, and a range of information from the quality of leadership and staff communication and engagement, to the working environment and training and development.

POSITIVE RESULTS FROM FIRST STAFF FRIENDS AND FAMILY TEST

In the first quarter of the staff Friends and Family Test, responses from our staff on whether they would recommend the hospital as a place to receive treatment have placed us third nationally out of 244 Trusts. When asked whether they would recommend the hospital as a place to work we are ninth and sixth overall when both scores are combined. This is an encouraging start to the test and complements the positive feedback we are already receiving from our patients in this aspect of the test.

SALISBURY CANCER PATIENTS RATE THEIR CARE HIGHLY IN NATIONAL SURVEY

Cancer patients have rated their care highly with 94% of those asked saying that it was very good or excellent in a national survey carried out by NHS England. Over 340 patients responded to the questionnaire which covered the patient's diagnosis and treatment, confidence in staff, hospital information and the support that they received at home. The Trust performed well and was in the top 20% of best performing Trusts in many of the questions, with privacy, pain control and the provision of information examples of positive areas highlighted in this survey. The survey did identify some areas for improvement, particularly in the provision of written information during treatment and discharge. We also plan to give more encouragement to patients who wish to bring a friend to sensitive consultations.

BREAST CANCER CAMPAIGN LAUNCH

We have now launched our new campaign to raise £750,000 for a dedicated Breast Cancer Unit at Salisbury District Hospital. The new unit will provide the best possible environment for women and men, with purpose-built waiting, diagnostic and treatment rooms for breast patients. Counselling rooms will be available to patients who have just received a cancer diagnosis or who need support, with sensitive design and décor creating a calm, light and dignified environment for patients. The new Unit will also enable faster care and treatment.

EARL OF PEMBROKE OFFICIALLY OPENS NEW PEMBROKE UNIT GARDEN

Around 100 patients, staff and carers joined The Earl of Pembroke when he officially opened the new Pembroke Unit Garden at Salisbury District Hospital. Patients who have had a stroke or need cancer treatment now have a quiet area to relax and gather their thoughts following the completion of the beautifully designed and landscaped courtyard garden in between Farley Stroke Unit and the Oncology Outpatient Clinic. The Pembroke Unit Garden, which cost £44,000 and was made possible through charitable donations to the Stars Appeal's ward funds, features two circular patios that can be approached by a smooth wheelchair- friendly pathway. It has a low wooden bridge crossing a " bog garden", and is surrounded by carefully selected shrubs and flowers that have created a natural wildlife habitat that patients can enjoy.

CHANGES TO PITTON WARD HELP IMPROVE CARE AND SURROUNDINGS FOR PATIENTS

Major changes have been made to the layout and decoration on Pitton Ward that will provide more calm and relaxing surroundings for patients and help with their care and wellbeing while in hospital. Improvements to Pitton Ward follow changes made to Redlynch Ward earlier in the year, as part of a programme to make general wards at Salisbury District Hospital more comfortable and stimulating for patients. This includes those with dementia who are admitted to hospital for other medical reasons. The aim is that over the next few years other wards will be improved as part of this programme of change.

STOPTOBER

We are backing the annual Stoptober 28 day challenge which encourages people to give up smoking. Research shows that people are five times more likely to stay 'smoke free' for good if they stop smoking for 28 days or longer and last year nearly a quarter of a million people in England and Wales signed up to Stoptober, giving them the opportunity to take advantage of the financial savings and health and social benefits of not smoking. This year we are again encouraging our staff to sign up to the 28 day challenge by contacting our Health Improvement Practitioner in Smoking Cessation. As part of Stoptober, she will be available to meet up with staff to advise and support them on giving up smoking, provide one-to-one weekly meetings in departments and advise on medication and support for staff who want to join one of the Trust's 12-week stop smoking programmes.

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. As we

continue to celebrate the 21st anniversary of Salisbury District Hospital, we had two presentations highlighting the clinical and technological developments that have taken place over the last 21 years, with a focus on diagnostics and nursing care. This was in addition to the annual review of the Trust's operational and financial performance.

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

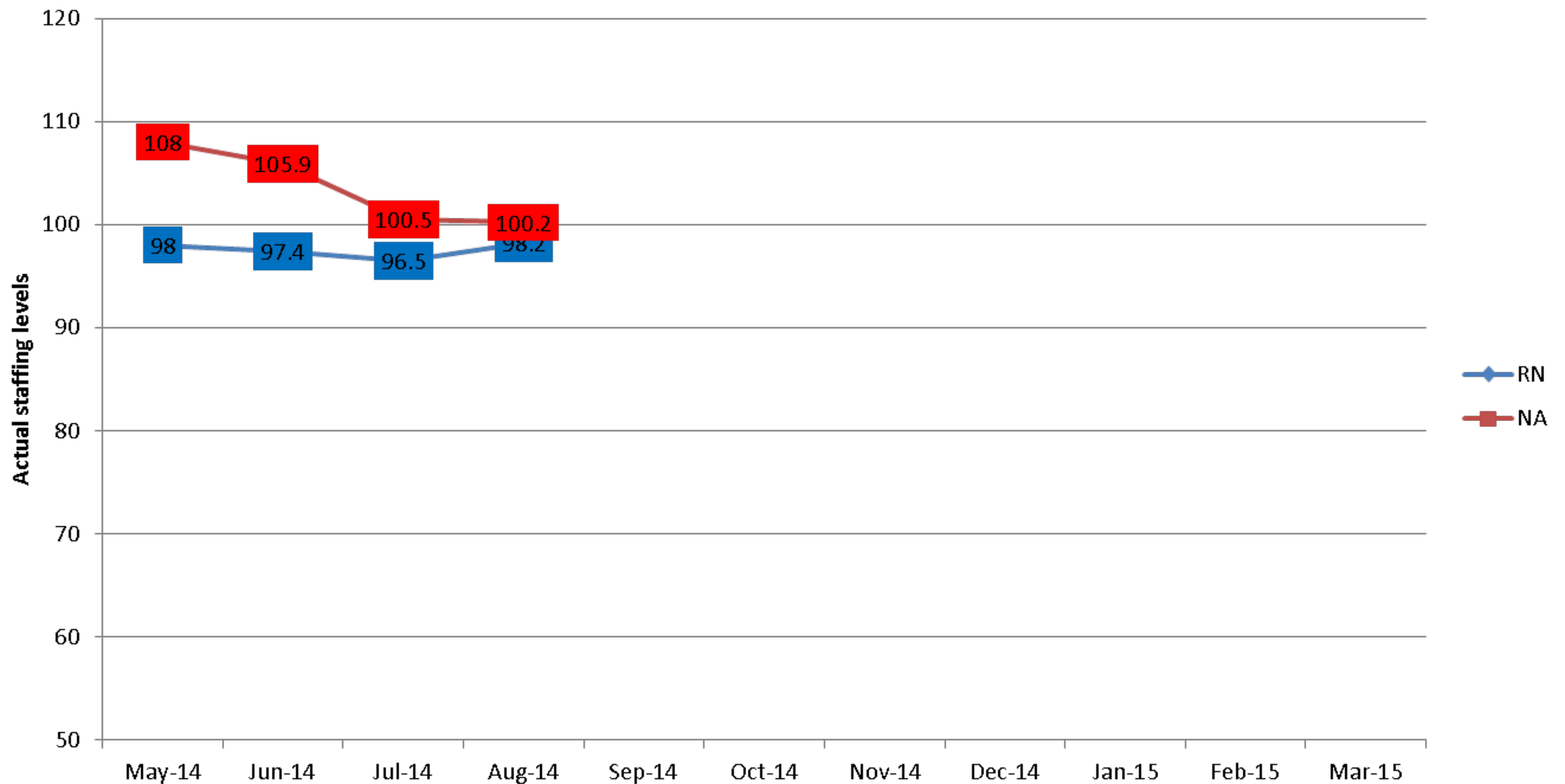
Safe Staffing NQB Report - August 2014

Presentation for Trust Board
October 2014

Fiona Hyett
Deputy Director of Nursing

Monthly Comparisons – Actual Staffing Levels

Registered Nurses			Nursing Assistants			Combined			Planned Skill Mix		Actual Skill Mix	
P	A	%	P	A	%	P	A	%				
55026	54048	98.2	34429	34510	100.2	89455	88,558	99	62	38	61	39



Overview of Nurse Staffing Hours – August 2014

	RN	NA
Total Planned hours (day shift)	33462	23371.5
Total Actual hours (day shift)	32386.5	22651
Percentage	**96.8%**	**96.9%**
Total Planned hours (night shift)	21564	11057.5
Total Actual hours (night shift)	21661.9	11859.1
Percentage	**100.5%**	**107.2%**

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

Nursing Hours by Day Shifts

	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**13272**	**12956.82**	**97.6%**	**10547.5**	**10437.23**	**99.0%**
Durrington	1069.5	1070.26	100.1%	945.5	1014.42	107.3%
Emergency Department	356.5	356.5	100.0%	356.5	356.5	100.0%
Farley Ward	1950.5	1846.26	94.7%	1534.5	1465.5	95.5%
Hospice	930	878	94.4%	821.5	692.5	84.3%
Pembroke Ward	930	814.5	87.6%	465	422	90.8%
Pitton Ward	1386	1367	98.6%	1143	1177.75	103.0%
Redlynch Ward	1386	1372	99.0%	1143	1342	117.4%
Tisbury Ward	2024	1828.5	90.3%	713	625	87.7%
Whiteparish Ward	1656	1758.8	106.2%	1069.5	887.68	83.0%
Winterslow Suite	1583.5	1665	105.1%	2356	2453.88	104.2%
Surgery	**6504.5**	**6242.84**	**96.0%**	**2764**	**2491.92**	**90.2%**
Britford Ward	2332.5	2162.25	92.7%	1245	1110.5	89.2%
Downton Ward	1320	1352.75	102.5%	1162.5	1038.42	89.3%
Radnor	2852	2727.84	95.6%	356.5	343	96.2%
Clinical Support	**3808**	**4219.5**	**110.8%**	**1952.5**	**1622.25**	**83.1%**
Maternity	2254	2478.5	110.0%	1279.5	1138	88.9%
NICU	713	923	129.5%	356.5	246.75	69.2%
Sarum Ward	841	818	97.3%	316.5	237.5	75.0%
Musculo-Skeletal	**9877.5**	**8967.39**	**90.8%**	**8107.5**	**8099.86**	**99.9%**
Amesbury Suite	1860	1619.17	87.1%	1627.5	1482.63	91.1%
Avon Ward	1552.5	1445.38	93.1%	1702.5	1719.8	101.0%
Burns Unit	1627.5	1548.42	95.1%	622.5	944.59	151.7%
Chilmark Suite	1552.5	1495.08	96.3%	1395	1260.75	90.4%
Laverstock Ward	1860	1862.17	100.1%	1162.5	1028.75	88.5%
Tamar Ward	1425	997.17	70.0%	1597.5	1663.34	104.1%
Grand Total	**33462**	**32386.55**	**96.8%**	**23371.5**	**22651.26**	**96.9%**

Nursing Hours by Night Shifts

	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**9406.5**	**9184.5**	**97.6%**	**4667.5**	**5274**	**113.0%**
Durrington	713	713	100.0%	356.5	483	135.5%
Emergency Department	356.5	356.5	100.0%	356.5	356.5	100.0%
Farley Ward	1069.5	1035	96.8%	713	701.5	98.4%
Hospice	494	494	100.0%	389.5	361	92.7%
Pembroke Ward	713	713	100.0%	0	0	
Pitton Ward	1069.5	1012	94.6%	713	770.5	108.1%
Redlynch Ward	1069.5	1008	94.2%	356.5	598	167.7%
Tisbury Ward	1426	1372.5	96.2%	356.5	359	100.7%
Whiteparish Ward	1426	1422.5	99.8%	356.5	356.5	100.0%
Winterslow Suite	1069.5	1058	98.9%	1069.5	1288	120.4%
Surgery	**4402**	**4399.67**	**99.9%**	**830**	**981.5**	**118.3%**
Britford Ward	930	970	104.3%	520	620	119.2%
Downton Ward	620	614	99.0%	310	350	112.9%
Radnor	2852	2815.67	98.7%	0	11.5	
Clinical Support	**3967.5**	**3721.5**	**93.8%**	**1782.5**	**1506.75**	**84.5%**
Maternity	2495.5	2248.5	90.1%	1069.5	812.25	75.9%
NICU	713	747.5	104.8%	356.5	345	96.8%
Sarum Ward	759	725.5	95.6%	356.5	349.5	98.0%
Musculo-Skeletal	**3788**	**4356.25**	**115.0%**	**3777.5**	**4096.83**	**108.5%**
Amesbury Suite	589	579.5	98.4%	883.5	883.5	100.0%
Avon Ward	620	920	148.4%	930	950	102.2%
Burns Unit	620	638.75	103.0%	310	744.08	240.0%
Chilmark Suite	589	570	96.8%	589	589	100.0%
Laverstock Ward	750	1048	139.7%	445	310	69.7%
Tamar Ward	620	600	96.8%	620	620.25	100.0%
Grand Total	**21564**	**21661.92**	**100.5%**	**11057.5**	**11859.08**	**107.2%**

Overview of Areas with Red/Amber Flags

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	Sarum	75		√	Day	Very small numbers of NA's used and some not filled due to low patient numbers
Red	NICU	69.2		√	Day	Very small numbers of NA's used – replaced by RNs
Red	Tamar	70	√		Day	Introduction of additional RN shift – not always filled
Red	Laverstock	77.7		√	Night	Low numbers of NA's used
Red	Maternity	75.9		√	Night	Low numbers of support workers used
Amber	Pembroke	87.6	√		Day	All shifts covered – long days used to cover short shifts resulting in hours discrepancy
Amber	Amesbury	87.1	√		Day	High vacancies – shifts assessed every day for safety
Amber	Hospice	84.3		√	Day	High tolerance for use of agency
Amber	Tisbury	87.7		√	Day	High tolerance for use of agency
Amber	Whiteparish	83		√	Day	High tolerance for use of agency
Amber	Britford	89.2		√	Day	All shifts covered – long days used to cover short shifts resulting in hours discrepancy
Amber	Downton	89.3		√	Day	All shifts covered – long days used to cover short shifts resulting in hours discrepancy
Amber	Maternity	88.9		√	Day	Low numbers of support workers used
Amber	Laverstock	88.5		√	Day	High tolerance for use of agency

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

Mitigation of Risk

There are several wards this month flagging amber/red against our internal measures.

- Vacancies higher across August – newly qualified nurses due to commence in September, but all shifts are assessed daily by Directorate Senior Nurses to ensure they are safe. .
- NA usage has remains lower reflected in the lower spend on specials this month.
- Agency fill rates have been challenging but all shifts are assessed daily by Directorate Senior Nurses to ensure they are safe.
- Wards often use staff on long days to cover 2 shifts – ward has the required level of staff but uses less hours resulting in shortfall in actual hours. DSNs monitoring to ensure appropriate numbers on shift.

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
- Staff on training days brought back to work clinically as required
- Sisters on management days work clinically
- Additional NAs rostered to support unfilled RN shifts
- CCOT team support wards where acuity of patients high

TRUST QUALITY INDICATOR REPORT – August 2014 SFT 3574

PURPOSE:

To provide the Board with August 14 data and improvement actions.

MAIN ISSUES:

- 4 cases of C Difficile.
- No MSSA bacteraemias for three months.
- 4 new serious incident inquiries.
- A decrease in the crude mortality rate. SHMI remains 108 to December 2013 and is as expected. HSMR has declined again and is 93 in May 14 and is as expected. There is the potential for an up to an 11 point rise in October 14 when figures are rebased. Sepsis Six care is the key improvement action being undertaken.
- A decrease in grade 2 pressure ulcers. One cluster identified.
- Safety Thermometer – 94% 'new harm free care'.
- Three falls resulted in moderate harm, two of which were a fractured ankle and a wrist and one which was a complex dislocation of a finger. All three were managed by plaster cast.
- Fractured hip patients being operated on within 36hrs increased to over 90%.
- A decrease to 80% of patients moving to the stroke unit within 4 hours. Action is in place to ensure all staff are familiar with the referral pathway. A decrease in the percentage of patients spending 90% of their time on the stroke unit. A significant increase (95%) of high risk TIA referrals seen within 24 hours.
- Escalation bed capacity and ward moves remain low. No non-clinical same sex accommodation breaches.
- Real time feedback showed patients felt they were treated with care and compassion and rated the quality of care as good. The Friends and Family test response rates were sustained in inpatients, but fell to 15.5% in ED and decreased in the Maternity Services. A new measure of the Friends and Family test response rates for outpatients and day cases shows a response rate of 14.1%.
- Q1 staff FFT shows 97% of staff are extremely likely or likely to recommend the hospital as a place to receive care or treatment and 83% are extremely likely or likely to recommend the hospital as a place to work. In a Health Service Journal survey comments from our staff have placed the Trust in the top 100 best healthcare organisations in the country to work. The assessors said "There is an open and honest feel at Salisbury Foundation Trust and a genuine desire to give good quality care throughout all levels and departments of the organisation."

CARE QUALITY COMMISSION OUTCOME:

Outcome 16 – assessing and monitoring the quality of service provision

ACTION REQUIRED BY THE BOARD/COMMITTEE/FORUM

1. To note the report.

Author: **Dr Christine Blanshard**
Title: **Medical Director**
Date: **23 September2014**

Salisbury NHS
NHS Foundation Trust

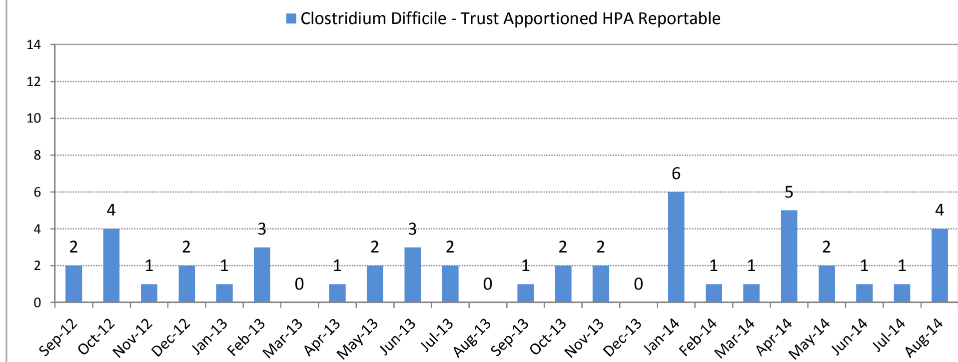
Trust Quality Indicators - August 2014

Quality Measures

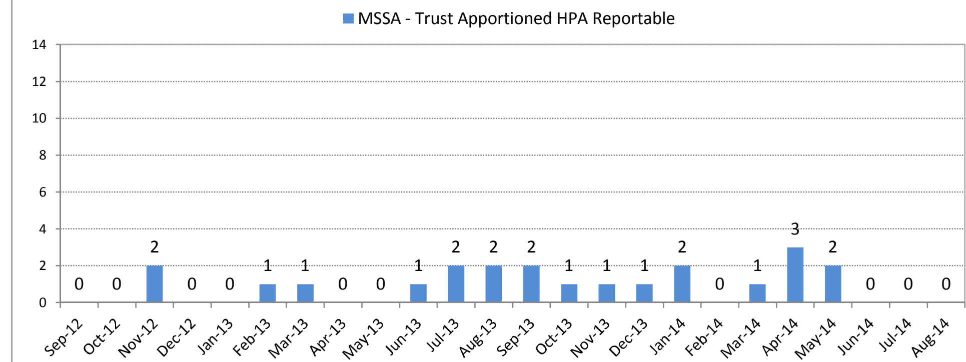
Infection Control	*2012-13 Total*	*2013-14 YTD*	*2014-15 YTD*
MRSA (Trust Apportioned)	**3**	**0 (+2)**	**1**

Trust Incidents	*2012-13 Total*	*2013-14 YTD*	*2014-15 YTD*
Never Events	**2**	**0**	**0**
Serious Incidents Requiring Investigation	**13**	**17**	**12**

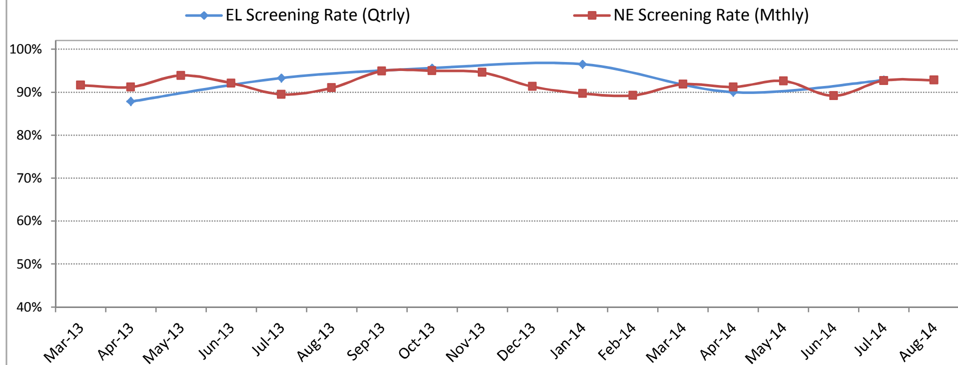
Clostridium Difficile - Trust Apportioned



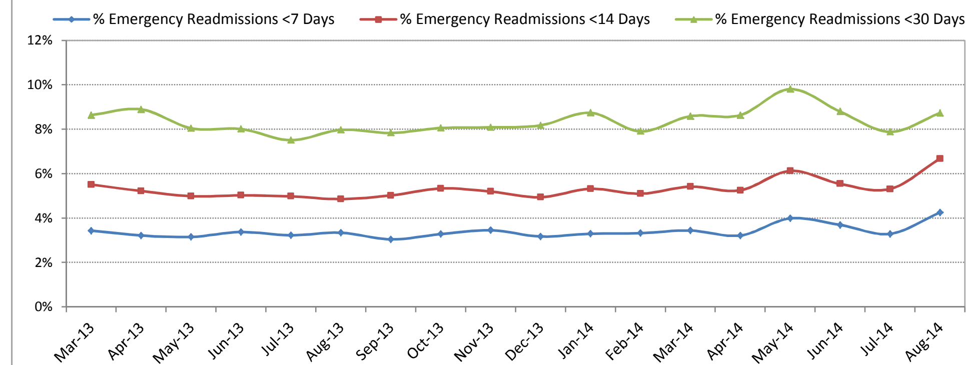
MSSA - Trust Apportioned



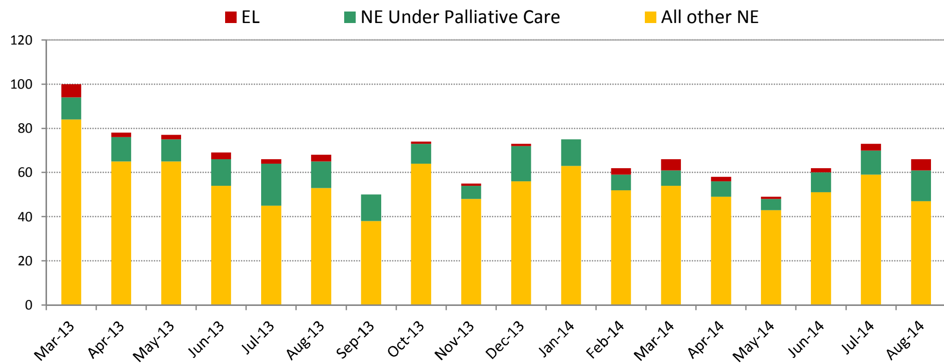
MRSA Screening



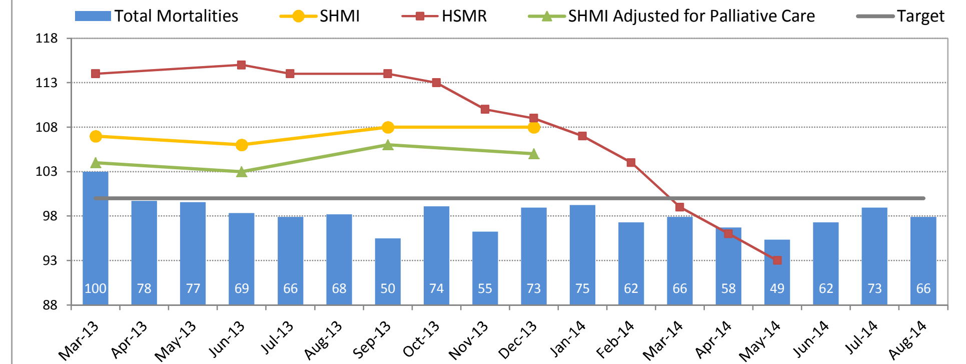
Emergency Readmissions within 7, 14 & 30 days of Discharge



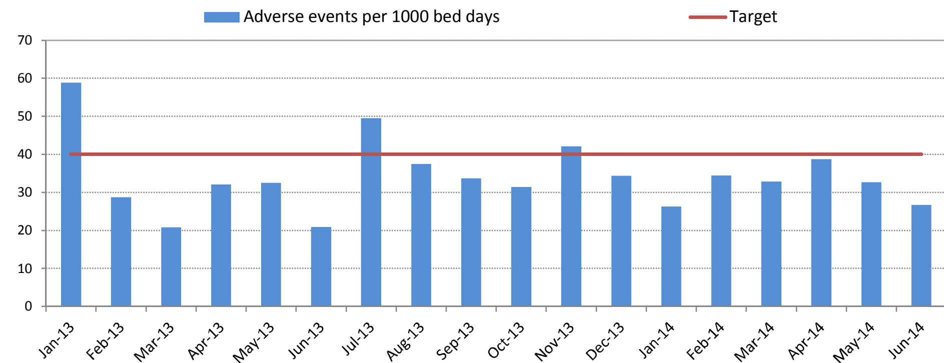
Hospital Mortalities



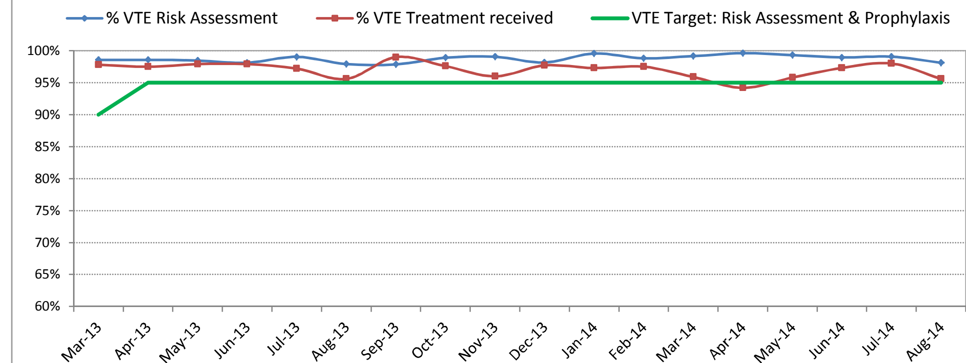
HSMR and SHMI



Global Trigger Tool



Venous Thrombous Embolism: Risk Assessment & Prophylaxis



Salisbury NHS
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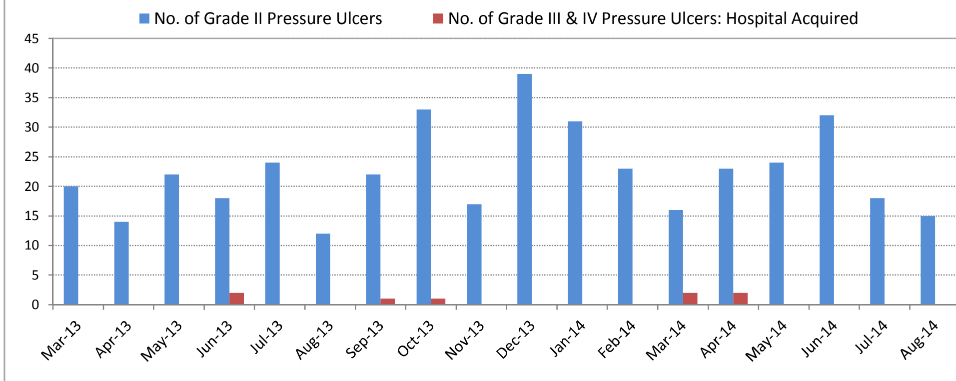
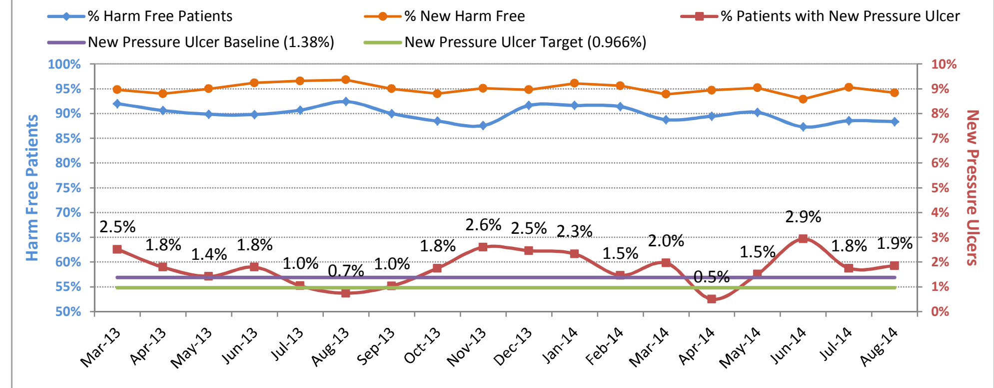
Trust Quality Indicators - August 2014

Quality Measures

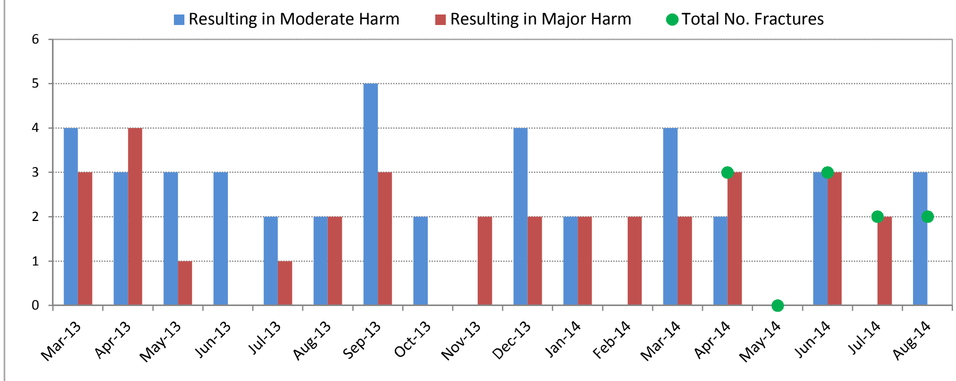
Pressure Ulcers - Total Number per Month



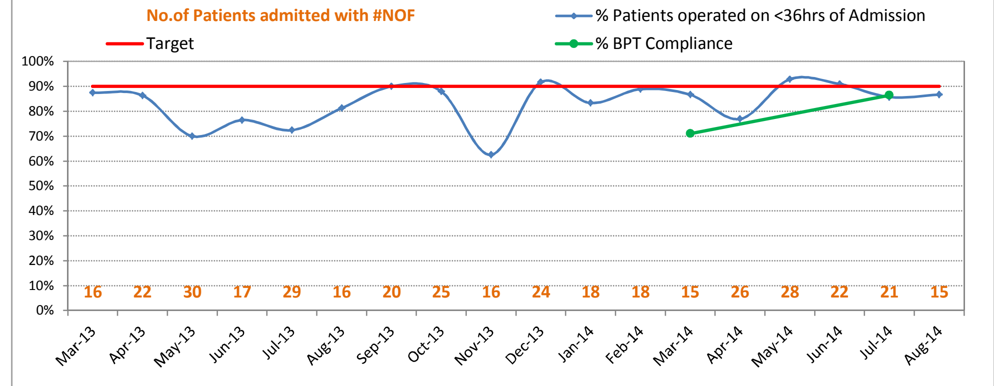
Safety Thermometer - One Day Snapshot per Month



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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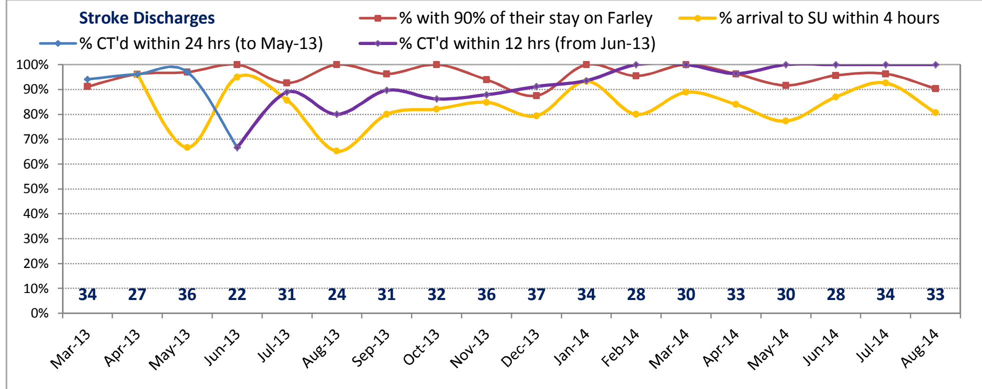
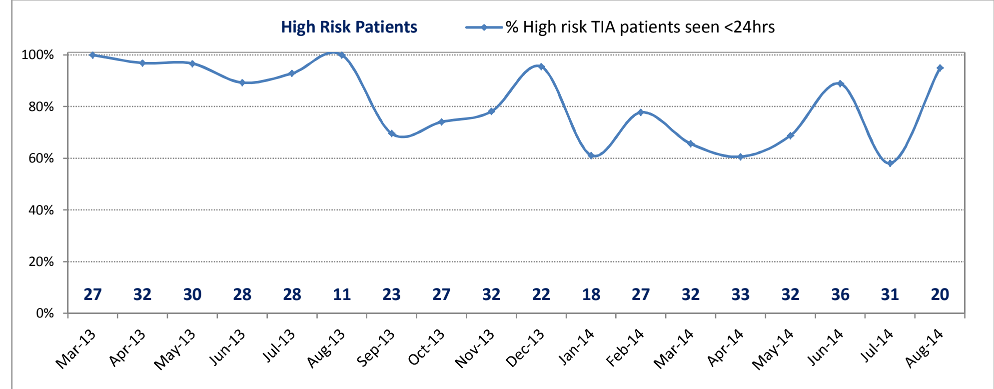
Trust Quality Indicators - August 2014

Quality Measures

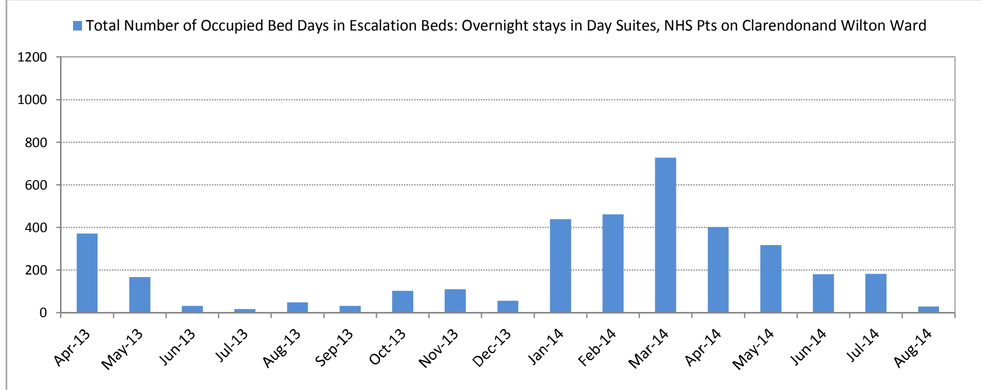
Stroke Care



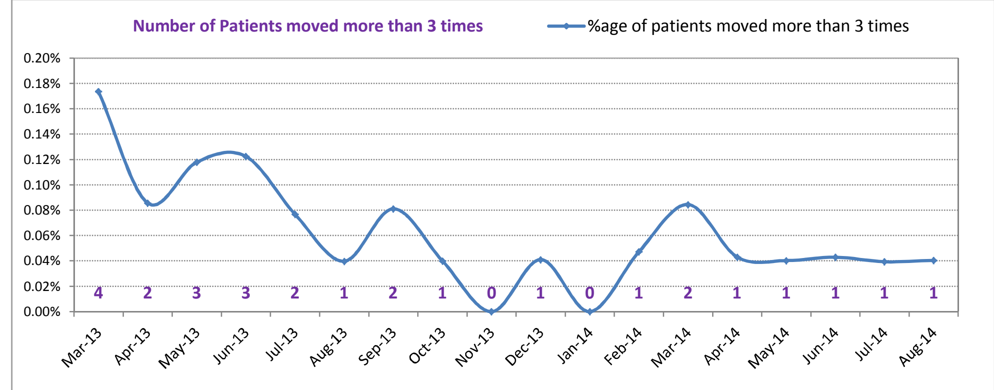
TIA Referrals



Escalation Bed Days



Patients moving multiple times during their Inpatient Stay



Please note, Durrington Ward (22 beds) was an escalation ward from Nov-11 to Mar-13 and has been counted within these figures for these months. The additional 10 beds above the Standard 30 beds on Winterslow Ward were escalation beds until Mar-13 and Breamore Ward has been included as an escalation ward from Apr-13 onwards. Wilton Ward opened as an excalation ward in Nov-13 and has been included in these figures since then. From Apr-14 Wilton (12 beds) and DSU if open overnight are the only escalation beds.

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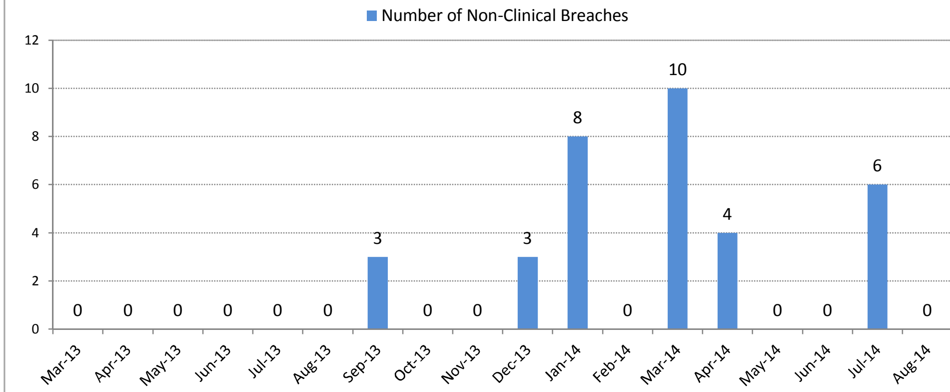
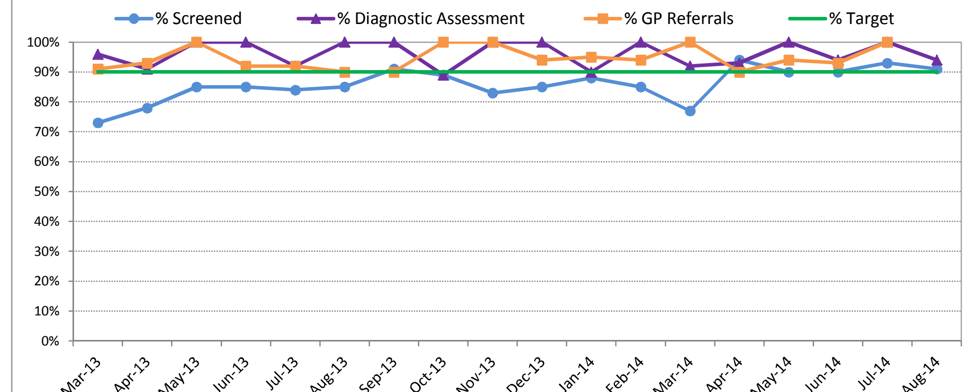
Trust Quality Indicators - August 2014

Quality Measures

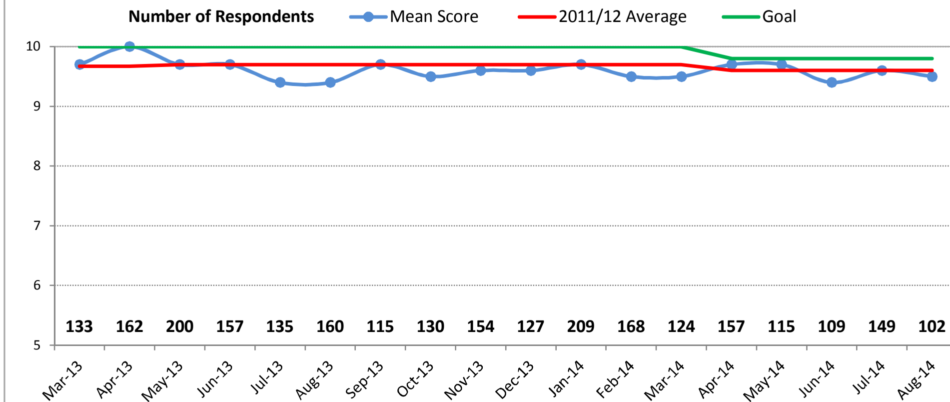
Delivering Same Sex Accommodation



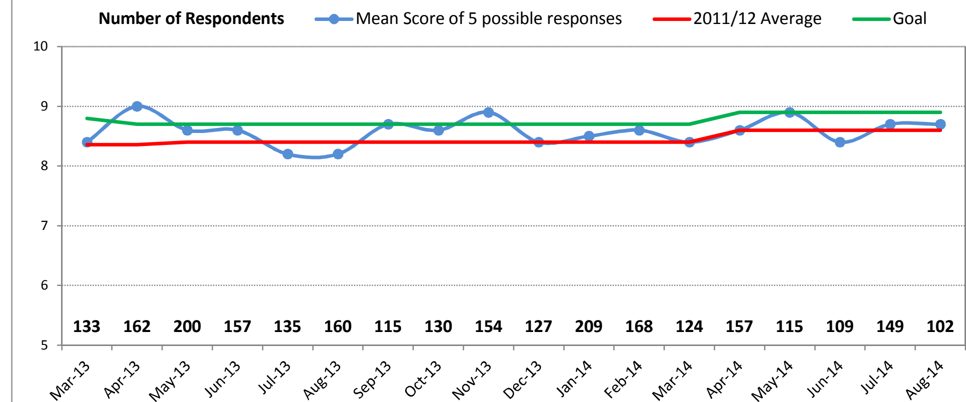
Dementia Audit of Patients Aged 75+

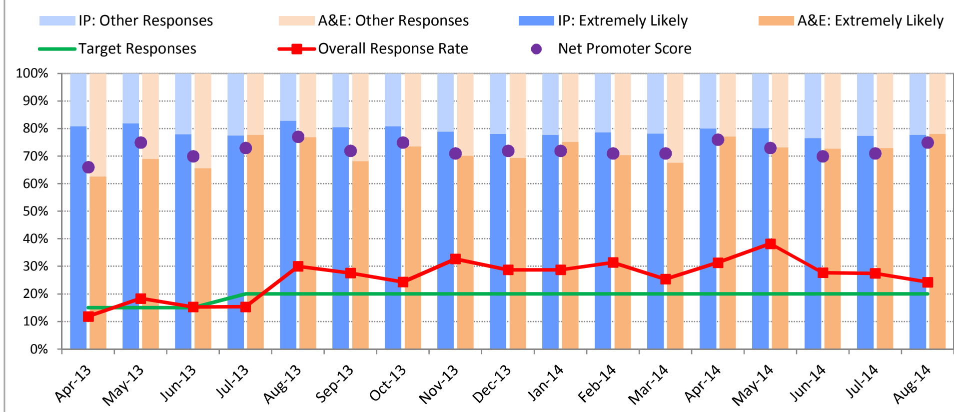


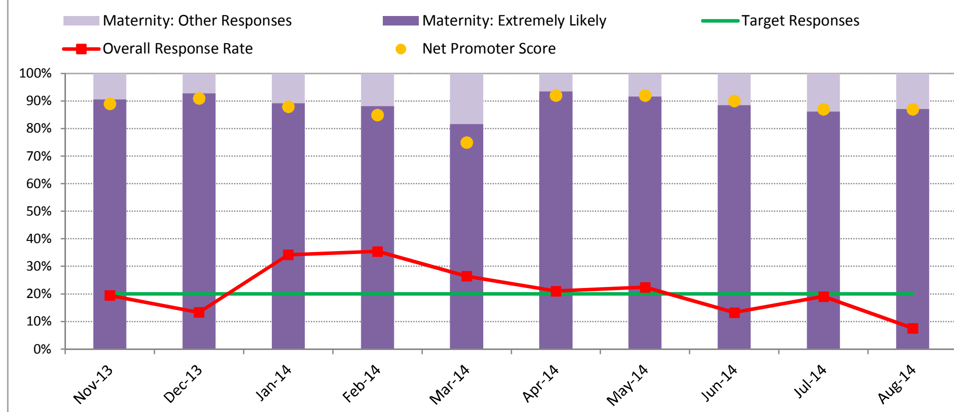
Real Time Feedback: Are you being treated with care and compassion?

