SALISBURY NHS FOUNDATION TRUST

TRUST BOARD

MONDAY 8 AUGUST 2016, 1.30 PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
1.30pm	**1**	**APOLOGIES FOR ABSENCE**			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES** Public Board Meeting held on 6 June 2016			1
	4	**MATTERS ARISING**			
1.35pm	**5**	**CHIEF EXECUTIVE**			
		1. Chief Executive's Report	PH	SFT 3789	9
1.45pm	**6**	**STAFF**			
		1. Workforce Performance Report to include Nurse Staffing	AK/LW	SFT 3790	11
		2. Annual Equality and Diversity Report	AK	SFT 3791	37
2.00pm	**7**	**PATIENT CARE**			
		1. Quality Indicator Report to 30 June (month 3)	CB/LW	SFT 3792	61
		2. Customer Care Report – Quarter 4	LW	SFT 3793	69
		3. Skill Mix Review	LW	SFT 3794	83
		4. National-In-Patient Survey Results	LW	SFT 3795	109
		5. Update on Progress of Medical Revalidation	CB	SFT 3796	173
2.30pm	**8**	**PERFORMANCE AND PLANNING**			
		1. Finance & Performance Committee Minutes 31 May and 27 June 2016	NM	SFT 3797	185
		2. Financial Performance to 30 June (month 3)	MC	SFT 3798	193
		3. Progress against Targets and Performance Indicators to 30 June (month 3)	AH	SFT 3799	203

		4. Update on Strategic Planning and Programme Management	LA	SFT 3800	207
3.00pm	**9**	**PAPERS FOR NOTING OR APPROVAL**			
		1. Annual Report of the Remuneration Committee	NM	SFT 3801	215
		2. Audit Committee Minutes - 20 May 2016	PK	SFT 3802	217
		3. Clinical Governance Committee minutes – 19 May & 23 June 2016	LB	SFT 3803	221
3.45pm	**10**	**ANY OTHER URGENT BUSINESS**			
	11	**QUESTIONS FROM THE PUBLIC**			
	12	**NEXT MEETING**			

The next public meeting will be held on Monday 3 October 2016, 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 6 June 2016

Board Members Present:	Dr N Marsden	Chairman
	Mr P Hill	Chief Executive
	Ms T Baker	Non-Executive Director
	Dr C Blanshard	Medical Director
	Dr L Brown	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
	Mr I Downie	Non-Executive Director
	Mr A Hyett	Chief Operating Officer
	Mr P Kemp	Non-Executive Director
	Mrs A Kingscott	Director of Human Resources and Organisational Development
	Mr S Long	Non-Executive Director
	Mrs K Matthews	Non-Executive Director
	Ms L Wilkinson	Director of Nursing
Corporate Directors Present:	Mr L Arnold	Director of Corporate Development
In Attendance:	Mr P Butler	Head of Communications
	Mr D Seabrooke	Secretary to the Board
	Mr P Lefever	Wiltshire Healthwatch
	Mr N Alward	Public Governor
	Mr M Mound	Public Governor
	Sir R Jack	Public Governor
	Dr A Lack	Lead Governor
	Dr J Lisle	Public Governor
	Dr B Robertson	Public Governor
	Mr R Polkinghorne	Appointed Governor
	Mrs L Taylor	Public Governor
	Dr J Hemming & Mrs F McCarthy	for SFT 3774

ACTION

2176/00 DECLARATIONS OF INTEREST AND FIT AND PROPER/GOOD CHARACTER

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

2177/00 MINUTES - 4 APRIL 2016

The minutes of the meeting of the Board held on 4 April 2016 were agreed as a correct record. The minutes of the Joint Meeting of the Board and Council of Governors held on 29 February 2016 were agreed as a correct record.

2178/00 MATTERS ARISING

The Chairman welcomed newly appointed Non-Executive Directors Kirsty Matthews and Tania Baker to their first Public Board Meeting.

2179/00 CHIEF EXECUTIVE'S REPORT - SFT 3770 – PRESENTED BY PH

The Board received the report of the Chief Executive.

The report highlighted the Care Quality Commission Report which had been published in April shortly after the last Board meeting. The CQC had highlighted issues around staffing ratios, patient documentation and an action plan was in place to address this range of issues which was on the agenda for further consideration by the Board.

The Adult Community Services would be starting on 1st July 2016. A Chair of Wiltshire Health and Care, the joint venture with the Trust, Bath and Swindon that would be delivering the contract had been appointed.

The Sustainability and Transformation Plan for Wiltshire, Bath and Swindon was progressing and a check point submission would be made at the end of June to NHS England.

Over 70 job offers had been made as a result of the recruitment campaign in the Philippines and those taking up post would be scheduled to start arriving in November and December. These experienced nurses would have the skills required for areas where the Trust found it difficult to recruit to such as theatres, and elderly care and the Spinal Unit.

The Trust had received a Queen's award for voluntary service in respect of the Engage initiative.

The Board noted the Chief Executive's report.

2180/00 STAFF

2180/01 Workforce Performance Report including Nurse Staffing - SFT 3771 - Presented by AK & LW

The Board received the Workforce Performance Report for month 1.

It was noted that nurse recruitment from Italy was currently underway. Turnover was around 11% - 150 registered nurses had been recruited and 84 had left through the year.

The Trust continued to work with the agencies to implement the final phase of the agency cap. It was also working with medical agencies to put in place a master vendor arrangement. Sickness levels were steady at 3.2%. Appraisal compliance had moved on to a reported 71% which had recently improved to 75% - the target remained 85%. A new requirement for staff to undertake safeguarding adults training had been introduced recently. The content of the workforce dashboard was currently being reviewed.

The Trust continued to review the sickness absence numbers in detail to identify any hotspots. No quality issues in relation to the implementation of the national agency caps had been reported.

The Nurse Staffing Report showed a generally satisfactory position and work was taking place with the provider of the Allocate system to provide better information on staffing numbers in relation to bed occupancy rates. There were a number of super numery staff on Whiteparish Ward affecting the report.

The Board noted the report.

2180/02 Voluntary Services Annual Report – SFT 3772 – Presented by AK

The Board received the Voluntary Services Annual Report for 2015/16. It was noted that the Royal Voluntary Services were no longer able to provide services in the Trust due to the reduction of volunteer numbers.

There had been 190 applications to be volunteers received during the year. The Trust continued to encourage volunteers to become members of the foundation trust. Pearl James had been elected as the Volunteer Governor during the year and had proven to be a great advocate for this constituency. The report described the winners and runners up in the Annual Staff Awards Volunteers category.

The Board noted that Friday 10 June was Volunteer's Day and all Board members were invited to afternoon tea at 2 pm in the Boardroom.

It was also noted that the recycling team were supporting the Save 7 initiative by enabling departments to check for available recycled equipment before new equipment could be purchased.

The Board noted the report.

2181/00 PATIENT CARE

2181/01 Quality Indicator Report to 30 April 2016 (Month 1) – SFT 3773 - Presented by CB and LW

The Board received the April Quality Indicator Report.

There were four new Serious Incident Inquiries commissioned in April, with a further seven in May. Hospital Standardised Mortality Rate had decreased to 109 in January 2016 and was higher than expected.

28% of in-patients were assessed as Green to Go. There were 41 Delayed Transfers of Care in the hospital which caused pressures on a range of hospital services.

There had been no non-clinical mixed sex accommodation breaches.

The Trust was reviewing deaths in the hospital and assessing whether these were avoidable. There was no nationally agreed methodology for these assessments.

The Board noted the Quality Indicator Report.

2181/02 Report of Director of Infection Prevention and Control – SFT 3774 – Presented by LW

The Chairman welcomed Fiona McCarthy and Julian Hemming to the meeting.

The annual report informed the Board of progress made against the Infection Control Annual Action Plan and provided significant assurance to the Board that infection prevention and control was being managed effectively in the Trust.

It was noted that during 2015/16 there had been two outbreaks of norovirus. There had been no MRSA bacteraemia cases during the reported period and there had been 15 trust apportioned C-Difficile cases which was within the ceiling of 19 cases.

The national PLACE assessment had taken place in Quarter 1 which had shown improvement across all areas of the Trust and was above national average figures. Hand Hygiene compliance audits had been continuing through the year and there had been some areas of poor compliance in relation to patients surroundings. All Results had been fed back to clinical leaders.

There were regular audits on antibiotic compliance. A challenging CQUIN, in terms of current resources, was in place for 2016/17.

The Board noted the report and the assurance provided and acknowledged its collective responsibility to oversee effective infection prevention and control in the Trust.

2181/03 CQC Action Plan and Progress Report – SFT 3775 – Presented by LW

The Board received a summary of the arrangements in place to oversee the delivery of the CQC Action Plan which had been submitted at the beginning of May. Each of the core areas of service had addressed the recommendations in the report and there was a Trust wide action plan as well.

Responsibility for the core areas was assigned to each clinical directorate as follows –

Musculoskeletal (MSK) – Spinal, Surgery (Part)
Surgery – Surgery, Critical Care, Outpatients
Children and Family Support – Children and Young People, Maternity and Gynae diagnostics
Medicine – Medical Care, Urgent and Emergency Care, End of Life Care

The action plan was being monitored via the directorate performance reviews through presentations to the Clinical Governance Committee and Joint Board of Directors and via dedicated reports to the Clinical Governance Committee which it was agreed it would be submitted on a quarterly basis. Any exceptions would be escalated to the Trust Board.

In addition to the above arrangements there were fortnightly meetings with the Musculoskeletal Management Team to progress the actions identified in a separate action plan which had been previously submitted to the CQC in response to the warning notice in relation to Spinal Outpatients and Video Uro-dynamic studies received in January.

The Board noted the report and governance arrangements.

2182/00 PERFORMANCE AND PLANNING

2182/01 Finance & Performance Committee Minutes - 21 March and 25 April 2016 – SFT 3776 – Presented by NM

The Board received for information the minutes of the Finance and Performance Committee for 21 March and 25 April.

2182/02 Financial Performance to 30 April 2016 – SFT 3777 – Presented by MC

The Board received the month 1 report. It was noted that a deficit of £382,000 for month 1 had been delivered which was a favourable variance against plan of £224,000. The Trust was planning to deliver £6.5m of savings via the Cost Improvement Programme and a further £3m was required via other initiatives.

Contracts were in the process of being finalised – a Payment by Results contract had been signed with Wiltshire CCG and Heads of Agreements had been signed with Dorset, West Hampshire and the Specialised Commissioner.

The Board also noted the update on the start-up of the joint venture to take forward the Sterilisation and Decontamination Service. A planning application for the new facilities would be submitted when design and build tenders had been evaluated.

It was also noted that an application had been made to the Independent Trust Financing Facility for a loan of £6m to cover the costs of implementing the Electronic Patient Record system.

The Board noted the report.

2182/03 Progress Against Targets and Performance Indicators to 30 April – SFT 3778 – presented by AH

The Board received the Operational Performance Report.

For the Emergency Pathway the Trust had failed to deliver the ED standard in month 1 with 90.5% of patients being admitted or discharged within four hours. This was however ahead of the performance trajectory the Trust had reported to NHS England. The Trust had been in escalation during the month. The Delayed Transfers of Care position was noted.

Referral to Treatment had been affected by the junior doctors strike action and the Trust had reported 91.1% against the 92% standard. Validation work on the April Cancer figures continued but the report was indicating provisionally that all standards except for the 62 Day Wait standard had been delivered. Diagnostic waiting times continued to decrease.

The Board noted the Performance Report.

2182/04 Update on Strategic Planning and Programme Management – SFT 3779 - Presented by LA

It was noted that the Trust had yet to receive detailed feedback from NHS Improvement on its Annual Plan 2016/17.

An update was given on the Sustainability and Transformation Plan and it was noted that there were five work streams identified and the Trust was leading on the Digital Technology work stream. An initial submission was required at the end of June.

On the Electronic Patient Record it was noted that work continued towards the go-live of 28 October and a dress rehearsal was planned for September. There was a large number of patient letter templates to rationalise into the system. There was work underway to validate and configure the data warehouse that would support the EPR system. There had been a

successful trial load of data into Lorenzo.

There was a Green/stable update for Scan 4 Safety (GS1).

Progress was being made towards the transition to Wiltshire Health and Care from 1st July.

2182/05 Capital Development Report – SFT 3780 – Presented by LA

The Board received the Capital Development Report. It was noted that the new Breast Unit funded by the Stars Appeal was underway for completion in October. The second phase of the Laverstock Ward refurbishment would be starting imminently The trust had applied for planning permission in support of the planned Maternity Unit expansion.

The Board noted the Capital Development Report.

2183/00 PAPERS FOR NOTING OR APPROVAL

2183/01 Audit Committee Minutes – 14 March 2016 – SFT 3781 – Presented by PK

The Board received for information the minutes of the meeting of the Audit Committee held on 14 March 2016.

2183/02 Minutes from Clinical Governance Committee – 25 February and 24 March 2016 – SFT 3782 – Presented by LB

The Board received for information the minutes of the Clinical Governance Committee held on 25 February and 24 March 2016.

2183/03 Council of Governors Committee Part I Minutes – 16 May 2016 – SFT 3783 – Presented by NM

The board received for information the draft minutes of the Council of Governors held on 16 May 2016.

2183/04 JBD Minutes from 13 April 2016 - Evidencing Presentation of Assurance Framework and Risk Register – SFT 3784 – Presented by PH

The Board received for information a minute extract from the Joint Board of Directors indicating its quarterly review of the Assurance Framework.

2184/00 ANY OTHER URGENT BUSINESS

No matters were raised.

2185/00 QUESTIONS FROM THE PUBLIC

In response to a question from Beth Robertson it was noted that the nurses recruited from the Philippines would start on the standard banding for qualified nurses.

It was also noted that the loan described by MC in support of the Electronic Patient Record would, if granted be over ten years with minimal interest payments to make.

In response to a question from Alastair Lack, AK undertook to review the trend lines used in the workforce dashboard. AK

It was noted that the proposed relocation of the Farley Stroke Unit was at a very early stage of consideration and prioritisation.

2186/00 DATE OF NEXT MEETING

The next ordinary meeting of the Board would be held on Monday 8 August 2016 at 1.30 pm in the Board Room.

CHIEF EXECUTIVE REPORT

MAIN ISSUES:

CURRENT PRESSURE ON SERVICES

Over the last few months we have seen increasing pressure on our services, with the highest number of attendances in our Emergency Department and additional beds opened right across the hospital to care for a larger number of frail and elderly people who are very unwell and need admission to hospital. This is at a time when we are having difficulties in getting some patients who are clinically fit to be discharged back out into the community. Our operational managers and support staff are working hard to manage the situation and our frontline staff are continuing to provide the very best care under difficult circumstances. We continue to work closely with our partners in health and social care on ways to alleviate the pressure on hospital services. In the meantime, the Trust Board and Governors would like to use my report to publicly thank our staff for all their efforts.

SUSTAINABILITY AND TRANSFORMATION PLANS

As part of the five year forward view all NHS organisations and local authorities are working in partnership within geographical areas to develop Sustainability and Transformation Plans (STPs), which aim to transform health and care services within available resources over the next five years. There are 44 geographical areas across the country known as footprints and we are working with our partners including: Wiltshire Council; hospital Trusts in Bath, Swindon and at AWP; Bath and North East Somerset, Wiltshire and Swindon CCGs; Great Western Ambulance and private providers Sirona and SEQOL. Over the past three months we have been working together to identify common challenges and opportunities across the footprint that will improve our local population's health and wellbeing, improve service quality and deliver financial stability. Staff and stakeholder engagement will be essential to the further development of these plans which we expect to evolve throughout this year.

PATIENTS GIVE A POSITIVE VIEW IN INPATIENT SURVEY

In the latest national inpatient survey published by the Care Quality Commission (CQC), the Trust has scored well, including confidence and trust in doctors and nurses, the level of privacy when being examined or treated and whether patients felt well looked after when in hospital. Around 750 patients who had spent at least one night during July 2015 were asked a range of questions about their admission, the ward environment and the care and treatment they received while in hospital. It's important that our patients receive good quality treatment and are looked after in a caring manner, and many comments gave a positive view of the standards of care that patients can expect when they come into hospital and the friendly and professional way in which our staff take care of our patients. We acknowledge that there is always room for improvement in some areas and this included the questions around whether people were asked for the views on the quality of their care and staff response to call bells which will form part of our action plans

SALISBURY CANCER PATIENTS RATE THEIR CARE HIGHLY IN NATIONAL SURVEY

Our patients have rated the quality of their care highly in the national cancer patient survey. Over 370 patients responded to the questionnaire which covered diagnosis and treatment, confidence in staff, hospital information and the support that patients received at home. Of those who responded 92% felt their care was very good or good and 90% felt they were always treated with respect and dignity by staff. While this survey reflects positively on the service we provide we feel there are areas that we will want to look at ourselves to further improve our patients' experience. This includes a national initiative

where all hospitals will now have to give patients an individual care plan that not only reflects their clinical care, but also their personal needs from diagnosis through their treatment and ongoing follow up in the community. This will be covered in the action plan that we are now developing following the survey.

HOSPITAL ENGAGE TEAM RECEIVES QUEEN'S AWARD

Her Majesty's Lord Lieutenant for Wiltshire, Sarah Troughton, officially presented our Engage volunteers with the Queen's Award for Voluntary Service, the highest award a voluntary group can receive in the UK. As part of the visit the Lord Lieutenant and deputy Lord Lieutenant, The Hon. Peter Pleydell-Bouverie spoke to volunteers and patients on Redlynch Ward before presenting the team with their award. Engage volunteers provide support for patients during their hospital stay, sitting with patients, talking to them and using techniques such as behavioural and reminiscence therapies, discussion groups and memory games that help keep them motivated. The award recognises excellence in voluntary activities and the outstanding contribution they have made to supporting older patients in hospital.

SUCCESSFUL TRANSFORMATION DAY

It's essential that are our staff are fully involved and engaged in service and quality improvements and we recognise that our staff have the ideas and knowledge that can make a real difference to our patients. As part of this our staff had an opportunity to find out about the latest projects taking place across the hospital and provide invaluable feedback at our Transformation Day in Springs Restaurant. This included information on large Trust projects from the implementation of the electronic patient record and a new electronic barcode system to more efficient use of resources through our Save 7 campaign and our recycling centre where staff can get used items such as desks and chairs rather than buy from new.

ARTCARE CELEBRATES 25TH ANNIVERSARY

ArtCare is celebrating its 25th anniversary this year, recognising the enormous contribution the team and art in general has made to the hospital environment and additional support to patients in hospital. Over the years they have organised over 400 projects, from temporary exhibitions to the Elevate programme, delivering workshops and participatory arts activities such as music, storytelling and dance sessions. They provide professional advice on interior design, including consultations with patients and community groups. The team also manage the archive of historic memorabilia, equipment and photographs stretching back to the 1700s.

STAFF RECEIVE LONG SERVICE AWARDS

Thirty four members of our staff were rewarded for their loyalty and commitment to patients when they received long service awards for completing 25 years continuous service. This included staff from a broad range of roles across a range of hospital services. In total this represents over 850 years of service to healthcare in Salisbury, highlighting the significant contribution our staff make to our patients and the local community.

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

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:
n/a

AUTHOR: Peter Hill
TITLE: Chief Executive

Salisbury NHS
NHS Foundation Trust

SFT 3790

Workforce Report
M3
2016-17

Alison Kingscott Director of HR&OD

Presented to

Trust Board

Previously presented to EWC - 25 July 2016

Summary

Salisbury NHS Foundation Trust

- Medical Consultant vacancies have halved since last month due to recent recruitment activity.
- Nursing and Midwifery recruitment continues at pace, although the total number of vacancies has not decreased since last month as the impact of recent international recruitment will be seen in Q4.
- Overall turnover shows a downward trend with medical and dental staff turnover being the lowest across the Trust.
- A&C and healthcare scientists have seen the greatest reduction in turnover since last year.
- Retaining staff is important and the Trust's Health and Wellbeing work supports the aim to be an employer of choice. This year H&WB is also linked to CQUINS (Commissioning for Quality and Innovation)
- Non-medical appraisals are at 77%
- Safer Staffing to follow

Achievements in Month

Salisbury NHS
NHS Foundation Trust

- The Unwind and Wander sessions, supported by the Equality and Diversity team continue to prove very successful as part of the health and wellbeing and diversity work for staff.
- Training on the updated appraisal system (SpIda) has begun with the purpose of upskilling and supporting appraisers and appraisees and improving the rate of uptake of appraisals further
- We are working with Hampshire NHS trust to support Reservists by providing work placements. Uptake within the trust has included welcoming reservists into the PMO.
- The contract with Total Assist to provide a supply of medical locums will be implemented in August, and will be located within the existing bank office, offering greater resilience within hours.
- The Freedom to Speak Up Guardian and the Dignity at Work Ambassadors continue to support Trust staff
- A visual impairment champion has recently been recruited to support staff
- Interviews for the Guardian of Safe Working (Junior Doctor Contract) are happening next week.

Patient-Centred & Safe | Professional | Responsive | Friendly

Directorate headlines

Salisbury NHS
NHS Foundation Trust

Surgery

Hitting the plan for medical appraisals with work to be done for non –medical appraisals at 71%. An improving picture on MAST levels, and sickness is lower (good) than the directorate target.

Facilities

Have the greatest reduction in use of temporary staff in the past 12 months; the highest achievement of appraisals at 96%; and exceeding the target in MAST.

MSK

Improvements in all appraisal areas and in MAST is required to reach the targets. Sickness is slightly above the directorate target.

Medicine

Sickness is better (good) than the target level, but appraisals and MAST require improvements to reach the trust levels.

CSFS

Medical appraisal compliance is very good with non-medical at 79% - above average. Good evidence of improvements in MAST through close performance management via monitoring including cluster meeting

Corporate & Quality

Each exceeding MAST targets. Appraisals below trust average.

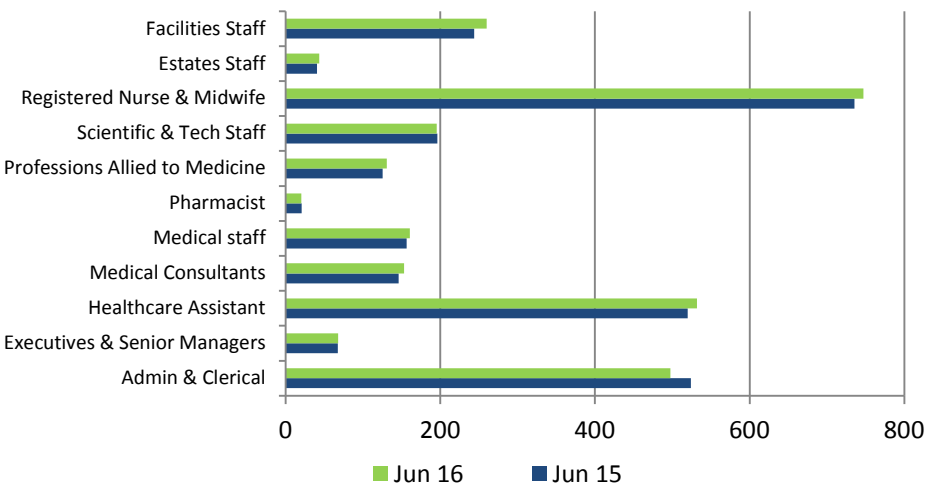
Workforce M3

Salisbury NHS Foundation Trust

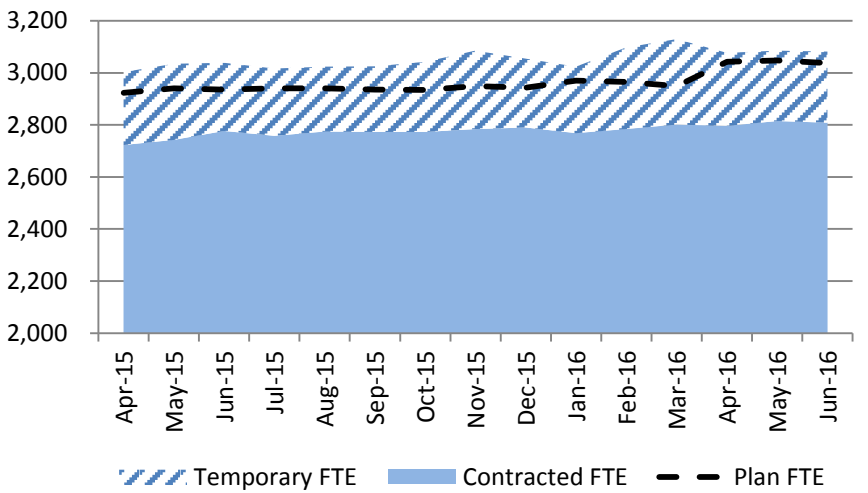
June 16

Contracted Total FTE
2,808
(June 15 - 2,777)

Contracted FTE - 2 Year Comparison



FTE



Additional Notes

1. The overall establishment remains over plan, accommodating special projects such as Electronic Staff Record, and operational issues relating escalation beds. The use of temporary staff is seen mainly in registered nursing and NA.

2. There have been increases in the number of contracted staff (FTE) up by 31 FTE compared with June 2015, due to additional recruitment to replace temporary staff. Key areas of increase are :

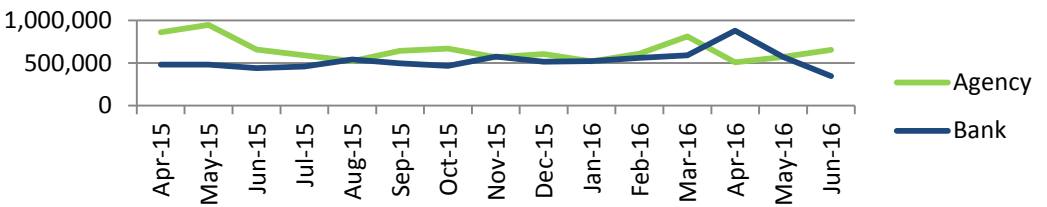
- **Registered Nursing and Midwifery: 11.71 FTE**
- **Healthcare Assistants : 12.01 FTE**
- **Senior Doctors (Consultant Medical Staff): 6.85 FTE**

Temporary Workforce
M3

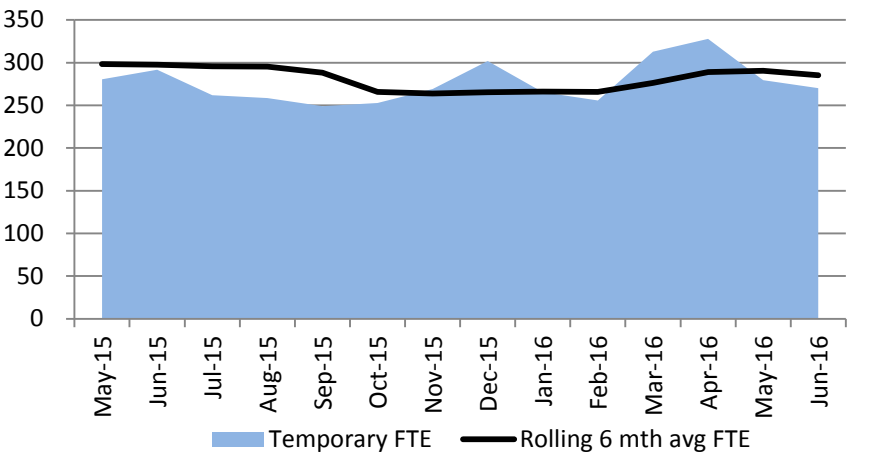
Salisbury NHS
NHS Foundation Trust

Temporary FTE 274
(June 15 - 262)

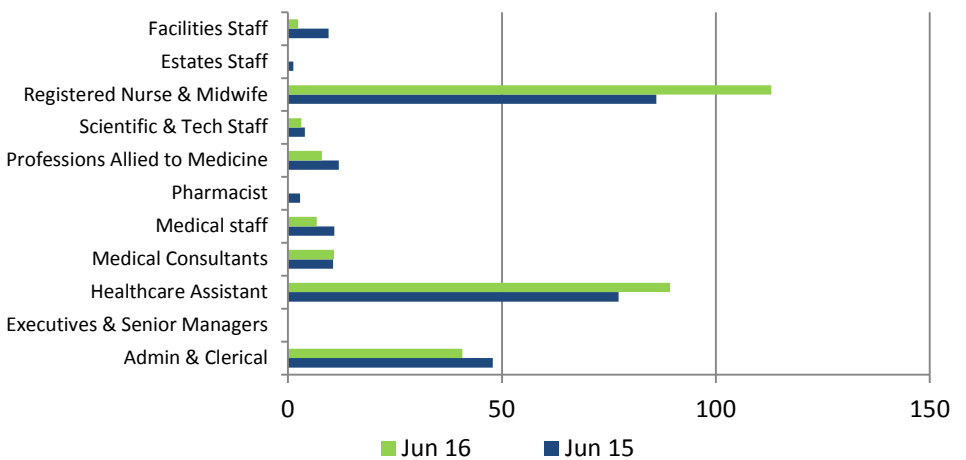
Agency and Bank Spend



Temporary FTE



Temporary FTE - 2 Year Comparison



Additional Notes

1. The number of temporary staff used in the Trust has decreased and this is reflected in the reduction in spend in bank, despite the Trust's strategy to increase bank in favour of agency.

2. Agency staff have decreased from 37% of temporary staff FTE in June 2015 to 33% in June 2016, which is a positive trend. The cost of the agency has not come down and the higher spend is related to high-cost shifts.

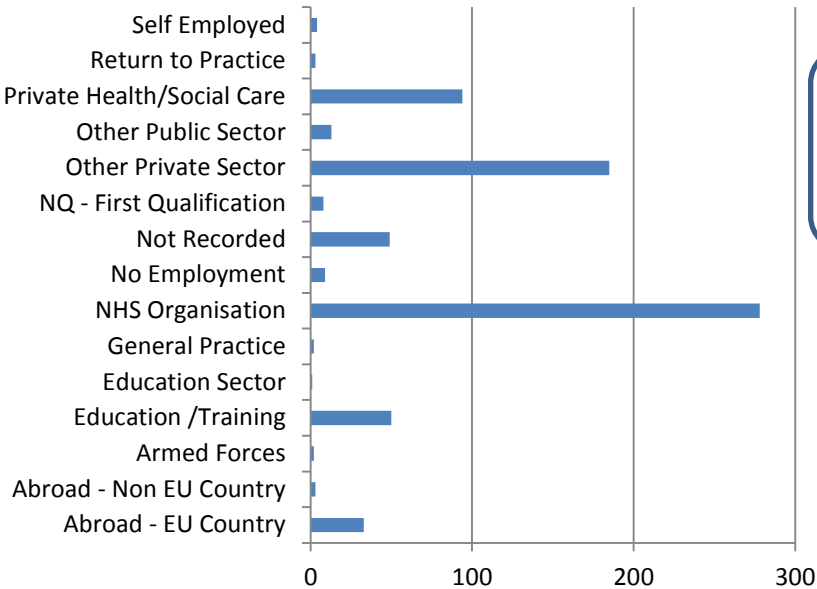
3. Facilities staff has seen a significant reduction in temporary staffing over the past 12 months

Note: Temporary FTE includes bank and agency staff.

Starters – Source of Recruitment
M3 (period to M2)

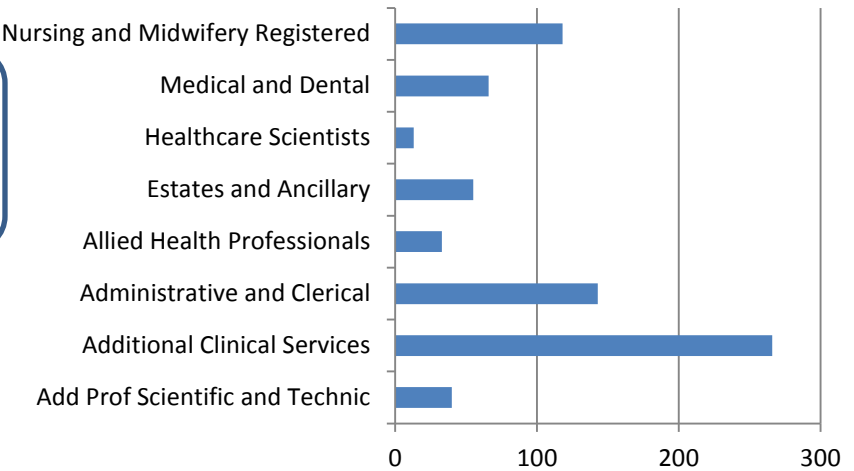
Salisbury NHS
NHS Foundation Trust

Number of Starters by Recruitment Source



Number of Starters 40

Number of Starters by Skills Group



Additional Notes

1. **The most common source of recruitment to the Trust was from other NHS Organisation; with the most popular NHS organisations being Southampton University NHS Trust, followed by Portsmouth, Basingstoke, Poole and Great Western Hospital, Swindon.**
2. **Private Sector and Private Health / Social Care is a valuable source of recruitment**
3. **The skills group with the greatest number of starters was "Additional Clinical Services". This group includes Nursing and Therapy assistants.**

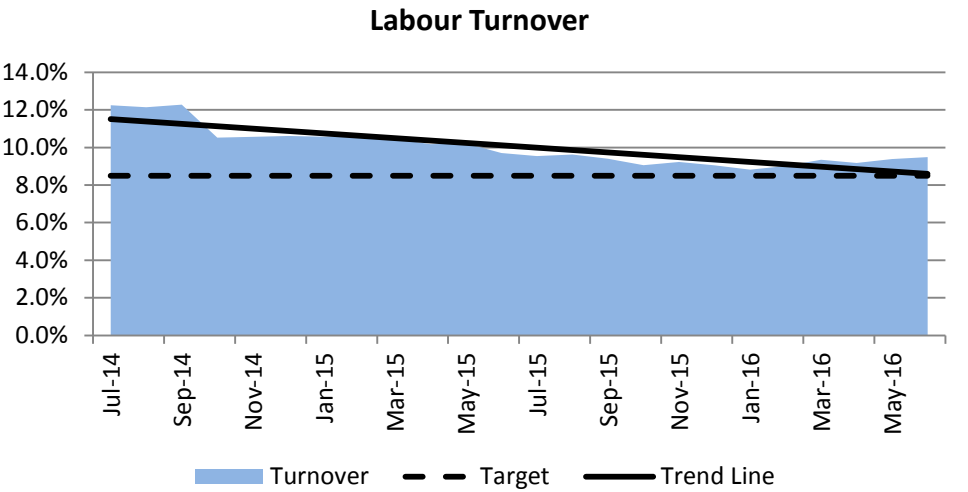
Figures are based on previous 12 months data.

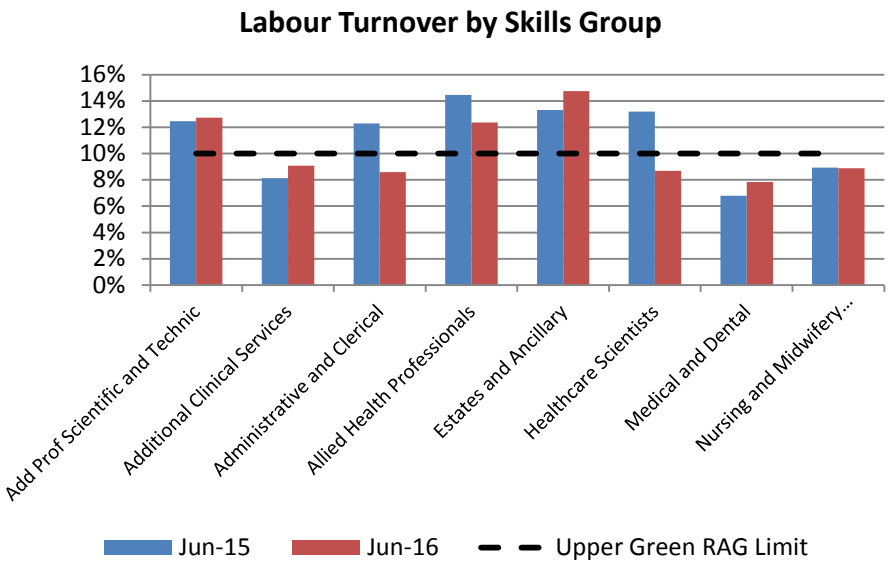
Labour Turnover
M3

Salisbury NHS
NHS Foundation Trust

June 16

9.7%
(June 15 - 10.4%)





Additional Notes

Note: Turnover figures are based on previous 12 months, and exclude bank staff and foundation and training doctors.

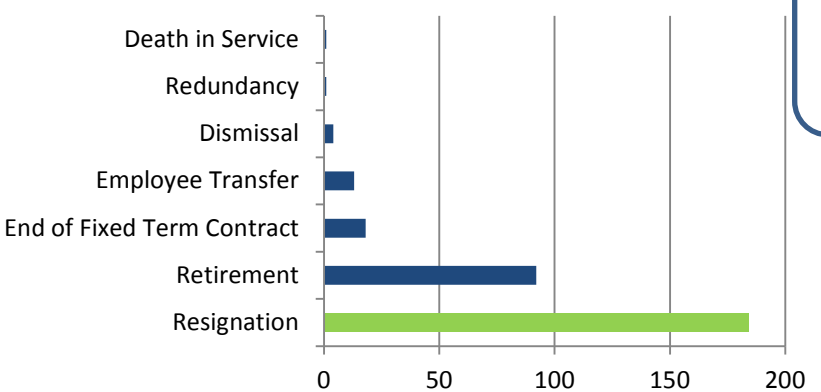
1. Groups with turnover higher than the Trust's 7-10% green RAG rating include "Estates and Ancillary" at 15.0% compared to the NHS-wide rate of 13.8% and "Additional Professional and Technical" at 13% compared to a national NHS rate of 19.5%. These groups have low vacancy rates and vacancies are filled easily from the local workforce.

2. "Allied Health Professional" turnover includes those child therapy staff whose services were transferred to another employer in March 2016. If these staff are excluded, the rate falls into the "green" level at 10.0%.

Leavers
M3

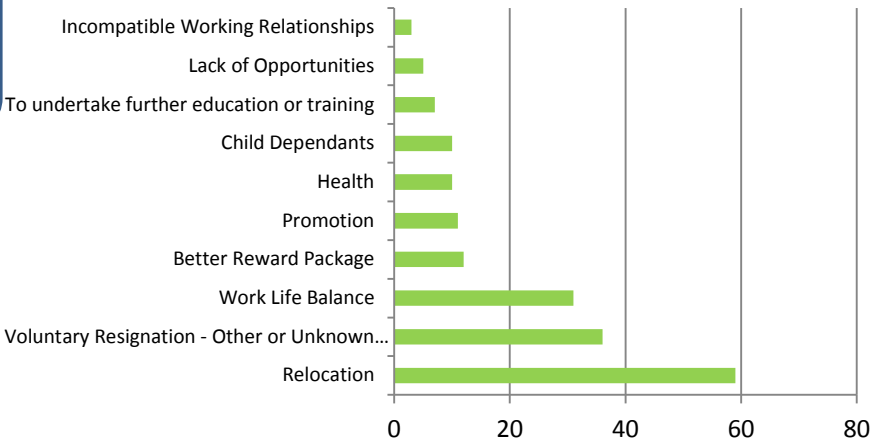
Salisbury NHS
NHS Foundation Trust

Number of Leavers by Reason

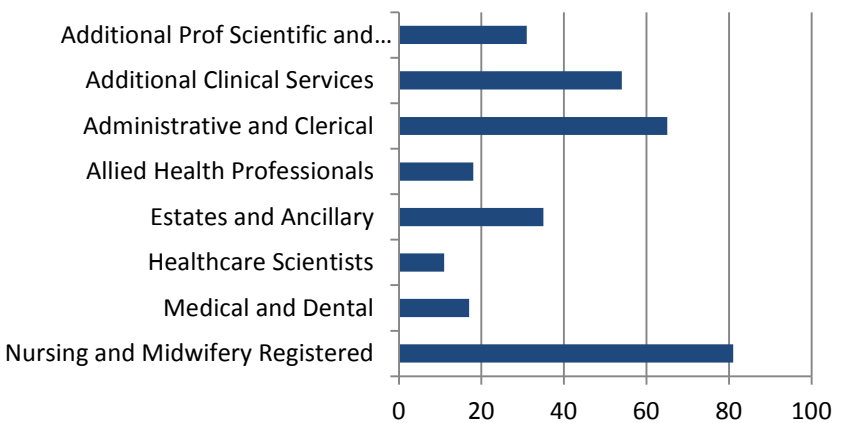


Number of Leavers
22
(June 2015 - 23)

Number of Resignations



Number of Leavers by Skills Group



Additional Notes

1. The most common reason for resignation was 'Relocation' which includes:

- **family 'relocation' due to re-basing of military partners.**
- **'Voluntary Resignation – Other or Unknown Reason' such as such as "opportunity to go travelling", "expiry of visa", "return to previous career", "less commuting" etc.**

2. All leavers can access an Exit Questionnaire or Interview.

Note: Figures based on previous 12 months data.

Vacancies by Skills Group
M3

Salisbury NHS
NHS Foundation Trust

Vacancies	Budget FTE	Contracted FTE	Vacancy FTE	%
Skills Group				
Admin & Clerical	532.69	497.62	35	7%
Executives & Senior Managers	66.54	67.98	-1	-2%
Healthcare Assistant	548.66	519.82	29	5%
Medical Consultants	160.64	156.16	4	3%
Medical staff	178.07	163.97	14	8%
Pharmacist	21.39	20.38	1	5%
Professions Allied to Medicine	142.80	130.81	12	8%
Scientific & Technical Staff	197.22	195.44	2	1%
Registered Nurse & Midwife	890.56	795.14	95	11%
Estates Staff	46.70	43.57	3	7%
Facilities Staff	251.96	259.94	-8	-3%
Total	**3,037.23**	**2,850.82**	**186**	**6%**

Additional Notes

1. The vacancy rate remained the same as last month, with some small changes within the workforce. Medical Consultant vacancies have decreased since last month by 4 FTE due to recent recruitment activity.

2. Within the nursing FTE, are included Nurses waiting for PIN numbers, and maternity leave circa 4.8%. 72 offers have been made to Nurses in the Philippines, and 30 Italian Nurses are awaiting PINs. Bank Nursing budgets are not included in budgeted FTE.

3. Where there are recognised gaps, risk assessments are conducted to establish the impact and identify mitigating actions.

4. Admin vacancies are principally in areas affected by Electronic Patient Record rollout, such as clinical admin areas, and medical records.

5. Areas shown over establishment (e.g. Facilities staff) do not have a budgeted establishment as such, but earn income to cover staff costs.

Note: Vacancies shown as positive and over establishments shown as negative.

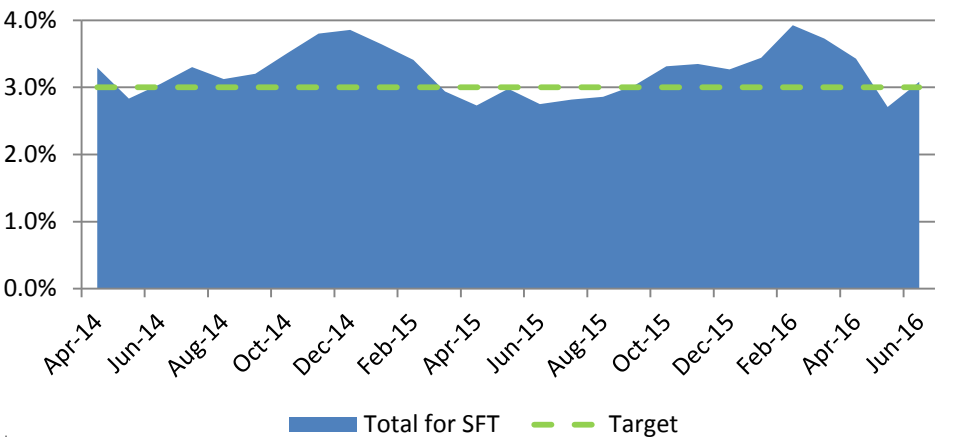
Sickness
M3

Salisbury NHS
NHS Foundation Trust

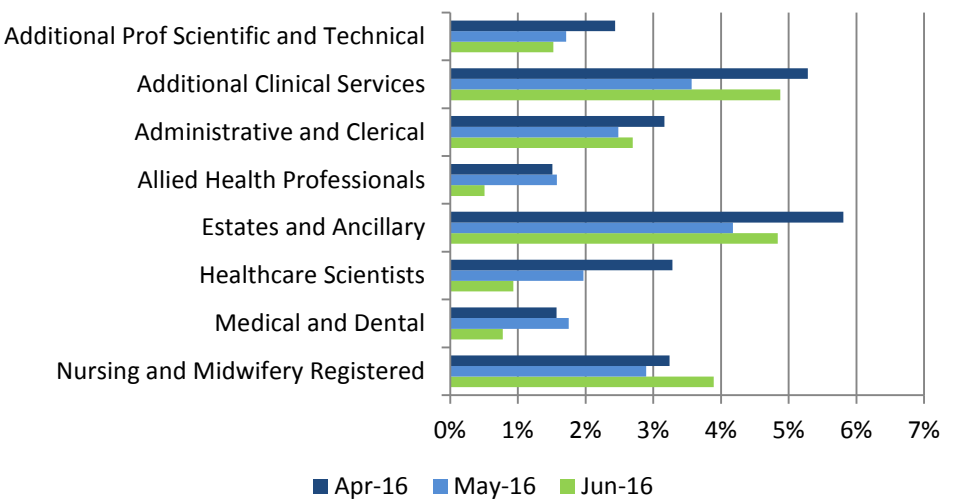
Jun 16

Percentage
3.2%
(June 15 – 3.3%)

Sickness Absence vs Target



Sickness Absence by Skills Group



Additional Notes

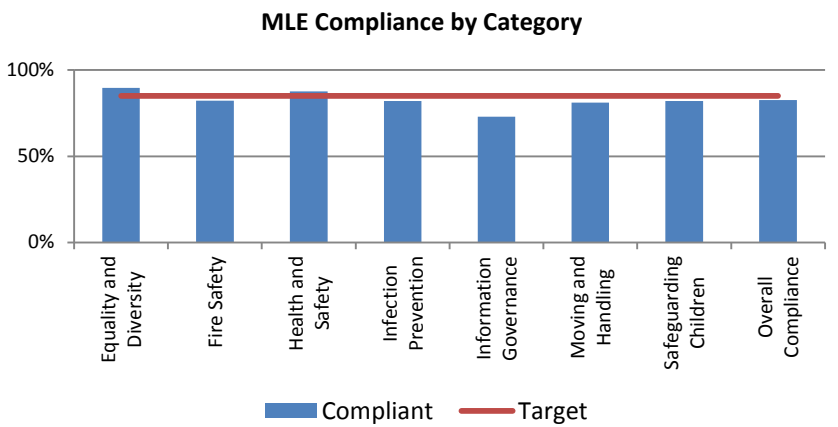
1. Each directorate has a set maximum tolerance for sickness and this is regularly monitored at performance meetings.

2. The most common reasons for sickness this month were 'Anxiety/stress/depression/other psychiatric illnesses' and 'Other musculoskeletal problems'. Occupational Health are providing support in these areas, and they form regular discussions at Operational Management Board.

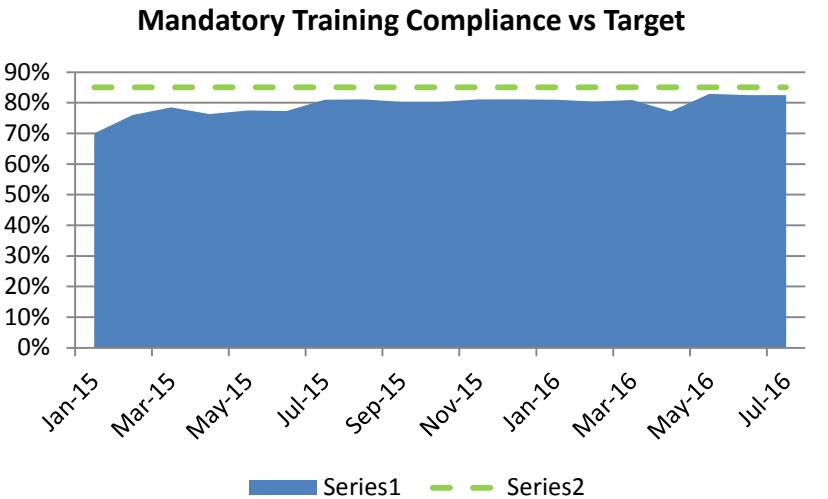
3. The skills group with the highest sickness rate was "Additional Clinical Services" with 4.9%, followed by "Estates and Ancillary" with 4.8%, both of which are well below the national NHS average sickness rates for these groups of 6.4% and 6.2% respectively.

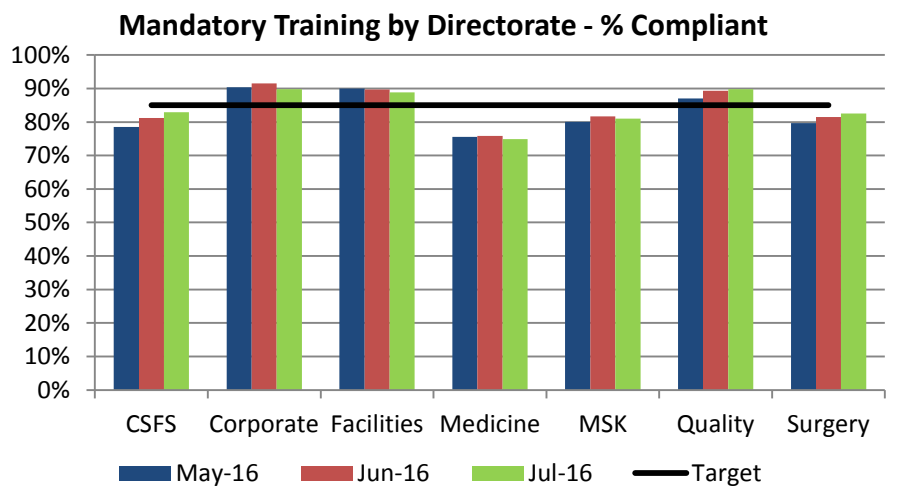
Mandatory Training
M3

Salisbury NHS
NHS Foundation Trust



Compliance Percentage 83% (July 2015 – 81%)





Additional Notes

1. The percentage of staff up to date with their mandatory training has remained at 83% this month against a target of 85%.
2. The directorate with the highest compliance rate was "Corporate" and "Quality" at 89.8%, and the directorate with the lowest compliance rate was Medicine with 74.9%.
3. Information Governance training has the lowest levels of compliance, and there is a review of where training compliance is not currently recorded on the MLE system.
4. Highest compliance is in Equality and Diversity, which is viewed as a result of the proactive work of the Head of E&D.
5. Also, Hand Hygiene work is being recorded in live time to give an up to date picture, currently at 71%, this included bank staff.

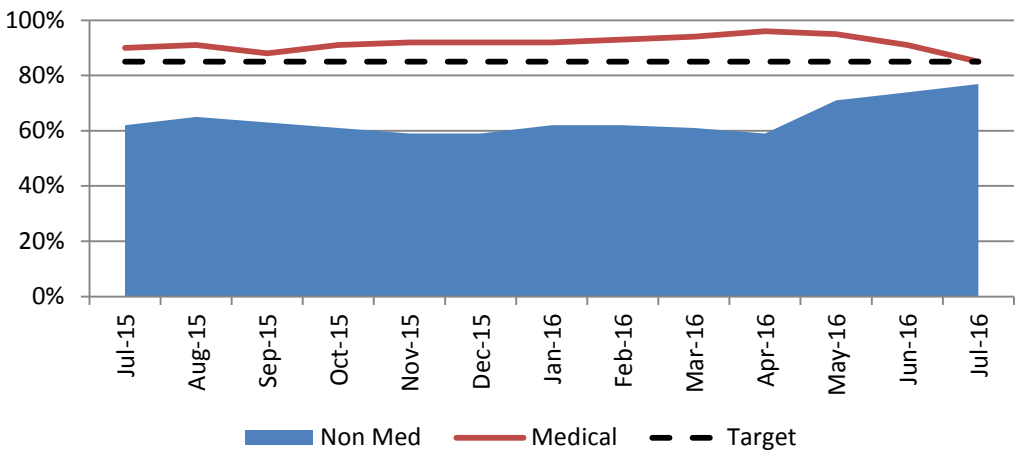
Appraisals
M3

Salisbury NHS
NHS Foundation Trust

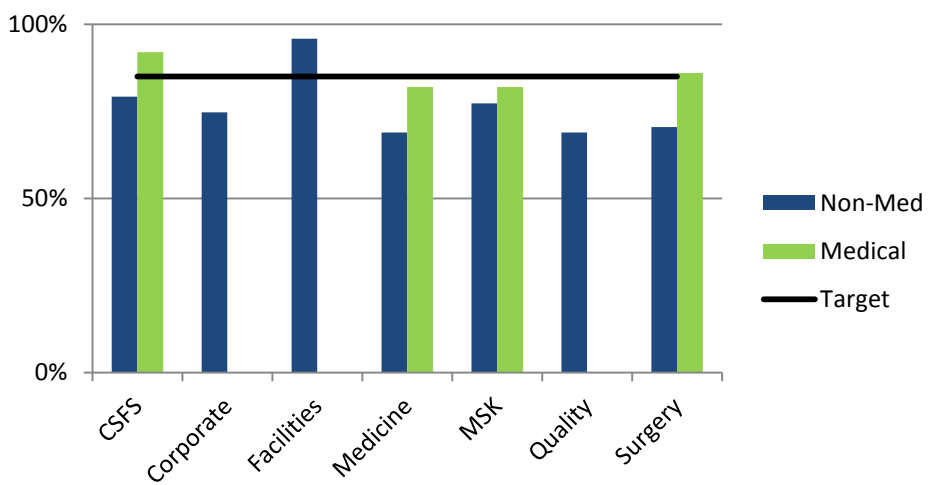
July 16

Compliance percentage - 77% non medical, 85% medical.