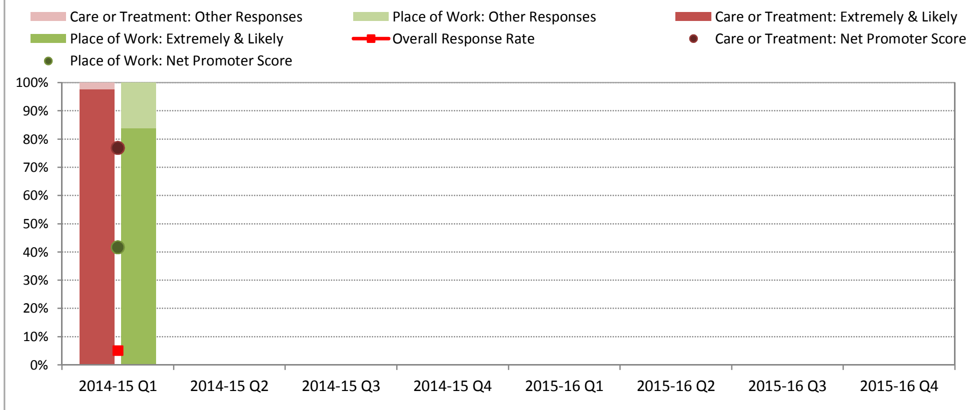


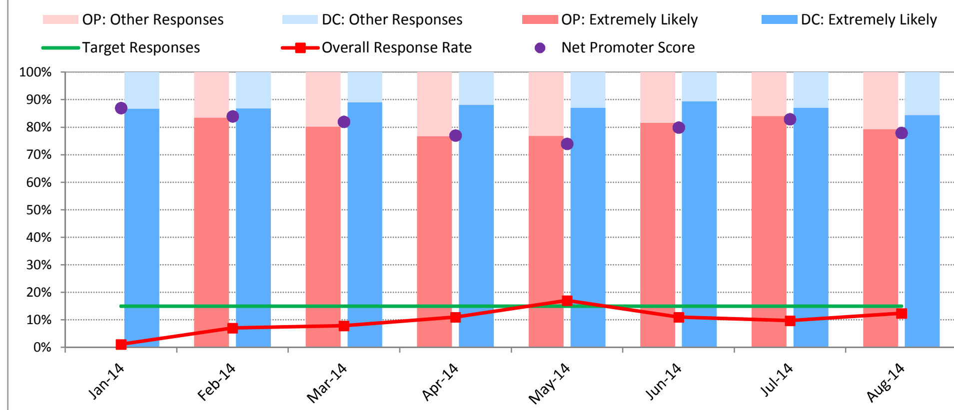
Real Time Feedback: Overall how would you rate the quality of care you received?











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Customer Care Report - Quarter 1
1 April – 30 June 2014

PURPOSE OF PAPER:

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

MAIN ISSUES:

The main issues from complaints are:

- Clinical treatment (26) - sub-themes were unsatisfactory treatment, correct diagnosis not made, inappropriate treatment, further complications, surgery unsuccessful and consent to treatment. There were no themes.
- Staff attitude (12) - 11 of these related to nursing staff and 1 to medical staff. A theme was identified and appropriate action was undertaken whilst an investigation took place. Again, a high number of comments were received in praise of staff through Real Time Feedback and the Friends and Family Test.
- Communication (10) – sub-themes were lack of communication, insensitive communication and information not given. There were no themes.

79 complaints were received in quarter 1. This compares to 76 complaints in quarter 4 (2013-14) and 92 complaints for the same period in the previous year. A breakdown of numbers and themes according to Datix is below.

	Clin Supp & Family Services	Medicine	Musculo-Skeletal	Surgery	Total 2014 -15	Total 2013 -14
Admission	0	1	0	0	1	1
Appointments	0	3	3	2	8	4
Attitude of staff	1	8	0	3	12	20
Capacity Issues	0	1	0	0	1	0
Clinical Treatment	8	9	7	2	26	40
Communication	1	2	6	1	10	10
Delay	2	0	1	0	3	0
Dementia	0	0	0	0	0	1
Discharge arrangements	0	3	0	0	3	6
Equipment, aids, appliances	0	0	0	0	0	1
Facilities on site	0	1	0	0	1	1
Falls	0	1	1	0	2	0
Infection Control	0	1	0	0	1	0
Information	0	0	0	1	1	1
Nursing Care	0	1	0	0	1	1
Hospital Procedures	1	0	0	0	1	0
Operation	0	0	0	0	0	1
Privacy and Dignity	0	0	0	0	0	1
Property	0	1	0	0	1	2
Transfer Arrangements	0	0	0	0	0	1
Transport	0	0	1	0	1	0
Waiting time	2	1	2	1	6	1
Totals:	15	33	21	10	**79**	**92**
Patient Activity	9185	29283	17328	17253		

In Quarter 1, the Trust treated 15,819 people as inpatients, day cases and regular day attendees. Another 11,632 were seen in the Emergency Department and 45,598 as outpatients. 79 complaints were received overall which is 0.1% of the number of patients treated. 1034 compliments were received across

the Trust in Q1, which represents 1.4% of the number of patients treated. Those sent directly to the Chief Executive or Customer Care Department were acknowledged and shared with the staff/teams named.

90% of complaints were acknowledged within three days. A new Complaints Co-ordinator will start on 1st October 2014, who will be responsible for acknowledging and tracking complaints to ensure the timescales are met.

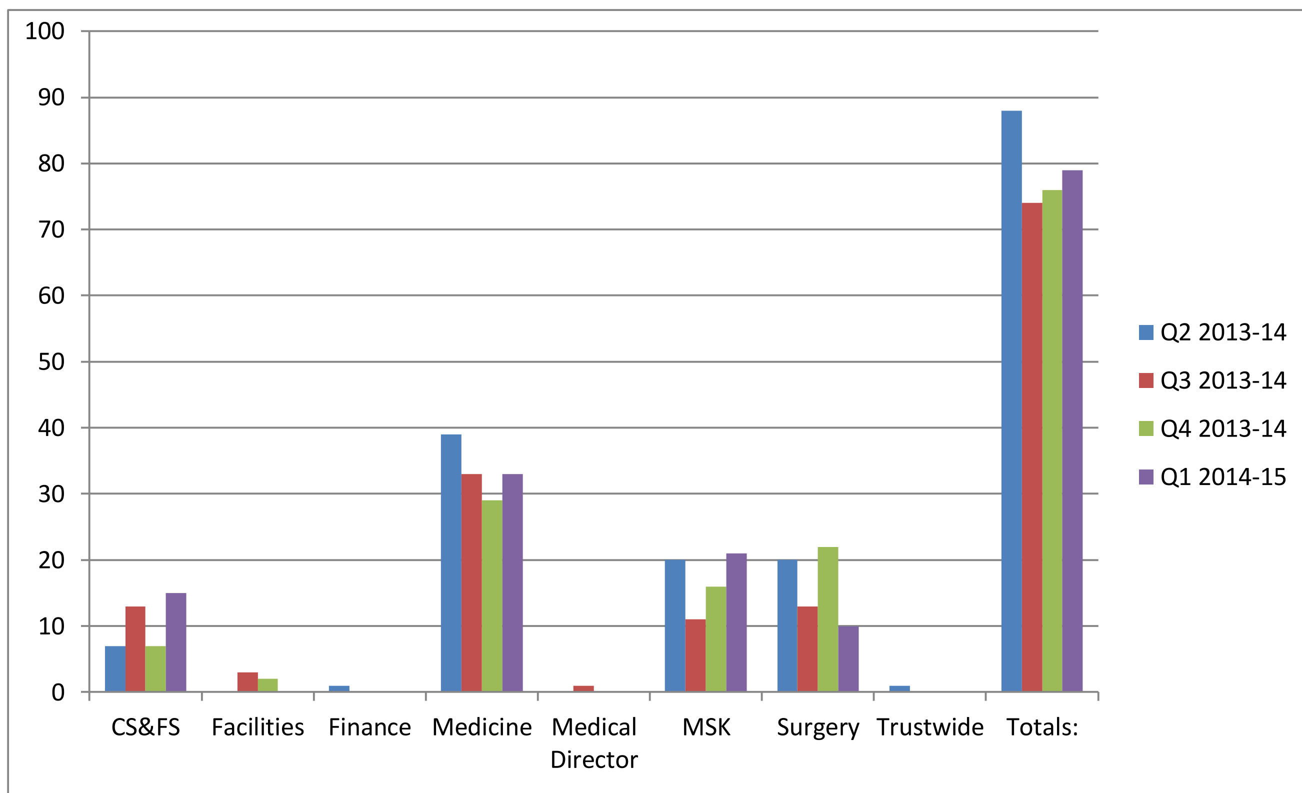
The overall number of enquiries, comments, concerns and complaints response times:

0-10 working days		**10-25 working days**		**25+ working days**	
178	56%	69	22%	69	22%

Reasons for some complaints taking more than 25 working days to respond to include: arranging meetings; joint investigation with another organisation; clinical review; failure to send the case file to the investigating manager after receipt; key members of staff on annual leave and awaiting a response from staff who no longer work at the Trust.

COMPLAINTS BY DIRECTORATE

The following graph shows the trend in the number of complaints by directorate over the last four quarters.



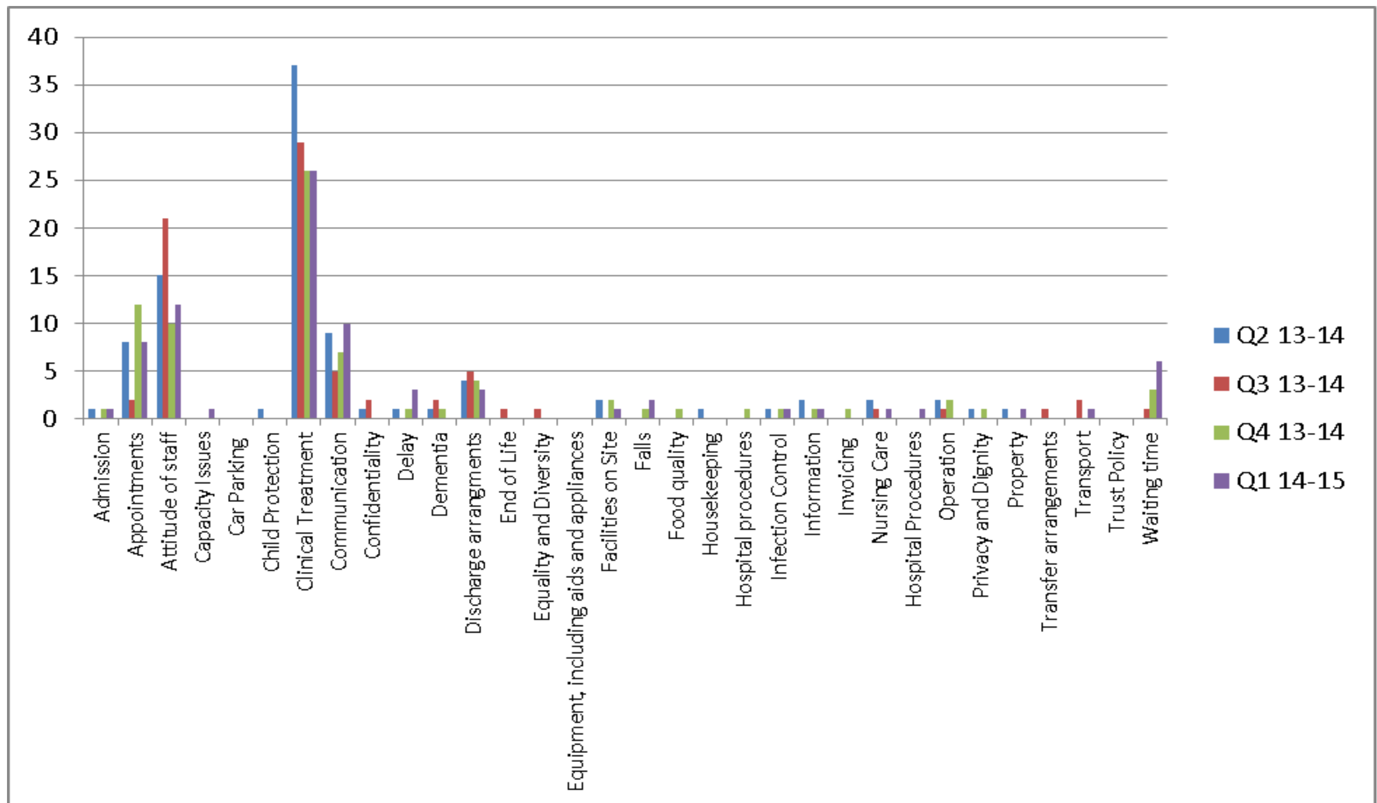
The complaints examined during this quarter's dip sampling by a Non Executive member all concerned attitude of staff. Two of the complaints examined related to the same member of staff and appropriate action is subsequently taking place with that individual.

Of the other complaints there were two in which members of staff offered to meet with the complainants.

COMPLAINTS BY SUBJECT

The following graph shows the trend in complaints by subject over the last four quarters. Complaints about appointments have reduced by a third since Q4. Staff attitude, communication and waiting times have shown a slight increase in Q1.

Although clinical treatment is still the highest theme, it has remained at 26 complaints as in Q4.



CLINICAL SUPPORT AND FAMILY SERVICES

- Complaints have increased from 7 in Q4 to 15 in Q1.
- 15 concerns and 140 compliments were received in Q1.
- Two complaints were re-opened.
- Eight complaints were about clinical treatment but no themes have been identified.
- There was one complex complaint which came from a solicitor dating back several years involving gynaecology, psychology and medicine. The Medical Director assisted with co-ordinating the response.
- There was one complaint about staff attitude and one complaint about communication which is a good improvement.

Actions

1. Track and trace system for managing responses. This has failed on two occasions resulting in a delay to response getting to patient. DSN and Customer Care Advisor met to decide on necessary actions to make improvements. System for recording changed and is working.
2. Face-to-face meetings offered on receipt of complex complaints.
3. Map themes and ask for local actions which will be monitored through DMT meetings.

Moving forward

- The Customer Care Advisor is now attending the DMT monthly meeting. This gives the DMT the opportunity to track themes across complaints, concerns, real time feedback and friends and family feedback.
- The DMT continue to work to improve the individual response times and keep track of complaints before the due date.

MEDICINE DIRECTORATE

- Complaints have increased from 29 in Q4 to 33 in Q1.
- 35 concerns and 293 compliments were received in Q1.
- Seven complaints were re-opened.

General actions

- The Directorate Senior Nurse and Customer Care Advisor are going to visit all wards to speak to staff about responding and resolving complaints early.
- All interviews for clinical staff have a specific question about how they would manage complaints, aiming at the need to address them locally when possible.

Themes and actions by area

Department/Ward	Topic	Actions
Emergency Department	Attitude of reception staff	• Customer Care training for admin staff in the Emergency Department • Manager aware if concerns are repeated with an individual staff member
All areas	Increase in identification of specific staff in complaint	• Formal and informal investigation involving the named member of staff • Manager aware if concerns are repeated with an individual staff member • Disciplinary process used if appropriate
General Ward Areas	Discharge plans	• Full investigation into the problem and some being raised as Safeguarding issues requiring Clinical Review or Serious Untoward Incident report • Discharge Planning Workshop arranged 8th September 2014
General ward areas	Falls resulting in injury/fracture	• Intentional rounding implemented on all wards • Falls assessment completed on all patients • Enhanced nursing assessment completed to identify if specialling is required • Falls subject of RCA and SUI and learning shared across Directorate • Falls focused workshop to be arranged

MUSCULOSKELETAL DIRECTORATE

- Complaints have increased from 17 in Q4 to 21 in Q1.
- 34 concerns and 156 compliments were received in Q1.
- Two complaints were re-opened (both orthopaedics) with one complainant being advised to contact the Ombudsman due to remaining dissatisfied with the Trust's responses.
- One complaint was referred to the Ombudsman and has since been not upheld.
- Orthopaedics and Spinal received the highest numbers of concerns and complaints. Orthopaedics received 14 complaints and 12 concerns and Spinal received 4 complaints and 7 concerns.
- One meeting took place for a patient unhappy with care on the Spinal Unit and a second meeting for the family of a patient cared for on Chilmark Ward.

General actions

- Eleven of the complaints/concerns were in relation to delays or cancellation to planned procedures. The Directorate Management Team has recognised the current issues with waiting lists and has added this to the Directorate Risk Register. The actions associated with this link to work ongoing with the Theatre Transformation Workstream and the review of job plans with recruitment of consultants. Where appropriate patient planned dates have been expedited

- The Directorate has been more stringent in ensuring that actions undertaken by the wards and departments are documented on completion of the response

Themes and actions by area

Department/Ward	Topic	Actions
Orthopaedic Inpatients	Reported broken ankle whilst in-patient Reported poor aftercare from total knee replacement Unhappy with nursing care Pharmacy and transport delays	• Confirmed not discharged with broken ankle • Community physio organised to support recovery • Apology given and complaint shared with nursing team • Apologies for delays
Orthopaedic Outpatients	Unhappy with treatment Patient unhappy with experience Patient unhappy with pain management	• Referral to an alternative hospital • Complaint shared with team and review of processes • Referred to the Pain Team
Spinal	Removal of psychological assessment documentation requested Drug errors noted by patient's wife (antibiotic administration)	• Meeting planned for 26th August • Administered by agency nurse who was safe but not in-line with Trust policy. New posters in place, ward guidance and followed up with agency
Plastics Inpatients	Hygiene practice, staff noise, confidentiality	• Shared with ward staff and POAU
Plastics Outpatients	Refusal of liposuction on NHS Unhappy with process for plastics trauma (Child)	• Full explanation for why not offered • Review of patient pathway (children)
Oral	Additional oral appointments required and reimbursement requested for travel time	• Travel costs offered for 3 OPD appointments

SURGICAL DIRECTORATE

- Complaints have decreased from 21 in Q4 to 10 in Q1.
- 28 concerns and 430 compliments were received in Q1.
- Five complaints were re-opened.
- One complaint was referred to the Ombudsman and the Trust is awaiting the outcome of the investigation.

Directorate challenges

- One complaint was not sent out within 25 days. This was due to a key clinician having since retired. The complainant was sent a holding letter with an explanation of the cause of the delay, sent prior to the due date.
- Patients continue to express concerns regarding the partial booking process for Ophthalmology.

Themes and actions by area

- Ophthalmology was a theme this quarter with patients raising concerns regarding their experience in clinic. As a result Customer Care undertook patient shadowing and obtained patient views. Customer Care will produce a report of their findings.
- Ophthalmology partial booking of outpatient appointments continues to be of concern to patients. Patients have reported dissatisfaction with short notice issue of appointments and difficulty in rescheduling to a suitable date. The issues are due to a difficulty in recruiting specialist trained staff and we have had to rely upon agency staff in the interim recruitment period.

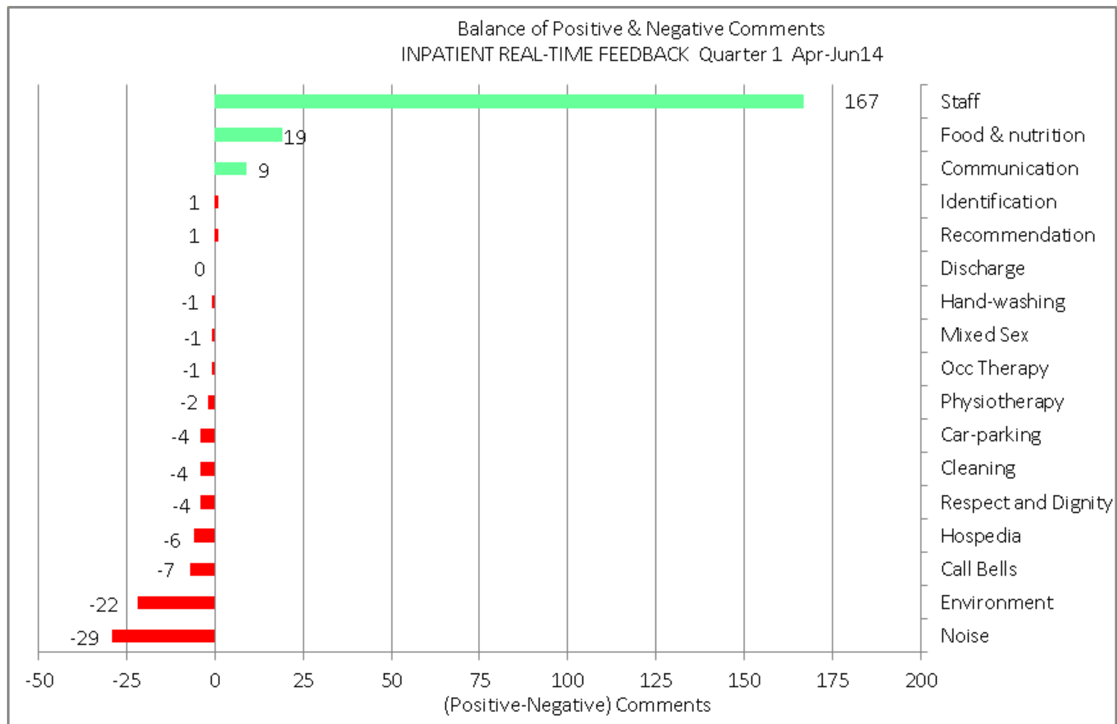
TRUSTWIDE FEEDBACK

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

Feedback area	Theme	Actions
Complaints	Clinical treatment Staff attitude Communication	• No themes. • One theme was identified about a member of staff's attitude and appropriate action was taken whilst the investigation took place. • No themes.
Inpatient RTF	Noise Environment Call bells	• Lots of work with Laundry who have installed notices for the lorry drivers informing them to keep the noise down and to not talk outside after 10.00pm until 5.30-6.00am. Laundry is very supportive. • Ward staff have been asked to remember to enable patients to get quality sleep at night. • General concerns relating to bathroom maintenance in a number of areas, no WiFi access, state of lifts, patients having their TV on late at night, lights on etc. All these problems are fed back to the nurse in charge to take immediate action. • Issues on Pitton Ward due to new system that is in place. This is being carefully monitored and adjusted. Call bell noise is more acceptable. There have also been areas where there are delays in call bell answering and overall the problems mainly appear to be due to workload and staff shortages, therefore call bell problems are intermittent and less of a concern than they have been.
FFT – Maternity FFT – Emergency Department FFT - Inpatients	Discharge Staff Waiting Communication Environment Staff Communication Noise	• A weekly email is sent to the relevant Directorate Management Team and ward/department managers informing them of the comments received through the FFT. Actions taken as a result of negative feedback are currently not recorded.

INPATIENT REAL TIME FEEDBACK

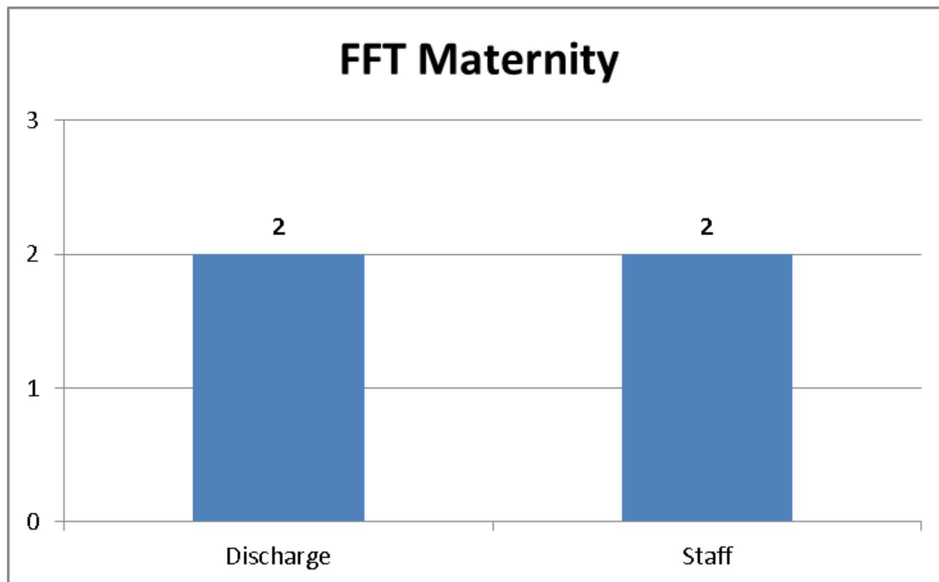
A total of 381 inpatients were surveyed in the quarter. They made 246 positive and 167 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below. The three main areas of concern were noise, environment (fabric and lack of WiFi) and call bells.

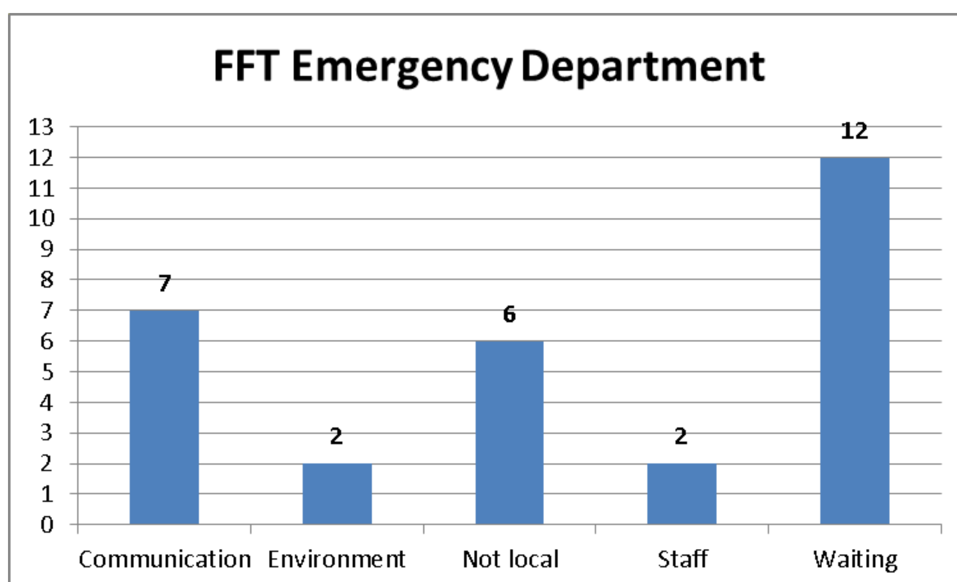


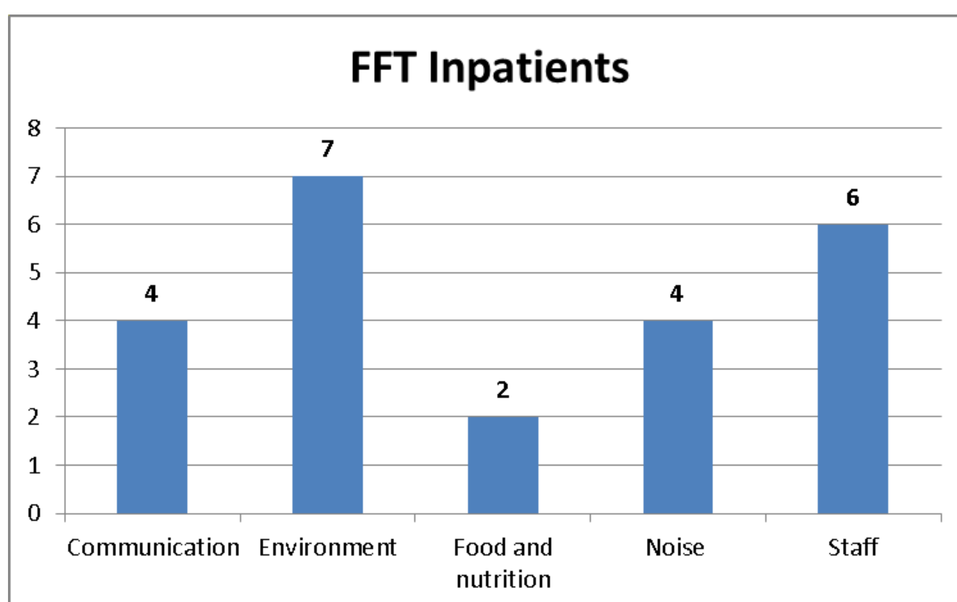
FRIENDS AND FAMILY TEST
Responses for the period were as follows:

		Rating		
	Total Responses Received	Extremely Likely	Unlikely	Extremely Unlikely
Inpatients	1618	1278	13	3
Emergency Department	1732	1267	15	15
Maternity	364	333	2	0

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.







FEEDBACK FROM COMPLAINANTS

79 (34.6%) complainants returned their questionnaires to the Survey of Complaints Management for 2013-14. Complainants used the range of resources available to them to make a complaint. The majority of comments were positive in relation to the response received and actions taken.
Overall the satisfaction rate of how people's complaints were handled in 2013-14 was:

Very dissatisfied	11	14%
Dissatisfied	19	24%
Satisfied	32	41%
Very satisfied	16	20%
No answer	1	1%

61% of complainants were satisfied/very satisfied with how their complaint was handled compared to 50% last year which is a great improvement.

The questionnaire for how concerns are handled has been agreed through the Patient and Public Involvement Group and these will be used once the post box has been installed outside Customer Care.

PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

In Q1 there were two new requests for independent review (1 for Musculo Skeletal and 1 for Surgery). The Musculo Skeletal case has not been upheld.

Of the ten cases in 2013-14, the Trust is awaiting a decision on two, six were not upheld and two were partially upheld. The recent case that has been partially upheld was due to the lack of pre-operative assessments that meant an opportunity to assess the patient for a higher level of post-operative care and monitoring was lost. The Ombudsman agrees that there is no guarantee that the eventual outcome would have been any different. The Trust is working on an action plan to describe what it has done and/or plans to reduce the likelihood of this failing in the future and ensure that lessons have been learnt from the failing identified.

The PHSO has launched online case studies where members of the public and service providers will be able to see the types of complaints the PHSO has investigated. They can be accessed at http://www.ombudsman.org.uk/make-a-complaint/case-summaries

NHS CHOICES WEBSITE

In Q1 there were six positive comments posted on the NHS Choices website relating to four different areas. One person said "They were all very efficient, professional and caring. We were very impressed - especially since the recent bad press concerning care of the elderly! It is good to know that Salisbury Hospital has excellent standards". There were also four negative comments and these people were invited to raise their concerns via the Customer Care Department.

HEALTH AND SOCIAL CARE INFORMATION CENTRE

Annually the Trust has to report a K041a return about the complaints received to the Health and Social Care Information Centre (HSCIC). Following recommendations made in Sir Robert Francis's report and the Hart/Clwyd report, the HSCIC is consulting users on changes to the data collected, the frequency of collection and the way the information is used to produce these statistics.

The key priority for the government is to improve the experience of people who use health and social care services and simply counting the number of complaints made to an organisation does not indicate how an organisation is performing. The aim of the changes is to provide clearer statistics which produce a clearer picture of the number of complaints being received, the subject areas of those complaints, the time taken to resolve them and the outcome.

The consultation will last eight weeks following its release on 11th July 2014. On completion of the consultation period views, opinions and evidence will be considered and inform the decision as to how this will work in progress. The outcome will be published at the end of September 2014. Any changes will come into effect from 1st April 2014.

ACTION REQUIRED BY THE BOARD: to note the report

AUTHOR: Hazel Hardyman
TITLE: Head of Customer Care
DATE: September 2014

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Trust Board October 2014

SFT 3577

Title	Six Monthly Skill Mix Review – October 2014
Meeting Date	6th October 2014
Sponsoring Executive	Lorna Wilkinson – Director of Nursing
Author	Fiona Hyett – Deputy Director of Nursing

Background

In November 2013 the National Quality Board (NQB) and the Chief Nursing Officer published guidance that set out the current guidance on safe staffing. The guidance *'How to ensure the right people, with the right skills, and in the right place at the right time'* clarifies the expectation on all NHS bodies to ensure that every ward and every shift have the right number of staff on duty to ensure that patients receive safe care. It requires Boards to take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.

There are 12 expectations within the NQB guidance with three key reporting elements that each Trust is required to have in place:

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

This report is a mid-year review which is intended to provide an update on progress and impact on staffing levels following the investment of £800k into nursing approved at the April Board, to provide indication of areas which require additional investment and early indications of areas where further resource maybe required following triangulation of the detailed skill mix review which has occurred with each ward during August and September.

Situation

All wards have been subject to a detailed review during August and September – at which the ward sister, Directorate Senior Nurse and Deputy Director of Nursing have met and triangulated the ward staffing levels against the 1:8 staffing benchmark, quality indicator / outcome data, HR indicators, financial information and professional judgement. The full analysis of these results now needs to be considered against Trust bed capacity modelling and anticipated bed footprint for the coming year.

As part of this programme the investment into the nursing skill mix in April was reviewed and the findings outlined below:

The Supervisory ward sister role has started to embed across all wards from mid July. Wards have reported a mixed ability in being able to fulfil the supervisory role due to vacancies which have required them to work as part of the staffing numbers. As vacancies reduce further impact of this role will be felt. A development programme, which will include action learning groups, has commenced to support their development in this role.

All wards were reviews to ensure they have a minimum of 2 Band 6 Junior Sisters. These roles were created by uplifting a band 5 post and have ensured that there is a sister on the wards across the 7 days. Many wards have chosen to make this a rotational post within their wards to enable career development.

The final element was amendments to ward establishments that were below the 1:8 ratio. The table below shows where changes were made and the impact of this investment:

Ward	Action	Impact
Chilmark	Convert NA to RN on late shift	Improved RN ratio and ward report staffing to feel improved
Laverstock	Additional RN x 3 nights per week Additional NA x 4 nights per week	Improved RN ratio /additional NA support with night shift – ward report staffing to feel improved with less specials expenditure
Amesbury	Additional NA on night shift	Ward report night to feel improved – staff and patient perspective
Redlynch	Convert NA to RN on late shift Convert NA to RN on night shift	Ward feels improved from RN perspective but decrease in NA's has proved challenging and starting to see specials expenditure
Pitton	Convert NA to RN on late shift Additional RN on night shift	Improvement on night shift, late shift improved from acuity but possible requirement for additional NA
Winterslow	Convert NA to RN on late shift	Improved RN ratio on late shift, ward continued to have high specials expenditure, but 10 beds now closed
Farley	Additional RN on long day shift and additional NA on night shift	Improved RN ratio / increased NA support. Ward report staffing to feel improved and specials expenditure reduced to nearly zero.
Tamar	Additional RN on night shift	Improved RN ratio on night shift

The Trust continues to use a large amount of temporary staff to support safe services, partly as a result of vacancies some of which is attributable to the above uplift in nursing establishments. The Trust is working with the ward teams to fill these with permanent staff.

Assessment
Initial analysis and findings of the skill mix reviews are included in Appendix A. The budgeted RN:Patient staffing ratio is demonstrated by shift alongside the average RN:NA ratio. Each ward now has been supported to develop and establish the supervisory Ward Sister/Charge Nurse role which is in addition to these ratios. Each ward is now supported by a minimum of 2 Junior Sisters which supports senior cover across 7 days.

All ward staffing levels are assessed daily by the nurse in charge and escalated to the Directorate Senior Nurses where it is felt the staffing levels do not match the acuity/dependency of the patients or where there are concerns around any shortfalls against planned levels. It should be noted there remain no mandated levels for staffing but the 1:8 ratio has been used as a benchmark. Night staffing levels have been included for review but it is nationally recognised that staffing levels are reduced at night time. Several wards utilise varied shift patterns such as twilights to maximise staffing to peaks in demand.

There are two key areas where the need for immediate further investment has been identified, Amesbury and Durrington. There are other areas where further investment maybe required but further analysis of the acuity and dependency of patient compared to staffing levels is needed, these include Whiteparish, Redlynch, Pitton, Downton, Avon and Sarum all of which will be part of the early implementers of the rollout of the SaferCare tool to further understand their requirements.

Recruitment into vacancies remains an on-going challenge with varied initiatives continuing to support maximising every opportunity to recruit staff. Attrition of the band 5 post is a significant and expected of nurse staff turnover due to the younger workforce wanting to gain wider clinical experience and staff at the other end of the age spectrum starting to retire. Wards have also seen staff opting to leave or reduce their hours to work for agencies, particularly Thornbury. Previous analysis has shown that the average annual turnover of RNs per year is approximately 40.

Several wards have higher numbers of vacancies – these include Amesbury, Pitton, Spinal Unit and Winterslow. Some of these areas have been identified as requiring additional staffing, the vacancies in these areas compound further the staffing challenges felt at ward level. Through the skill mix reviews it has become evident that exit interviews are not routinely performed for all leavers so it is not possible to analyse whether there are any themes underlying high numbers of vacancies.

A group of 21 newly qualified nurses commence within the organisation at the end of September and on-going work continues to further recruit overseas and increase the bank staffing resource .

The introduction of the Allocate electronic rostering system has now embedded across the Trust. The next steps with this project is to implement the SaferCare tool which will allow measurement of the acuity/dependency levels of the patient compared to staffing levels on a shift by shift basis. September saw the rollout of Single Sign On across the wards which enables all nursing staff on the ward to access the rostering system, this is a pre-requisite to implementation of the SaferCare tool. A project plan is being developed to roll the tool across all wards over the next 3-6months – there may be some requirement for some additional resource to support this implementation. Based on the initial findings from the skill mix review the areas identified for additional staffing may benefit from being the first to roll out this tool.

Recommendations

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

- Analyse the full findings of the skill mix reviews against the bed capacity modelling and financial requirements, to be presented at a future Board meeting
- Support additional staffing for RN on Amesbury late shift and NA on Durrington night shift, approximate cost £117k.
- Assess the immediate staffing requirements to support 21 beds inclusive of 3 HDU beds on Avon. Fully analyse nurse staffing within the context of on-going full review of spinal services.
- Support the rollout requirements for SaferCare tool to assess acuity and dependency levels on wards against staffing levels – with the pilot to include Whiteparish, Pitton, Redlynch, Downton and Sarum
- Continue Trust focus on recruitment, including overseas recruitment of at least 20 nurses to arrive early in the New Year
- With HR look to fully embed the use of exit interviews for all nurse leavers

Ward	RN: Patient Ratio (Early)	RN: Patient Ratio (Late)	RN: Patient Ratio (Night)	RN : HCA (based on establishment)	Comments / Recommendations
Whiteparish	1: 5(6)	1 5(6)	1: 7	68 : 32	Review requirement for RN to cover middle shift (10am – 6pm) to cover high demand. Pilot SaferCare tool.
Tisbury	1: 5	1: 5	1: 7	76 : 24	Staffing levels appear adequate
Pitton	1: 6	1: 6 (9)	1: 9	59 : 41	Review late shift – requirement for additional NA for workload. High levels of vacancy and vacant band 7. Pilot SaferCare tool.
Redlynch	1: 6	1: 6 (9)	1: 9	65 : 35	Review late shift and night shift – requirement for additional NA – pilot SaferCare tool
Farley	1: 5 (6)	1: 5	1: 10	57 : 43	Staffing levels appear adequate
Durrington	1: 7	1: 7	1: 10.5	59 : 41	Requirement for additional NA on night shift (high specials usage)
Winterslow 40 30	1: 8 1: 7.5	1: 8 (10) 1: 7.5	1: 13 1: 10	50 : 50	Beds reduced to 30 – staffing to be reviewed using SaferCare tool to see if levels set adequate, vacancies reduced as result of bed closures
Pembroke	1: 5	1: 5	1: 5	78 : 22	Staffing levels appear adequate
Hospice	1: 5	1: 5	1: 5 (10)	62 : 38	Staffing levels appear adequate
Amesbury	1: 8	1: 11	1: 16	50 : 50	Requirement for additional RN on late shift. High levels of vacancy particularly for registered nurses.
Chilmark	1: 6 (8)	1: 8	1: 12	56 : 44	Staffing levels appear adequate
Burns	1: 6	1: 6	1: 8.5	75 : 25	Staffing levels appear adequate
Laverstock	1: 5	1: 9	1: 8/13	63: 37	Staffing levels appear adequate
Avon	1: 5	1: 5	1: 7	46 : 54	4 closed beds due to vacancies, needs full analysis regarding respiratory HDU facility. High levels of vacancy

Tamar	1: 7	1: 7	1: 10.5	50 : 50	Staffing levels appear adequate
Britford	1: 5 (6)	1: 6	1: 8	64 : 36	Staffing levels appear adequate
Downton	1 : 7	1: 9	1: 13.5	60 : 40	Review requirement for additional NA on night due to workload. Pilot SaferCare tool
DSU	1: 7	1: 7	N/A	79 : 21	Staffing levels appear adequate
Sarum	1: 8	1: 8	1: 8	73 : 27	Review staffing levels against SaferCare tool specifically night times

*Of note Critical Care, Maternity and ED are all excluded from this review – Critical Care is subject to mandatory staffing levels, ED and maternity are subject to their own review.

PAPER - SFT 3578

FINANCE COMMITTEE – REVISED TERMS OF REFERENCE

PURPOSE

To approve a revision to the Terms of Reference of the Finance Committee.

MAIN ISSUES

The Committee did not meet in August.

At the 22 September meeting, the committee discussed its terms of reference and recommends the addition of a new duty to review the preceding month's operational performance. The report will continue to come to the board. The committee recommends a change of name to reflect this.

ATTACHMENTS AVAILABLE TO VIEW ON WEBSITE

None

ACTION REQUIRED BY THE BOARD

To approve the revised Terms of Reference for the Finance Committee

Nick Marsden
Chairman

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance Committee
Held on 22 September 2014

Present:	Dr N Marsden	Chairman
	Dr L Brown	Non-Executive Director
	Mr I Downie	Non-Executive Director
	Mr A Freemantle	Non-Executive Director
	Ms K Hannam	Chief Operating Officer
	Mr P Hill	Chief Executive
	Mr M Cassells	Director of Finance and Procurement
Apologies:		
In Attendance:	Mr M Ace	Associate Executive Director
	Mr D Seabrooke	Head of Corporate Governance

1. MINUTES – 21 July 2014

The minutes of the meeting held on 21 July 2014 were agreed as a correct record.

2. MATTERS ARRISING

Dorchester Pathology Contract – a further update would be given to the October meeting of the Committee.

3. FINANCE REPORT TO 31 AUGUST 2014 (MONTH 5)

The Committee received the Finance Report to 31 August.

Malcolm Cassells reported a slight deterioration in month 5. The Trust was breaking even but levels of spend were continuing to rise and he emphasised the need for the Trust's planned savings to be delivered. A half year consolidated position would be presented to the next meeting of the Committee. Cash was in accordance with plan and the Continuity of Service Rating was 4. Discussions with the CCG about access to Resilience Funding were continuing. The Chairman requested that there be a more detailed analysis of the surplus and loss arising from individual streams of activity on the half yearly review.

The Finance Committee noted the report.

4. TRANSFORMATION AND COST IMPROVEMENT

The Committee received the Transformation and Cost Improvement Programme Reports.

It was noted that on cost improvement there was 92% achievement year to date but not enough of this was recurrent savings. However on a straight line basis the amount achieved falls to just over 50%.

It was noted that there were 29 Delayed Transfers of Care and further 16 patients currently on an intermediate care waiting list. The introduction of ten Discharge to Assess beds had resulted in a corresponding closure of beds at the hospital. Arrangements continued to be made to commission a further 15 Intermediate Care beds in Salisbury. There was generally felt to be more visibility around the issue of Delayed Transfers of Care in the locality. There would need to be a mixture of short term and long term solutions to the issue including via the 100 Day Challenge and the Better Care Fund.

Activity on the transformation schemes continued including around Outpatients.

KH confirmed that the information presented had been validated by the Senior Responsible Officers in relation to each project.

5. CAPITAL DEVELOPMENT REPORT

The Committee received the Capital Development Report and it was noted that the second CT scanner had been installed and that ITU had been successfully decanted to Downton Ward to enable expansion work there to proceed.

An Information Governance issue had arisen in respect of the Trust's in house system of generating electronic discharge summaries. This concern about the regulation of user access was being addressed and would be reported as necessary.

It was also noted that the Springs redevelopment project had been delayed until 2015.

6. TERMS OF REFERENCE

The Committee received a revised Term of Reference which included a new responsibility for the review of Operational Performance and a new name of Finance and Performance Committee.

It was recommended to the Board that the revisions to the Finance Committee's Terms of Reference and name be approved.

7. FINANCE COMMITTEE DATES 2015

The following dates were approved –

26 January
23 February
30 March
27 April
18 May
29 June
27 July
24 August
28 September
26 October
30 November
21 December

8. ANNUAL REVIEW OF TREASURY MANAGEMENT POLICY

The Committee received as an additional item of business the annual review of the Treasury Management Policy which set out minor amendments and updates to the policy including the removal of the Prudential Borrowing Limit, new post in the Finance Department and the introduction of the National Loans Fund.

The Committee approved the amended Treasury Management Policy.

9. ANY OTHER BUSINESS

Genomics Service – an update on discussions about the possible future location of the Genetics/Genomics Service hosted by the Trust was given. The Service's income was about £5m per annum and it made a contribution to overheads of approximately £1m.

8. DATE OF NEXT MEETING

Monday 20 October 2014 at 9.30 am in the Boardroom.

SALISBURY NHS FOUNDATION TRUST

PERFORMANCE TO 31 AUGUST 2014

PURPOSE:

To inform the Board of the financial and contracting position to 31 August 2014.

MAIN ISSUES

1. GENERAL

The report summarises the position for the first five months of the year.

Key indicators of performance for the period to 31 August 2014 are summarised below and detailed in Appendix 1.

	FT Plan to 31.08.14	Actual To 31.08.14	% of Plan to 31.08.14
EBITDA £m	6.578	6.123	0.93
I & E Surplus £m*	0.413	0.078	
Total spells	23,864	25,137	1.05
Outpatient attendances	92,004	89,313	0.97
A&E Attendances	18,093	19,492	1.08
RAF Rating	4	4	

*Including donated assets treated as income under new rules

I & E Summary £m	FT Plan to 31.08.14	Actual to 31.08.14
I & E (Deficit)/Surplus - Trust	0.008	0.005
I & E Surplus – Net Donated income	0.333	0.073
Total I & E Surplus	**0.413**	**0.078**

The above figures represent just the Trust’s performance and plan for the five months to 31 August 2014. They exclude the results of the Trust’s subsidiary companies, Salisbury Trading Limited and Odstock Medical Limited (both of which are showing a small surplus) for the year to date. The consolidated figures will be included in the report for the six months to 30 September 2014.

The plan figures to 31 August 2014 are derived from the 2-year plan submitted to Monitor in early April.

Operating income is £80.77m, which is above the FT plan of £79.65m (Appendix 2). Operating expenditure within EBITDA amounted to £74.65m against a plan of £73.08m.

EBITDA is £6.123m which is below the plan of £6.578m, part of this shortfall relates to donated income falling short of the planned figure at 31 August 2014.

A surplus of £0.078m has been achieved against a planned position of £0.413m however the majority of the planned surplus relates to charitable donations of equipment and the position will change markedly when the CT scanners are both installed.

Net current assets amounted to £11.53m against a plan of £10.13m, with a cash balance of £16.83m against a plan of £16.97m.

The contracts with Wiltshire CCG, and Dorset CCG have been signed. A contract has been signed with West Hampshire CCG on behalf of the other Hampshire CCGs.

The contract with NHS England has now been finalised and signed. The financial values have all been agreed with the Associates to the contract, which includes the Military commissioner.

2. SALES

Activity and contract performance is detailed in Appendix C.

Activity is now being reported via the new contract management system (CIVICA/SLAM). All plans have now been loaded into the Civica system except for the specialist plan and non-contracted activity, which are still in the process of being loaded.

Elective inpatients activity in the five months to 31 August 2014 was slightly down on the same period last year. Elective daycases, which include regular day attendances remain well above both the plan and the same period last year.

Non-elective activity levels were higher than in the same period to 31 August 2014. Due to the national tariff payment system, the Trust will only receive 30% of tariff for activity above 2008/09 non-elective levels, so although the Trust is busy income is not rising commensurately. ED attendances reduced slightly in the month and now stand at 3.1% above the corresponding period last year.

Outpatient activity is marginally below the level experienced at this stage last year.

Neonatal care activity at 856 'badger' days is considerably down on the same period in 2013-14 when 1,047 days were recorded. Births are also down on this time last year at 967 births to 31 August 2014 compared with 1,016 in 2013.

Activity coded as 'spinal' (paid on a bed day basis) has continued the strong start to the year and remains considerably above the same period last year (6,188 bed days compared with 5,085 last year).

Critical care activity at 1,226 bed days remained slightly ahead of the 1,196 bed days recorded at this stage last year. Burns activity was lower in the month and has fallen back below the figures for the same period last year (811 bed days versus 835 bed days last year).

Performance v 2013-14 and 2014-15 plans	Actual M5 2013/14	Actual M5 2014/15	FT plan M5 2014/15	*Comm plan M5 2014/15	FT plan Variance M5 2014/15	*Comm plan Variance M5 2014/15
Elective: Inpatients	2,616	2,540	2,602	2,605	-62	-65
Elective: Daycases	11,335	11,856	11,007	11,063	849	793
Non-elective spells	10,295	10,741	10,255	10,338	486	403
Outpatient: Initial attendances	24,956	26,351	26,239	26,239	112	112
Outpatient: Follow-up attendances	49,956	47,838	49,126	49,126	-1,288	-1,288
Outpatient procedures	14,826	15,124	16,639	16,639	-1,515	-1,515
Total Outpatient	89,738	89,313	92,004	92,004	-2,691	-2,691
ED Attendances	18,902	19,492	18,093	18,093	1,399	1,399

***Comm = Commissioning plan (CCGs, Specialist Services and Military)**

3. COST OF SALES INCLUDING INDIRECT COSTS

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 total for all Directorates is an overspend position of £821k. The position is summarised below:

Directorate	Net Budget to 31.08.14 £000	Net Expend to 31.08.14 £000	Variance to 31.08.14 £000
			[+ over/- under]
Medicine	16,149	16,375	226
Musculo Skeletal	12,962	12,966	4
Surgery	13,928	14,063	135
Clinical Support & Family	13,845	14,165	320
Facilities	1,876	1,848	-28
Sub-Total	**58,760**	**59,417**	**657**
Other Directorates	9,525	9,689	164
TOTAL	**68,285**	**69,106**	**821**

At the end of Month 5, nursing and healthcare assistants budgets are underspent by £37k, compared to £63k overspent last month. In Month 5 £62k was spent on 'Specialing' patients compared to £31k in Month 4. The main increases have been on Laverstock Ward and the Burns Unit.

The year to date spend is £18,073k on nurses and healthcare assistants compared to £17,952k for the same period last year, an increase of £121k.

The use of Agency staff for nursing and healthcare assistants cost £1,029k compared to £1,705k for last year a decrease of £676k, an encouraging reduction. Work continues to reduce agency spend further. Agency shifts are beginning to reduce which is reflecting in the spend. Evidence is now suggesting that the Talent agency are now regularly providing more shifts than the much more expensive Thornbury Agency.

At the end of Month 5, Medical budgets are overspent by £242k, compared to £165k at the end of month 4. In the first five months £796k has been spent on agency consultants & staff grades (compared to £606k in the first four months) and £615k on agency junior doctors (compared to £522k in the first four months).

The main areas overspent this month are Spinal (agency junior cover), Radiology (agency consultant vacancies), Gynaecology (agency consultant and junior cover), Emergency Department (agency consultant vacancies and agency junior doctors cover) and Elderly Care (agency junior cover).

The large increase in agency consultants relates to increased expenditure incurred in Dermatology, Gastroenterology and Ophthalmology. Agency consultant spend still continues in Acute Medicine, Emergency Department, Radiology, Obstetrics and Gynaecology.

There has also been a significant increase in expenditure on homecare drugs in August with the spend growing by £200k. This should be funded through specialist services income.

4. STATEMENT OF FINANCIAL POSITION (BALANCE SHEET)

The Trust's cash position at 31 August 2014 was £16.83m, which was slightly below plan. NHS Trade Receivables includes accrued income for additional activity in the year to date, which will be shortly be invoiced to the Trust's commissioners. Interest earned was £29k.

The Capital Programme expenditure for the period to 31 August 2014 was £2.5m against a plan for the year of £12.1m (Appendix 3). All schemes continue to be reviewed to ensure expenditure profiles are understood. There is likely to be slippage on the Capital Programme in 2014-15.

5. COST IMPROVEMENT PLANS

The total cost improvement savings target for the year is £9.0m, which includes revenue generation as well as expenditure reduction schemes. Monitor requires revenue generation and expenditure reduction to be separately reported. It should be noted that the £9.0m figure included £1m for agency reductions which was to reduce overspending rather than reduce baseline budgets.

The savings achieved are £1,815k, against a plan for the month of £2,022k, For the achieved savings, only 37% are recurring. The savings are weighted towards the latter part of the year. If the savings were split equally throughout each month of the year then the amount required to date would be

£3,300k. Against this figure we have achieved 55% (month 4 – 49%). Considerable work is needed to ensure the planned savings are achieved in the remaining months of the year and a gap does not develop between the planned and achieved figures.

6. RISKS

The Trust's key financial risks for 2014-15 can be summarised as follows:

- Deliver the CIP target – this is probably the greatest financial challenge
- Meet contractual obligations and avoid penalties such as on CDiff
- Meet CQUIN targets
- Manage budgets effectively particularly in respect of: nursing agency and 'specialing' costs, and locum doctors and additional payments to doctors
- Match capacity to demand in the most cost effective way in order to avoid losing work to local competitors
- The financial position of commissioners and their ability to pay for over-activity

7. OTHER ISSUES

- Discussions have taken place and emails exchanged with Wiltshire CCG regarding the use of Resilience Funding. We are aware that Wiltshire CCG has funded GWH and RUH for the loss of the 70% of the tariff for non-elective work above 2008-09 levels. SFT is now seeking similar funding for loss of income as the growth in non-elective work this year is well above the 2008-09 level. No agreement has been reached as yet.
- We are also in discussion with commissioners regarding the funding for waiting list work to reduce the number waiting over 18 weeks for treatment. We have sought funding at tariff plus 30% and about 400 cases have been done. We expect this funding to come through.

8. CONCLUSION

The Trust has a surplus at Month 5 of £78k, which is below the planned position however the forecast outturn at this stage remains in accordance with Plan. The RAF score is 4.

9. RECOMMENDATION

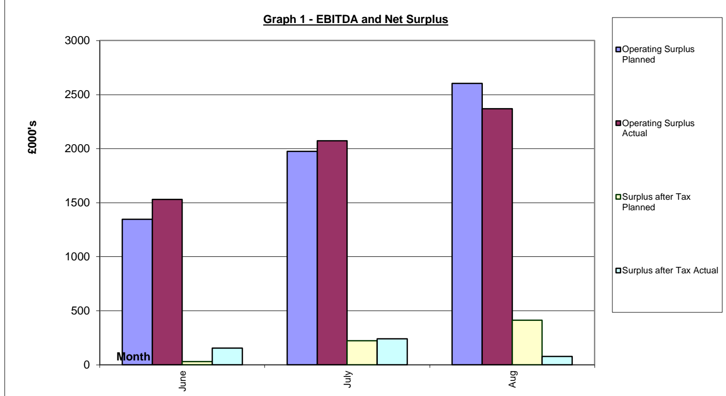
The Trust Board is asked to consider the position at 31 August 2014.

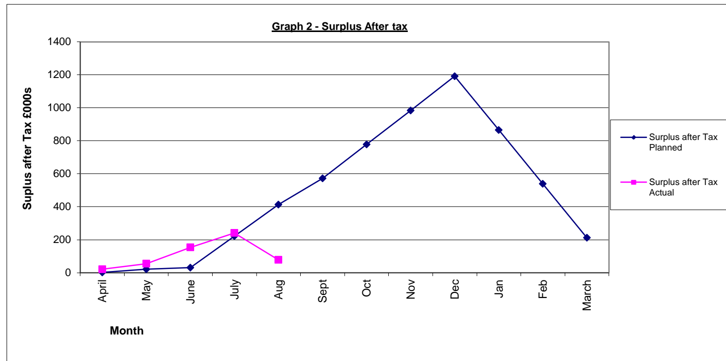
Malcolm Cassells
Director of Finance
23 September 2014

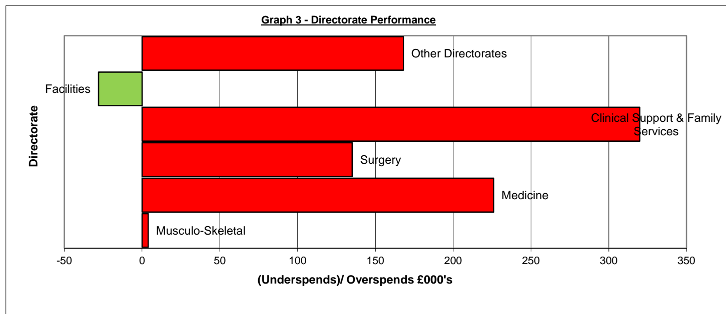
ATTACHMENTS TO VIEW ON WEBSITE

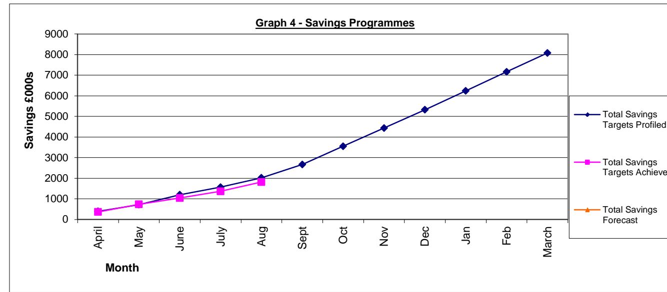
Appendix 1 – Summary Financial Activity and Budget position
Appendix 2 – Income & Expenditure
Appendix 3 – Capital Programme

Appendix 1 - August (Month 5) Dashboard 2014-15









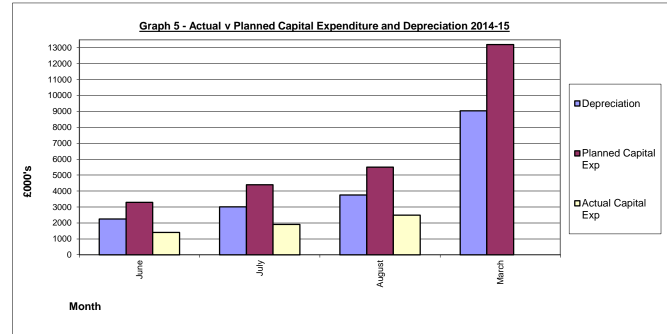


Table 2 New FRR

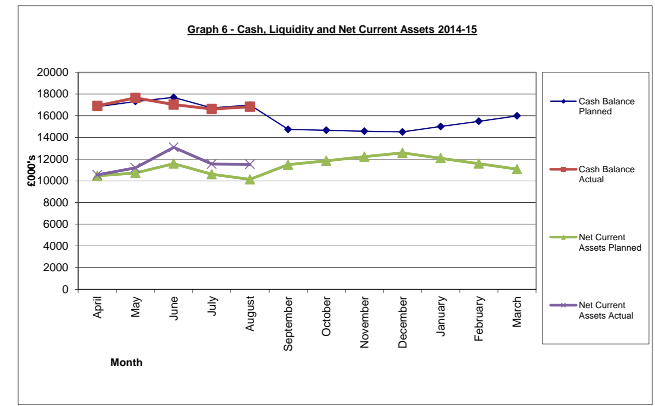
Ratio	Description	Planned Risk Score	Actual			Rating	Risk Ratings
Capital Service	Revenue Avaliable for Debt Service Divided by Capital Service Costs	4	4767.00 2601.00	=	1.83	3	50%
Liquidity	cash for liquidity purposes/operating expenses * no. of days in period	4	9670.00 74649.00	=	19.43	4	50%
Total Weighted Score		4.0				3.5	100%

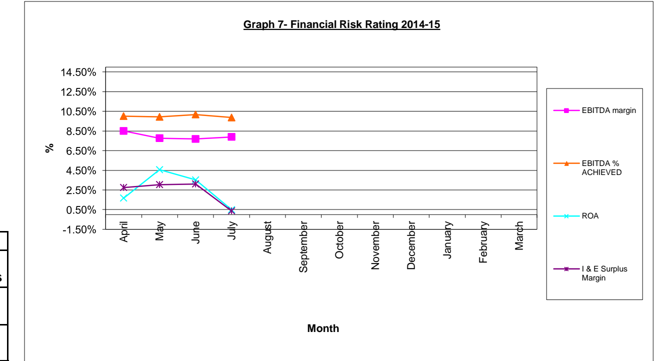
Table 1 - Financial Risk Rating Calculations:

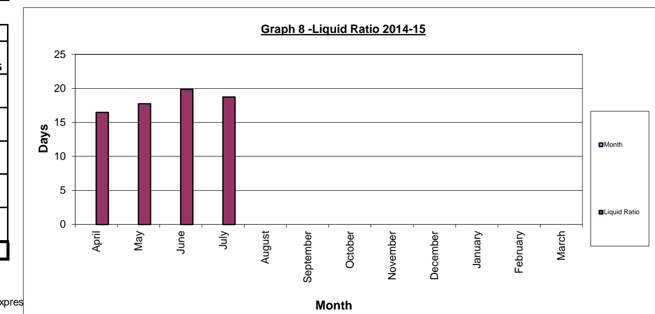
Ratio	Description	Planned Risk Score	Actual			Rating	Risk Ratings
EBITDA Margin	EBITDA divided by Total Income *	3	6.12 80.72	=	7.6%	3	25%
EBITDA %	EBITDA Actual divided by EBITDA Plan	4	6.12 6.58	=	93.0%	4	10%
ROA	(Net Surplus/(Deficit) minus PDC Capital minus FA Impairments) divided	3	0.08 61.98	=	0.1%	3	20.0%
I&E Surplus	(Net Surplus/(Deficit) minus FA Impairments) divided by Total Income	2	0.08 80.72	=	0.1%	2	20.0%
Liquid Ratio**	See below	4	21.4 Days			4	25%
Total Weighted Score		3.2				3.2	100%

NB: *Total income consists of NHS Clinical Income, Non NHS Clinical Income, Other Income (Education and Training, R&D) and PFI Specific Income.

NB: The liquidity ratio is defined as cash plus trade debtors plus unused working capital facility minus (trade creditors plus other creditors plus accruals) expres







	units	sense	Actual Year 2013/14 £M	Plan August £m	Actual August £m	Variance August £m
Operating						
NHS Clinical Revenue						
NHS Acute Activity Income						
Elective inpatients						
Tariff revenue	£m	(+ve)	18.665	8.106	7.695	-0.411
Non-Tariff revenue	£m	(+ve)	0.100	0.045	0.072	0.027
Elective activity revenue, Total	£m		**18.765**	**8.151**	**7.767**	**-0.384**
Elective day case patients (Same day)						
Tariff revenue	£m	(+ve)	16.944	6.429	7.585	1.156
Non-Tariff revenue	£m	(+ve)	1.263	0.504	0.471	-0.033
Elective Day Case activity revenue, Total	£m		**18.207**	**6.933**	**8.056**	**1.123**
Non-Elective patients						
Tariff revenue	£m	(+ve)	46.673	16.774	16.554	-0.220
Non-Tariff revenue	£m	(+ve)	16.542	4.531	4.761	0.230
Non-Elective activity revenue, Total	**£m**		**63.215**	**21.305**	**21.315**	**0.010**
Outpatients						
Tariff revenue	£m	(+ve)	27.050	10.681	9.454	-1.227
Non-Tariff revenue	£m	(+ve)	2.651	1.074	1.012	-0.062
Outpatients activity revenue, Total	**£m**		**29.701**	**11.755**	**10.466**	**-1.289**
A&E						
Tariff revenue	£m	(+ve)	4.915	1.960	2.191	0.231
Non-Tariff revenue	£m	(+ve)	0.000	0.000	0.000	0.000
A&E activity revenue, Total	**£m**		**4.915**	**1.960**	**2.191**	**0.231**
Other NHS activity						
Direct access & Op, all services	£m	(+ve)	2.688	1.150	1.715	0.565
Unbundled chemotherapy delivery	£m	(+ve)	0.819	0.370	0.441	0.071
Unbundled external beam radiotherapy	£m	(+ve)	0.000	0.000	0.000	0.000
Maternity Pathway tariff	£m	(+ve)	0.000	3.667	3.711	0.044
Other tariff revenue	£m	(+ve)	0.134	0.118	0.078	-0.040
Tariff revenue	£m	(+ve)	3.641	5.305	5.945	0.640
CQUIN revenue	£m	(+ve)		1.367	1.450	0.083
Diagnostic tests & Imaging revenue outside tariff	£m	(+ve)		1.605	1.673	0.068
Critical care (outside tariff) Adult, Neonate, Paediatric	£m	(+ve)		2.567	2.184	-0.383
High cost drugs revenue from commissioners	£m	(+ve)		4.460	5.473	1.013
Other drugs revenue (all types all bands including Chemotherapy)	£m	(+ve)		0.000	0.000	0.000
Other non-tariff revenue	£m	(+ve)		5.195	4.980	-0.215
Non-Tariff revenue	£m	(+ve)	33.073	15.194	15.760	0.566
Other NHS activity revenue, Total	**£m**		**36.714**	**20.498**	**21.705**	**1.207**
Total NHS Tariff income	**£m**		**117.888**	**49.255**	**49.424**	**0.169**
Total NHS Non-Tariff income	**£m**		**53.629**	**21.347**	**22.076**	**0.729**
NHS Acute Activity Income, Total	**£m**		**171.517**	**70.601**	**71.500**	**0.899**
Sub-total NHS Clinical Revenue	**£m**		**171.517**	**70.601**	**71.500**	**0.899**
CHANGE Contract penalties or adjustments not included above	**£m**	**(+ve)**	**0.000**	**0.000**	**0.000**	**0.000**
NHS Clinical Revenue, Total	**£m**		**171.517**	**70.601**	**71.500**	**0.899**
Non Mandatory/Non protected revenue						
Private patient revenue	£m	(+ve)	1.865	0.307	0.766	0.459
Other Non Mandatory/Non protected clinical revenue	£m	(+ve)	5.572	1.542	2.470	0.928
Non Mandatory/Non protected revenue, Total	**£m**		**7.437**	**1.848**	**3.236**	**1.388**
Other Operating Revenue						
Research and development revenue	£m	(+ve)	0.789	0.303	0.330	0.028
Education and training revenue	£m	(+ve)	5.260	2.125	2.347	0.222
PFI specific revenue	£m	(+ve)	0.000	0.000	0.000	0.000
Donations & Grants received of PPE & intangible assets (see comment)	£m	(+ve)	0.000	0.000	0.000	0.000
Donations & Grants received of cash to buy PPE & intangible assets	£m	(+ve)	0.648	0.333	0.073	-0.260
Donations& Grants received of PPE & intangibles	£m	(+ve)	**0.648**	**0.333**	**0.073**	**-0.260**
Parking revenue	£m	(+ve)	1.276	0.533	0.563	0.030
Catering revenue	£m	(+ve)	0.861	0.360	0.364	0.004
Accommodation revenue	£m	(+ve)	1.296	0.533	0.552	0.019
Revenue from non-patient services to other bodies	£m	(+ve)	0.959	2.483	1.042	-1.441
Misc. other operating revenue	£m	(+ve)	4.226	0.533	0.765	0.232
Other Operating revenue, Total	**£m**		**15.315**	**4.443**	**3.286**	**-1.157**
Operating Revenue, IFRS, Total	**£m**		**194.269**	**79.654**	**80.772**	**1.118**
Operating Expenses						
Raw Materials and Consumables Used						
Drugs	£m	(-ve)	-14.704	-6.810	-6.825	-0.015
Clinical supplies	£m	(-ve)	-19.221	-7.525	-8.366	-0.841
Decrease (increase) in inventories of finished goods & WIP	£m	(-ve)	0.000	0.000	0.000	0.000
Vehicle Fuel costs (ambulance trusts)	£m	(-ve)	0.000	0.000	0.000	0.000
Non-clinical supplies	£m	(-ve)	-17.890	-7.127	-7.370	-0.243
Raw Materials and Consumables Used, Total	**£m**		**-51.815**	**-21.462**	**-22.561**	**-1.099**
Cost of Secondary Commissioning of mandatory services	£m	(-ve)	-2.595	-1.125	-1.558	-0.433
Employee Expenses [was "Pay"]						
Employee expenses, permanent staff	£m	(-ve)	-113.833	-46.982	-46.831	0.151
Employee expenses, agency & contract staff	£m	(-ve)	-6.038	-2.762	-2.857	-0.095
Employee Expenses, Total	**£m**	**(-ve)**	**-119.871**	**-49.744**	**-49.688**	**0.056**
Research & Development expense	£m	(-ve)	-0.449	-0.167	-0.142	0.025
Education and training expense	£m	(-ve)	-0.348	-0.125	-0.098	0.027
Consultancy expense	£m	(-ve)	-0.330	-0.135	-0.225	-0.090
Misc. other Operating expenses	£m	(-ve)	-1.182	-0.145		0.145
(Increase)/decrease in Provisions, Current and Non-Current, net	£m	(+/-ve)	-0.084	0.000	0.000	0.000
(Increase)/decrease in Impairment of receivables, Current and Non-Current, net	£m	(+/-ve)	-0.105	0.233		-0.233
PFI operating expenses						
PFI unitary payment	£m	(-ve)	-0.935	-0.407	-0.377	0.030

IFRIC12 revenue/(expense) adjustment	£m	(+/-ve)	0.000	0.000	0.000	0.000
Other PFI expenses	£m	(-ve)	0.000	0.000	0.000	0.000
PFI operating expenses, total	**£m**	**(-ve)**	**-0.935**	**-0.407**	**-0.377**	**0.030**
Operating Expenses within EBITDA, Total	**£m**		**-177.714**	**-73.076**	**-74.649**	**-1.573**
Depreciation and Amortisation						
Depreciation and Amortisation - owned assets	£m	(-ve)	-8.282	-3.567	-3.341	0.226
Depreciation and Amortisation - donated assets	£m	(-ve)	-0.334	-0.142	-0.165	-0.023
Depreciation and Amortisation - owned assets			**-8.616**	**-3.708**	**-3.506**	**0.202**
Depreciation and Amortisation - assets held under finance leases	£m	(-ve)	-0.062	-0.025	-0.026	-0.001
Depreciation and Amortisation - PFI assets	£m	(-ve)	-0.493	-0.242	-0.222	0.020
Depreciation and Amortisation, Total	**£m**		**-9.171**	**-3.975**	**-3.754**	**0.221**
Impairment (Losses) / Reversals net (on non-PFI assets)	£m	(-/+ve)	0.000	0.000	0.000	0.000
Impairment (Losses)/ Reversals net on PFI assets	£m	(-/+ve)	0.000	0.000	0.000	0.000
Restructuring Costs	£m	(-ve)	0.000	0.000	0.000	0.000
Operating Expenses excluded from EBITDA, Total	**£m**	**(-ve)**	**-9.171**	**-3.975**	**-3.754**	**0.221**
Operating Expenses IFRS, Total			**-186.885**	**-77.051**	**-78.403**	**-1.352**
Surplus (Deficit) from Operations			**7.384**	**2.603**	**2.369**	**-0.234**
Non Operating						
Non-Operating income						
Finance Income [for non-financial activities]						
Gain (Loss) on Financial Instruments Designated as Cash Flow Hedges	£m	(+ve)	0.000	0.000	0.000	0.000
Gain (Loss) on Derecognition of Available-for-Sale Financial Assets	£m	(+ve)	0.000	0.000	0.000	0.000
Gain (Loss) on Derecognition of Non-Current Assets Not Held for Sale, Total	£m	(+ve)	0.000	0.000	0.000	0.000
Gain (Loss) on Investments & Inv.Property (NOT charitable funds)	£m	(+ve)	0.000	0.000	0.000	0.000
Interest Income	£m	(+ve)	0.068	0.028	0.029	0.001
Dividend Income	£m	(+ve)	0.000	0.000	0.000	0.000
Share of profit (loss) from equity accounted Associates, Joint Ventures						
Share of Private Patient Income from equity accounted Associates, Joint Ventures	£m	(+ve)	0.000	0.000	0.000	0.000
Share of non Private Patient Income from equity accounted Associates, Joint Venture	£m	(+ve)	0.000	0.000	0.000	0.000
Share of expenses from equity accounted Associates, Joint Ventures	£m	(-ve)	0.000	0.000	0.000	0.000
Share of profit (loss) from equity accounted Associates, Joint Ventures, Total	£m		0.000	0.000	0.000	0.000
Finance Income [for non-financial activities], Total	**£m**		**0.068**	**0.028**	**0.029**	**0.001**
Other Non-Operating income	£m					
Gain/(loss) on asset disposals	£m	(+/-ve)	0.000	0.000	0.000	0.000
Income of NHS Charitable funds (if consolidated)	£m	(+ve)	0.000	0.000	0.000	0.000
Gain (Loss) of NHS Charitable funds' investments (if consol.)	£m	(+ve)	0.000	0.000	0.000	0.000
Other Non-Operating income	£m	(+ve)	0.000	0.000	0.000	0.000
Other Non-Operating income, Total	**£m**		**0.000**	0.000	0.000	0.000
Non-Operating income, Total	**£m**		**0.068**	**0.028**	**0.029**	**0.001**
Non-Operating expenses						
Finance Costs [for non-financial activities]						
Interest Expense						
Interest Expense on Overdrafts and Working Capital Facilities	£m	(-ve)	0.000	0.000	0.000	0.000
Interest Expense on Bridging loans	£m	(-ve)	0.000	0.000	0.000	0.000
Interest Expense on Non-commercial borrowings	£m	(-ve)	-0.028	-0.005	-0.005	0.000
Interest Expense on Commercial borrowings	£m	(-ve)	0.000	0.000	0.000	0.000
Interest Expense on Finance leases (non-PFI)	£m	(-ve)	-0.026	-0.011	-0.008	0.003
Interest Expense on PFI leases & liabilities	£m	(-ve)	-1.908	-0.798	-0.724	0.074
Interest Expense, Total	**£m**		**-1.962**	**-0.814**	**-0.737**	**0.077**
Other Finance Costs	£m	(-ve)	-0.010	0.000	0.000	0.000
PDC dividend expense	£m	(-ve)	-3.510	-1.405	-1.583	-0.178
Finance Costs [for non-financial activities], Total	**£m**		**-5.482**	**-2.219**	**-2.320**	**-0.101**
Other Non-Operating expenses						
Non-Operating PFI costs (eg contingent rent)	£m	(-ve)	0.000	0.000	0.000	0.000
Other Non-Operating expenses (developments)	£m	(-ve)	0.000	0.000	0.000	0.000
Misc Other Non-Operating expenses	£m	(-ve)	0.000	0.000	0.000	0.000
Non-Operating expenses, Total	**£m**		**-5.482**	**-2.219**	**-2.320**	**-0.101**
Surplus (Deficit) before Tax	£m		1.970	0.413	0.078	-0.335
Income Tax (expense)/ refund	£m	(-/+ve)	0.000	0.000	0.000	0.000
Surplus (Deficit) After Tax	**£m**		**1.970**	**0.413**	**0.078**	**-0.335**
Profit/(loss) from discontinued Operations, Net of Tax	£m	(+/-ve)	0.000	0.000	0.000	0.000
Surplus (Deficit) After Tax from Continuing Operations	**£m**		**1.970**	**0.413**	**0.078**	**-0.335**
Elements of Comprehensive Income						
Share of comprehensive income from associates and joint ventures	£m	(+/-ve)	0.000	0.000	0.000	0.000
Revaluation gains/(losses) straight to revaluation reserve	£m	(+/-ve)	0.000	0.000	0.000	0.000
Impairments/(reversals) straight to revaluation reserve	£m	(+/-ve)	0.104	0.000	0.000	0.000
Fair Value gains/(losses) straight to reserves	£m	(+/-ve)	9.904	0.000	0.000	0.000
Additions/(reduction) in "Other reserves"	£m	(+/-ve)	0.000	0.000	0.000	0.000
Other recognised gains and losses	£m	(+/-ve)	0.000	0.000	0.000	0.000
Actuarial gains/(losses) on defined benefit pension schemes	£m	(+/-ve)	0.000	0.000	0.000	0.000
Total			**10.008**	**0.000**	**0.000**	**0.000**
Total Comprehensive Surplus/(Deficit)			**11.978**	**0.413**	**0.078**	**-0.335**
Memorandum lines						
Total Revenue	£m		194.337	79.682	80.801	1.119
Total Expenses	£m		-192.367	-79.270	-80.723	-1.453
Total Operating Revenue for EBITDA	£m		194.269	79.654	80.772	1.118
Total Operating Expenses for EBITDA	£m		-177.714	-73.076	-74.649	-1.573
EBITDA (for FRR calculation)	£m		16.555	6.578	6.123	-0.455
EBITDA Margin Metric (YTD)	£m		8.52%	0.138	7.58%	-0.062
Operating Surplus (Deficit)	£m		7.283	2.603	2.369	-0.234
Surplus (Deficit) After Tax (for FRR calculation)	£m		1.869	0.413	0.078	-0.335

Cost Centre	Project Name	Area	Board Approved 2014/15	Schemes B/Fwd to 2013/14	Slippage from 2013/2014	14/15 Board Approved + 13/14 final slippage - 13/14 b/fwd	Adjustments to final Plan	Brought Forward from 2015/16	Slippage to 2015/16	Revised Plan	Spend to 31st August 2014	Under/(Over) spent on Project	Outstanding Spend 2014/15
1	**Donated Assets**												
7082C0	Benson Suite - Donated	A1	0	0	16,138	16,138	0	0	0	16,138	5,895		10,242
7081C0	NICU / Parents Accommodation - Donated Assets	A1	0	0	15,769	15,769	0	0	0	15,769	0		15,769
SDA	Small Donated Additions	A1	0	0	0	0	67,385	0	0	67,385	67,385		0
1	**Donated Assets - Totals**		**0**	**0**	**31,907**	**31,907**	**67,385**	**0**	**0**	**31,907**	**73,280**	**0**	**26,011**
2	**Phase 3 Building Schemes**	BWG		0									
7230C0	CT Scanner Building and Enabling	A2	155,000	-5,530	0	149,470	165,530	0	0	315,000	14,440		300,560
7067C0	Helter Skelter Storage	A2	150,000	0	0	150,000	0	0	0	150,000	0		150,000
7085C0	Laundry Buildings	A2	0	0	56,636	56,636	0	0	0	56,636	1,299		55,337
7084C0	Maternity - DoH Grant	A2	0	0	30,367	30,367	0	0	0	30,367	56,749	-26,382	0
7073C0	Radnor Ward Development	A2	1,168,000	0	0	1,168,000	0	0	0	1,168,000	8,854		1,159,146
7087C0	Springs entrance development	A2	400,000	0	989,924	1,389,924	30,000	0	-1,000,000	419,924	47,462		372,462
7086C0	Ward changes - Dementia Patient Care	A2	230,000	0	397,156	627,156	0	0	0	627,156	295,873		331,283
2	**Building Schemes - Totals**	0	**2,103,000**	**-5,530**	**1,474,083**	**3,571,553**	**195,530**	**0**	**-1,000,000**	**2,767,083**	**424,678**	**-26,382**	**2,368,788**
3	**Building and Works**	BWG		0									
7014C0	Accommodation - Langley House Kitchen Upgrade	BWG	29,000	0	0	29,000	0	0	0	29,000	4,835		24,165
7009C0	Accommodation - Replacement glazing units	BWG	0	0	3,023	3,023	0	0	0	3,023	2,062		961
7035C0	Accommodation & Leisure Centre Boilers	BWG	100,000	-24,072	0	75,928	-5,300	0	0	70,628	70,188		439
7040C0	Accommodation key security	BWG	0	0	7,000	7,000	0	0	0	7,000	0		7,000
7088C0	AGSS Overhaul & Med Gas Racking	BWG	0	0	15,000	15,000	-15,000	0	0	0	0		0
7041C0	AHU replacement yr 3 (2014/15) of 7	BWG	280,000	0	140,593	420,593	3,034	0	0	423,627	53,655		369,972
7042C0	Asbestos management	BWG	0	0	22,217	22,217	0	0	0	22,217	3,995		18,222
7814C0	BMS upgrade 3rd year of 3 - invest to save	BWG	0	0	42,679	42,679	0	0	0	42,679	0		42,679
7043C0	Catering boiling pan replacement	BWG	0	0	3,153	3,153	0	0	0	3,153	0	3,153	0
7008C0	Catering Dishwasher	BWG	126,000	0	0	126,000	0	0	0	126,000	0		126,000
7006C0	Catering - Oven Replacement	BWG	0	0	0	0	22,000	0	0	22,000	14,679		7,321
7044C0	Catering refrigeration upgrade	BWG	0	0	27,427	27,427	-17,427	0	0	10,000	0		10,000
7090C0	Catering Replacement Cooking Equipment	BWG	0	0	9,175	9,175	0	0	0	9,175	0	9,175	0
7046C0	Catheter Suite - Rebalance of Heating System	BWG	20,000	0	0	20,000	0	0	0	20,000	0		20,000
7220C0	Central Clinical Notes Preparation	BWG	0	0	0	0	9,800	0	0	9,800	0		9,800
7091C0	Childrens OPD Audiology Soundproof Room	BWG	0	0	72,043	72,043	0	0	0	72,043	49,829		22,214
7079C0	Decentralisation of Boilers	BWG	0	0	0	0	263,200	0	0	263,200	800		262,400
7092C0	DSU Replacement Insulation to Air Handling System	BWG	0	0	8,600	8,600	0	0	0	8,600	0		8,600
7019C0	DSU Roof Repairs	BWG	0	0	0	0	20,000	0	0	20,000	0		20,000
7010C0	DSU Theatres - Flooring	BWG	0	0	1,882	1,882	0	0	0	1,882	0		1,882
7093C0	Ductwork & Fire Damper Cleaning Whole Site 2nd year of 2	BWG	70,000	0	119,508	189,508	0	0	-80,000	109,508	3,741		105,767
7066C0	ED Data Centre Ventilation	BWG	40,000	0	0	40,000	0	0	0	40,000	515		39,485
7094C0	Education Centre Reception DDA Compliance	BWG	0	0	8,000	8,000	0	0	0	8,000	5,125		2,875
7828C0	Electricity at Work Regulations Compliance - Year 3 (2013/14) of 3	BWG	0	0	133,505	133,505	0	0	-30,000	103,505	70,845		32,660
7012C0	Endoscopy Ensuite Enema Room	BWG	30,000	-30,000	30,000	30,000	0	0	0	30,000	29,439		561
7017C0	Eye clinic expansion	BWG	0	0	4,377	4,377	0	0	0	4,377	0		4,377
7065C0	Fertility Air Conditioning	BWG	12,000	0	0	12,000	5,000	0	0	17,000	0		17,000
7215C0	Finance fire alarm system upgrade	BWG	0	0	21,600	21,600	0	0	0	21,600	0		21,600
7001C0	Finance Office Refurbishment	BWG	0	0	-1,899	-1,899	1,899	0	0	0	0		0
7050C0	Fire alarms - detection & prevention equip - various	BWG	0	0	5,548	5,548	10,000	0	0	15,548	10,074		5,475
7062C0	Fire compartmentation SDH north - remedial works	BWG	0	0	58,013	58,013	-10,000	0	0	48,013	0		48,013
7036C0	Fire Suppression to Transformer Rooms	BWG	42,000	-372	0	41,628	0	0	0	41,628	0		41,628
7007C0	Gas mains test	BWG	0	0	7,000	7,000	0	0	0	7,000	7,848	-848	0
7030C0	Genetics Air Conditioning	BWG	11,000	0	0	11,000	-5,000	0	0	6,000	2,365		3,635
7059C0	Hedgerows - Public WC's Refurbishment	BWG	0	0	2,598	2,598	-2,598	0	0	0	0		0
7005C0	Hedgerows extension	BWG	0	0	14,935	14,935	-14,935	0	0	0	0		0
7201C0	Hot Water Pipes - SDH Various Areas	BWG	100,000	0	65,990	165,990	-140,000	0	0	25,990	0		25,990
7052C0	IVF lab. Ventilation system modifications	BWG	0	0	854	854	0	0	0	854	0		854
7054C0	Legionella risks	BWG	0	0	85	85	0	0	0	85	0		85
7096C0	Level 2 Flooring	BWG	0	0	98,721	98,721	-68,721	0	0	30,000	0		30,000
7097C0	Level 4 Bedspace Power Sockets	BWG	0	0	69,460	69,460	-7,000	0	0	62,460	850		61,610
7056C0	LIfts overhaul - year 3 (2014/15) of 3	BWG	80,000	0	76,298	156,298	25,000	0	-50,000	131,298	117,146		14,152
7098C0	Main Entrance L3 Upgrade	BWG	0	0	54,556	54,556	20,000	0	0	74,556	32,525		42,031
7070C0	Main Theatres 4th Laminar Flow System	BWG	0	0	185,000	185,000	0	0	-185,000	0	0		0
7032C0	Maternity Obstetric Theatre Refurbishment	BWG	78,000	0	0	78,000	0	0	0	78,000	0		78,000
7029C0	Maternity Post Natal Upgrade	BWG	122,000	0	0	122,000	0	0	0	122,000	0		122,000
7033C0	Maternity Relocation - Enabling	BWG	0	0	1,622	1,622	0	0	0	1,622	0		1,622
7080C0	Mattress Laundering	BWG	0	0	2,521	2,521	0	0	0	2,521	0		2,521
7031C0	MDMC Infusion Device Analyser	BWG	8,000	0	0	8,000	0	0	0	8,000	7,824		176
7072C0	Medical Air (Dryers) SDH North	BWG	0	0	4,120	4,120	0	0	0	4,120	0		4,120
7051C0	Medical Gas Hoses 1st year of 2 (2014/15)	BWG	66,000	0	0	66,000	15,000	0	-40,000	41,000	0		41,000
7852C0	Medical Gas System	BWG	0	0	3,456	3,456	0	0	0	3,456	0	3,456	0
7003C0	Microbiology - Category 3 Room	BWG	0	0	58,164	58,164	-13,034	0	-9,000	36,130	41,350	-5,220	0
7013C0	Mortuary electrical installation compliance	BWG	0	0	11,673	11,673	7,000	0	0	18,673	9,508	0	9,165
7142C0	Mortuary Refrigeration	BWG	0	0	15,901	15,901	0	0	0	15,901	10,109	5,792	0
7492C0	Noise Reduction & Facilities Equipment	BWG	0	0	29,488	29,488	0	0	0	29,488	0		29,488
7202C0	Nurse Call System Upgrade - SDH North & Maternity - 2nd year of 2	BWG	70,000	0	103,397	173,397	0	0	-75,000	98,397	39,076		59,321
7203C0	Occupational Health Replacement Boilers	BWG	0	0	1,068	1,068	0	0	0	1,068	0		1,068
7894C0	Oral Surgery - Theatre 9 (plus more dental chairs)	BWG	0	0	44,659	44,659	0	0	0	44,659	120		44,538
7204C0	Pathology & Histopathology OSNA Room (4.5.20) Air Conditioning	BWG	0	0	4,973	4,973	0	0	0	4,973	0		4,973
7057C0	Piped medical gas system safety valves replacement	BWG	0	0	3,683	3,683	0	0	0	3,683	0	3,683	0
7208C0	Procurement Out of Hours Bay	BWG	0	0	5,642	5,642	0	0	0	5,642	6,919	-1,277	0
7848C0	Productive Operating Theatres	BWG	0	0	27,415	27,415	0	0	0	27,415	4,839		22,576
7209C0	Public & Staff WCs L5,L4,L3	BWG	0	0	84,000	84,000	2,598	0	0	86,598	0		86,598
7210C0	Public Spaces Fund	BWG	0	0	18,404	18,404	0	0	0	18,404	5,700		12,704
7211C0	Radiology Recovery Area Improvements	BWG	0	0	60,000	60,000	-10,000	0	0	50,000	9,783		40,217
7095C0	Relocation of Liquid Oxygen VIE Plant	BWG	0	0	28,148	28,148	0	0	0	28,148	0		28,148
7061C0	Rheumatology temperature control	BWG	0	0	17,079	17,079	0	0	0	17,079	0		17,079
7020C0	Roads and paving repairs	BWG	0	0	160,949	160,949	0	0	0	160,949	0		160,949
7880C0	Roof Repairs - Various	BWG	0	0	20,866	20,866	0	0	0	20,866	28,082	-7,215	0
7212C0	SDH Main Chillers Replacement	BWG	42,000	0	-15,188	26,812	0	0	0	26,812	1,767		25,046
7218C0	SDU X 2 Washers	BWG	100,000	0	0	100,000	0	0	0	100,000	0		100,000
7214C0	Security Improvements 2013/14	BWG	0	0	35,431	35,431	0	0	0	35,431	15,955		19,476
7037C0	Server Rooms - Air Conditioning	BWG	0	0	41,522	41,522	0	0	0	41,522	0		41,522
7038C0	Shower Cubicle Drainage Improvements	BWG	30,000	0	0	30,000	0	0	0	30,000	0		30,000
7219C0	Site Signage 2013/14	BWG	0	0	3,580	3,580	0	0	0	3,580	689		2,892
7049C0	Spinal treatment centre refurbishment	BWG	0	0	189,935	189,935	0	0	0	189,935	219		189,716
7016C0	Spinal Unit - wheelchair cleaning and storage	BWG	0	0	3,370	3,370	0	0	0	3,370	3,818	-448	0
7024C0	Spinal Unit Double Glazing 1st yeat of 2 (2014/15)	BWG	60,000	0	0	60,000	0	0	0	60,000	0		60,000
7026C0	Spinal Unit Fire Escape	BWG	17,000	0	0	17,000	0	0	0	17,000	0		17,000
7890C0	Spinal X-ray booking facilities and doors	BWG	0	0	28,677	28,677	0	0	0	28,677	20,740		7,937
7217C0	Theatres 1 - 10 Replacement Taps	BWG	0	0	4,051	4,051	0	0	0	4,051	3,256		794
7018C0	Walls - repairs to failing walls	BWG	0	0	8,000	8,000	0	0	0	8,000	0		8,000
7022C0	Wessex Rehab Windows and Cladding	BWG	0	0	11,466	11,466	0	0	0	11,466	0		11,466
7077C0	Wilton Ward Winter Pressures 13/14 (Block 79)	BWG	0	0	33,924	33,924	0	0	0	33,924	0		33,924
3	**Building Projects/Building and Works Totals**	BWG	**1,533,000**	**-54,444**	**2,358,938**	**3,837,494**	**95,516**	**0**	**-469,000**	**3,464,010**	**690,269**	**10,251**	**2,763,490**
4	**Information Technology**	IT		0									
7968C0	Abdominal Aortic Aneurysm (AAA) Project	IT	0	0	0	0	0	0	0	0	0		0
7962C0	ACS Licences	IT	12,000	0	0	12,000	0	0	0	12,000	0		12,000
7901C0	AD Upgrade to 2008	IT	0	0	28,827	28,827	0	0	0	28,827	21,048		7,779
7990C0	Allocate' Roster System	IT	0	0	39,168	39,168	0	0	0	39,168	39,000		168
7995C0	Auditbase link to iPM	IT	0	0	20,000	20,000	0	0	0	20,000	0		20,000
7930C0	Backup Tape Library Replacement	IT	52,000	0	0	52,000	0	0	0	52,000	8,123		43,877
7714C0	Blood Tracking	IT	0	0	17,491	17,491	0	0	0	17,491	0		17,491
7996C0	Blood Tracking Phases 1 - 3	IT	200,000	0	137,177	337,177	0	0	0	337,177	0		337,177
7993C0	BMS Network Upgrade	IT	0	0	31,955	31,955	0	0	0	31,955	0		31,955
7940C0	Brocade Switch Replacement	IT	0	0	7,513	7,513	0	0	0	7,513	0		7,513
7980C0	Clikview Reporting System	IT	80,000	0	0	80,000	0	0	0	80,000	0		80,000
7954C0	Clinical Coding Encoder	IT	0	0	23,692	23,692	0	0	0	23,692	0		23,692