Appraisal Compliance vs Target



Annual Appraisal by Directorate - % Compliant



Additional Notes

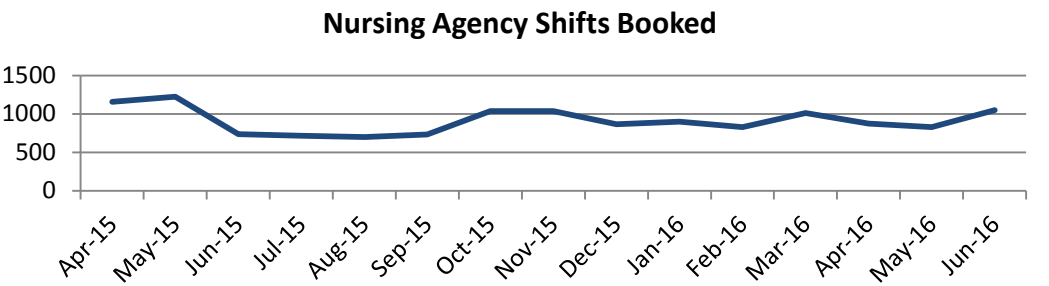
1. **Appraisal compliance is up this month to 77% from 74%.**
2. **Detailed non-compliance reports are now live and available to managers (providing the names of non-compliant individuals) for further action.**
3. **CFFS is the only directorate that has maintained its levels in medical appraisals.**
4. **The percentage of medical staff with an annual appraisal in the last 12 months has decreased this month to 85% from 91%**

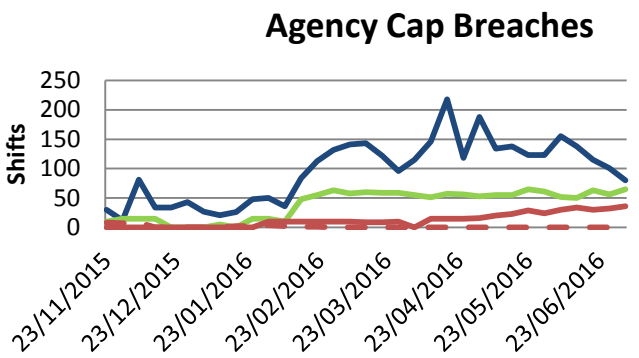
Patient-Centred & Safe | Professional | Responsive | Friendly

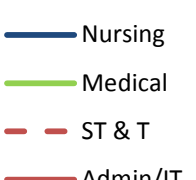
Agency Cap Breaches
M3

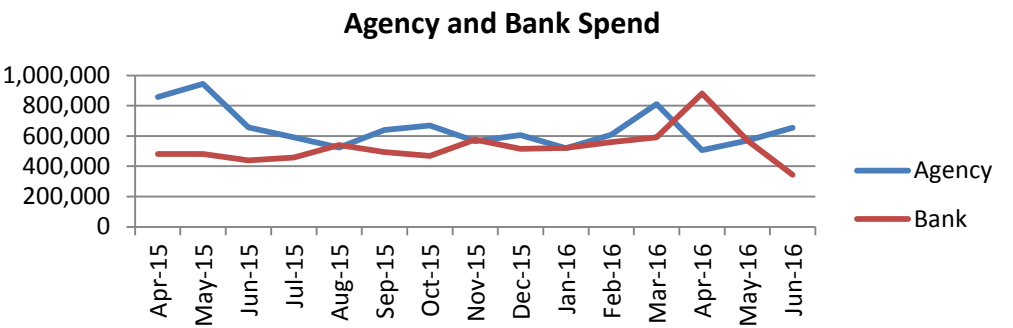
Salisbury NHS
NHS Foundation Trust

Agency Nursing Shifts 1051
Agency Nursing Cap Breaches 632 (60%)
Agency Medical Shifts 282
Agency Medical Cap Breaches 282 (100%)







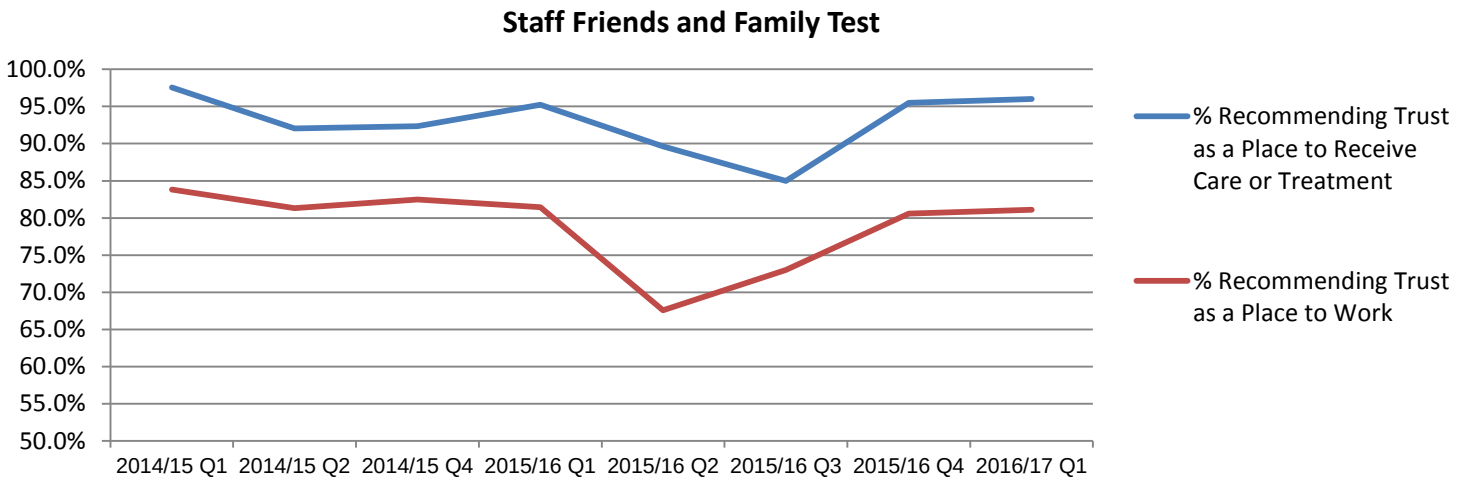


Additional Notes

1. **The data shows a reducing spend on agency since April last year . The breaches of the Monitor caps reveals that the cost of agency is not reducing across all shifts and that the cost for agency, when it is used last minute, can be considerably high. The number of shifts booked for nursing (agency) has remained fairly static with small reductions since last October.**
2. **Escalation means that the use of bank and agency is likely to continue at similar rates in the immediate months.**

Staff Friends and Family Test
M3

Salisbury NHS
NHS Foundation Trust



Additional Notes

1. 96% of respondents recommended the Trust as a place to receive treatment; 81% recommended the Trust as a place to work.

2. Open text responses to the FFT were overwhelmingly positive with a few negative comments relating to issues ranging from: pressure of work to local departmental concerns. There were a total of 91 comments in Q1 2016/17.

3. Positive and Negative themes have been shared with the Directorates concerned for action as part of the performance management process.

Key Assurances

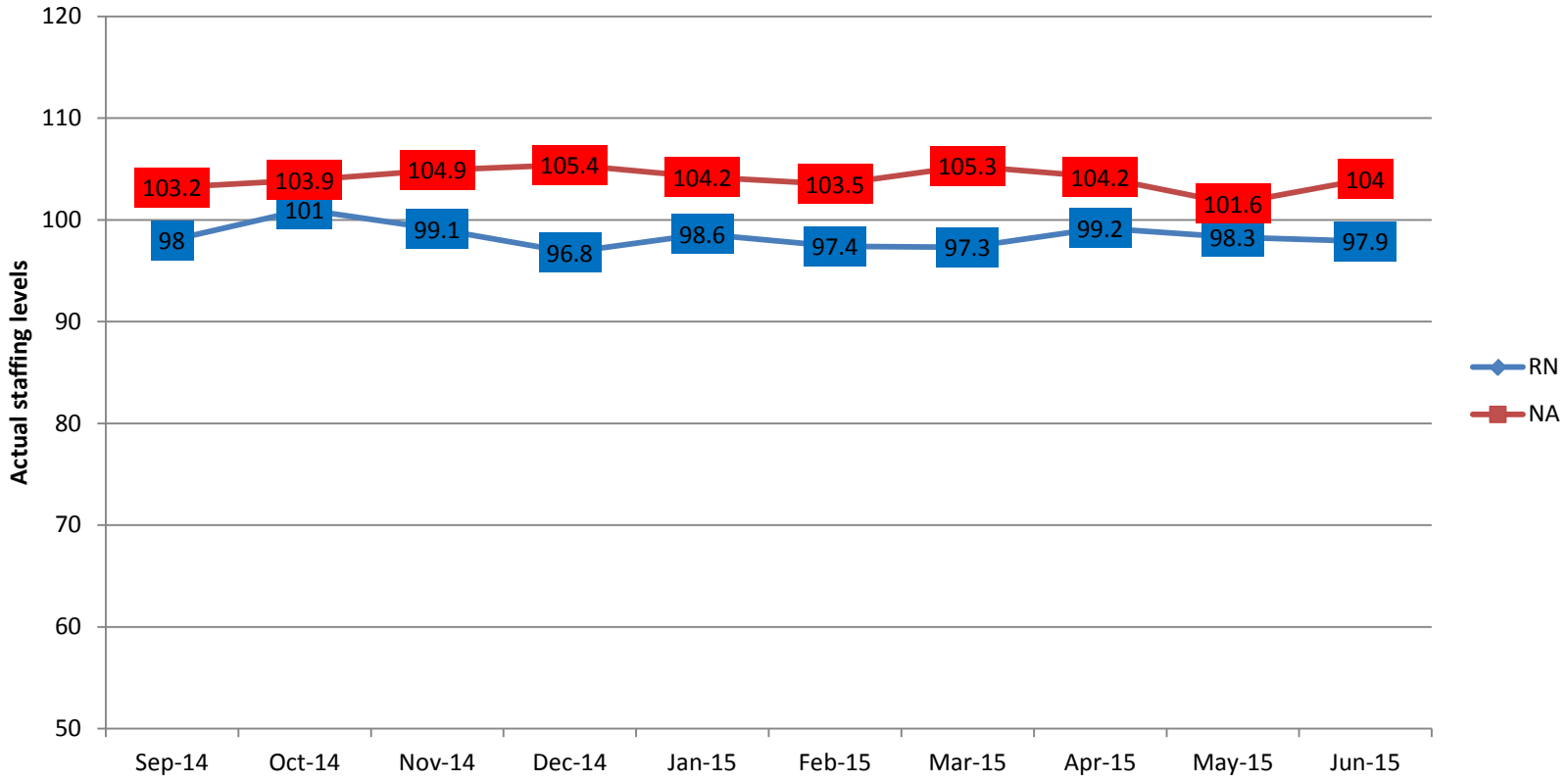
Salisbury NHS Foundation Trust

- HR policies are being regularly reviewed to ensure that support to management is provided and good practice followed. Management guidance is being / has been developed in employee relations areas such as bullying and harassment. Recent policies for review have included the leave policy, bullying and harassment and management of attendance (inc. sickness)
- Appraisals rates are improving with additional information accessible to managers this month allows for transparency and better targeted action. There is an Appraisal and MAST Steering Group to oversee improvements.
- More work will be done to ensure that exit interviews and or questionnaires are assessed to inform our retention work
- Health and Well-being a key retention feature and an update action plan has been produced this month
- We are attending a number of webinars focused on new contracts.

Safe Staffing NQB Report – June 2016

Monthly Comparisons – Actual Staffing Levels

Registered Nurses			Nursing Assistants			Combined			Actual Skill Mix	
P	A	%	P	A	%	P	A	%		
56443.4	55258.4	97.9%	32714.1	34032.2	104%	89157.5	89290.6	100%	62%	38%



Overview of Nurse Staffing Hours – June 2016

	RN	NA
Total Planned hours (day shift)	33831.6	21806.1
Total Actual hours (day shift)	32764	21964.4
Percentage	**97%**	**101%**
Total Planned hours (night shift)	22611.8	10908
Total Actual hours (night shift)	22494.4	12067.8
Percentage	**99%**	**111%**

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

Nursing Hours by Day Shifts

Row Labels	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**13203.98**	**13379.40**	**101.3%**	**9614.00**	**10725.67**	**111.6%**
Breamore Ward	967.50	1143.50	118.2%	868.00	911.00	105.0%
Durrington Ward	1047.50	1005.25	96.0%	842.00	1149.00	136.5%
Farley Ward	1798.00	1750.75	97.4%	1420.50	1562.50	110.0%
Hospice	874.50	884.50	101.1%	643.50	769.50	119.6%
Pembroke Ward	832.50	837.00	100.5%	328.50	539.67	164.3%
Pitton Ward	1409.50	1514.50	107.4%	1150.00	1169.50	101.7%
Redlynch Ward	1395.48	1393.15	99.8%	1123.50	1041.00	92.7%
Tisbury Ward	1967.00	1840.75	93.6%	690.00	711.00	103.0%
Whiteparish Ward	1552.50	1746.50	112.5%	989.50	1001.00	101.2%
Winterslow Suite	1359.50	1263.50	92.9%	1558.50	1871.50	120.1%
Surgery	**6618.50**	**6420.42**	**97.0%**	**3026.00**	**2527.00**	**83.5%**
Britford Ward	2151.00	2129.33	99.0%	1230.00	1116.00	90.7%
Downton Ward	1297.00	1424.25	109.8%	976.50	994.50	101.8%
Radnor	3170.50	2866.83	90.4%	819.50	416.50	50.8%
Clinical Support	**4929.75**	**4380.83**	**88.9%**	**1977.95**	**1438.25**	**72.7%**
Maternity	2624.00	2419.58	92.2%	1294.95	1125.00	86.9%
Sarum Ward	963.00	967.00	100.4%	338.00	268.25	79.4%
Musculo-Skeletal	**9079.40**	**8583.32**	**94.5%**	**7188.17**	**7273.52**	**101.2%**
Amesbury Suite	1479.00	1402.25	94.8%	1373.75	1364.50	99.3%
Avon Ward	1438.00	1513.50	105.3%	1637.00	1862.02	113.7%
Burns Unit	1460.50	1462.80	100.2%	546.25	498.75	91.3%
Chilmark Suite	1528.25	1524.75	99.8%	1109.00	1095.75	98.8%
Laverstock Ward	1863.25	1489.68	80.0%	1051.25	1009.25	96.0%
Tamar Ward	1310.40	1190.33	90.8%	1470.92	1443.25	98.1%
Grand Total	**33831.63**	**32763.97**	**96.8%**	**21806.12**	**21964.43**	**100.7%**

Nursing Hours by Night Shifts

Row Labels	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**9260.00**	**9373.25**	**101.2%**	**5123.50**	**6275.75**	**122.5%**
Breamore Ward	690.00	759.00	110.0%	690.00	632.50	91.7%
Durrington Ward	690.00	690.00	100.0%	690.00	1056.25	153.1%
Farley Ward	1035.00	1000.50	96.7%	690.00	954.50	138.3%
Hospice	570.00	571.75	100.3%	397.00	489.00	123.2%
Pembroke Ward	686.00	667.00	97.2%	0.00	218.00	0
Pitton Ward	1036.50	1188.75	114.7%	690.00	695.00	100.7%
Redlynch Ward	1034.50	1045.25	101.0%	345.00	517.50	150.0%
Tisbury Ward	1367.50	1344.50	98.3%	345.00	333.50	96.7%
Whiteparish Ward	1380.00	1369.50	99.2%	345.00	356.00	103.2%
Winterslow Suite	770.50	737.00	95.7%	931.50	1023.50	109.9%
Surgery	**4547.50**	**4380.83**	**96.3%**	**1120.00**	**1260.50**	**112.5%**
Britford Ward	900.00	909.83	101.1%	600.00	639.00	106.5%
Downton Ward	600.00	590.00	98.3%	520.00	610.00	117.3%
Radnor	3047.50	2881.00	94.5%	0.00	11.50	0
Clinical Support	**4479.33**	**4185.08**	**93.4%**	**1414.50**	**1130.50**	**79.9%**
Maternity	2410.00	2242.25	93.0%	1035.00	947.50	91.5%
Sarum Ward	1034.33	1011.33	97.8%	34.50	56.50	163.8%
Musculo-Skeletal	**4325.00**	**4555.25**	**105.3%**	**3250.00**	**3401.00**	**104.6%**
Amesbury Suite	1035.00	1034.75	100.0%	690.00	770.00	111.6%
Avon Ward	700.00	900.00	128.6%	790.00	860.00	108.9%
Burns Unit	600.00	612.00	102.0%	300.00	290.00	96.7%
Chilmark Suite	570.00	589.00	103.3%	570.00	551.00	96.7%
Laverstock Ward	820.00	819.00	99.9%	300.00	340.00	113.3%
Tamar Ward	600.00	600.50	100.1%	600.00	590.00	98.3%
Grand Total	**22611.83**	**22494.42**	**99.5%**	**10908.00**	**12067.75**	**110.6%**

Overview of Areas with Red/Amber

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	**Radnor**	51%		√	Day	NAs are used flexibly . Staffing templates are currently being re-validated by Finance . RN staffing ratios were met on each shift
Red	**Sarum**	79%		√	Day	RSCN numbers are appropriate and NA staff moved flexibly to ensure safe staffing levels – see night shifts where NAs are >100%
Red	**Laverstock**	80%	√		Day	The ward is temporarily relocated whilst refurbishment work is carried out. This has resulted in 3 less beds and so staffing is judged on a daily basis and current template not always filled based on professional judgement.
Amber	**Maternity**	87%		√	Day	There are 8 NA vacancies currently within the maternity unit however there is a template issue where the number of shifts available exceed the budgeted levels. All ratios are being met following risk assessments and the use of flexible rostering

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

Overview of Overstaffed Areas >115%

Ward	%	RN	NA	Shift	Comments
Sarum	164%		√	Night	An increase of 36% on additional shifts compared to last month. Following risk and patient acuity assessments, a skilled NA staff member is occasionally rostered to cover an unfilled night shift gap. Any increase in shift fill by the NA staff results in an exaggerated appearance of staffing due to the small numbers involved.
Breamore	118%	√		Day	6% increase on May but this has been just identified as a Roster data input error and advice has been given to ensure accurate data entries on future rosters .
Durrington	136%		√	Day	Overstaffing on NAs on days and nights. Both shifts were to provide enhanced care (one to one) to ensure patient safety for 2 patients in particular who had either Mental Health issues, confusion or a risk of falls .
	153%		√	Night	
Winterslow	120%		√	Day	Overstaffing for the ward has been reduced by 37% during June. This was to provide enhanced care (one to one) for patients who had either Mental Health issues, confusion or were at risk of falls .
Pembroke	164%		√	Day	65% increase due to 1:1 enhanced care for a patient at risk of falls
Avon	129%	√		Night	15% decrease on last month but still above budgeted levels to support escalation. Daily reviews are undertaken by the DSN
Downton	117%		√	Night	A further 11% increase on night cover since May over 6 nights due to high patient acuity .
Farley	138%		√	Night	40 % increase on May for 1:1 enhanced care due for patient s who had either Mental Health issues, confusion or at risk of falls . Band 2 staff were utilised to save on RN costs following a risk assessment.
Hospice	123%		√	Night	A 25% increase above budgeted establishments for additional staff to support enhanced 1:1 care as above.
Redlynch	150%		√	Night	A 44% increase on May. Band 2 staff were used to for 1:1 enhanced care for a patient at high risk of falling due to Korsikoffts dementia.

Mitigation of Risk
for Red/Amber

Maternity:-The department is undertaking active recruitment to increase MCA staff within the different areas. The increase in the spread of shifts & skills for the Maternity Assistants results in the same number of staff covering a wider number of shifts within the unit.

Sarum has unfilled day shifts until new Band 2 staff have completed inductions

Nursing ratios have been met (although not reflected in the reporting figures) by these staff under guidance alongside the placement of a 3rd year student.

Laverstock:-The reduction in bed -stock by 3 means some flexing of the template.

Risk assessments are undertaken and scrutiny of patient acuity the staffing for the unfilled shifts was deemed safe with the skill mix available. The supervisory sister was available to cover core shifts if required

Over-Staffing

NA staffing levels maintain a consistent trend over budgeted levels (peaking in March to 105.3%) with 104% above established levels for June.

Many NA staff have excellent skills sets enabling them to be used to support RN staff & cover any shift gaps plus enhance care rather than utilising costly qualified temporary staff. This increases the levels of NA shifts above establishment and is reflected the regular skill mix of 62/38%.

All shifts are subject to intense scrutiny to ensure they are required and that patient safety is not compromised through appropriate risk assessments

There has been a general increase in the levels of over-staffing Trust wide during June - 90% of these are due to the patient requirements for enhanced 1:1 care.

Whilst some wards demonstrate a decrease in the overall demand of overstaffing, others have had to implement increased levels for this reason.(Winterslow, Durrington, Breamore, Farley, Hospice, Pembroke)

Downton had 6 shifts with high levels of patient acuity requiring 1:1 cover.

Sarum :- The very small number of skilled NA staff involved can result in exaggerated figures. Successful recruitment has resulted in 3 RSCNs being on duty for the majority of the time.

Avon is supporting non spinal Trust escalation capacity and utilising skilled NAs to support respiratory patients

Actions taken to mitigate risk

Actions required remain unchanged:-

Over-staffing is only used to support high patient acuity & dependency & where appropriate, using unregistered staff.

The reasons for requesting “additional shifts” has been refined with a clear set of definitions and this was implemented on 20th June. Any impact will not be demonstrated until at least the August reporting period. All shifts over and above the budgeted establishment are subject to DSN approval.

- Staffing levels are flexed according to patient acuity and dependency levels. These are assessed by the nurse-in-charge of individual wards.
- The skills set of staff is carefully accounted for when deciding on the band of staff needed. Safety is a priority with careful consideration to cost efficiency.
- Additional NAs are rostered to support unfilled RN shifts as demonstrated
- All shifts are assessed on a shift by shift basis.
- Staff are moved across wards by Directorate Senior Nurses and Clinical Site Team as required. This ensures safe levels of care are maintained whilst trying to reduce reliance on expensive temporary staff
- Staffing levels are reduced when beds empty/ procedure lists reduced whilst maintaining appropriate staffing ratios
- Shifts that are difficult to cover (nights and weekends) are prioritised.
- If all of the above measures have been taken there may be a requirement that staff on training days are brought back to work clinically as required and / or Sisters on supervisory shifts work clinically.
- CCOT team support wards where acuity of patients high.

PAPER: SFT 3791

Equality, Diversity & Inclusion Annual Report 2016

PURPOSE:

This paper provides an annual Equality, Diversity and Inclusion update to the board.

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

This report provides the board with an update and progress report in relation to the EDS2(Equality Delivery System) and contributes to meeting our PSED (Public Sector Equality Duties) and publishing our annual data on the Trusts main functions in relation to equality.

EDS2 Progress August to July 2016

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

The 2015 EDS2 annual review RAG gradings are predominately green coloured which illustrates that the Trust is in the 'achieving' category. In one area we are graded as purple, which is the highest grading colour and illustrates that we are 'excelling' in this particular objective, Outcome 3.2, 'The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations.' This rating has not changed over the last 2 years.

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

The EDSG (Equality and Diversity Steering Group) has developed an EDI Service Plan which identifies the Trusts 4 strategic equality objectives with specific actions and outcomes. (Appendix 1 – Equality Objectives 2016 Onwards)

The EDS2 has been integrated into the strategic business of the Trust through both the Quality Account and Annual Strategic Plan.

WRES (Workforce Race Equality Standard)

The evidence of the link between the treatment of staff and patient care is well evidenced for BME staff in the NHS, to this end the NHS has launched the WRES (Workforce Race Equality Standard). We have collated data from April 2015 to March 2016, our annual WRES action Plan and WRES data has been published on our hospital website. Nationally we fare well with our data results, however the national picture is not a positive one for BME staff.
http://www.salisbury.nhs.uk/AboutUs/EqualityAndDiversity/Pages/EqualityDeliverySystem.aspx

Our Workforce

This section of the report highlights headline workforce, gender pay & grievances data, refer to Appendix 2 for further detailed data.

Occupations by Ethnicity – At the Trust 9.30% of the workforce describe themselves as from the BME (Black and Minority Ethnic) communities. The Office for the National Statistics estimates that 4.7% of Wiltshire population identify as BME. Of the 9.30% BME staff working in the Trust 43% work in roles from band 4 and below, 38% in band 5 to 6 and 19% in band 7 and above. This data includes clinical and non-clinical staff. Further work is required to reflect BME diversity at senior management levels, this has been reflected in our WRES action Plan 2016 onwards (appendix 5)

Age Range of Workforce - The chart shows the proportionality of staff ages across the workforce. Of the staff aged over 60 who work at the Trust, 12% work in band 4 and below positions and 61% aged 40-59 work in band 7 and above positions.

Gender Pay Gap - The average mean salary for women is £27,402 and the average mean salary for men is £35,753 (appendix 2). The total average salary for both men and women is £29,504. This is not unusual as this depicts a trend that is reflected across most sectors whereby a larger proportion of senior roles or higher skilled roles within the organisations are held by male employees. Of the male staff employed at the Trust 13% work in band 7 or above positions, of the female staff working at the Trust 10% work in band 7 or above positions. All staff at the Trust have the same opportunities to work flexibly, with on site child care arrangements, home working options, carers leave and flexible hours which contribute to the opportunities for staff with childcare and carers responsibilities.

The EDSG conducted a deep dive into this data and concluded that of the gender make up of men and women at band 8b and above, women make up 53% and men make up 46%. It would appear that for both medical and non medical staff, women are currently under-represented at the higher grades predominately in medical roles. Further work to promote opportunitites for flexible working, including job share is required.

The gender balance on the Executive Board with its current gender make up of 3 men and 3 women at Executive Director level, 3 women and 3 men at Non-Executive Director level and 1 male Chairman.

Sexual Orientation - In total 85% of our staff describe themselves as heterosexual/straight, 14% either did not want to disclose their sexual orientation or chose to tick the undefined category, 1% of our workforce has identified themselves as LGBT (Lesbian, Gay, Bisexual or Transgender).The Government Equalities Office has stated a reasonable estimate of 5% to 7% of the population consider themselves as LGBT. The Trust will continue progressing with the sexual orientation agenda to develop a culture of fairness and inclusiveness.

The Trust supports the LGBT agenda and has an active LGBT staff network called the RainbowSHED, a dedicated LGBT Staff Champion and a LGBT Allies Programme.

NHS Jobs – applications, shortlisted and appointed - The Trust has analysed NHS Jobs data from March 2015 to April 2016 which illustrates applications, shortlisted and appointed under ethnic background, gender, disability, age, region

and sexual orientation, (refer to Appendix 3). The report continues to identify disproportionality with White applications to appointments in comparison with BME applications to appointments; this theme also applies to female applications to appointments in comparison to male applications to appointments. As part of the WRES Action Plan 2016 onwards we have identified piloting BME observer's at interview stage (appendix 5).

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

Staff Survey - Details of the staff survey and action plan can be viewed following this link:www.salisbury.nhs.uk/aboutus/media/pages/salisburyscoreswellonindependentstaffsurvey.aspx 90% of our staff believe that the Trust provides equal opportunities for career progression or promotion. 11% of the staff completing the survey identified they have experienced discrimination at work in the last 12 months; the national average for Acute Trusts is 11%. We are working with the 'Staff Survey Action Plan' team to resolve some of these issues.

Workforce Data - Further workforce data is available under appendix 3, which also includes equality data on grievances, dismissals and complaints about discrimination. We know from our data that In 2015/16, 90% of promoted staff were white, 7% were BME. This compares to a ratio of 89% white staff to 9% BME staff in the workforce as a whole. The WRES Action plan 2016 onwards. Further disaggregated data can be sought from the author of this report.

Occupations by Gender (Part & Full Time) - Of the Trusts female workforce, 40% are full time and 60% are part time. In total 70% of male staff are full time and 30% are working part time. The gender balance varies considerably by occupational group.

Our Patients (Different Protected Characteristics)

Feedback from the National Inpatient Survey 2015 showed that when patients were asked if they felt they were treated with respect and dignity, 86% said "always" and 13% said "sometimes". Patients were asked to score their overall care on a sliding scale between 0 (I had a very poor experience) and 10 (I had a very good experience). 28% rated their overall care as 10 with a further 26% rating it as 9.

Appendix 4 describes the protected characteristics of patients attending outpatients and inpatients from January 2015 to December 2015. The equality data includes, age, ethnicity, disability, religion, gender, transgender, pregnancy and maternity attendances. The Trust currently does not collate all sexual orientation data from patients. The Trust does collate data on Transgender, in total 5 people identified under this category.

In total there were 38,355 female patients and 37,894 male patients. 83% patients described themselves as White. 3% patients described themselves from a BME (Black Minority & Ethnic) community, whilst 14% of patients did not specify or not stated.

The hospital has a varied distribution of age ranges. 22% of our patients are aged 19 or below, 49% of our patients are within the age category of 20 to 60, and 29% of our patients are aged 60 and above.

In total there were 26 PPI (Patient and Public Involvement) projects this year, using many different methods including patient stories, focus groups and questionnaires. For further information contact the Customer Care Team

Key Activities 2015/16

The EDI team have worked with Audiology and supported the role of a Hearing Champion which involved improving communication between staff and patients, supporting patients and staff in the management of hearing loss and hearing aids. We have also led on several hearing loss workshops in collaboration with Salisbury Hearing Loss Charity and a local lip reading teacher.

During our CQC visit in December, the inspector(s) requested to meet with BME staff to hear about their experience working at the Trust. The final report is presented under the 'Well Led Domain' headed Equality & Diversity. There were no additional recommendations from the report.

The EDI department has continued to engage with staff, patients and the wider community. A quarterly newsletter is published both internally and externally, this has led to EDS2 members contributing to articles and engaging with our services through its publication.

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

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

The Head of EDI was awarded Regional NHS Leader of Inclusivity in November 2015 and then awarded National NHS Leader of Inclusivity in March 2016 by the NHS Leadership Academy.

Equality Analysis (EA)

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

Equality Compliments and Complaints from Patients

In 2015-16 the Customer Care Team received 1959 compliments for many wards and departments. There were no formal complaints recorded under discrimination.

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

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:
Appendix 1 – Equality Objectives 2016 onwards
Appendix 2 - Workforce, Gender Pay Gap & Grievances Data 2015/16
Appendix 3– NHS Job Equality Data (applied, shortlisted & appointed) 2015/16
Appendix 4 – Patient Equality Data Jan 2015 – Dec 2015
Appendix 5 – WRES Action Plan 2016 onwards

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

Trust vision: An outstanding experience for every patient

Equality Objectives 2016 onwards:

	Care	Choice	Our staff	Value
Trust goals:	**Patients are treated with care, compassion and kindness and kept safe from harm**	**To be the hospital of choice with a full range of local services enhanced by our specialist centres**	**A place to work where staff feel valued and can develop as individuals and within teams**	**Using our resources innovately to deliver efficient and effective care**
Trust values:	**Patient centred and safe**	**Responsive**	**Friendly**	**Professional**
	As part of our understanding of alcohol misuse in society we will review patients who attended the Emergency Department or are admitted with alcohol related issues	We will explore how we can improve our services for our patients who are hearing impaired, which will result in an improved experience whilst at the hospital	Using the staff survey results, we will continue to support staff through our Dignity at Work Ambassadors to improve their experience at work and to support staff who may be experiencing bullying, harassment and/or discrimination	We will develop a mentoring network to support staff from protected groups to develop into leadership roles

An **outstanding** experience for **every patient**

Salisbury NHS Foundation Trust

"Better health outcomes for all"

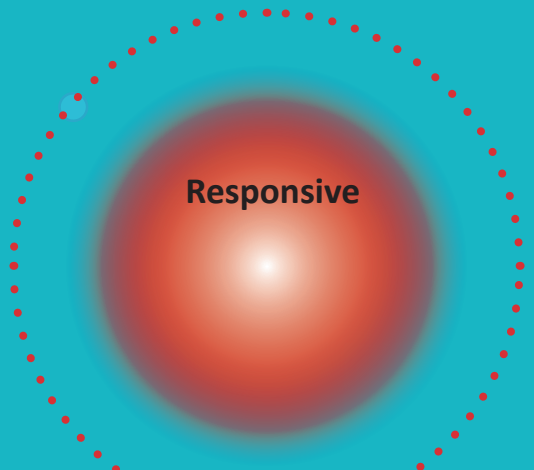
As a result of the alcohol misuse review we will understand the needs of our community. This will help us deliver a targeted approach to specific equality groups

Care

Choice

"Improved patient access and experience"

We will continue to work with local interest groups and review whether we are making improvements



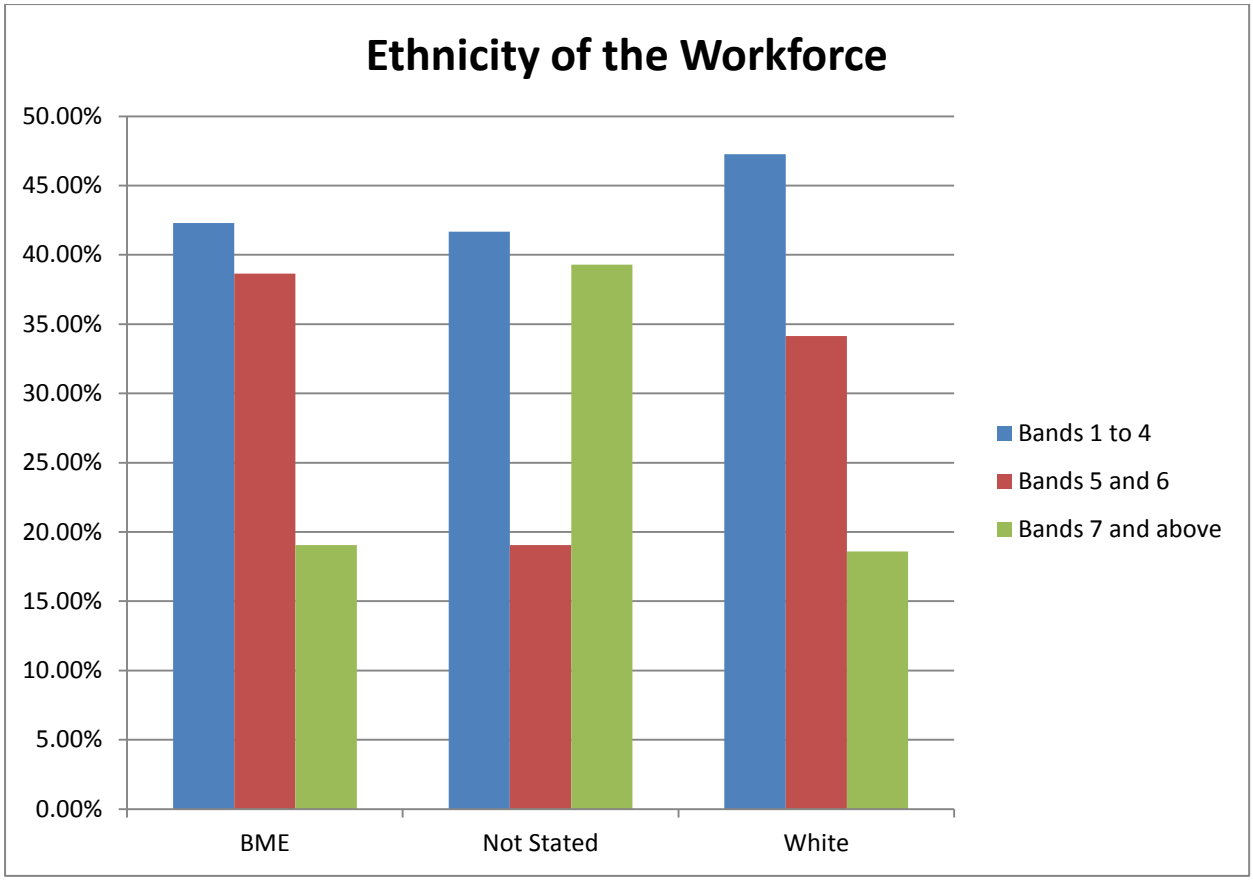
"Empowered, engaged and well supported staff"

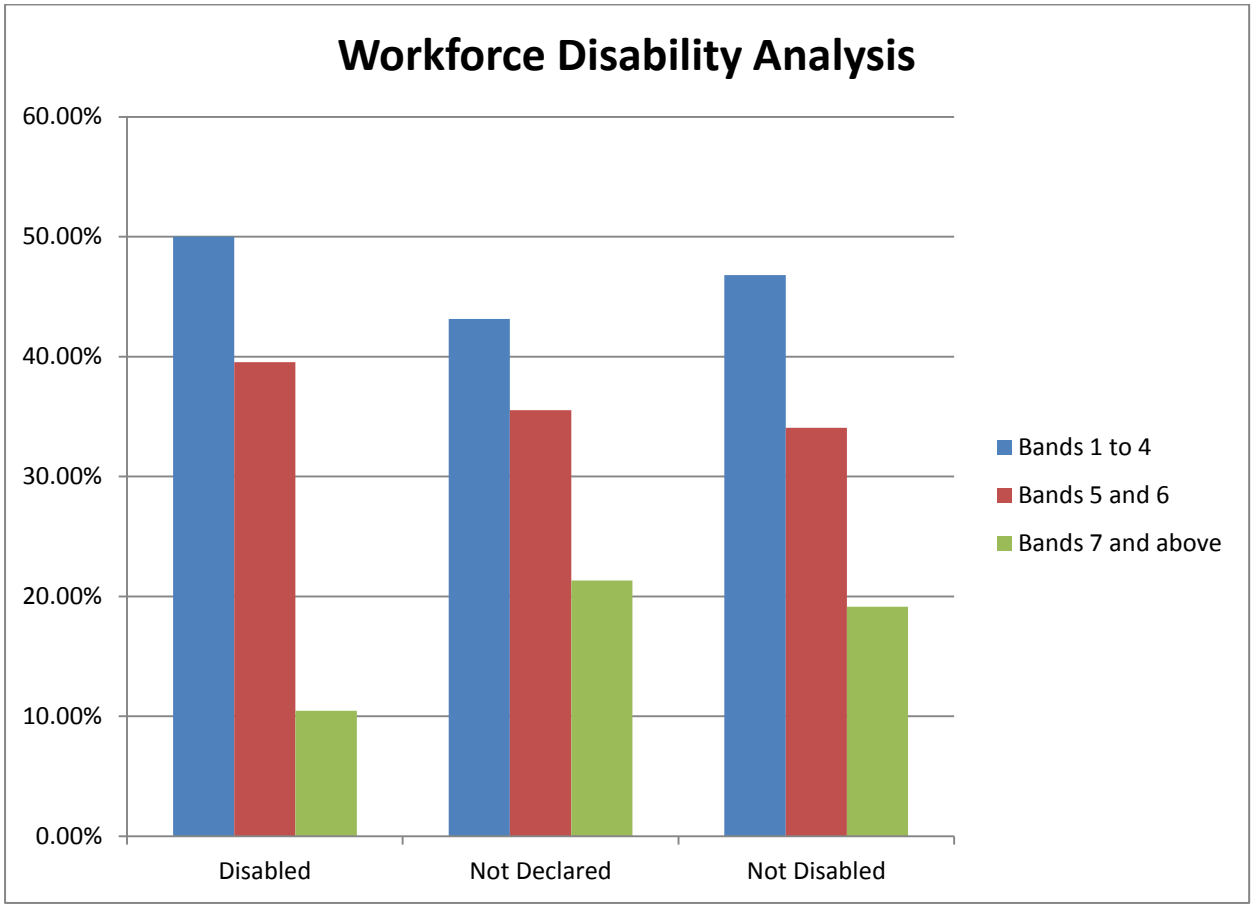
We will assess data at the end of each quarter to determine whether different equality groups have varying experiences

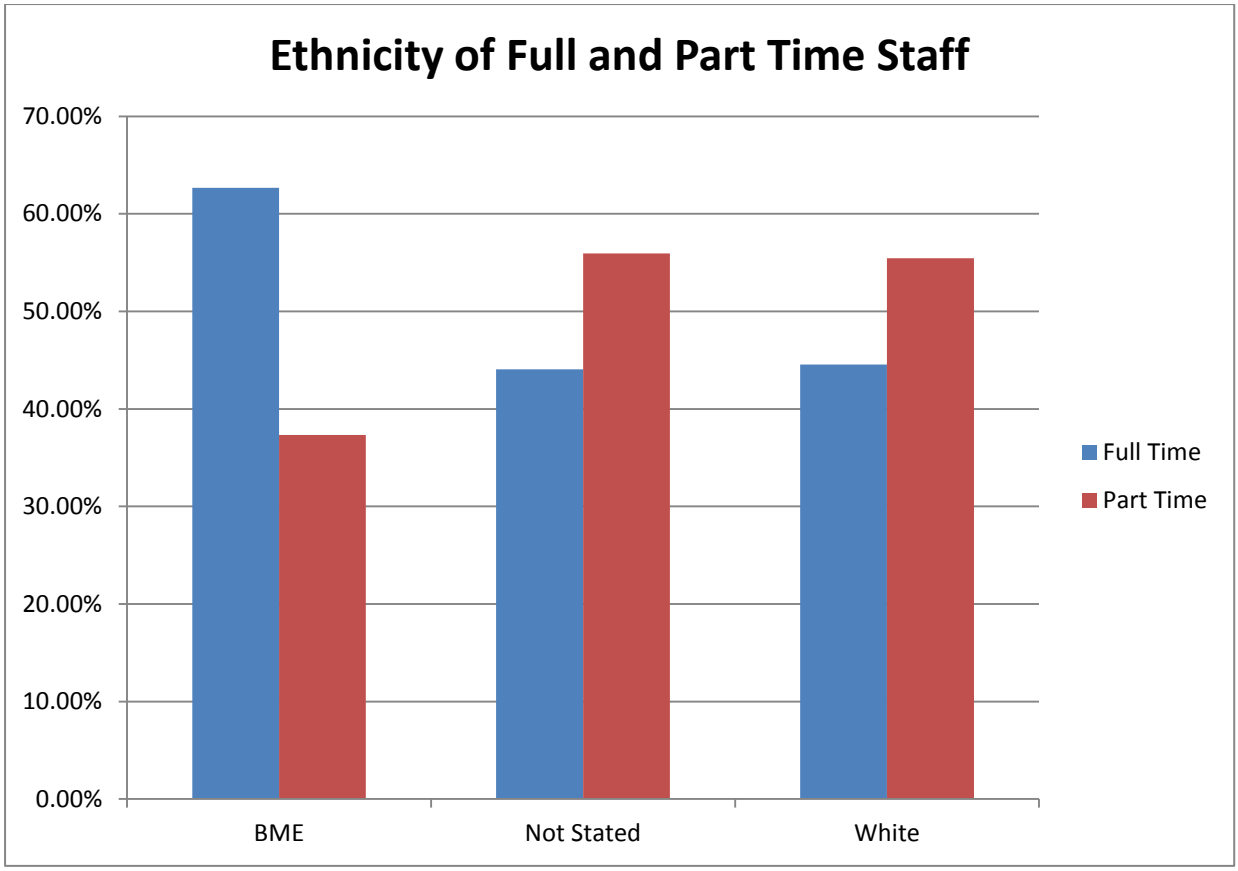
Staff

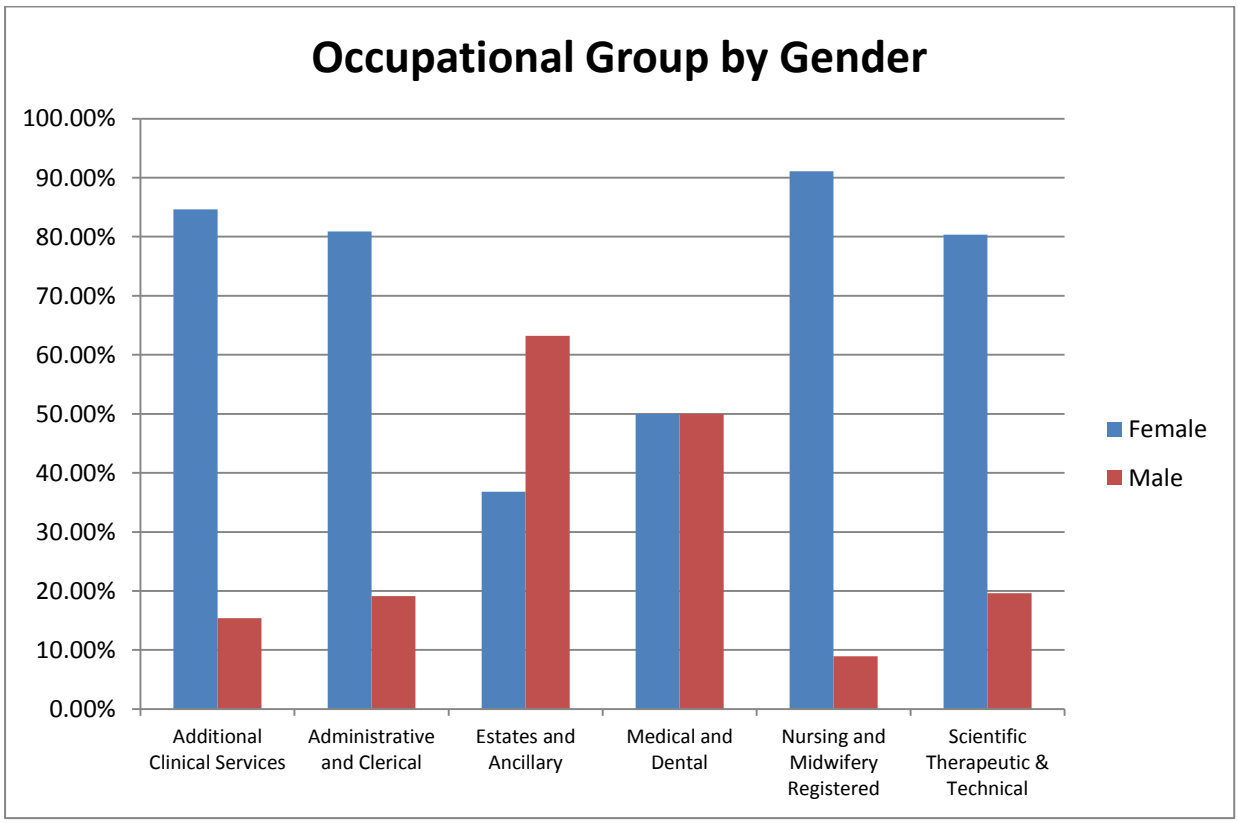
"Inclusive leadership at all levels"

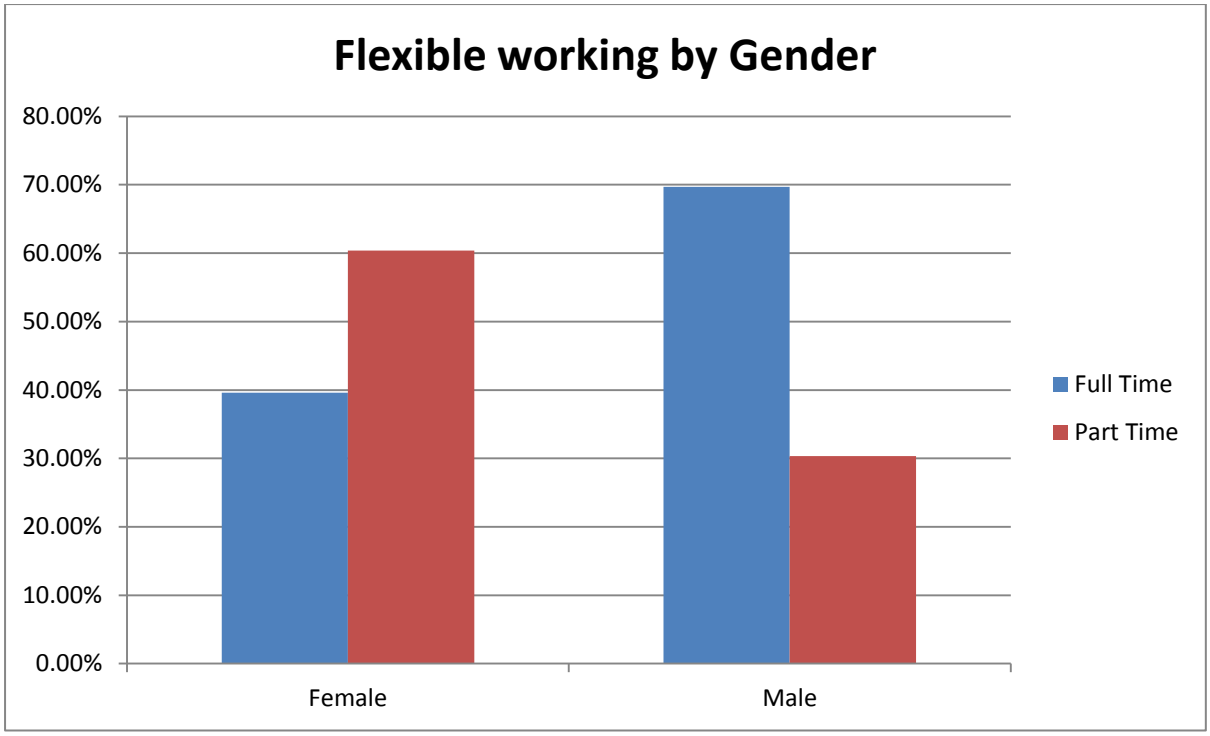
As part of our commitment to ensure that we are representative at all levels of our organisation we support women, BME, disabled and LGBT staff to support them to develop leadership skills, equipping them to apply for leadership roles