Cost Centre	Project Name	Area	Board Approved 2014/15	Schemes B/Fwd to 2013/14	Slippage from 2013/2014	14/15 Board Approved + 13/14 final slippage - 13/14 b/fwd	Adjustments to final Plan	Brought Forward from 2015/16	Slippage to 2015/16	Revised Plan	Spend to 31st August 2014	Under/(Over) spent on Project	Outstanding Spend 2014/15
7984C0	Community Midwifery system trial	IT	0	0	35,748	35,748	0	0	0	35,748	0		35,748
7915C0	Connectivity Upgrade for Warminster & Shaftesbury	IT	42,000	0	0	42,000	0	0	0	42,000	0		42,000
7904C0	COSD - Cancer Database	IT	24,000	0	0	24,000	0	0	0	24,000	0		24,000
7969C0	Dell Kace Push Software	IT	96,000	-96,000	1,437	1,437	0	0	0	1,437	267		1,170
7909C0	Desktop PC Windows 7 Upgrade	IT	0	0	12,472	12,472	0	0	0	12,472	2,354		10,118
7110C0	Diabetic Retinopathy Screening	IT	0	0	1,621	1,621	0	0	0	1,621	1,165		457
7911C0	EDCR-Changes to improve air flow and balance	IT	0	0	9,500	9,500	0	0	0	9,500	0		9,500
7920C0	Edge Security replacement	IT	0	0	0	0	5,000	0	0	5,000	0		5,000
7997C0	Electronic Letters	IT	0	0	24,160	24,160	0	0	0	24,160	2,778		21,382
7961C0	EPMA (Yr 2 (2014/15) of 7)	IT	82,000	0	70,438	152,438	0	0	0	152,438	19,700		132,738
7925C0	Estates Management Information System	IT	0	0	5,000	5,000	0	0	0	5,000	1,405		3,595
7926C0	Exchange 2010 Upgrade	IT	0	0	23,301	23,301	-5,000	0	0	18,301	15,211		3,089
7903C0	Genetics High Spec Analysis Equipment & Software	IT	86,000	0	0	86,000	0	0	0	86,000	0		86,000
7929C0	Histopathology Hardware	IT	20,000	0	0	20,000	0	0	0	20,000	141		19,859
7912C0	Inhouse development team - applications, databases and Dashboards (subject to bus case)	IT	78,000	0	14,176	92,176	0	0	-92,176	0	0		0
7927C0	iPad Security	IT	0	0	22,000	22,000	0	0	0	22,000	21,840		160
7913C0	Lab Medicine-Tpath to Nxt Gen	IT	0	0	0	0	0	0	0	0	0		0
7916C0	Maternity PC & Screens Replacement	IT	22,000	-22,000	22,000	22,000	0	0	0	22,000	724		21,276
7914C0	Mobile Computing	IT	50,000	0	26,332	76,332	0	0	0	76,332	15,826		60,506
7972C0	Moorefield's Eye Hospital Software	IT	0	0	27,000	27,000	0	0	0	27,000	0		27,000
7956C0	Network Load Balancers	IT	36,000	0	0	36,000	0	0	0	36,000	13,027		22,973
7928C0	Network Upgrade Consultancy	IT	21,000	0	70,500	91,500	0	0	0	91,500	0		91,500
7974C0	Neurophysiology Project	IT	0	0	4,446	4,446	0	0	0	4,446	0		4,446
7960C0	Nexus 5 Expansion	IT	49,000	0	0	49,000	0	0	0	49,000	0		49,000
7934C0	Open Eyes System	IT	68,000	-36,000	8,152	40,152	0	0	0	40,152	0		40,152
7942C0	Order Comms (includes System Admin Bid & Sexual Health Bid)	IT	0	0	22,889	22,889	0	0	0	22,889	14,624		8,265
7943C0	PACS Reprocurement	IT	0	0	78,940	78,940	-2,169	0	0	76,771	2,609		74,163
7931C0	Palliative Care EPR	IT	0	0	4,437	4,437	35,000	0	0	39,437	0		39,437
7908C0	PAS 2016 Replacement - Consultancy Costs	IT	70,000	0	0	70,000	0	0	0	70,000	35,521		34,479
7902C0	Patient Observations Monitoring and Decision Support/Early Warning System/POET	IT	280,000	-12,617	0	267,383	0	0	0	267,383	61,971		205,412
7552C0	Patient Tracking	IT	0	0	1,253	1,253	0	0	0	1,253	936		317
7905C0	Radiologists 'on-call' Laptops	IT	12,000	0	0	12,000	2,169	0	0	14,169	0		14,169
7918C0	Radiology - OrderComms	IT	0	0	71,257	71,257	0	0	0	71,257	0		71,257
7923C0	Radiology Replacement PC's	IT	10,000	0	0	10,000	0	0	0	10,000	0		10,000
7992C0	RAM Asset Maintenance Module	IT	0	0	1	1	0	0	0	0	2,639	-2,639	0
7906C0	Results System in GP Practices 'Review' System	IT	30,000	0	0	30,000	0	0	0	30,000	5,523		24,477
7985C0	RIS patient self check in	IT	0	0	7,848	7,848	0	0	0	7,848	6,250		1,598
7982C0	SBAR for PAS	IT	0	0	0	0	100,000	0	0	100,000	0		100,000
7988C0	SBAR re NACS Update to ED Symphony	IT	0	0	1	0	7,500	0	0	7,500	0		7,500
7970C0	Scanned Health Rtecords	IT	0	0	7,418	7,418	0	0	0	7,418	5,100		2,318
7981C0	SDU Quality System	IT	0	0	0	0	12,600	0	0	12,600	3,613		8,987
7977C0	SLAM	IT	0	0	805	805	0	0	0	805	407		398
7952C0	Sophos Renewal	IT	36,000	-36,000	0	0	0	0	0	0	0		0
7948C0	Telecomms Voice Over IP - invest to save	IT	0	0	16,397	16,397	0	0	0	16,397	0		16,397
7987C0	Telepath enhancements	IT	0	0	46,365	46,365	0	0	0	46,365	8,000		38,365
7913C0	Telepath to NexGen (Phase 3 of 4 2014/15)	IT	75,000	0	0	75,000	-75,000	0	0	0	0		0
7950C0	Theatre management system - balance	IT	0	0	1,496	1,496	0	0	0	1,496	0		1,496
7944C0	Upgrade of low spec equipment (680 machines)	IT	0	0	0	0	71,340	0	0	71,340	35,640		35,700
7935C0	UPS Replacement Programme	IT	24,000	0	2,036	26,036	0	0	0	26,036	516		25,519
7922C0	UPSs - Room based for Computer Rooms	IT	0	0	27,000	27,000	0	0	0	27,000	5,850		21,150
7979C0	VMWare Upgrade	IT	20,000	0	0	20,000	0	0	0	20,000	0		20,000
7924C0	Wireless Expansion	IT	0	0	2,710	2,710	0	0	0	2,710	0		2,710
4	**Information Technology Totals**	**IT**	**1,575,000**	**-202,617**	**974,959**	**2,347,341**	**151,440**	**0**	**-92,176**	**2,406,604**	**351,808**	**-2,639**	**2,057,435**
5	**Medical Devices**	**MDC**		**0**									
7106C0	Anaesthetic Machines	MDC	100,000	0	0	100,000	0	0	0	100,000	0		100,000
7122C0	B-Braun Review of Theatre Instruments	MDC	300,000	0	0	300,000	0	0	0	300,000	0		300,000
7131C0	BED replacement programme - 2nd (2014/15) yr of 4	MDC	150,000	0	43,885	193,885	0	0	0	193,885	193,231		653
7105C0	Birthing Beds x8	MDC	60,000	0	0	60,000	0	0	0	60,000	60,000		0
7124C0	Clinical Radiology 2 x Ultrasound	MDC	160,000	0	0	160,000	0	0	0	160,000	0		160,000
7119C0	DSU Operating Theatre Lights	MDC	110,000	0	0	110,000	0	0	0	110,000	0		110,000
7128C0	ED Trolleys x 20	MDC	0	0	0	0	66,347	0	0	66,347	0		66,347
7129C0	Fertility - Time Lapse Imaging (Primo Vision) x 2 Cameras	MDC	0	0	0	0	74,802	0	0	74,802	64,252		10,550
7145C0	Fluoroscopy Loop System in Room 7	MDC	0	0	1	0	9,750	0	0	9,750	9,570		180
7116C0	Foetal Heart Monitors X 6	MDC	0	0	7,531	7,531	0	0	0	7,531	0		7,531
7104C0	ICSI Rig	MDC	67,000	-67,000	0	0	0	0	0	0	0		0
7118C0	Laparoscopic instrumentation	MDC	0	0	53,902	53,902	0	0	0	53,902	0		53,902
7112C0	Laser Holmium Yag Machine - Urology	MDC	50,000	0	0	50,000	42,085	0	0	92,085	92,085		0
7121C0	Maternity Theatre Equipment	MDC	63,000	0	0	63,000	0	0	0	63,000	45,687		17,313
7113C0	Medical Equipment < £50k 12/13	MDC	0	0	73,800	73,800	-66,347	0	0	7,453	8,533	-1,081	0
7103C0	Medical Equipment < £50k 13/14	MDC	0	0	115,234	115,234	0	0	0	115,234	2,448		112,786
7101C0	Medical Equipment <£50k 14/15	MDC	350,000	0	0	350,000	5,580	0	0	355,580	44,246		311,334
7127C0	Orthodontics & Oral Surgery Cone Beam CT Scanner	MDC	110,000	0	0	110,000	0	0	0	110,000	0		110,000
7134C0	Patient monitoring and stations 2nd phase of 2	MDC	52,000	0	3,392	55,392	0	0	0	55,392	46,125		9,267
7135C0	Patient trolleys x 14 + 1 Radiology	MDC	0	0	69,000	69,000	0	0	0	69,000	66,517		2,483
7139C0	Replacement Mattresses (x 15)	MDC	0	0	0	0	30,000	0	0	30,000	4,963		25,037
7144C0	Retinal Screening Equipment	MDC	0	0	0	0	38,981	0	0	38,981	34,596		4,385
7140C0	Revenue Grouped Items 2013/14	MDC	0	0	25,525	25,525	0	0	0	25,525	7,731		17,794
7123C0	Revenue Grouped Items 2014/15	MDC	100,000	0	0	100,000	0	0	0	100,000	31,577		68,423
7136C0	Rigid hysteroscopes x 4 plus stack	MDC	0	0	39,842	39,842	0	0	0	39,842	309		39,533
7125C0	Vascular Unit Ultrasound Machine	MDC	90,000	0	0	90,000	0	0	0	90,000	0		90,000
7111C0	Ventillators Programme - 1st year of 5 (2014/15)	MDC	60,000	0	0	60,000	0	0	0	60,000	0		60,000
7114C0	Zimmer Meshers & Dermatones	MDC	75,000	-75,000	4,382	4,382	0	0	0	4,382	0		4,382
5	**Medical Equipment Totals**	**MDC**	**1,897,000**	**-142,000**	**436,494**	**2,191,493**	**201,198**	**0**	**0**	**2,392,691**	**711,872**	**-1,081**	**1,681,900**
6	**Other**	**OTHER**		**0**									
7766C0	Car Park Machinery	OTHER	30,000	0	0	30,000	-30,000	0	0	0	0		0
7716C0	Catering Trolley Replacement x20	OTHER	170,000	-170,000	4,652	4,652	0	0	0	4,652	0		4,652
7712C0	Drinking Water Stations	OTHER	0	0	700	700	0	0	0	700	0		700
7703C0	Efficiency schemes	OTHER	200,000	0	138,370	338,370	-100,400	0	0	237,970	423		237,547
7701C0	Finance systems 2011/2012	OTHER	30,000	0	10,170	40,170	0	0	0	40,170	0		40,170
7709C0	Fire Safety Training Equipment	OTHER	0	0	820	820	0	0	0	820	0		820
7700C0	Forklift Truck Replacement - Procurement	OTHER	0	0	17,500	17,500	0	0	0	17,500	0		17,500
7707C0	LED Lighting	OTHER	0	0	81,675	81,675	0	0	0	81,675	12,561		69,113
7762C0	Microfibre Cleaning	OTHER	44,000	0	0	44,000	-44,000	0	0	0	0		0
7710C0	Outpatient Kiosks	OTHER	0	0	198,000	198,000	0	0	0	198,000	79,870		118,130
7790C0	Phhotovoltaic's / Solarthermal PV	OTHER	0	0	49,276	49,276	6,007	0	0	55,283	42,059		13,224
7760C0	Project costs 2013/14	OTHER	10,000	0	4,715	14,715	0	0	0	14,715	10,539		4,176
7713C0	Staff Accommodation Fire Door Closers	OTHER	0	0	0	0	16,000	0	0	16,000	0		16,000
7795C0	Telecoms Trunk Lines	OTHER	0	0	0	0	7,000	0	0	7,000	0		7,000
7711C0	TRV's (details to be taken to CapCG Oct mtng)	OTHER	0	0	17,500	17,500	-17,500	0	0	0	0		0
7706C0	Voltage Optimization	OTHER	0	0	94,705	94,705	-6,007	0	0	88,698	88,699		0
7718C0	Ward Waste Bins	OTHER	50,000	0	91,839	141,839	0	0	0	141,839	0		141,839
6	**Other Totals**		**534,000**	**-170,000**	**709,921**	**1,073,921**	**-168,900**	**0**	**0**	**905,021**	**234,150**	**0**	**670,871**
	TRUST TOTALS		**7,642,000**	**-574,591**	**5,986,302**	**13,053,709**	**542,169**	**0**	**-1,561,176**	**11,967,316**	**2,486,057**	**-19,851**	**9,568,494**
7	**Outside of Trust Sourced Funding**												
7708C0	Laundry Equipment	A2	0	0	112,500	112,500	0	0	0	112,500	0	112,500	0
	Outside of Trust Sourced Total		**0**	**0**	**112,500**	**112,500**	**0**	**0**	**0**	**112,500**	**0**	**112,500**	**0**
			7,642,000	**-574,591**	**6,098,802**	**13,166,209**	**542,169**	**0**	**-1,561,176**	**12,079,816**	**2,486,057**	**92,649**	**9,568,494**

PAPER: SFT 3582

CAPITAL DEVELOPMENT REPORT FOR THE PERIOD JUNE - SEPTEMBER 2014

PURPOSE:

The purpose of this paper is to update the Board on developments with some of the more significant capital schemes on the Salisbury District Hospital site since the date of the last report (May 2014).

MAIN ISSUES:

Springs main entrance redevelopment (7087C0)

This project will comprise two single storey extensions to the existing SDH North building, internal alterations close to the corridor end of Springs restaurant, creation of a new main entrance lobby with retail space, replacement of the covered pedestrian walkway and minor alterations within car park 8. Due to other building schemes in that area, and the requirement for full ground survey investigations, including issues relating to fire regulations, work on site is now expected to start on site in early 2015 with completion expected in autumn 2015.

Dementia patient care project in Redlynch and Pitton Wards (7086C0)

Following the receipt of DoH funding (£800k), the refurbished Pitton Ward opened in July and has been very positively received by patients and visitors. Plans for further improvements to the Phase 1 wards in SDH North will be progressed to identify areas for immediate improvement and also longer term plans for more wholesale changes in line with the Pitton/Redlynch improvements.

ITU Expansion

A £1.2m major redevelopment of Radnor Ward Intensive Therapy Unit began in mid September which will increase the potential bed capacity from 8 to 12. Radnor successfully decanted into Radnor on 8th September. The building work in Radnor will be complete by mid December.

Other SDH Site Redevelopment schemes

Work is continuing to investigate development opportunities for the vacated areas of SDH South. The approval of the Trust's strategic service review and the estates review now gives the opportunity to engage with the two preferred bidders in detail dialogue. An initial list of potential schemes has been shared with each bidder for further joint working. An invitation to negotiate was published during May outlining how the proposed joint venture will work and provide a basis for the Trust to appoint a preferred partner. The next set of discussions took place on 15th September.

Second CT Scanner

Sufficient funding was secured to purchase two new CT Scanners. The replacement for the current scanner arrived in the hospital on the weekend of 30th/31st August and will be operational before the end of September. The additional scanner is due to arrive on site on the weekend of 25/26th October.

IT Schemes

Single Sign On (SSO)

The ability for clinical staff to login to computers on the wards using their staff badges ('fast user switching') and to switch quickly between clinical systems without having to login anew every time (SSO) was introduced into the wards during late July, early August. Feedback has proved extremely positive. The next steps are to extend this functionality into ED (October) and into outpatients (December). The Informatics department is working on context management – ie the ability for users to switch between systems and the patient details to be carried between systems.

As part of the SSO project, there has been extensive investment in ward infrastructure with new PCs with Windows 7 which have wider applications. The Trust is looking at its approach to mobile technology and increasingly deploying more handheld and laptop hardware.

Patient Observation and Escalation Tool (POET)

Progress on the development which will enable the recording and visualisation of patients' physiological observations electronically continues. An external company is helping with the user interface and the inhouse Development Team is leading on the database structure and coding of the system. The system will be trialled in November, starting in Laverstock ward, and again the use of mobile technology will be crucial. The initial version will focus on the recording of patient vital observations and the creation of a track and trigger score. The escalation aspect will follow.

The system will include the ability to record data and link to systems which will assist with other Trust priorities, eg infection control and the sepsis six.

Electronic Discharge Summaries

The Trust is now recording more than 60% of its discharge summaries electronically, with many of these being sent to Wiltshire practices electronically.

Electronic Patient Record (EPR)

The Trust has submitted a bid to the Technology Fund to secure funding for the introduction of an EPR. The Trust has progressed to the second stage and attended an interview on 5th September to progress the bid. We hope to hear in October whether the bid has been successful and in the meantime are planning how we take the project forward.

ACTION REQUIRED BY THE BOARD:

To note the progress of the Trust's significant capital schemes.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

Other significant schemes in the Approved Capital Programme for 2014/2015 (Appendix A to C inclusive)

Laurence Arnold
Director of Corporate Development

APPENDIX A

Other significant schemes in the Approved Capital Programme for 2014/15

Building and Works schemes	Completion date	Budget cost incl VAT
Efficiency schemes (7703C0) Funding available to support efficiency projects with rapid payback revenue savings.	March 2015	£238k
Main Theatres Laminar Flow system (7070C0) This scheme will see Theatre 5 converted into a laminar flow facility. Scheme subject to OJEU as no framework agreement for Laminar Flow and therefore likely to Slip into 2015-16.	Slipped to 2015	£185k
Spinal Treatment Centre refurbishment (7049C0) Replacement of single glazed windows with double glazed units along with range of smaller refurbishment items prioritised in the 2014/15 programme. Works ongoing to Nurses stations. Start date of 3/11/14	2014/15	£190k
Main Entrance Level 3 upgrade (7098C0) Scheme to improve patient flow and service and accommodate centralised outpatient reception. The building works completed in March with a new reception desk installed in August. The self check in kiosks have been ordered and the technical implications of their installation being reviewed.	Summer 2014	£75k
Main Chillers replacement (7212C0) Project 1st phase to replace the main chiller units located in SDH north with modern compliant and energy efficient plant.	March 2014 (now complete)	£484k

Rolling work programmes (multi year projects)

Building and Works schemes	Completion date	Budget cost incl VAT
Air Handling Units (7041C0) This is the third year of a 7 year (£2m) programme to replace the 50 specialist ventilation systems supporting SDU, Pharmacy, ED/SSEU, Pathology, Spinal X ray and all the Theatres.	March 2020	£423k this year
Ductwork and fire damper cleaning (7093C0) Across whole SDH site, ventilation ductwork and fire dampers will be cleaned out to comply with fire and health and safety legislation. 2nd year of 2.	March 2015	£110k (this year)
Nurse Call System upgrade (7202C0) Project to replace ageing nurse call systems through out wards in the main SDH north building and maternity wards. 2nd year of 2. £75k slipped to 15-16 to link with refurbishment requirements	March 2015	£98k (this year)
Lift Refurbishment Programme (7056C0) A programme to upgrade all the lifts in Phase 1 building. Year 3 of 3. Lifts 3 & 4 completed work in progress on lifts 1 & 2	March 2015	£131k
SDU – x2 New Washers (7006C0) To replace two of the five SDU washers which are more than ten years old	November 2014	£152k
Decentralisation of Boilers (7079C0) To provide local boilers to the central area administration blocks following the failure of the aged distribution pipework.	Sept 2014	£263k

APPENDIX B

Information Technology schemes	Completion date	Budget cost incl VAT
Clinician's View (7932C0) Phase 2 (Single Sign On (SSO)) allows staff to log in once and access the same patient's records from various systems has now been rolled out to the ward areas. Plan in place to rollout to Outpatients in late October 2014. Phase 3 (Electronic Document Management) – Supplier is reviewing our existing letter processing configuration with a view to recommending changes to speed the import of letters. Options paper being written for EPR PMB to advise on best options for use of product.	November 2014 November 2014	
PACS/RIS (7943C0) Main project now complete – A planned upgrade during September was implemented but had to be rolled back due to issues suffered by the supplier. Work continues on progressing on XDS (Cross Data Sharing)	October 2014	
Order Comms and Results Reporting (7942C0) About to go live with primary care TQuest upgrade to new version which will enable us to deliver Review and Radiology requesting to GP's by January 2015.	January 2015	£100k
Blood Tracking Phase 2 (7996C0) Project to allow tracking of blood from "vein to vein". 100 % Traceability is a regulatory requirement under the Blood Safety and Quality regulations (2005). Phase 2 "Bedside Administration" is due to be implemented in November with Phase 3 "Sampling" being scheduled for the first quarter of 2015.	Early 2015	£337K

Electronic Prescribing and Medicines Administration (EPMA) (7961C0) In collaboration with 3 other Trusts to procure system. HM Treasury approval given for funding to proceed to tender. Scoring of tender submissions has now taken place. Contract award expected now in January 2015.	April 2015	£152K
Patient Observation and Escalation Tool (POET) The initial works with the external design consultancy firm is complete. This group developed the styling and the visual aspects required to improve operability for nursing staff. The development team are now working on the integration with existing PAS system. Pilot phase will start during November.	November 2014	£267k

APPENDIX C

Medical Devices schemes	Completion date	Budget cost incl VAT
Bed Replacement Programme (7131C0) The bed replacement programme is now in it's second year. So far, 192 beds have been replaced. Areas with new beds include Redlynch Ward, Pitton Ward, Winterslow Ward, Farley Stroke Unit, Durrington Ward, Sarum Ward, the Hospice, Burns Unit and the Pembroke Ward.	Year 2 of a 4 year programme	£150k (2014/15)
Theatres Operating Lights (7128C0) The phased replacement programme is now in year 2. Theatres 5, 6 and 8 in Main Theatres and Theatre C in the Day Surgery Unit have been replaced. Theatres A, B, D and E in Day Surgery have been ordered and are awaiting installation.	September 2014	£115k
Anaesthetic Machines (7106C0) The machines in the Obstetric Theatre and DSU recovery are in need of replacement. The plan is to standardise the machines with those already being used around the Trust – to reduce risk and enable flexible working.	September 2014	£100k
Orthodontics and Oral Surgery Cone Beam CT Scanner (7127C0) The scanner produces images which are used to aid diagnosis and treatment planning of orthodontic and orthognathic cases. Evaluations are currently being undertaken and a specification finalised in order to go to tender.	June 2015	£110k
Review of Theatre Instruments (7122C0) The Trust commissioned an external review of instrumentation. A working group has been established under the Transformation umbrella to look at specialities on a rolling programme. The aim is to rationalise trays whilst replacing old instrumentation. Urgent instrumentation is being purchased according to necessity. A specification will be drafted and a tender issued by the end of the calendar year.	December 2015	£300k

Medical Devices schemes	Completion date	Budget cost incl VAT
Clinical Radiology 2 x ultrasound machines (7124C0) Royal College guidelines advise replacing ultrasound machines every 5 to 7 years. An informal rolling programme is in place to monitor this situation. The ultrasound machines in both the ante natal clinic and room 1 (general use) are 7 years old and will be replaced using the Supply Chain framework. A specification is being drafted and quotes being sought.	March 2015	£160k
Fertility Time Lapse Imaging System (7129C0) A key factor in the success of any IVF program is to select the embryo for transfer which has the highest chance of implantation. Other local centres had already invested in this technology so, for SFT to remain competitive, a system was evaluated. It was found to be effective whilst minimising risk and was therefore purchased at the end of the pilot period.	August 2014	£67k

PAPER - SFT 3584

JOINT BOARD OF DIRECTORS (JBD) MINUTES FROM 16 JULY 2014 RE: QUARTERLY REVIEW OF ASSURANCE FRAMEWORK AND RISK REGISTER

PURPOSE

To evidence the quarterly review by the JBD of the Assurance Framework and Risk Register for which it has delegated responsibility. This responsibility is set out in the JBD's Terms of Reference.

MAIN ISSUES

During the year delegated responsibility for reviewing the Assurance Framework and Risk Register falls to a combination of the Finance Committee, Clinical Governance Committee and the Joint Board of Directors (JBD). The Assurance Framework was reviewed at the 8 September seminar day.

Extract of JBD minutes – 16 July 2014

ASSURANCE FRAMEWORK REVIEW
The Board received the report from the Head of Risk Management and it was noted that newly identified gaps in control were in relation to C Diff performance and capacity to manage to deliver IT projects. There were newly identified positive assurances in relation to mortality and workforce matters. PH requested that the Assurance Framework be updated ahead of the Annual Board Workshop on 8 September. The Board approved the update to the Assurance Framework subject to these comments.

ATTACHMENTS AVAILABLE TO VIEW ON WEBSITE

none

ACTION REQUIRED BY THE BOARD

To note updated assurance framework reviewed on the Board's behalf by JBD.

Nick Marsden
Chairman

PAPER: SFT 3585

RISK MANAGEMENT ANNUAL REPORT

PURPOSE:

To inform the Trust Board of the progress made against the strategic objectives within the Risk Management Strategy (2013).

Reported period is 1st April 2013-31st March 2014

MAIN ISSUES:

The Trust recognises that Risk Management must be fully embedded in order for the organisation to function safely and effectively. Robust Risk Management processes must be in place for the Board to be assured on performance and standards. To achieve this aim the Trust Board needs to be confident that the systems, policies and staff it has put in place are operating in a way that is effective, focused on key risks, and driving the delivery of the corporate objectives. To demonstrate this there is a robust Risk Management Strategy in place, which was agreed by the Trust Board in October 2013. The Risk Management Annual Report is the mechanism for measuring the progress that has been made towards achieving the strategic goals and objectives within the Risk Management Strategy.

This report presents the achievements as measured against the strategic goals within the Risk Management Strategy (2013) over the last financial year (1st April 2013 – 31st March 2014). The 2014/15 Risk Management Annual Plan is also presented (Appendix 2 of the full report), to show progress against objectives at mid year 2014/15.

Key Items to note are:

- Progress against the strategic goals as set out in the Risk Management Strategy (2013)
- Progress against the Annual Risk Management Plan 2013/14 (Appendix 1)
- Part Year progress report against the Annual Risk Management Plan 2014/15 (Appendix 2)
- Annual Report Card 2013/14

ACTION REQUIRED BY THE BOARD:

The Trust Board is asked to note the achievements within the Annual Report 2013/14 and Annual Risk Management Plan 2014/15.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

Risk Management Annual Report, 2013/14

AUTHOR: **Fenella Hill**
TITLE: **Head of Risk Management**

SALISBURY NHS FOUNDATION TRUST

Risk Management Annual Report 2013/14

Executive Summary

The Risk Management Annual Report provides detailed evidence around each of the strategic goals for Risk Management, and how they are being achieved within the organisation.

The 2013 staff survey indicated that the numbers of staff reporting incidents was average compared with other Trusts however reporting across the Trust has increased by 9% in 2013/14 (following on from an 11% increase in the previous year), with reported incidents from both clinical and non clinical staff. This is reinforced by the National Reporting and Learning System which shows us as higher than average reporters of incidents, including incidents that result in no harm to patients and near misses. Staff also reported in the survey that they felt there was fairness and effectiveness in incident reporting procedures. This continues to reflect an environment in which staff feel confident in the process and able to report.

The annual report summarises the success of the clinical review and serious incident inquiry process and the lessons learnt as a result of this process. Work has been undertaken to scrutinise the process to reduce the time taken to complete reviews and therefore expedite the sharing of learning Trust wide and provide timely feedback to patients and their families.

There are robust mechanisms in place for the regular review of incidents by specialist committees within the Trust, to identify key themes and trends for action. Incidents are also discussed at the Directorate Management Team Performance Meetings (formerly 3:3), focusing on quality, with the Executive Directors.

The workplan for 2013/14 supports the standard activity of risk management within the trust but will also focus on the implementation of Datixweb, a web based reporting system with modules to support the management of incidents, complaints, claims and risks. Web based reporting will allow the provision of timely information and feedback to staff, managers and the Trust Board and provide the Trust with intelligent information during challenging and changing times.

1. Introduction

1.1. The Trust recognises that Risk Management must be fully embedded in order for the organisation to function safely and effectively. Robust Risk Management processes must be in place for the Board to be assured on performance and standards. To achieve this aim the Trust Board needs to be confident that the systems, policies and staff it has put in place are operating in a way that is effective, focused on key risks, and driving the delivery of the corporate objectives. To demonstrate this there is a robust Risk Management Strategy in place, which was agreed by the Trust Board in October 2013. The Risk Management Annual Report is the mechanism for measuring the progress that has been made towards achieving the strategic goals and objectives within the Risk Management Strategy.

This report presents the achievements as measured against the strategic goals within the Risk Management Strategy (2013) over the last financial year (1st April

2013 – 31st March 2014). The 2014/15 Risk Management Annual Plan is also presented (Appendix 2), to show progress against objectives at mid-year.

2. Risk Management Strategy Objectives

2.1 The Risk Management Strategy (2013) sets out the strategic goals towards which Salisbury NHS Foundation Trust has been working with regards to Risk Management, and provides a framework which sets out clear expectations of the roles and responsibilities of all Trust staff.

2.2.1 Strategic Goals

The strategic goals within the Risk Management Strategy (2013) are as follows:

- 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 licensing authorisation.

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

- 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.

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

- To further develop the organisational safety culture and its effectiveness through the continued implementation of the Patient Safety First Campaign interventions.

- To develop an Annual Risk Management Plan, which is agreed, reviewed and monitored by the Trust Board.

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

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

- To ensure compliance with the NHSLA Risk Management Standards, Monitor, Care Quality Commission registration requirements and Health and Safety Standards.

3 Progress Against Strategic Goals 2013/14

3.1 Licensing Authorisation - To ensure the Trust remains within its licensing authorisation as defined by Monitor

3.1.1 Monitor has a very clear compliance framework which ensures that all NHS Foundation Trusts are able to demonstrate that they are remaining within their agreed licensing authorisation. It is imperative that the Trust is aware of any risks which may impact on its ability to adhere to this framework. The Assurance Framework, Trust risk register, and risk processes enable the Trust to identify risks which may affect the Trust's financial and Governance ratings throughout the year and respond to these.

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

3.2.1 The Trust Board carried out an annual review of the Assurance Framework in September 2013 (ratified at the October 2013 Board Meeting). Trust Board members agreed the principal risks for inclusion in the 2013/14 framework.

3.2.2 The Assurance framework template identifies the principal risks facing the Trust, provides the links to the Care Quality Commission registration requirements and identifies the assurances in place to ensure risk containment is being carried out effectively. The Head of Risk Management attends all three Assurance Committees on a quarterly basis to co-ordinate this process, ensuring the monitoring and management of principal risks is in place, as well as updating and co-ordinating the continued development of the document.

3.2.3 The Audit Committee monitors the overall Assurance Framework process bi annually. The Assurance Framework process was presented to the Audit Committee in October 2013 and February 2014. The Audit Committee members were satisfied that the current process produces a compliant assurance framework where key information and risks travel upward within the organisation and subsequent actions taken are very clear. Positive feedback was received in relation to the engagement of the assuring committees in the review of the Assurance Framework and overall management of the document.

3.2.4 Internal audit carried out a full review of the Assurance Framework and Risk Register processes during 2013/14. This included a full documentary evidence review. The subsequent report gave an overall opinion of 'significant assurance' with no actions required. No exceptions were found during the review and therefore the Risk Assessment for the year was 'Risk Managed'.

3.2.5 The Trust produced an Annual Governance Statement for 2013/14, which was fully compliant and evidenced through the Assurance Framework and supporting documentation.

3.3 Risk Management Policies - To ensure that Risk Management policies are implemented

3.3.1 The Risk Management Strategy sets out the strategic goals and direction for Risk within the organisation. This is an overarching strategy document underneath which sits the following operational policies:

- Risk Management Policy and Procedure

- Adverse Events Reporting Policy
- Serious Incident Immediate Response Policy.
- Adverse Events: An Organisation Approach to Investigation, Analysis, and Learning
- Adverse Events: Supporting Those Involved

This suite of supporting policies provide the 'how to' practicalities for staff. All of these documents will be updated as a result of the introduction of Datix web and review of changing practices and processes.

3.3.2 All Directorates have risk registers and high risks (12+) are monitored via quarterly quality performance meetings. During 2013/14 work has continued to ensure that monitoring within the performance meetings is adequately documented within the minutes and the Trust Risk Register is updated accordingly.

3.3.3 The Adverse Events Reporting Policy remains current but will require significant updating with the implementation of Datixweb, web based incident reporting. Reporting across the Trust has increased again during 2013/14 (9% increase in reported incidents in addition to an 11% increase in 2012/13), which continues to reflect an environment in which staff feel able to report, and identify the process as worthwhile. There has also been an increase in the number of both clinical and non-clinical staff reporting incidents.

- The 2013 Staff Survey indicated that the percentage of staff witnessing potential harmful errors, near misses and incidents in the last month had increased and placed the Trust in the worst 20% of Trusts. The 2012 staff survey by comparison, indicated the Trust was below average compared to other acute Trusts and therefore work was undertaken following last year's result to ensure staff were aware of the Adverse Events Reporting Policy and what constitutes and incident or near miss. This year's increase may well reflect a more informed workforce.

- The National Patient Safety (NPSA) National Reporting and Learning System report for April 2013-Sept 2013 identified the Trust to be above the middle 50% of reporters of incidents with 8.61 incidents per 100 admissions reported. The median for small acute organisations is 8.06 incidents per 100 admissions. 92.4% of reported incidents resulted in no harm to patients.
  It is important to note that the NPSA state that a high reporting rate of actual incidents as well as near misses indicates a strong reporting and learning culture and therefore is a positive measure.

3.3.4 The process for commissioning and carrying out a Clinical Review/Serious Incident Inquiry is set out in the Adverse Events Reporting Policy. During 2013/14 there were 17 Serious Incident Inquiries and 9 Clinical Reviews. These figures compare with 12 Serious Incident Inquiries and 13 Clinical Reviews in 2012/13.

Of the 17 Serious Incident Inquiries, 6 were grade III and IV hospital acquired pressure ulcers. This demonstrates a small decrease in hospital acquired pressure ulcers and the continued success of shared learning and the Trust Wide Action plan for pressure ulcers. Monthly reviews are also undertaken to identify areas where 'clusters' of hospital acquired grade 2 pressure ulcers are identified to promote a proactive approach to learning before deterioration of pressure areas.

Ongoing liaison with the CCG, and development of the National Framework for reporting Serious Incidents, has resulted in the reporting of patient falls that result in fracture and major harm, maternity incidents and potential Healthcare Acquired

Infection (HCAI) outbreaks and periods of increased incidence (PII). Previously these would have been investigated, however this would have been through the clinical review or fracture root cause analysis process.

All Clinical Reviews/Serious Incident Inquiries are reported to the 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 these reviews. The themes arising from such reviews during 2013/14 have led to some key pieces of work being undertaken including:

- Additional training within the Maternity Unit re: CTG use and monitoring in labour;
- Discharge planning workshop focusing on communication and documentation;
- Mental Health Awareness, assessment of patients and escalation;
- Consistency of documentation including assessments, intentional rounding and family interactions in relation to falls;
- Focusing on ‘clusters’ of Grade 2 pressure ulcers for learning and prevention of deterioration.

3.3.5 The Trust has continued to uphold the principles of being open and recognises that promoting a culture of openness is essential to improve the safety and quality of services and benefits staff, patients and families. Families and patients are encouraged to identify questions that can be addressed within the review and this contributes to learning for staff. Ongoing support and communication with a key point of contact within the Risk Management team takes place for staff, patients and families whilst they go through the Serious Incident Inquiry or Clinical Review process, as per the “Adverse Events: Supporting Those Involved Policy”. Staff are also given details of the Trust’s Staff Counsellor who can be accessed independently for support.

Communications with families is often highlighted as an area for improvement in reviews and from October 2014 there will be a statutory ‘Duty of Candour’ on all providers registered with the CQC. The Duty of Candour will place a requirement on providers of health and adult social care to be open with patients when things go wrong. Work is ongoing to ensure that this can be evidenced including documentation of patient and family communications in all incidents graded as moderate or above. However, ‘Duty of Candour’ has been achieved for all serious incident inquiries and clinical reviews in the last year.

3.3.6 The Risk Report Card is reviewed monthly by the Clinical Risk Group and quarterly by the Clinical Management Board and Clinical Governance Committee. Key themes and trends are identified along with feedback on work streams being taken forward to improve patient safety and reduce risk.

Directorate Management Teams receive a quarterly Report Card which is reviewed and discussed at their performance meetings with the Executive Directors. This information is also disseminated via the DMT’s to their teams as it identifies key themes for inclusion into service plans and objectives. The report cards also include the numbers of adverse incidents that have been closed by Risk Management, outstanding recommendations from clinical reviews and serious incident inquiries and days taken between ‘incident date’ and ‘reported to risk management’ date, the latter monitoring timely submission of incident reports. In addition quality meetings with the

DMT's aim to draw together the themes of education, service development, risk, complaints, patient and public involvement and governance in conjunction with the quality walks to provide an overarching view of quality within the directorates and will continue to be developed in 2014/15 with the implementation of Datixweb.

Any clinical or non clinical working group are able to utilise the incident report cards to review and analyse incident data in more detail. The reports can be structured depending on the requirements of the group. This is exemplified by sharps and needlestick incidents for the Needlestick Action Group, medication errors for the Medicines Safety Group and security incidents for the Security Management Committee. Reports are also compiled for clinical areas with active risk groups so that they may review themes within incidents and use this to inform their risk registers.

An annual Complaints, Litigation and Incident Partnership (CLIP) report is produced or each Directorate. This provides aggregated information from Risk, Customer Care and Litigation which is intended to inform Directorate Service Plans by identifying key areas for focus. Attempts have been made to provide more detailed aggregation of themes and trends which can then be combined to provide an overall Trust wide view of corporate themes. Whilst there are links between incidents and complaints within the timeframe reviewed, there is disparity with claims data as there is often a time lag between the incident and a claim being brought. The introduction of Datixweb will support directorates and teams being able to review data independently and aggregate their own themes over differing time periods.

Ongoing developments have taken place in 2013/14 to meet the requirements of quality in line with commissioner contracts and the Quality Account. This work will continue in 2014/15 as part of the Quality Meetings.

A project to develop a new risk management system to replace the existing Datix system was identified in 2012/13. Initially this development was to be led by IT however a decision has since been made to purchase Datixweb, a commercially available upgrade of our current system. This supports the recommendations laid out in the 'Francis Report', feedback received from the Care Quality Commission on previous visits and will also provide evidence to support compliance with statutory duties such as 'Duty of Candour'. The Trust has purchased 4 modules: incident reporting, risks, complaints and claims which allows incidents to be reported in 'real time' and analysed for themes and trends in a timely way. In addition all Trust risks will be able to be held on the database allowing an overall Trust picture of risks. This work has formed a major part of the work plan for the Risk Management Team in 2013/14 and continues as this roles out across the Trust.

3.4 Key Performance Indicators (KPIs) - To monitor the effectiveness of Risk Management Policies and procedures via the monitoring of agreed Key Performance Indicators

3.4.1 The following KPIs are reported by Directorate within the Mid and End of Year Risk Management Report Cards and consist of the following:

3.4.2 All Departments report incidents across all staff groups. The level of reporting is high across the Trust as a whole and continues to increase. The numbers of major and catastrophic category incidents has decreased within this increase, which is positive. There is also an increase on last years figure in the number of incidents identifying no harm, which is an encouraging indicator of reporting within the Trust. All departments and staff groups in the Trust report incidents although some more

frequently than others. There is continued work to identify low reporting areas and understand the reason for this which will be a focus of work going forward to identify areas where reporting 'dips' with the change over to web reporting. However it should be noted that the following staff groups increased reporting rates in 2013/14: Nursing, Administration/clerical, Managers and Medical staff.

3.4.3 A KPI was introduced to ensure that all department risk registers are robust and in line with the Trust Risk Management Policy and Procedure, and to support staff in understanding this process. This has been a challenge over the last years however the implementation of Datixweb will facilitate all risks, regardless of their score, being held within the risks module and therefore on a central database. This will allow the Trust to build a picture of organisational risks at all levels and support the allocation of resources to mitigate Trust wide risks.

3.4.4 An ongoing KPI within the Risk Management Strategy is to achieve 100% compliance with the Trust policy following a needlestick or sharps injury.

During 2013/14, there have been 53 reported needlestick injuries and 33 reported sharps injuries which compares to 52 reported needlestick incidents and 42 reported sharps during 2012/13. There has been a decrease in the number of reported near miss incidents resulting in no harm from 48 during 2012/13 to 25 during 2013/14.

Work during 2013/14 included utilising information relating to sharps/needlestick injuries captured from microbiology testing information cross referenced with incidents reported using adverse event forms. This work was to identify any gaps or themes relating to reporting and while the numbers do not directly correlate (due to differences in the mode of capture), it does promote opportunity for discussion and offer insight into trends and the work will therefore continue.
Another key piece of work has been to introduce needle safe devices to bring the Trust in line with national legislation. The needle safe devices are currently being rolled out to all areas within the Trust for general clinical procedures (for example cannulation, blood taking and administering injections) which should be completed by October 2014.

3.4.5 The Risk Management Strategy 2010 introduced a target of 100% compliance with Venous ThromboEmbolism (VTE) assessment across the Trust. This audit is carried out on all patients and is monitored via the Clinical Management Board. 99% of patients admitted to the Trust during 2013/14 were risk assessed for VTE compared to 98% in 2012/13. We are a VTE exemplar centre, leading the way on VTE prevention, taking forward the national prevention programme and helping other Trusts to learn from the work carried out here in Salisbury. Following a routine assessment by NHS England and the Exemplar Centres Network, this status has been retained.

3.4.6 The reduction of hospital acquired grade III and IV pressure sores continues to be a focus for the Trust. In 2013/14 6 patients experienced a grade III or IV pressure ulcer as an in-patient, which is a slight decrease in comparison with 2012/13 when 7 patients experienced a grade III or IV pressure ulcer compared with 12 patients in 2011/12. The Trust wide action plan is ongoing to ensure that work in this area continues to see a reduction in pressure area development and the focus continues in supporting root cause analysis in ward areas that see clusters, 2 or more in a month, of grade II pressure areas to identify learning.

3.4.7 The Risk Management Strategy in 2011 introduced a new KPI to evidence 100% completion of a full root cause analysis for all fractures following a fall. This is now

successfully embedded in practice and used across the Trust. The falls RCA tool allows consistent capture of data and analysis of this information to identify any key issues and identify opportunities for learning. Since October 2013, there has been a requirement to report all major grade falls and fractures externally, following our Serious Incident Inquiry process.

A total of 21 fractures were reported in 2013/14 compared to 32 fractures in 2012/13. Of the 21, 9 were categorised as major harm (patient required surgical repair) and 4 of these were subject to external reporting as an SII due to the new criteria. The remaining 12 were graded as moderate harm (requiring conservative management such as immobilisation in plaster cast). A quarterly report, including themes and actions, of all falls root cause analysis continues to be discussed at the Falls Group, Clinical Risk Group, Clinical Management Board and fed back through the Contract Quality Review Meeting. This reporting is being further extended by including discussions at the Nursing, Midwifery and Allied Health Professional Forum to share learning more widely with ward level staff.

Ongoing work includes the revision of falls and bedrails assessments, roll out of intentional rounding across the Trust, improving communication with families following a patient's fall.

Looking forward, interventions are underway such as the adaptation of the new electronic reporting system Datixweb to incorporate a trigger to ensure the timely capture of incidents resulting in serious harm, duty of candour information given to families in addition to falls reduction measures such as availability of temporary footwear, balance classes and highlighting sink areas as slip hazards. It is envisaged that these measures will support a reduction in patient falls however, falls continue to be a focus of the risk work plan for 2014/15.

3.4.8 The Risk Management Strategy 2010 introduced the requirement to maintain NHSLA level 2 status for both Maternity and General during 2011. These were maintained and both were due for reassessment in 2014 however it has been confirmed that changes at the NHSLA have resulted in all mandatory assessments being withdrawn Trusts maintaining their baseline status (level 2 for SFT). A focus of the 2014/15 work plan will be to ensure that standards, policies etc. are maintained without the focus of a planned inspection.

3.4.9 The Risk Management Strategy 2012 introduced a KPI for the Trust-wide implementation of the Safety Thermometer to allow monitoring of our work in reducing patient harm and benchmarking against other hospitals. This data is now reliably uploaded on a monthly basis and the overall position of the Trust and individual ward data available and included in the monthly quality indicator report.

3.5 The Annual Risk Management Plan - To develop an Annual Risk Management Plan, which is agreed, reviewed, and monitored by the Trust Board.

The 2013/14 Annual Risk Management Plan was developed by the Risk Management Team and agreed and monitored by the Clinical Risk Group and Clinical Governance Committee (See Appendix 1). It was presented to the Trust Board in October 2013 as part of the Annual Report. All objectives have been completed or are ongoing. Notable successes are:

- Ongoing support of the Quality and Safety Walks to ensure that staffs views and concerns are heard and actioned, including raising health and safety concerns

- Maintaining the tracking of recommendations from internal reviews and follow up where progress lacking
- 'Significant Assurance' from internal audit (TIAA) review of Risk Management Processes and the Assurance Framework 2013/14
- 'Substantial Assurance' from internal audit (TIAA) review of the management of serious incidents
- The use of reported incidents to support the security agenda including security provision and training for high risk areas

The 2014/15 Annual Risk Management Plan has been agreed at the Clinical Risk Group and is enclosed in Appendix 2 for Trust Board Approval.

3.6 Accountability and Responsibility Arrangements - To ensure that all individuals within the organisation are aware of their role, responsibilities, and accountability with regard to Risk Management.

3.7.1 The Head of Risk Management continues to work closely with Directorate Management Teams to ensure they understand their accountabilities and responsibilities for managing risks in their areas, This is formalised through the quarterly 3:3 meetings and stocktakes with the Executive Directors.

3.7.2 Incidents reported within the Directorates are reviewed quarterly at the performance meetings via the Risk Management Report Cards.

3.7.3 Patient Safety and Risk Management continues to be integral to the educational programme for junior doctors as part of the Foundation Programme.

3.8 Organisational Arrangements and Risk Management Structure - To ensure that the structure and process for managing risk across the organisation is reviewed and monitored annually.

3.8.1 There have been no changes to the Risk Management Structure during 2013/14.

3.8 Ensuring Compliance with National Standards - To ensure compliance with the NHSLA Risk Management Standards, Monitor and Health and Safety standards

3.8.1 With the changes at the NHSLA, the 2014/15 work plan include work to ensure that standards, policies etc. are maintained without the focus of a planned inspection.

3.8.2 The Risk Management Team continues to work with the Chief Executives Office in order to demonstrate compliance with the Care Quality Commission's regulations and provide additional information where requested from the CQC.

3.8.3 The Head of Risk Management works in close collaboration with the Head of Clinical Effectiveness, Head of Litigation, Head of Customer Care and Information Governance Manager, to ensure an integrated approach to clinical governance, safety, and service improvement.

3.8.4 The Risk Management Team continues to collaborate with NHS England. This includes the Trust's participation in the National Reporting and Learning System as well as co-ordinating a Trust response to the national alerts/notices/rapid response reports. This activity is co-ordinated by the Clinical Risk Group and monitored by the Clinical Governance Committee.

NPSA Patient Safety publications have been superseded by NHS England Patient Safety Alerts, and the Trust currently has three open alerts, none of which are beyond their due date and all have actions underway.

4 Future Developments

The Risk Management Team will continue to ensure implementation of the revised Risk Management Strategy through the Annual Risk Management Plan 2014/15 (appendix 2).

4.1.1 2014/15 will see the implementation of Datixweb to support the Trust in its risk management processes and provide accurate and timely information to staff, managers and the Trust Board.

4.1.2 2014/15 will see ongoing development of the Assurance Framework to ensure that it is providing the Trust Board with intelligent information during increasingly challenging times.

4.1.3 The Serious Incident Inquiry and Clinical Review process will be scrutinised to reduce delays in the completion of reports and expedite Trust wide learning.

4.1.4 The Risk Management team shall actively support ongoing work regarding the Care Quality Commission regulations.

4.1.5 The Risk Management team shall continue to ensure that risk information is provided to the commissioners as per the 2014/15 contract requirements.

4.1.6 The Risk Management Team will monitor the use of the RCA tool for falls, adapting the tool as necessary to ensure appropriate information is captured and promotes learning to shape future care with the aim of preventing falls.

4.1.7 The Risk Management Team will work with Trust departments to support the development of robust local risk registers that can be transferred in their entirety to Datixweb.

4.1.8 The Risk Management Team will develop closer links with The Health and Safety Team to ensure that staff and the organisation are supported through collaborative working.

4.1.9 The processes and structures for effective Risk Management are firmly established within the organisation but continue to evolve in response to national and local directives. There is a continued drive towards maintaining a safety culture whilst responding to the challenge of efficient management of resources.

Appendix 1

Risk Management Plan 2013/14 (End of Year)

Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Outcome
Step 1. Building a Safety Culture – *create and environment where staff are confident to use the Risk Management processes in supporting decisions*				
Reassess the safety culture within the Trust through the validated Staff Survey	• Use information from the literature review undertaken to redesign the patient safety survey and gain approval from CRG prior to use • Undertake Staff Safety Survey	To link with new Health and safety Manager and take forward as joint project	FH October 2013 FH and PK December 2013	
Step 2. Lead and Support Staff – *Risk Management Department will exhibit strong leadership and ensure that all staff have access to or are competent in using the Risk Management processes*				
Ongoing development of Patient Safety and Quality Walkrounds.	• Maintain clear action leads and identify on Datix • Review process with the introduction of DATIXweb • Monitor compliance with actions via 3:3 • Provide annual report to CGC	Updated after each walk by risk representative. Taken to each 3:3	FH March 2014 FH March 2014 FH March 2014 FH August 2014	Completed Ongoing Completed Completed annually
Monitor Risk Management training attendance in line with training needs analysis and review current training	• Evidence of review by Clinical Risk Group and H&S Committee • Dissemination to Directorates	Risk management Training to be updated with introduction of DATIXweb Monthly report set up to be sent out via MLE. To ensure that all staff complete incident reporting training on induction following changes to statutory/mandatory training requirements.	FH and CG March 2014 To FH monthly FH / Directorates Q1 2013 Quality 3:3	Completed Completed Completed in conjunction with Head of Learning Development.

Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Outcome
Step 2. Lead and Support Staff – *Risk Management Department will exhibit strong leadership and ensure that all staff have access to or are competent in using the Risk Management processes*				
Work with Trust Departments to ensure that robust departmental risk registers are in place in line with the Trust Risk Management Policy	• Identify Training requirements for Directorates and Departments with the introduction of the DATIXweb Risk module • Monitor trends and identify departments that may have ineffective/absent centrally held risk registers and monitor at 3:3s • Identify further work plan for 2013/14 in light of NHSLA changes when published	For Trust wide work as part of implementation of DATIXweb. Awaiting new standards, assessment processes to be dissenminated	FH/CG January 2014 FH/CG March 2014 FH/CH March 2014	Completed Completed For review in light of changes at NHSLA
Update suite of Risk policies in line with NHSLA requirements and any changes to process	Policies to be submitted to CRG and approval boards: Adverse Event Reporting Adverse Events – supporting those involved Learning from incidents, complaints and claims Risk Management Policy and Procedure	All policies to be updated with implementation of DATIXweb.	FH and CG All by March 2014 December 2013 December 2013 March 2014	All policies extended to August 2015 and being updated as Datixweb rolls out across Trust

Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Outcome
Step 3. Integrate Risk Management Activity – *All components of Risk Management (clinical, financial, organisational) are integrated in such a way as to support corporate decisions*				
Following Level 2 compliance April 2011, ensure action plan in place to maintain level 2 until new risk management standards / new assessment methods published Maintain compliance with Maternity NHSLA Risk Management Standards	• Review of NHSLA standards/assessment on publication		FH and CG December 2013 LJ December 2013	No Longer applicable
Ensure compliance with the CQC Regulations and associated Outcomes (Outcome 2 Consent to Care and Treatment and Outcome 20 Notification of Other Incidents).	• Monitor completion of work identified in action plans to ensure continuous improvement and maintain PCA document • Review Patient survey and update with aim of increasing response rate • Consent Audit to be completed • Survey results to be presented to CMB • Confirm with CMB if further data collection to continue • Review of Consent Policy	Updated July 2013 Data collection commenced	FH Quarterly during 2013/14 FH & EW October 2013 FH August 2013 FH November 2013 FH January 2014	CQC PCA outcome 2 no longer applicable however evidence maintained of work within Trust. Completed Completed Completed
Ensure risk and safety reporting requirements as per the contract are reported to commissioners	• Reporting requirements met • Maintain timeliness of SII reports to meet national and local targets and Commissioner input as required		FH March 2014	Completed

Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	*Outcome*
Step 3. Integrate Risk Management Activity – *All components of Risk Management (clinical, financial, organisational) are integrated in such a way as to support corporate decisions*				
Produce an Annual Report clearly illustrating progress made in 2013/14 on the management of Risk within the organisation	• Risk Management Annual Report presented to Trust Board	Report for CGC September 2013	FH October 2013	Completed
Review the Risk Management Strategy	• Risk Management Strategy revised and ratified by Trust Board		FH October 2013	Completed
Continue to develop and embed the Assurance framework ensuring its status as a key document in steering the focus of the Trust Board and Assurance Committees with a clear audit trail of actions taken to reduce strategic risk.	• Dynamic assurance framework in evidence • Assurance framework deemed compliant by Internal audit review 13/14		FH present at Assurance Committees 2013/14 FH March 2014	Presented quarterly. Completed with 'significant assurance'
Continue to develop the risk management links within service development and project planning processes within the Trust	• Risk reviews incorporated into these processes giving clarity of purpose, associated risks, and monitoring of mitigation activities		FH ongoing	Completed
Contribute to the development of the Quality Account in relation to risk and patient safety information	• Ongoing data input to KQIs		FH ongoing	Completed

Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	*Outcome*
Step 4. Promote Reporting – *clinical and non clinical incidents*				
Following the purchase of 4 modules for DATIXweb (incidents, risks, complaints and claims) to work with IT to implement the systemm and roll out acroass the Trust.	• Link with project manager (Carol Perren) to confirm workstreams required		FH and Risk Team Ongoing	Completed
	• Completion of 'kick off' day	Booked for September 2013	FH September 2013	Completed
	• Development project plan and team		CP and FH October 2013	Completed and revised
Work with IT, Customer Care and Litigation to identify implementation plan for complaints and claims modules	• Project plan and implementation		FH/Risk Team, HH and PP October 2013	Completed
Continue to monitor themes and trends from reported adverse events via the Risk Report Cards and subsequently DATIXweb. Maintain a robust monitoring report of progress against recommendations from Clinical Reviews and SIIs	• Directorate and Trust wide Risk Report cards evidenced with emerging themes/trends and actions • Ongoing work with Directorates via DMT 3:3 pre-meetings • Ongoing development of mid and end of year CLIP reports • Evidenced through Annual Report	Monitored monthly via CRG and at quarterly at 3:3 meetings Compliance reports presented at CGC, CMB. Actions progressed and followed up where progress unknown.	FH/CG March 2014	Completed Completed
Through the Risk Report Cards and DATIXweb monitor reporting by Department and Professional group with focussed work resulting in those areas showing low engagement.	• Directorate and Trust wide report cards to show reporting by Department and staff group for mid and end of year reports • Actions taken as a result of above data • Maintain levels of reporting identified by staff survey and national data	Ongoing as part of report cards	FH/CG March 2014	Completed

Step 4. Promote Reporting – *clinical and non clinical incidents*

Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Outcome
Maintain staff awareness of incident reporting, feedback mechanisms and shared learning. Adverse event reporting policy to be updated with the implementation of DATIXweb and training provided for staff at all levels of the organisation. Mechanisms for staff feedback to be incorporated into incident reporting pathway for DATIXweb Presentation at Clinical Governacne half day to promote incident reporting and demonstrate Trustwide actions and learning.	• Maintain comparison levels with other Trusts regarding reporting • Continue improvement of staff perception and understanding of incident reporting • Realtime feedback/themes available to DMT and staff • Evidence through staff survey	NRLS report used to monitor incident reporting against other small acute Trusts. Evidence of Trust being higher than average reporters of incidents. Monitor staff survey results and participation in action plan.	FH and Risk Team March 2013 FH & Risk Team, DMT's March 2014 CG November 2013	Completed Completed Completed Completed
Implement changes to external reporting mechanisms as systems become available. This will be impacted by the restructure of the NPSA and SHA	• Implementation of systems as they arise		FH March 2014	Completed
Review the Trust scoring matrix to reflect the most up-to-date guidance from the NPSA regarding grading of harm and including definitions for security, falls and IG	• Update Matrix and approval from CRG		FH/CG December 2013	Not Completed. To be completed as part of policy rewrite in 2014/15

Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Outcome
Step 5. Involve and Communicate with Patients and the Public				
Continue to maintain and strengthen Trust Being Open policy and responsibilities in relation to Duty of Candour with ongoing promotion of an open culture with families, patients and staff when patient safety incidents have occurred	• Consideration to be given for inclusion of Duty of Candour questions within electronic incident reporting form • Patient and family support	Incorporated into electronic incident reporting form. Information session provided by Trust's solicitors as part of CGHD.	FH/, CP & Risk Team December 2013	Completed
Step 6. Learn and Share Safety Lessons – *sound investigative techniques are applied and robust solutions are implemented as a result*				
Continue to work with the NPSA ensuring that patient safety lessons learnt on a national level are incorporated into the Trust's working practices	• NPSA Alerts quarterly progress report • Implement process for follow up and review of risk assessments linked to NPSA alerts	 Raised through 3:3 process with DMT, if appropriate action not taken for escalation through CRG	CG March 2014 CG/FH July 2013	Completed Completed
Review all risk management training with the implementation of DATIXweb and ensure compliance with NHSLA standards/assessment once known	• Incident reporting • Risk Assessment Training • Investigation (joint training) • Attendance to be monitored as detailed in Step 2	Training to be further reviewed with implementation of new incident reporting system	CG/FH Jan 2014 Committee Chairs/FH March 2014	Completed

Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Outcome
Continue to implement the RCA tool for falls and identify key issues for learning.	• Key issues/learning from completed RCAs to be presented at Trust Falls Group to agree actions • Present to CRG and CGC as part of falls reporting • Focused work to review near misses and promote learning • Links with other Trusts to share learning • Involvement in the review and Introduction of devices to prevent falls i.e. ultralow beds, sensor mats	Ongoing trust action plan Established Links with RBH Work commenced	CG Oct 2013 CG Quarterly CH October 2013 CG December 2013	Completed Completed Completed Completed
Review the Serious Incident Inquiry and Clinical Review process to ensure that reports completed in a timely way and to facilitate the shoring of learning across the Trust	• Reduction in the time from commissioned report to completion.	Timeline completed and changes in process being trialled Time frames recorded and decrease evidenced.	FH & CG December 2013	Completed
Step 7. Implement Solutions to Prevent Harm – *includes identification of local solutions, system redesign (proactively and reactively)*				
Continue Trust participation in uploading data to NHS South West Quality and Patient Safety Programme extranet for monitoring compliance Maintain the profile of the Safety project within the Trust during strategic changes within the SHA	• Further development of metrics associated with each intervention to evidence improvement • Monitoring of impact through extranet reports presented at workstream meetings and CGC • Provide ongoing links to Safety project from Risk Department including involvement in the General Ward stream. • Continued development across the work streams despite changes to external influences	NHS South West Quality and Safety Programme no longer exists however use of the extranet site continues for posting data and monitoring compliance. Safety Steering Group dissolved and reports made directly to appropriate monitoring groups.	GC, FH & CG Ongoing	Completed.

Appendix 2

Risk Management Plan 2014/15 (with part-year progress)

Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Completion Date
Step 1. Building a Safety Culture – *create an environment where staff are confident to use the Risk Management processes in supporting decisions and escalate concerns*				
Reassess the safety culture within the Trust through the validated Staff Survey	• Use information from the literature review undertaken to redesign the patient safety survey and gain approval from CRG prior to use • Undertake Staff Safety Survey	Survey is draft for further discussion	FH November 2014 FH and PK January 2015	
Review solutions available to ensure that there is a feedback mechanism in place for staff reporting incidents/raising concerns.	• Staff reporting feedback available to them • Increased/sustained reporting • Trust upgrading Datix system to version 14 when available where feedback can be set to mandatory.		FH - February 2015 FH - March 2015 IT - November 2014	
Staff feeling able and competent to complete risk assessments and escalate concerns	• Risk assessment completion and escalation		CG and FH – March 2015	
Ongoing development of Patient Safety and Quality Walkrounds continuing to ensure a safe environment for staff to raise concerns.	• Maintain clear action leads and identify on Datix • Review process with the introduction of Datixweb • Monitor compliance with actions via performance meetings • Provide annual report to CGC	Updated after each walk by risk representative. Taken to each performance meeting	FH March 2015 FH March 2015 FH March 2015 FH August 2015	

Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Completion Date
Step 2. Lead and Support Staff – *Risk Management Department will exhibit strong leadership and ensure that all staff have access to or are competent in using the Risk Management processes*				
Review Risk Management training in line with identified needs of the organisation and changes in working practices.	• Training that matches current practices and requirements. • Evidence of review by Clinical Risk Group and H&S Committee	Training already changed for staff moving to Datixweb	FH and CG March 2015	
Monitor Risk Management training attendance in line with training needs analysis and review current training	• Dissemination to Directorates		FH / Directorates	
Ensure that all staff completes incident reporting training on induction following changes to statutory/mandatory training requirements.	Monthly report figures.	Monthly report set up to be sent out via MLE.	FH - Monthly	
Step 2. Lead and Support Staff – *Risk Management Department will exhibit strong leadership and ensure that all staff have access to or are competent in using the Risk Management processes*				
Work with Trust Departments to ensure that robust departmental risk registers are in place in line with the Trust Risk Management Policy	• Identify Training requiremtns for Directorates and Departments with the introduction of the Datixweb Risk module • Monitor trends and identify departments that may have ineffective/absent centrally held risk registers and monitor at performance meetings	For Trust wide work as part of implementation of Datixweb.	FH/CG January 2015 FH/CG March 2015	

Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Completion Date
Update suite of Risk policies in line with Trust processes including updating the Trust risk matrix for assessing incidents and risks for grading.	• Policies to be submitted to CRG and approval boards: Adverse Event Reporting Adverse Events – supporting those involved Learning from incidents, complaints and claims Risk Management Policy and Procedure	All policies to be updated with implementation of Datixweb.	FH and CG All by August 2015	
Support staff in the move to web reporting of incidents to maintain reporting culture. Create feedback process for informing staff of outcome and actions	• Sustained figures for the reporting of incidents • Staff receive positive and supportive feedback with regards to reporting and training. • Version of Datix compatible with providing automatic feedback		SK – monthly monitoring of reported figures and staff groups reporting	
Ensuring all staff have the ability and access to facilities to maintain incident reporting across the Trust	• Sustained figures for the reporting of incidents • Training records		SK – monthly monitoring of reported figures and staff groups reporting	

Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Completion Date
Step 3. Integrate Risk Management Activity – *All components of Risk Management (clinical, financial, organisational) are integrated in such a way as to support corporate decisions*				
Ensure compliance with the CQC Regulations and associated Outcomes/Domains	• Monitor completion of work identified in action plans to ensure continuous improvement • Consent Audit to be completed • Survey results to be presented to CMB • Confirm with CMB if further data collection to continue • Review of Consent Policy	Updated July 2013 Data collection completed Action plans requested	FH Quarterly during 2013/14 JH and FH August 2014 FH November 2014 FH January 2015	Completed
Ensure risk and safety reporting requirements as per the contract are reported to commissioners	• Reporting requirements met • Maintain timeliness of SII reports to meet national and local targets and Commissioner input as required		FH March 2015	

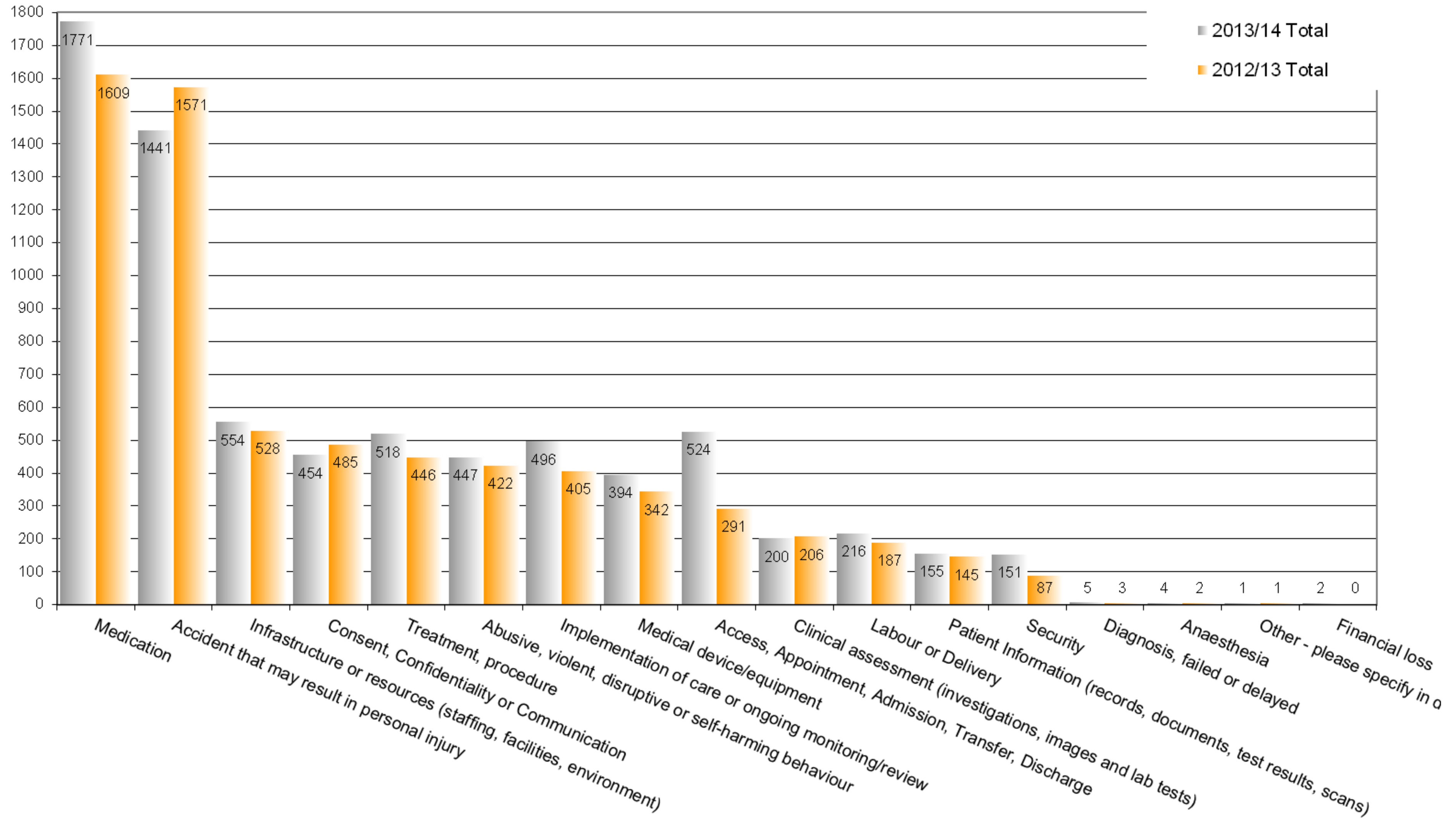
Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Completion Date
Step 3. Integrate Risk Management Activity – *All components of Risk Management (clinical, financial, organisational) are integrated in such a way as to support corporate decisions*				
Produce an Annual Report clearly illustrating progress made in 2014/15 on the management of Risk within the organisation	• Risk Management Annual Report presented to Trust Board	Report for CGC September 2014 Report for Trust Board October 2014	FH October 2014	
Review the Risk Management Strategy	• Risk Management Strategy revised and ratified by Trust Board		FH October 2014	
Continue to develop and embed the Assurance framework ensuring its status as a key document in steering the focus of the Trust Board and Assurance Committees with a clear audit trail of actions taken to reduce strategic risk. Ensure that the AF reflects risks to achieving the Trusts key objectives	• Dynamic assurance framework in evidence • Assurance framework deemed compliant by Internal audit review 14/15	Trust Board workshop planned September 2014	FH present at Assurance Committees 2014/15 FH March 2015	
Continue to develop the risk management links within service development and project planning processes within the Trust i.e Capital bids process	• Risk reviews incorporated into these processes giving clarity of purpose, associated risks, and monitoring of mitigation activities		FH ongoing	
Contribute to the development of the Quality Account in relation to risk and patient safety information	• Ongoing data input to KQIs		FH ongoing	
Ensure that risks entered onto Datix risk module and deemed 'high/extreme' risks are automatically triggered for escalation appropriately through the organisation.	• Awareness of high risks at DMT and Executive level	Triggers to be confirmed and set up on Datix web.	SK – January 2015	

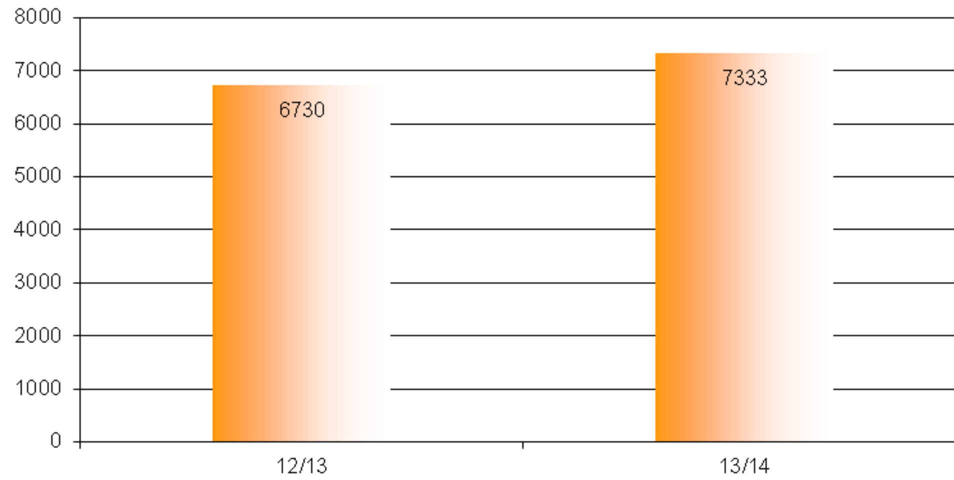
Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	*Completion Date*
Step 4. Promote Reporting – *clinical and non clinical incidents*				
Roll out Datixweb modules (incidents, risks, complaints and claims) across the Trust. Work with IT, Customer Care and Litigation to identify implementation plan for complaints and claims modules	• Roll out initially of incidents • Evaluation of pilot areas, implement and cascade changes • Roll out risk and complaints modules	ED pilot in progress Training commenced	FH and Risk Team Ongoing FH/Risk Team, HH October 2014	
Continue to monitor themes and trends from reported adverse events via the Risk Report Cards and subsequently Datixweb. Maintain a robust monitoring report of progress against recommendations from Clinical Reviews and SIIs	• Directorate and Trust wide Risk Report cards evidenced with emerging themes/trends and actions • Ongoing work with Directorates via DMT performance pre-meetings • Evidenced through Annual Report	Monitored monthly via CRG and at quarterly at performance meetings Compliance reports presented at CGC, CMB. Actions progressed and followed up where progress unknown.	FH/CG March 2015	
Through the Risk Report Cards and Datixweb monitor reporting by Department and Professional group with focussed work resulting in those areas showing low engagement or falling numbers of reported incidents.	• Directorate and Trust wide report cards to show reporting by Department and staff group for mid and end of year reports • Actions taken as a result of above data • Maintain levels of reporting identified by staff survey and national data (NRLS)	Ongoing as part of report cards	FH/CG March 2015	
Identification of a feedback mechanism so staff aware of outcomes of incident reporting and actions taken.	• Upgrade to Datix version 14 when available	Launch planned November 2014.	IT- December 2014	

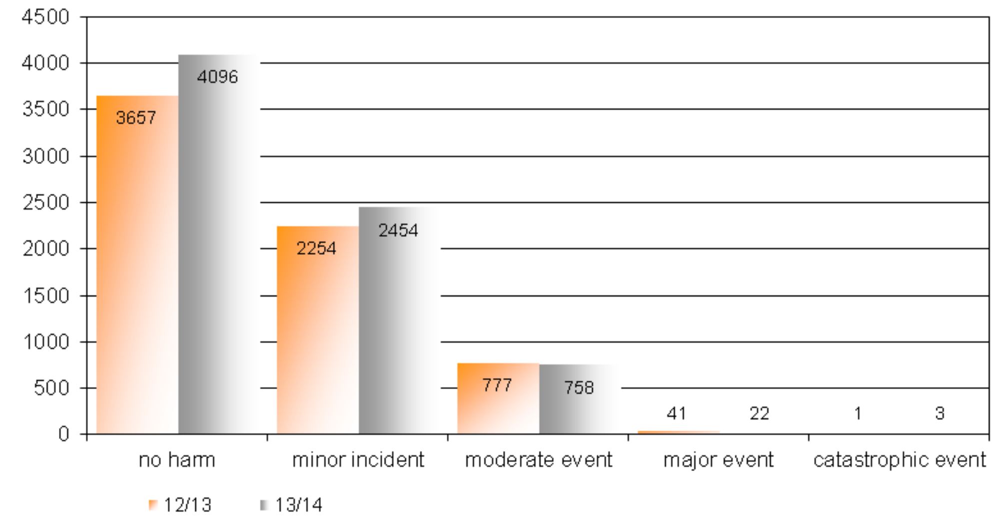
Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Completion Date
Step 4. Promote Reporting – *clinical and non clinical incidents*				
Maintain staff awareness of incident reporting, feedback mechanisms and shared learning. Adverse event reporting policy to be updated with the implementation of Datixweb and training provided for staff at all levels of the organisation. Mechanisms for staff feedback to be incorporated into incident reporting pathway for Datixweb	• Maintain comparison levels with other Trusts regarding reporting • Continue improvement of staff perception and understanding of incident reporting • Realtime feedback/themes available to DMT and staff • Evidence through staff survey	NRLS report used to monitor incident reporting against other small acute Trusts. Evidence of Trust being higher than average reporters of incidents. Monitor staff survey results and participation in action plan.	FH and Risk Team March 2015 FH & Risk Team, DMT's March 20145	
Implement changes to external reporting mechanisms as systems become available. This will be impacted by the restructure of the NPSA and SHA	• Implementation of systems as they arise		FH March 2014	
Review the Trust scoring matrix to reflect the most up-to-date guidance regarding grading of harm and including definitions for security, falls and IG	• Update Matrix and approval from CRG		FH/CG August 2015	

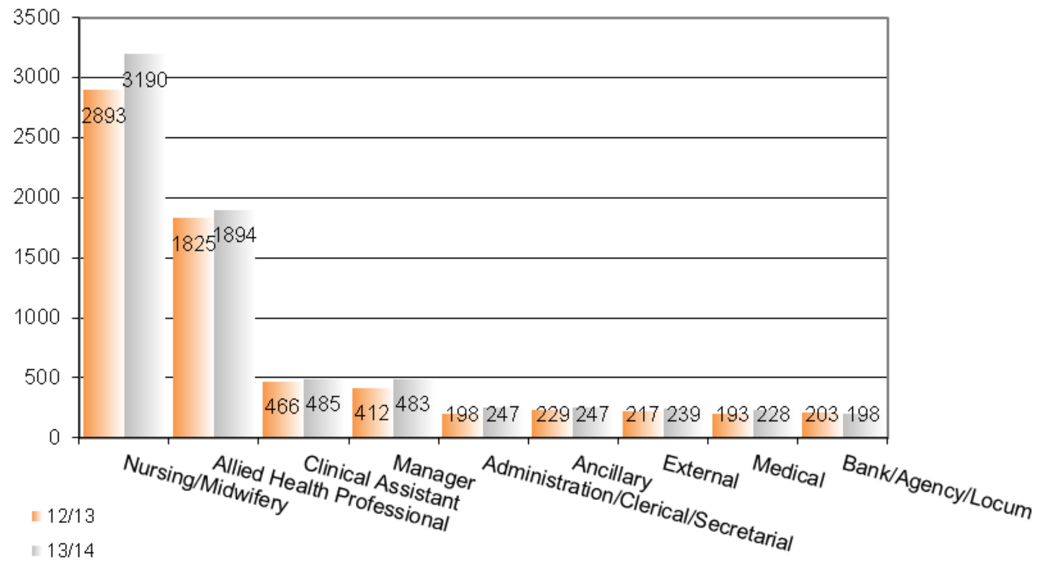
Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Completion Date
Step 5. Involve and Communicate with Patients and the Public				
Continue to maintain and strengthen Trust Being Open policy and responsibilities in relation to Duty of Candour with ongoing promotion of an open culture with families, patients and staff when patient safety incidents have occurred	• Duty of Candour included on electronic incident reporting form • Monitor completion and actions taken • Patient and family support • Ensure contact maintained with patients/families during reviews and feedback findings.		FH & Risk Team December 2014 Ongoing	
Step 6. Learn and Share Safety Lessons – *sound investigative techniques are applied and robust solutions are implemented as a result*				
Continue to work with NHS England to ensure that patient safety lessons learnt on a national level are incorporated into the Trust's working practices	• NHS England Alerts quarterly progress report • Implement process for follow up and review of risk assessments linked to alerts	Cascaded as required and outcome/actions fed back to MDMC Raised through performance meeting process with DMT, if appropriate action not taken for escalation through CRG	CG March 2015 CG/FH July 2014	Completed
Continue to implement the RCA tool for falls and identify key issues for learning.	• Key issues/learning from completed RCAs to be presented at Trust Falls Group to agree actions • Present to CRG and CGC as part of falls reporting • Focused work to review near misses and promote learning • Involvement in the review and Introduction of devices to prevent falls i.e. ultralow beds, sensor mats	Ongoing trust action plan Established Work commenced	CG Oct 2013 CG Quarterly CG Ongoing	Completed
Maintain timeframes for timely completion of Serious Incident Inquiry and Clinical Review process to ensure opportunities not missed for preventing similar incidents and the sharing of learning across the Trust	• Reduction in the time from commissioned report to completion.		FH & CG Ongoing	

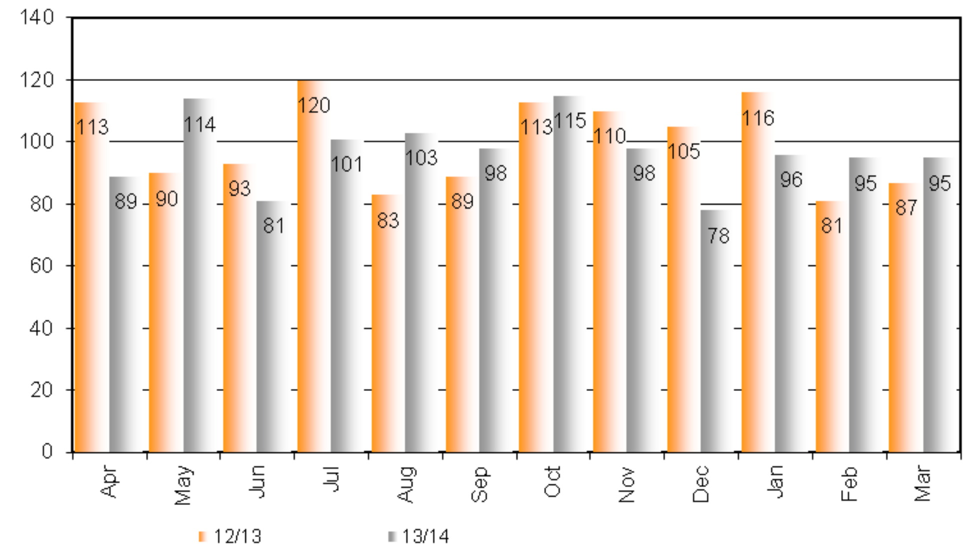
Objective	Recognised Outcome/Measure	Progress Against Objective	Person(s) Responsible & Target for Completion	Completion Date
Step 7. Implement Solutions to Prevent Harm – *includes identification of local solutions, system redesign (proactively and reactively)*				
Use themes identified through reporting of incidents and risks across the organisation to drive changes	• Evidence of sharing, learning from mistakes		FH & CG Quarterly	
Participation in the 'Sign up to Safety Campaign'	•			
Introduction of a Patient Safety 'Newsletter' for sharing learning	• Increased staff awarenss		FH & CG December 2014	

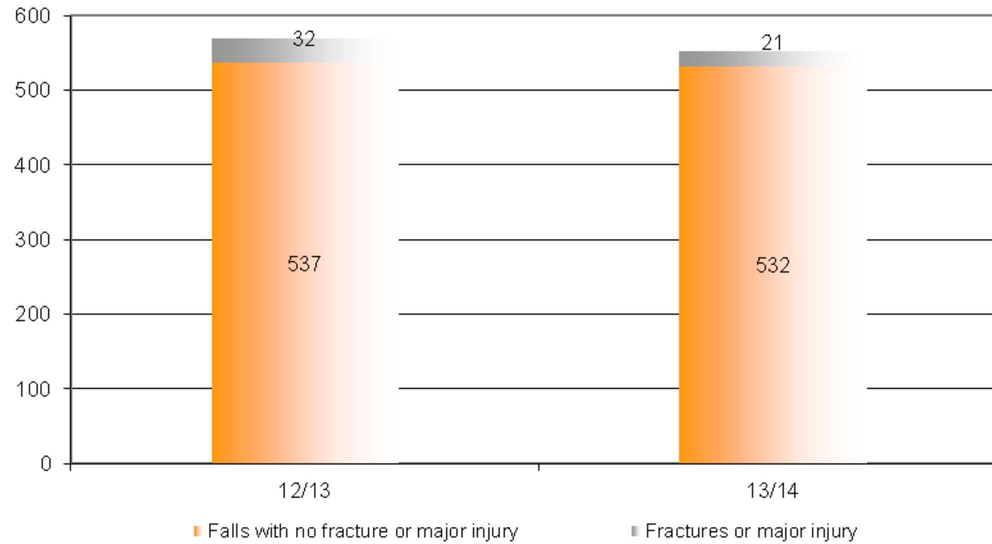

Incidents reported by Stage of Care
2013/14 Total
2012/13 Total
1800
1700
1600
1500
1400
1300
1200
1100
1000
900
800
700
600
500
400
300
200
100
0
1771
1609
1441
1571
554
528
454
485
518
446
447
422
496
405
394
342
524
291
200
206
216
187
155
145
151
87
5
3
4
2
1
1
2
0
Medication
Accident that may result in personal injury
Infrastructure or resources (staffing, facilities, environment)
Consent, Confidentiality or Communication
Treatment, procedure
Abusive, violent, disruptive or self-harming behaviour
Implementation of care or ongoing monitoring/review
Medical device/equipment
Access, Appointment, Admission, Transfer, Discharge
Clinical assessment (investigations, images and lab tests)
Labour or Delivery
Patient Information (records, documents, test results, scans)
Security
Diagnosis, failed or delayed
Anaesthesia
Other - please specify in o
Financial loss

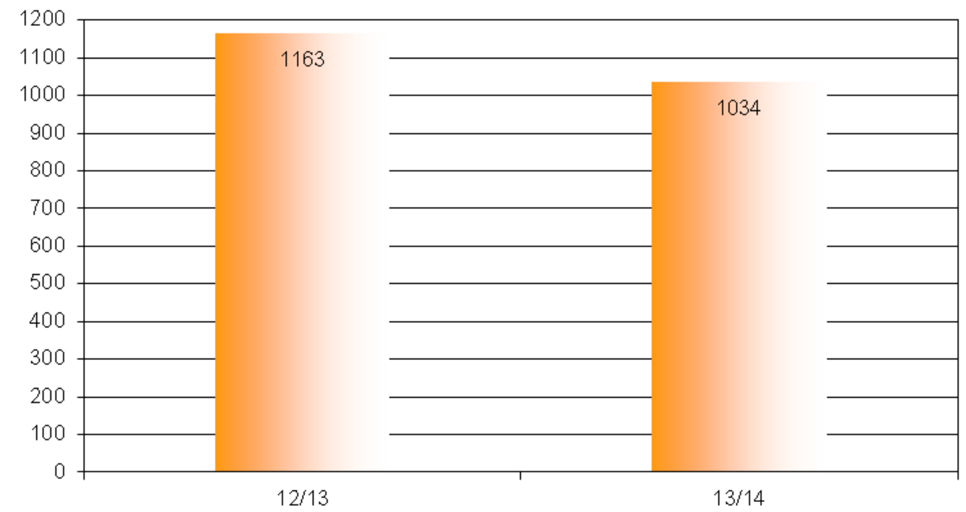

Total Incidents Reported
8000
7000
6000
5000
4000
3000
2000
1000
0
6730
7333
12/13
13/14

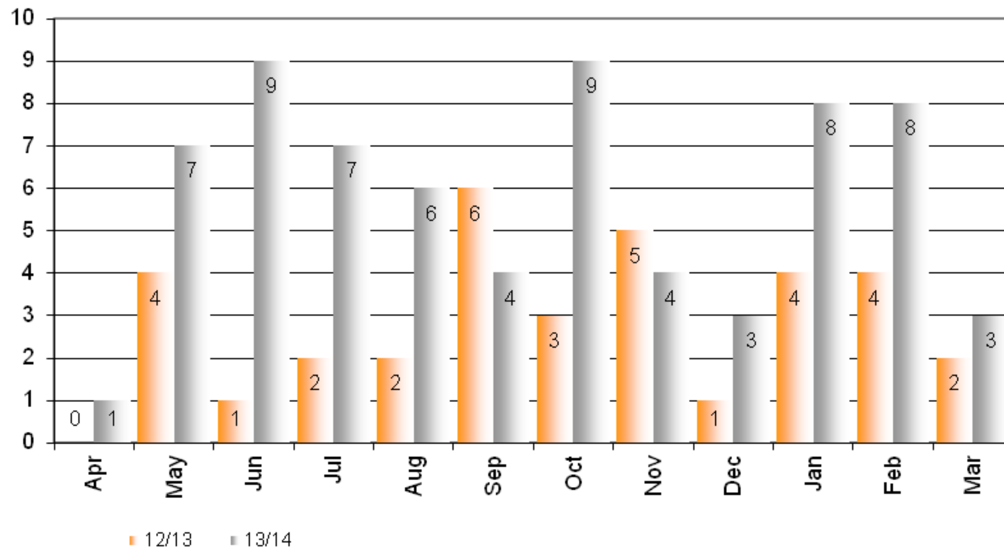

Incidents Reported by Severity
4500
4000
3500
3000
2500
2000
1500
1000
500
0
3657
4096
2254
2454
777
758
41
22
1
3
no harm
minor incident
moderate event
major event
catastrophic event
12/13
13/14

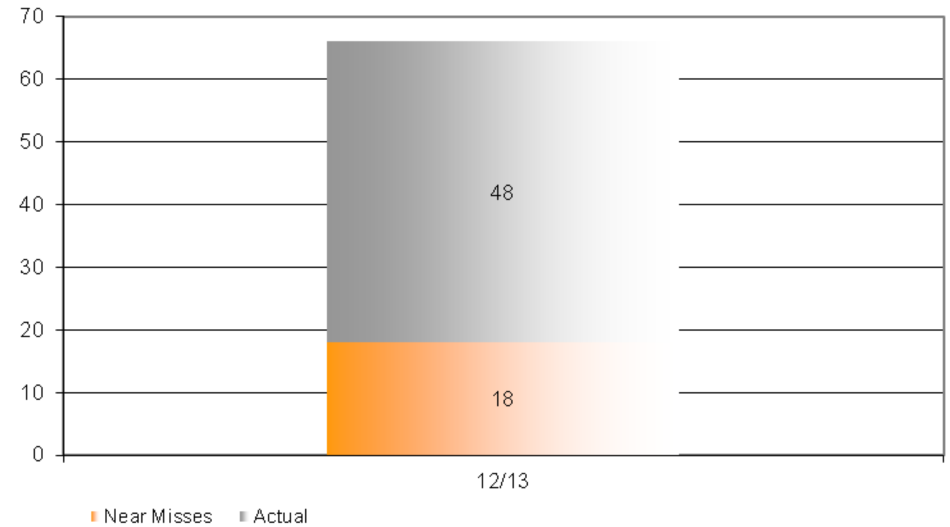

Staff Types reporting incidents
3500
3000
2500
2000
1500
1000
500
0
2893
3190
1825
1894
466
485
412
483
198
247
229
247
217
239
193
228
203
198
Nursing/Midwifery
Allied Health Professional
Clinical Assistant
Manager
Administration/Clerical/Secretarial
Ancillary
External
Medical
Bank/Agency/Locum
12/13
13/14

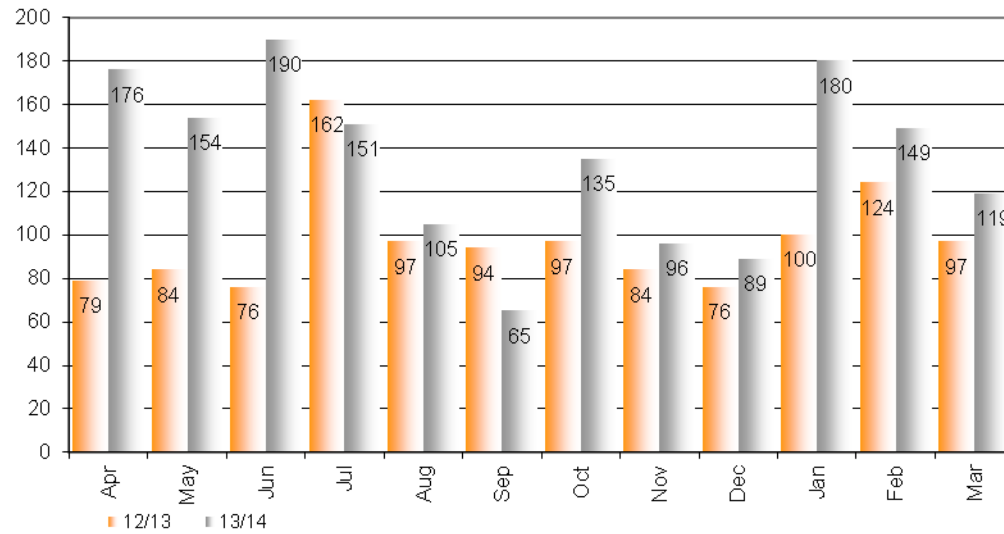

Slips, Trips, Falls and Collisions
140
120
100
80
60
40
20
0
113
89
90
114
93
81
120
101
83
103
89
98
113
115
110
98
105
78
116
96
81
95
87
95
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
12/13
13/14