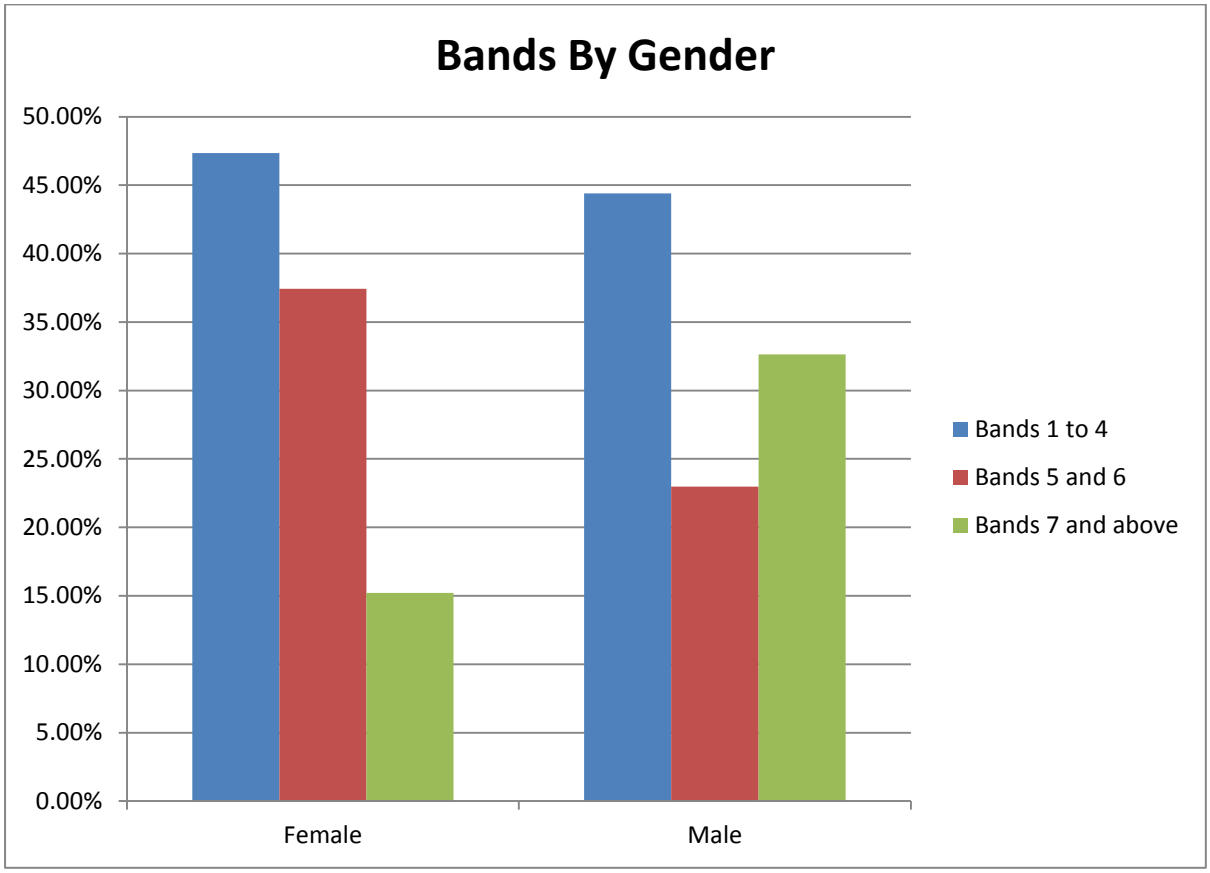

Ethnicity of the Workforce
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
BME
Not Stated
White
Bands 1 to 4
Bands 5 and 6
Bands 7 and above

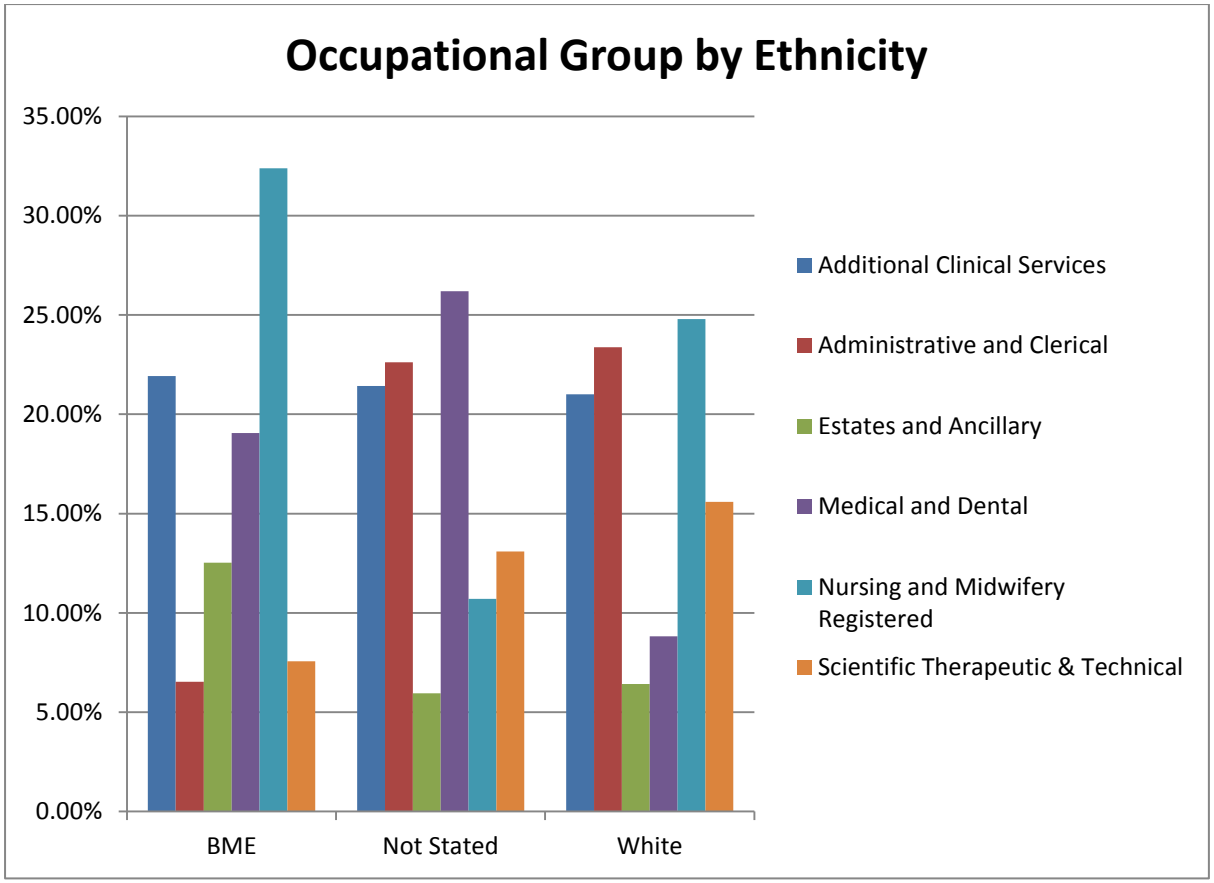

Workforce Disability Analysis
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Disabled
Not Declared
Not Disabled
Bands 1 to 4
Bands 5 and 6
Bands 7 and above

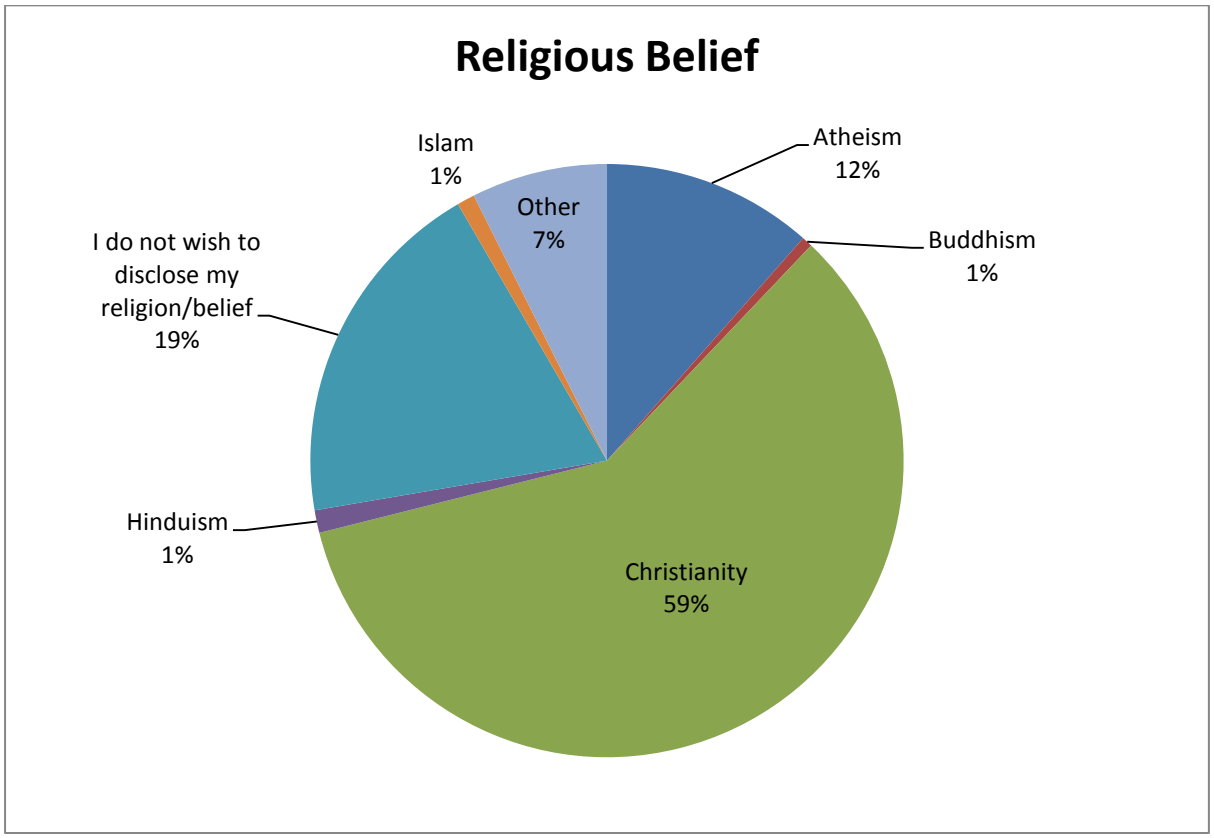

Ethnicity of Full and Part Time Staff
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
BME
Not Stated
White
Full Time
Part Time

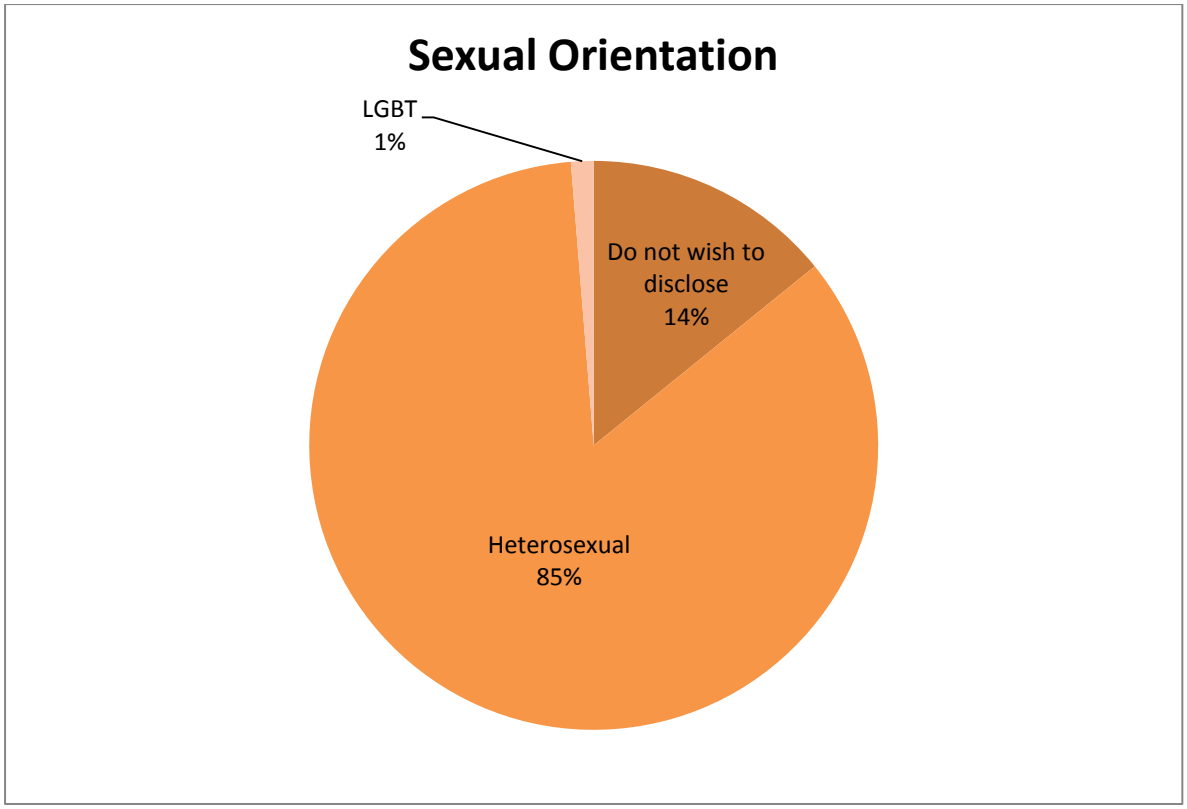

Occupational Group by Gender
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Additional Clinical Services
Administrative and Clerical
Estates and Ancillary
Medical and Dental
Nursing and Midwifery Registered
Scientific Therapeutic & Technical
Female
Male

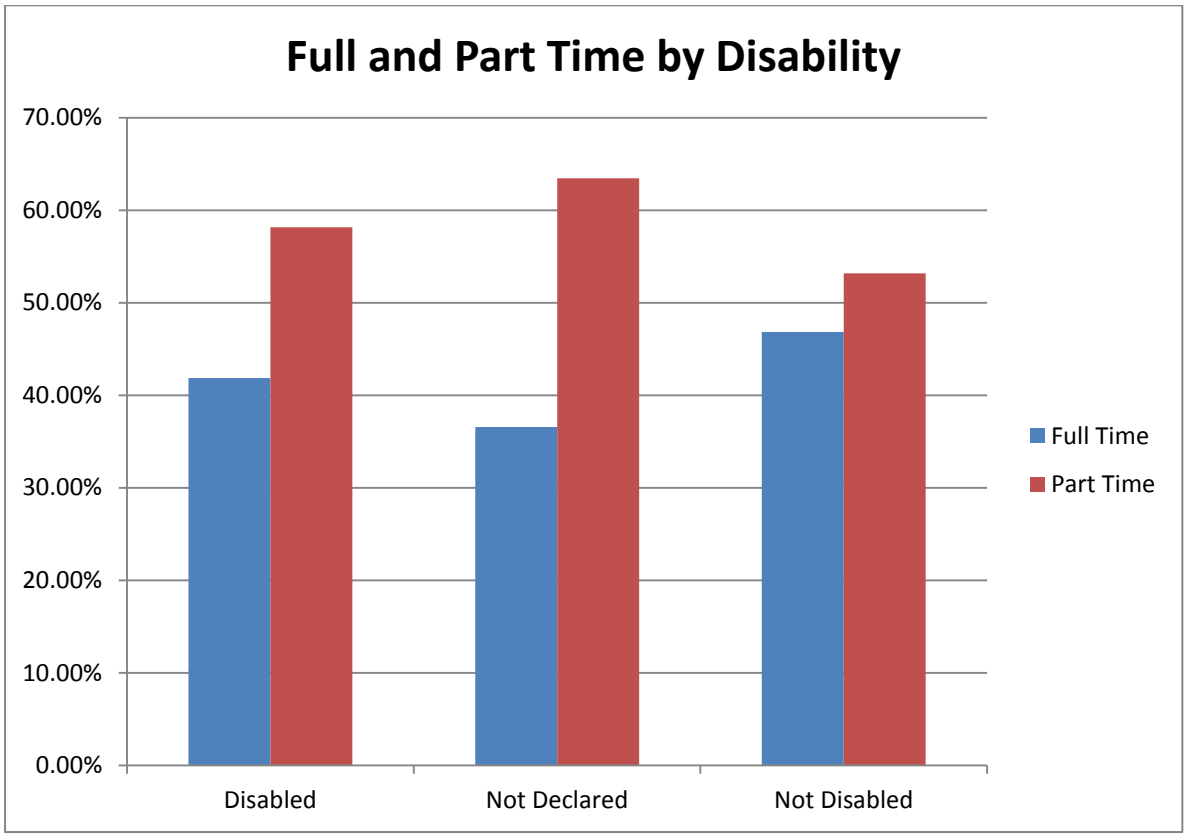

Flexible working by Gender
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Female
Male
Full Time
Part Time

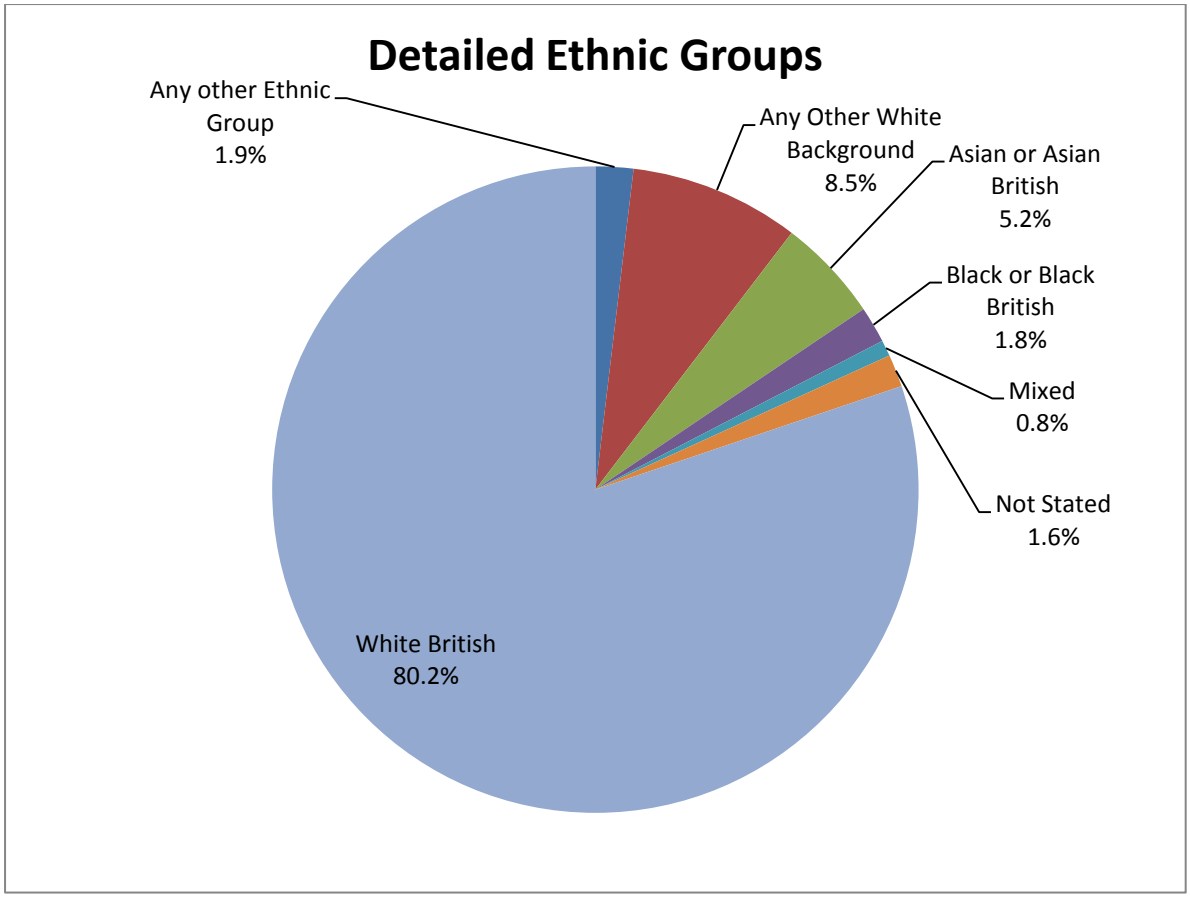

Bands By Gender
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Female
Male
Bands 1 to 4
Bands 5 and 6
Bands 7 and above

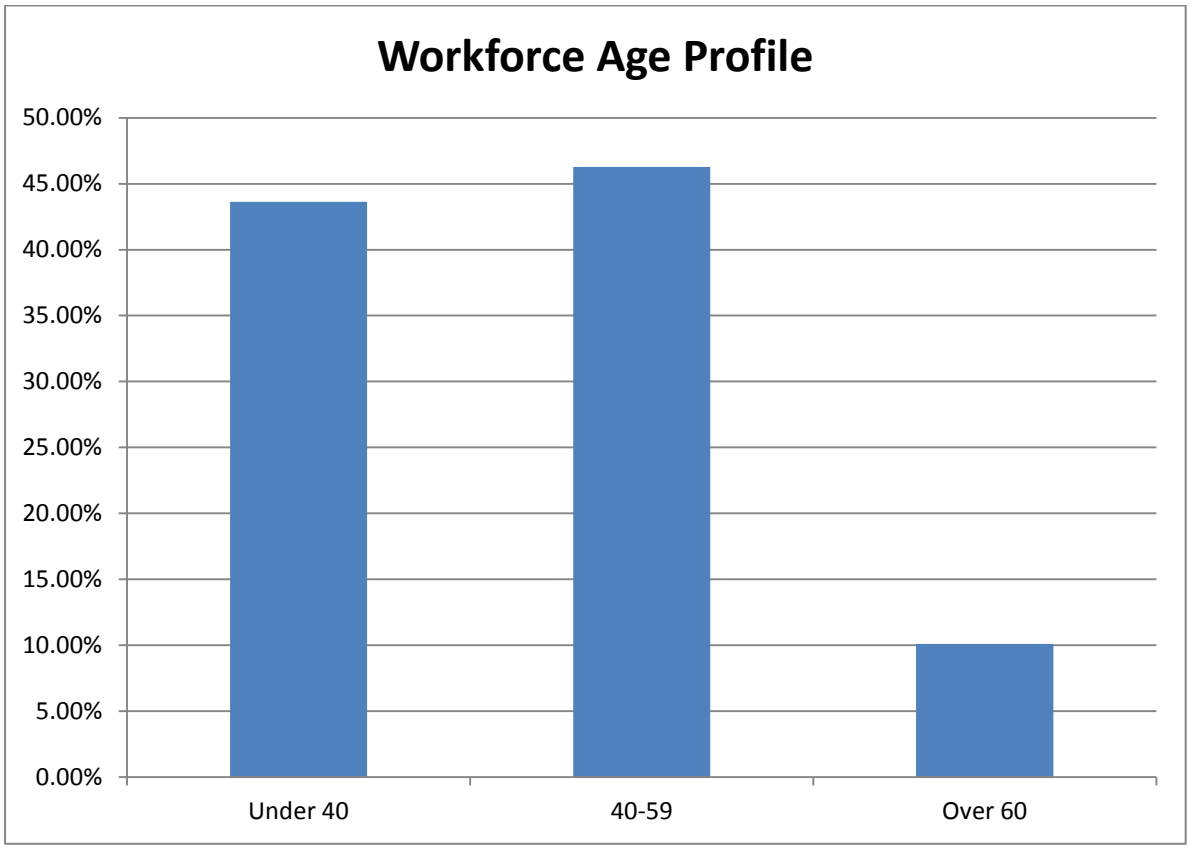

Occupational Group by Ethnicity
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
BME
Not Stated
White
Additional Clinical Services
Administrative and Clerical
Estates and Ancillary
Medical and Dental
Nursing and Midwifery Registered
Scientific Therapeutic & Technical

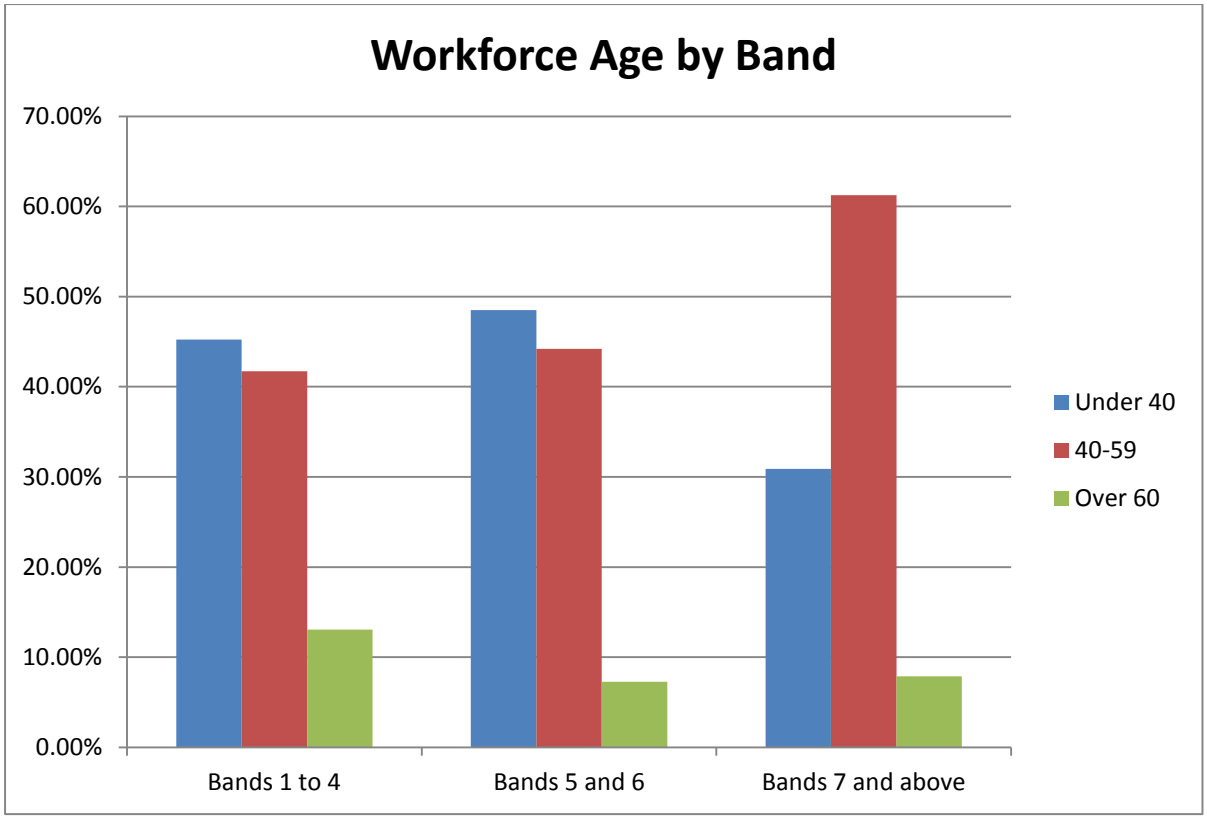

Religious Belief
Islam 1%
Atheism 12%
Other 7%
I do not wish to disclose my religion/belief 19%
Buddhism 1%
Hinduism 1%
Christianity 59%

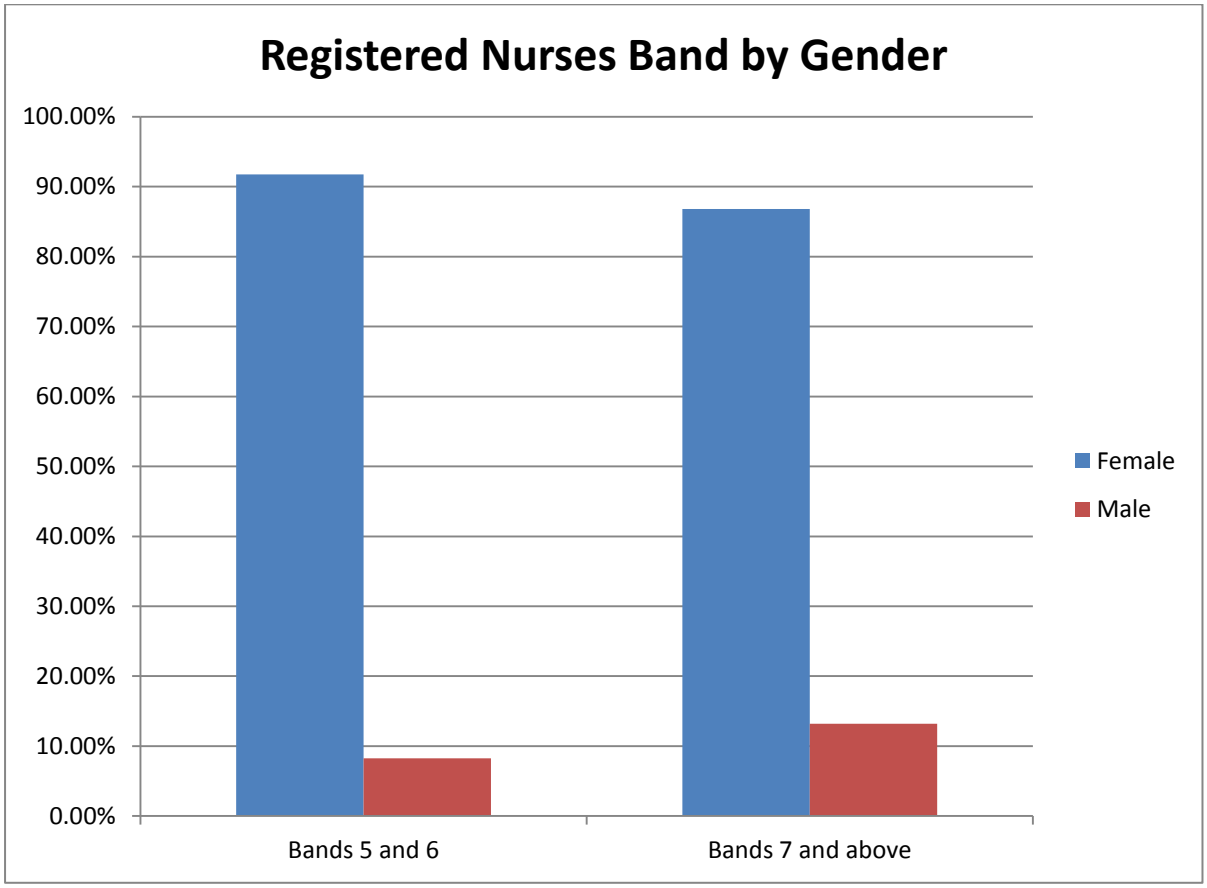

Sexual Orientation
LGBT
1%
Do not wish to
disclose
14%
Heterosexual
85%

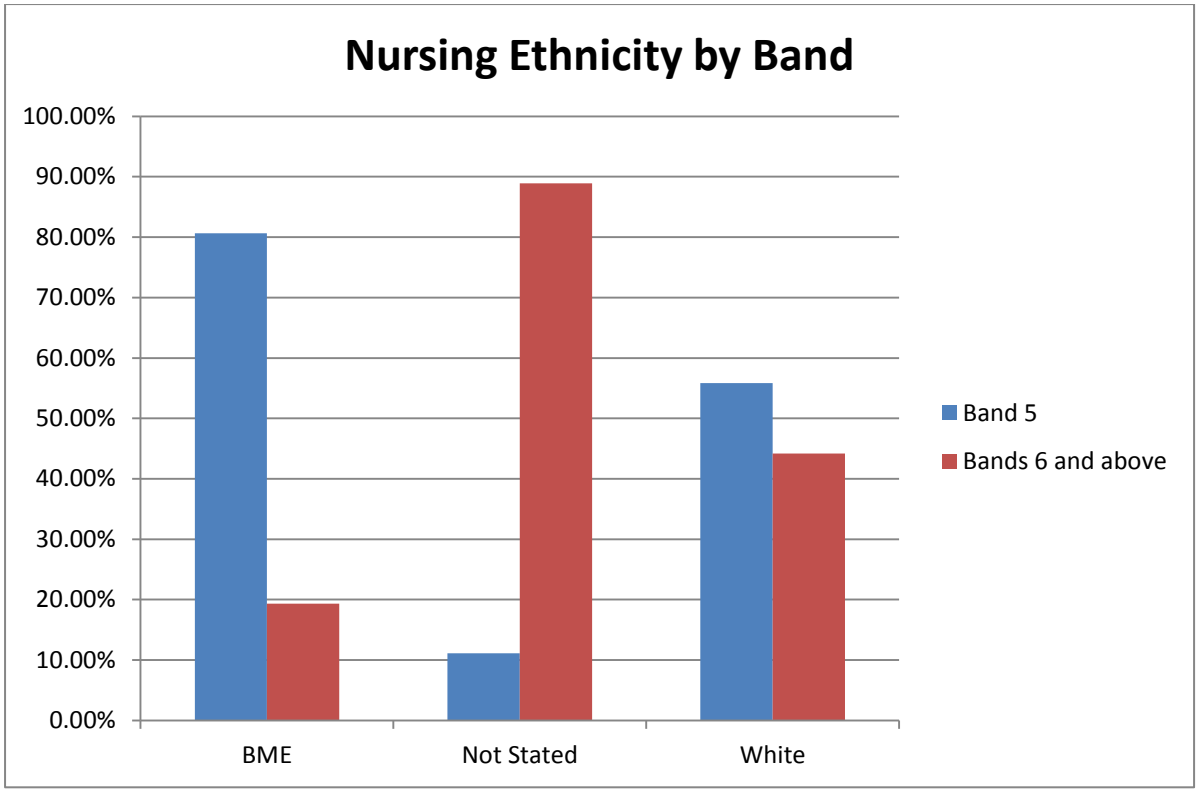

Full and Part Time by Disability
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Disabled
Not Declared
Not Disabled
Full Time
Part Time


Detailed Ethnic Groups
Any other Ethnic Group 1.9%
Any Other White Background 8.5%
Asian or Asian British 5.2%
Black or Black British 1.8%
Mixed 0.8%
Not Stated 1.6%
White British 80.2%


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


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


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



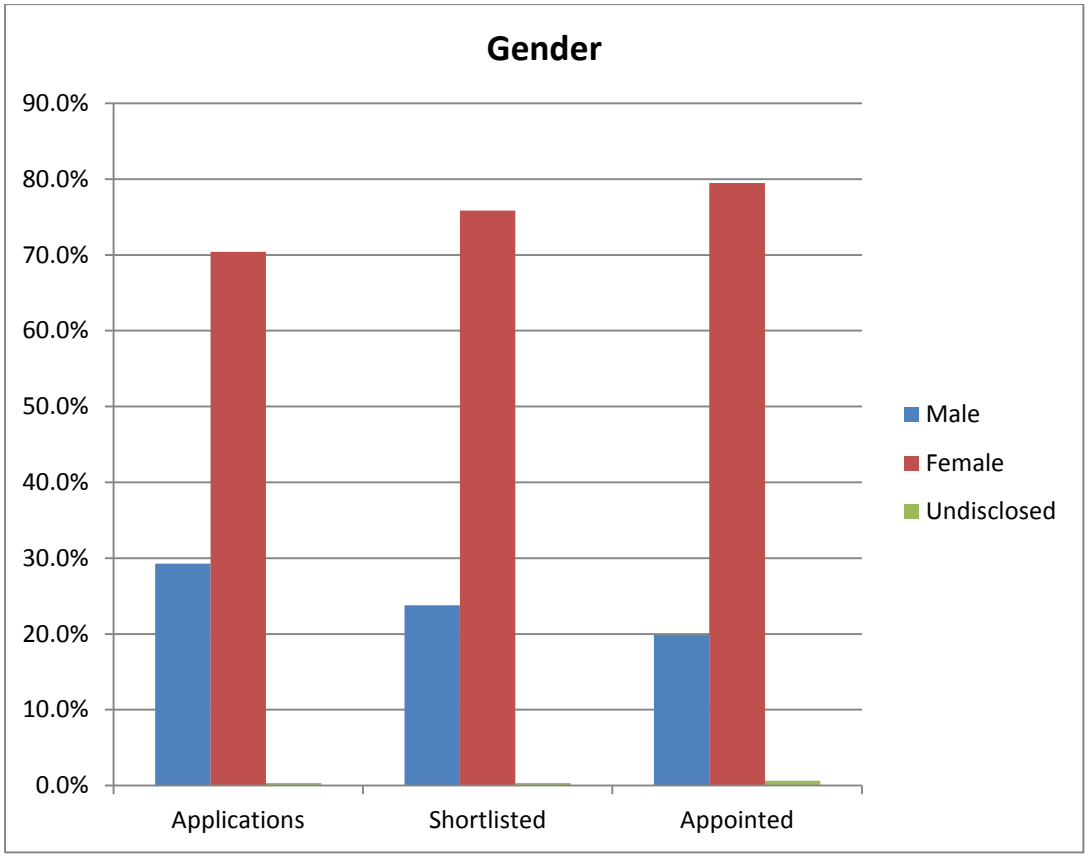
Grievance and Dismissal Information
In 2015/16 there were a total of 18 grievance, disciplinary and capability cases. 9 of the staff involved were male, 9 were female.
As per EHRC guidance, analysis by any other protected characteristic is not possible due to the small number of staff involved.
3 staff were dismissed for misconduct or capability reasons. It is not possible to provide further analysis due to the small numbers involved.

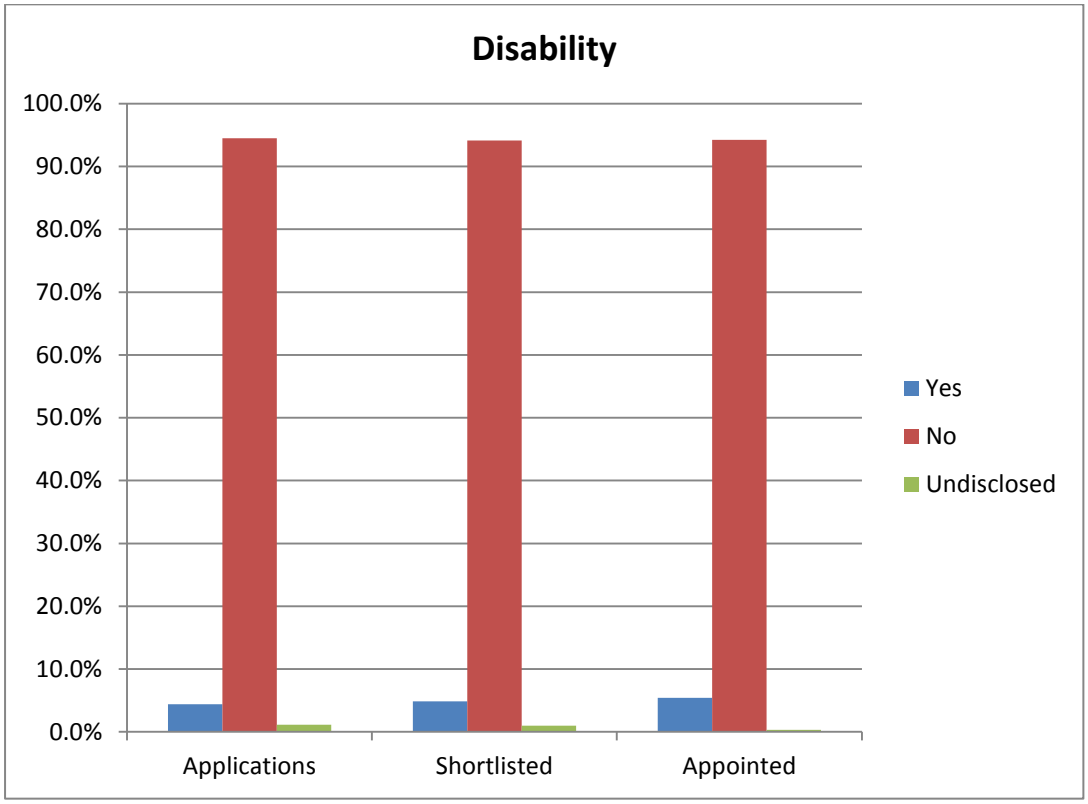
Complaints About Discrimination and Other Prohibited Conduct
In 2015/16 there were **0** formal allegations against the Trust of discrimination on the grounds of race, disability, age and religion or belief.

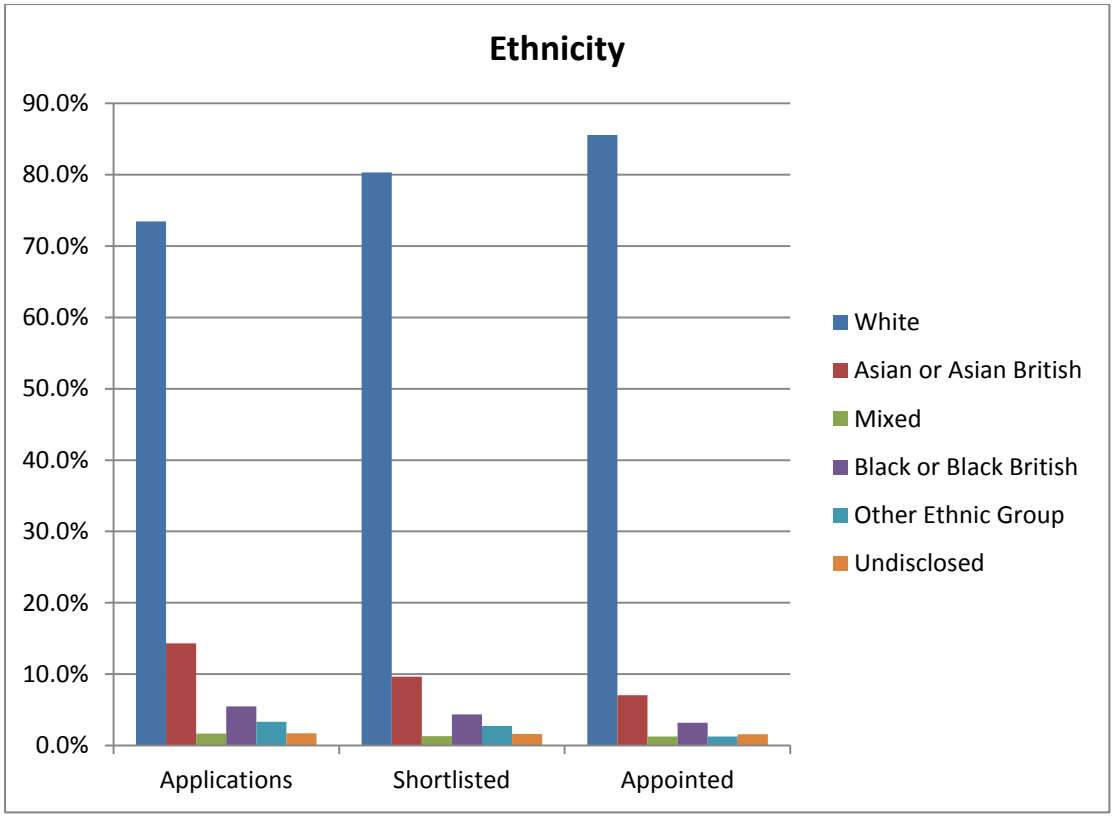
Gender Pay Gap

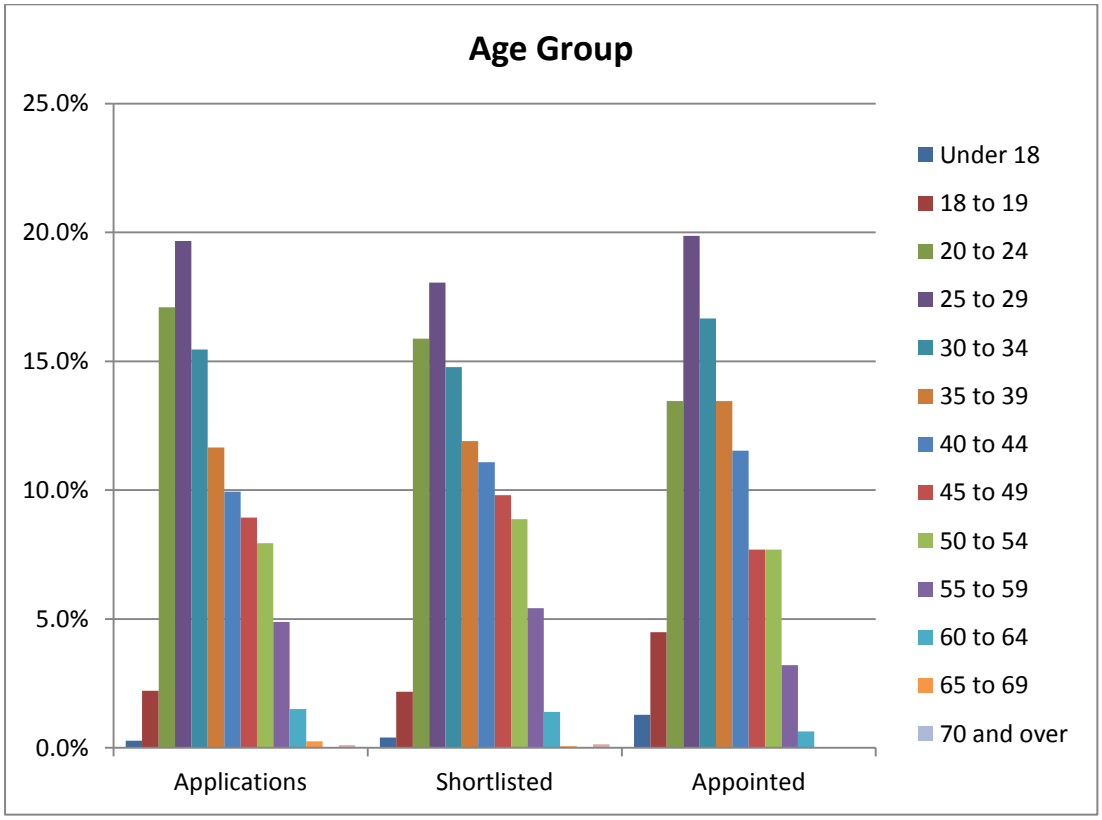
	Total Salary	FTE	Average Pay
Female	£58,189,343	2124	£27,402
Male	£25,531,407	714	£35,753
Total	**£83,720,750**	**2838**	**£29,504**

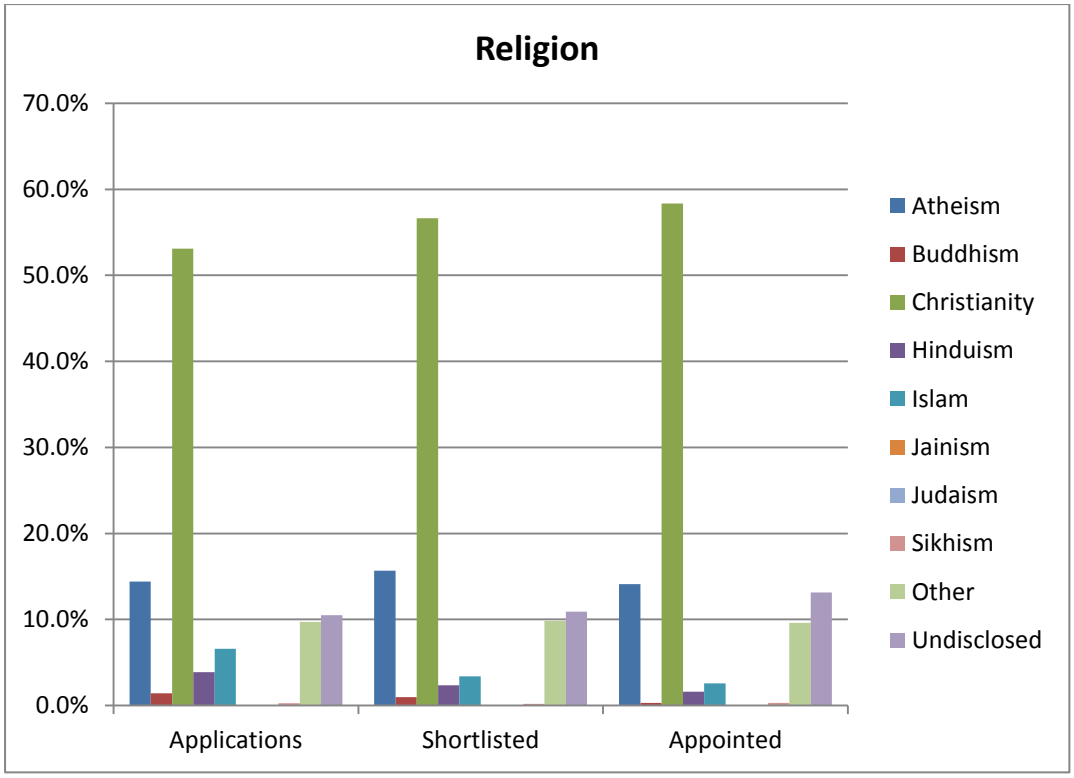
AfC- Band	Female	Male
1	3.5%	12.7%
2	29.2%	29.5%
3	12.5%	9.0%
4	5.5%	6.7%
5	23.8%	16.2%
6	15.3%	13.0%
7	7.6%	6.8%
8a	1.5%	1.9%
8b	0.8%	2.5%
8c	0.2%	1.0%
8d	0.1%	0.7%
9	0.0%	0.0%
	100.0%	100.0%

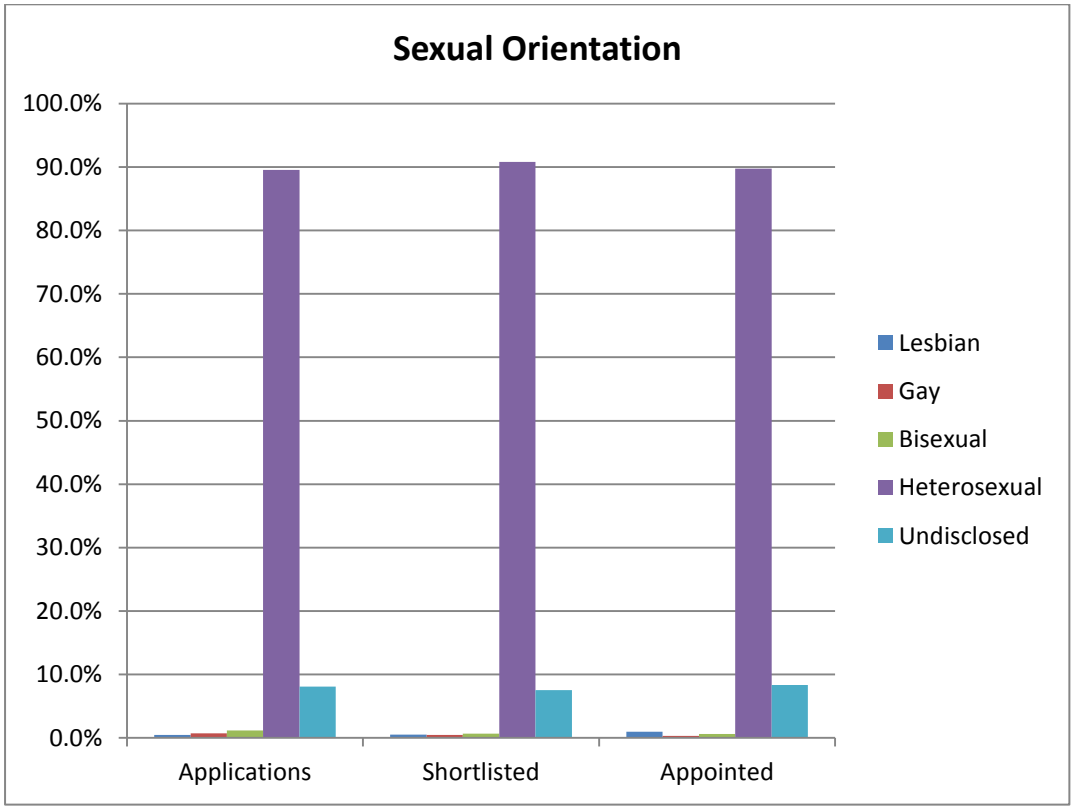

Gender
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Applications
Shortlisted
Appointed
Male
Female
Undisclosed


Disability
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Applications
Shortlisted
Appointed
Yes
No
Undisclosed


Ethnicity
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Applications
Shortlisted
Appointed
White
Asian or Asian British
Mixed
Black or Black British
Other Ethnic Group
Undisclosed


Age Group
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Applications
Shortlisted
Appointed
Under 18
18 to 19
20 to 24
25 to 29
30 to 34
35 to 39
40 to 44
45 to 49
50 to 54
55 to 59
60 to 64
65 to 69
70 and over

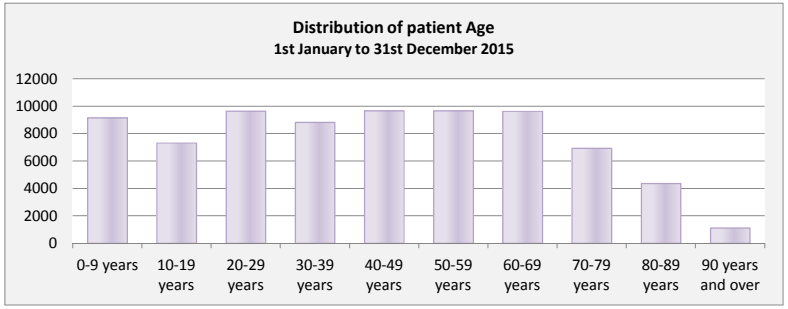

Religion
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Applications
Shortlisted
Appointed
Atheism
Buddhism
Christianity
Hinduism
Islam
Jainism
Judaism
Sikhism
Other
Undisclosed


Sexual Orientation
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Applications
Shortlisted
Appointed
Lesbian
Gay
Bisexual
Heterosexual
Undisclosed