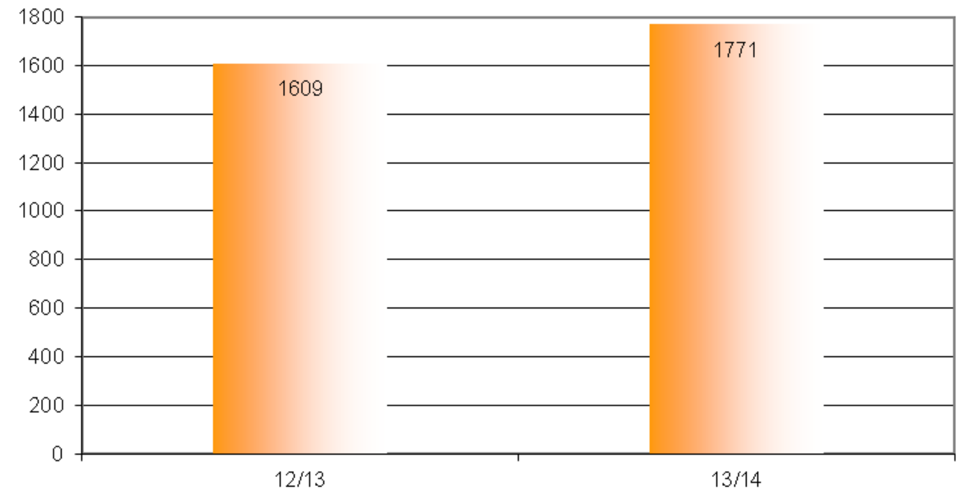

Falls resulting in Fractures or major injury
600
500
400
300
200
100
0
32
21
537
532
12/13
13/14
Falls with no fracture or major injury
Fractures or major injury

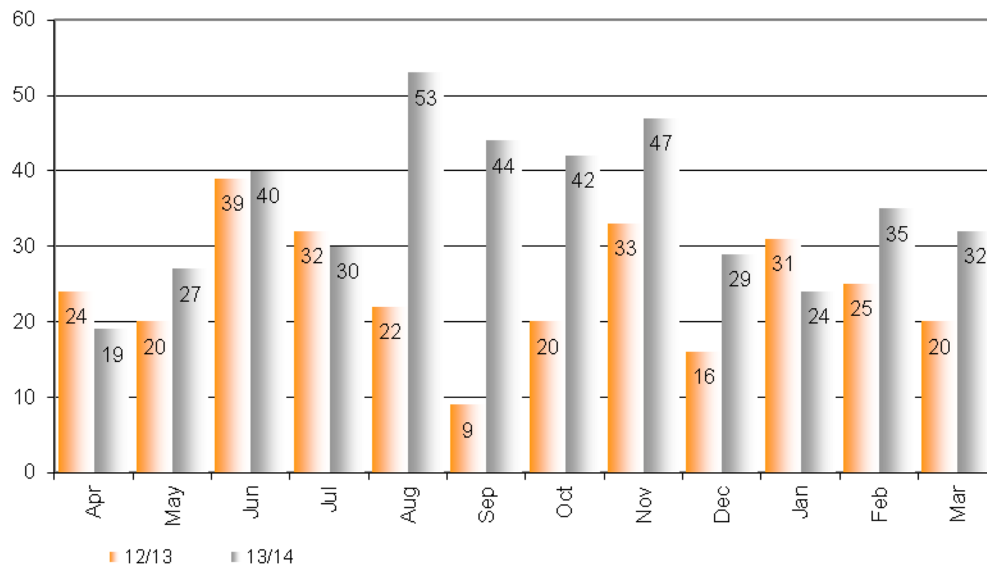

Slips, Trips, Falls and Collisions Total
1200
1100
1000
900
800
700
600
500
400
300
200
100
0
1163
1034
12/13
13/14

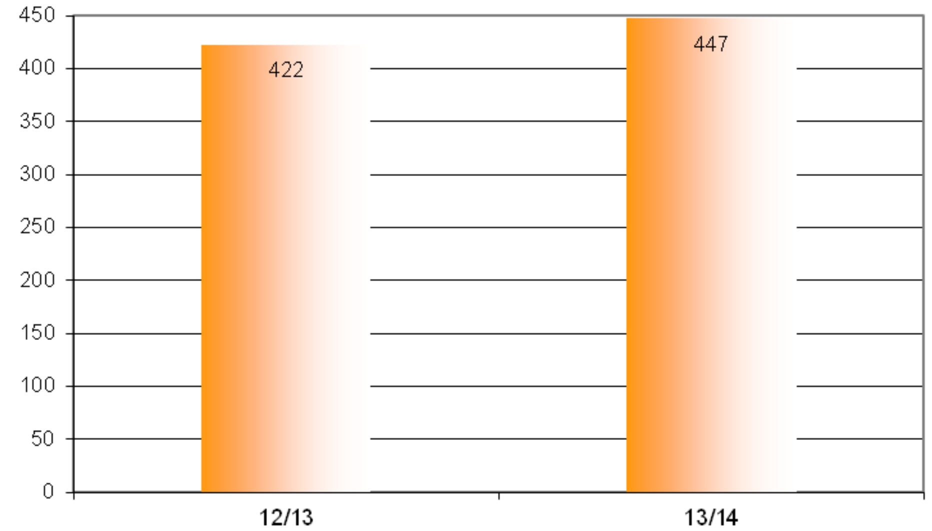

Needlestick Injuries (includes near misses)
10
9
8
7
6
5
4
3
2
1
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
12/13
13/14

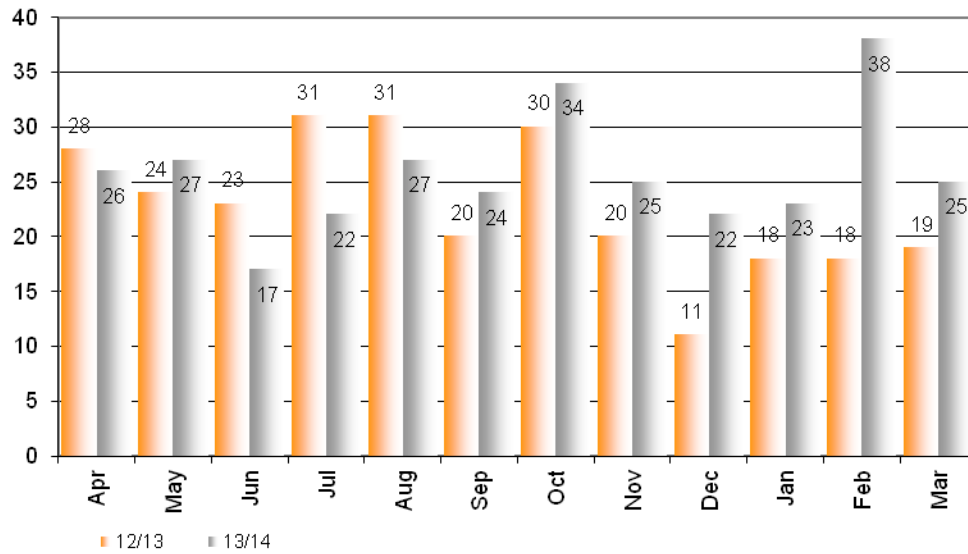

Needlestick Injuries Total (includes near misses)
70
60
50
40
30
20
10
0
48
18
12/13
Near Misses
Actual


Medication Errors
200
180
160
140
120
100
80
60
40
20
0
79 176 84 154 76 190 162 151 97 105 94 65 97 135 84 96 76 89 100 180 124 149 97 119
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
12/13 13/14


Medication Errors Total
1800
1600
1400
1200
1000
800
600
400
200
0
1609 1771
12/13 13/14


Verbal/Physical Violence
60
50
40
30
20
10
0
24 19 20 27 39 40 32 30 22 53 9 44 20 42 33 47 16 29 31 24 25 35 20 32
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
12/13 13/14


Verbal/Physical Violence Total
450
400
350
300
250
200
150
100
50
0
422 447
12/13 13/14


Communication
40
35
30
25
20
15
10
5
0
28 26
24 27
23 17
31 22
31 27
20 24
30 34
20 25
11 22
18 23
18 38
19 25
Apr
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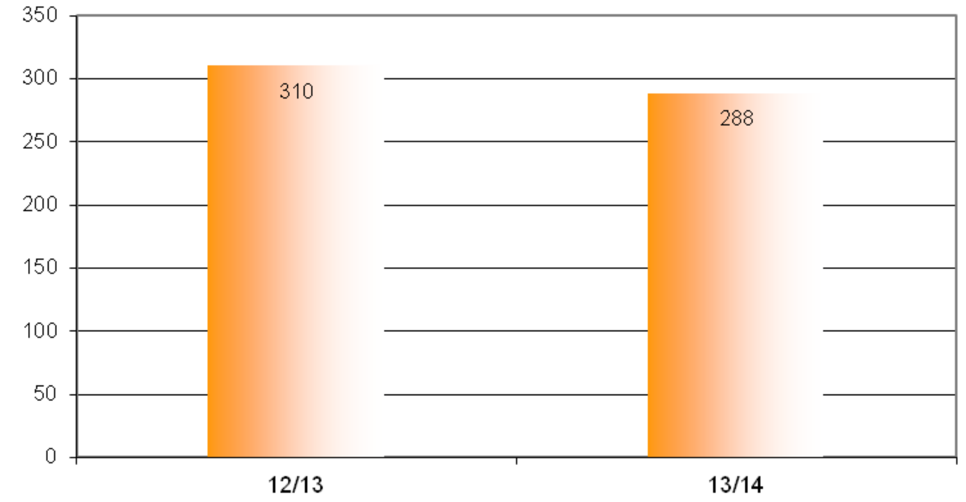
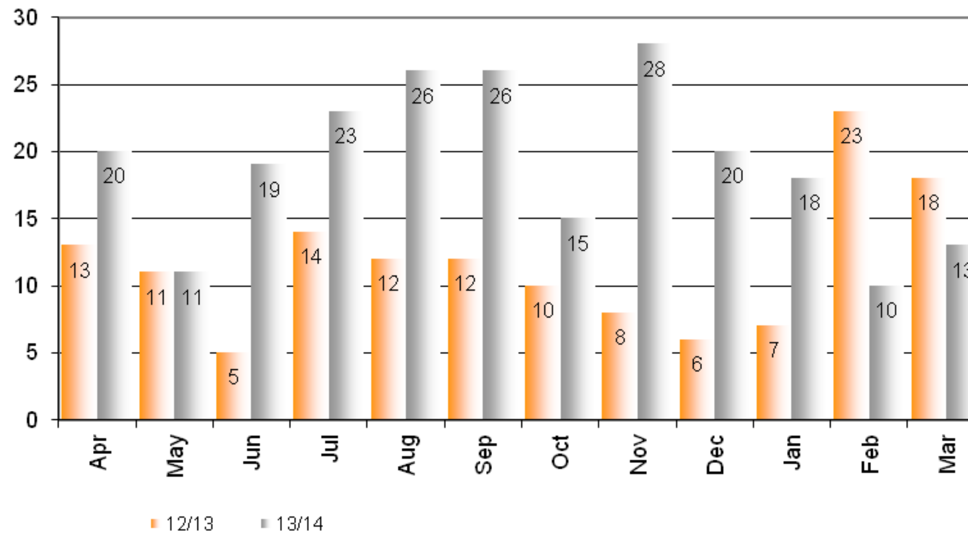
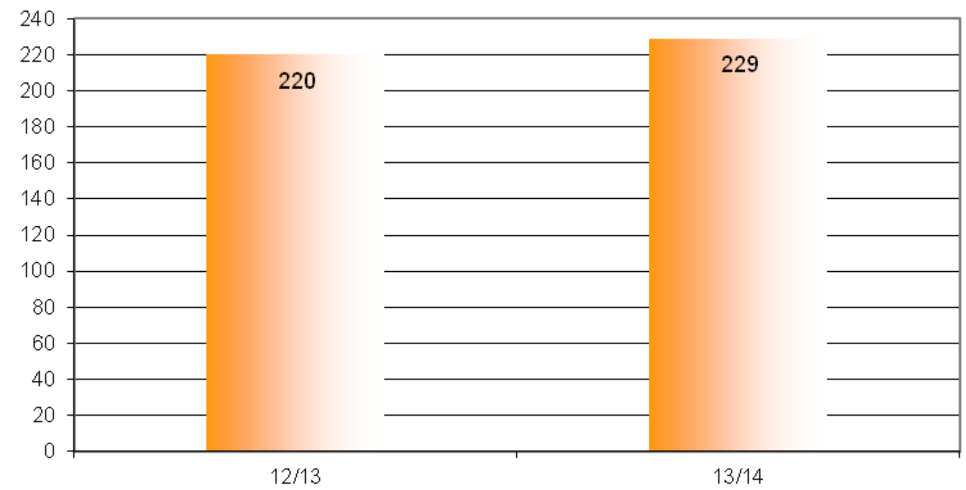
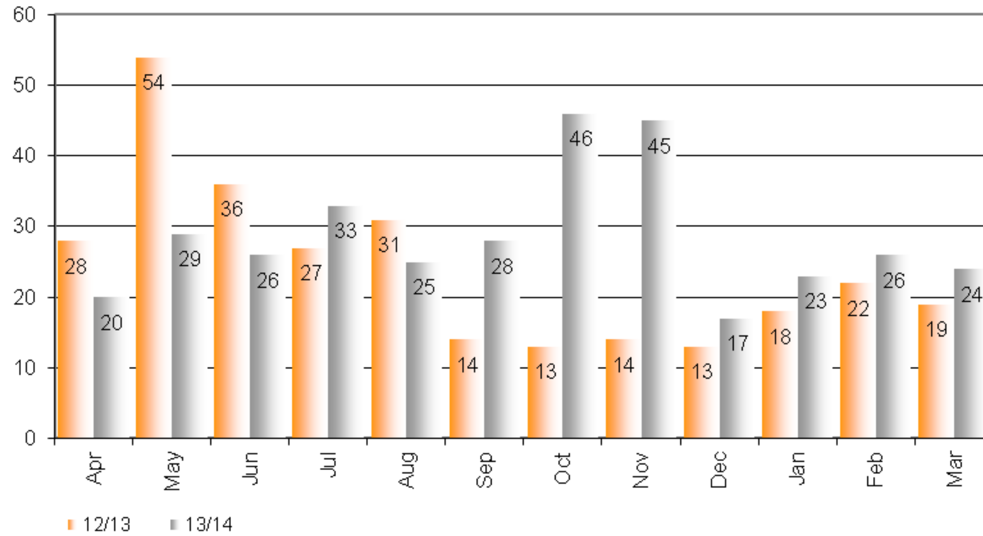
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
12/13
13/14


Communication Total
350
300
250
200
150
100
50
0
310
288
12/13
13/14

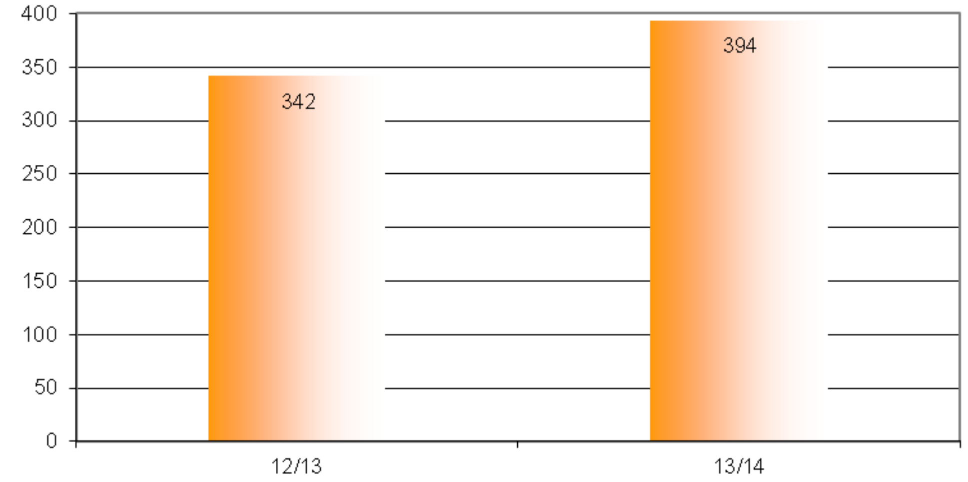

Staffing
30
25
20
15
10
5
0
13 20
11 11
5 19
14 23
12 26
12 26
10 15
8 28
6 20
7 18
23 10
18 13
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
12/13
13/14


Staffing Total
240
220
200
180
160
140
120
100
80
60
40
20
0
220
229
12/13
13/14

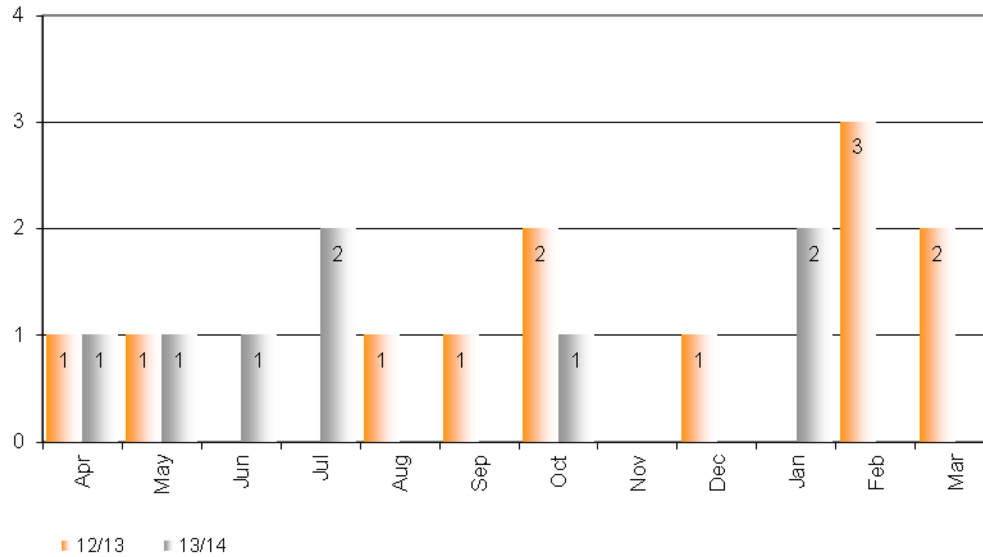
Equipment



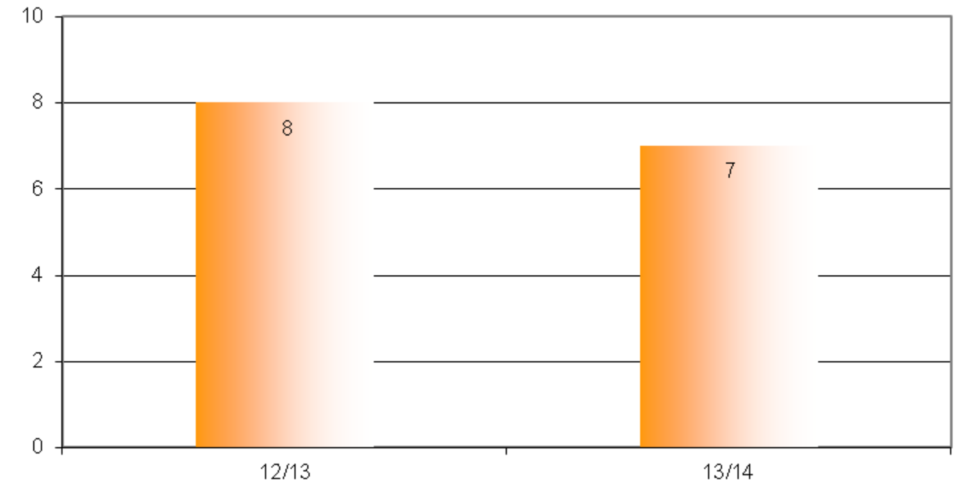
Equipment Total



Hospital Acquired Grade III/IV Pressure Ulcers



Hospital Acquired Grade III/IV Pressure Ulcers Total



PAPER: SFT 3586

RISK MANAGEMENT STRATEGY 2014/15

PURPOSE:

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

MAIN ISSUES:

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.

Key items to note:

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

- Achieve an overall Monitor financial risk rating of 3 or above;
- Maintain full registration with the Care Quality Commission;
- All departments reporting incidents across all staff groups;
- To remain above average reporters of incidents when benchmarked against Trusts of a similar size (NRLS Report);
- Evidence that dynamic Risk Registers are held within all departments covering key risks;
- Involvement in 'Sign up to Safety' and patient safety collaborative;
- 100% completion of a full root cause analysis for all fractures, resulting in moderate or greater harm, following a fall;
- Evidence of a decreasing trend in grade 3 and 4 pressure ulcers acquired during hospital admission;
- 95% compliance with VTE assessment is evidenced across all applicable departments with full root cause analysis completed for any hospital acquired case;
- 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 SIRI's;

- Cascade and Timely response to NHS England Patient Safety Alerts.

ACTION REQUIRED BY THE BOARD:

The Trust Board is asked to consider and approve the revised Risk Management Strategy 2013.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

Risk Management Strategy, 2014/15.

AUTHOR: Fenella Hill

TITLE: Head of Risk Management

Salisbury NHS
NHS Foundation Trust

Directorate Responsible for Policy:	Quality Directorate
Name of responsible board/committee:	Trust Board
Post Holder Responsible for Policy:	Head of Risk Management
Contact Details:	Risk Management 01722 336262 x2496
Date Written:	September 2006
Approved and Ratified by:	Trust Board
Date ratified:	6 October 2014
Date Policy Becomes Live:	6 October 2014
Next Due for Review:	October 2015

Risk Management Strategy

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.

Table of Contents

1 Introduction
2 Purpose of the Risk Management Strategy
3 Promoting a Fair and Open Culture
4 Strategic Goals
5 Compliance and Assurance
6 The Trust Risk Register
7 Risk Management Policy
8 Key Performance Indicators
9 The Annual Risk Management Plan
10 Accountability and Responsibility Arrangements
11 Organisational Arrangements and Risk Management Structure
12 Ensuring Compliance with National Standards
13 Approval and Review

Appendix A – The Trust's Assurance Committees

Appendix B - Organisational Chart of Risk Management Committees

Appendix C - Organisation Chart for Risk Management Team

Appendix D - Assurance Framework Report to Trust Board

Appendix E - Other Reading

Appendix F - The Implementation Plan

Appendix G - Equality Analysis

Appendix H - Non applicable - There is no requirement for a Privacy Impact Assessment as there is no processing of personal data within the Risk Management Strategy.

Salisbury NHS Foundation Trust

Risk Management Strategy

1) Introduction

1.1 The principal purpose for Salisbury NHS Foundation Trust (SFT) is to provide 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.

1.2 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.

1.3 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. Risk management is the responsibility of all managers and staff.

1.4 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.

1.5 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.

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

1.7 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 reputation and performance and is fully endorsed by the Trust Board.

3) Promoting a Fair and Open Culture

3.1 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 and 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 referred accordingly.

4) Strategic Goals

4.1 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.

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

4.3 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

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

4.5 To further develop the organisational safety culture and its effectiveness through implementation of Striving for Excellence, and Patient Safety Collaborative interventions.

4.6 To develop an Annual Risk Management Plan, which is agreed, reviewed and monitored by the Trust Board.

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

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

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

5) Compliance and Assurance

5.1 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.

5.2 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 are at risk due to a gap in control and/or assurance. This allows the organisation to respond rapidly.

5.3 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.

5.4 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.

5.5 The whole Assurance Framework is reviewed 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 who is responsible for managing and reporting on the overall risk. The identified local risk manager is normally an Executive Director. An Assurance Committee is also identified to assure the Trust Board that each principal risk is being monitored, gaps in controls identified, and processes put into to place to minimise the risk to the organisation.

5.6 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.

5.7 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).

5.8 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 will attend the Assurance Committees 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 will formally review the Assurance Framework annually.

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

5.10 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.

6) The Trust Risk Register

6.1 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).

6.2 Each Directorate will continue to maintain a comprehensive risk register, which will be formally reviewed at three 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.

6.3 The departmental and directorate risks identified at the performance meetings which impact on the corporate objectives are combined with the corporate risks 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.

6.4 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.

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

7) Risk Management Policy

7.1 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.

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

- Adverse Events Reporting Policy
- Serious Incident Immediate Response Policy
- Adverse Events – Supporting Those Involved
- Adverse Events – An Organisational Approach to Investigation, Analysis, and Learning

8) Key Performance Indicators (KPIs)

8.1 To monitor the effectiveness of the Risk Management processes and policies the following agreed KPIs shall be monitored via the Directorate performance meetings and Assurance Committees.

- Achieve an overall Monitor financial risk rating of 3 or above;
- Maintain full registration with the Care Quality Commission;
- All departments reporting incidents across all staff groups;
- To remain above average reporters of incidents when benchmarked against Trusts of a similar size (NRLS Report);
- Evidence that dynamic Risk Registers are held within all departments covering key risks;
- Involvement in 'Sign up to Safety' and patient safety collaborative;
- 100% completion of a full root cause analysis for all fractures, resulting in moderate or greater harm, following a fall;

- Evidence of a decreasing trend in grade 3 and 4 pressure ulcers acquired during hospital admission;
- 95% compliance with VTE assessment is evidenced across all applicable departments with full root cause analysis completed for any hospital acquired case;
- 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 SIRI's;
- Cascade and Timely response to NHS England Patient Safety Alerts.

9) The Annual Risk Management Plan

9.1 The Annual Risk Management Plan will be developed by the Head of Risk Management and will be agreed and monitored by the Trust Board.

9.2 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.

10) Accountability and Responsibility Arrangements

10.1 The Chief Executive

The Chief Executive 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. The Head of Risk Management supports the Executive Lead for Risk.

10.2 Executive and Non Executive Directors

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 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 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.

10.3 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.

The Head of Risk Management is responsible for ensuring risk reports are available for the Contract Quality Review Meeting (CQRM) in line with contract requirements.

The Head of Risk Management is responsible for producing and coordinating Risk Management training programmes in conjunction with the Patient Safety Facilitator.

The Head of Risk Management is responsible for collaborating with external stakeholders key to Risk Management e.g. Commissioners, links with CQC and other Trusts.

The Head of Risk becomes a point of contact for patients and families during the review process.

10.4 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.

10.5 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 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.
- 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

10.6 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.

10.7 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.

11) Organisational Arrangements and Risk Management Structure

11.1 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.

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

12) Ensuring Compliance with National Standards

12.1 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.

12.2 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

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

13) 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.

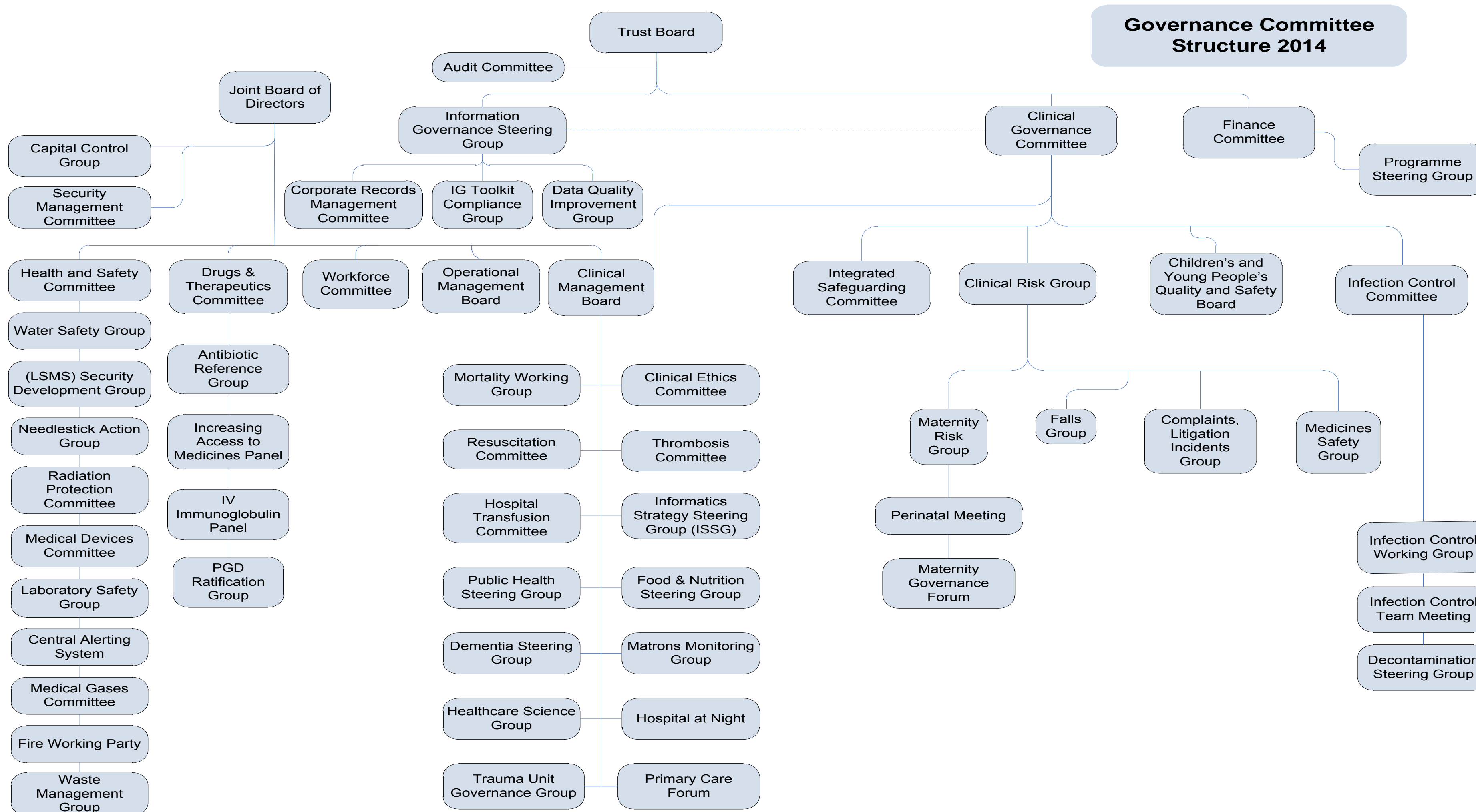
e) To agree policy and procedural change as required.

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



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
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			

Salisbury NHS
NHS Foundation Trust

APPENDIX G

Race	Disability	Gender	Sexual Orientation	Religion	Age

EQUALITY IMPACT ASSESSMENT
Stage 1. Screening

Name of activity: Risk Management				Date: 11/09/14
Name of person responsible for the activity: Fenella Hill				Directorate: Quality
Names of people undertaking screening: Fenella Hill				Department: Risk Management
Briefly describe the purpose of the activity:	The objective of this strategy is to ensure that robust risk management processes are in place which will assure the Trust Board that the trust is discharging its responsibilities appropriately.			
Who will benefit from this activity?	The whole organisation, patients, contractors, volunteers and visitors			
	Yes	**No**	**Please give details**	
1. Could or does the activity affect one or more of the equality groups in a different way to others?		X		
2. Could or do different equality groups have different needs in relation to the policy?		X		
3. Does the policy actually or potentially hinder equality of opportunity?		X		
4. Does the policy actually or potentially contribute to equality of opportunity?	X		The policy makes no distinction between equality groups, but aims to provide a clear framework that sets out clear expectations about the roels, responsibilities and requirements of all staff.	
5. Does the policy offer opportunities to promote equality?	X		As above	
6. Does the policy offer opportunities to promote positive relations?	X		As above	

Does this activity/policy require further impact assessment, action or amendment?	**No**	(if yes, pleasecomplete FORM B))

Please state in your policy documentation that it has been equality impact assessed and include your completed screening form (FORM A) as an appendix.

Screening form completed by: Fenella Hill	When will the policy and screening be reviewed? October 2015

Please forward a copy of your policy/activity document and completed screening form (FORM A) to Pamela.Permalloo-Bass@salisbury.nhs.uk

ANNUAL CLINICAL GOVERNANCE REPORT 2013 – 2014 SFT 3587

PURPOSE:

To inform the Board of progress made in assuring and improving the quality of care and quality priorities for 2014 – 2015.

MAIN ISSUES:

- The report is structured around the Quality Governance Framework and the work needed to ensure compliance with the NHS Outcomes Framework in 14/15.
- The Quality Account is the key driver for improvement and overall the Trust has made good progress in improving the quality of care in 13/14. Nevertheless, there are still improvements to be made which are reflected in the quality priorities for 14/15.
- A number of notable highlights are presented along with areas for improvement in order to support clinicians and DMTs to sustain and improve quality further.
- Sharing best practice is crucial to supporting quality improvement and examples are provided from the Clinical Governance half days, newsletters and striving for excellence awards.

CARE QUALITY COMMISSION OUTCOME:

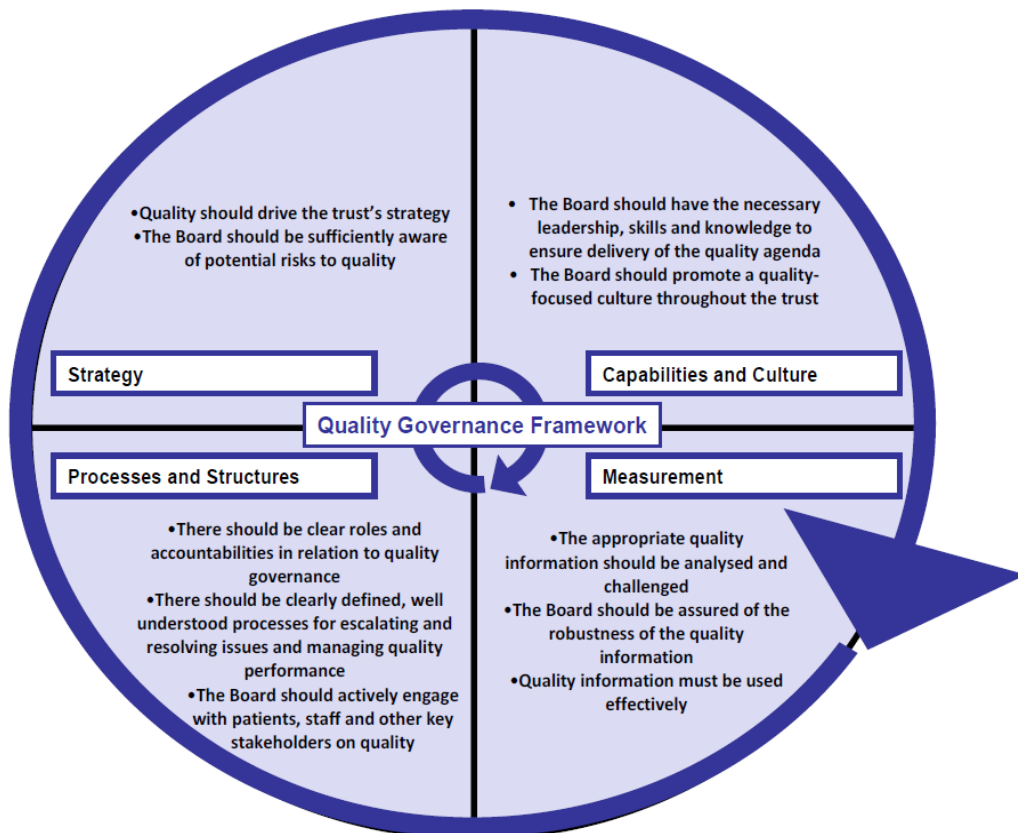
Outcome 16 – assessing and monitoring the quality of service provision

ACTION REQUIRED BY THE COMMITTEE.

1. To note the report.

Author: Dr Christine Blanshard
Title: Medical Director
Date: September 2014

Salisbury NHS Foundation Trust



ANNUAL QUALITY GOVERNANCE REPORT 2013 – 2014

Approved by: **Clinical Governance Committee – June 2014**
Author: **Claire Gorzanski, Head of Clinical Effectiveness**
Date: **May 2014**

1.0 Introduction

This annual report sets out the progress made between April 2013 and March 2014 to improve the quality of care for patients within the Trust and to provide assurance to the Clinical Governance Committee. Our quality priorities for 2014 to 2015 are also set out within the report.

2.0 Quality governance

High quality care consists of three elements which is only achieved if all three are delivered together:

- Effectiveness of treatment and care provided to patients measured by both clinical outcomes and patient related outcomes.
- Safety of treatment and care provided to patients.
- The experience patients have of the treatment and care they receive.

Quality governance is achieved through a robust quality governance framework which delegates responsibility from the Board down to the operating levels in the organisation. There is a culture within the organisation that enables clinicians and clinical teams to work at their best and measure and monitor quality. Clinicians are supported to escalate issues when needed so that appropriate action can be taken, lessons learnt and shared and services are continuously improved. The quality governance framework sets out a definition of quality governance and its component parts can be seen in the diagram on the front cover of this report. Its purpose is to:

- Ensure required standards are achieved
- Investigate and take action on sub optimal performance
- Plan and drive continuous quality improvement
- Identify, share and ensure delivery of best practice
- Identify and manage risk to the quality of care

This is described within the Trust's Quality Strategy.

3.0 Quality strategy

The Trust's Quality Strategy sets out the 3 year vision and framework for delivery of quality throughout the Trust. The Strategy aims to:

- Provide high quality care for all our patients by staff who understand their role and responsibility in delivering safe, effective and compassionate care.
- Put quality at the heart of everything we do and continuously strive to improve so that every patient has an outstanding experience.
- Continuously measure quality and patient outcomes to analyse trends and benchmark against others to drive improvement.
- Look to the future and work with our partners to make sure our patients benefit from advances in treatment and new models of care.
- Maintain our regulatory and registration requirements as defined by Monitor and the Care Quality Commission.

Delivery of the Quality Strategy is supported by the publication of the annual Quality Account which sets out the progress made in our five quality priorities in 2013/14 and the five quality priorities selected for 2014/15. These will be measured and monitored via the quality indicator report, patient real time feedback, national audit and survey results, the Friends

and Family test, complaint themes, patient stories and clinical effectiveness reports at the Clinical Governance Committee.

The NHS Outcomes Framework 2014/2015 focuses on health outcomes which matter to patients and the public. Measuring and publishing information on health outcomes drive improvements in quality. The framework sets out 5 domains where health improvement can be achieved over a number of years.

These domains are:

Domain 1	Preventing people from dying prematurely.
Domain 2	Enhancing quality of life for people with long term conditions.
Domain 3	Helping people to recover from episodes of ill health or following injury.
Domain 4	Ensuring that people have a positive experience of care.
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm.

In the quality account 13/14 we have reported our performance against these domains. In particular, the Trust has provided a detailed response and action plan on the Francis report and published it on our website. Of the 90 applicable recommendations, the Trust is compliant with 80 and partially compliant with 10. In addition, the Trust has developed actions in response to the Keogh report and the Berwick report and learnt from the failings at other Trusts such as Morecambe Bay.

4.0 Quality account

The Trust is required by Monitor to provide a Quality Account for the public each year. The purpose is to inform people about progress made in improving the quality of care in 2013/2014 and is the key driver for improvement and the quality priorities in 2014/2015.

Overall, the Trust has made good progress in improving the quality of care in 2013/2014 but evidence and patient feedback tells us there are still further improvements to be made. In setting the quality priorities for 2014/2015 we have listened to a broad range of stakeholders in helping us to decide them along with the work streams to support them. KPMG gave the account limited assurance (best possible) with one recommendation for improvement in data quality of the 62 day cancer wait target.

Progress of the priorities will be measured and monitored via a mid year report and an annual report to the Clinical Governance Committee.

5.0 Highlights for the year 2013/2014

5.1 Patient safety

- HSMR declined to 'as expected'.
- 10% reduction in the actual number of grade 2 pressure ulcers. A reduction from 7 to 6 in grade 3 and 4 pressure ulcers.
- 35% reduction in falls resulting in fracture or major harm.
- 12% reduction in hospital acquired VTE events.
- Low infection rates – C Difficile 21 Trust apportioned cases against a target of 21 cases, 2 MRSA bacteraemias both contaminants.
- No 'never events' due to a strong focus on surgical safety and learning from previous events.
- Increased awareness of adult safeguarding issues. Strengthened assurance through the set up of a joint adult and children's safeguarding committee.
- CQC intelligent monitoring puts the Trust in band 6 (lowest possible).

5.2 Clinical effectiveness

- Highest number of patients recruited into clinical trials (908 patients into 42 studies).
- Links established with the new local Wessex CRN and AHSN.
- Library literature searches increased to the highest recorded and 'up to date', an evidence based medicine resource made available throughout the Trust.
- The Library Quality Assurance Framework increased from 95% to 96.88% and is the highest in the Thames Valley and Wessex region.
- High participation in national audits - 30 (94%) and NCEPOD audits – 3 (100%)
- A high percentage of national audits published in 2013 presented to CMB by clinicians – 12 (86%)
- Increased percentage of local re-audits from 21% in 12/13 to 33% in 13/14.
- Increased percentage of local audits resulting in an action plan from 48% in 12/13 to 100% in 13/14.

5.3 Patient experience

- A nursing, midwifery and AHP strategy which included the 6 C's (care and compassion, courage, commitment, competence and communication) presented to the AGM and Putting Pride into Practice event.
- Nursing skill mix review paper presented to the Board and an £800K investment into nursing agreed.
- Implementation of an electronic rostering system which enables better linking of nursing staffing levels to the acuity and dependency of patients.
- The national staff survey response for staff recommending the Trust as a place to work and for their friends and family to be treated was the highest result ever achieved.
- National inpatient survey results were good with improved score in the responsiveness to the personal needs of patients.
- In the national maternity survey SFT was the highest scoring Trust in antenatal check-ups and care in hospital after the birth. Overall results are 'better' in all three categories.
- The Friends and Family test response rate was over 20% with overwhelmingly positive comments from patients.

5.4 Risk management

- Increase in the number of incidents reported from 7.4 incidents per 100 admissions in 12/13 to 8.0 incidents per 100 admissions (to 30/9/13).
- A decrease in the percentage of incidents resulting in severe harm or death from 0.8% in 12/13 to 0.65% in 13/14 (to 30/9/13).
- Improved turnaround times of serious incident inquiries and clinical reviews.

5.5 Other achievements

- Full delivery of CQUINs worth £3.7M + £40K for non contracted activity.
- Retained the patient Information Standard accreditation.
- Completed the redesign of the Salisbury Organisational Risk Tool.
- An electronic review process introduced for ICID clinical policies and guidelines.
- Raising concerns policy (whistleblowing) updated and widely communicated across the organisation.
- A successful joint public health campaign with Wiltshire Council in November 2013 during self care week.
- Introduction of the Salisbury Hospital App.

6.0 Areas for improvement/development

These are set out in the Quality Account priority work streams for 2014/15.

6.1 Patient safety

- Introduction of the 'Sign up to Safety' campaign and delivery of the Sepsis Six campaign.
- Maintain low infection rates.
- Completion of the introduction of Datixweb.
- Improve end of life care in the light of the National Care of the Dying Audit results.

6.2 Clinical Effectiveness

- Continue to increase the number of patients recruited to clinical trials and build on the relationship with the AHSN.
- Further reduce the number of NICE guidelines with areas of non compliance.
- Reduce the number of people dying from preventable conditions by better health promotion.
- Improve the care pathway of older people, stroke patients and patients with major traumatic injury.

6.3 Patient experience

- Maintain the improvements in the care of patients with long term conditions, dementia and carer support.
- Improve learning from themes arising from complaints and concerns and work on improvement actions.
- Embed the Trust values and behaviours so care and compassion is at the heart of everything we do.
- Publish nursing staff numbers on every shift and every ward.
- Develop a patient information centre co-located with customer care staffed by volunteers, librarians and customer care staff for patients and their families.
- Continue the work with the Patients Association to ensure changes are made where needed.
- Work with Healthwatch and other external stakeholders to gain the views of a range of people and hard to reach groups to improve.

7.0 Capabilities and culture

7.1 Leadership

Whilst the Trust Board has overall responsibility for quality, safety and patient experience, leadership for these areas is delegated to the Medical Director and the Director of Nursing. The Medical Director is the Trust's Responsible Officer with statutory responsibility for quality governance in the Trust.

In respect of the 5 domains in the new NHS Outcomes Framework the Medical Director drives quality improvement through clinical leadership to achieve the improved outcomes for patients in Domains 1 to 3.

The Director of Nursing drives quality improvement through clinical leadership to achieve improved outcomes for patients by leading on Domains 4 and 5 of the Outcomes Framework.

7.2 Culture

There is a strong culture of reporting and learning from mistakes supported by robust policies of being open and honest and raising concerns. The new duty of candour reinforces the need to be open and honest.

The development of the workforce is key to delivering high quality care. The Trust has refreshed the values and behaviours it expects of all staff and these are starting to be embedded in the new SPIDA appraisal system and personal development plans. There is also a better uptake of mandatory e-learning since it has been linked to pay progression. A number of staff have attended leadership development opportunities via the NHS Leadership Academy and used the skills learnt to lead improvement projects. Staff involvement in improvement projects is crucial to sustaining improvements as seen in the HIMP projects and the PMO transformation programme.

Patients and staff have been assured of the quality of care, compassion, dignity and respect that they receive in this hospital following the publication of the Francis report and the Government's response. Lessons learnt in other organisations will continue to be shared to ensure any recommendations relevant to the Trust are embedded in culture and practice.

7.3 Sharing the learning

7.3.1 Clinical Governance half days

There are six clinical governance half days a year which support the quality governance framework. Four of the core sessions are held in the lecture theatre (topics in the table below). The protected time allows teams to meet together to discuss and improve aspects of quality as well as attend core sessions which cover patient safety, effectiveness and patient experience. Core sessions are evaluated by attendees and improvements made where possible.

Date	Topic
May 2013	Patient Experience
July 2013	HIMP group
November 2013	Learning from Complaints and Risk
January 2014	Mortality, Global Trigger Tool report and end of life care

7.3.2 Quality Governance newsletter

The Quality Governance newsletter enables the Trust to publicise good practice and highlight areas for improvement. The newsletter is published to coincide with feedback from the clinical governance half days and this year we have published three bulletins on mortality, patient experience and a special edition on the junior doctor's HIMP presentations. The newsletter is distributed in hard-copy to all clinical leads and a broadcast with the link is sent out to all staff on the day of publication. It is also available on the intranet. Stakeholder feedback suggests the newsletters support best practice and are well received.

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7.3.3 Striving for excellence awards

The Trust held its 7th annual awards day in November 2013 to recognise the achievements of staff and the way they have improved services for patients across the hospital. There were 9 categories which included service improvement projects, equality and diversity, customer care, as well as the Chairman's outstanding contribution award, the Chief

Executive's leadership award, a Governor's volunteer of the year award, and an unsung hero award.

8.0 Structure and processes

8.1 Quality structure

The Trust Board is responsible for overseeing the quality of care being delivered across all services within the organisation and being assured that quality, safety and good clinical outcomes are being achieved throughout the organisation. Some of this responsibility is delegated to the Clinical Governance Committee (CGC). A report on the effectiveness of the Committee was presented to the Trust Board in year. The CGC monitors quality through a robust reporting schedule and has received a range of quality assurance reports and presentations from all four clinical Directorates during the year. Patient experiences are heard through patient stories presented by patients or relatives at the beginning of each meeting. Quality is also assured and enhanced by Executive safety and quality walk rounds.

The Clinical Management Board (CMB) has reviewed its terms of reference and reporting schedule. The reports of 12 (86%) published national clinical audits and 3 (100%) national confidential enquiries were reviewed by the CMB by the clinical lead responsible for implementing the changes. The majority of working groups, boards or committees that report to the CMB have presented progress against their work programmes throughout the year.

8.2 Quality processes

Each individual service undertakes a six monthly self assessment using the Salisbury Organisational Risk Tool which alerts the DMT to risks relating to the quality of care and enables plans to be put in place for improvement. A quality 3 to 3 Directorate performance meeting is held three times a year where quality information is reviewed to provide assurance of effectiveness, safety and a good patient experience in each individual service. Quality improvement plans are agreed where needed. Information reviewed includes Directorate key quality indicators, mortality rates, clinical audit results, patient survey feedback, real time patient feedback, comments, complaints and compliments and a risk report card highlighting adverse events.

9.0 Quality measurement

Measurement is a key component of assessing whether quality care is being provided and quality improvement is making a difference. It underpins all quality processes. Work is ongoing to develop clinical information systems supported by Informatics.

The Trust board receives quality indicator reports to enable members to analyse trends and benchmark against others to enable challenges to be made and acted upon where appropriate. Key risks to quality are identified and remedial action taken to mitigate the risk.

10. Quality priorities for 2014 – 2015

There are a number of areas where we would like to make further quality improvements and the following priorities have been agreed in consultation with key stakeholders.

Priority 1 - Reduce the numbers of people dying from preventable conditions

Priority 2 - Ensure all patients receive high quality care including those with long term conditions

Priority 3 - Continue to help patients recover from illness or injury

Priority 4 - Ensure every patient has individualised co-ordinated care

Priority 5 - Continue to keep patients safe from avoidable harm

10.1 Monitoring progress

Progress in these priority areas will be measured and monitored through the Trust's quality governance process. The Trust board, the CGC and the CMB will receive quality indicator reports, clinical effectiveness, customer care and risk reports and commission further work where quality improvement is needed. A mid and end of year Quality Account report will be presented to the CGC and our commissioners.

11.0 Summary

Overall, the Trust's Quality Governance Framework is robust and effective in providing assurance that patients receive an outstanding experience of care. There are a number of challenges for improvements in the coming year.

Claire Gorzanski
Head of Clinical Effectiveness
June 2014

PAPER: 3588

MATERNITYRISK MANAGEMENT STRATEGY 2014/15

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 Community and Safeguarding Managers.

Section 12: Additional text regarding Datix web.

Appendix 11: Additional Terms of Reference detailing SOM Trusts Assurance meetings.

ACTION REQUIRED BY THE BOARD:

The Trust Board is asked to consider and approve the revised Maternity and Neonatal Risk Management Strategy 2014.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

Maternity and Neonatal Risk Management Strategy, 2014.

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 2014
Next due for revision:	October 2015
Date policy becomes live:	

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.

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1. INTRODUCTION

The purpose of the Maternity and Neonatal Services Risk Management Strategy is to underpin 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, reputational and political 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, and support for 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 Trust Policies which are all available on the intranet:

- Risk Management Strategy
- Risk Management Policy and Procedure
- Adverse Events Reporting Policy
- Management of Claims Policy
- Customer Care Policy
- Adverse Events: An Organisation Wide Approach to Investigation, Analysis, and Learning
- Adverse Events – Supporting Those Involved
- Health and Safety 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 South of England's SI Trigger List 2013

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 are 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 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
- 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 3:3 meetings where risk registers and incident report cards are reviewed at Directorate level (or nominated deputy).
- Regular (at least quarterly) 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 3:3 where risk issues are discussed through presentation of the Directorate Risk Register and Incident Report Card.
- Regular (at least quarterly) 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 coordinator and Community Manager to coordinate Risk management issues for the Maternity , Neonatal and Community setting.

Specific duties include:

- 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.
- Coordinate responses to complaints and documents/reports for claims in conjunction with the Customer Care and Litigation departments.
- Ensure all recognised processes are in place as outlined in NHSLA.
- 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:

- Attends the Maternity and Neonatal Risk Management Group and Clinical Risk Group (or nominated deputy) to provide expert clinical advice on risk and incidents.
- Involved in Obstetric panel investigations and recommendations for improving practice as nominated.
- 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 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 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.

8.2.7 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.

8.2.8 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.
- Coordinates the running of Perinatal Morbidity and Mortality Forum.

8.2.9 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.

8.2.10 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.

8.2.11 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 and be familiar with the reporting 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.

A single framework for the assessment, rating, and management of risk is to be used throughout the Maternity and Neonatal Services, this process and the templates to use are described in detail within the Risk Management Policy and Procedure (Appendices 1-3 intranet). 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 Midwife Risk Manager who will ensure its input onto Datix (risk software used across the Trust). This then provides the departmental risk register.

The Midwife Risk 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

The Directorate Management team have access to their departmental risks on Datix. All risks scoring 12 or above will be included on the Directorate Risk Register and will be formally reviewed at the Governance 3:3 Meetings at least 3 times per year. At this forum the Directorate Risk Register (including departmental risks scoring 12 or above) is presented for discussion with the executives and the Head of Risk Management. At the Directorate 3:3 it will be agreed which risks require escalation onto the Trust risk register, this occurs if:

- All action has been taken to minimise the risk but the risk score remains 12 or above.
- Trust wide consequences associated with corporate objectives have been identified.
- Activity presents a risk at corporate level.

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. (see appendix 9).
An incident form should be completed and a checklist/proforma, where appropriate. Serious incidents are managed in accordance with the Trust Serious Incident Policy .

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. Sheet 1 of the incident form is sent to the Risk Management department within 12 hours (or as soon as reasonably possible) for the incident to be inputted onto Datix. Sheet 2 of the incident form is then completed and forwarded as soon as the investigation is complete so that too can be inputted onto Datix. (see appendix 8). Datix web will be implemented throughout the department in the foreseeable future and so the above will be subject to change.

All staff should be aware of the Trust Adverse Event Reporting Policy and the requirements for the immediate reporting of serious events as set out in the Serious Incident Policy. All incidents should be reported on the Trust adverse event reporting form. 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 via the maternity and neonatal risk report card 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 Untoward Incidents 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.

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. The maternity and neonatal incident report card will be shared with all staff and changes/recommendations fed back through the communication cascade folders ,community meetings and quarterly newsletter/report

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 and a tracker ensures follow up on completed actions.

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 Datix 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 10)
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. The database is circulated to members of the maternity and neonatal forum one week prior to the maternity and neonatal risk meeting. Any cases that are identified needing further review will be put onto the agenda for Perinatal the following month. Lessons learnt will be circulated through direct feedback to individuals involved, communication groups, SOM meetings and community meetings. A quarterly report is produced summarising the activity and any actions and submitted to Maternity Risk/Perinatal and the Trusts Clinical risk group.

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.
- Quarterly newsletter
- Theme of the month

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	Communication cascade signed sheets. Quarterly newsletter	M&NRM group - action plan if required
Staffing levels review	Staffing levels for midwives, obstetricians & anaesthetists are reviewed	Annual audit Quarterly dashboard review at M&NRM	M&NRM group M&NRM group - action plan if required
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

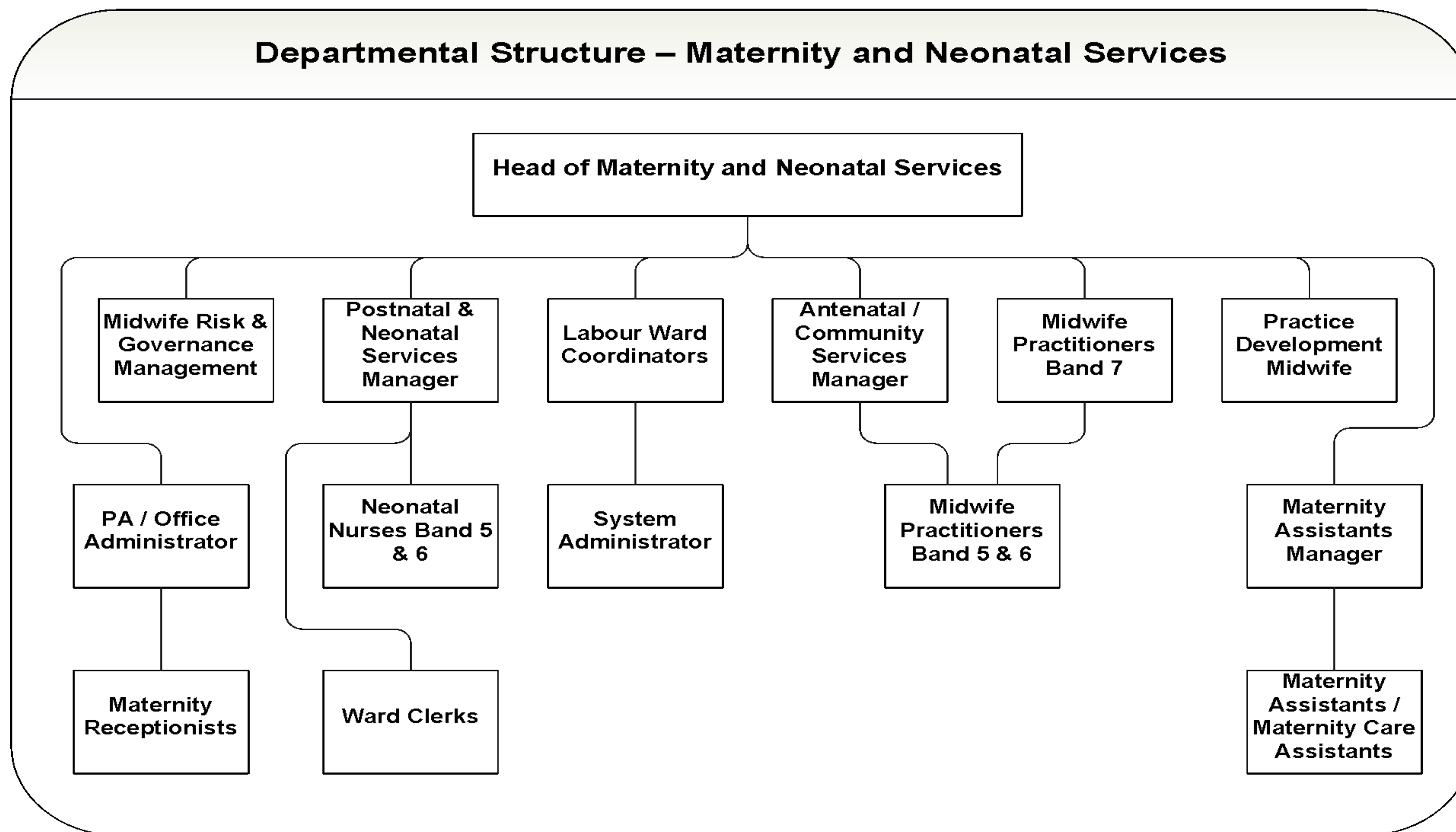
Maternal incident / near miss	Fetal / neonatal incident / near miss
Maternal death Maternal resuscitation Unexplained maternal collapse Undiagnosed breech Shoulder dystocia Blood loss >1000mls Return to theatre Eclampsia Hysterectomy/Laparotomy Venous thromboembolism Pulmonary embolism 3rd and 4th degree 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

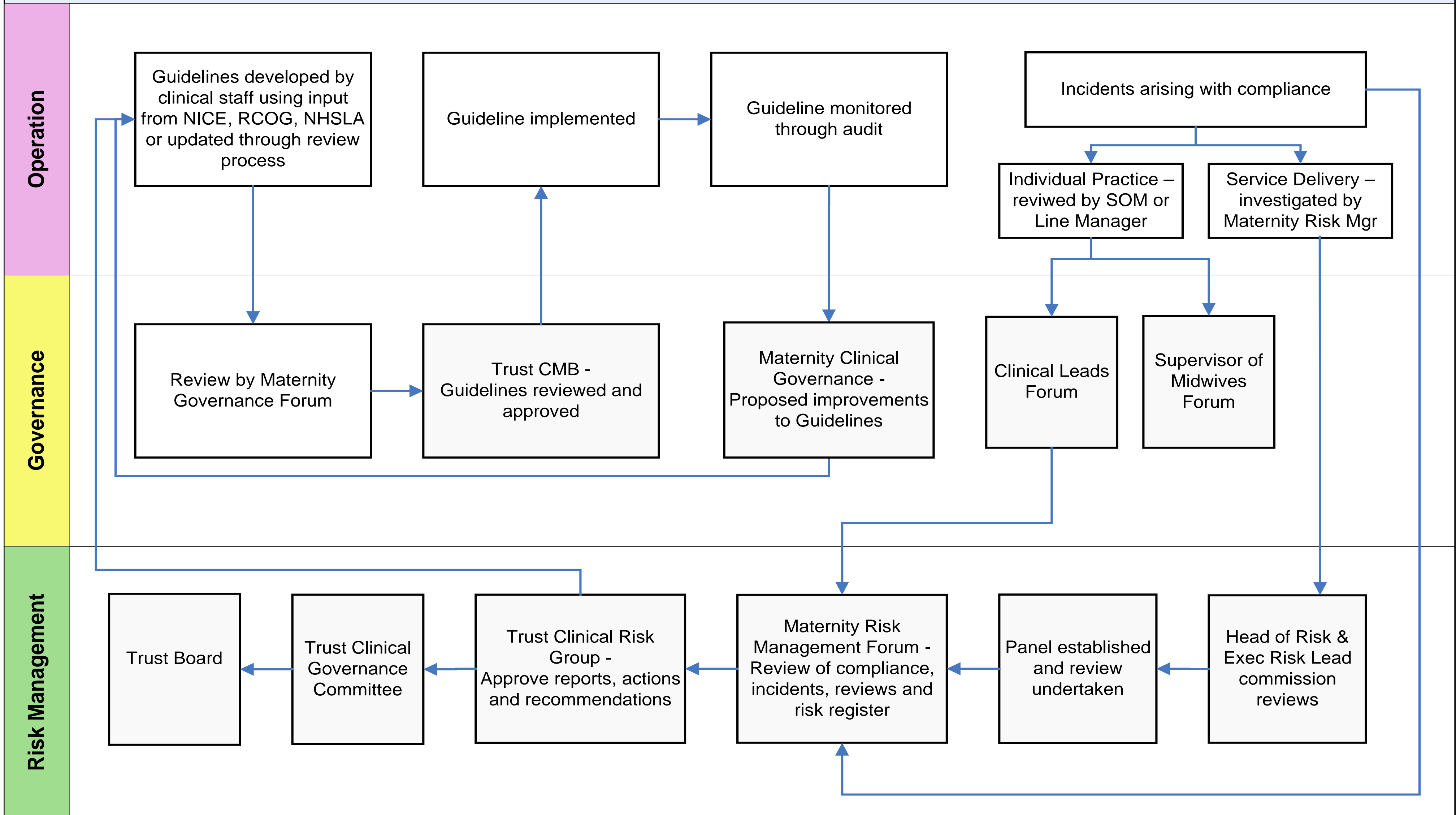
- Please take responsibility for reporting facts on Sheet 1
- Send top sheet to Risk Management Department and send copy sheets 1 & 2 to Louise Jones, Midwife Risk, Maternity Services.
- Completed reports will be sent to Risk Management Department and entered on Datix database
- Outcomes and recommendations will be discussed as outlined in the Maternity and Neonatal Services Risk Management Strategy

References: RCOG Clinical Governance Advice No. 2 October 2005.

SHC Policy for adverse events and near misses (Reporting and Investigating).

Reporting structure : Band 2 - to Head of Midwifery Appendix 2




Governance Monitoring Structure - Maternity
Operation
Governance
Risk Management
Guidelines developed by clinical staff using input from NICE, RCOG, NHSLA or updated through review process
Guideline implemented
Guideline monitored through audit
Incidents arising with compliance
Individual Practice – reviwed by SOM or Line Manager
Service Delivery – investigated by Maternity Risk Mgr
Review by Maternity Governance Forum
Trust CMB - Guidelines reviewed and approved
Maternity Clinical Governance - Proposed improvements to Guidelines
Clinical Leads Forum
Supervisor of Midwives Forum
Trust Board
Trust Clinical Governance Committee
Trust Clinical Risk Group - Approve reports, actions and recommendations
Maternity Risk Management Forum - Review of compliance, incidents, reviews and risk register
Panel established and review undertaken
Head of Risk & Exec Risk Lead commission reviews

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, CEMACE 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 CEMACE, 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 (CMACE) 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 (A named midwife will act as Chair person and this name will be made known to all members of the panel)

- 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 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 Labour Ward 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
Risk Manager

This panel will again review the presentations of the case, if at this stage they cannot agree the appropriateness of care they may suggest a Local Review.

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 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

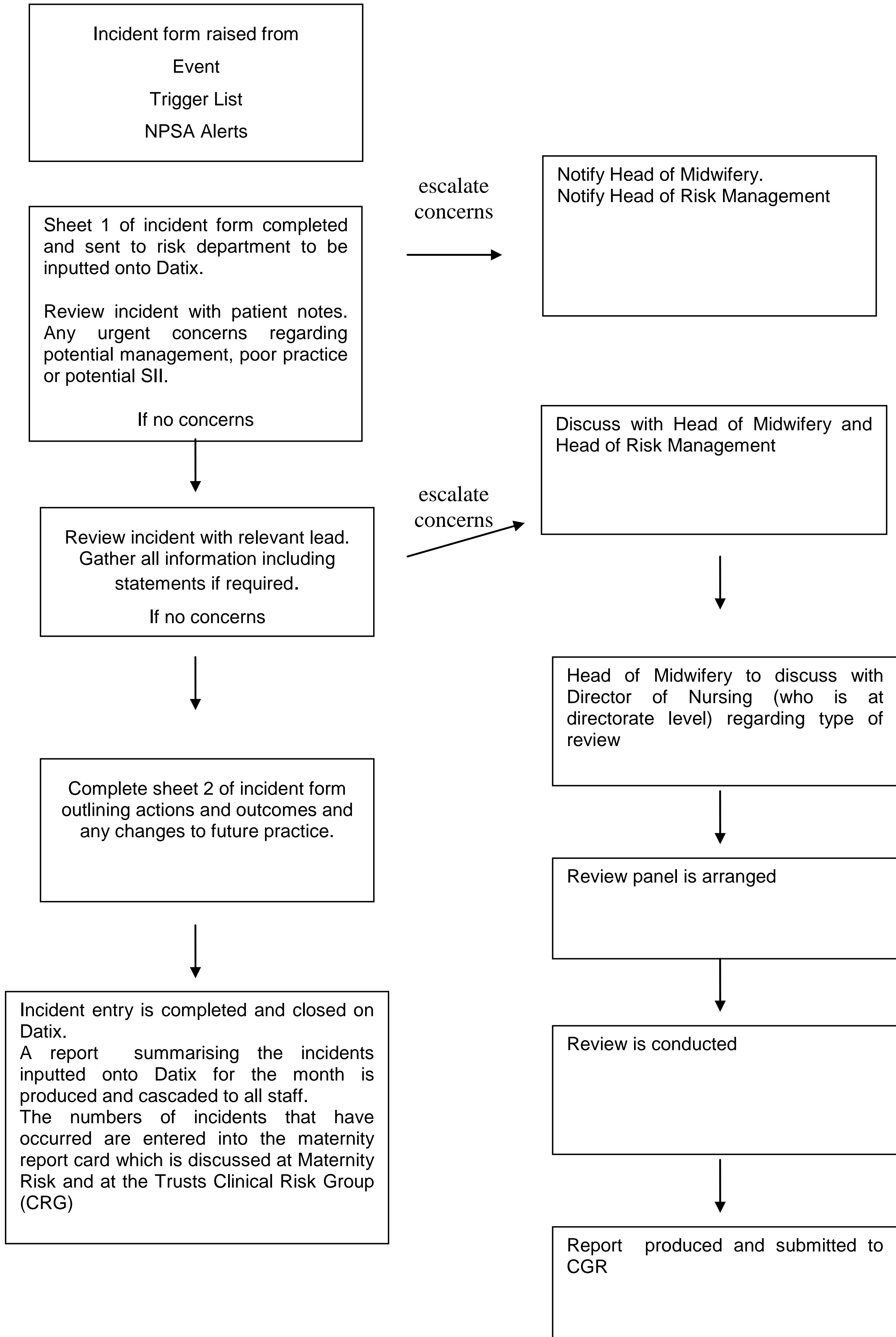
Open to all clinical staff within the maternity and Gynaecology department and where necessary to include members of relevant multi-disciplinary teams from outside the department.

Objectives of the Group

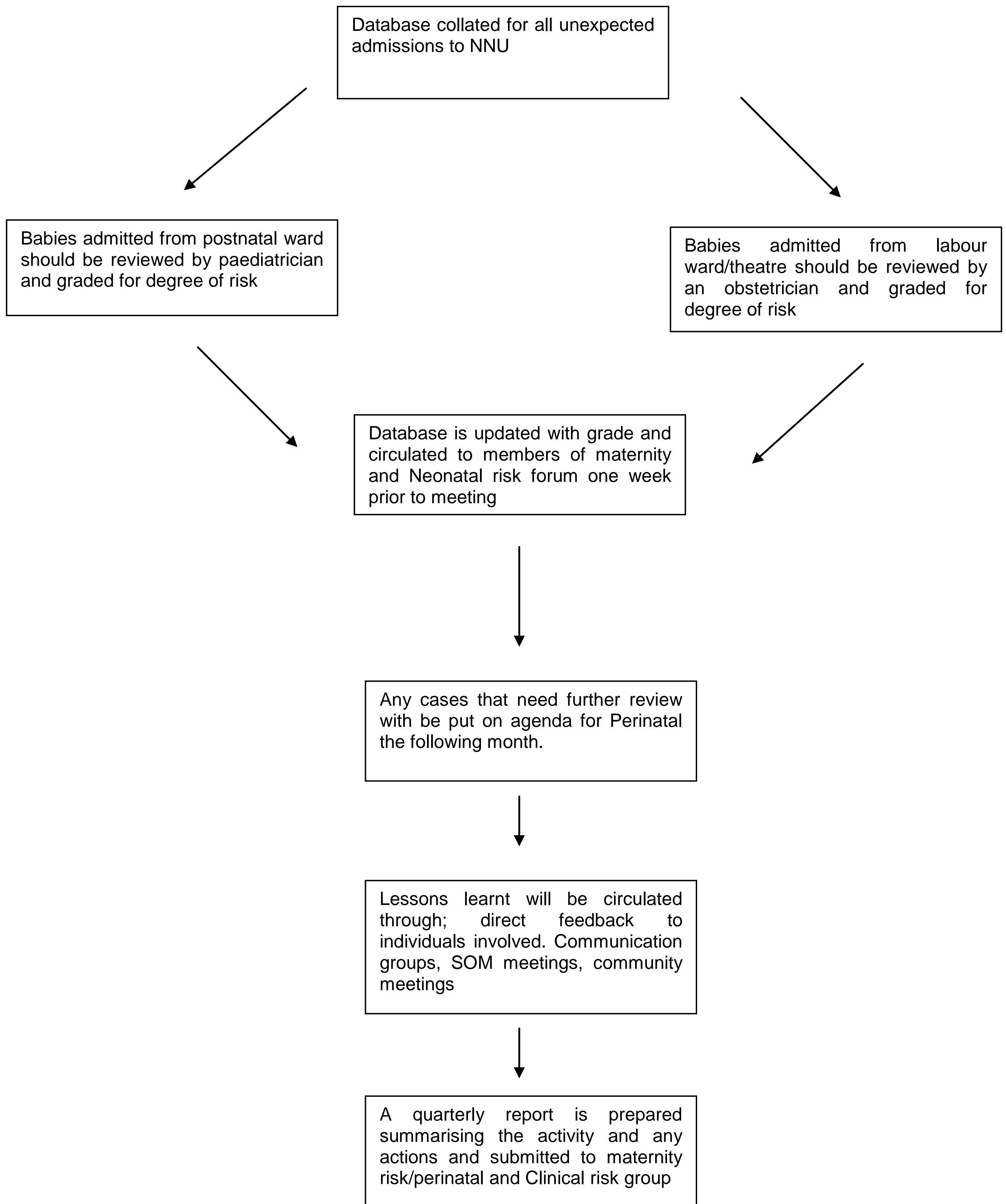
- To present anonymised cases including serious untoward incidents identifying lessons that have been learnt and need to be shared including any action plans to be implemented.
- Present audit that has been undertaken within the Maternity and Gynaecological services and discuss implications of the findings and agree further actions and audit if required.
- Present findings and recommendations form all relevant confidential enquiries such as CEMACH, 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.

Escalation of an incident

Appendix 9



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.

Terms of reference December 2013
Review date: December 2014

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/
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THE MATERNITY & NEONATAL RISK MANAGEMENT ANNUAL REPORT

PURPOSE:

This paper covers the period 1st April 2013 to 31st March 2014 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 and learning arising from incidents has led to clear changes in practise and new equipment, such as electronic CTG analysis for antenatal patients. A number of clinical and local reviews conducted this year have highlighted electronic fetal monitoring in both the Intrapartum and antenatal periods. Both individual practices and fetal monitoring (CTG) equipment issues have been analysed. The expectation around annual training has been increased and is being adhered to, according to the training needs analysis.
- CTG equipment was found to be an issue and specific protocols around the equipment have been put in place after training. Some of the outdated machines have been replaced and all these measures are now being audited. Training measures for both the obstetric and midwifery teams have been intensified.
- There has been discussion 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 increased from 3.6 to 3.9%.The Trust is not an outlier nationally even with this increase and there are no clear contributing factors apart from women are larger today (which is a known risk factor) according to a recent local audit and report.
  It should be noted that the national rate of 3rd degree tears has recently increased from 5% to 5.6%. Representatives of the Royal College of Midwives, Royal College of Obstetricians and Gynecologists, Care Quality Commission and NHS England have met to discuss concerns about increasing UK and international rates of birth-related third and fourth degree perineal tears. An audit was undertaken within the department to try and identify any themes.

  The number of 4th degree tears have decreased by 50 % - 4 compared to 8 in the previous year.

  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.

- As a result of feedback, an Information leaflet has been designed to inform husbands/ partners, of what to expect when his partner is rushed to theatre in an emergency

The following lessons have also been disseminated to obstetric and maternity staff following incident investigations:

- Training of theatre staff in manoeuvres required for releasing shoulder dystocia (SPP) has been implemented as a result of reported events.
- All women to be informed during the antenatal period about the risks associated with purchasing their own hand held sonicaid and that they should seek clinical advice at all times should they have any concerns at all during their pregnancy.

Summary of 2013/4 achievements

- Positive progress in most of the Risk Management Strategy measurable objectives
- Due to the successful bid for government money the labour ward refurbishment is now completed which provides an enhanced environment for birth.
- Friends and Family testing has been consistently positive since its implementation in October 2013.
- The real time feedback for the Maternity Service has been consistently positive.
- The ongoing development of a rag rated clinical dashboard enabling benchmarking.
- Recruitment of Named Midwife for Safeguarding Children (job share) This partnership, combining the roles of the Community Midwifery Manager and the Named Midwife for safeguarding children was appointed to. This has been a great success and the Supervisors continue to support them with the increased multiagency work. It is always a challenging situation when working with Social Care and other agencies to support removal of babies at birth when women are inpatients of the acute unit, and this has been the case on nine occasions in the first half of this year alone. We have seen a rise of approximately 70% in the safeguarding activity this year. This is resource intensive both in the community and in the acute unit as the cases are mostly vulnerable women with high levels of social risk and they require significant input.
- A huge amount of ongoing work 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.
- Complex care planning further developed as there is a constant increase in the number of women becoming pregnant who have more complexities than seen previously. The Maternity Service has seen a greater proportion of women over 40 having a first baby, the average BMI of women is now over 30 and complex health issues are becoming more prevalent such as cystic fibrosis, HIV and mental health issues. All these require greater input from midwives, obstetricians, primary and secondary care.
- A mock NHSLA assessment was undertaken in October 2013 led by the Trust Risk Manager and the Director of Nursing. This was overall a positive experience. Real time audits were undertaken by the assessors on the day which demonstrated compliance within the various standards that were being assessed. Part of the assessment was tailored to monitor themes and learning relevant to the departments serious incident investigations and clinical reviews. This was to demonstrate, where possible, that the learning and outcomes had led to changes to practice, (e.g. swab counts, evidence of escalation following abnormal observations).
- A 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.
- The National Maternity Survey from the CQC was released to the public.

Women were asked to comment on the care they received in pregnancy, labour and postnatally. Salisbury Maternity Department scored 9 out of 10 for care in labour and 8.5 out of 10 for care following the birth of their baby which was amongst the best results nationally.

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.
- To enhance fetal surveillance by adopting customised fetal growth charts as per newly released national guidance.
- To restructure the departments PROMPT training. To incorporate CTG training 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.
- Introduce Datix web for reporting of incidents within maternity and neonatal unit.
- Midwifery Staffing - To introduce birth rate plus to review data regarding activity and staffing.
- Complete the review of obstetric theatre provision

.

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 2014**

SALISBURY NHS FOUNDATION TRUST

Maternity and Neonatal Risk Management Annual Report 2013/14

1. Introduction

This paper covers the period 1st April 2013 to 31st March 2014 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**

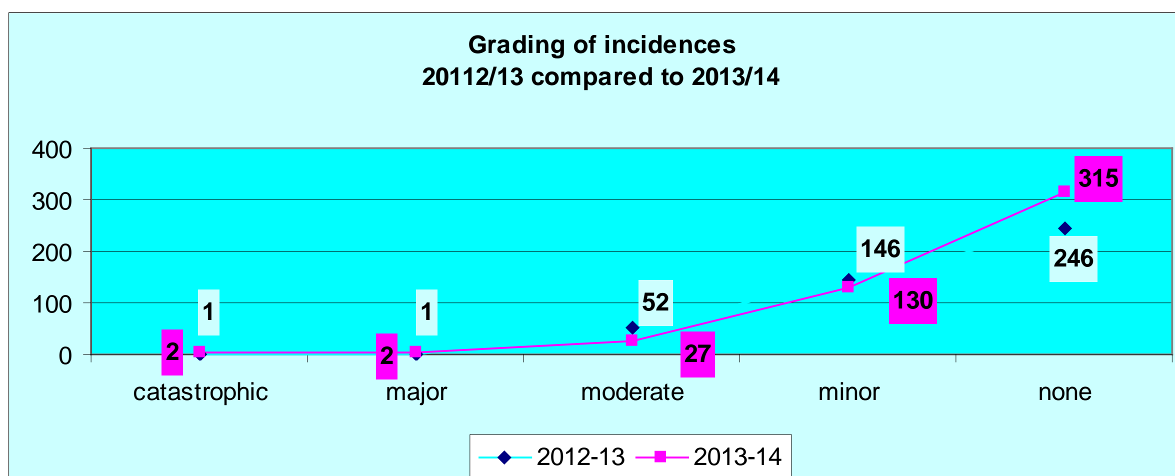
The total number of incidents reported has increased by 31 (6.5%) on the previous year. An open and supportive approach towards risk continues, which reflects an environment in which staff should feel able to report. The monthly incident report summary continues to be cascaded to all staff outlining 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 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.

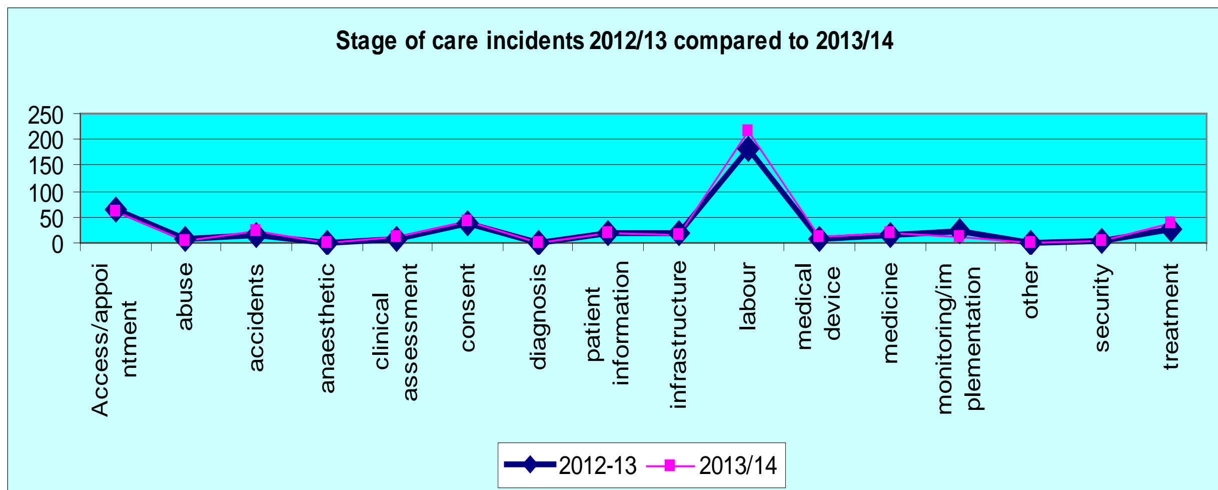
The Maternity Risk and Governance Manager is working collaboratively with the Risk Management Department to ensure duty of candour is extended and upheld for all moderate incidents.

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 catastrophic and major categories from 2 to 4 incidents over the year (all subject to SIIs or Clinical Reviews), with a reduction in moderate and minor events and an increase in the number of no harm reported.

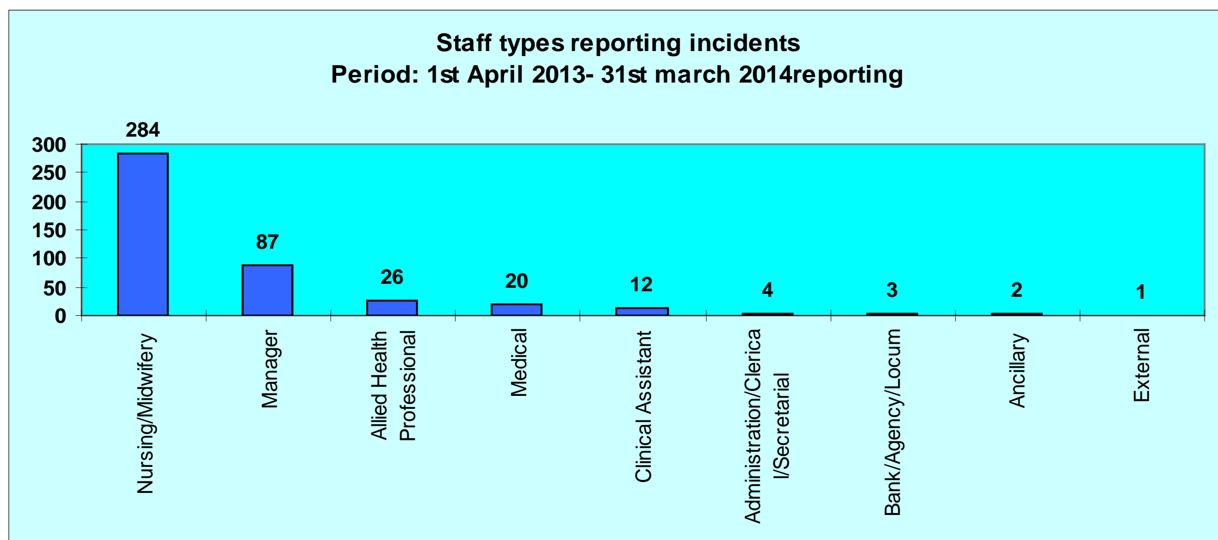


The largest number of reported incidents 215, (45.%), were clinical incidents within the labour and delivery stage of care (intrapartum), this is unchanged from the previous year. The majority of these are trigger events which are known potential complications of labour that all maternity units should 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 improved reporting rates amongst non midwife groups.



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.

Incident forms are reviewed by the Maternity Risk and Governance Manager to firstly ensure there are no 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.

Relevant Incident forms are disseminated to the clinical ward leads who are able to respond with their area of expert knowledge and can complete the sheet 2. These are then returned to the Maternity Risk and Governance manager for grading to be confirmed and are subsequently entered onto the Trusts Datix reporting system by the risk team. The Trust's 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.

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.

2.5.1 Some of the recommendations and learning arising from incidents has led to clear changes in practise and new equipment, such as electronic CTG analysis for antenatal patients. A number of clinical and local reviews conducted this year have highlighted electronic fetal monitoring in both the Intrapartum and antenatal periods. Both individual practices and fetal monitoring (CTG) equipment issues have been analysed. The expectation around annual training has been increased and is being adhered to, according to the training needs analysis.

CTG equipment was found to be an issue and specific protocols around the equipment have been put in place after training. Some of the outdated machines have been replaced and all these measures are now being audited. Training measures for both the obstetric and midwifery teams have been intensified.

2.5.2 There has been discussion 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 increased from 3.6 to 3.9%.The Trust is not an outlier nationally even with this increase and there are no clear contributing factors apart from women are larger today (which is a known risk factor) according to a recent local audit and report.
It should be noted that the national rate of 3rd degree tears has recently increased from 5% to 5.6%. Representatives of the Royal College of Midwives, Royal College of Obstetricians and Gynecologists, Care Quality Commission and NHS England have met to discuss concerns about increasing UK and international rates of birth-related third and fourth degree perineal tears. An audit was undertaken within the department to try and identify any themes.

The number of 4th degree tears have decreased by 50 % - 4 compared to 8 in the previous year.

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.

2.5.3 As a result of feedback, an Information leaflet has been designed to inform husbands/ partners, of what to expect when his partner is rushed to theatre in an emergency

The following lessons have also been disseminated to obstetric and maternity staff following incident investigations:

- Training of theatre staff in manoeuvres required for releasing shoulder dystocia (SPP) has been implemented as a result of reported events.

- All women to be informed during the antenatal period about the risks associated with purchasing their own hand held sonicaid and that they should seek clinical advice at all times should they have any concerns at all during their pregnancy.

2.6 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 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.

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 is due to be presented at the October 2014 Trust Board. Birth Rate Plus have been commissioned to undertake work within the department within the next 6 months to provide further detail around staffing and the units activity. 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 for the purchase of equipment such as new delivery beds and CTG monitors.
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. The Trust are aware of the current challenges around registered midwife staffing and are supporting the department through a work force plan and the commissioning of birth rate plus. However, there have been significant difficulties in recruiting experienced midwives along with high levels of attrition through retirement which has led to problems maintaining the funded establishment over the year.

  To mitigate against this a robust escalation plan is utilised on a day to day and shift to shift basis. This is led by the supervisors of midwives out of hours and a duty manager during office hours.

- ***The dedicated obstetric theatre*** is only open between 8am to 5pm. This risk is reviewed 3 monthly on the risk register. Although the team have mitigation actions in place there have been recent reviews highlighting issues when delivery has occurred in main theatres due to the isolation of the staff away from labour ward and the neonatal unit. There is a piece of work reviewing this provision which is being coordinated by the Lead Obstetric Anaesthetist.

3. Serious Incident Inquiries(SII)/Clinical Reviews.

The department has undertaken 13 reviews during the 2013/14 period compared to 8 in 2012/13. 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.

Six reviews were completed using the local review format, two the clinical review process, and 5 were reported as SII's. All reviews had engagement from staff involved in all aspects of care, and involvement with the family 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 that number remained unchanged in 2013/14. Each case continues to be reviewed individually at the monthly Perinatal meeting and when necessary, are commissioned as a clinical review/SII. Between April 2013 and March 2014 no links or trends have been identified.

4. User Feedback

All complaints, concerns and comments are examined for trends and themes. During this period there have been 7 complaints and 15 concerns

4.1 Complaints

A complaints theme identified relates to clinical management decisions whilst on the labour ward. However, there is little similarity between each case.

These cases include

- Care given directly following the birth and the management of a subsequent postpartum hemorrhage by the attending midwives.
- Staff attitude during an EM LSCS
- Perineal suturing technique was questioned after complainant experienced difficulties with managing pain levels.
- Management decision during the antenatal and intrapartum period.
- Appropriate triaging of a woman in labour and attitudes of the attending ambulance service.

Other complaints have highlighted:

- Clinical management in the postnatal period and the lack of communication when discharge out to another NHS provider.
- Issues with contacting the Community Midwifery Team.

4.2 Concerns

Reviewing the concerns there are several themes which have emerged.

Communication remains a factor as does staff attitudes.

- There is a broad spectrum of issues which has been raised regarding communications. This varies from the lack of information offered to awaiting birthing partners whilst their loved ones are in theatre (information now produced), to the lack of communication between the postnatal wards and the community teams.

- 5 concerns focus on staff attitude, however, these are isolated incidences. 2 of which relates to how bad news was shared with the families.

Several concerns were raised regarding the provision of care and the facilities on the postnatal ward.

5. Summary of 2013/4 achievements

- Positive progress in most of the Risk Management Strategy measurable objectives
- Due to the successful bid for government money the labour ward refurbishment is now completed which provides an enhanced environment for birth.

- Friends and Family testing has been consistently positive since its implementation in October 2013.
- The real time feedback for the Maternity Service has been consistently positive.
- The ongoing development of a rag rated clinical dashboard enabling benchmarking.
- Recruitment of Named Midwife for Safeguarding Children (job share) This partnership, combining the roles of the Community Midwifery Manager and the Named Midwife for safeguarding children was appointed to. This has been a great success and the Supervisors continue to support them with the increased multiagency work. It is always a challenging situation when working with Social Care and other agencies to support removal of babies at birth when women are inpatients of the acute unit, and this has been the case on nine occasions in the first half of this year alone. We have seen a rise of approximately 70% in the safeguarding activity this year. This is resource intensive both in the community and in the acute unit as the cases are mostly vulnerable women with high levels of social risk and they require significant input.
- A huge amount of ongoing work 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.
- Complex care planning has been further developed by the team of supervisors as there is a constant increase in the number of women becoming pregnant who have more complexities than seen previously. The Maternity Service has seen a greater proportion of women over 40 having a first baby, the average BMI of women is now over 30 and complex health issues are becoming more prevalent such as cystic fibrosis, HIV and mental health issues. All these require greater input from midwives, obstetricians, primary and secondary care.
- A mock NHSLA assessment was undertaken in October 2013 led by the Trust Risk Manager and the Director of Nursing. This was overall a positive experience. Real time audits were undertaken by the assessors on the day which demonstrated compliance within the various standards that were being assessed. Part of the assessment was tailored to monitor themes and learning relevant to the departments serious incident investigations and clinical reviews. This was to demonstrate, where possible, that the learning and outcomes had led to changes to practice, (e.g. swab counts, evidence of escalation following abnormal observations).
- A 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.
- The National Maternity Survey from the CQC was released to the public.
  Women were asked to comment on the care they received in pregnancy, labour and postnatally. Salisbury Maternity Department scored 9 out of 10 for care in labour and 8.5 out of 10 for care following the birth of their baby which was amongst the best results nationally.

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.
- To enhance fetal surveillance by adopting customised fetal growth charts as per newly released national guidance.

- To restructure the departments PROMPT training. To incorporate CTG training 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.
- Introduce Datix web for reporting of incidents within maternity and neonatal unit.
- Midwifery Staffing - To introduce birth rate plus to review data regarding activity and staffing.
- Complete the review of obstetric theatre provision.

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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
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 Neonatal department).

PAPER: SFT 3589

MANAGEMENT LETTER 2013/14

PURPOSE:
To present to the Trust Board for noting the Management Letter for 2013/14 and received by the Audit Committee on 14 July 2014.

MAIN ISSUES:
The Management Letter summarises the significant issues and conclusions from the 2013/14 audit, conducted by KPMG under their contract with the Trust.

The letter confirms that the Auditor has issued an unqualified opinion on the Trust's annual accounts and has also issued his "limited assurance" report in relation to the Trust's Quality Account.

ACTION REQUIRED BY THE BOARD:
The Board is asked to note the Management Letter for 2013/14.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

Audit Commission Management Letter – July 2014

AUTHOR: Peter Hill

TITLE: Chief Executive

Annual Audit Letter

Salisbury NHS Foundation Trust

July 2014

Content

The contacts at KPMG in connection with this report are:

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A. **Reports issued and recommendation themes**	5

This report is addressed to Salisbury NHS Foundation Trust (the Trust) and has been prepared for your use only. We accept no responsibility towards any member of staff acting on their own, or to any third parties. Monitor has issued a document entitled Audit Code for NHS Foundation Trusts. This summarises where the responsibilities of auditors begin and end and what is expected from the audited body. We draw your attention to this document.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

If you have any concerns or are dissatisfied with any part of KPMG's work, in the first instance you should contact Jon Brown, who is the engagement lead to the Trust, telephone 0117 905 4362, or email jonathan.brown@kpmg.co.uk who will try to resolve your complaint.

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Purpose of the Annual Audit Letter and scope of work

Purpose of this letter

The purpose of this Annual Audit Letter is to summarise the key issues arising from our audit of Salisbury NHS Foundation Trust (the Trust). We highlight areas of good performance and provide recommendations to support areas where you could improve performance. All the issues summarised in this letter have previously been reported to you and a list of all reports we have issued is provided in Appendix A.

Although this letter is addressed to the directors and governors of the Trust, it is also intended to communicate key issues to relevant external stakeholders, including members of the public.