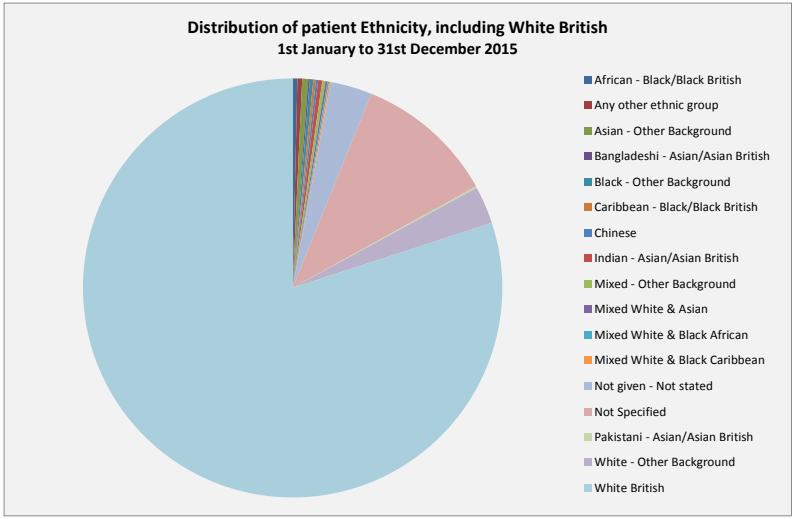
Equality & Diversity Data

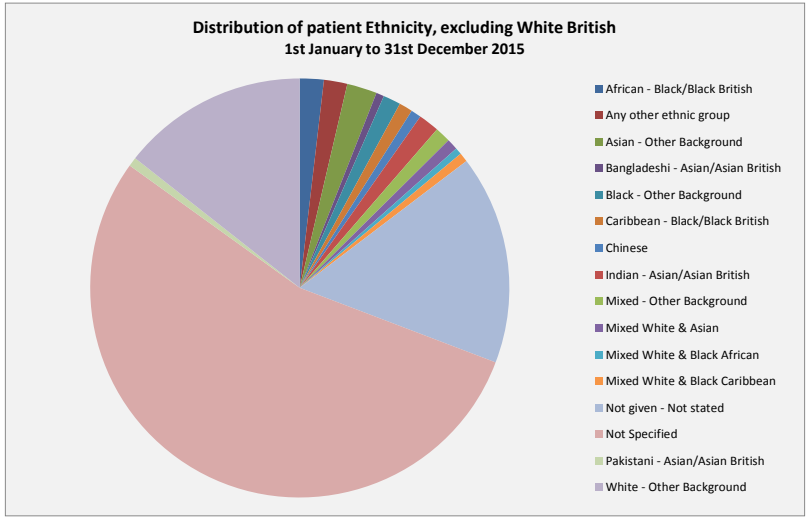
1st January to 31st December 2015

Age Group	Total
0-9 years	9154
10-19 years	7315
20-29 years	9629
30-39 years	8818
40-49 years	9658
50-59 years	9654
60-69 years	9627
70-79 years	6921
80-89 years	4359
90 years and over	1114
Grand Total	**76249**



Ethnicity	Total
African - Black/Black British	281
Any other ethnic group	273
Asian - Other Background	351
Bangladeshi - Asian/Asian British	91
Black - Other Background	206
Caribbean - Black/Black British	161
Chinese	117
Indian - Asian/Asian British	242
Mixed - Other Background	184
Mixed White & Asian	128
Mixed White & Black African	78
Mixed White & Black Caribbean	111
Not given - Not stated	2449
Not Specified	8215
Pakistani - Asian/Asian British	107
White - Other Background	2179
White British	60841
White Irish	235
Grand Total	**76249**



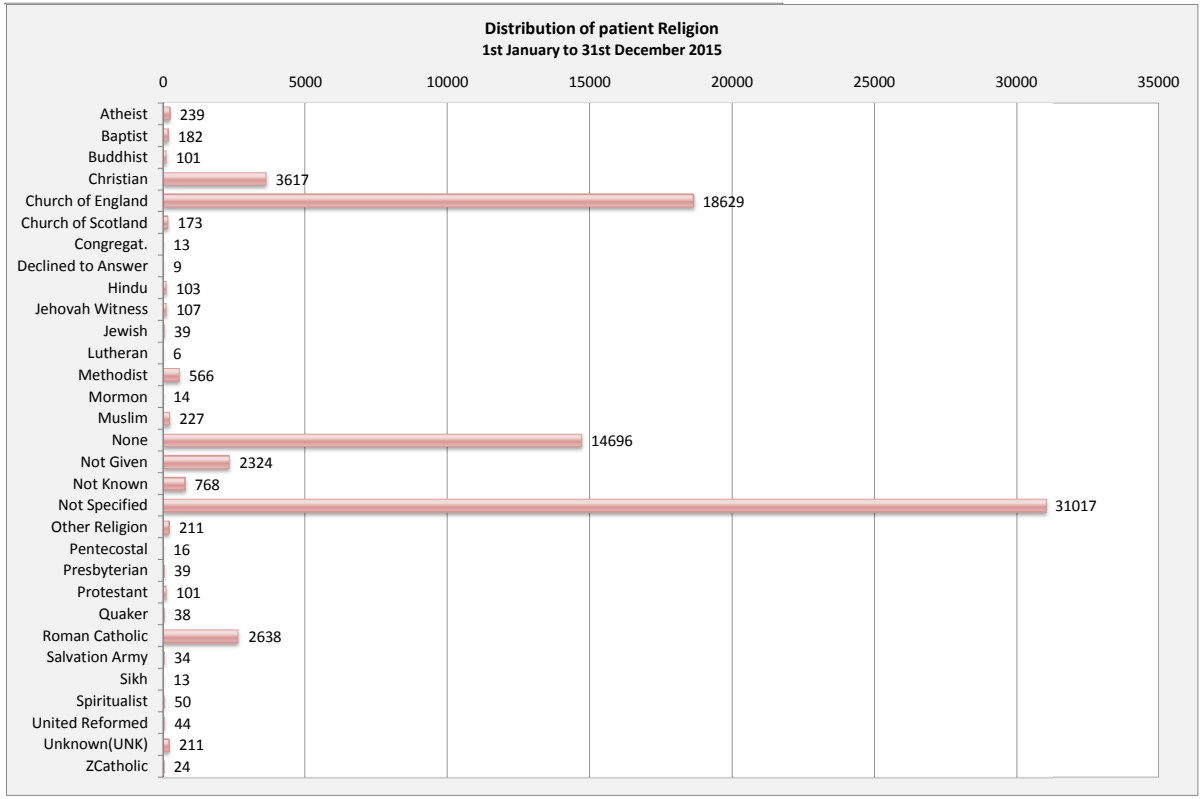


Disability	Total
N	76248
Y	1
Grand Total	**76249**

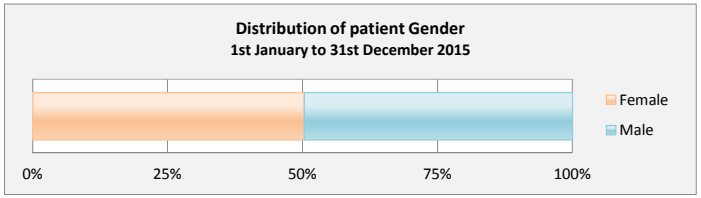
Equality & Diversity Data

1st January to 31st December 2015

Religion	Total
Atheist	239
Baptist	182
Buddhist	101
Christian	3617
Church of England	18629
Church of Scotland	173
Congregat.	13
Declined to Answer	9
Hindu	103
Jehovah Witness	107
Jewish	39
Lutheran	6
Methodist	566
Mormon	14
Muslim	227
None	14696
Not Given	2324
Not Known	768
Not Specified	31017
Other Religion	211
Pentecostal	16
Presbyterian	39
Protestant	101
Quaker	38
Roman Catholic	2638
Salvation Army	34
Sikh	13
Spiritualist	50
United Reformed	44
Unknown(UNK)	211
ZCatholic	24
Grand Total	**76249**



Gender	Total
Female	38355
Male	37894
Grand Total	**76249**



Gender Reassignment

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

F649: Gender identity disorder, unspecified
F640: Transsexualism

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

Sexuality

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

Pregnancy

Number of Deliveries by Location	Total
In transit on route to hospital	7
Unplanned homebirth	21
Theatre	656
Delivery Suite	1639
Other	8
Homebirth planned	53
Grand Total	**2384**

WRES – Priorities 2016/17	Current Position 2016	Plans for 2016/17	Future Developments Plans for 2017/18
We will share our WRES audit with all our workforce with a narrative to explain the data	We have published the WRES on the hospital website.	For the July 2016 publishing data we will provide a briefing to go via Cascade Brief, broadcast and through BME staff, staff side, EDSG, network groups and local interest groups. We will promote BME annual promotion data to staff. Highlight this area as success.	
We will set up a WRES network group to assist with issues that have arisen for the WRES audit, and help with tangible results to close the gap between White and BME staff treatment, experience and opportunities in the workplace.	We are drafting an email which will be sent to all BME staff from Steve Long and Nick Marsden, requesting BME representation and support onto the WRES network.	We plan to set up a network, which will facilitate further discussion and debate on the WRES. Monthly reviews on NHS Jobs shortlisted/ appointed under BME, publishing and raising the profile of this data. Analyse BME data 8-9 and review doctors/consultants with managing responsibilities.	We will invite local interest groups to attend WRES network sessions and have a minimum of 2 examples of tangible work undertaken.

We will nominate a Board member responsible for WRES implementation in our organisation.	Steve long is currently the E&D lead on the Board, Alison Kingscott is the Executive Lead and responsible for the E&D Dept.	NED E&D lead to become the WRES lead on Trust Board. To raise the profile of the WRES at each Trust Board meeting.	
We will identify senior BME role models within our organisations.	We are drafting an email which will be sent to all BME staff from Steve Long and Nick Marsden, requesting BME representation and support onto the WRES network.	We intend to identify several BME role model. Similar to the 'Equality Champions' pen portraits we will highlight their career achievements and provide opportunities for an open Q&A forum, throughout the year.	Review and potentially build on this work. Review BME data under AfC bands to assess differences., over and under representation.

Trust Board meeting **SFT 3792**

Quality indicator report – June 2016 & Q1 16/17

Date: 26 July 2016

Report from: Dr Christine Blanshard, Medical Director & Lorna Wilkinson, Director of Nursing
Presented by: Dr Christine Blanshard, Medical Director & Lorna Wilkinson, Director of Nursing

Executive Summary:

- No MRSA bacteraemias in Q1.
- 4 MSSA bacteraemias in June, none were device related. Q1 total – 5 MSSA bacteraemias.
- 1 Trust apportioned C Difficile case in June. Q1 total – 3 cases below upper limit at the end of Q1.
- 4 new serious incident inquiries commissioned in June. Q1 total – 15. No never events in Q1.
- A new chart showing compliance with early warning scores to recognise deteriorating patients and escalation implementation.
- A decrease in the crude mortality rate in Q1 with an increase in admissions. SHMI is 112 to December 2015 and remains as expected. HSMR is 110 to March 16 and is higher than expected. New item - CUSUM alerts triggered when a diagnosis or procedure group has a higher number of deaths observed than expected. Each alert is investigated by the appropriate clinician and reported to the Mortality Surveillance Group to ascertain if the death was avoidable and any learning points to improve the patient pathway. One new alert in March 16.
- Time to theatre for patients with a fractured neck of femur improved in Q1, as did BPT compliance at 83%.
- 42 grade 2 pressure ulcers in Q1 compared to 54 in Q1 15/16. 3 grade 3 pressure ulcers in Q1 compared to the same number in Q1 15/16. Share and learn meetings continue to drive improvements.
- Safety Thermometer – a decrease in 'new harm free care' in June 16 and of patients admitted to hospital with a harm.
- In June there were 2 falls, 1 resulting in major harm (fractured hip requiring surgery) and 1 resulting in moderate harm (fractured fibula managed with a cast). In Q1 there were 7 falls, 3 resulting in major harm (2 fractured hips requiring surgery & 1 fractured elbow requiring internal fixation) and 4 resulting in moderate harm (fractured fibula, 2 fractured wrists all managed with casts and a head injury).
- In Q1 CT scan within 12 hours was achieved for all except one stroke patient. In June, an increase in patients spending 90% of their time on the stroke unit. Patients arriving on the unit within 4 hours significantly improved in June following improvement work between ED and the stroke unit. In Q4, SNNAP was a grade C.
- In Q1 a decrease in high risk TIA patients being seen within 24 hours. In June 5 patients were not seen within the timeframe due to lack of same day clinic availability (3), investigations not completed within 24 hrs (1) and a patient seen in a general medical clinic rather than a TIA clinic (1).
- A new chart showing the number of complaints and concerns received and re-opened with 100% acknowledged within 3 working days. Work is progressing towards a more proactive approach in the initial phase of a complaint and learning from themes.
- Escalation bed capacity reduced in June but still remains at a high level with significant demand continuing in the non-elective pathway including admissions and the number of delayed transfer of care and 'green to go' patients.
- In June 16 there were 2 non-clinical mixed sex accommodation breaches affecting 12 patients all on AMU, all for a short periods of time to enable timely access to medical care, and all due to bed capacity issues and patient acuity. In Q1 a total of 8 non-clinical mixed sex accommodation breaches occurred affecting 62 patients all on AMU.
- New items - of patients experiencing ward moves more than once, twice and three times with a significant increase in moves more than once in June reflecting the pressures on bed capacity and patient acuity. Also

included is the time of patient moves for ongoing monitoring purposes. The majority of overnight moves are from Whiteparish, SSEU and Britford SAU to maintain patient flow. However, there were a number of moves from one ward to another to maintain patient flow. The majority of discharges between 10 pm and 7 am are from ED/SSEU, Whiteparish and Britford SAU.

- Real time feedback in Q1 for patients rating the quality of their care was consistent with the previous year's average. Responses to the Friends and Family test consistently shows that patients would recommend wards, the maternity service and ED to their friends and family if they needed similar care or treatment

Proposed Action:

1. **To note the report**

Links to Assurance Framework/ Strategic Plan:
CQC registration

Appendices:
Trust quality indicator report – June 2016

Supporting Information

Salisbury NHS
NHS Foundation Trust

Trust Quality Indicators - June 2016

Quality Measures

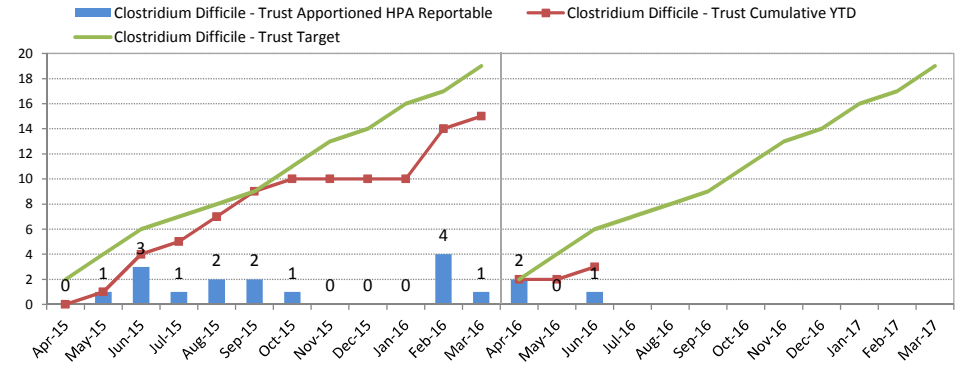
Infection Control	*2015-16 YTD*	*2016-17 YTD*
MRSA (Trust Apportioned)	**0**	**0**

Trust Incidents	*2015-16 YTD*	*2016-17 YTD*
Never Events	**2****	**0**
Serious Incidents Requiring Investigation	**28*****	**15**

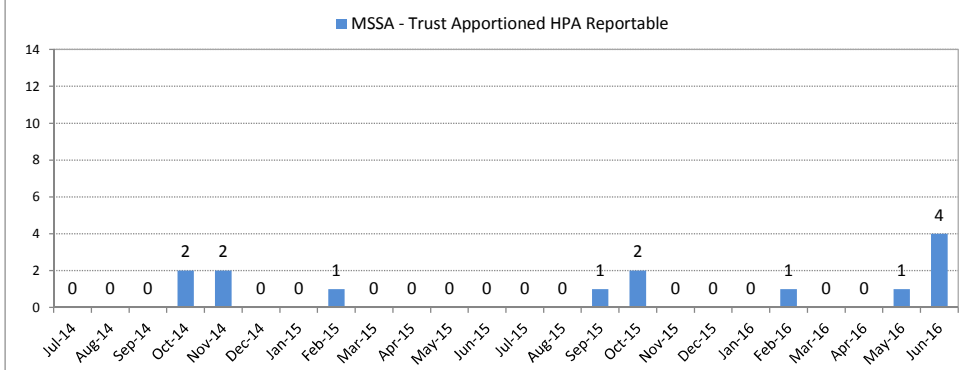
** A formal agreement was reached with the CCG to downgrade a third never event as it did not meet the definition.

*** Of these SIIs commissioned, 2 have been downgraded following a formal agreement with the CCG as they did not meet the SI definition.

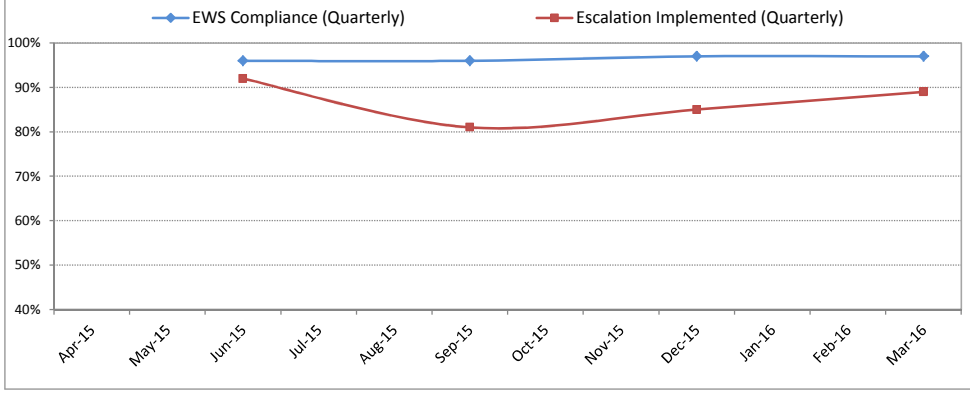
Clostridium Difficile - Trust Apportioned



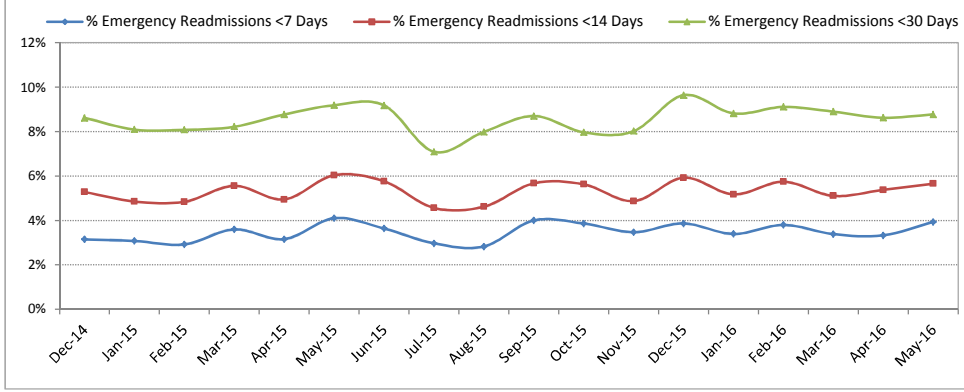
MSSA - Trust Apportioned



EWS (Early Warning Score) & Escalation



Emergency Readmissions within 7, 14 & 30 days of Discharge

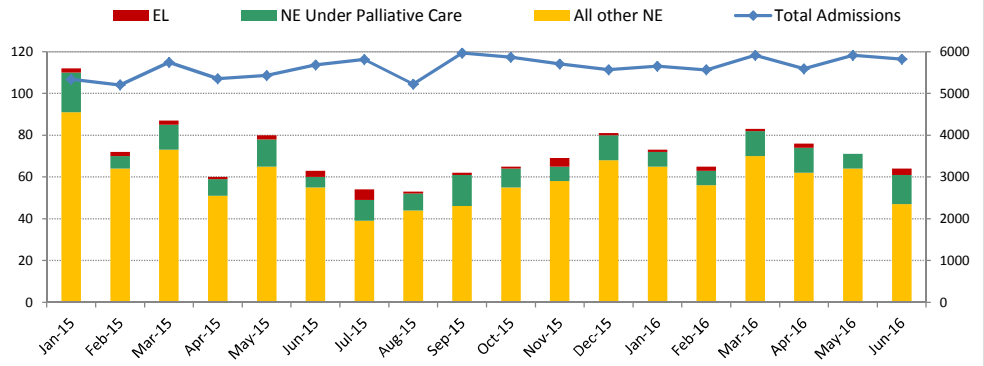


Salisbury NHS
NHS Foundation Trust

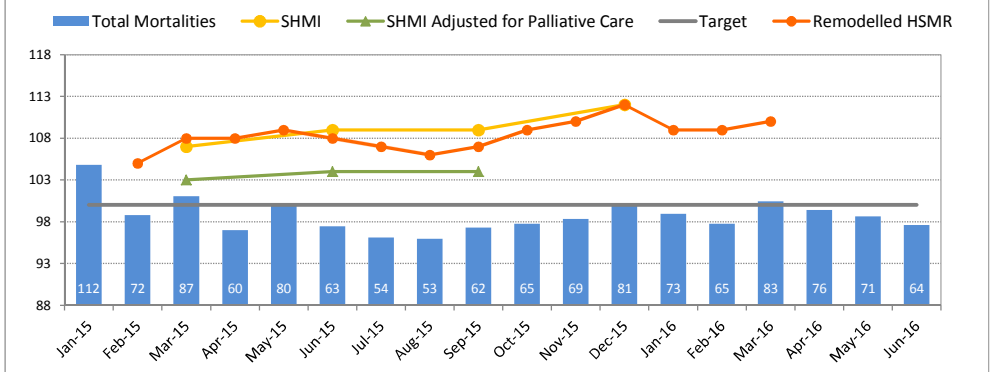
Trust Quality Indicators - June 2016

Quality Measures

Hospital Mortalities

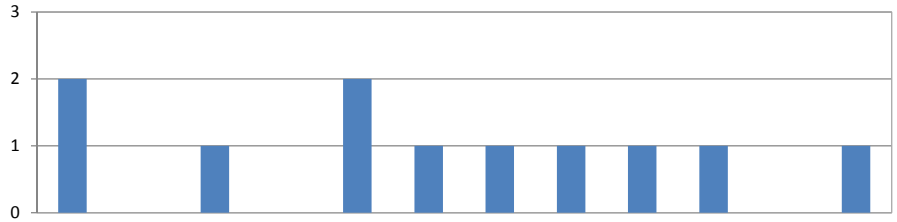


HSMR and SHMI



CUSUM Alerts

Cumulative sum of mortality outcomes (Observed > Expected)

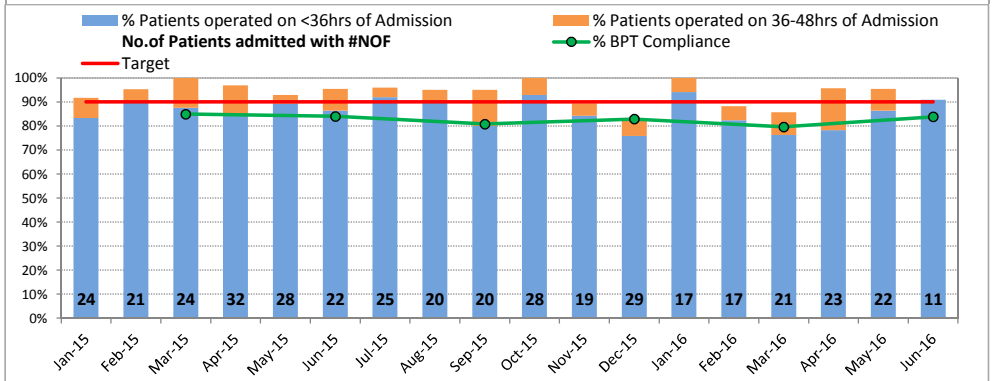


	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
CUSUM	2	0	1	0	2	1	1	1	1	1	0	1

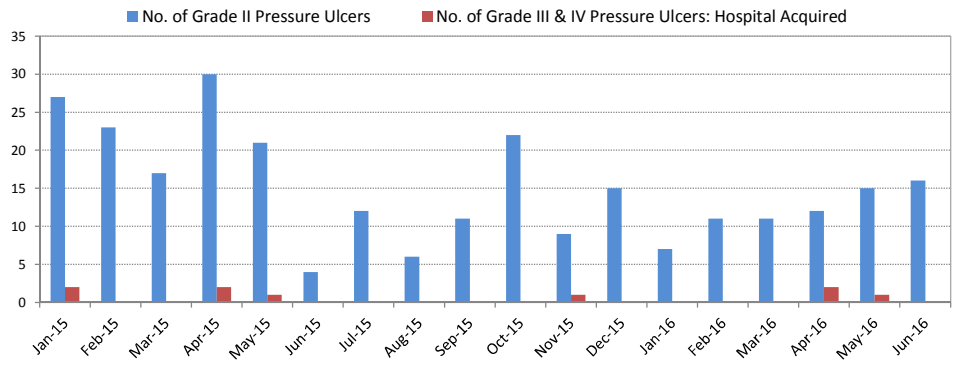
Date of latest alert: Mar-16

1 Alert: Other connective tissue disease - 11 Observed vs 3.7 Expected (RR296)

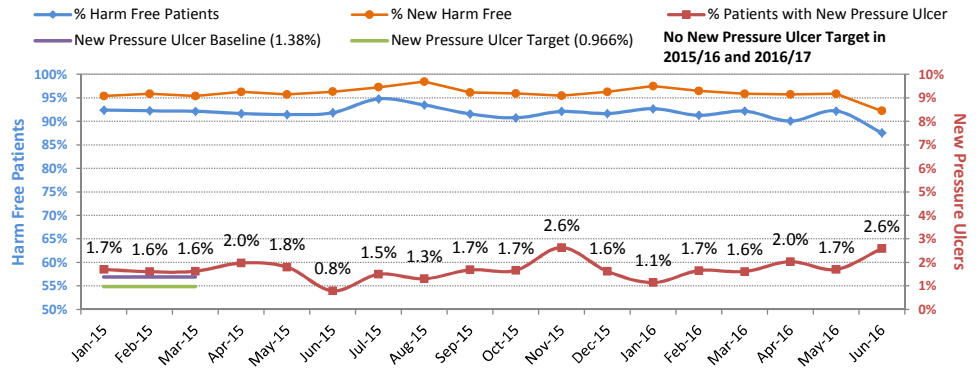
Fracture Neck of Femur operated on within 36 hours (Revised following TIAA Audit)



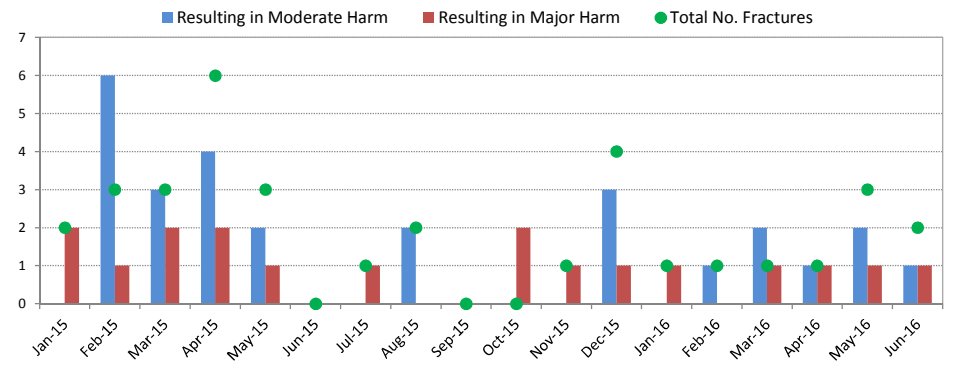
Pressure Ulcers



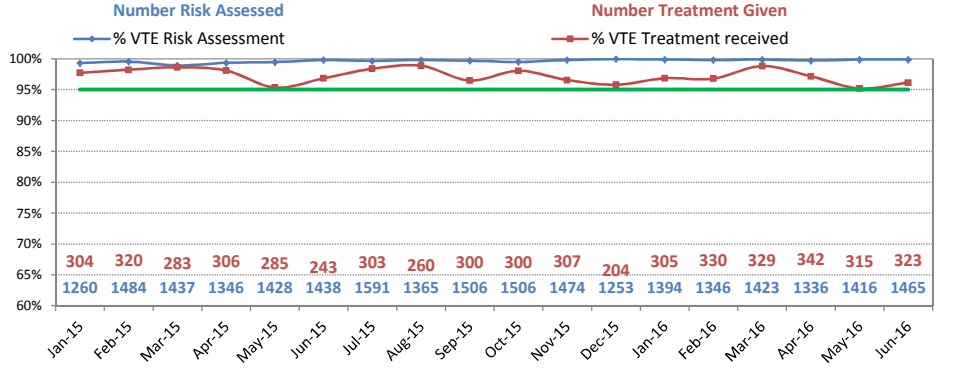
Safety Thermometer - One Day Snapshot per Month



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



Venous Thrombous Embolism: Risk Assessment & Prophylaxis



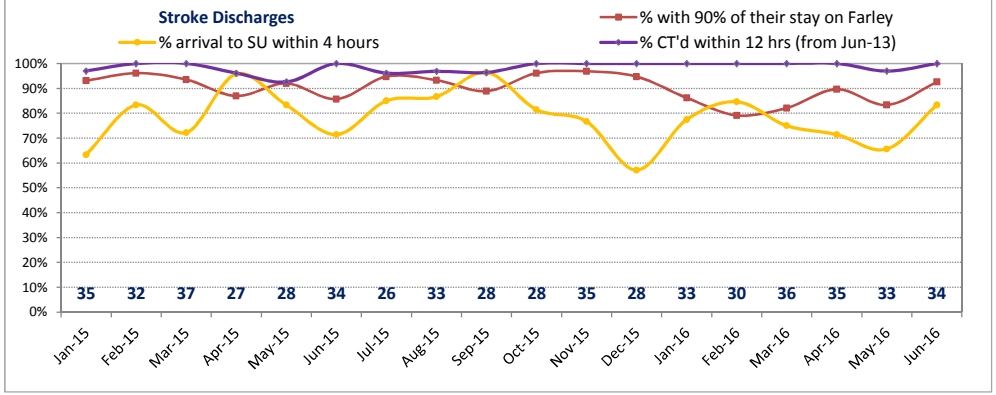
Please note, due to the time it takes to complete Clinical Coding, the current months Fracture Neck of Femur data will be subject to change over the following months.

Salisbury NHS
NHS Foundation Trust

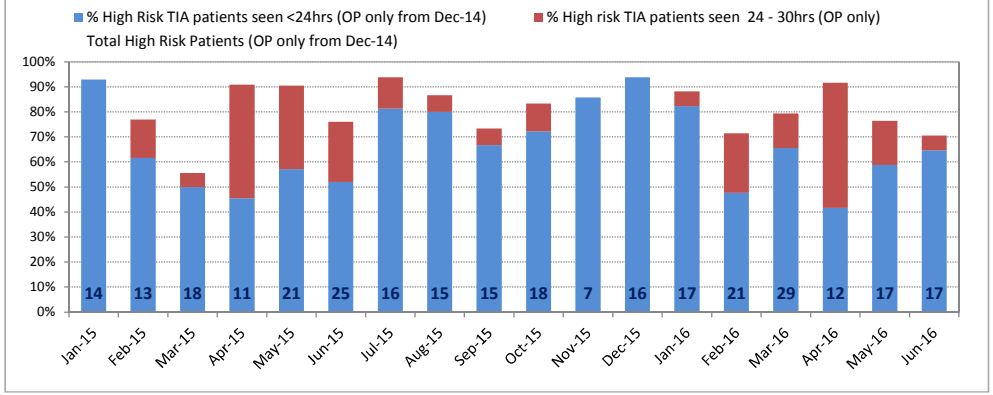
Trust Quality Indicators - June 2016

Quality Measures

Stroke Care



TIA Referrals



SSNAP Case Ascertainment Audit

Highest level = Grade A

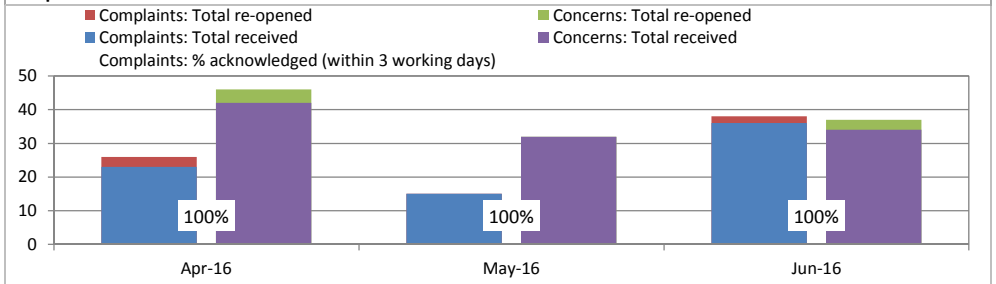
Lowest level = Grade E

(These Grades are measured quarterly)

	Q1	Q2	Q3	Q4
2014-15	B	D	C	C
2015-16	D	C	C	C
2016-17				

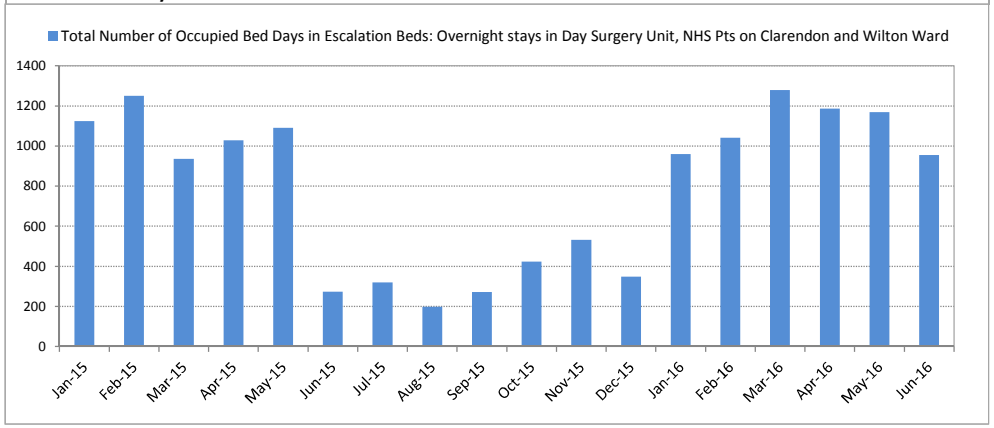
Please note, from Sep-14 escalation bed capactity is Winterslow 8 beds, Wilton 12 beds and DSU if it stays open at night. Breamore ward opened from 1st January 2015 with a further 27 escalation beds and closed on 29th May 2015. From 1st April 2015 Wilton closed for escalation beds. On 4th January 2016 Breamore Ward opened as a planned winter escalation ward.

Complaints and Concerns

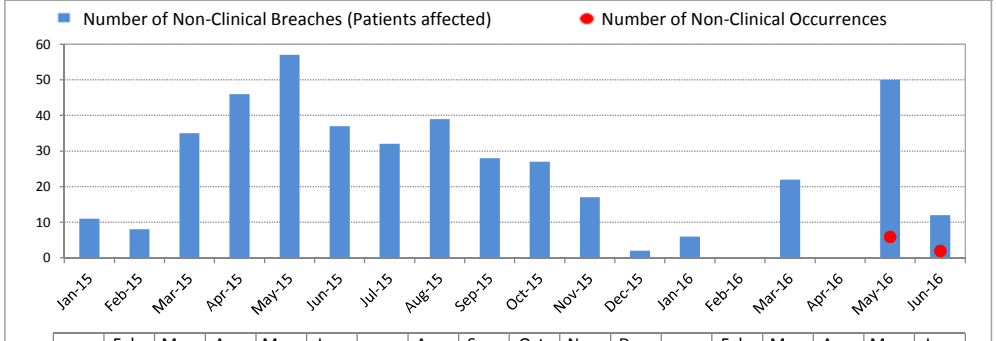


	Apr-16	May-16	Jun-16
Complaints: Total received	23	15	36
Complaints: Total re-opened	3	0	2
Concerns: Total received	42	32	34
Concerns: Total re-opened	4	0	3

Escalation Bed Days

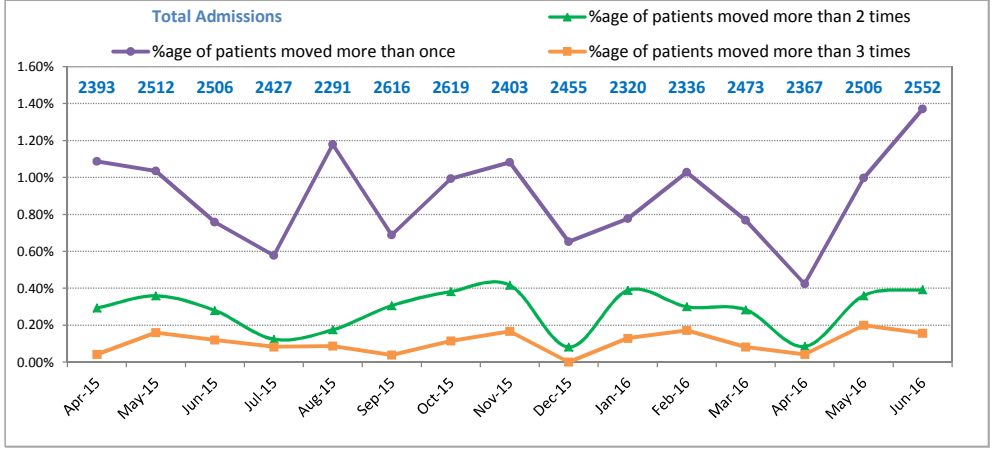


Delivering Same Sex Accommodation



	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
■	11	8	35	46	57	37	32	39	28	27	17	2	6	0	22	0	50	12
●																	6	2

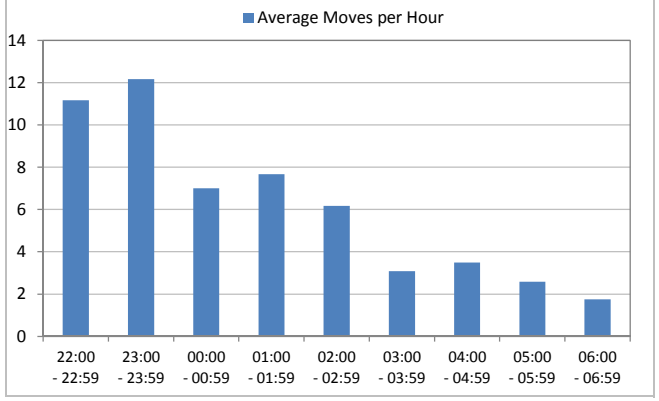
Patients moving multiple times during their Inpatient Stay



Please note, the number of Non-Clinical Breach Ocurrences is being reported from May 2016.

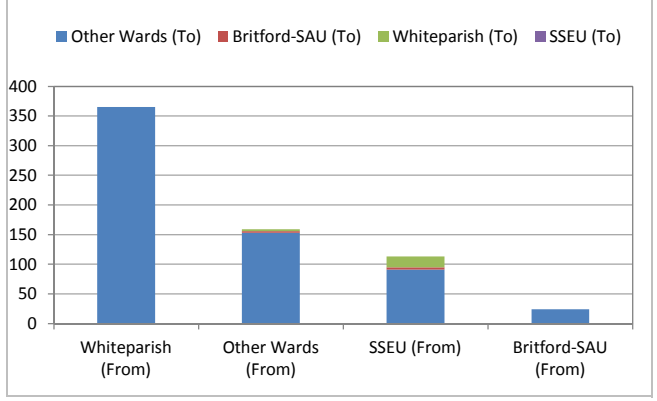
Ward moves between 22:00 and 07:00

01 April 2016 to 31 March 2017



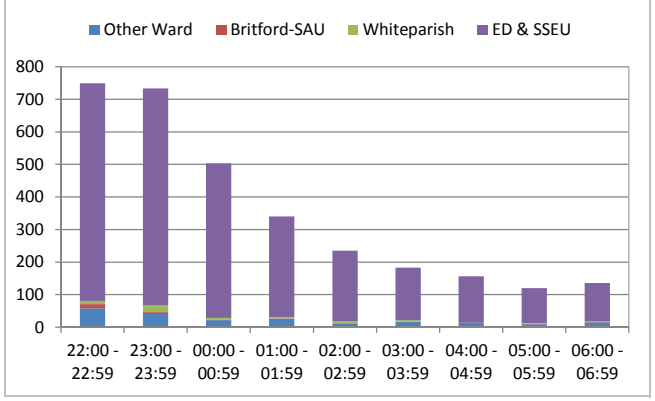
Ward to Ward moves between 22:00 and 07:00

01 April 2016 to 31 March 2017

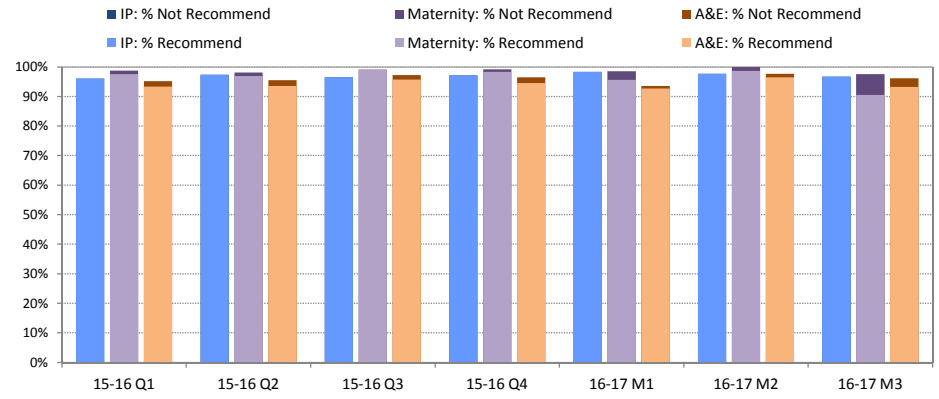


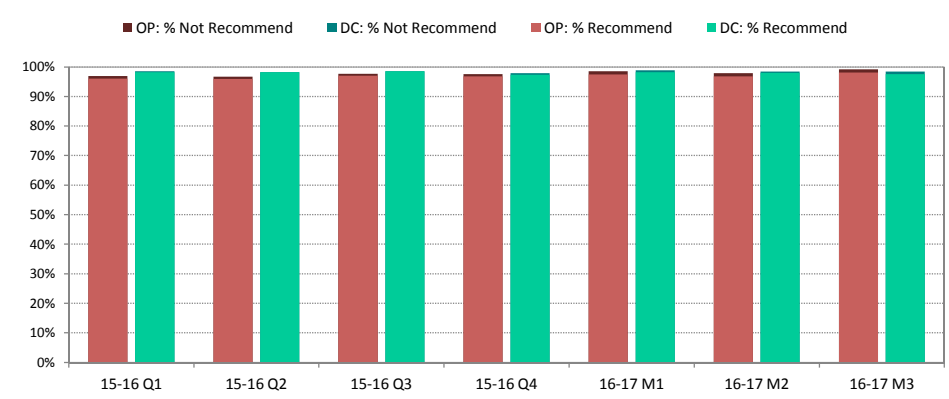
Discharges by Hour

01 April 2016 to 31 March 2017

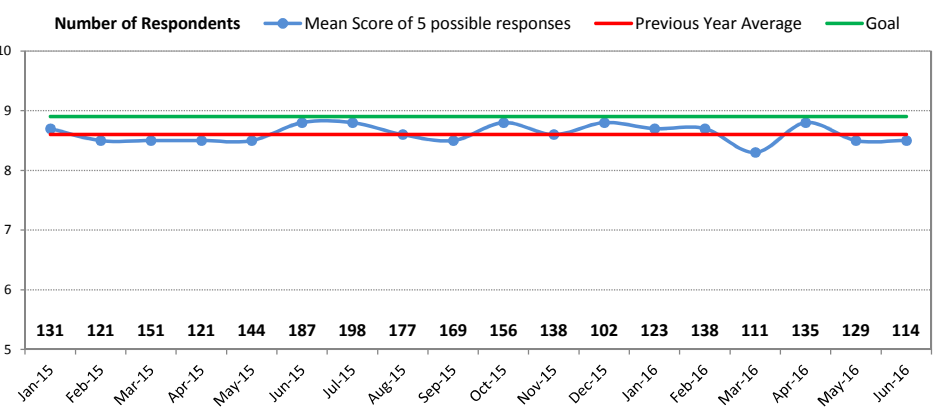


Friends & Family Test: Responses by Area

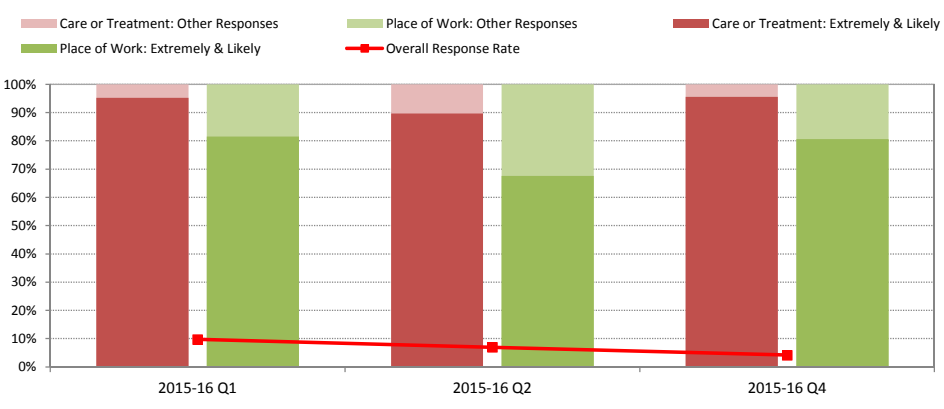




Real Time Feedback: Overall how would you rate the quality of care you received?



Friends & Family Test: Staff (% Responses)



The new score measures the % Recommended (Likely + Extremely Likely) and the % Not Recommended (Unlikely + Extremely Unlikely) to show the pecentage of responses that would or wouldn't recommend the Trust.
Don't Know and Neither Likely or Unlikely responses are excluded from this measure.

CUSTOMER CARE REPORT - Quarter 4 (1st January – 31st March 2016)

Date: 8 August 2016

Report from: Hazel Hardyman
Head of Customer Care

Presented by: Lorna Wilkinson
Director of Nursing

Executive Summary:

84 complaints were received in quarter 4 compared to 66 complaints in quarter 3 and 74 complaints for the same period in the previous year. The activity from comments, concerns and enquiries has decreased from 491 in Q4 last year to 433 in Q4 this year.

The main issues from complaints are:

- Clinical treatment (31), 9 more than Q3 - sub-themes were 22 unsatisfactory treatment across15 different areas, 3 correct diagnosis not made, 2 pain management, 2 inappropriate treatment, and 1 each for consent to treatment and further complications. The Emergency Department received 5 complaints about clinical treatment with 2 relating to missed fractures. Ophthalmology had 4 complaints relating to clinical treatment with no themes.
- Communication (16), 12 more than Q3, - sub-themes were 6 lack of communication across 6 different areas, 5 wrong information; 3 delay in receiving/sending information; and 1 each for insensitive communication and letter sent incorrectly.
- Appointments (14), 1 less than Q3 (15) – sub-themes were 6 cancelled appointments, 3 appointment date required, and 2 appointment delays and 1 each for unsatisfactory outcome, wrong information and appointment system procedures, across 10 different specialties.
- Staff attitude (12), 1 less than Q3 (13) – 5 related to medical staff, 4 nursing staff, and 3 administrative across 11 different areas.

The main issues from concerns are appointments (29), clinical treatment (20) and staff attitude (12).

There was one new request for independent review by the Parliamentary and Health Service Ombudsman.

A total of 372 inpatients were surveyed for real time feedback in the quarter. They made 250 positive and 260 negative comments with the main negative issues being level of service at weekends, noise and food and nutrition on the wards.

The main area of concern from the Friends and Family Test was waiting times.

There were 4 new requests to undertake Patient and Public Involvement projects.

NHS Choices received 23 comments in Q4 with 20 positive and 3 negative.

Proposed Action:
To note the report.

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

Appendices:
None

Supporting Information
None

Customer Care Report - Quarter 4
1st January – 31st March 2016

PURPOSE OF PAPER:

- To provide assurance that the Trust is responding appropriately to complaints from patients and demonstrate that learning and actions are taken to improve services in response to the complaints and feedback. To provide assurance of the Trust's activity to promote patient and public involvement in service codesign and improvement.

1. COMPLAINTS

The main issues from complaints are:

- Clinical treatment (31), 9 more than Q3 - sub-themes were 22 unsatisfactory treatment across15 different areas, 3 correct diagnosis not made, 2 pain management, 2 inappropriate treatment, and 1 each for consent to treatment and further complications. The Emergency Department received 5 complaints about clinical treatment with 2 relating to missed fractures. Ophthalmology had 4 complaints relating to clinical treatment with no themes.
- Communication (16), 12 more than Q3, - sub-themes were 6 lack of communication across 6 different areas, 5 wrong information; 3 delay in receiving/sending information; and 1 each for insensitive communication and letter sent incorrectly.
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- Staff attitude (12), 1 less than Q3 (13) – 5 related to medical staff, 4 nursing staff, and 3 administrative across 11 different areas.

The main issues from concerns are appointments (29), clinical treatment (20) and staff attitude (12). The main specialties for clinical treatment across concerns and complaints were the Emergency Department (8) and Orthopaedics (7).

84 complaints were received in quarter 4 compared to 66 complaints in quarter 3 and 74 complaints for the same period in the previous year. The activity from comments, concerns and enquiries has decreased from 491 in Q4 last year to 433 in Q4 this year. A breakdown of numbers and themes from complaints according to Datix is below:

	Clin Supp & Family Services	Corporate	Medicine	Musculo Skeletal	Surgery	Q4 total 2015 -16	Q4 total 2014 -15
Admission	0	0	0	1	0	1	4
Appointments	0	0	1	5	8	14	10
Attitude of staff	2	0	3	1	6	12	12
Call bells	0	0	0	0	0	0	1
Capacity	0	0	0	0	0	0	1
Clinical treatment	4	0	11	6	10	31	31
Communication	2	0	1	7	6	16	6
Confidentiality	0	2	0	0	0	2	3
Delay	2	0	0	1	1	4	1
Discharge arrangements	0	0	1	0	1	2	1
Nursing care	0	0	0	0	0	0	2
Operation	0	0	0	0	0	0	1
Privacy & dignity	0	0	0	0	0	0	1
Property	0	0	1	0	0	1	0
Transfer arrangements	0	0	0	0	1	1	0
Totals:	10	2	18	21	33	**84**	**74**
Patient Activity	10,015	0	28,372	17,778	16,937		

In Quarter 4, the Trust treated 17,117 people as inpatients, day cases and regular day attendees. Another 11,099 were seen in the Emergency Department and 44,886 as outpatients. 84 complaints were received overall which is 0.1% of the number of patients treated, this percentage has remained unchanged. There were no complaints about mental health issues this quarter. 440 compliments were received across the Trust in Q4, which represents 0.6% 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.