Responsibilities of the auditor

The statutory responsibilities and powers of appointed auditors are set out in the National Health Service Act 2006 ('the Act'). In discharging these specific statutory responsibilities and powers, auditors are required to carry out their work in accordance with *Monitor's Audit Code for NHS Foundation Trusts* (the Code) which is available from www.monitor-nhsft.gov.uk. This summarises where the responsibilities of auditors begin and end and what is expected from you as the audited body.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

The scope of our work

Under the Code we are required to review and report on:

- the **use of resources –** that is whether you have made proper arrangements for securing economy, efficiency and effectiveness (value for money) in your use of resources;
- the **accounts** – that is the financial statements and the Annual Governance Statement;
- the **quality report** – whether this has been prepared in accordance with the detailed guidance issued by Monitor.

This letter summarises the significant issues arising from each of these areas of work.

Adding value to the External Audit Service

We have added value to our service throughout the year through:

- Attendance at meetings with members of the Executive Team to broaden our knowledge of the Trust and to provide information on sector developments and examples of best practice;
- A proactive and pragmatic approach to issues arising in the production of the financial statements to ensure that our opinion is delivered on time;
- Building a strong and effective working relationship with Internal Audit to maximise assurance to the Audit Committee, avoid duplication and provide joint value for money.

Acknowledgement

We would like to take this opportunity to thank the officers of the Trust for their support throughout the year.

Fees

Our fee for the audit in 2013/14 was £48,000 plus VAT. This fee was in line with that highlighted within our audit plan issued in October 2013.

Our fee for the external assurance on the quality report in 2013/14 was £6,500 plus VAT. This fee was in line with that highlighted within our terms of reference issued in April 2014.

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Key Messages

Key messages

	Key Message
Financial Statements and Use of Resource Opinions	We issued a satisfactory (unqualified) audit opinion on the Trust's 2013/14 financial statements and concluded that the Trust had made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2013.
Annual Governance Statement (AGS)	We reviewed the 2013/14 AGS and considered the completeness of the disclosures in meeting the relevant requirements. We also identified any inconsistencies between the disclosures and the information that we are aware of from their work on the financial statements and other work. We did not identify any significant issues in relation to the AGS.
Overall Financial Results	Financially, 2013/14 was another strong year for the Trust as it reported a surplus from operations of £2.9 million against a plan of £1.9 million. The Trust set a challenging CIP target in 2013-14 of £9.2 million, which included £7.0 million of cost savings and £2.2 million of additional revenue generation. During the year, significant challenges were noted in the delivery of these plans, with the final CIP delivery of £2.8 million. The Trust did however exceed the revenue generation target, with the outturn position at 31 March 2014 of £3.3 million. The annual plan for 2014/15 includes a total CIP target of £9 million, the majority of which has been identified by the Trust. The Trust is also reporting a robust cash position as at the year end of £20.1 million.
Accounts Production and Adjustments	We received a complete set of draft accounts in advance of the deadline set by Monitor. The quality of the working papers and the draft accounts provided for audit was high. There is one unadjusted audit difference in relation to partially completed spells. Salisbury NHS Foundation Trust do not recognise income for partially complete spells which are incomplete at year end. This is not fully compliant with accounting standards, however is consistent with prior years, and immaterial. These audit differences were discussed and approved at the Audit Committee on 23 May 2014.
Regulator Risk Ratings	The Trust's received a green governance rating and continuity of service rating of 4 for quarter 4 of 2013/14. These ratings represent the highest possible ratings in each category.
Mandated reviews	***Care Quality Commission (CQC)*** The Trust is registered with the CQC and per the CQC website, has met all the relevant standards. The Care Quality Commission has not taken enforcement action against the Trust during 2013/14. The Trust is subject to periodic review by the Care Quality Commission, with the most recent review taken place on 2 October 2013. The report reviewed staffing and records standards, with the report concluding the Trust had 'met the standard' in each instance. The latest intelligent monitoring report noted one area of elevated risk relating to Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators and a risk identified relating to Composite indicator: indicator: In-hospital mortality - Endocrinological conditions. We note that neither recommendation impacts upon our ability to issue our use of resources opinion.

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Key Messages (continued)

Key messages

	Key Message
Other work	In our audit plan for 2013/14 we identified the following key issues in relation to our audit: ■ Going Concern ■ Provisioning for non-NHS debtors / Interauthority We maintained continuous dialogue with Trust staff during the year to update our understanding of how the Trust performed in each of these areas. We provided the audit committee with an update on our work in relation to these areas in our ISA 260 report on 23 May 2014. We did not identify any significant issues that affected our conclusion on the Trust's use of resources for 2013/14.
Quality Accounts	We have completed our audit of the Trust's 2013/14 Quality Accounts. Overall, based on the work performed: ■ The Trust achieved a clean limited assurance opinion on the content of your Quality Report which could be referenced to supporting information and evidence provided. This represents an unqualified audit opinion on the Quality Report. ■ This year we tested '62 day Cancer waits' and 'Clostridium difficile' cases as the two mandated indicators. Our detailed testing on the indicators has concluded that we are able to give a clean limited assurance opinion on the presentation and recording of these. For the avoidance of doubt, a clean limited assurance opinion is the best available opinion for the external assurance on Quality Accounts. Limited assurance is driven by the scope of the work mandated by Monitor, rather than the findings. ■ Our work on the local indicator, 'number of grade two, three and four pressure ulcers', has not indicated any significant issues.
Whole of Government Accounts	We issued an unqualified Group Audit Assurance Certificate to the National Audit Office regarding the Whole of Government Accounts submission with no exceptions.

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Appendix A
Reports issued and recommendation themes

We have recorded below a summary of the audit outputs that have been delivered as part of the 2013/14 external audit process.

In addition we have summarised the main recommendations that we have identified in that period. The detail of the recommendations has been communicated to the Trust and relevant committees during the year. All recommendations were agreed with the Trust and action plans have been put in place for implementation. We will follow up progress against the recommendations made as part of our 2013/14 audit.

		Number of recommendations made		
Report	**Date issued**	**High risk**	**Moderate risk**	**Low risk**
ISA 260 Report	May 2013	0	2	6
External Assurance on the Quality Account	May 2013	0	1	0
Total		0	3	6

Title	Recommendation
ISA 260 Report	
Fixed Asset Verification	As part of our discussions around disposals of assets it was noted that there is no formal annual fixed asset verification process in place. To provide assurance that the Trust has included relevant assets in the financial statements at the period end, the Trust should look to introduce an annual verification process. This process should involve relevant departments / divisions or budget holders verifying that assets that are allocated to them still exist and are used within the relevant department. This will also help the Trust develop capital plans as they will be able to identify areas where additional assets maybe required. Given the number of assets at the Trust, management may consider a rolling verification programme, whereby a select number of areas are reviewed each year, with the aim of reviewing the whole register over a specified time period.
Timeliness of Donated Asset additions being added to the Fixed Asset Register	We tested a sample of fixed asset additions and noted that one of the additions relating to a donated asset, was donated to the Trust in March 2013 but was not added to the fixed asset register until January 2014 as the invoice had not been identified There is a risk that if assets are not identified and added to the fixed asset register in a timely manner they will not be depreciated over the correct term meaning that fixed assets in the accounts could be misstated. The assets of the Trust would also be understated which may impact on key metrics for Monitor reporting requirements and PDC dividends. We recommend that the Trust implement a review of all fixed assets donated from the charitable funds on a quarterly basis, to ensure that assets donated are captured on a timely basis and included within the Trust accounts.
Journal Authorisation	Of the sample of journals tested, one of the journals selected was noted as missing the relevant signature to confirm it had been formally reviewed. Internal audit verbally confirmed that the review had been completed, however, without the signature, there is a lack of audit trail to support this. We recommend that all journals are formally signed off as reviewed. If specific circumstances arise whereby a verbal agreement is made, the signature should be included at a later date, with supporting evidence to confirm that the journal was reviewed before it was posted into the finance system.

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Appendix A
Reports issued and recommendation themes (continued)

Title	Recommendation
ISA 260 Report	
Enhancement of Board Reporting	We have reviewed the current Board reporting against best practice from across our client base and noted a number of areas where the Trust could enhance the current reporting: • Clarity of action plans: It was noted on both the quality indicator report and finance report that where issues are identified, the relevant action plan to address the issue is not included within the Board papers. The Trust should look to incorporate the actions to address the issue, including the timetable for completion of these so the Board can hold the relevant Executive to account and monitor progress. • CIP Dashboard: Given the challenges surrounding CIP, it is common for Finance Papers to the Board to include summary information on key CIP schemes. This normally takes the form of a CIP dashboard, with schemes RAG rated to identify those that are the greatest risk to the Trust as well as those that are recurrent/non-recurrent. The Trust should consider incorporating the reporting into the monthly Board papers.
Approval of Instructions to Engage District Valuers	We have noted that no committee within the Trust reviews and approves the instructions issued to District Valuers user to revalue the PPE. We also note that details of changes made to Trust assets in the period were not formally communicated to the District Valuers in order to be used within the desktop valuation. As the revaluation can have a significant impact on the surplus for the period, the Trust needs to ensure that these instructions are robust and appropriate. To ensure the instructions provided are robust, a relevant sub-committee of the Board should formally approve the instructions prior to these being issued to the District Valuer.
Calculation of staff headcount	The ARM requires that the average WTE headcount is disclosed in the accounts. The current disclosure is calculated based on the WTE number of staff employed by the Trust in month 12 of the financial year. It is possible that this may not be an accurate reflection of the average throughout the year. The Trust should consider ensuring there are appropriate mechanisms in place to calculate the average headcount across the full financial year.
Segmental Reporting	We noted that the Trust did not report by detailed operating segments in the 2013/14, and the 2012/13 financial statements. The risk is that the Trust may not be compliant with Monitor guidance issued in the Annual Reporting Manual or the requirements of IFRS8. It is recommended that the Trust discloses results by segment in order to ensure that the Trust is in compliance with the ARM and IFRS8.
PFI Model RPI	We performed a review of the PFI model as part of our 2013/14 audit. It was noted that the model had not been updated for the current year RPI. There is a risk that this could result in the PFI disclosure in the accounts being incorrect. Although this did not have a material impact in 2013/14 we recommend that the PFI model is updated annually prior to preparing the annual accounts disclosure.

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Reports issued and recommendation themes (continued)

Title	Recommendation
External Assurance on the Quality Account	
Incorrect classification noted within 62 day cancer referral indicator	During our testing, one case was identified where a legitimate clock pause was not entered onto SCIS. The patient's wait time therefore was shown as 66 days when in fact it should have been only 47. There is a risk that the data underpinning 62 day cancer wait indicator is inaccurately reported due to the failure to correctly apply clock pauses. This may result in the Trust true performance being understated. We recommend that a weekly check of the DNA operations list against patients on SCIS is undertaken to ensure that all cases have been captured and the appropriate clock pause has been entered onto the system.

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SFT 3590

MINUTES OF THE CLINICAL GOVERNANCE COMMITTEE held at 10am-12pm, Thursday 24th July 2014 in the Boardroom, Salisbury District Hospital

Present:

Lydia Brown (Chair)	Nigel Atkinson	Steve Long
Peter Hill	Christine Blanshard	Fiona Hyett
Kate Hannam	Claire Gorzanski	Emma Taylor

In attendance:

	Item
Helena Eagles (Minute-taker)	
Frances Williamson, Jo Baden-Fuller, Shirley Kinsey, Andrew Stagg, Colette Martindale	CGC0705 & 06
Hazel Hardyman	CGC0710
Fiona McCarthy	CGC0712
Stef Scott	CGC0713, 14 & 15
Denise Major	CGC0718
Fenella Hill	CGC0716, 20 & 21
Sally Tomlin	CGC0722

Apologies:

Sarah Mullally, Mark Stabb, Fiona Coker

Lydia Brown welcomed everyone to the Committee and confirmed the meeting was quorate.

CGC0701 - MINUTES OF THE MEETING HELD ON 26th JUNE 2014

The Committee approved the minutes as an accurate record of the meeting on 26th June 2014.

CGC0702 - MATTERS ARISING/ACTION TRACKER

May 2014 CGC0507 & June 2014 CGC0607 – Quality Indicator Report

C.difficile action plan under agenda item CGC0712. Ribotyping report to come to CGC in September 2014. Complete.

June 2014 CGC0602 – Raising Concerns Policy/Whistleblowing
See agenda item CGC0703. Complete.

June 2014 CGC0608 – Dr Foster's Care Quality Tracker

In respect of the PLACE scores Trusts can appoint an external validator – their purpose is to ensure the process is followed correctly and not to influence the outcomes or scores. Scores of 100% are not validated or verified and no auditing takes place nationally – difficult to do if you claim the process is driven by patients locally. Complete.

June 2014 AOB

Terms of Reference for attendance under CGC0704. Complete.

STRATEGY

CGC0703 - Raising Concerns Survey Results

Following discussion at the Clinical Governance Committee in May 2014 it was agreed to survey members of staff to determine staff awareness. This was because there had only been one whistleblowing concern raised in 2013/14 and the Clinical Governance Committee wanted assurance that staff are aware of the policy and felt confident to use it.

A questionnaire was devised and publicised at Cascade Brief and via a broadcast email.

225 responses were received in one month (1-30 June 2014). Of these there was good representation from front-line staff.

Themes for reasons why respondents had not raised a concern were:

- Fear of reprisal/intimidation
- Not wanting to cause trouble
- Past experience of raising a concern
- Belief that nothing would be done.

Themes for reasons why respondents were not satisfied with the way their concern was raised were:

- Nothing happened as a result of raising a concern (not listened to, not taken seriously)
- No feedback
- Conduct of investigation
- Reprisal/consequences of raising a concern.

CGz – the online survey had a very good response rate. In general staff think very carefully before raising a concern due to the potential consequences.

The survey compared results to those raised by Public Concern at Work which is a charitable organisation. In conclusion our results our broadly similar to the national picture.

NA raised concern that a number of people do not know about how to raise a concern through the policy and this should be clearer within the Trust. NA suggested an HR audit trail to protect whistleblowers.

PH felt neutral towards the survey results; SFT is a courageous organisation to run the survey. We are a learning organisation. Many positives have come from the experience.

CB – the primary reason for running the survey was that we had only had one concern raised via the Whistleblowing policy. Staff are aware of the policy but need to be more confident to use it when necessary.

SL – the key message is that SFT wants to know about any problems and take action when needed.

The Committee agreed that the results could be published on the intranet in the spirit of transparency and demonstrate that learning points would be undertaken.

PH – the actions need to be progressed in a managed way. Firstly by raising awareness through Cascade Briefings and then by taking to the Executive Meeting for dissemination through the teams before going onto the intranet.

Action: CGz to progress the actions described in the survey, **CGz**

CGC0704 - Attendance of a Governor at CGC – agreeing terms of reference

The Committee agreed the terms for the attendance of a governor at CGC meetings and agreed that one should be invited to attend from September 2014 onwards.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC0705 - Core Services Report – Maternity Services

LB explained that this was the first of our new style presentations, CGC has moved away from whole Directorate presentations to concentrate on specific core services.

FW explained that today's presentation aimed to provide assurance about maternity services at SFT.
The SORT has been used by the service as a review tool and help improve performance.

FW highlighted the following:

Governance structure – maternity are proud of their governance structure and meet every month to discuss the latest guidelines and policies. Maternity has a high volume of ICID guidelines but have a robust structure to handle this.

Learning is put into place wherever possible.

GROW programme – this programme has been developed in Birmingham at the Perinatal Institute and is a customised growth chart system.

Challenges to safety – there are significant staffing challenges, the unit has been very busy and have been struggling with recruitment. Recently the Trust has taken on some new Band 5 midwives and have just shortlisted for 5 Band 6 midwives this week. The workforce is flexible but the unit has quite a high sickness rate.

Additional antenatal monitors have been purchased to increase safety for fetal monitoring.

Ultrasound programme – some concerns noted.

Safeguarding – an increase in safeguarding cases and removals at birth are challenges for staff.

Maternity dashboard - JBF discussed the maternity dashboard. SFT does not have any benchmarking figures and this has been recognised as a problem for obstetric units for some time. JBF has worked with IT to develop a system using medians and average statistics so that maternity can develop targets. As we are a small unit a slight change in numbers can change the flags from green to red.

Home birth rate – SFT has a higher than average home birth rate.

Leadership, team and commitment – a large part time workforce can be a challenge, communication can pose some issues.

Complaints – the team try to meet with any complainants early in the process to resolve any problems.

Training - The team follow multidisciplinary training and have recently been doing training around sepsis.

Army redeployment – the team are putting forward a plan to be able to cope with the increase in births.

Reputation – very good locally.

The forthcoming mock CQC inspection in September was discussed; the CQC look at maternity every time they visit. SFT could look at other CQC reports for local organisations to see how we may compare.

NA would like to see data to back up the internal assessment discussed in the report. JBF agreed that this is a challenge as there is no national data like this for maternity for SFT to benchmark against.

FHy supported the use of the SORT tool to see how the senior team assessed themselves in comparison to the workforce.

SL discussed absence management and morale. FW agreed that these were fair concerns, morale is low when the unit is busy, SFT is short of staff and the workforce would like to see action taken to remedy this. We do not know if this has affected sick leave.

CM – CSFS are undertaking a whole Directorate survey on bullying and harassment, 30% of respondents said they felt stress at work. There is a high level of anxiety regarding the new e-rostering system. The survey was based on the previous Theatres survey model.

CB asked what was Maternity's biggest concern and proudest point.

JBF noted the biggest concern is the increase in the birth rate due to forces redeployment and not having a 24 hour obstetric theatre. The proudest point is how the staff pull together.

LB thanked the team and agreed that the quality of discussion had been much better as a result of the new style presentation.

The Committee noted the report.

CGC0706 LSA Report & Local Action Plan

The report is still in draft as there are finer points regarding accuracy that the Salisbury SoM group are currently discussing with the LSA Midwifery Officer (LSAMO). Also the action plan is to be completed with actions that supervisors locally wish to complete this year.

SK reported that the LSA have a statutory responsibility to inspect annually. Some inconsistencies in the report will be followed up by SK and corrections put forward.

The report is generally positive with some improvements recommended. This year there was a target of 90% of annual reviews to be completed on the database and we have met this, next year it will be 95% of all annual reviews.

Some very good comments were received concerning the Listening Clinic. Work has been ongoing about patient information and comments taken on board. The Report felt that SFT Maternity Services could improve their website and this is now in the hands of IT. There were some comments on the building and environment but hopefully we will see improvement after the postnatal refurbishment.

The team need to be better at demonstrating we have incorporated actions from feedback.

NA felt this was a very good report.

PH would like to have the final LSA report ready for the CQC mock inspection in September and SK will follow this up.

The Committee noted the report.

CGC0707 Spinal Unit Leadership

KH provided a verbal update on progress since Trust Board. Nicky Ward from Systems Thinking Team has been here for 2 weeks on a shadowing and scoping exercise which will take 4 weeks in all. The team have been very engaged and positive and a step change in leadership has been noted. A visit to Stoke Mandeville has also taken place and there is now good interest in the accreditation programme.

The team are grateful we are moving forward.

The next Clinical Governance Half Day has been set aside to talk about the next steps.

SL asked about consultant engagement. KH replied that they are being shadowed and there will be coaching where necessary and honest feedback. KH will follow up with the consultants.

The Committee noted the update and agreed this matter should keep returning to CGC to see progress.

CGC0708 Nursing, Midwifery & AHP Strategy Update

FHy provided a verbal update; the DSNs have given some initial feedback but the feedback and activity plan will come to CGC with the main report in November.

The Committee noted the update.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC0709 - Friends & Family Update

FHy – the Friends & Family test now must include staff. There has been a lot of recent activity and it is challenging to keep momentum and staff engagement high and ensure the targets are being met. We have tried to be innovative in finding ways to keep response rates up.

CGz – the new FFT guidance has just been released but will only offer a few real changes. The biggest change will be the inclusion of feedback from children and

young people. More demographic information will also have to be collected in future. We need to do more work to encourage areas to display their comments.

It is good that outpatients and day cases will not have a target set against them.

The Friends & Family App was discussed – there is a difficulty in that it cannot be used on site due to our IT infrastructure and lack of wifi. The app would have to be downloaded before visiting the hospital. Other Trusts have reported that feedback via the website and app has been low.

The Committee noted progress with the Friends and Family Test (FFT) for inpatients, the Emergency Department and Maternity Services and noted the commencement of FFT for outpatients, day cases and staff.

CGC0710 - Annual Customer Care Report 2013/14 and Complaints Survey

HH – the past year has been challenging for Customer Care and we have not met the 3 day acknowledgement of a complaint in Q3 & Q4. This has been reinforced to the team and personal objectives have been set.

The partial booking system has been responsible for some complaints.

6 out of 10 complaints passed to the Ombudsman have not been upheld so far.

There is some work to be done with night-time noise from the laundry and nurses on the wards – reminders have been sent to ward leaders.

The backlog has been cleared and the Patient Experience Facilitators are now being encouraged to do more frontline patient experience work rather than administration.

Elaine Willman will be leaving SFT in September.

CB – the report itself is much better and more informative but was a little short on recommendations as a result of the survey.

HH will progress chase Education regarding the MLE problems with the Customer Care online module.

The work that is being done to improve the numbers of people who were happy with the way their complaint was resolved was discussed and LB asked for assurance that the work of the Transformational Programme is not negatively affecting patients.

Action: KH will bring a report to CGC in September to discuss the Quality Impact Assessment for the Cost Improvements/Transformation. **KH**

The Committee noted the content of the report.

CGC0711 - Food & Nutrition Annual Report

The report updated the members of both CMB and CGC on the achievements in Food and Nutrition across the Trust and reported on the work of the Food and Nutrition Group to provide assurance on the function of the group through evidence of progress against the 2013/14 work plan and outline the work plan for 2014/15.

The following papers are circulated:

- Annual Report Summary – gives an overview of the meeting structure, meeting membership and frequency of meetings. Also highlights key achievements and challenges during 2013/14
- End of Year Update on 2013/14 Food and Nutrition Work Plan which identifies those actions completed and those still in progress
- Areas of challenge and the new Work Plan for 2014/15

FHy explained that the Food & Nutrition Steering Group is now just one main, monthly meeting – rather than having a separate working group. Task and finish groups are arranged as necessary.

There is some good feedback from Whiteparish and initiatives on ensuring patient weights are recorded.

The new hot trolleys are being rolled out in September and this should help with food temperature.

The volunteer feeding rota is a problem and more volunteers are needed to keep this going.

Mealtime observations are going well and HE and FHy have been working hard to get feedback from ward leaders on any issues raised.

FHy asked for support from DSNs yesterday at CMB to discourage doctors from interrupting patients when they are mid way though their meals.

Projects in the pipeline include adapted cutlery which we hope will be successful in the same way as the blue plates for dementia patients.

FHy has started to map objectives in the work plan against the CQC requirements as we move forward.

The Committee noted the content of the report.

ASSURING CLINICAL EFFECTIVENESS

CGC0712 - Quality Indicator Report Q1 2014/15 including C.difficile action plan and MRSA bactaeremias

- 8 cases of C Difficile against an annual target of 18 cases.
- 5 MSSA bacteraemias.
- 6 new serious incident inquiries.
- A decline in the crude mortality rate from Q4 13/14. HSMR is 99 in March 14 and is as expected. Anticipate up to an 11 point rise in September/October 14 when figures are rebased. Sepsis Six is the key improvement action.
- An increase in grade 2 pressure ulcers compared to Q4 13/14. Two grade 3 pressure ulcers in Q1. No clusters identified.
- Safety Thermometer – 87 - 90% ‘harm free care’. An increase in new hospital acquired pressure ulcers.

- Six fractures of which four resulted in moderate harm and two resulted in a fractured hip.

- Fractured hip patients being operated on within 36hrs remains below target. The 'golden patient' initiative has been reinstated. A new quarterly measure of compliance with the best practice tariff introduced.

- Inconsistent performance on the stroke 4 hour target due to ED pressures and stroke unit capacity. Patients spending 90% of their time on the stroke unit ranged from 88 to 96%. This was due to patients being moved off the stroke unit for bed capacity reasons or late inpatient referrals. An improvement in CT performance within 12 hours and high risk TIA referrals seen within 24 hours.

- Escalation bed capacity has gradually decreased and ward moves remain low. Four non-clinical same sex accommodation breaches in Q1.

- Real time feedback showed patients felt they were treated with care and compassion and rated the quality of care as good. The Friends and Family test response rates improved in inpatients and ED but dipped in the Maternity Services.

FHy, CB and FM spoke to this item. FHy informed the committee there had been an MRSA bacteraemia case in July.

There have been challenges regarding colonisation on PEG lines and the wards have been asked to do some work.

Pressure ulcers remain low.

There was a Cluster Review last week and any learning will be fed back to ward leaders.

Fractured hips – the golden patient initiative has been reinstated. The specials spend last month was the lowest ever but we must ensure that this does not correspond with an increase in falls.

The mortality figures are under 100, figures will be rebased in the autumn. There are some adverse events showing on the Global Trigger Tool regarding PICC line infections and we will be doing a piece of work on this to make improvements. SFT is still using escalation capacity even though it is July and we remain very busy.

FHy and FM ran through the C.difficile action plan which falls under four main headings; this was produced following the CCG's critical friend report.

The CCG felt we had good policies but tended to focus on the management of C.difficile rather than preventing the event – the policy will be adapted.

Antibiotic prescribing was discussed as the C.difficile action plan recommends that antibiotic policies are reviewed to ensure best practice is being followed. ET assured the group that this is occurring on an ongoing basis via the Antibiotic Reference Group but perhaps work is needed to improve the way this review process is recorded and reported and that policies need to be better referenced.

Fortnightly antibiotic stewardship audits show that practice is in general good but

improvements are still needed with regard to documentation of stop and review dates. This being addressed by the ARG and in the longer term the introduction of an Electronic Prescribing system will be of help.

Isolation policy – in other organisations patients who are suspected to have C.difficile are admitted directly Into a side ward. Alongside this staff need to feel empowered to make decisions without always waiting for Infection Control.

Action: Steve Cotterill is writing a report on ribotyping results and this will be brought to CGC in September. **SC**

The handwash supplies were discussed.

Work will be done for use of different coloured aprons to wear in different areas of the wards – if hygiene practice is not being observed this will make it easier to challenge.

CB noted some issues with antibiotic prescribing as we do not have clinical guidance to follow for all highly infectious conditions.

ET responded that we do have robust antibiotic guidelines in place detailing antibiotic choice and course length for most infective conditions however the issue appears to be around the diagnostic process - the support of CB to address this was requested.

CB agrees this should be worked on.

CGC0713 - Annual Research & Development Report

The Annual Report describes the contribution that the Trust has made towards the NIHR CRN high level objectives.

SS reported on another successful year for Trust research.

Highlights for the Trust during 2013/14 include:

- Meeting the following targets on time or ahead of schedule:
    - increased percentage of Trust projects that are eligible for the NIHR CRN portfolio (this is a marker of quality) to 93%
    - more than quadrupled recruitment into NIHR CRN portfolio studies over the last 5 years;
    - maintained the proportion of commercial contract portfolio research;
    - the median time taken issue NHS permission to proceed through CSP for NIHR studies to 23 days, with 79% of projects approved within 30 days;
    - 10 clinical trials involving medicines were monitored and audited;
- The targets to reduce the time taken to recruit the first study participant and recruitment to time and target were not met. This is largely for reasons beyond the Trust's control, but remain a key areas for development;
- Targets have been set for 2014/15 relating to consolidation of the above, and to meet the revised NIHR targets.

SS explained that the action plan was ratified at Clinical Management Board yesterday. SFT needs to be wary that there is a financial challenge as we will not be able to find such a high recruiting study this year.

LB confirmed that CGC ratified the action plan for 2014/15.

The Committee noted the report.

CGC0714 - Research Support Service Framework

The National Institute of Health Research (NIHR) published the Research Support Service (RSS) Framework in January 2001. In March 2011, CMB and CGC approved and ratified an R&D Operational Capability Statement (RDOCS) version 1.0 for the Trust and agreed that CGC would review updated RDOCS on an annual basis. The RDOCS has been updated for 2014/15 (version 4.0 circulated prior to the meeting.).

The Committee noted the report and approved approved the Trust R&D Operational Capability Statement v4.0.

CGC0715 -Trust Policies for Research

SS asked the Committee to consider and ratify the revised policies for:

- Income Distribution from Commercial Research Policy
- Research Governance Policy
- Research Sponsorship Policy
- Research Misconduct & Fraud Policy

All policies were ratified at CMB yesterday.

There was some discussion at CMB about the policies, particularly the Income Distribution Policy and CMB were pleased that it explains how income is dealt with so explicitly.
LB agreed that the Committee ratified the policies.

LB congratulated SS and her team on their achievements over the past year.

The Committee noted the items.

CGC0716 – Assurance Framework

The Assurance Framework must be reviewed and updated quarterly by the delegated Assurance Committees to ensure that scrutiny is applied to assure the Board that the Trust's principal risks are being managed and controlled effectively in order for the corporate objectives to be achieved.

A Trust Board reporting template was circulated identifying key changes since the last meeting. Those changes are also highlighted in red within the main body of the document

The Trust Risk Register (extract of clinical risks scoring 12 and above) was submitted for reference so that the Assurance Committee can either be assured that specific risks are being managed effectively locally or if not to identify how this may be ascertained.

FHi highlighted C.difficile, Safeguarding, and DoLS and explained there is a lot of background work going on at SFT at present.

LB stated that CGC accept the risks and are assured.

The Committee noted the report.

CGC0717 - New Procedures Report

CB explained that there were 4 new procedures and all procedures have been carried out with no adverse events. 2 procedures are on hold but are approved.

The Committee noted the report.

ASSURING SAFETY

CGC0718 - Safety Plan including Safety Thermometer

Safety Thermometer:

The monthly completion data collection and analysis is a requirement of the 2013-14 CQUIN for patient safety. The Trust is expected to achieve a 30% reduction in new pressure ulcers during this year. The focus on reduction in pressure ulcers will continue as part of CQUIN for 2014-15 but will require working with services external to the Trust.

- A continued 100% compliance with data reporting with current plans to provide a reporting process for wards to be able to monitor trends and further review of individual patient episodes for learning
- The percentage of harm free care is between 87.56% and 92.40%. There does not appear to be consistency with decreased percentage and increase in activity (from this data specifically)
- Further discussion required at Nursing, Midwifery and AHP Forum regarding use of the dashboard

DM reported that it is challenging to pull this report but IT have worked on a solution to gather the data to produce an overall picture. This is a snapshot for a day and there does not seem to be any issues with compliance. The real focus is around the pressure ulcer CQUIN and the new safety system which will be brought in when Lorna Wilkinson joins SFT as our new Director of Nursing.

PH – there are 2 new safety programmes that SFT will be involved in. The first is led by the Academic Health Service Network and is called Patient Safety Collaborative. LW has been involved in its establishment and will lead this scheme at SFT. The second system is Sign Up to Safety which has more of a political edge and is led by Jeremy Hunt. A pilot will be done with 12 Trusts across the country.

SL questioned whether the Safety Thermometer adds value. DM responded that the data is useful for the ward sisters and since Informatics developed the dashboard it is much easier to compare ward performance against each other and the system now links to PiMS. It is difficult to benchmark against any other Trusts.

Safety Plan:

All interventions have made progress. We remain one of the only organisations using the Extranet to enter data monthly. The Committee is asked to note the following:

- The work continues reporting on >60 datasets monthly to the Extranet. This allows us to track progress over time.
- The Critical Care work stream is well established and continues sustaining changes to practice.

- The perioperative continues demonstrating compliance with all sections of the WHO checklist in both Day Surgery and Main Theatres.
- The Medicines Management Group continues to collect data around medicine reconciliation data from all wards.
- The General Ward Group continue with challenges with achieving reliability across all ward areas with the SKIN bundle and Intentional Rounding. Work on the Urinary Catheter Care insertion bundle continues to be rolled out across the organization. The Ongoing Catheter Care Bundle continues to be held up by the wait for the revised Daily Management Plan.
- Work on the Sepsis 6 implementation has begun in ED with Martin Cook leading on this intervention
- Work on central venous catheter on-going care bundle has begun on one ward.

Key Next Steps:

- Continued roll out of the Urinary Catheter Insertion Bundle
- Launch of the updated Daily Management Plan to support introduction of the On-going Catheter Care and peripheral venous cannula bundles
- Implementation of the Sepsis 6 bundle in ED
- Compliance with risk assessments for falls and pressure ulcers within the Medical Directorate
- Compliance with Intentional Rounding and SKIN Bundle within the Medical Directorate
- Review of the peripheral cannula insertion and ongoing care bundles by Infection Control
- Central venous catheter on-going care bundle spread to other key general wards

FHy highlighted the changes that will come into the Safety Plan over the forthcoming months and explained that Sign Up to Safety looks broadly similar.

The Committee noted the reports.

CGC0719 – Learning Disabilities Mid-year Report

The work plan was circulated prior to the meeting.

Key achievements:

- Easy Read menus have been a benefit to many patient groups, not just Learning Disabilities
- LD flagging on PiMS
- Reduction seen in complaints and calls related to LD

Challenges:

- Information sharing process with CTPLD to support flagging of patients continues to challenge
- Clinical representation on the LDWG
- Transition 'Named Consultants' unlikely to develop, looking at a 'Buddy System' used at the Royal Marsden

FHy explained that Gill Cobham will be off for a short while and Katrina Glaister will take over chairing the group.

There have been 2 or 3 freedom of information requests recently asking about SFT's provisions for learning disability patients recently.

There is funding in place for a named nurse to work on the 'Buddy System'.

The Committee noted the report.

CGC0720 – SII/CR Report Q1

Updates since May 2014 CGC to outstanding recommendations:
CR 94 - All recommendations completed
CR 104 - All recommendations completed
CR 107 - All recommendation completed
CR 108 - Recommendations 1-6 completed
SII 127 - Recommendations 1, 3-6 and 8 completed
SII 128 - Recommendation completed
SII 131 - Recommendation completed

Reviews with outstanding recommendations:
CR 106, CR 108, SII 127, SII 129

Reviews with recommendations added to Department/Directorate Risk Register
Nil

New Recommendations since May 2014 CGC
CR 107 (CS&FS) , CR 108 (Surgery/MSK) , SII 127 (CS&FS), SII 128 (Medicine), SII 129 (Medicine), SII 130 (MSK), SII 131 (Medicine), SII 132 (Medicine).

Serious Incident Inquiry/Clinical Review for Closure
CR 94, CR 104, CR 107, SII 128, SII 130, SII 131, SII 132.

FHi discussed the report and highlighted the items above.

The Committee noted the report.

CGC0721 - Never Events 2013/14 NHS England Interim Report.

The Never Events 2013/14 NHS England Interim Report was presented. Although there had been no Never Events reported at SFT during this period the opportunity was taken to review recommendations made and actions taken as a result of reported Never Events in the previous year (2012/13). Evidence confirms these changes are still in place and since November 2012 no further incidents have been classified as Never Events. An Assurance Review of Management of Serious Incidents has been completed by Internal Audit and an overall assurance assessment of substantial assurance given.
The Committee noted the report.

CGC0722 - Medication Safety Report

The report highlights areas of work being undertaken in the Trust to deliver the national, regional and local agendas regarding medicines management.

The report details the latest work undertaken by the Antibiotic Reference Group, the Medicines Safety Group and the Medical Gas Group. It also sets out information on a number of medicines related audits and activities underway to manage medicines risk effectively within the Trust. The report also provides a resume of recent national publications regarding medicines and the local implications of these.

ST highlighted the recruitment of a pharmacist to help with homecare medicines – this has made a big difference. ST is particularly pleased with the link with Southampton for the Medicines Information Service – outsourcing this has been a success.

The Committee discussed missed doses. 25 doses were unaccounted for where the chart was left blank and the issue has been taken to the Nursing and Midwifery Forum and picked up under clinical reviews. 25 missed doses is a very small number considering the number of patients SFT treats but is still a concern. It is thought that agency staff who are not familiar with the fold out flap in the drugs charts may have been involved in the unaccounted doses.

FHy reported that the Electronic Prescribing System will help.

The Committee noted the report.

PAPERS FOR NOTING

The Committee noted the following:-

CGC0723 Clinical Risk Group Minutes (May 2014)
CGC0724 Clinical Management Board Minutes (June 2014)
CGC0725 Information Governance Group (no meetings since Feb 2014)
CGC0726 Infection Prevention & Control Committee Minutes (April 2014)
CGC0727 Children & Young People's Quality & Safety Board (June 2014 minutes will come to CGC in September 2014)

CGC0728 - ANY OTHER URGENT BUSINESS

The Committee agreed that a governor would be invited to the next meeting in September.

Dr Elizabeth Stanger was invited to a CGC meeting on a one-off basis but since the meeting Dr Stanger has contacted HE and confirmed she would like to attend a Clinical Governance Half Day session rather than a CGC meeting.

Action: CGz to liaise with Colette Martindale to invite the Children & Young People's Service team to present their core service report in September 2014. **CGz**

FHy raised the NHS Choices website and explained that SFT has a red flag for infection control and cleanliness; this relates to our C.difficile figures over the past 3 months and last year's PLACE audit. When the figures refresh next time the MRSA bacteraemia will cause a red flag. We do not know where we are benchmarked nationally for the latest PLACE audit. The earliest the red flag can be removed is November 2014.

Action: HE to circulate the 2015 meeting dates. Post meeting note – action complete. **HE**

NEXT MEETINGS

Thursdays, 10am-12pm, Boardroom.

- 25th September 2014
- 23rd October 2014
- 27th November 2014

- 29th January 2015
- 26th February 2015
- 26th March 2015
- 28th May 2015
- 25th June 2015
- 23rd July 2015
- 24th September 2015
- 22nd October 2015
- 26th November 2015

PAPER - SFT 3591

MINUTES FROM THE COUNCIL OF GOVERNORS MEETING HELD ON 21 JULY 2014

PURPOSE

To present these approved minutes to the Board for information as to issues discussed by the governors.

MAIN ISSUES

The Council received updates on key capital developments and heard from the Trust's Appointed Auditor, KPMG.

ATTACHMENTS AVAILABLE TO VIEW ON WEBSITE

The draft minutes from the Council of Governors meeting held on 21 July 2014.

ACTION REQUIRED BY THE BOARD

To note the minutes of the Council of Governors meeting held on 21 July 2014

Nick Marsden
Chairman

SALISBURY NHS FOUNDATION TRUST

Minutes of the Council of Governors Meeting – Part 1
At Salisbury District Hospital
Held on Monday 21 July 2014

Governors Present:	Sarah Bealey John Carvell Mandy Cripps Brian Fisk Shaun Fountain June Griffin Chris Horwood Raymond Jack Alastair Lack John Markwell Nick Marsden (Chairman) Colette Martindale (Lead Governor) John Noeken Carole Noonan Beth Robertson Katherine Saunders Janice Sanders Nick Sherman Lynn Taylor Lynda Viney Chris Wain Christine White	**Apologies:**	Mary Mornington Rob Polkinghorne

In Attendance:
Peter Hill (Chief Executive)
David Seabrooke (Head of Corporate Governance)
Isabel Cardoso (Membership Manager)
Lydia Brown (Non-Executive Director)
Nigel Atkinson (Non-Executive Director)
Steve Long (Non-Executive Director)
Rees Batley (KPMG)
Jonathan Brown (KPMG)
Claire Gorzanski (Head of Clinical Effectiveness)
Fiona McCarthy (Senior Nurse, Infection Control)
Laurence Arnold (Director of Corporate Development)

ACTION

1. ANDREW FARROW

Governors joined the Chairman in holding a one minute silence in the memory of Andrew Farrow who had died earlier in July.

2. WELCOME

The Chairman welcomed Jan Sanders, Katherine Saunders and Lynn Taylor to their first Council of Governors meeting since being elected.

3. MINUTES

The minutes of the meeting of the Council held on 12 May 2014 were agreed as a correct record.

4. CONFIRMATION OF DEPUTY LEAD GOVERNOR

The Council was reminded that Beth Robertson had stood down as Deputy Lead Governor from 30 June. The Lead Governor proposed to accept a nomination from Alistair Lack to serve as Deputy Lead Governor until the next Lead Governor is selected in spring 2015.

It was agreed unanimously to support Alistair Lack as Deputy Lead Governor.

(Alastair Lack left the meeting during the consideration of this item and the voting thereon.)

5. TRUST PERFORMANCE TO 31 MAY (MONTH 3)

The Council received the Performance Report for June 2014.

PH highlighted the following principal points:

- A&E had been seeing record attendances and was performing slightly below the four hour target.
- On C Diff the Trust's ceiling was 18 cases for the year and there had been eight in Quarter one.

Fiona McCarthy the Trust's Senior Infection Control Nurse described the actions taken in response to this which included a Critical Friend review in June by West Hampshire and Wiltshire CCGs and a review by the Clinical Governance Committee.

Recommendations had arisen relating to policies, cleaning and training.

In relation to a question from Raymond Jack about 62 day cancer waits it was noted that the complexity of diagnosis and patient choice could be factors affecting the Trust's performance.

In response to a question from Alastair Lack it was noted that the availability of beds in the hospital and the volume of patients in the minors area of A & E had been especially high. It was noted that the results of the next PLACE Audit would be undertaken in September.

Concerns were expressed about the condition of the overhead matrix structure of the Level 4 carousel and whether this could be a source of contamination for equipment passing through there. Equipment should not ideally be stored in corridors and anything retrieved from this for use should be cleaned first.

It was noted that there had been concerns among GPs locally about the rate for wound infections for some hospital procedures. It was noted that of 72 knee operations, four cases had experienced superficial infections approximating to 5.5% however there had been no significant wound infections and the Infection Control Team were not unduly

concerned. The Trust's Orthopaedic Surgeons had been made aware of these concerns.

The Council noted the performance report.

6. FINANCE REPORT

The Council received the Finance Report to 31 May 2014.

It was noted that the Trust was generally working to plan, however the small surplus generated could easily be cancelled out by, for example, agency usage. At present, CIP were meeting targets. The Council received a general update on the progress with the main transformation programmes. More schemes needed to be generated to deliver the £9m saving targets.

Peter Hill undertook to invite Kate Hannam to present to the next meeting of the Council of Governors on capacity issues. It was noted that the Trust was looking at demand and capacity in orthopaedics. PH/KH

The high number of delayed Transfers of Care remained a problem for the Trust.

The Council noted the report.

7. UPDATES ON SOUTH SIDE AND CT SCANNER

Laurence Arnold attended for this item and described the continuing tender process between two specialist firms that would complete later in 2014. It was requested that further updates be given to the Strategy Sub Group.

The first CT scanner was scheduled to arrive at the end of August followed by building work to remove the old one, followed in turn by the arrival of the second one at the end of October. It was planned that by early December 2014 the project would be completed.

It was noted also that the Springs entrance redevelopment would starting in January and was expected to run for 32 weeks. There had been no firm interest in the retail opportunity available in the design so far. It was also noted that the Springs Restaurant would remain open during the refurbishment period.

8. CUSTOMER CARE REPORT - QUARTER FOUR

The Council received the Quarter Four Customer Care Report. It was noted that the biggest single complaints category continued to be clinical treatment. Other principal points made were as follows:

- The rollout of the Trust's new Values and Behaviours was continuing.
- The Trust's overall rate of complaints was comparatively low.
- Complaints were frequently used as feedback to improve the Trust's services.

FH

There was a concern that the Trust's Customer Care on-line training remained unavailable on the intranet and this had been the case for some time.

In relation to a question about the availability of nurses on wards at night it was noted that the Board had agreed a £1m investment to improve nurse staffing levels.

9. KPMG

Rees Batley and Jonathan Brown from KPMG attended for this item and the Council received a summary of the Audit finding, external assurance on the Quality Report and Annual Audit Letter for 2013/14.

Jon Brown apologised for the use in places of 'boilerplate texts' in some parts of the report but this was due to pre-set wording required in the guidance applicable to the audit process.

He informed the Council that the audit of the accounts had been completed in line with the plan and had resulted in minor recommendations only. The Quality Report was singled out as one of the best that KPMG had seen from their client base. In relation to challenges facing the Trust the delivery of CIP was a challenge and a number of other high risk areas for attention were set out in the report. John Brown highlighted future changes to the format of the Quality Report. He highlighted the recent review of ten challenged health economies and a recent review by Monitor of 'smaller' hospitals.

Nigel Atkinson, as Chairman of Audit Committee echoed a number of the points raised.

The Council received the Summary of Audit Findings, External Audit on Quality Report and Annual Audit letter.

10. 2013 INPATIENT SURVEY RESULTS

The Council received a report setting out results of the 2013 Inpatients Survey.

Claire Gorzanski highlighted the high response rates from both Maternity and Inpatients and the Council was reminded that at the time this survey was taken the main kitchens were under refurbishment and the weather had been extremely hot.

The Council noted the 2013 Inpatients Survey Results.

11. PROCESS FOR ELECTION OF LEAD GOVERNOR

The Council received a proposal for a revised process for the selection and tenure of the Lead Governor and Deputy Lead Governor. It was agreed that Governors should give their views to the Lead Governor by email. The report also highlighted the need for an addition to the

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Governor's Standing Orders to allow explicitly for the amendment of the Standing Orders. This amendment was agreed.

12. FEEDBACK FROM INFORMAL MEETING OF GOVERNORS AND NON-EXECUTIVE DIRECTORS HELD ON 16 JUNE 2014

The Chairman indicated that he would give further feedback on the issues raised at the next informal meeting to be held on 11 August. The notes of the West Wiltshire Constituency Meeting held in Warminster on 13 May were received.

13. WORKING GROUP REPORTS

The Council received the notes of the Membership and Communications Group on 30 April, notes from the Staff Governors Engagement Event in Hedgerows on 26 June, the Strategy Working Group held on 1 May and Patient Experience Sub Group Reports in respect of car parking, hospital noise, information for patients and relatives on parking and traffic management issues and the Signage Group on 15 May 2014.

14. DATES OF FUTURE MEETINGS

The Council received a note setting out the remaining informal meetings with the Chairman and Non-Executive Directors, Development Session, AGM and Public Meetings of the Trust Board. The next full meeting of the Council of Governors would be on 24 November.