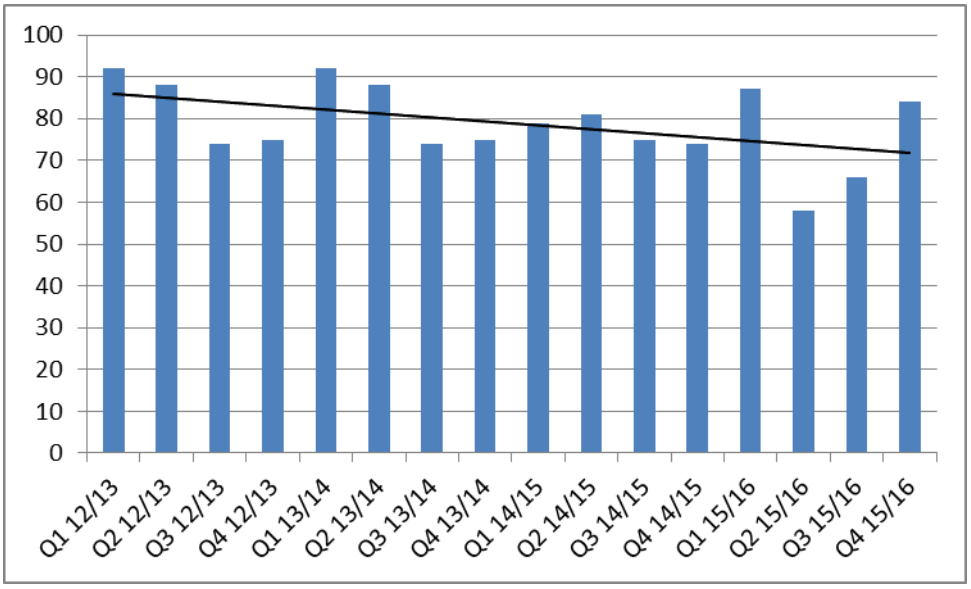
100% of complaints were acknowledged within three working days. Twelve complaints were re-opened in Q4 compared to 11 in Q3 (see below in the directorate section). The overall number of enquiries, comments, concerns and complaints response times was:

0-10 working days		11-24 working days		25+ working days	
384	74%	84	16%	49	10%

Reasons for some complaints taking more than 25 working days to respond to is: arranging meetings; one was a joint investigation with Medvivo (Out of hours GP Service); and a key member of staff on leave. The overall response timescale for 25+ working days has decreased in compliance in Q4 (10%) compared to Q3 (9%).

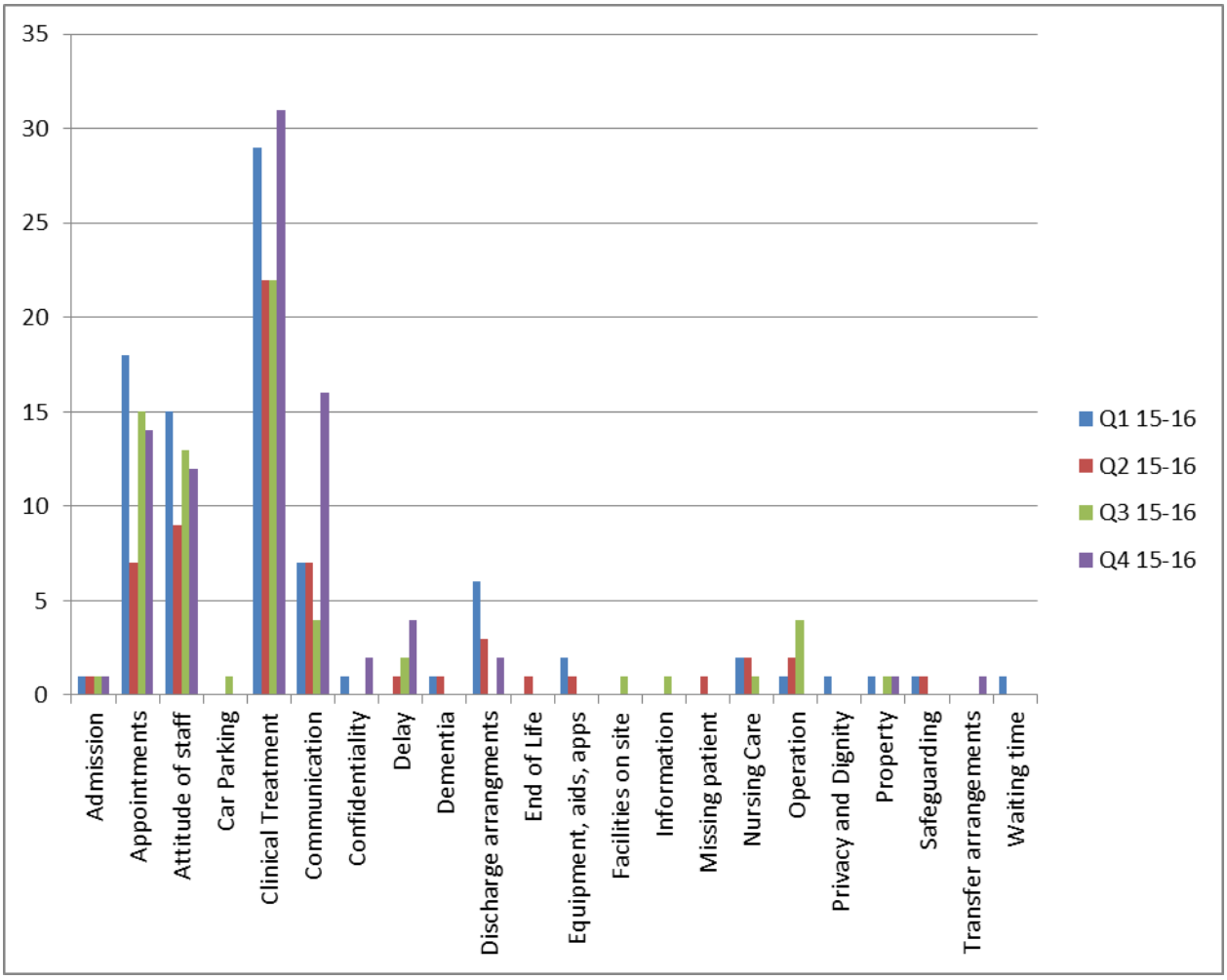
COMPLAINTS BY QUARTER

The following graph shows the trend in complaints received by quarter. There has been a rise in complaints in Q4 compared to Q3 15/16. The specialty areas with the most complaints are Ophthalmology (10), Orthopaedics (8) and General Surgery (8) 10 related to unsatisfactory treatment with no particular theme.



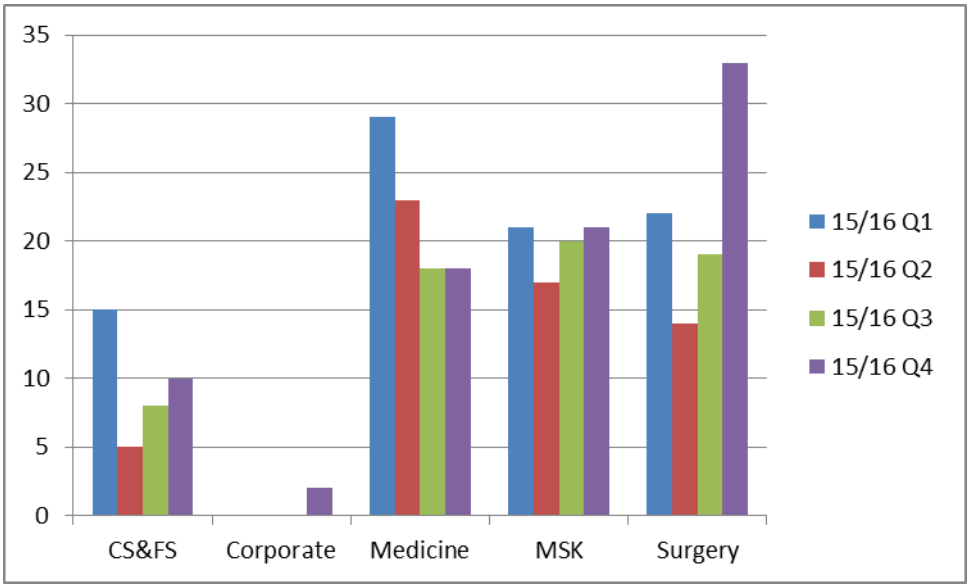
COMPLAINTS BY SUBJECT

The following graph shows the trend in complaints by subject over the last four quarters. Complaints about Communication (16) has increased from Q3 (4) by 12. The sub themes are lack of communication 7; wrong information 4; delay in receiving/sending information 3; and 1 each for insensitive communication and letter sent incorrectly. Clinical Treatment (31) has increased from Q3 (22) by 9 with the sub-themes unsatisfactory treatment 22; correct diagnosis not made 3; pain management 2; inappropriate treatment 2 and 1 each for consent to treatment and further complications.



COMPLAINTS BY DIRECTORATE

The following graph shows the number of complaints by directorate over the last four quarters with Surgery seeing an increase from 19 in Q3 to 33 in Q4. The two main areas of increase were clinical treatment (from 4 in Q3 to 10 in Q4) across 4 areas with 9 relating to unsatisfactory treatment and 1 to consent; and communication (from 1 in Q3 to 6 in Q4) across 5 different areas.



CLINICAL SUPPORT AND FAMILY SERVICES

	Quarter 4 2014-15	Quarter 3 2015-16	Quarter 4 2015-16
Complaints	14	8	10
Concerns	17	16	15
Compliments	284	141	85
Re-opened complaints	1	0	1
% complaints responded to within 25 working days	71%	75%	60%

- 2 more complaints were received in this quarter in comparison to quarter 3, although the number is reduced compared with quarter 4 2014-15.
- 1 complaint was re-opened this quarter following further diagnoses from another hospital. .
- Total activity within the directorate was 10,015 and of this number 0.1% raised a complaint.
- No meetings were undertaken this quarter.
- There has been a decrease in the number of concerns raised, with Radiology having the highest number (5) with no particular theme.
- The number of compliments received this quarter has also decreased.

Themes and actions

Department/Ward	Topic	Actions
Sarum Ward Radiology Benson Suite Pathology All areas	Attitude of nursing staff	Staff reminded of their responsibilities Use of Trust pride in practice standards Ensure appraisals undertaken
Anti-coagulation Service	Communication - Email - - Answer phone - Minutes	Redesign email sign off Adjust email documentation to highlight changes and communication more clearly Use answerphone appropriately Minutes of meetings held with complainants to be shared and agreed before being finalised
Sarum Ward	Knowledge of staff regarding Haemophilia	Department update undertaken

Compliments

In total 86 compliments have been received across the directorate with the breakdown as: Sarum Ward = 30, Bowel Screening = 16, Labour ward = 16, NICU = 10, Endoscopy = 5, Radiology = 3 and 1 each for the Maternity Day Assessment, Benson Suite, Children's Outpatients, Pathology, Postnatal and Speech and Language Therapy.

MEDICINE DIRECTORATE

	Quarter 4 2014-15	Quarter 3 2015-16	Quarter 4 2015-6
Complaints	28	18	18
Concerns	25	20	27
Compliments	25	232	151
Re-opened complaints	4	5	1
% complaints responded to within 25 working days	60%	83%	77%

- The number of complaints was the same as quarter 3, although the number has reduced compared with quarter 4 2014-15.
- 1 complaint was re-opened in this quarter.
- Total activity within the Directorate was 17,273 and of this number 0.1% raised a complaint.

- 1 meeting was offered for this quarter.
- There has been an increase in concerns raised, with the Emergency Department having the highest number which was 8 in total followed by Pitton Ward that had 4.
- The number of compliments received this quarter has decreased since quarter 3.

Themes and actions

Department/Ward	Topic	Actions
Emergency Department	Unsatisfactory treatment and nursing care Correct diagnosis not made	Increased communication / information with waiting times for the waiting room via plasma information screen in the waiting room and via triage nurse. Discharge checklists in place that include checking cannulas are removed – for ED and SSEU. All notes of patients discharged overnight are reviewed by ED consultant on the next day to ensure correct decisions have been made.
All areas	Attitude of staff	Working with staff on Farley Ward to improve communication between staff/family and GPs. Taking back individual concerns to identified staff and sharing communication issues from concerns/complaints with ward staff at team meetings.

Compliments

In total 151 compliments have been received across the Directorate with the breakdown as: Pembroke ward = 53, Emergency Department = 33, Durrington ward = 24, Farley ward = 18, 5 each for Pitton and Redlynch wards, Cardiology = 4, Whiteparish = 3, 2 each for the Cardiac Suite and Hospice and 1 each for Oncology Outpatients and Gastroenterology.

MUSCULOSKELETAL DIRECTORATE

	Quarter 4 2014-15	Quarter 3 2015-16	Quarter 4 2015-16
Complaints	22	20	21
Concerns	33	35	21
Compliments	138	113	74
Re-opened complaints	6	5	6
% Complaints responded to within 25 working days	63.5%	65%	52%

- The number of complaints responded to within 25 working days has decreased in Q4 and this is due to additional operational pressures within the Directorate Management Team.
- The number of concerns has fallen compared to Quarter 4 in 2014-15.
- Total activity within the Directorate was 17778 and of this number 0.1% raised a complaint.
- There have been six re-opened complaints. In one case a discussion over the telephone resolved the concerns. Further questions and clarity was asked from other complainants and in one case the patient was unhappy with the extensive investigation undertaken and referred to the Parliamentary and Health Service Ombudsman.
- The area with the greatest number of concerns and complaints is Orthopaedics with appointments being the most common theme. There is ongoing work to minimise impact on elective care and waiting times in both Plastics and Orthopaedics.
- There have been two complaint meetings held and one meeting for a concern.

General actions

- Complaints Co-ordinator invited to attend DMT meetings monthly.

- The DMT has reviewed the current process for allocation and management of complaints within the Directorate which includes an additional manager which should result in improving the response times. This includes attempts to provide immediate remedial actions for patients to shorten the complaints process. This is exemplified by a patient who required reimbursement of his lost earnings and was resolved on the same day.

Themes and actions

Department/Ward	Topic	Actions
Orthopaedic	Appointment waiting times	Linked to the Orthopaedic business case and expansion of orthopaedic services. Actions progressing in May to reduce long waiting times by appointment of one locum consultant.
Plastics Department	Appointment waiting times	Two locum consultants commencing employment in June 2016 to manage patients across the plastics pathway.
Oral Surgery	Appointment waiting times	Ongoing recruitment and management of capacity to reduce waiting lists.

Compliments

In total 73 compliments have been received across the Directorate with the breakdown as: Amesbury = 16, Dermatology = 13, Chilmark = 8, Laverstock = 7, Burns Unit = 6, Orthopaedics = 6, Tamar = 6, Oral = 5, Rheumatology = 2 and 1 each for Avon Ward, Plastics Department, Spinal Unit and Laser Clinic.

SURGICAL DIRECTORATE

	Quarter 4 2014-15	Quarter 3 2015-16	Quarter 4 2015-16
Complaints	13	19	33
Concerns	22	19	23
Compliments	111	143	104
Re-opened complaints	1	1	2
% complaints responded to within 25 working days	92%	89%	90.9%

- An increase in complaints received this quarter for the Directorate.
- Total inpatient and outpatient activity within the Directorate was 16937 and of this number 0.18% raised a complaint.
- Four complaints were re-opened in this quarter.
- The highest number of complaints was in Ophthalmology, with 10 cases.
- In total 4 cases in Ophthalmology related to unsatisfactory treatment.
- The highest number of concerns was in General Surgery, with 5 cases.
- One meeting was held with resolution agreed and the case closed.

Themes and actions

Department/Ward	Topic	Actions
Ophthalmology	A range of issues covering attitude, appointment rescheduling, dissatisfaction at treatment	The service is under a great deal of pressure as recruiting additional medical staff remains a challenge. An additional consultant has been appointed for 3 months, and two additional untrained nursing posts to support the department are being recruited. As a result additional capacity will be made available and this should reduce the need to rearrange appointments at short notice due to availability and overdue

		appointments. The additional nursing posts should relieve some pressure on the nursing team. The dissatisfaction in treatment related to hurried appointments which link to the overarching issue of the capacity challenge. The service is moving towards using virtual appointments where appropriate to increase the use of non-medical staff to further support the workload.

Compliments
In total 104 compliments have been received across the Directorate with the breakdown as:
Downton Ward = 35, Britford Ward = 26, Radnor Ward = 17, Day Surgery Unit = 11, General Surgery = 5, Bowel Screening = 3, ENT = 3, Wilton Ward = 2 and 1 each for Audiology and POAU.

In February 2016 the Interim Deputy Director of Nursing met with the DSNs to develop ways for the directorates to report on the actions taken and demonstrate how the wards/departments have used the learning from incidents, complaints and RTF to improve services. From Q1 2016 the directorates will write a quarterly report that provides evidence of some of the key actions taken in the directorates to respond to the learning to improve the quality of care/patient experience.

Directorates will provide patient safety and experience reports to the Head of Customer Care to be appended to the quarterly Customer Care report that is presented to Clinical Governance Committee, Trust Board and the Commissioners in the future.

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

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

Feedback area	Theme	Actions
Complaints	Clinical treatment Communication Appointments	• All notes of patients discharged overnight are reviewed by ED consultant on the next day to ensure correct decisions have been made. • Anti-Coagulation Service has redesigned email sign off and reiterated appropriate use of answerphones. • Ongoing recruitment, management of capacity to reduce waiting lists and recruitment of consultants in a number of specialties.
Inpatient RTF	Noise Service at weekends Food and	• Britford Ward has liaised with Estates Technical Services regarding problems with a squeaky trolley. • Chilmark Suite is participating in a 'noise at night' campaign. Pitton Ward is also looking at ways to reduce noise at night. • Laverstock Ward has noted that the noise is mainly coming from VACS machines which are old and need replacing. • Development of a pathway for gastroenterology patients admitted at weekends. • Downton Ward is looking at ways to address the number of visitors attending at the weekends. • Avon Ward undertakes a staffing review for that day, plus the days ahead to ensure staffing matches the current establishment. The issue has also been reviewed at Discuss-It meetings held between staff and patients. • The Burns Unit, Chilmark Suite, Downton Ward and Pitton Ward are trying to source more volunteers to help with a morning drink

	nutrition	round. • Amesbury Suite has been working on a 'welcome pack' to include information about tea rounds encouraging patients to ask for refreshments if they require them.
FFT Emergency Department Medical Surgical Outpatients	Out-of-hours GP Service Communication Waiting Times	• Meeting with Medvivo to discuss the lack of communication between the OOH GP/practitioner and the patients who are waiting. Notices have been put up in the GP waiting area advising patients to ask the OOH practitioner for information on waiting times. • LED screen displaying waiting times for majors and minors with plans to provide further information, such as patient information, sign-posting, names of consultants, nurse practitioner and receptionists, waiting times and explanations. • All reception staff have received customer care training. • Some patients may experience longer waits but these must be balanced against the care received. Doctors go to great lengths to give patients the time they need and this is often longer than the appointment time, hence the delays. Waiting times are displayed on a screen in the waiting area.

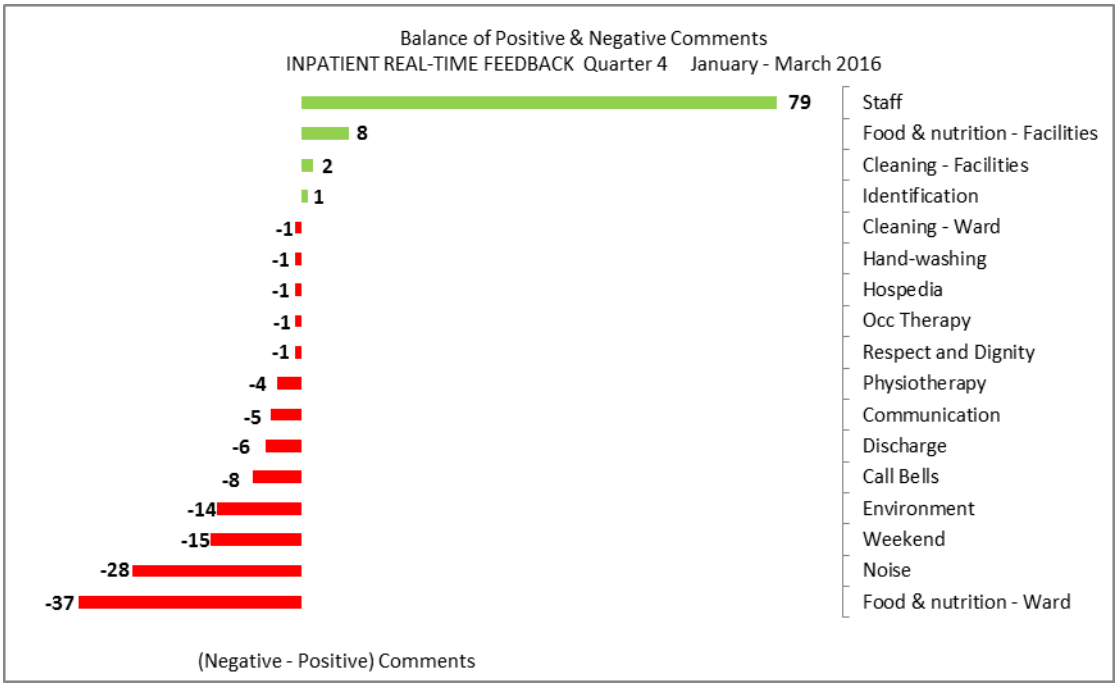
3. PICKER REAL TIME FEEDBACK (AFTER FRANCIS PROJECT)

The recruitment of patients closed on 4th April 2016. A staff survey then took place until 1st May 2016. The purpose was to understand how staff use patient experience feedback and their thoughts on real time feedback. The responses given by staff will be used to help Picker develop a toolkit for other NHS Trusts to help them decide if a real time feedback approach is right for them.

The reports are available on the Intranet at:
http://intranet/website/staff/quality/customercare/picker+afterfrancisstudy/index.asp

4. INPATIENT REAL TIME FEEDBACK

A total of 372 inpatients were surveyed in the quarter. They made 250 positive and 260 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 food and nutrition on the ward, noise and weekend.

A total of 43 negative and 6 positive comments were received regarding food and nutrition on the ward. The negative comments have been categorised in the table below.

REASON	WARD
Temperature (25)	Tisbury (7)
	Chilmark (4)
	Pembroke (4)
	Farley (3)
	Burns (2)
	Avon (1)
	Britford (1)
	Laverstock (1)
	Pitton (1)
	Redlynch (1)
Portion size (7)	Burns (2)
	Redlynch (2)
	Amesbury (1)
	Pitton (1)
	Tisbury (1)

REASON	WARD
Lack of refreshments (6)	Amesbury (1)
	Burns (1)
	Chilmark (1)
	Downton (1)
	Pitton (1)
	Whiteparish (1)
Quality (4)	Chilmark (1)
	Downton (1)
	Redlynch (1)
	Whiteparish (1)
More help with meals (1)	Chilmark (1)

A total of 30 negative and 2 positive comments were received regarding noise. The areas of negative comments are as follows:

REASON	WARD
Equipment (14)	Britford (3)
	Chilmark (3)
	Amesbury (2)
	Burns (1)
	Downton (1)
	Laverstock (1)
	Pembroke (1)
	Pitton (1)
	Tisbury (1)
Staff (4)	Tamar (2)
	Amesbury (1)
	Breamore (1)

REASON	WARD
Staff and patients (3)	Britford (1)
	Laverstock (1)
	Tisbury (1)
Laundry (2)	Pitton (1)
	Redlynch (1)
Patients (1)	Tamar (1)
Staff and equipment (1)	Britford (1)
Not specified (5)	Whiteparish (3)
	Britford (1)
	Redlynch (1)

A total of 22 negative and 7 positive comments were received regarding weekends. The negative comments are categorised as follows:

REASON	WARD
Lack of staff (9)	Downton (2)
	Pitton (2)
	Amesbury (1)
	Avon (1)
	Redlynch (1)
	Tamar (1)
	Tisbury (1)
Food (5)	Redlynch (2)
	Amesbury (1)
	Chilmark (1)
	Farley (1)

REASON	WARD
Quality of care (4)	Amesbury (2)
	Redlynch (1)
	Tamar (1)
Cleanliness (1)	Pitton (1)
Environment (1)	Tamar (1)
Staff attitude (1)	Redlynch (1)
Visitors (1)	Downton (1)

Action taken on areas of concern
Food and Nutrition on the Wards
Many wards have been participating in action planning workshops looking at themes arising through the various sources of feedback (concerns, complaints, real-time, Friends and Family Test and national patient surveys). As a result, work is being undertaken to address the issue of food remaining hot until it reaches the patient.

The Sisters on the Burns Unit, Chilmark Suite and Pitton Ward are trying to source more volunteers to help with a morning drink round.

Amesbury Suite has been working on a ‘welcome pack’ which will include information about tea rounds and will encourage patients to ask for refreshments if they require them.

Noise
The Sister on Britford Ward has liaised with Estates Technical Services regarding problems with a squeaky trolley.

Chilmark Suite is participating in a 'noise at night' campaign. Pitton Ward is also looking at ways to reduce noise at night.

Laverstock Ward has noted that the noise is mainly coming from VACS machines, which are old and need replacing. The ward is currently using up the consumables for the old machines.

Level of Service at Weekends
One issue related to a gastroenterology patient who was placed on Amesbury Suite when admitted on a Sunday. Steps have been taken to develop a pathway to ensure such patients receive the correct treatment. The patient in question was subsequently moved to Redlynch Ward where they report that they had received excellent care.

The Sister on Downton Ward is looking at ways to address the number of visitors attending at the weekends.

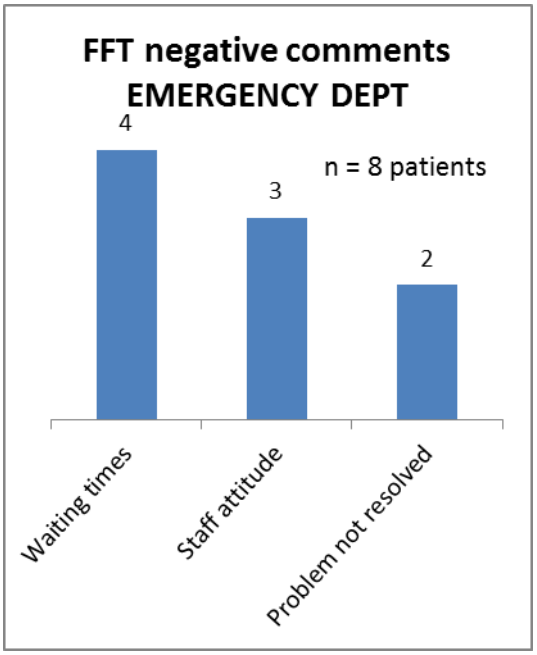
The level of staffing on Avon Ward is constantly reviewed. Each day there is a staffing review for that day, plus days ahead and they try hard to ensure staffing matches the current establishment. The issue has also been reviewed at Discuss-It meetings held between staff and patients.

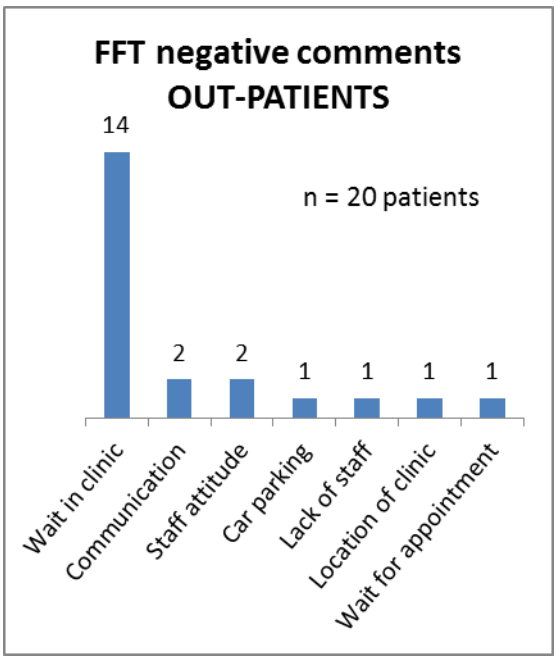
5. FRIENDS AND FAMILY TEST

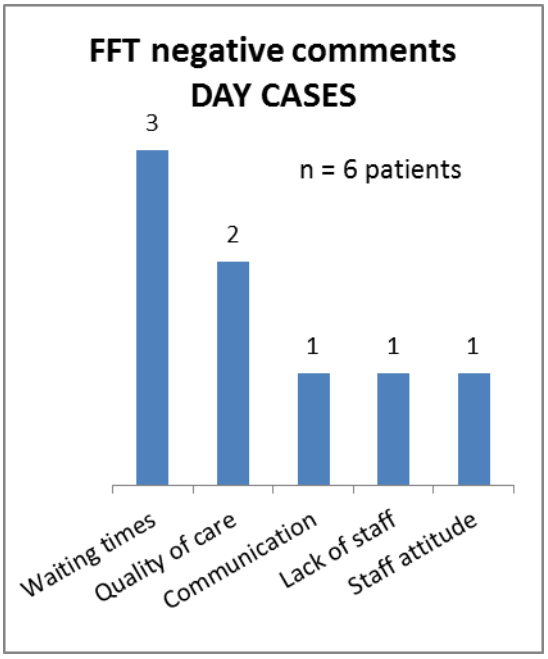
Responses for the period were as follows:

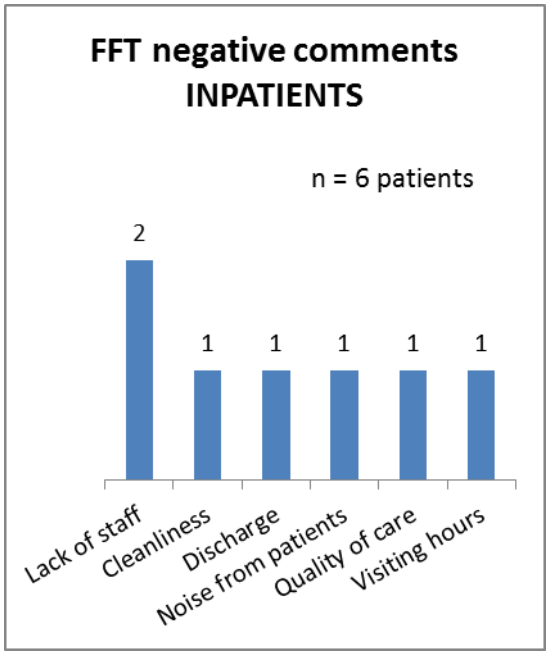
		Rating		
	Total Responses Received	**Extremely Likely**	**Unlikely**	**Extremely Unlikely**
Inpatients	1314	1044	6	3
Emergency Department	590	462	7	4
Maternity	234	212	1	1
Outpatients	2936	2439	7	16
Day Case	923	840	3	2

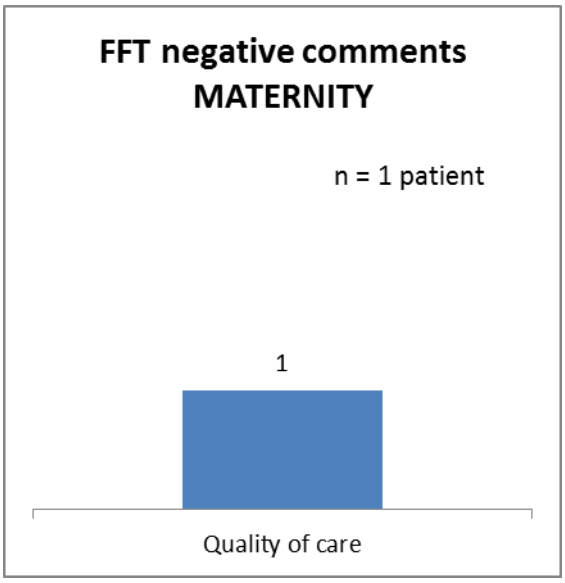
Comments made by those patients who stated they would be unlikely or extremely unlikely to recommend the hospital have been categorised as set out in the graphs below.











The main area of concern is waiting times.

Action taken on areas of concern
Emergency Department
Issues around waiting times relate to the out-of-hours (OOH) GP service which is co-located within the Emergency Department. Staff from the department met with the company, Medvivo, to discuss the lack of communication between the OOH GP/practitioner and the patients who are waiting. Notices have been put up in the GP waiting area advising patients to ask the OOH GP/practitioner for information on waiting times.

There is currently a LED screen displaying waiting times for majors and minors. Plans are at an advanced stage to provide information for all areas on the plasma screen in the waiting room. This will include patient information, sign-posting, names of consultants, nurse practitioner and receptionists, waiting times and explanations.

All reception staff have received customer care training.

Outpatients
The area with the most comments was Medical and Surgical (7). It is inevitable that some patients may experience longer waits than is desirable but these must be balanced against the care received. The doctors go to great lengths to give patients the time they need and this is often longer than the appointment time, hence the delays. However, the department does display waiting times on a screen in the waiting

area and always addresses enquiries regarding delays, doing their best to alleviate any anxieties which arise.

6. ACTION PLANNING WORKSHOPS

Customer Care has delivered workshops to wards to look at themes arising through the various sources of feedback (concerns, complaints, real time feedback, Friends and Family Test and national patient surveys). The idea is to involve as many different staff from the wards to identify their themes, and work together in developing and delivering their action plans. Historically action plans have been developed by the ward lead but this new way enables all staff to take ownership so they can learn and make improvements to the patient experience.

7. PATIENT AND PUBLIC INVOLVEMENT (PPI)

In Q4 there were four new project requests to the Patient and Public Involvement Group:

- The Stoma Team has noticed a change in practice over the last few years, in that patients with spinal cord injury (SCI), are undergoing elective colostomy for bowel management during their initial inpatient rehabilitation period following SCI. Traditionally colostomy is performed much later, usually several years after their injury when they have tried traditional bowel care management for longer at home. The Stoma Team want to find out whether in the longer term it is the right thing to have a colostomy performed so early. They want to check such early intervention does not result in physical or psychological harm and whether this observed change in practice is safe and in the best interest of this patient group. A questionnaire has been developed to gain this information.
- The Neo-Natal Unit wants to receive feedback from parents who use the Unit so that they can improve the service. A questionnaire has been developed to gain this information.
- Oncology has developed a questionnaire to collate patient feedback so that improvements to services/assessment processes can be made. It is also a Peer Review requirement for cancer of unknown primary (CUP).
- Urology has developed a questionnaire to assess patient satisfaction with the flexible cystoscopy service to identify any improvements that can be made.

A PPI Projects page is still being developed on the Intranet and once it is complete, it will be replicated on the Trust website. The page is available at:
http://intranet/website/staff/quality/customercare/patientandpublicinvolvement/ppiprojects/index.asp

8. PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

In Q4 there was one new request for independent review from the PHSO for a Plastic Surgery complaint. The ENT complaint which was sent to the PHSO in August 2015 was closed and not upheld. The PHSO found no failing in the service provided by the Trust that has led to the distress suffered.

The PHSO quarter 3 report on complaints about acute Trusts is available at:
http://www.ombudsman.org.uk/reports-and-consultations/reports/health/quarterly-reports-on-complaints-about-acute-trusts

9. NHS CHOICES WEBSITE

At Trust Board, it was raised that Salisbury District Hospital has two NHS Choices webpages and people are posting comments on both. This may have led to inaccurate reporting in previous Customer Care reports. The Head of Communications and the Business Relations Manager are following this up.

In Q4 there were 23 comments posted on the NHS Choices website relating to 12 different areas. Of the 20 positive comments, one person said of the Stroke Unit “I must stress the excellent care I received whilst I was in the Unit. I can only stress that nothing was too much for the wonderful staff that was looking after me. Thank goodness we have such a super Stroke Unit in Salisbury. I find the food was very good and it catered for all sorts of appetites. Thank you all for looking after me so well. I know without your help I would not have been able to send you this message”. Of the 3 negative comments, one person said of

Gastroenterology “After seeing the nurse in Oct 2014, I received an appointment for Oct 2015. This was cancelled and since I have had no new date, despite contacting the hospital three times”. All the feedback was shared with the departments.

AUTHOR: Hazel Hardyman
TITLE: Head of Customer Care
DATE: May 2016

Trust Board meeting **SFT 3794**

TITLE OF REPORT Six Monthly Skill Mix Review to Trust Board

Date: August 2016

Report from: Lorna Wilkinson, Director of Nursing

Presented by: Lorna Wilkinson, Director of Nursing

Executive Summary:

The nursing and midwifery skill mix review has been completed and is being presented to the Trust Board to allow for a discussion on the findings and recommendations.

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

This review covers the Emergency Department and Maternity as well as the inpatient ward areas. All of these areas have been subject to a detailed skill mix review using a defined approach to ensure consistency for comparison, which included a range of information; triangulating the ward staffing levels against nurse sensitive indicators, NICE standards, quality indicator / outcome data, Care Hours Per Patient Day (demand and required), HR indicators, and financial information, as well as CQC findings. Professional judgement was ensured as each review has been undertaken by the Directorate Senior Nurse and Ward Sister with a DSN from outside the Directorate to add objectivity and provide initial challenge. The Director of Nursing and/or Deputy Director of Nursing attended each meeting.

Proposed Action:
The Board are asked to:

- Discuss and agree any areas for investment from this skill mix review paper with full impact analysis to be included in next skill mix review due December 2016.
- Support the actions listed in section 9 with reported outcomes incorporated into future skill mix reviews
- Support the analysis work from the Safecare tool across the ward areas to inform future skill mix requirements
- Support the continuation of recruitment and retention activities

Trust Board August 2016

Title	Six Monthly Skill Mix Review
Meeting Date	August Public Board
Sponsoring Executive	Lorna Wilkinson – Director of Nursing
Author	Denise Major – Directorate Senior Nurse

1. Background

This is the 3rd year of skill mix reviews to be undertaken within this format and forms one of three reporting requirements that every Trust is expected 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 6 months. ✓

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

The Trust was inspected by the Care Quality Commission (CQC) in December 2015 with the resulting report published in April 2016. One of the areas for improvement identified was the review of nurse staffing levels and skill mix to ensure there are consistently sufficient numbers of suitably qualified and experienced nurses to deliver safe, effective, and responsive care in the following areas:

- Surgical Wards - Night shifts on Amesbury ward, Downton ward, and Chilmark ward.
- Emergency Department
- Critical Care
- Midwifery
- Sarum Ward
- Spinal Unit
- Areas where children are cared for

This report provides an assessment of the current nurse staffing provision at Salisbury NHS Foundation Trust (SFT) as assessed locally, against national guidance and validated tools, and the CQC feedback. All inpatient wards have been subject to a detailed skill mix review during April 2016. The reviews were undertaken using a defined approach to ensure consistency for comparison which included a range of information; triangulating the ward staffing levels against nurse sensitive indicators, quality indicator / outcome data, Care Hours Per Patient Day data, HR indicators, and financial information. Professional judgement was ensured as each review has been undertaken by the Directorate Senior Nurse (DSN) and Ward Sister for that area with the Director and/or Deputy

Director of Nursing and the DSN for Musculoskeletal Services from outside the Directorate to add objectivity and provide challenge.

This results in recommendations where additional resource is recommended. It is important to note that the nursing requirements will change over time as acuity/dependency and overall case mix changes which is why it is important to ensure a review is carried out twice a year.

2. Previous Investment

During 2014/15 there was investment into ward based nurse staffing as a result of the 2 skill mix reviews totalling £917 000. This included the move to supervisory status for all ward leaders. It is therefore important to note that these Band 7 staff are not included in any of the ratios cited in this paper.

During 2015/2016 there was investment totalling approximately £529,615 in the following:

- Maternity - 5 band 6 and 5 Band 5 Registered Midwives. as a result of a comprehensive review undertaken using BirthRate+

- Weekend cover extending the RN early shift to a long-day shift on Redlynch and Pitton Wards was agreed at the October Trust Board on a six month pilot

- ED – to recurrently fund the uplift in band 5 and band 6 nursing to ensure 24/7 band 6 cover and provide an extra Band 5 to work across majors/resus depending on demand.

3. General Wards:

3.1 Ratio of RNs to Patients:

All of the wards remain compliant with the NICE guidance recommendation that day shift ratios in general wards should not exceed 1:8 with the exception of Amesbury Ward which is currently 1:11 on the late shift. This has changed by moving an RN to the night shift (see below) but will be supported with the introduction of a B4 on the long-day shift.

Night shifts have a higher ratio of RN to patients and the previous range across the wards was 1:5-1:16. From the skill mix review in April 15, Amesbury Ward which had a ratio of 1:16 was identified as an area of concern. Following an unsuccessful trial of a twilight shift, in January 2016 the decision was made following consultation with Amesbury staff for all staff to work an early/ long day/night patterns as opposed to staff working short and long day shifts. This resulted in a change to shift times and has facilitated a 3rd RN on the night shift from the late shift commencing in March 2016. This has had a positive impact for staff working this shift and Real Time Feedback (RTF) and Friends and Family will be monitored to assess the impact upon patients.

This has subsequently resulted in a range of 1:5 – 1:13 across the Trust at night. The CQC report however, made a clear recommendation that staffing at night on the following wards must be reviewed:

- Amesbury - see above, after attempts to pilot a twilight shift this ward has now increased the number of RNs on nights to 3, giving an RN to patient ratio of 1:11, an improvement from 1:16
- Downton 1:12
- Chilmark 1:12

- Laverstock 1:13 (at weekends only)

During this round of skill mix reviews the data for the above was reviewed in depth and there was no evidence to suggest that care was compromised or unsafe at night on either Downton or Chilmark reflected in the ward quality indicator reports (see appendix A) as well as the professional judgement of the senior ward sisters. Therefore there are no planned changes to increase the RN numbers for Downton or Chilmark at this time but this will be reviewed again in the September 2016 skill mix or earlier if concerns are evidenced.

There is evidence from Laverstock Ward Sister that the night shift at the weekend which runs on 2 RNs rather than 3 RNs as in the week, there are delays in the administering of IV drugs after midnight and some comments within RTF regarding weekend working and number of nursing staff (although the feedback does not specify nights at the weekend). Over the next 6 months this will be more fully explored and reviewed in the September skill mix review.

3.2 Ratio of RN to Nursing Assistant (NA)
The ratios of RN:NA are listed in appendix B .This continues to vary as expected from ward to ward depending on case mix of patients. The wards range from 86:14 to 50:50, however there are 2 wards that fall below 50% RNs**;** Avon (40:60) and Tamar (42:58). Both of these wards are within the Spinal Injuries Rehabilitation Unit and have a higher number of band 3 roles, which take on extended skills, than other ward areas for this group of patients.

In areas where we are developing the Band 3 and 4 roles (such as elderly care) this can have a negative impact on the ratio even where it adds to the continuity of ward staffing and enhancement of skills.

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

3.3.1 The following areas have been identified for recommended action:

- **Redlynch and Pitton Weekends**

Since November 1st 2016 Redlynch and Pitton wards have been piloting extending an early RN shift to a long-day so increasing the RN number on the late part of the shift. The wards sisters have reported improvements in quality data during the pilot as exemplified by a reduction in falls and pressure ulcers in conjunction with improved RTF for weekend working (Appendix C). Staff also report an improvement to call bell response times.

- **Redlynch Night Shifts**

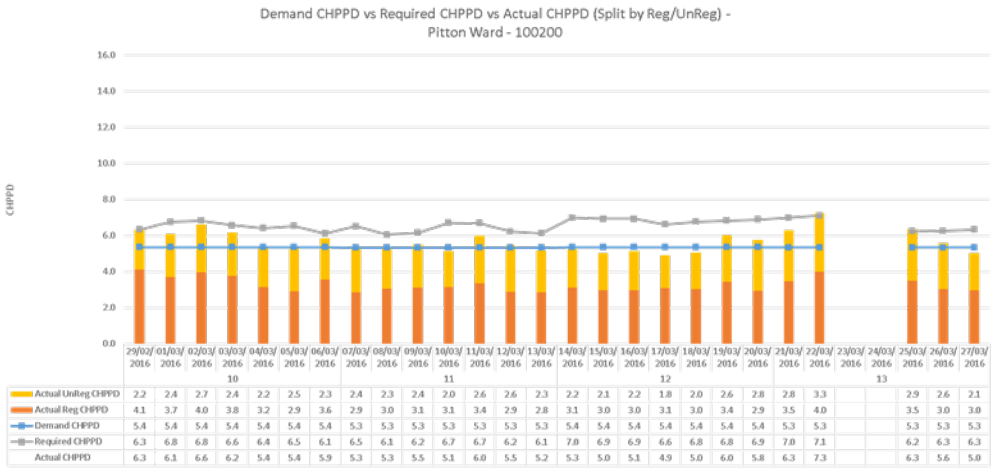
The night shift has been flagged in previous skill mix reviews as an area for review. The ward currently runs on 3 RNs and 1NA .It is the professional judgement of those working in this area that a second NA is required on the night shift. Patients' feedback through RTF that there is a delay in call bell response times at night (see appendix D) and tasks are often left for the day shift to pick up. The clinical condition of patients on Redlynch also results in a regular use of specials especially at night this is usually due to patient detoxifying and being in a confused, agitated and aggressive state.

Currently this is met through the use of temporary staffing with the cost of Band 2 specials (mainly on nights) during 2015/16 reaching £57,709. National work has identified that 1:1 or a special for these patients with temporary staff does not support the requirements of these patients. Increasing the B2 establishment at night would facilitate improved quality for patients and staff and reduce the cost of temporary staff. The CHPPD data also shows a gap in the actual and required staffing levels

(appendix D). Although it is not possible to separate the day and nights hours in the CHPPD the actual versus required gap with professional judgements suggests that this is due to the night.

- **Pitton Day Shifts**

Since January 2015 Pitton has become the speciality base for respiratory medicine and as such now takes all patients requiring non-invasive ventilation (NIV) and patients with tracheostomies leaving ITU. The increasing acuity levels on Pitton ward, specifically the care of patients with tracheostomy have resulted in the increasing frequency of an additional RN during the day to provide care due to high acuity. CHPPD data (below) shows a gap between required and actual nursing hours to deliver care based on the acuity and dependency of this patient group. It is recommended that there is an increase of 1 RN on the long day Monday to Friday. This is not required at the weekend as the staffing level facilitates a 1:6 ratio required for respiratory care as a shift co-ordinator role has a caseload which cannot be facilitated during the weekday shifts.



	29/02/2016	01/03/2016	02/03/2016	03/03/2016	04/03/2016	05/03/2016	06/03/2016	07/03/2016	08/03/2016	09/03/2016	10/03/2016	11/03/2016	12/03/2016	13/03/2016	14/03/2016	15/03/2016	16/03/2016	17/03/2016	18/03/2016	19/03/2016	20/03/2016	21/03/2016	22/03/2016	23/03/2016	24/03/2016	25/03/2016	26/03/2016	27/03/2016
				10							11							12							13			
Actual UnReg CHPPD	2.2	2.4	2.7	2.4	2.2	2.5	2.3	2.4	2.3	2.4	2.0	2.6	2.6	2.3	2.2	2.1	2.2	1.8	2.0	2.6	2.8	2.8	3.3			2.9	2.6	2.1
Actual Reg CHPPD	4.1	3.7	4.0	3.8	3.2	2.9	3.6	2.9	3.0	3.1	3.1	3.4	2.9	2.8	3.1	3.0	3.0	3.1	3.0	3.4	2.9	3.5	4.0			3.5	3.0	3.0
Demand CHPPD	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.3	5.3			5.3	5.3	5.3
Required CHPPD	6.3	6.8	6.8	6.6	6.4	6.5	6.1	6.5	6.1	6.2	6.7	6.7	6.2	6.1	7.0	6.9	6.9	6.6	6.8	6.8	6.9	7.0	7.1			6.2	6.3	6.3
Actual CHPPD	6.3	6.1	6.6	6.2	5.4	5.4	5.9	5.3	5.3	5.5	5.1	6.0	5.5	5.2	5.3	5.0	5.1	4.9	5.0	6.0	5.8	6.3	7.3			6.3	5.6	5.0

- **Whiteparish (Acute Medical Unit)**

Whiteparish historically reduces the number of RNs on day shifts at weekends by 1. This staffing model developed when the medical takes through this route were lower at weekends than on weekdays. However over the last 6 months the unit has seen a sustained increase and a flattening out of the daily pattern. There has been an increasing trend in the number of patients attending within the 'medical take' at weekends during the last 6 months (see Appendix E) and there is no indication to suggest that this will reduce to the numbers previously seen. This results in an increased pressure to manage the flow in Whiteparish which has a negative impact upon the flow from ED. Currently the number of RNs on the day shift at weekends is less than during the week which reflects historical activity patterns. To manage the increasing trend requires an increase of 1 RN on Saturday and Sunday long-day to match Monday – Friday staffing levels in response to increasing activity levels reflected over 7 days.

- **Avon Ward**

There is currently no agreed national recommendation for staffing levels within spinal injuries units. Each unit varies with regards to the number of acute injury, respiratory, rehabilitation and secondary admissions beds. South Tees are leading the Spinal CRG work regarding national staffing levels for spinal injury patients. Current benchmarking shows significant differences in staffing and patient number models with variations in the ability to recruit to the registered nursing posts available.

This is managed well at SFT by the use of highly skilled band 3 nurses who undertake respiratory competencies and can support this complex patient group. This also supports the further challenge of recruitment of RNs which has a recognised national shortage whilst providing progression for the B2 workforce. The latest skill mix review has identified that an increase in the B3 workforce would

further support the requirements to adequately monitor the ventilated respiratory patients who need to be within line-of-sight. The most recent challenge for this patient group has been the extended period of care required within a side room setting as opposed to a bay.

This recommendation increases the band 3 s within the Avon skill mix. It is proposed that a B2 is converted into a B3 during the day which supports both the respiratory and non-respiratory patients as these staff can deliver elements of care to support the RN. Currently at night there are 3 RNs, 1B3 and 1B2 who are required to provide line-of sight as well as undertake a varying number of 5 man turns and routine skin care. There are currently 2 RN and 2 NAs on Tamar Ward who may also require 5 man turns and routine skin care and the 2 wards work together to ensure that staff assist each other during the night. Professional judgement from senior sisters recommends that 1 additional B3 on the night would support this level of care.

In addition it is also recommended a further review of the Spinal Unit staffing requirements is undertaken over the next 6 months in conjunction with defining the service model. This needs to be completed alongside developments nationally and from information obtained following visits to Glasgow and Stanmore Spinal Units by the Directorate Management Team.

4. Care of Children

The CQC inspection report made a clear recommendation that the Trust should review the staffing in areas providing care to children. The Trust has a dedicated paediatrics department which consists of a 16 bedded inpatient ward, a Day Assessment Unit, as well as the Outpatients area. Other areas caring for children include Day Surgery Unit, ED and Burns.

4.1 Sarum. Since the inspection the staffing levels on Sarum have been adjusted to ensure there are 3 RSCN on Sarum in-patients (day and night), complimented during the day by 2 RSCN in DAU and a fully supervisory B7. This is further supported by a nursing assistant and play therapist. Staffing levels are reviewed daily by the DSN with the nurse in charge to identify any additional requirements. The RCN guidance recommends 1 nurse to 3 children aged less than 2 years old and 1 nurse to 4 children over 2 years old. Approximately 45% of children admitted to Sarum Ward are under 2 years of age. An acuity tool was introduced in November 2015 and will be reviewed as more data becomes available and further capacity work will be undertaken by the DMT during 2016.

4.2 Burns Prior to the CQC visit, SFT met with representatives for the Burns Network and Specialist Commissioning to discuss the RSCN and RN nursing levels on the Burns Unit. It was agreed that 1 RSCN per shift alongside an RN burns nurse with paediatric competencies is an acceptable model to provide safe and effective care to paediatric burns patients within the Burns Unit. However the Burns Unit struggles to recruit RSCNs into what is a predominantly adult ward. As a temporary measure, whilst a full evaluation is carried out, burns children are being cared for on Sarum ward.

It is recommended that a Trust wide review of the care of children is undertaken to address all of the requirements for this group, the findings of which will be undertaken separately from the skill mix review process.

5. Emergency Department (ED)

All of the recommendations from the nurse staffing review in ED carried out by the Lead Nurse in 2015 have been actioned except for the allocation of an RN to Minors.

It is recommended that the allocation of a trained nurse into Minors will have a positive impact on both ENP productivity and the four hour target. ENP productivity has already shown to increase significantly with the allocation of a nurse to undertake complex treatments, administer IV antibiotics or arrange an admission (pilot undertaken 2014) - those tasks outside the remit of the Nursing Assistant. Weekend ED presentations are particularly high for minors cases and often when Majors is under pressure flexibility in registered nurse support cannot be provided to the minors area. Patients often wait prolonged periods of time when they are waiting for treatment to be delivered and subsequently breach the 4 hour target. Patient flow is significantly affected when a nurse is taken from the Majors area to carry out treatments in Minors.

The trained nurse will work alongside the current Minors Nursing Assistant to care for adults and children. A rotational post has been considered (and will continue to be reviewed) for the staff on Sarum and ED however, given that children are not always present in ED, the trained nurse must be able to feel confident to care for adults as well as children.

Future recommendations regarding the care of children in ED will be included as part of the review of services for children at SFT as identified in section 4.

A full multiprofessional workforce review has been commissioned for ED in order to look across all disciplines including and beyond nursing, on a backdrop of increasing demand.

6. Critical Care

Due to increased demand for critical care during 2015/16 the Board had made the decision to increase the number of commissioned beds from 9 to 10. At the time of the CQC inspection it was noted how busy the unit was and a recommendation was made to review staffing in this area however there were no concerns identified within the quality data (appendix F). Recruitment has been undertaken to staff the increase in establishment. A total of 12 new RNs have currently been recruited and the unit will be at full establishment by the end of August.

7. Midwifery

A skill mix and work force review of maternity was completed with analysis from Birth rate plus and the senior maternity teams in 2014-15. The finding suggested that 12 additional WTE midwives were needed to align the midwife to birth ratio to the current guidance from the RCOG safer staffing paper which recommends a ratio of 1 midwife: 28 births. Acuity was scrutinised and analysed as part of this assessment. The board initially approved an investment of 5 additional band 6 midwives which coincided with a similar amount of resignations. Six months later, the board then approved a further 5 midwives increasing the overall establishment to 83 WTE by November 2015. Recruitment is ongoing to fill the vacancies and the expectation is that all vacancies will be filled by October 2016. The birth rate and the acuity of women and babies continue to be measured and analysed and a monthly birth to midwife ratio is calculated (appendix G).

8. Care Contact Time

Laverstock Ward has completed short episodes of monitoring contact care time to evaluate the impact on having an additional band 4 on the late shift. This had previously been achieved on some but not all late shifts by utilising hours of staff working a long day pattern and was therefore cost neutral. The care contact hours has identified that during these shifts the RNs had time released as exemplified by more -timely drug rounds. Further work will be undertaken with the Laverstock Senior Sister to review this in line with additional evidence to support any changes that might be required on the late shift.

Within the ED skill mix review meeting the challenges to the ED coordinator role was discussed, specifically regarding the number of priorities they attempt to manage whilst coordinating. It was agreed that observing a period of care contact time would help to identify which appropriate resource is required to allow the coordinator to focus on that role.

Appendix H provides further information regarding the work by the Trust related to the efficient use of the nursing workforce and the national work into Care Hours Per Patient Day (CHPPD).

9. Recommendations:

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

9.1 Investment

In considering the recommendations resulting from this skill mix review the nursing workforce have considered what contribution could be offered to provide a cost neutral solution and it is recommended that the supervisory ward sister status is reduced from 100% to 80%, thereby releasing 1 shift per week to the rotas.

The tables below identify savings, cost avoidance and recommendations for investment:

Proposed Saving	**£ amount**	**Cost avoidance**	**£ amount**
Reduction of B7 supervisory from 1.0WTE to 0.8 WT	**£124,087**	B2 specials cost on Redlynch	**£57,709**
		B5 specials cost on Pitton	**£121,206**
TOTAL	**£124,087**	**Total**	**£178,915**

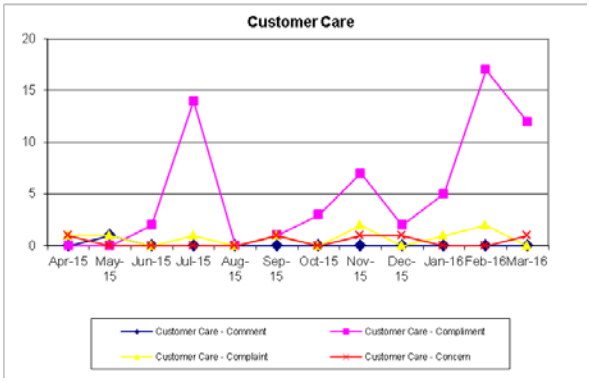
Proposed Investment	**£ amount**
B2 night shift Redlynch	**£62,689**
B5 long-day Pitton	**£55,452**
Substantive funding of weekend pilot for Redlynch and Pitton	**£18,530**
ED minors nurse 10:00-22:00	**£52,116**
Avon B3 establishment increase	**£71,495**
Whiteparish RN at weekends	**£26,637**
TOTAL	**£286,919**

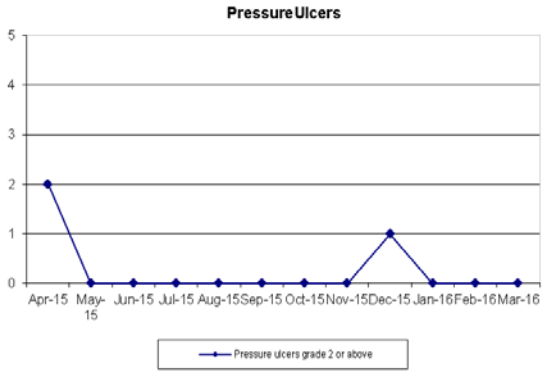
9.2 Trust Board Actions:

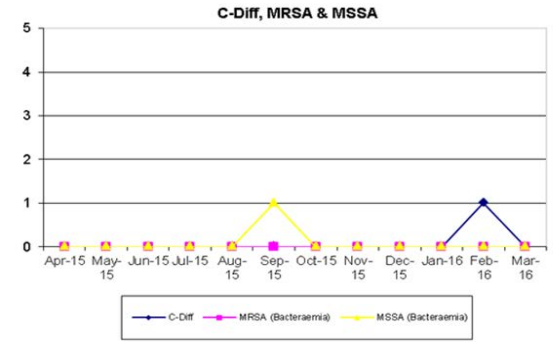
- To consider the proposed investments and make decisions based on identified risks and benefits within this paper.
- To commission a review of areas caring for children to bring all strands into one review
- To commission a review of spinal unit staffing based on the national work underway and the unit requirements i.e to open to full capacity

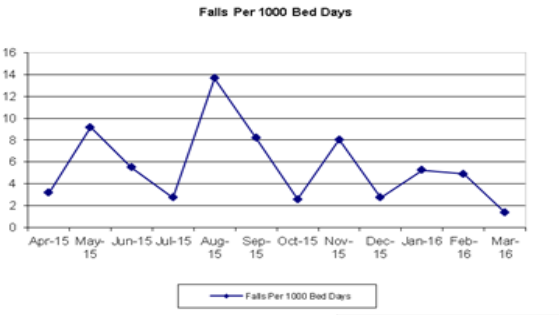
Appendix A

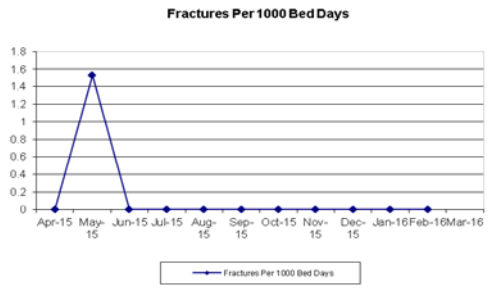
1. Downton Quality Indicators



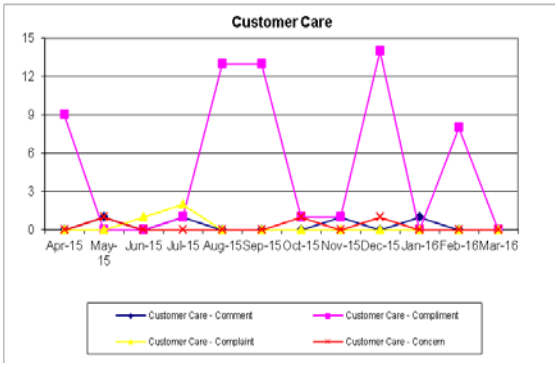


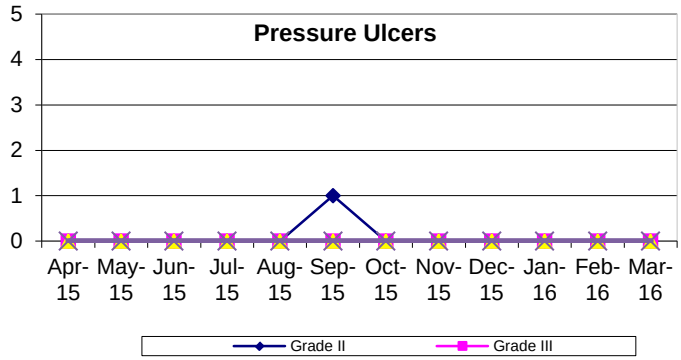


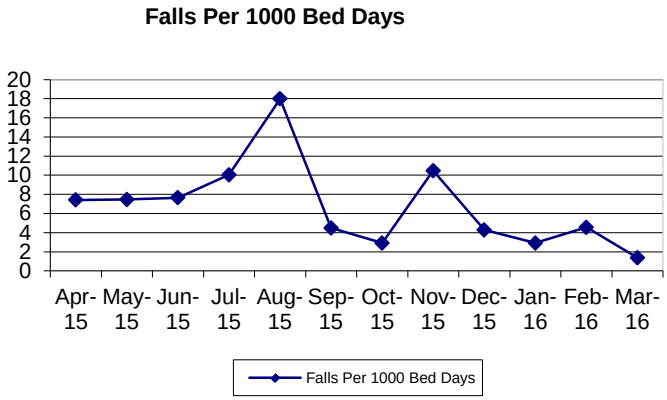


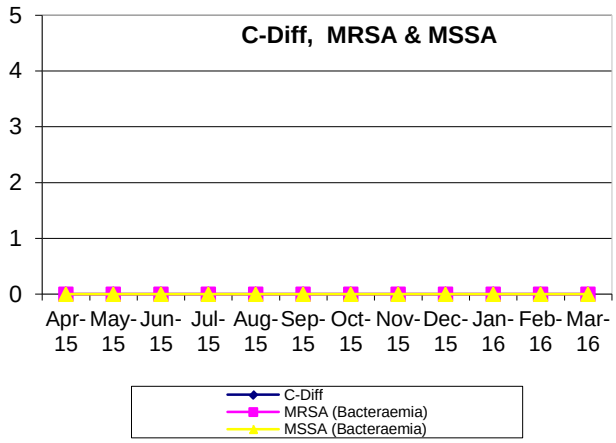


2. Chilmark Ward Quality Indicators:

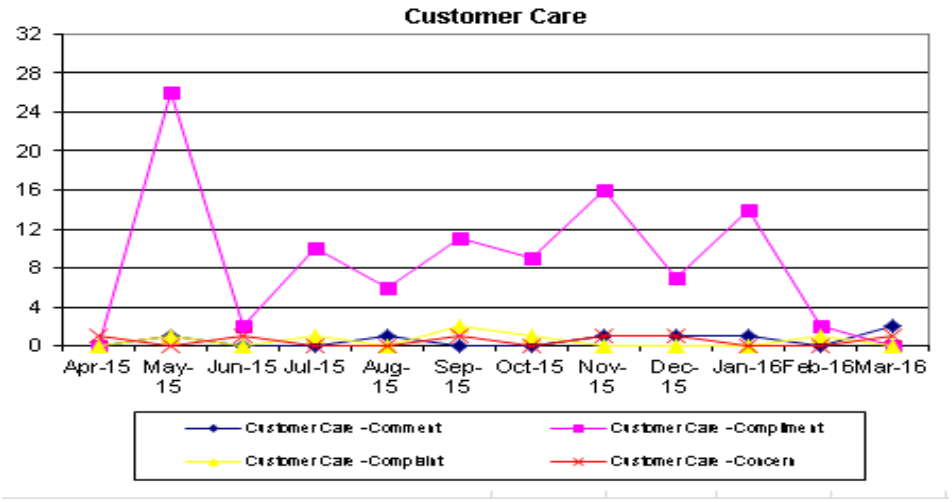


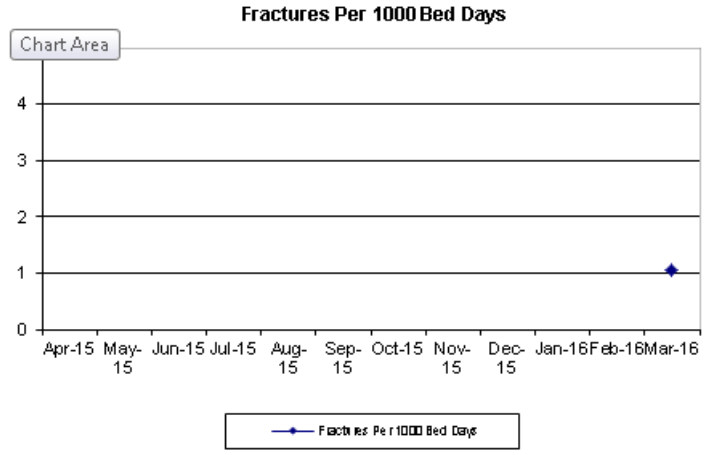


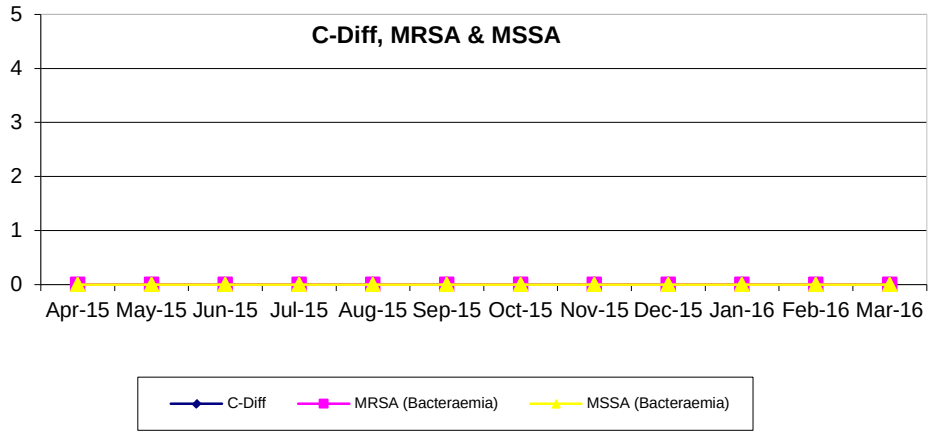




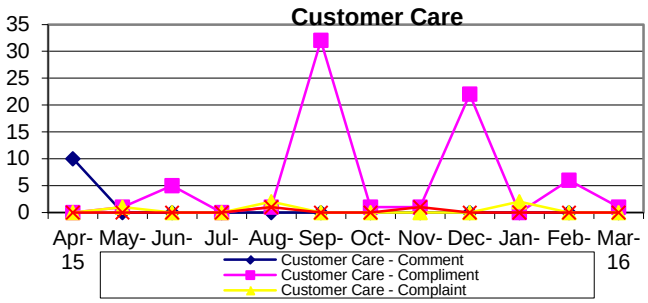
3. Amesbury Ward Quality Indicators

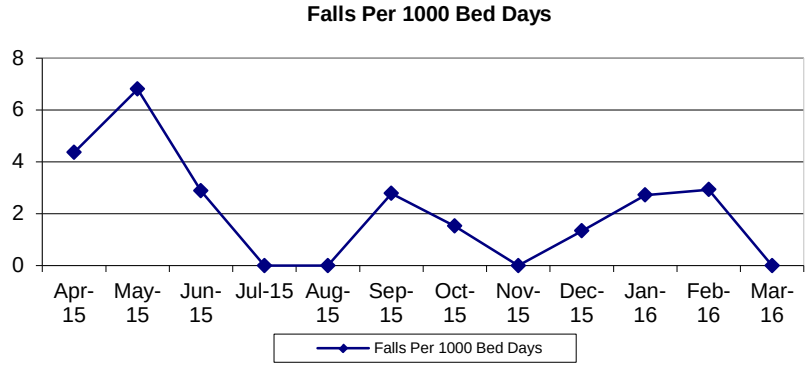


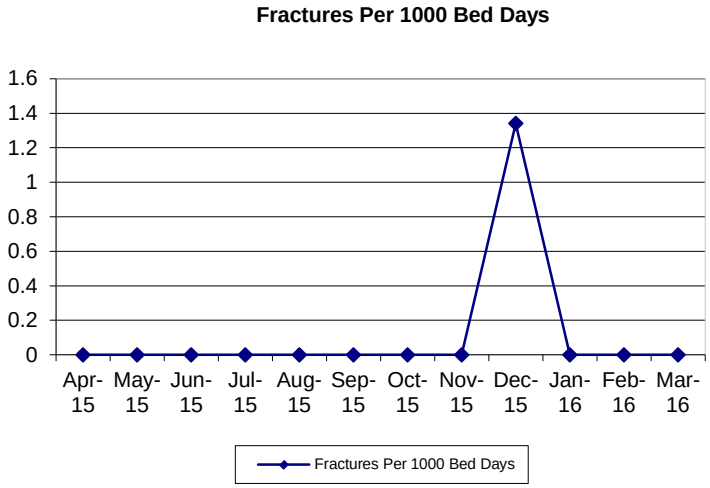


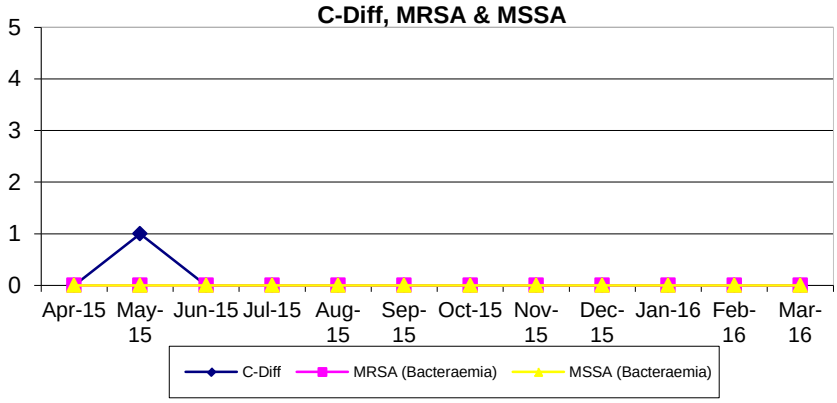


4. Laverstock Ward

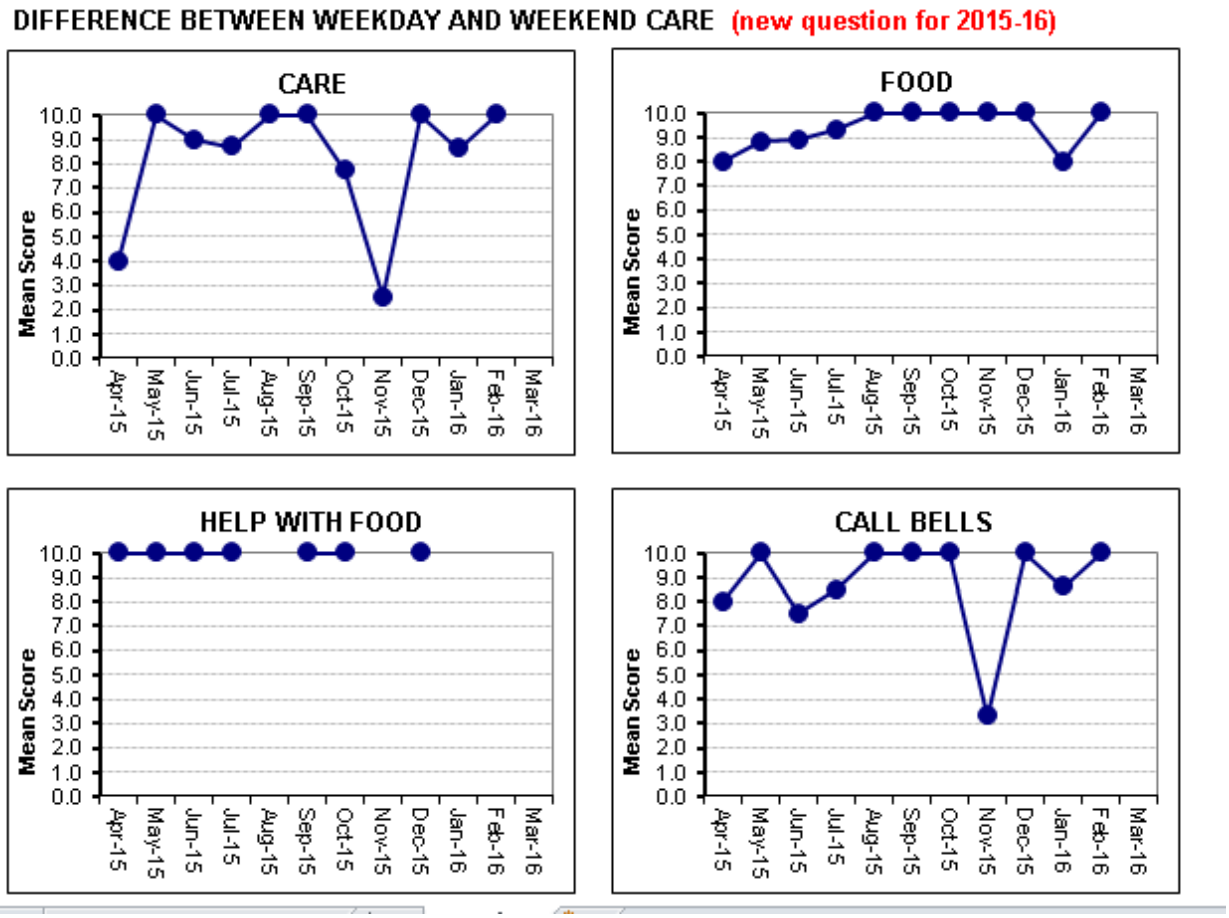








5. RTF Laverstock Ward



Appendix B
Six Monthly Skill Mix Review June 16

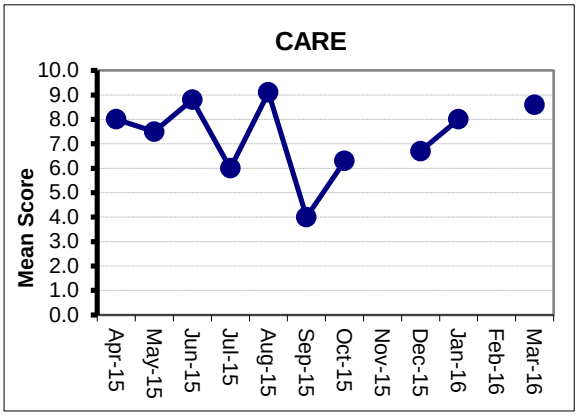
Ward	RN: Patient Ratio (Early)	RN: Patient Ratio (Late)	RN: Patient Ratio (Night)	% RN : HCA (based on establishment)	Comments / Recommendations
Whiteparish	1:5 (1:6)	:5 (1:6)	1:5.6 (lower with twilight)	70:30	• Increase RN on Saturday and Sunday long-day in-line with Monday - Friday
Tisbury	1:4.5/2.5	1:4.5/2.5	1:5.75	81:19	• No recommendations
Pitton	1:6.75	1:6.75	1:7.6	64:36	• Substantiate weekend staffing levels as a result of pilot • Increase B5 long day related to increased acuity and current high use of temporary staffing
Redlynch	1:6.75	1:6.75	1:7.6	57:43	• Substantiate weekend staffing levels as a result of pilot • Funding of additional B2 on nights to meet acuity needs and reduce spend on temporary staffing
Farley	1:6	1:6	1:10	60:40	• Improve compliance with Safe care data for next 6 months
Durrington	1:7	1:7	1:10.5	50:50	• No recommendations
Winterslow 40	1:8	1:8	1:13.3	49:51	• Trial moving B2 for the early to the late shift and monitor trends in falls data
Pembroke	1:5	1:5	1:5	81:19	• Review the requirements of the B2 on nights – consider changes to the B2 late shift (later finish to support the night)
Hospice	1:5	1:5	1:5	57:43	• Improve compliance with Safe care data for next 6 months
Amesbury	1:6	1:11	1:11	55:45	• Undertake baseline establishment review following repeated changes • Review changes to B5 establishment to support increase in B4
Chilmark	1:6	1:8	1:12	57:43	• Transfer B4 to B2 budget and use for 10-6pm shift to support increased activity. Consider using WTE to support ward sister admin support role. No issues at night
Burns	1:4.6 (1:3 Paed)	1:5.6 (1:3 Paed)	1:8.5	70:30	• Review requirement to reduce B2 and increase B3 to support minor dressings and pressure garments • Review of RSCN requirements to provide 1 RSCN per shift as per Network agreement. Consider flexible post linked with Sarum Ward – 4.0WTE • Contribute to Trustwide childrens staffing review

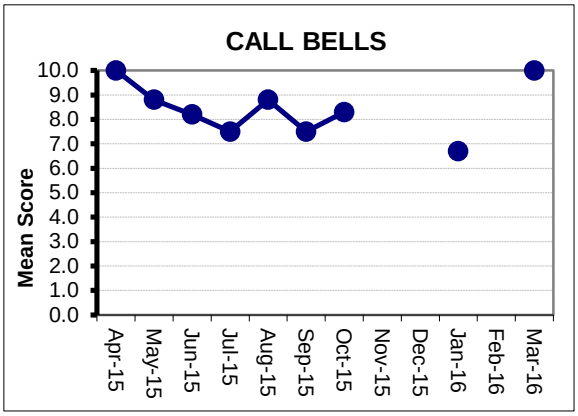
Laverstock	1:5.2	1:8.6	1:8.6 (1:13)	67:33	• Complete more contact care hours audit to understand requirements for weekend 3rd B5 at night (to match Monday-Friday) • Consider change of time for late B2 shift • Consider using ward clerk WTE to support ward sister admin support role
Avon	1:4.25	1:5.6	1:8.5	40:60	• Establishment to be funded to reduce B2 and replace with B3 to support skill mix and vacancy. • B3 at night to support spinal care • Participate with data collection and contribution to spinal CRG staffing levels for spinal injuries
Tamar	1:7	1:7	1:10.5	42:58	• Participate with data collection and contribution to spinal CRG staffing levels for spinal injuries • Care contact hours audit to be completed June 2016
Britford	1.5	1:5	1:7	63:37	• DMT to consider business case for 24 hour funding of SAU
Downton	1:8	1:8	1:12	62:38	• No issues at night. No recommendations
DSU ward	1:7	1:7	N/A	50:50	• DMT to consider business case for 23hr surgical ward • No current headroom within budget
Sarum	1.5	1.5	1.5	86:14	• Participating in trust wide childrens review
ED	N/A				• Contact care hours during April 2016 to audit coordinators role • B5 10:00-22:00 in minors as final phase recommendation from April 15 skill mix review • Full workforce review commissioned (multiprofessional)
Radnor	ICS Levels of care 1:1 or 1:2				• 10 beds commissioned in April 16 – currently recruiting to this gap • Change to B2 per shift to support night shift – cost neutral • Current pilot of B3 therapy assistant within budget

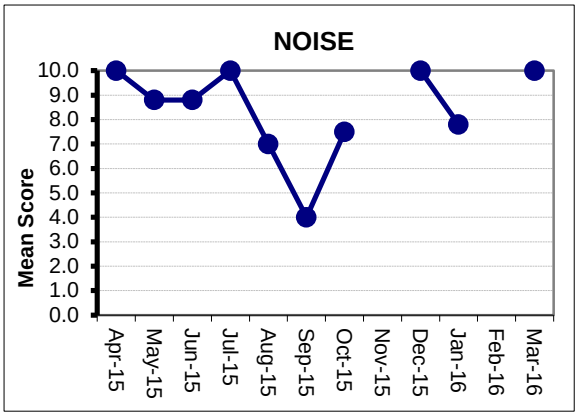
*** weekend numbers**

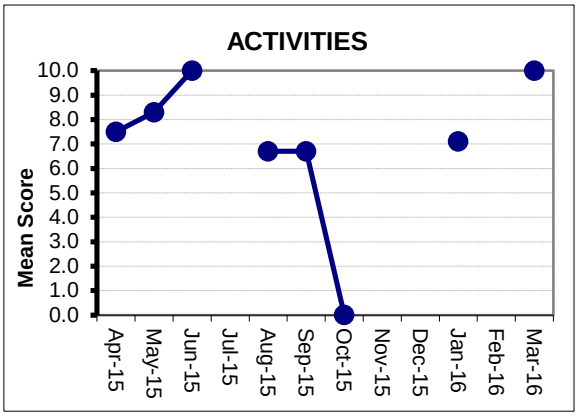
Appendix C

Pitton RTF – Difference Between Weekday and Weekend Care

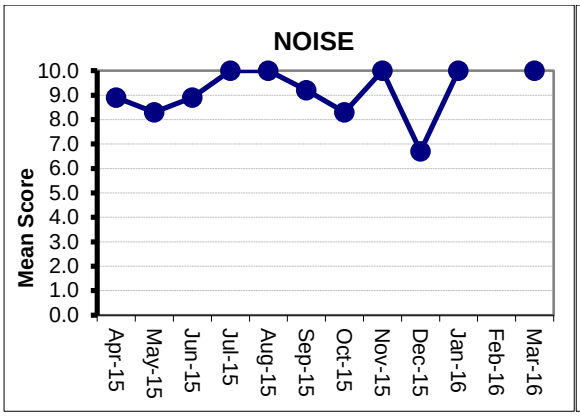


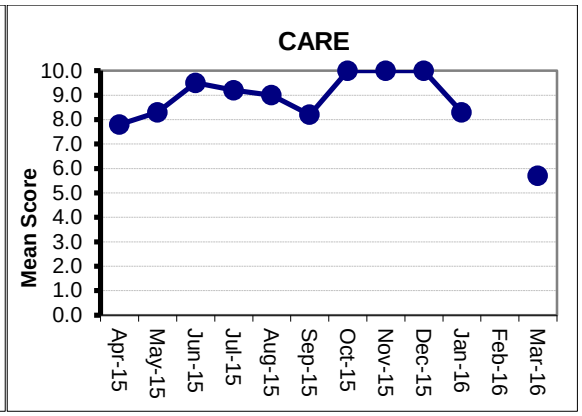


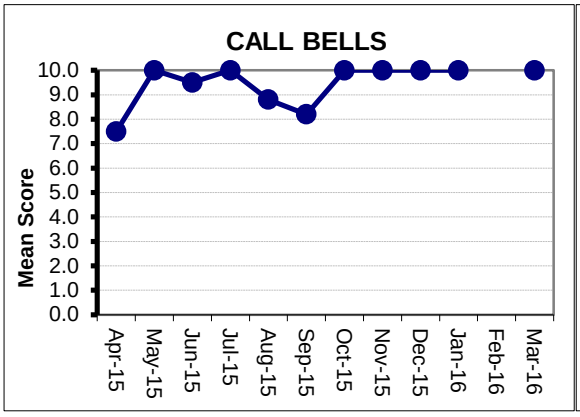


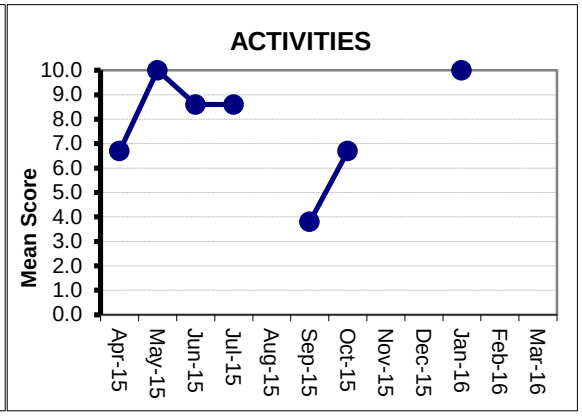


Redlynch:



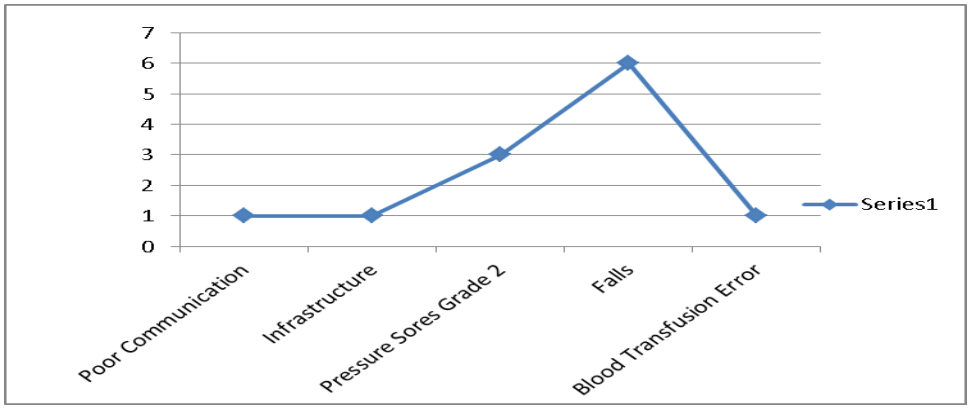




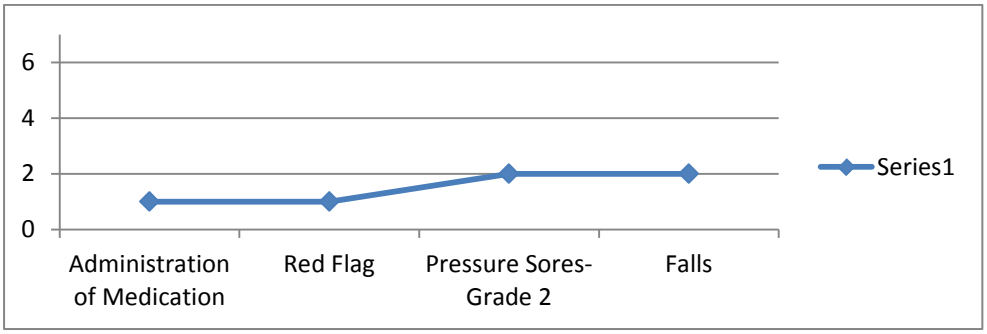


Redlynch Incident Data

Saturday April15-31st October 15



Saturday November 15-March 16



Weekend Real Time Feedback/Friends and Family Feedback Redlynch Ward

April-31st October 2015

- Food late coming up at weekend so some food was not very warm
- More care needed at the weekend when serving meals
- Nurses not always available at weekends when needed

November-March 2016

- More relaxed at the weekends.
- Weekend staff need more compassion
- The care received was excellent. Hard working staff at all times of week and weekends. A credit to the N.H.S. Thank you very much.

Appendix D

Night Shift Working Proposal and Evaluation - Redlynch

Since our night shift staffing was changed from *2x Band5's and 2x Band 2's* to *3x Band5's and 1x Band2*, staff have struggled to complete night time tasks.

Plan

1. Present data 6monthly at Skill mix Review
2. Evidence why our night shift staffing is not adequate and staff are struggling to complete daily tasks.
3. To try a new way of working within our own substantive staffing.
4. Staff to raise Red Flags when staffing was inadequate
5. To limit substantive carers to working two night shifts at a time, for safe staffing and morale
6. To ensure security was used when required

Within our substantive numbers, 3Band5's and 1 Band 2, it was decided at a staff meeting that we would trial a new way of using our staff.

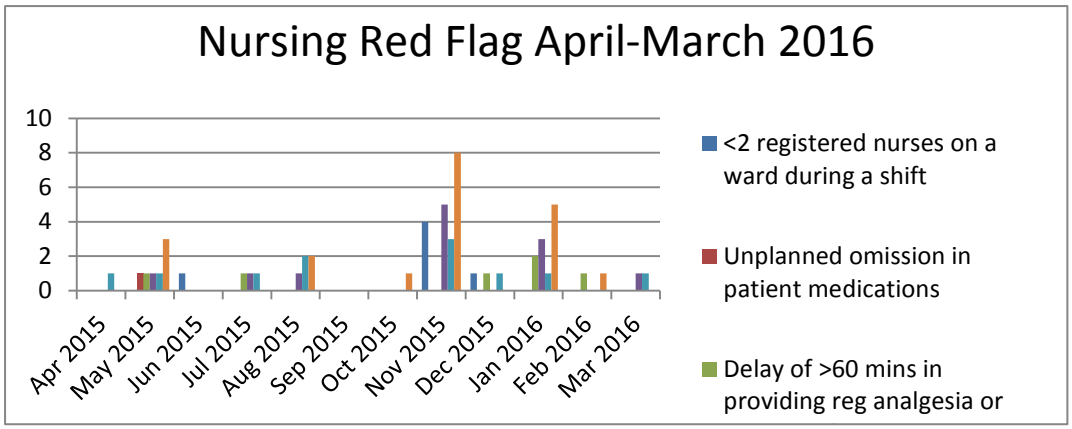
2x Band 5's would do intravenous medication and 1x Band 5 and 1x Band 2 would complete pressure area care and the night time carer tasks. We set this trial period for 3months from 01/12/2015-29/02/2016.

Evaluation

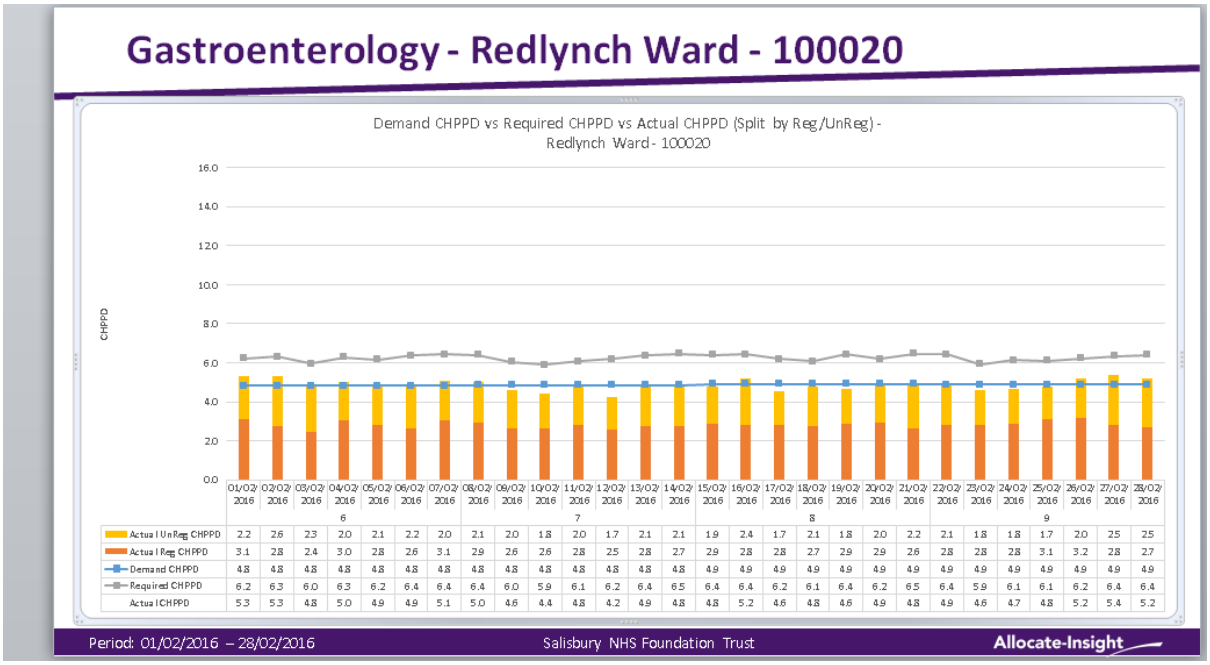
During this period it was clearly evidenced by staff that 3 registered nurses are needed to safely complete intravenous medication, documentation, be with acutely unwell/confused patients. During the trial period there were 16 Nursing Red Flags raised for various reasons such as staff unable to take breaks and delay in giving medication.

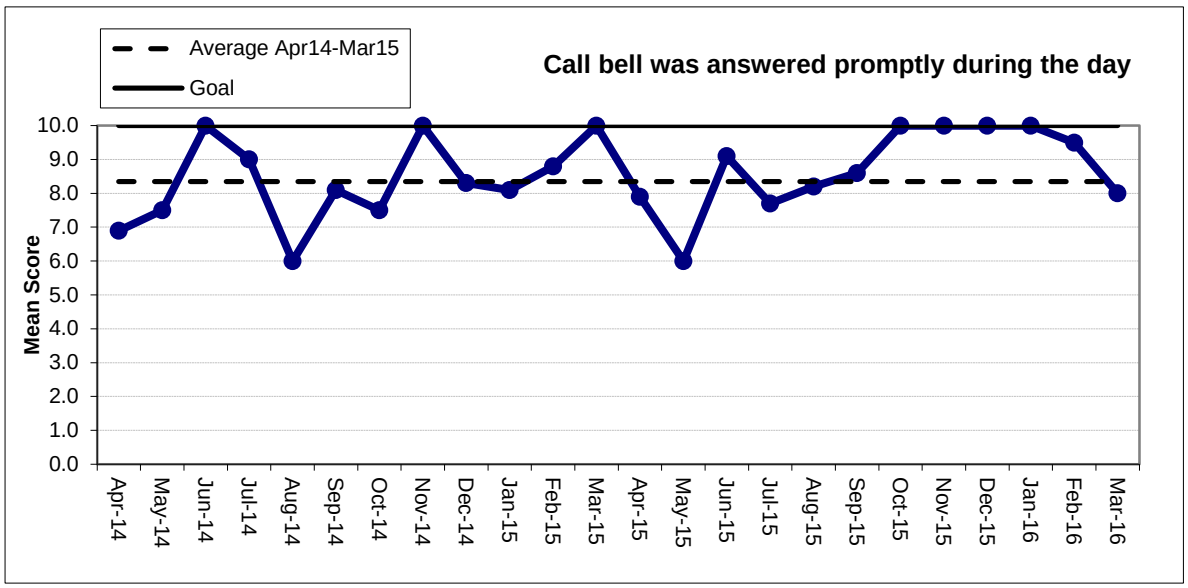
Night Shift Real Time Feedback/ Friends and Family Nov 15-March16 Redlynch Ward

- 21Nursing Red Flags raised since November '15 during the night; Staff Unable to take a break, Staff unable to give pain medication within 30 Minutes
- Very unhappy with nursing care overnight. I had to wait 45minutes to be turned.
- Hard working staff at all times of day and night. A credit to the N.H.S. Thank you very much.
- Staff work very hard, clean environment, cannot fault staff, such a shame the whole hospital is overstretched and staff aren't able to assist patients as quick as we would like.
- Ward short staffed but the hardest worked people in the hospital are night staff.
- Would like to see staffing levels increased at night, I had to wait a long time for a bottle.
- Friendly helpful personnel, but can be very noisy and disruptive at night


Nursing Red Flag April-March 2016
10
8
6
4
2
0
Apr 2015
May 2015
Jun 2015
Jul 2015
Aug 2015
Sep 2015
Oct 2015
Nov 2015
Dec 2015
Jan 2016
Feb 2016
Mar 2016
<2 registered nurses on a ward during a shift
Unplanned omission in patient medications
Delay of >60 mins in providing reg analgesia or

CHPPD Data


Gastroenterology - Redlynch Ward - 100020
Demand CHPPD vs Required CHPPD vs Actual CHPPD (Split by Reg/UnReg) - Redlynch Ward - 100020
CHPPD
Actual UnReg CHPPD
Actual Reg CHPPD
Demand CHPPD
Required CHPPD
Actual CHPPD
Period: 01/02/2016 – 28/02/2016
Salisbury NHS Foundation Trust
Allocate-Insight


Average Apr14-Mar15
Goal
Call bell was answered promptly during the day
Mean Score
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
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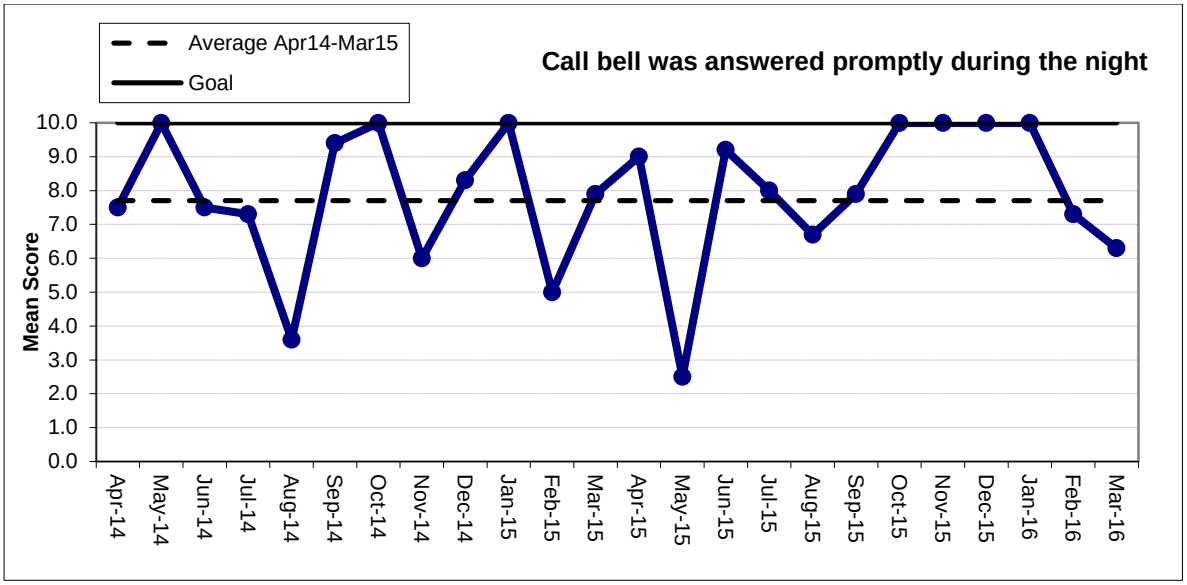
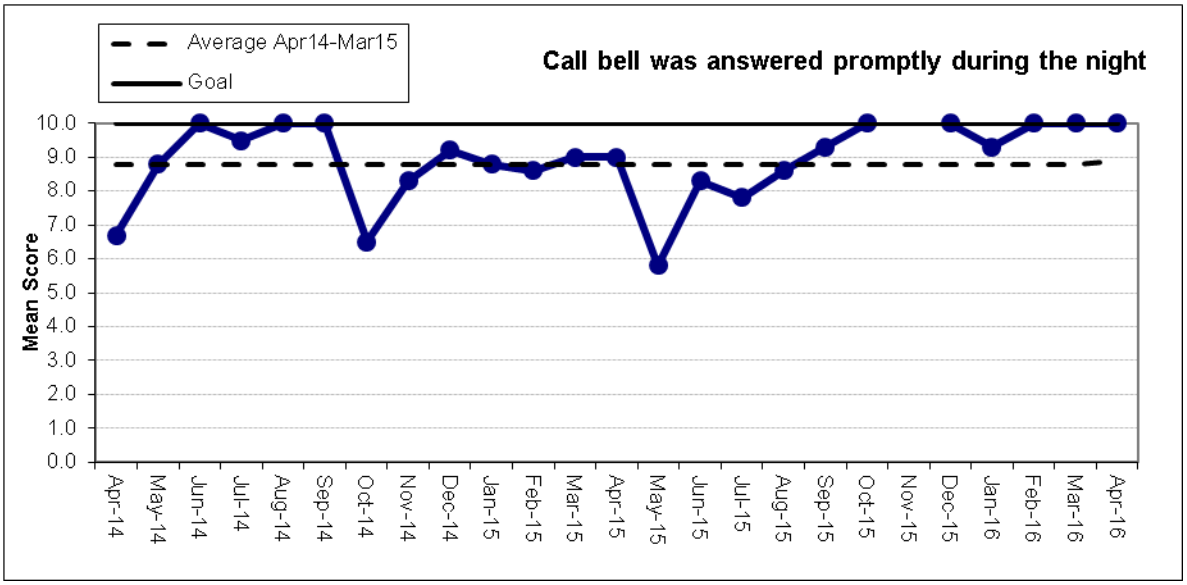
Feb-16
Mar-16



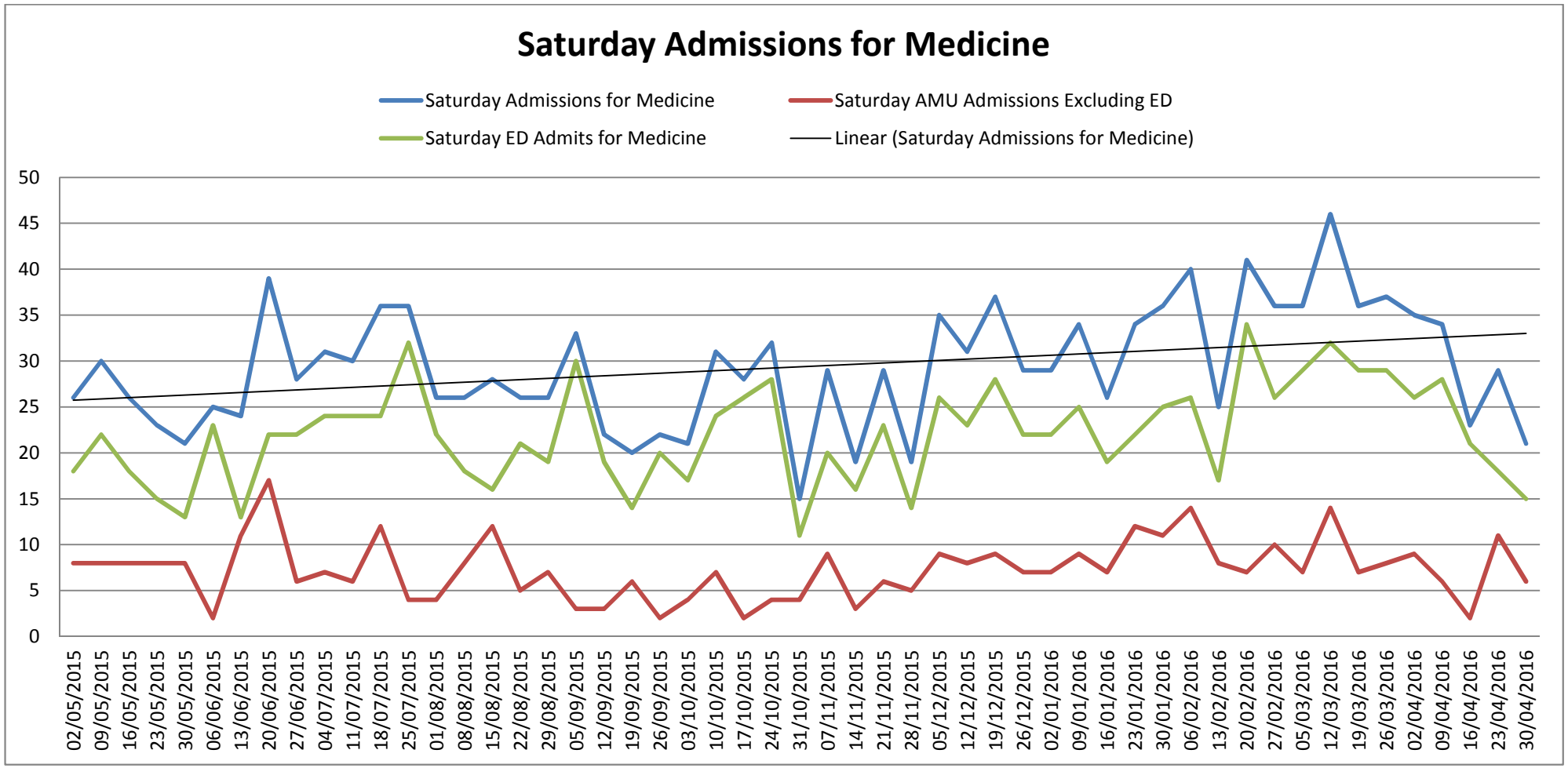
Compared to Pitton:



Medicine Admissions – Weekday and Weekend Comparison

1st May 2015 to 30th April 2016

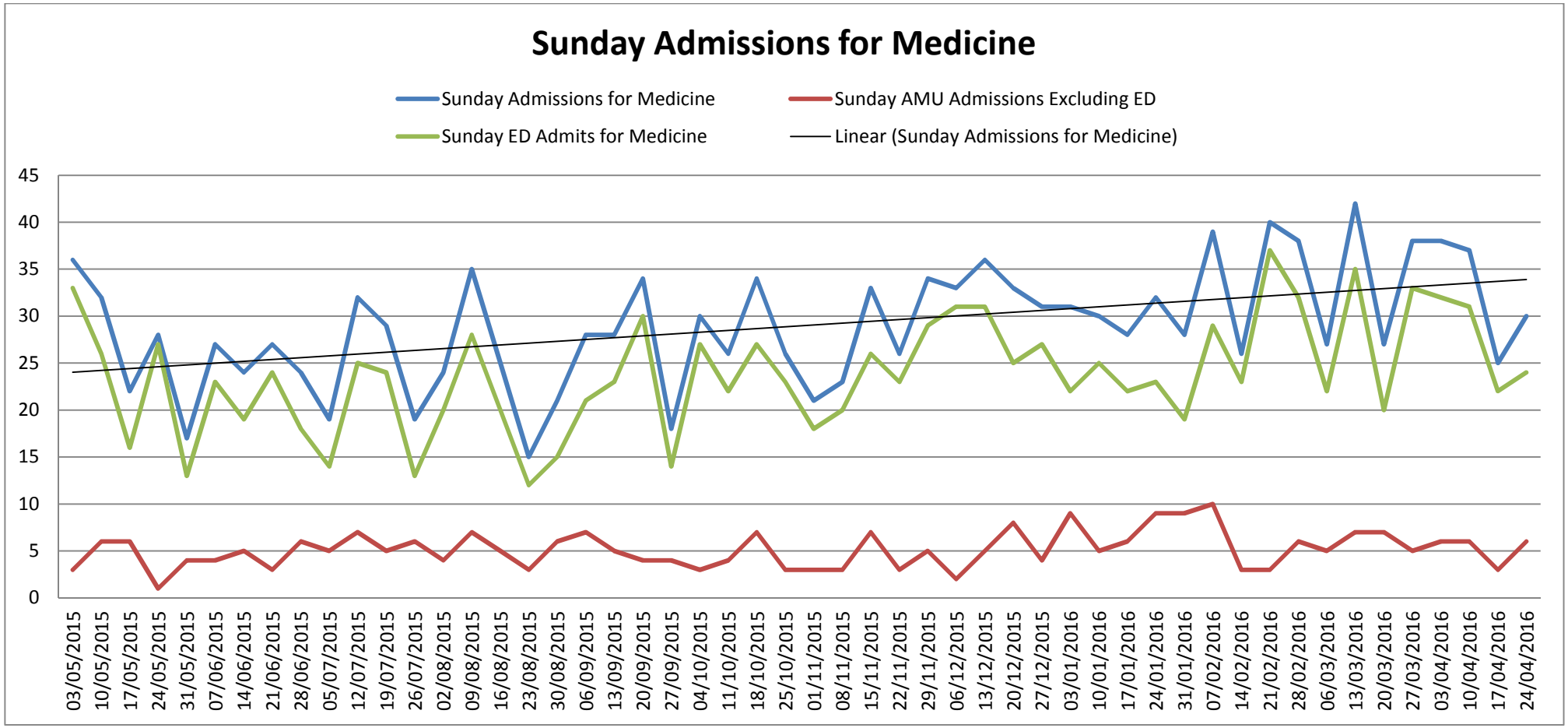
Number of Saturday admissions for Medicine showing split between AMU and ED Admits (Admissions to AMU from ED will only show in ED figures)



Medicine Admissions – Weekday and Weekend Comparison

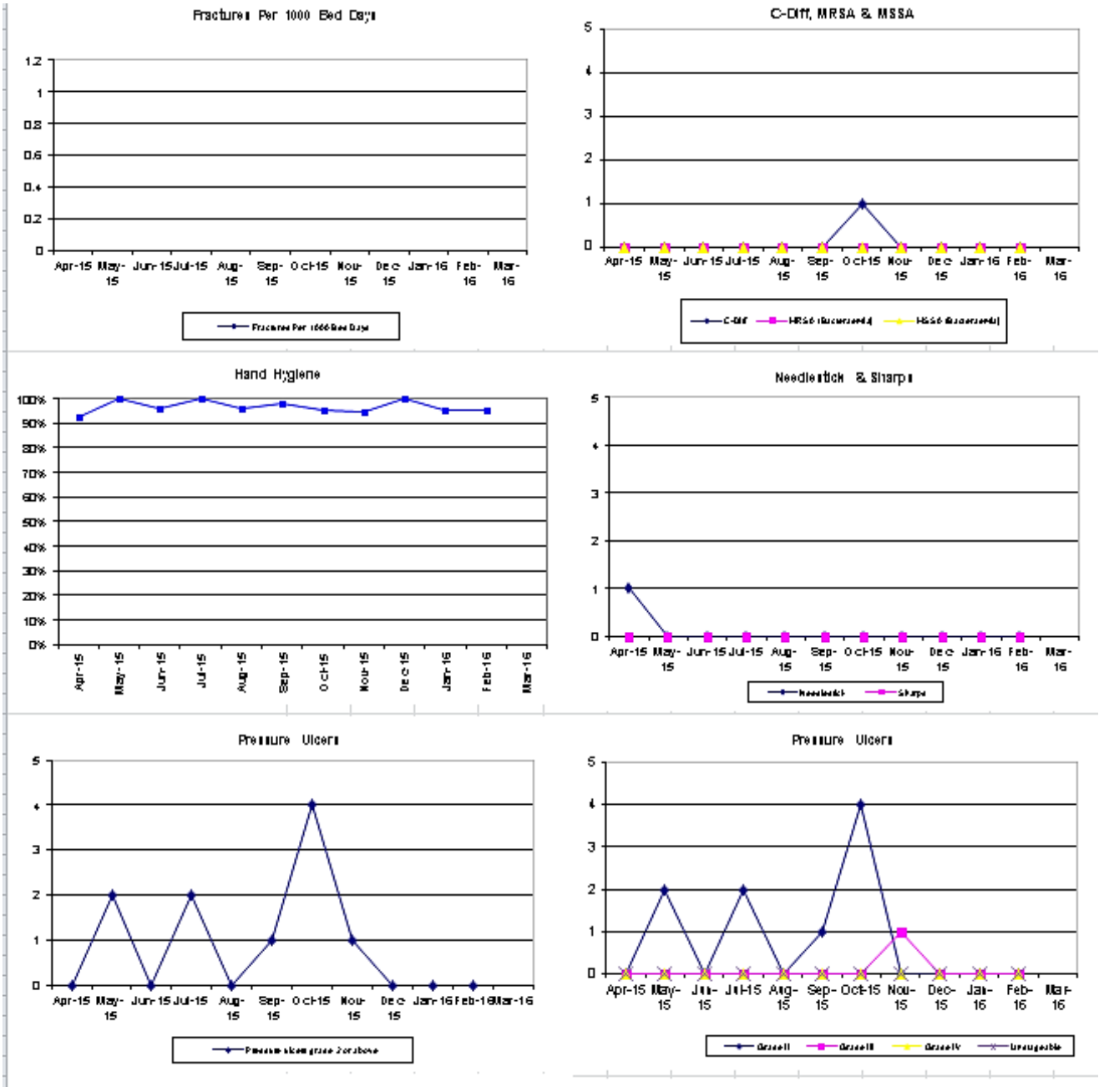
1st May 2015 to 30th April 2016

Number of Sunday admissions for Medicine showing split between AMU and ED Admits (Admissions to AMU from ED will only show in ED figures)



Appendix F

Radnor Quality Indicators



Appendix G Midwife to Birth Ratio

Midwives to Births Ratio
(excluding HOM & Management time)

Month	Number of Midwives	Reg Births (E3)	Non Reg Births (E3)	Total Births	Midwife to Birth ratio		12 Month average
Jan-14	65.4	186	1	187	1:34	34	
Feb-14	65.4	171	1	172	1:32	32	
Mar-14	65.4	192	1	193	1:35	35	
Apr-14	65.4	197	0	197	1:36	36	
May-14	65.4	198	4	202	1:37	37	
Jun-14	65.4	206	1	207	1:38	38	
Jul-14	65.4	206	2	208	1:38	38	
Aug-14	65.4	209	4	213	1:39	39	
Sep-14	65.4	235	3	238	1:44	44	
Oct-14	65.4	238	2	240	1:44	44	
Nov-14	65.4	198	3	201	1:37	37	
Dec-14	65.4	198	1	199	1:37	37	
Jan-15	65.4	229	3	232	1:43	43	38
Feb-15	65.4	146	1	147	1:27	27	38
Mar-15	65.4	190	2	192	1:35	35	38
Apr-15	65.4	184	2	186	1:34	34	38
May-15	65.4	205	4	209	1:38	38	38
Jun-15	71.21	191	3	194	1:33	33	37
Jul-15	71.21	204	1	205	1:35	35	37
Aug-15	71.21	178	1	179	1:30	30	36
Sep-15	71.21	221	3	224	1:38	38	36
Oct-15	71.21	223	4	227	1:38	38	35
Nov-15	71.21	225	4	229	1:39	39	36
Dec-15	71.21	188	3	191	1:32	32	35
Jan-16	71.21	220	4	224	1:38	38	35
Feb-16	71.21	176	1	177	1:30	30	35
Mar-16	71.21	204	2	206	1:35	35	35
Apr-16	71.21	209	5	214	1:36	36	35
Totals		5627	66	5693			

<=1:28
>1:28-<1:35
>=1:35

Appendix H

1. Lord Carter – Productivity and Efficiency Programme

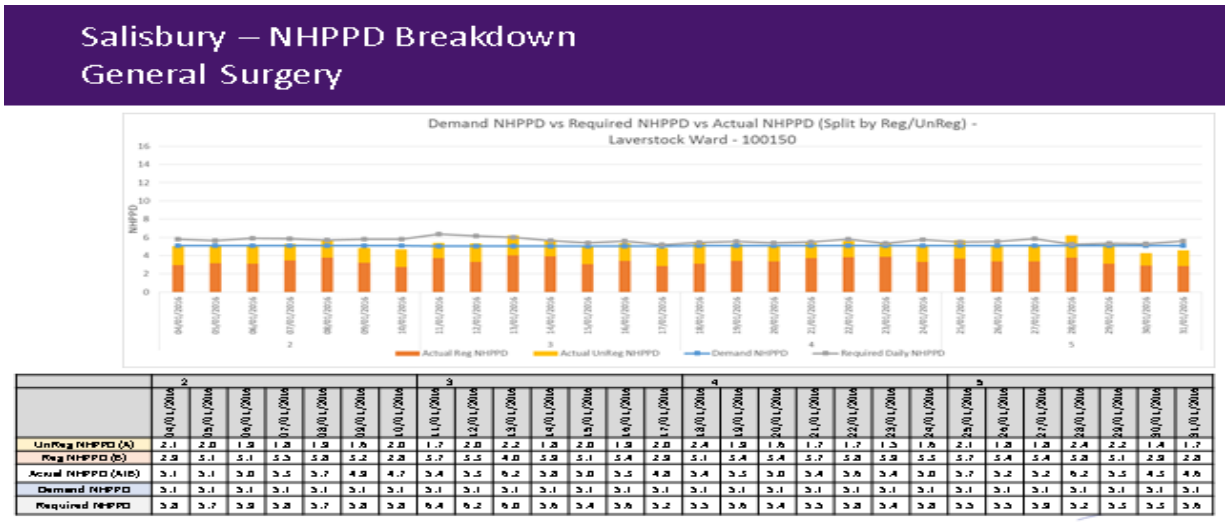
1.1 Workforce Efficiency Collaborative

During the period July 2015 – March 2016 there has been a closer national focus upon the nursing workforce as part of the Lord Carter review of efficiencies within the NHS. For nursing specifically this has focussed upon the efficient utilisation of the established nursing workforce; in essence ensuring there is no wastage of a limited valuable resource. SFT were 1 of the first 22 Trusts to join this work and as a result participated in a national workforce collaborative. A number of Trusts identified an efficiencies project in July 2015 and via monthly data submission, teleconferences and webinars shared learning and development. This also included 3 national collaborative meetings with the final meeting an opportunity for each Trust to share the outcomes and impact of their projects.

1.2 Care Hours Per Patient Day (CHPPD formerly NHPPD)

SFT are 1 of only 3 Trusts participating in a further programme linked to the Workforce Efficiency Collaborative to define the use of CHPPD. CHPPD is a systematic nursing workload monitoring and measuring system that provides a guide to the number of nurses (registered and non- registered) required for service provision within a specific clinical area. The CHPPD model is not designed as a rigid, mandatory determinant of staffing but relies on clinical judgement to assess adequate staffing to deliver care on a daily basis. The model is used to calculate the number of direct nursing hours required to provide patient care and as a framework to establish a nursing roster. This model has been used in the USA and Australia for some time and it is hoped this will be used in further skill mix reviews alongside professional judgement and existing guidance.

The involvement in this project by SFT has resulted in funding of £40k by the Department of Health for SFT to implement the mobile technology required to effectively use the Safe care tool that is currently being used across the ward areas. The use of this via a tablet will allow a view of staffing across the Trust whilst indicating areas of high acuity and areas using nurse specials.
An example of this data is shown below:



NATIONAL INPATIENT SURVEY 2015
ANALYSIS OF CQC BENCHMARK REPORT AND LOCAL ACTION PLANS

PURPOSE:

To provide the Board with an analysis of the Care Quality Commission's benchmark report on the National Inpatient Survey 2015 and the actions to be taken by the Trust.

MAIN ISSUES:

1.0 Introduction

Salisbury NHS Foundation Trust participated in the 13th national inpatient survey between September 2015 and January 2016. Questionnaires were sent to patients who had stayed at Salisbury District Hospital for at least one night during the month of July 2015.

2.0 Sample Size

In previous years, the sample size has always been set at 850 patients. For the latest survey, this was increased to 1,250 in an effort to produce more reliable data nationally to provide a greater insight into patient experience.

3.0 The Benchmark Report

Each year the Care Quality Commission (CQC) produces a report for each acute Trust in England showing the results weighted against other Trusts. Weighting is applied in three specific areas:-

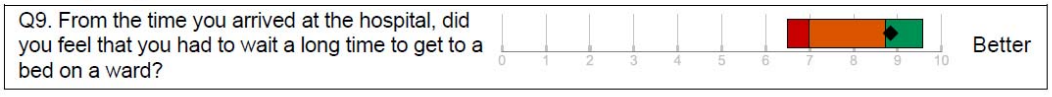
a) a high percentage of responses from older people who tend to report more positive experiences than younger respondents;
b) a high percentage of women respondents who tend to report less positive experiences than men;
c) a high percentage of respondents from emergency admissions who tend to be more negative than those respondents who had a planned admission.

A scoring system is used which marks each question out of a maximum of 10 points.

In the report, the word 'better' or 'worse' is displayed if a Trust's score is significantly better or worse than most other Trusts, as shown in Example 1 below.

Example 1

Waiting to get to a bed on a ward



The tables at the back of the report show SFT's score compared to the lowest and highest score across all Trusts, and the number of SFT respondents for that question. The tables also indicate with an arrow whether a Trust's score is significantly up or down on the previous year, as shown in Example 2 below.

Example 2

Survey of adult inpatients 2015
Salisbury NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
The hospital and ward							
S4	Section score	8.3	7.7	9.1			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	8.8	7.9	9.8	619	8.3	↑

The CQC expects Trusts to use the report to understand their own performance and to identify areas for improvement.

4.0 Analysis of the Benchmark Report

The survey contained 63 core questions which could be analysed. Other questions (known as filters) instructed respondents to skip certain questions or sections that did not apply to them.

The results are grouped into 11 sections and Trusts are scored for their overall performance in each section.

SFT scored 'better' than most other Trusts in one section:

Section	SFT score	National average score
Waiting to get to a bed on a ward	8.8	8.0

SFT scored 'about the same' as most other Trusts in the remaining 10 sections:

Section	SFT score	National average score
The Emergency/A&E Department	9.0	8.7
Waiting list and planned admissions	9.0	8.9
The hospital and ward	8.3	8.4
Doctors	8.9	8.8
Nurses	8.7	8.5
Care and treatment	8.1	8.0
Operations and procedures	8.6	8.5
Leaving hospital	7.5	7.2
Overall views of care and services	5.7	6.0
Overall experience	8.4	8.2

SFT scored 'better' than most other Trusts in 6 of the 63 individual questions:

Question	SFT score	National average score
From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	8.8	8.0
Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	9.3	9.0
Did a member of staff answer your questions about the operation or procedure?	9.1	8.8
Did hospital staff take your family or home situation into account when planning your discharge?	7.9	7.2
Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	6.7	6.3
Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	9.1	7.3

When compared with its own 2014 benchmark results, SFT had significantly improved in 7 areas:-

Question	SFT 2015 score	SFT 2014 score
From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	8.8	8.3
Did you ever share a sleeping area with patients of the opposite sex?	8.8	8.3
Did nurses talk in front of you as if you weren't there?	9.2	8.8
Did you find someone on the hospital staff to talk to about your worries and fears?	6.6	5.9
Were you given enough privacy when discussing your condition or treatment?	8.9	8.5
Do you think the hospital staff did everything they could to help control your pain?	8.7	8.3
Did hospital staff take your family or home situation into account when planning your discharge?	7.9	7.3

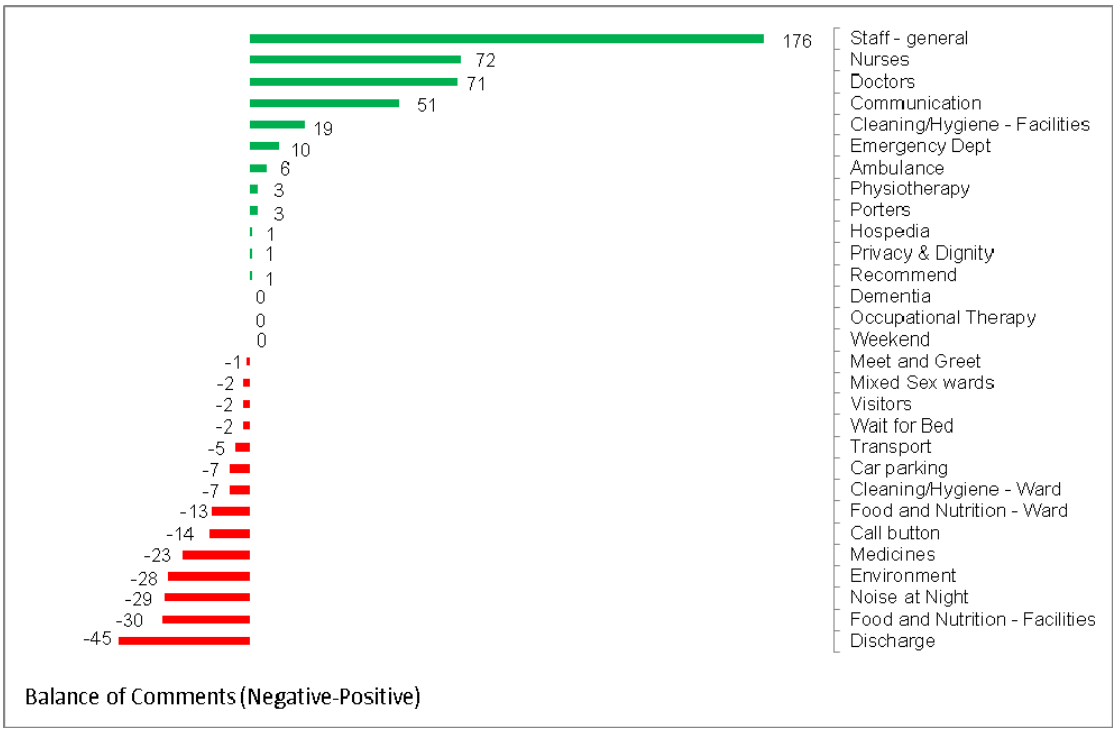
5.0 Comparisons with Demographic Characteristics

The split between male and female respondents was 50% male and 50% female, compared with 47%/53% nationally. Age group, religion and sexual orientation responses were in line with national figures. SFT's ethnicity responses for the White group were slightly higher than nationally (96% compared with 90%); responses from other ethnic groups were 4% compared with 10% nationally.

6.0 Local Results Analysis and The Next Steps

In addition to the standard questions, patients were invited to make comments about anything which they felt was particularly good about their care or things that they felt could be improved. A total of 448 comments were received regarding things that were good about the patients' stay and 330 comments on things that could be improved. These have been

categorised and analysed to show the areas where further attention is required, as indicated in the graph below:



The Patient Experience Analysis Group met in February 2016 to look at the results in conjunction with themes arising from incidents, concerns and complaints. The questionnaires for real-time feedback 2016/17 have been adjusted to reflect concerns raised and to gather more detailed information where required.

A new exercise was carried out in spring 2016 whereby members for the Customer Care team met with ward staff of all grades to look at the comments received through the national patient survey, real-time feedback, Friends and Family Test, concerns and complaints. Action plans were drawn up to work on the main themes over the coming three months. At the end of this period, the plans will be reviewed, completed actions removed and further work identified from more recent comments. This work will continue on a three-month rolling programme.

The ward action plans are presented in the appendices by Directorate (Appendices A – D). A progress report will be presented to the Clinical Governance Committee in November 2016.

7.0 Comparisons with Neighbouring Trusts

Work has been undertaken to compare this Trust's results with those of other Trusts in the area.

Salisbury has the highest or joint highest mean score in 7 of the 11 overall sections and 27 of the 63 individual questions.

Salisbury has the lowest or joint lowest score in 2 of the individual questions:
- Did you ever share a sleeping area with patients of the opposite sex?
- Did you see, or were you given, any information explaining how to complain about the care you received?

Full details of the comparisons are contained in Appendix E.

ACTION REQUIRED BY THE BOARD:

Board members are invited to endorse this approach and note the contents of this report.

ATTACHMENTS AVAILABLE TO VIEW ON WEBSITE:

Appendix A Action plan for Clinical Support and Family Services
Appendix B Action plan for Medicine
Appendix C Action plan for Musculo-Skeletal
Appendix D Action plan for Surgery
Appendix E Graphs showing comparison scores with neighbouring Trusts

AUTHOR: Lorna Wilkinson

TITLE: Director of Nursing

APPENDIX A

ACTION PLANNING 2016 – CLINICAL SUPPORT AND FAMILY SERVICES

WARD: SARUM

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Food	Ward Housekeeper to review negative comments received and implement changes where possible.	Ensure children are offered the child-friendly menu and receive the food they ordered.	Monitor feedback via RTF and FFT to ascertain whether number of negative comments has decreased.	Jan Keah	31 July 2016	
Staffing levels	N/A	Review staffing levels. Confirmation with Burns as to potential plans regarding their staffing levels and impact for Sarum. Outcome of skill mix review. Revision of summer staffing levels on DAU and ward as acuity, attendances and occupancy allows.	Ongoing use of acuity tool.	Mandy Cooper	31 July 2016	
Security	As a result of negative feedback, extra security measures have been installed whereby visitors to the ward cannot leave without the door being opened by a member of staff.			Mandy Cooper	Already in place.	Work complete.

APPENDIX B

ACTION PLANNING 2016 - MEDICINE

WARD: DURRINGTON (via Picker project)

OBJECTIVE FOR IMPROVEMENT	ACTIONS OVER ONE MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
All staff introduce themselves to the patient 100% of the time.	Safety brief notes and newsletter	Review RTF. Internal ward audit.	MDT Team. NA's project-"My Name Is." ADSN	31 March 2016	Indicated in safety brief. A majority of substantive NA's have left leaving 75% vacancies so unable to raise project yet. Extend to end of August.
Staff will respond to call bells in a timely way based on the patients need.	Safety brief notes and newsletter	Review RTF Complaints/concerns	MDT Team ADSN	31 March 2016	No complaints or concerns in the audit time. Still raised in RTF but % of patients responding to RTF has gone down ?due to dependency / frailty of patients which has gone up during audit period.
All patients being transferred to other departments will be prepared safely and with dignity	Safety brief notes and newsletter	Review RTF Complaints/concerns	Porters MDT Team ADSN	31 March 2016	Reported to head of x-ray for actioning. No complaints or concerns. (1 complaint regarding a discharge wearing in-adequate clothes, but dual responsibility with ambulance crew.
Mealtimes will truly be protected.	Re-launch of protected mealtimes as a priority for all staff	Project planning	MDT team	31st August 2016	

EMERGENCY DEPARTMENT AND SHORT-STAY EMERGENCY UNIT
(via Picker project and CQC inspection)

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Improve patient flow through the Emergency department; reduction in patient waiting times.	Completion of CQC action plan for Outcome 1.	Identification of ED patient flow actions for 'Patient Flow Board'.	Attendance to fortnightly board meetings and updates provided to set action plan.	Nickola Gipp – DSN for EM, Nicola Heydon – ED Senior Sister, Dr Lynch – ED Consultant.	Latest deadline on CQC action plan Sept 2016	
Reduce the waiting times for patient assessments (triage) for those self-presenting patients.	Completion of CQC action plan for Outcome 4a/4b.	Carry out a triage patient flow mapping exercise and review the current processes in place.	To review the proposed IT process for Lorenzo and patient assessment. To undertake 2 hourly 'safety' rounds on those pts in the waiting room.	Nickola Gipp – DSN for EM, Nicola Heydon – ED Senior Sister, Dr Lynch – ED Consultant.	Latest deadline on CQC action plan Oct 2016	
To care for children in an environment to provide audio and visual separation from those adult patients. To ensure that all nursing staff are competently trained to care for children < 16yrs.	Completion of CQC action plan for Outcome 2 & 6.	To identify a senior nursing lead to support the competencies for nursing staff and the training programme commencing Sept 2016.	To support the completion of the competency document for August 2016.	Nickola Gipp – DSN for EM, Nicola Heydon – ED Senior Sister, Dr Lynch – ED Consultant.	Latest deadline on CQC action plan Oct 2016	

WARD: FARLEY WARD

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Staffing levels	Ongoing recruitment, out to advert at present for Band 2 and Band 3.	Closing date for adverts. Short-listing to begin.	Continual recruitment of staff	Kirsty Anderson (KA)	5 November 2016	
Communication	Discussions on ways to improve the MDT approach and communication issues. Information in Staff Room for all to contribute towards how more effective communication can be achieved. Identified on safety brief.	Implementation of the “day” shift role, roles and responsibilities identified for this weekly role. Identified on safety brief.	Clear objectives for staff to achieve within each weekly period. Review RTF and FFT.	Senior team	5 November 2016	
Noise at Night	Noise at night champion appointed. Lights to be out by 2300 at the very latest. Staff respecting that it is night time and lower their voices accordingly. Identified on safety brief.	Production of ward poster highlighting the need for a restful night. Identified on safety brief.	Senior sister to conduct night duty and supervisory shifts over a night duty.	Mary Galannza (MG, Noise at night champion) KA	5 August 2016	

Food & Nutrition	Meal time and food & hydration link nurses identified. Senior HCSW team (SHCSW) identified. Change water jugs at 2200 hrs and in the morning. Identified on safety brief.	SHCSW meeting to identify responsibilities. Implementation of new responsibilities and structured routines. Identified on safety brief.	Donations received and purchase of new patient tea/coffee machine.	Emma Ward (EW) Maura Armstrong (MA)	5 November 2016	
Call bells	Tone of bells to be kept at high during the hours of 8am - 8pm. Call bell champion identified. Identified on safety brief. Ensuring all levels of staff answer bells in all areas.	Tone of bells to be kept at high during the hours of 8am - 8pm. Identified on safety brief.	Reviewing RTF and FFT feedback. Tone of bells to be kept at high during the hours of 8am - 8pm. Identified on safety brief.	Susan Scotting (SS) Call bell champion Senior Team	5 November 2016	

WARD: PEMBROKE

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
37% of negative feedback related to food		1. Discussion with kitchen about meal trolleys being delivered too early. 2. Assist patients with meal choices and ensure correct menu is given. 3. React accordingly if patient choice varies, allow where possible to change menu choice if possible.	Audit required over 1 week to review the time that the meal trolley arrives and time last patient is served.	1. Debbie – ward clerk 2. Ward sisters to discuss with staff, entered in ward communi-cation book	May 2016	Spoke to kitchen in November 2015 re: meal trolley. Improved but needs monitoring.
Staffing levels on ward is 14 % of negative feedback		1. Skill mix review to monitor staffing levels. 2. Review shift patterns. Explore use of HCSW on different shift patterns to support night staff.		Claire Smith – ongoing Ward sisters to discuss before May 2016	May 2016	
Noise on ward is 11% of negative feedback	Follow up proposed work to fit silencers to all doors that slam shut	Work to doors to be carried out. Team meeting reinforced noise at night, all staff made aware. Encourage staff to 'settle patients early where possible at night and to move patients, where possible, to promote individualised care, i.e. nurse patients in side rooms that may require more intensive nursing care. Consider transferring phone from desk on ward into office at night to reduce noise		ETS to carry out work to doors. All staff accountable for noise on ward. Staff on late shift to arrange via switchboard.	May 2016	

11% of negative comments relating to discharge planning	Remind all staff to utilise discharge checklists and to liaise with medical staff early in day to consider discharge dates.	Discuss with medical staff and pharmacy delays in discharge.	Work with respiratory clinicians to improve rate of late discharges.	Ward sisters	June 2016	

WARD: PITTON

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Poor communication between the medical team and patients	Inform the nursing team via safety brief to promote communication with the patients.	Discuss with the medical team during the morning multi-disciplinary meetings and encourage explanations of all interventions to each individual patient.	Attempt to implement a routine whereby the nurse in charge follows the doctors on the ward round and can communicate all information to both the staff and the patients. Unfortunately, due to time limitations, this may not always be possible.	- Nursing team - Doctors - Ward clerk - Physiotherapists - Occupational therapists	15 June 2016	
Cold food	Continue to change the routine in which the food is served and always use the metal lids to keep food hot.	Promote protected meal times to avoid the patients' food becoming cold.	Discuss with the Kitchens the timings they deliver food in order to prepare and serve straight away.	- Nursing assistants - Medical team - Nurse in charge	15 June 2016	
Noise levels at night and weekends	Become stricter with the visiting rules and allow only 2 visitors at bedside.	Potentially close the bay doors on a night shift depending on the patient acuity.	Real-time feedback states noise levels from staff is consistently improving and call bell answering times are decreasing. Continue this and ensure all bells are answered promptly, which will also improve the noise levels.	- Patients - Nurses - Care assistants - Relatives	15 June 2016	

Certain staff are 'snappy'	Inform the entire team of this feedback stating how unacceptable this is.	As a nurse in charge/ Sister, observe the team closely.	Continue to do manager walk rounds where the sister will have discussions with the patients about the service they are receiving.	- All staff - Sister - Patients	15 June 2016	
Low staffing levels	Attend the Interviews scheduled this week for potential new nurses.	Continue to recruit staff whether this is a nurse or a nursing assistant. Also, continue to complete the roster in advance therefore the shifts can be filled.	Senior sister to attend job interviews for the entire medical division with the aim to improve staffing levels throughout the trust.	- Senior staff members	15 June 2016	

WARD: REDLYNCH WARD

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Staffing levels	Ongoing recruitment. Adverts out for Band 5's and Band 2's	Await outcome from skill mix review for extra staffing on nights / weekends. Shortlist from adverts.	Continual recruitment of staff	Lead Rachael Ashcroft. RA	Ongoing.	
Food	Nurse-in-charge to continue to serve meals. Use Mealtime co-ordinator badge. Ensure individual patient dietary requirements are met by ordering suitable food.	Encourage relatives to help at meal-times. Discuss with families on admission to ward and provide information using posters.	Discuss with Catering lead, punctual delivery of meals to ward. Monitor and report any delays in late meal delivery.	Rachael Ashcroft and Meal time co-ordinator.	31st August 2016	
Call Bells	Use Safety Brief to remind all staff that it is everyone's job to respond to call bells promptly.	Discuss any issues surrounding call bells at monthly team meeting.	Review call bell waiting times to see if improvements in response times have been achieved	Rachael Ashcroft	31st August 2016	

Explaining medication to patients	Use Safety Brief to remind all RN's of their responsibility to explain medications to their patients and respond to any queries they may have. Refer to Pain Team as appropriate.	Support staff to continue to review medication with their patients. Escalate and involve pharmacy link as necessary.	Monitor and review feedback to note any improvement.	Rachael Ashcroft	31st August 2016	

WARD: TISBURY

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Answering of buzzers. Call bell out of reach.	Inform staff that this theme has come up. Ensure we are not leaving buzzers behind beds.	Nurse-in-charge to monitor buzzer answering.	To continue to monitor. If we receive more negative feedback then to audit buzzer response times.	Holly Allen and Senior nursing team.	31 July 2016	
Unsure who is looking after me.	Patients board now behind all bed spaces. Reminder to staff to update patient boards.	Continue to check patients' boards and update when any changes needed.		All staff	Complete and ongoing.	Complete
Hot drinks - tepid	Use of a tea/coffee making machine. This has a light to tell us when the water is at the correct temperature. Machine is within service period still and appears to be working correctly.	Monitor RTF and FFT feedback to ensure no further negative comments made on this issue.		Holly Allen and Senior nursing team.	Complete and ongoing.	Complete
No ward activities	We have a box of activities which can be used, including board games, word searches, etc.	Monitor RTF and FFT feedback to ensure no further negative comments made on this issue.		Holly Allen and Senior nursing team.	Complete and ongoing.	Complete
Staff don't wash their hands.	Each month we audit hand hygiene, anyone who is seen to miss an opportunity to wash their hands is confronted.	Ongoing audits		Rachel Burville/ Ashlee Rendle	Ongoing	

Staff very noisy until midnight - Radio at night	Radio has been removed. Staff are reminded about noise at night, however we are an acute ward and nights are very busy with patient care.	Continue to monitor	Senior nurses	Ongoing	
More fruit	Kitchens have been providing us with fruit recently. We ensure that the fruit bowl is taken around with each tea round and patients have the option to 'tick' for fruit on their daily menus.	Continue to monitor	All staff.	Ongoing	Complete and ongoing.
Food/Kitchen - Cold food	Meeting with kitchen supervisor as at present we are trialling ways to improve communication between ward and kitchen and ways of making the meal time process more seamless.	Ongoing trials to improve communication.	Holly Allen / Ashlee Rendle	31 July 2016	
Waiting for pharmacy and no pharmacy at weekends	At times there is a wait for medications to come from Pharmacy. We keep patients as updated as possible on timings for discharge. We also ensure that Pharmacy ring us when medications are urgent so that we can collect rather than waiting for deliver. Pharmacy is open on Saturdays but not Sundays. There is on-call pharmacist for urgent request.	Continue to monitor.	Holly Allen and Senior nursing team.	31 July 2016	

Lights disturbing at night	Staffs only have lights on when needed for patient care. Cardiac monitors have lights which do flash, needed for patient care.	Continue to monitor.	Holly Allen and Senior nursing team.	31 July 2016	
Cleaning - Bathrooms can be messy	Regular meeting with cleaning supervisor, monthly audit of ward by cleaning supervisor and senior sister.	Continue audits/meeting	Holly Allen	Ongoing	
Staff - Speak too fast - Explaining of medications - Left to wash alone	Inform staff of these comments. Most of Tisbury feedback is very complementary of staff so this shall be monitored.	Monitor for comments related to these issues.	Holly Allen	Ongoing	

WARD: WHITEPARISH AMU

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Discharge	Ensure issue is included in forthcoming ward study day.	Study day planned in next rota.	For all staff to attend study day	Snr Sr Helen Benfield	October 2016	
Communication – keeping patients and relatives informed	Ensure issue is included in forthcoming ward study day.	Information sheet developed for Waiting Room to ensure all staff hand out to patients.	Monitoring to ensure staff compliant	Snr Sr Helen Benfield	Ongoing	
Short-staffed at weekends	N/A	N/A	Proposed recommendations from skill mix review taken to board for approval	Snr Sr Helen Benfield	July 2016	
Evening beverage round	Instigate this task to Band 2 at start of night shift.	Review and change time to handover period if needed	Continue initiative if successful.	Snr S/N Siara Tuffey	Ongoing	
Hand wipes for patients after using commode.	Ensure hand wipes are made available.	Monitor availability.	Monitor availability.	Snr Sr Helen Benfield	Ongoing	
Uncomfortable chairs	Purchase new chairs.			Snr Sr Helen Benfield		Action complete. New visitors' chairs have been purchased.

WARD: WINTERSLOW (via Picker project)

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
<u>Response time</u> For 90% of call bells to be answered within 5 mins dependant on patients' needs	To gain access to call bell log	• Collect data and analysis • Feedback to staff the data	• Monthly audits • Discuss with staff the trends / how to break these • Display data	Senior sister / Junior sisters		
<u>Communication</u> All staff to introduce themselves to patients and relatives	• Discuss with team to ensure they are always introducing themselves • Discuss with therapy and Doctors to ensure they are always introducing themselves • Put on safety brief	Monitor: - real time feedback - complaints - concerns - complements to ensure compliance	• Continue to monitor • Display data from real time feedback to staff	Consultants Therapy staff Nursing staff		
<u>Communication</u> Ensure patients and NOK are included on discussions surrounding: - plan of care - medication - discharge planning Ensure to check that patients and NOK understand	Share results with doctors and therapy / nursing team. Put on safety brief	Sisters to check via weekly audits with patients / NOK that they understand their plan of care, etc.	Continue to monitor all feedback from patients and NOK Continue checks	Consultants / Doctors Therapy staff Nursing staff		

ACTION PLANNING 2016 – MUSCULO-SKELETAL

WARD: AVON AND TAMAR

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Noise at Night	Answer buzzers quickly and reduce volume at night. Nurses to speak quietly.	Apron rolls - find quieter way to dispense. Re-position to different wall away from patients bed head.	Request sensory bins	Nursing Team, DH, EB. AW	30 June 2016	
Better communication of plan of care between doctors/nurses and patients	Update consultant list end each shift. D/W patient ensure they know the currents plan	Better updated documentation within care plans and notes. Document outcomes of ward rounds in patients care plan at end of ward round.	NIC to meet with SHO beginning of shift to update any new concerns. Attend patient with SHO if possible.	Nursing team, SHO, Consultants.	30 June 2016	
Nurses/NA behaviours and attitudes to patients	All staff to show care and compassion at all times.	Assess staff stress – look at reasons why how can we offer more support. Assess any learning needs.	Patient to give feedback on the nursing team – what needs improving. Ensure all staff up to date with MLE Customer Service.	Nursing Team, DH, EB. AH	30 June 2016	
Ward Cleanliness	Ensure cleaning list folder completed each day. Wiping down	Encourage patients to take home /remove some belongings so that	D/W ward cleaners / Housekeeping how we can improve to make it easier for	DH, EB. AW	30 June 2016	

	patients table and surfaces part of routine when making beds.	effective cleaning of surfaces can take place.	them to do their job effectively.			
Weekend lack of physio/ things to do.	Inform all patients that gym open session is available at weekends. Is it being utilised.	D/W physio is it possible to provide more W/E cover	Increase W/E recreational activities to relieve boredom	Physio, DH, EB AW AS volunteers	30 June 2016	
Food Cold/Lack of choice	Patients to come to trolley to collect their food. Then return immediately to eat whilst hot.	Ensure all patients aware of vouchers to use outside of unit at springs. Serve cold food first before opening trolley.	More theme nights – pizza, curry, etc.	Nursing Team, Recreational team.	30 June 2016	

WARD: AMESBURY SUITE

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Call bell – reduction in time	Discuss at safety briefing daily	Call bell audit to monitor.	Monitor audits and discuss with staff	SR All of team	Six months	
Improved discharges.	To create discharge checklist/flowchart	To monitor Datix and telephone calls for discharge complaints	Monitor issues arising from discharges	SR AB	Six months	
Improved Bowel care	Education to all staff.	To give staff Education sheet	Monitor concerns	TW SR DP	Six months	

WARD: CHILMARK SUITE

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Improve noise at night levels within the ward	1) Shut all doors where appropriate at night. This should hopefully block out some of the noise both at the nurses stations and in the main corridor. How-ever, sometimes this will not be feasible, for example with wandering patients. 2) Offer earplugs to patients on the bedtime drug round.	1) Send out email to all hospital workers asking them to be considerate of their noise levels in the main corridor at night-time. 2) Put up sign on entrance doors to the Chilmark/Amesbury corridor reminding staff members to reduce noise levels at night.	1) Continue with plan. 2) Ask patients what they think of noise levels at night. 3) Monitor real time feedback in regards to noise at night.	**Lead:** Nurse in charge on the night shift. **Who to Involve:** All night staff not only on Chilmark ward but throughout the rest of the hospital as well.	End of May (3 Months)	
Improve communication between staff and patients	1) Introduce our-selves to patients every shift so they are aware of the nurse and nursing assistant looking after them. 2) Try and ensure that other members of the multi-disciplinary team,	1) Update information leaflets on injuries and ensure we are offering and providing them to patients. This will give them more of an idea of what to expect regarding treatment,	1) Continue with plan. 2) Ask patients if they know who their nurse and consultant are. 3) Monitor real time feedback regarding communication.	**Lead:** All registered nurses **Who to Involve:** All members of the multi-disciplinary team on Chilmark ward.	End of May (3 Months)	

	such as doctors and the therapy team, are introducing themselves to patients. 3) Update boards by patients beds every shift to include the nurse, consultant and nursing assistant looking after them to remind patients.	operations and therapy.				
Improve Meal Provision	1) Send out email requesting a volunteer to help out at mealtimes. This will enable us to get meals to patients quicker and hope that meals will be hotter. 2) Use the metal lids provided by kitchens on dinner plates to keep food warmer.	1) Consider changing the early shift and break routine. If staff members are all back from their break at 11.30 then it gives 30 minutes to sit all patients up ready for meals and clear table spaces for dinner trays. This should speed up dinner times and keep food warmer longer. 2) Consider asking kitchens to bring up trolleys 10 minutes later so there is more time to prepare patients. Registered nurses may have also	1) Continue with plan. 2) Ask patients regularly what they think about their meals. 3) Monitor real time feedback in regards to meal provision.	**Lead:** Everyone **Who to Involve:** All members of the nursing team on Chilmark ward and the catering/kitchen department.	End of May (3 Months)	

		finished their drug rounds by this point and can help with meal provision.				

WARD: BURNS UNIT

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Hot food too cold when it reaches the patient.	Ensure patients are ready to receive their meals - ward staff to do a pre-meal round clearing tables, making sure patients are sat up and have been to the toilet. Consider serving main course before hot puddings if workload on ward manageable.		Discuss with Catering possible later collection of empty supper trolley to give ward staff more time to serve meals.	Emma Budgell Claudine Alonsagay	31/10/16	Comments shown to all staff and action plan shared.
Noise at night – sometimes drug rounds not completed until late evening (11-12pm) due to ward workload.	Remind night staff of need to keep noise levels to a minimum. If shift times change, patients will be able to be settled earlier and drug rounds will be finished sooner.		Discuss with ETS ways of rectifying noisy doors in sluice, changing room and front door.	Emily Brown	31/10/16	Comments shown to all staff and action plan shared.
Temperature in certain rooms too cold intermittently.	Encourage staff to complete DatixWeb incident forms for incidents where temperature levels drop.		Discuss with ETS possible ways of rectifying issue.	Amy Johnson Emily Brown	31/10/16	Comments shown to all staff and action plan shared.

WARD: LAVERSTOCK WARD

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Cold food	To speak to kitchens for more lids to go over the plates. Tables to be cleared of clutter before meals are served	Patients to be encouraged to be sat out or be sat up in bed.	To discuss with kitchens having lids for the bowls or to go back to having metal bowls with lids.	S/N Grant and HCA Withers	October 2016!	Discussion with ward staff to engage in changes

ACTION PLANNING 2016 - SURGERY

WARD: BRITFORD

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Noise at night from staff	Communicate with all staff via the safety briefing folder each shift. • Ensure all staff who work on ward and visit ward during the night are aware of the requirement to keep noise to a minimum • Ear plugs to be offered to all patients Manage patient expectations regarding noise by informing them that some noise is unavoidable due to the requirement to provide 24 hour care to patients.	Cascade concerns regarding noise via the Britford Bulletin. Manage patient expectations.	Spot checks of the ward at night. Review patient feedback forms and real time feedback for signs of improvement	Senior Sister Jayne Sheppard S/r Tracy Cannings S/r Carol Davis	End of June 2016	Britford Bulletin emailed to all staff, and safety brief continues on all 3 shifts. Spot checks to be completed. Improvement should be seen by The Friends and Family test and Real time feedback results, as well as complaints and compliments. This can be undertaken on a monthly basis. Monthly ward rounds undertaken by DSN to speak to patients and alleviate any issues at an early stage so we can react and improve.

Call Bells not within reach of patient or not answered promptly.	Communicate with all staff via the safety briefing folder each shift . Manage patient expectations, explaining to patients that there may be times that the staff are involved with another patient but will attend to them as soon as possible	Cascade concerns regarding call bells not being within reach of patients via the Britford Bulletin.	Review patient feedback forms and Real-time feedback from Governors	All staff to be involved. Lead to be Senior Sister Jayne Sheppard S/r Tracy Cannings S/r Carol Davis	End June 2016	Britford Bulletin written, need for call bells to be within reach cascaded via safety brief. 28/03/16 Monthly ward rounds undertaken by ward lead and DSN to speak to patients and alleviate any issues at an early stage so we can react and improve.
Patients concerned that level of care and understanding changes at weekends and on nightshifts due to agency staff	Ensure that all temporary staff members have been shown the temporary staff folder with relevant ward information. Nurse in charge to report to bank any negative concerns or feedback from patients.	To continue listening and reporting any issues with agency staff	Review patient feedback forms and Real-time feedback from Governors	Senior Sister Jayne Sheppard S/r Tracy Cannings S/r Carol Davis	End of June	Temporary folder has been in operation since 2015. Bank office has been informed of unsuitable Agency nurse and subsequently banned from Britford 2015. Monthly ward rounds undertaken by ward lead and DSN to speak to patients and alleviate any issues at an early stage so we can react and improve
Communication by doctors poor at times, patients felt under informed	Ensure that a nurse is present where possible on Drs ward rounds. Email lead consultant to cascade patient feedback			Mr Saboor Ghauri	March 2016	Monthly ward rounds undertaken by ward lead and DSN to speak to patients and alleviate any issues at an early stage so we can react and improve Improvement should be seen by The Friends and

						Family test and Real time feedback results, as well as complaints and compliments. This can be undertaken on a monthly basis.

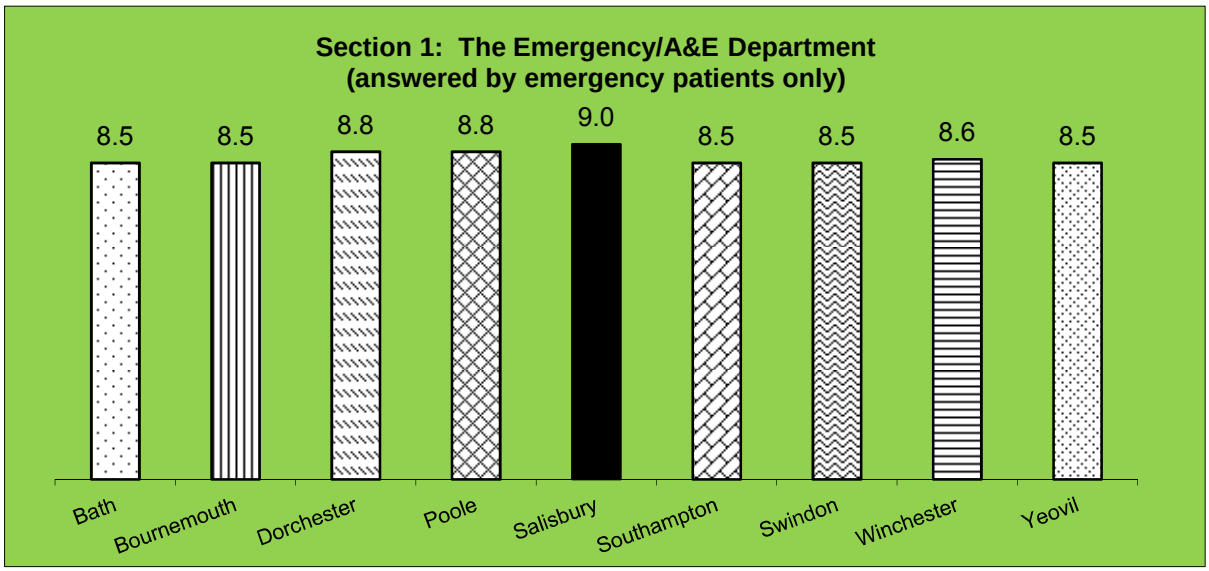
WARD: DOWNTON

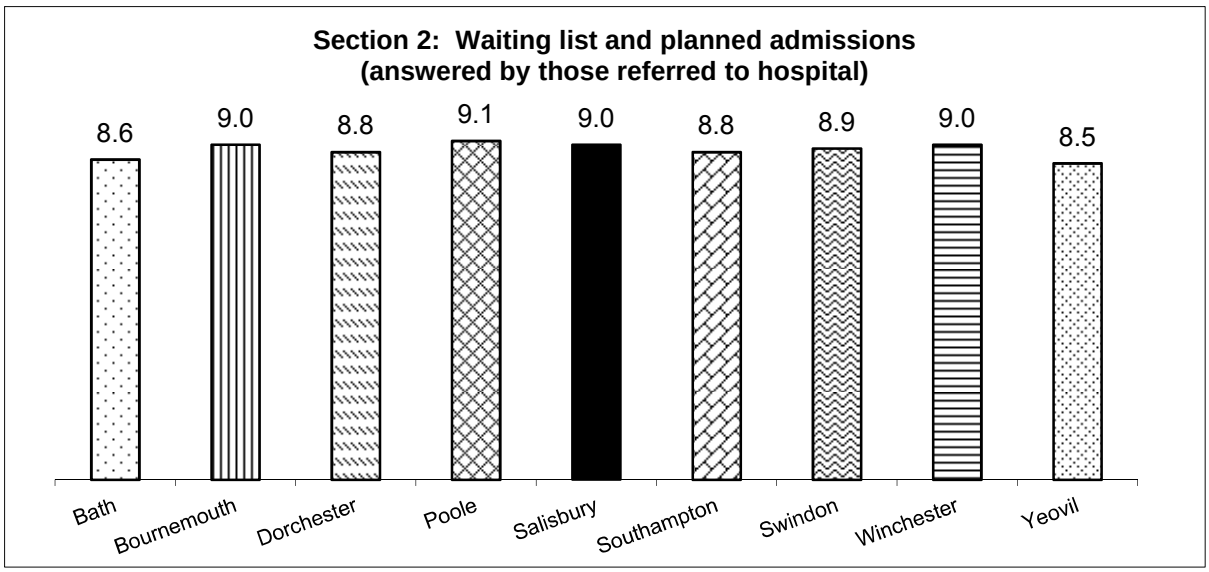
OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
Noise at night	• Communicate with staff via the safety briefing. • Offer ear plugs to patients • Challenge visiting staff members when on the ward • Manage patients expectations informing them that some noise is unavoidable (in welcome pack already)	• Cascade information to team through Downton news letter	• Review patient feedback on friends and family forms and RTF. • Spot checks of the ward at night.	Sr Donna Arnold Sr Vicky Moody Sr Amy Hibbs	June 2016	Monthly ward rounds undertaken by senior sister and DSN specifically asking about noise at night. Spot checks to be completed. Ongoing communication with staff via safety briefing, and Downton news.
Food temperature	• Ensure all staff are using supplied equipment to ensure food is hot when received by patients. • Senior to supervise meal delivery to ensure its happening in a timely manner.	• Communicate to staff via Downton newsletter. • Contact a member of the catering team to come and do some temperature checks whilst dinner service is in progress.	• Continue to monitor feed-back through Friends and Family and RTF. • Monitoring through monthly confidence-in-care walk arounds with DSN. • Ensure all staff have completed food hygiene training.	Sr Donna Arnold Sr Amy Hibbs Sr Vicky Moody All staff who help with meals	June 2016	Monthly ward rounds undertaken by senior sister and DSN specifically asking about food temperatures. Ongoing communication with staff via safety briefing, and Downton news.

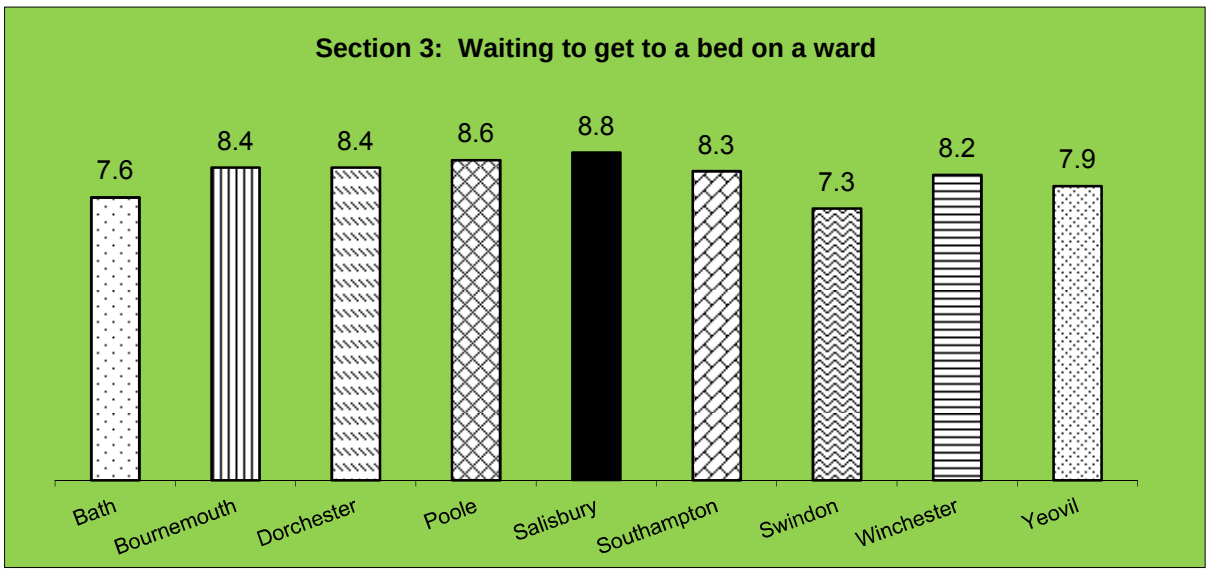
Call bells not within reach of patients or answered promptly	• Communicate with staff via safety briefing • Manage patients expectations explaining that at times staff may be dealing with other patient's but that call bells would be answered as soon as possible	• Communicate to staff via Downton news letter	• Monitoring through monthly confidence in care walk arounds with DSN. • Continue to monitor feedback through Friends and Family and RTF. • Spot checks my senior ward staff	Sr Donna Arnold Sr Amy Hibbs Sr Vicky moody	June 2016	Monthly ward rounds undertaken by senior sister and DSN specifically asking about call bell responses. Ongoing communication with staff via safety briefing, and Downton news.

2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

= SFT highest or joint highest score = SFT lowest or joint lowest score







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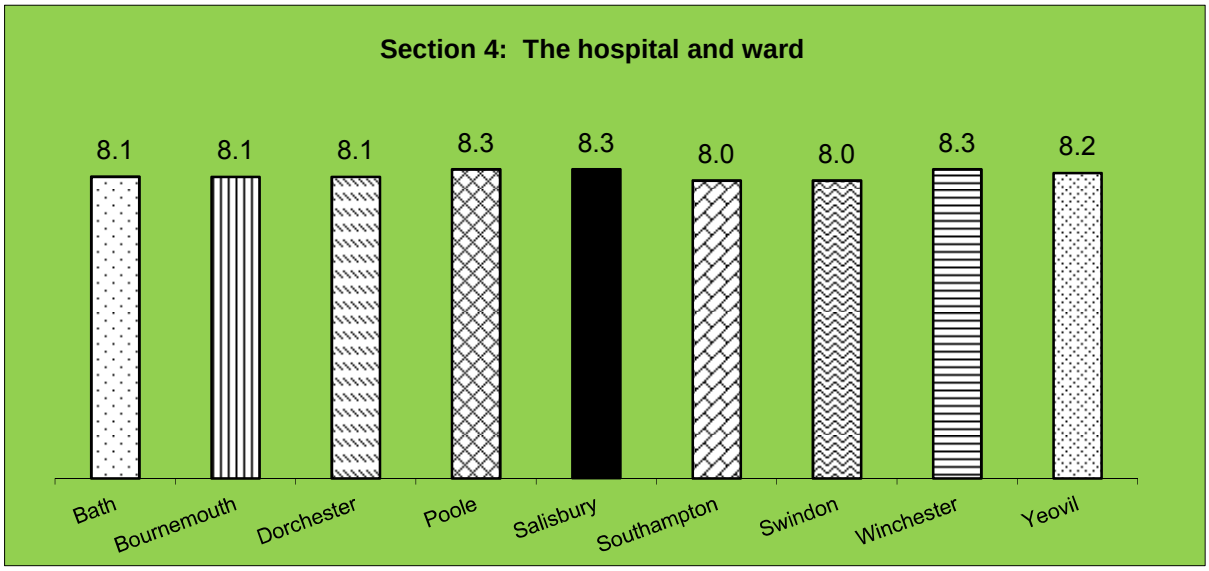
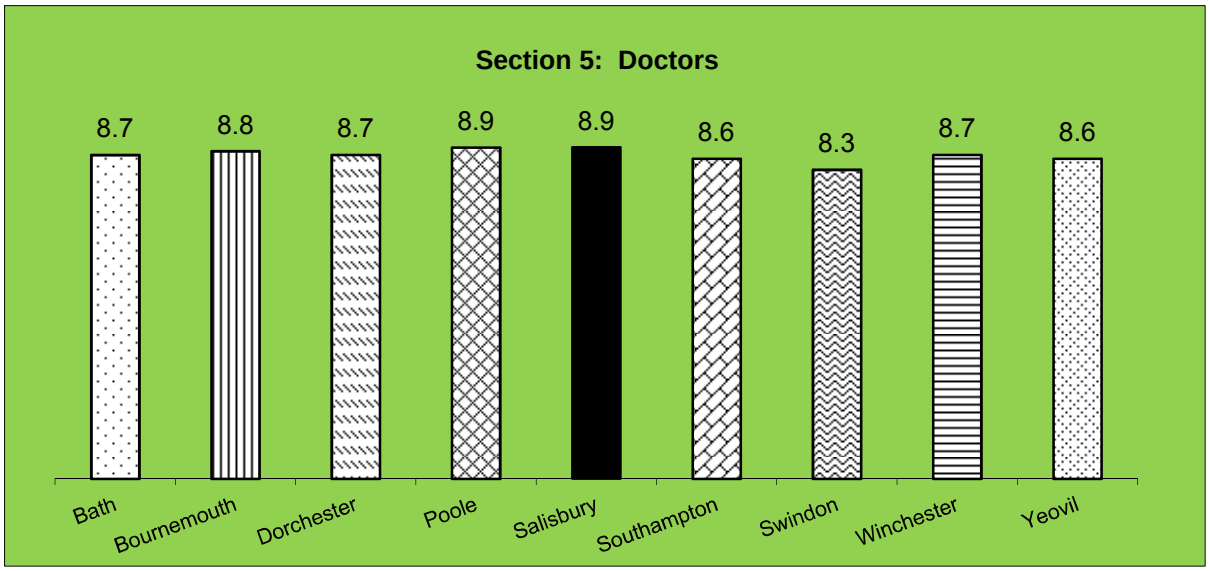
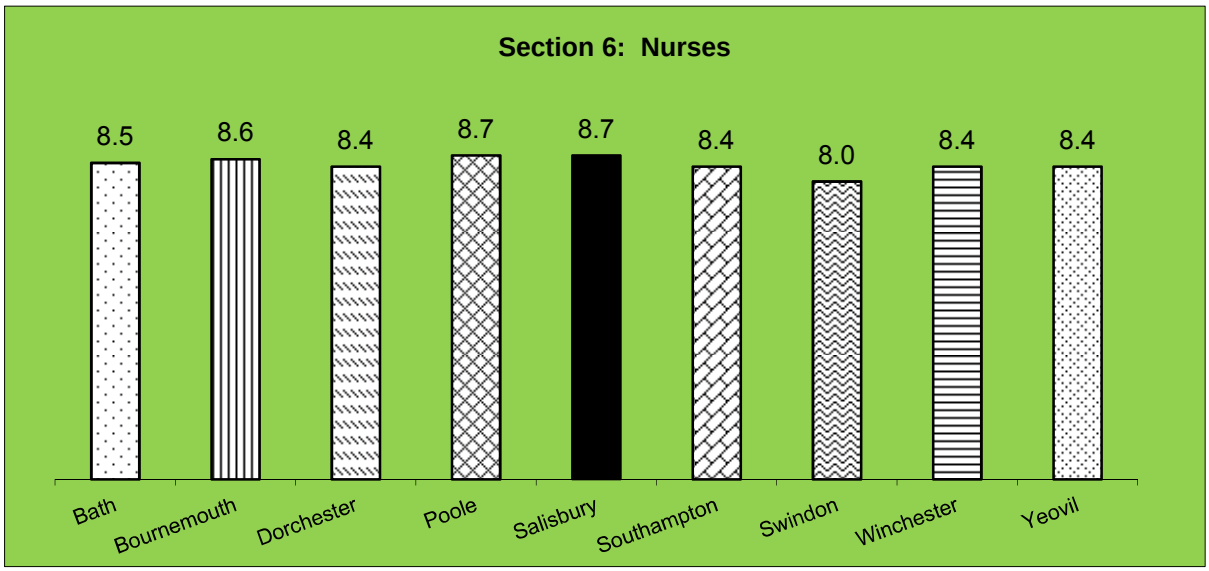
Clinical Governance Administrator
June 2016

SECTION SCORES

2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts







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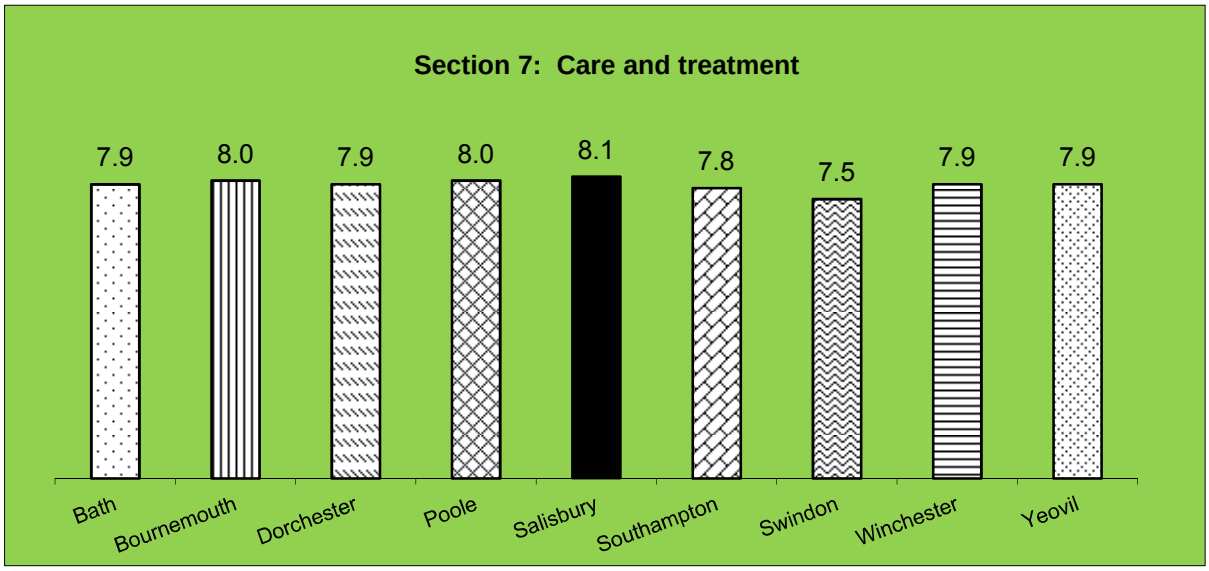
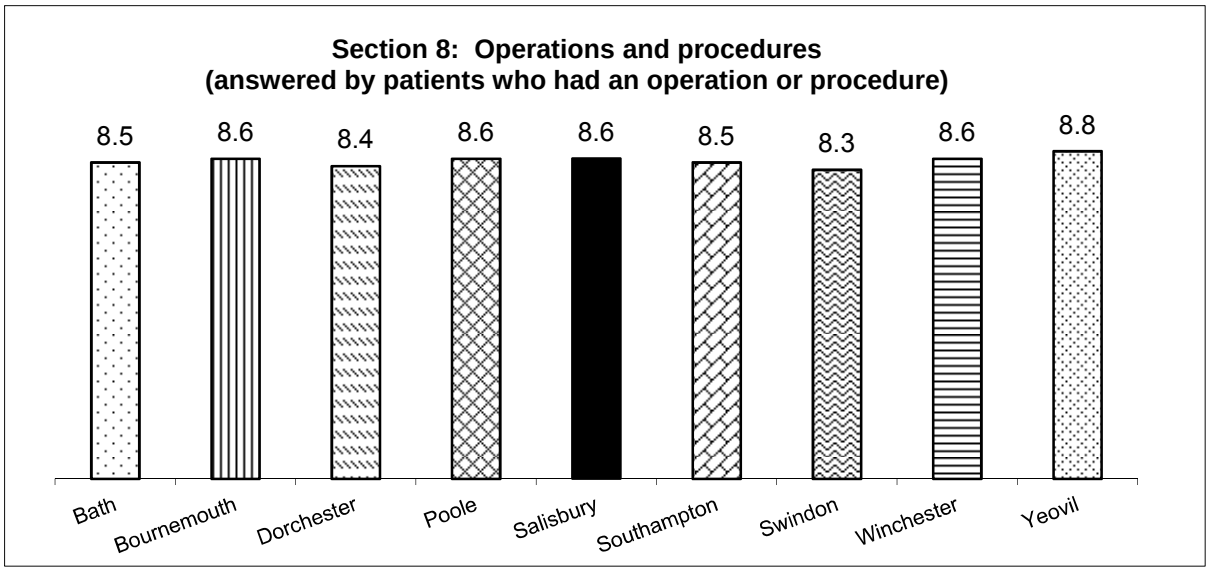
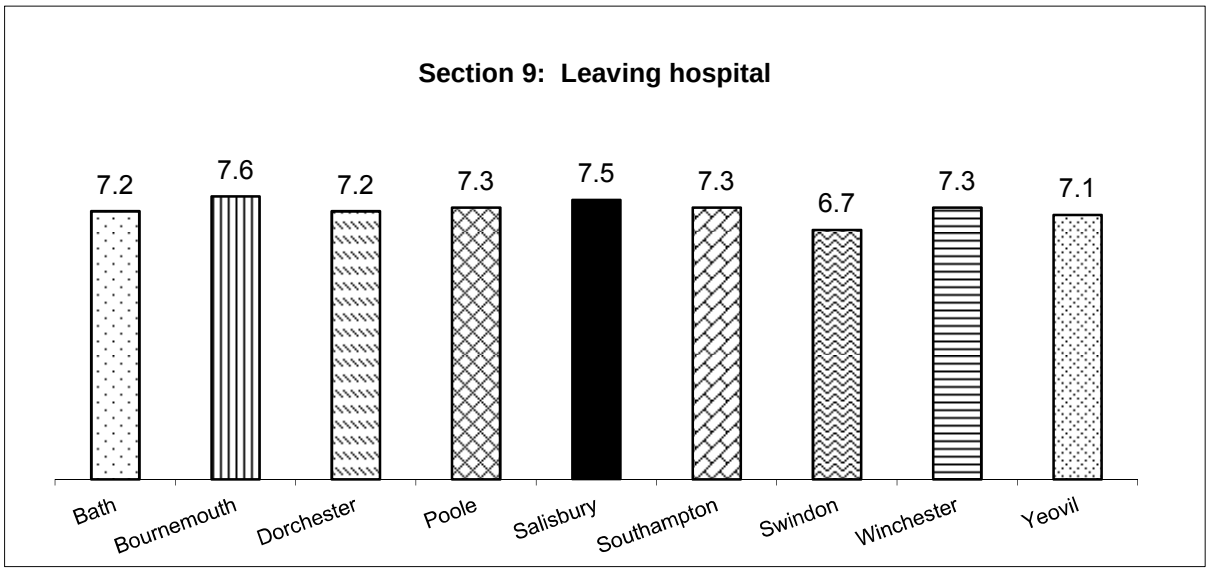
SECTION SCORES

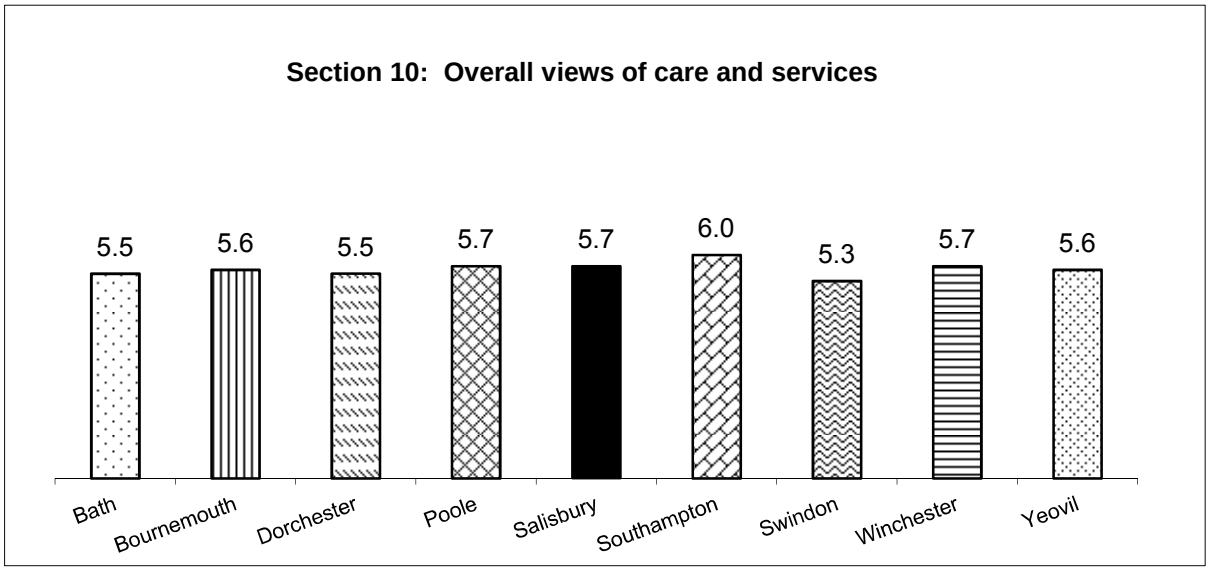
2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

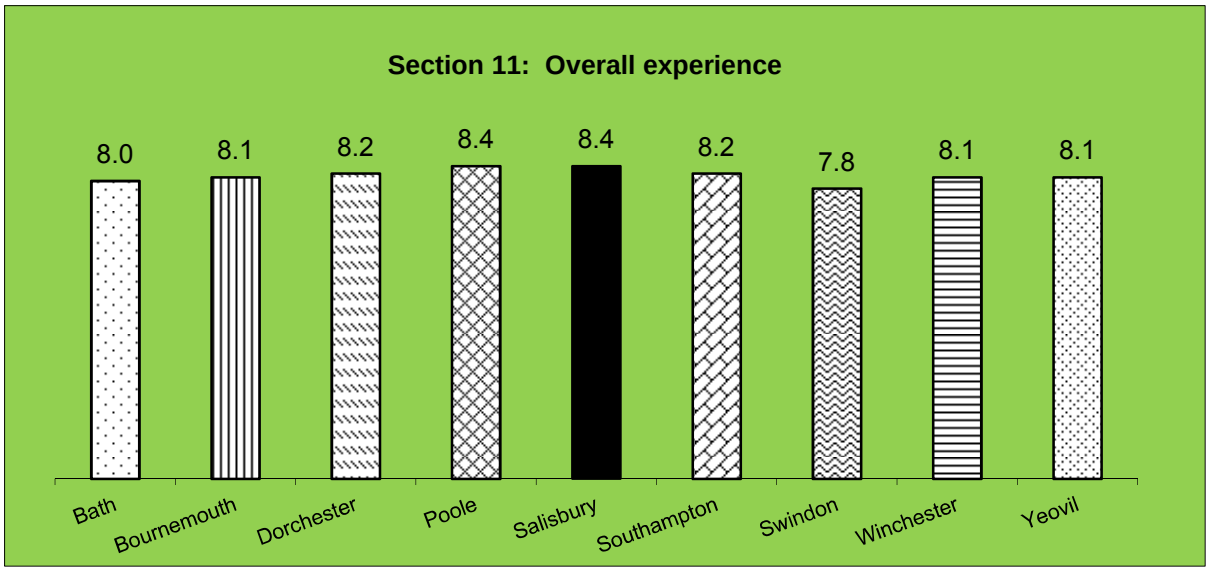






2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

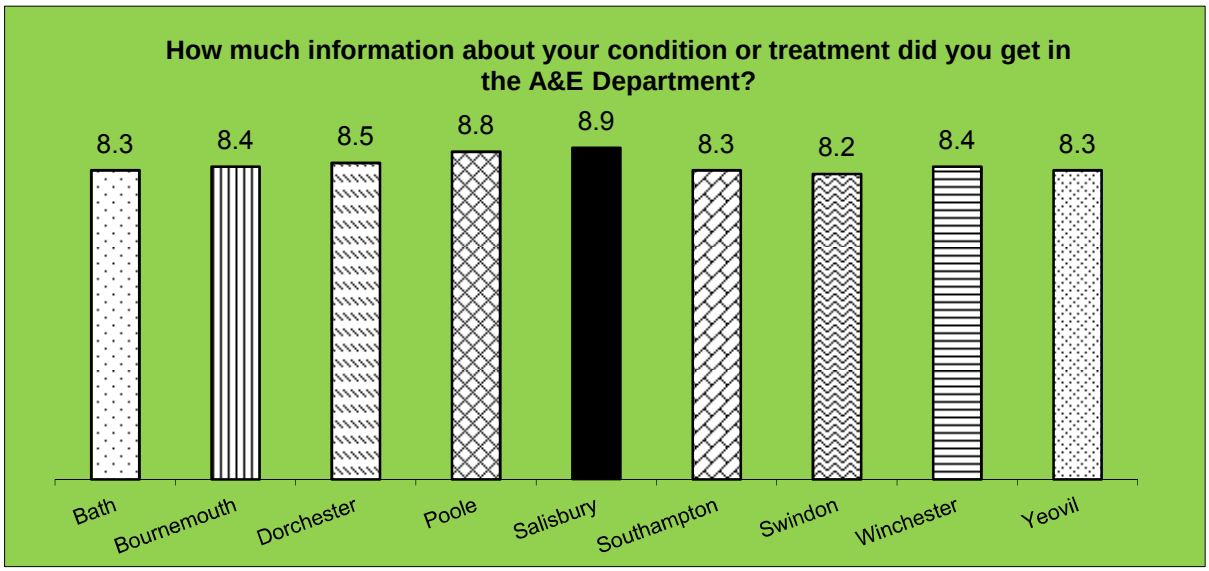


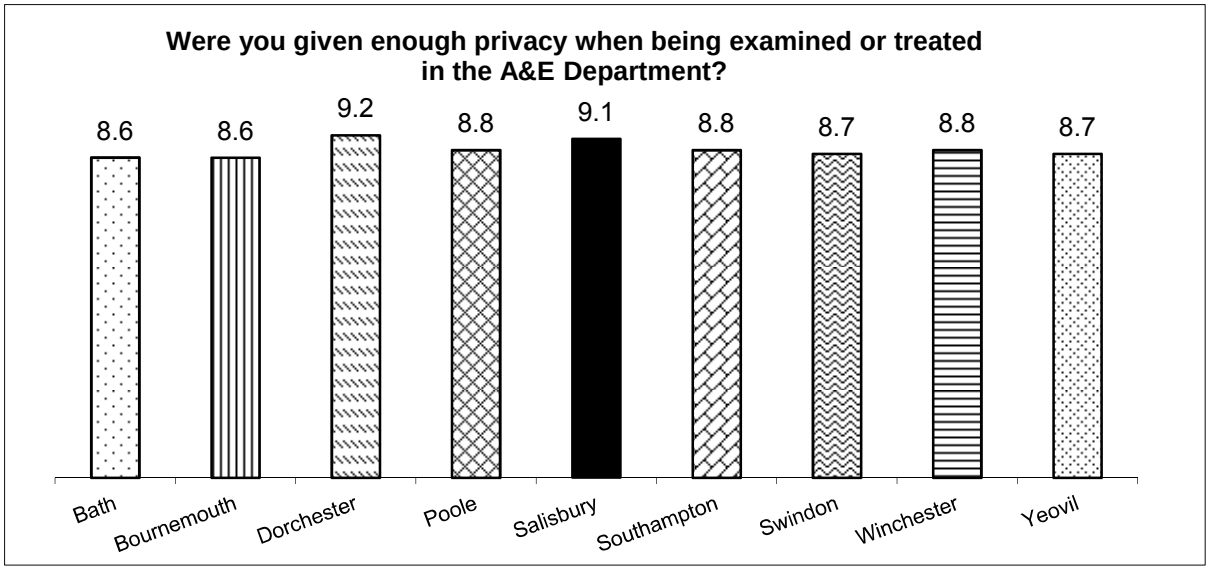


2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

= SFT highest or joint highest score

= SFT lowest or joint lowest score





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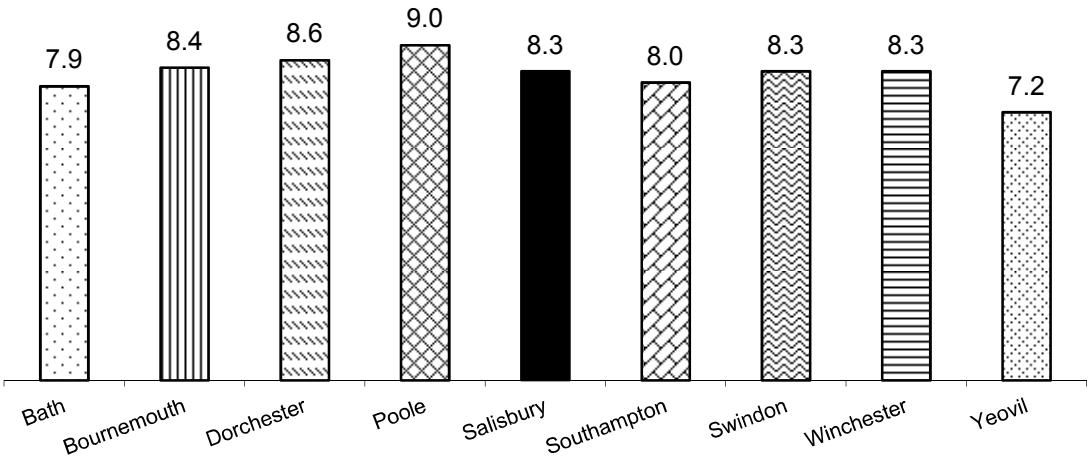
THE A&E DEPT

2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

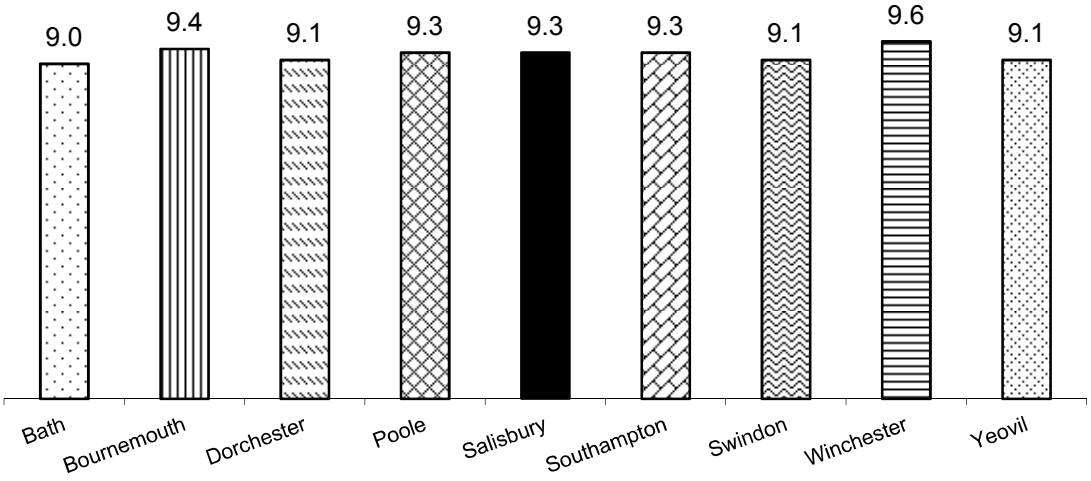
= SFT highest or joint highest score

= SFT lowest or joint lowest score

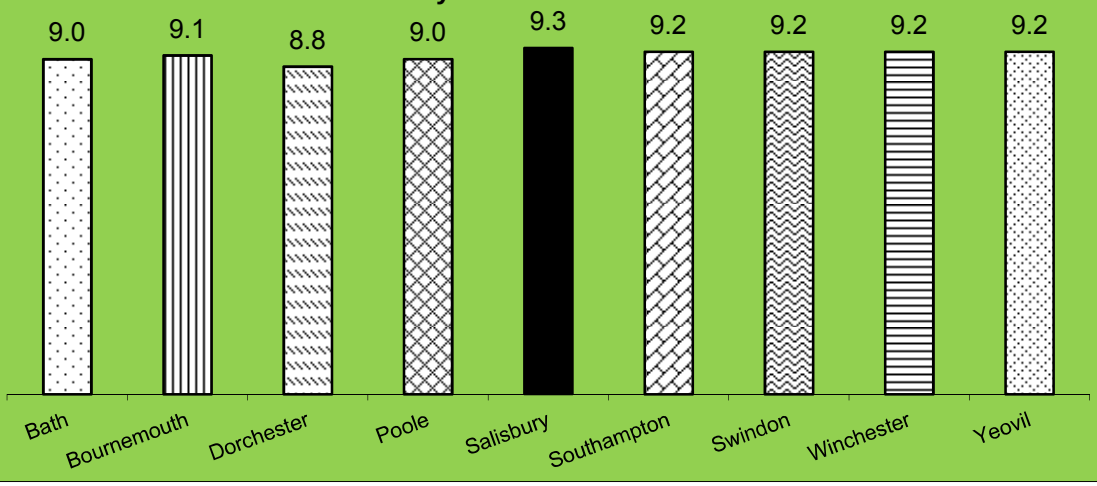
How do you feel about the length of time you were on the waiting list?



Was your admission date changed by the hospital?



Had the hospital specialist been given all necessary information about your condition?



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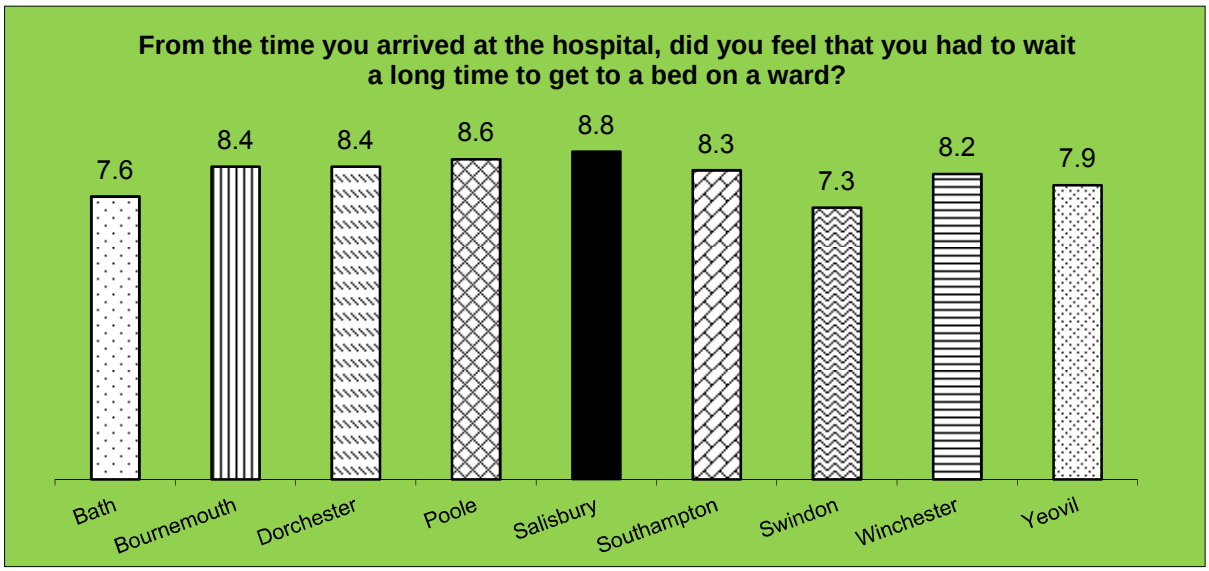
ADMISSION

2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

= SFT highest or joint highest score

= SFT lowest or joint lowest score



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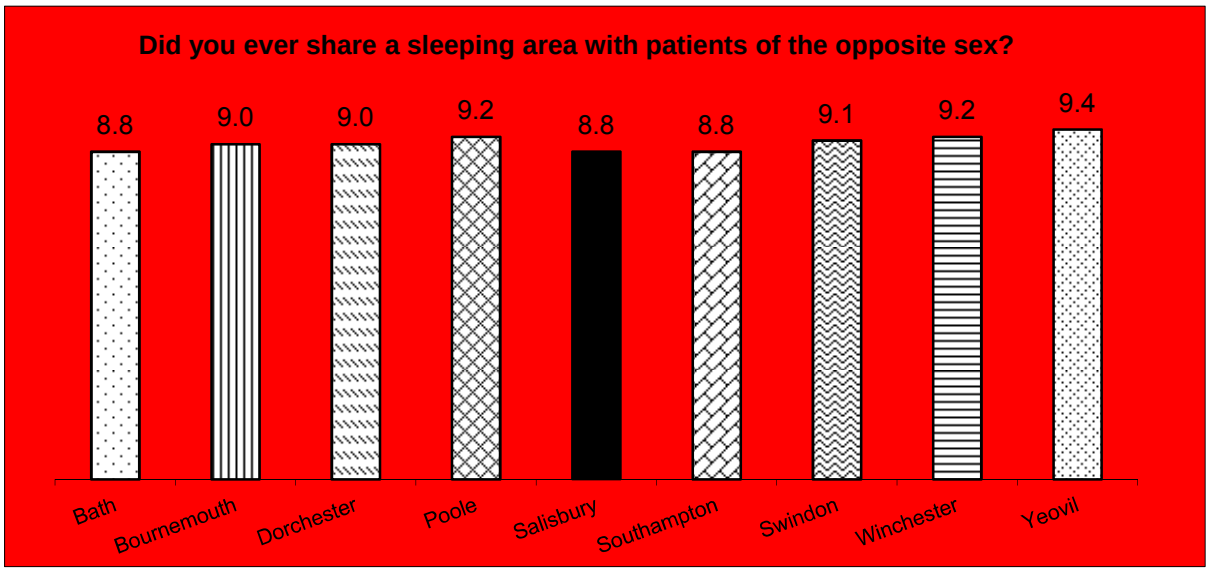
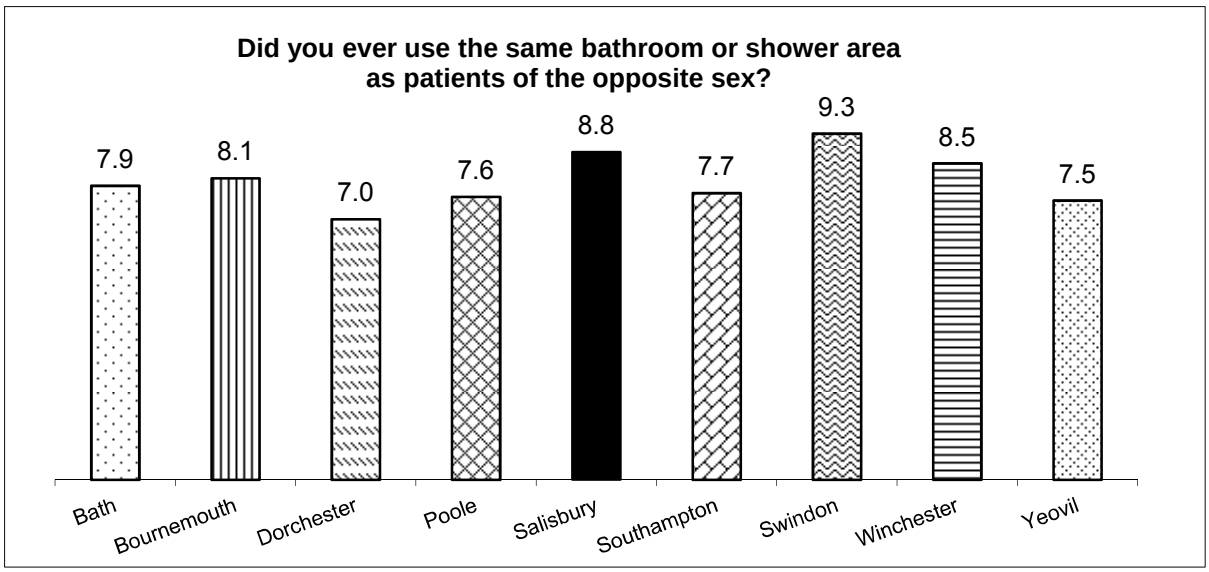
WAITING TO GET TO A WARD

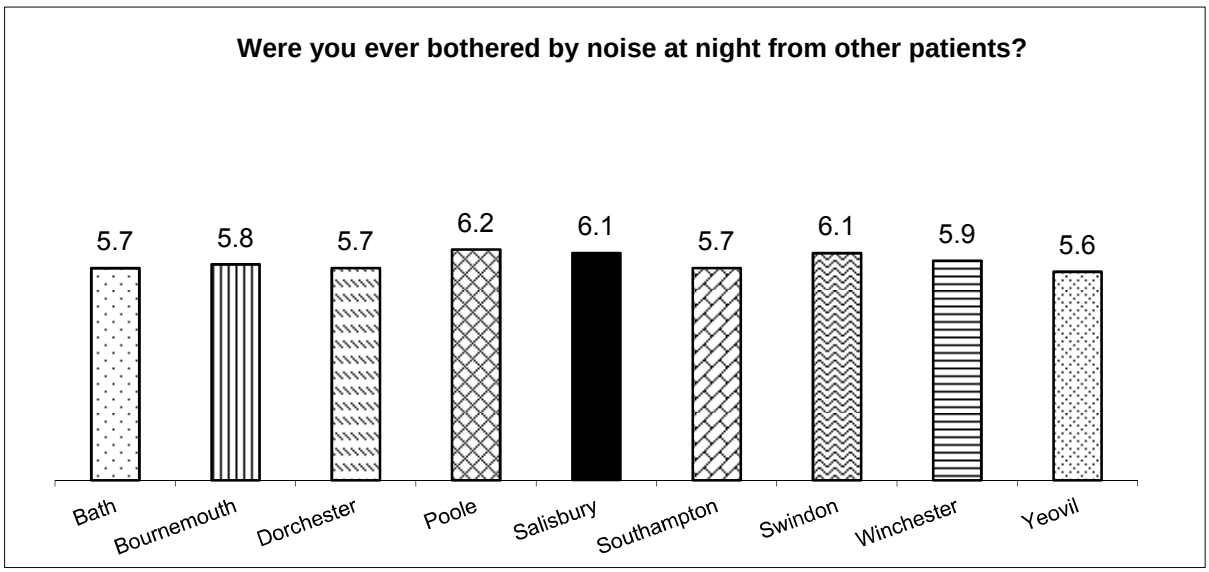
2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

= SFT highest or joint highest score

= SFT lowest or joint lowest score







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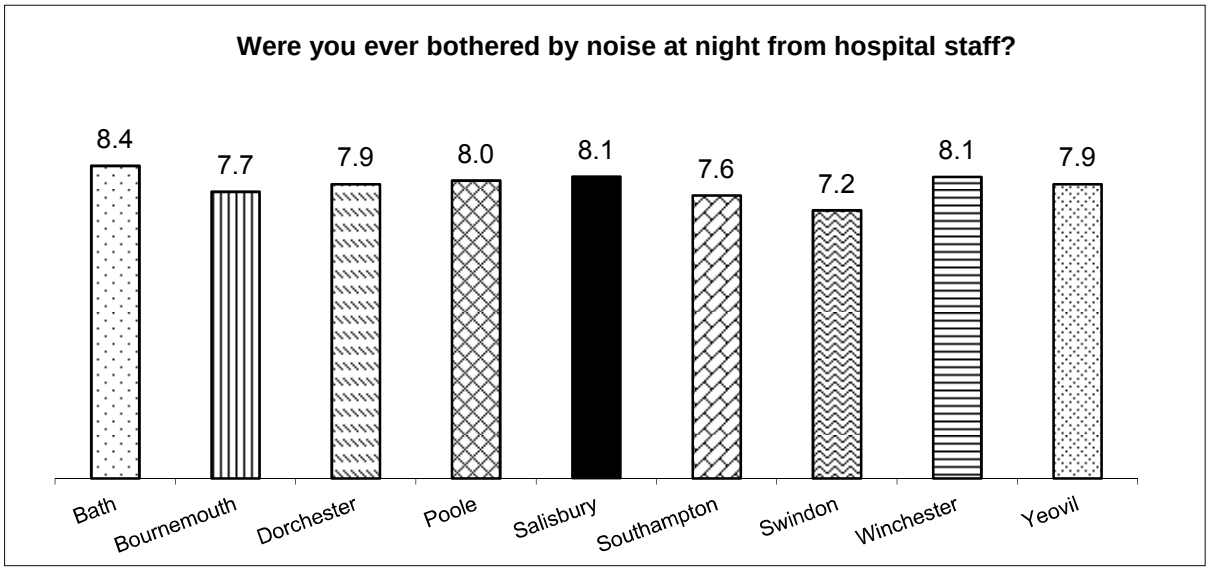
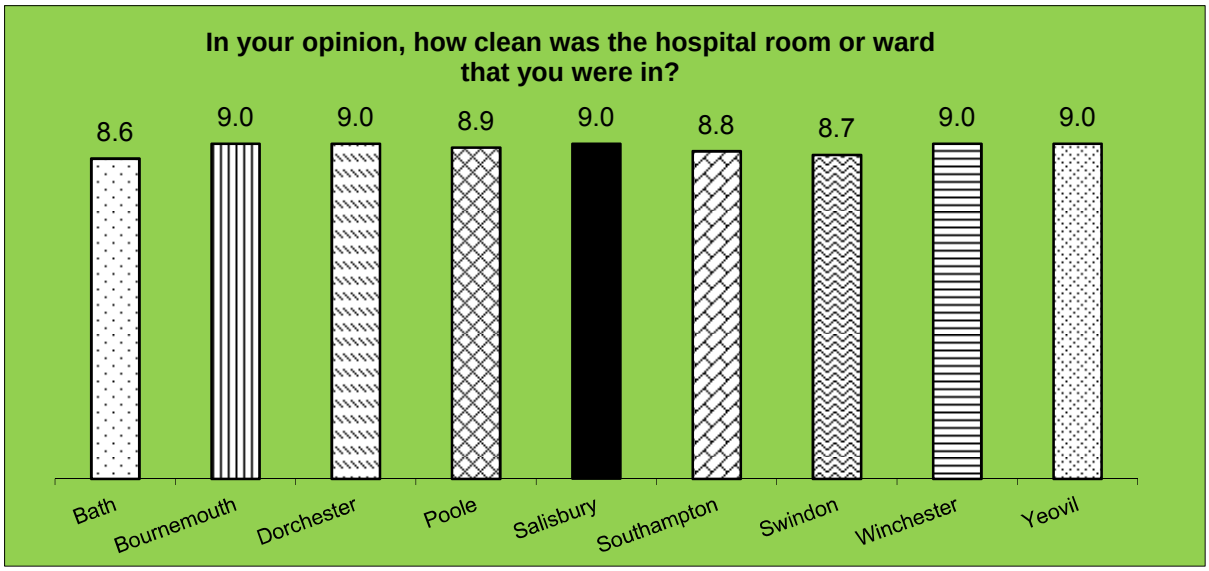
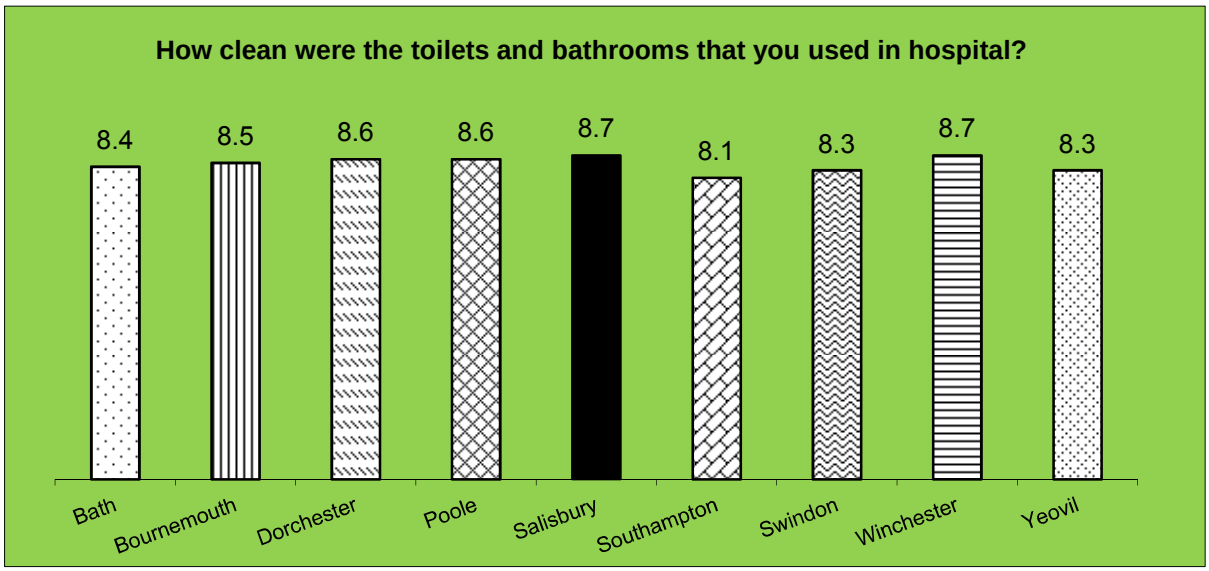
June 2016

HOSPITAL AND WARD

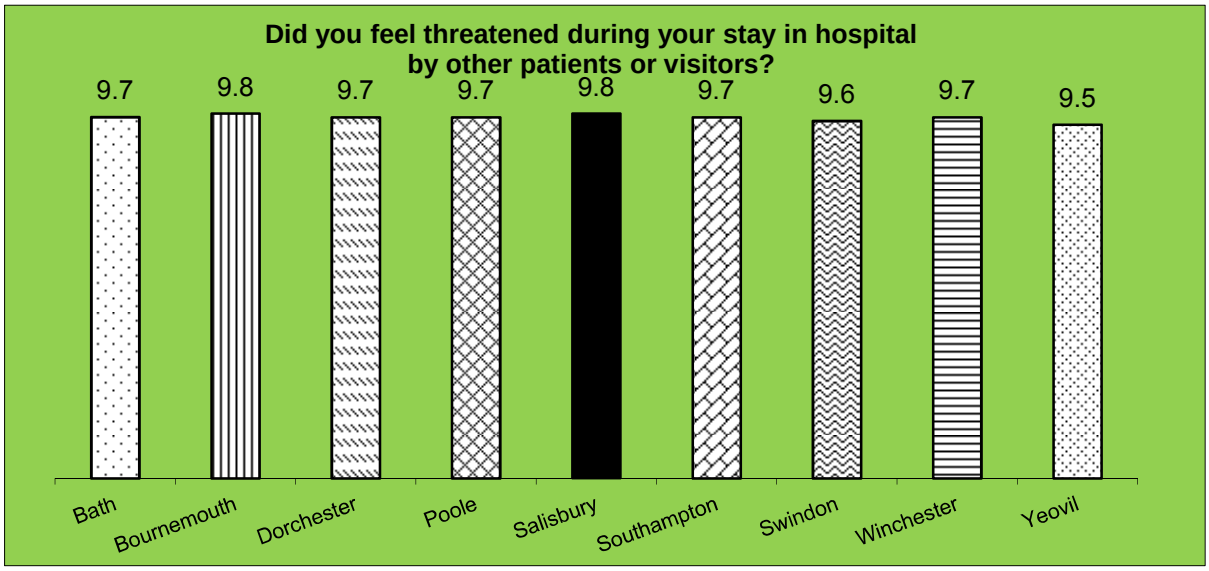
2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

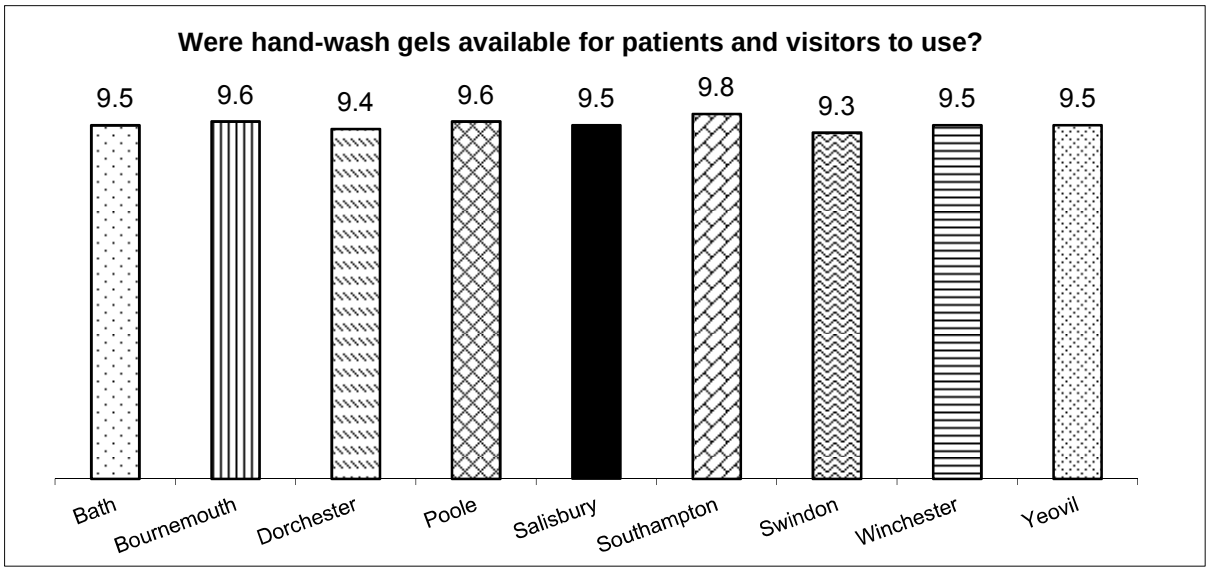


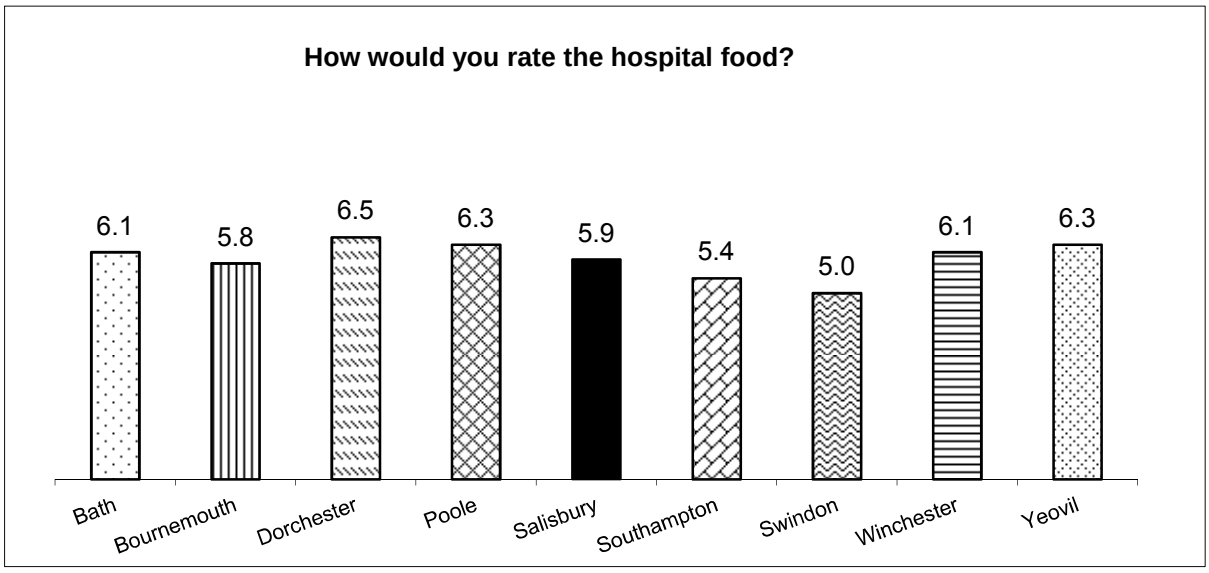




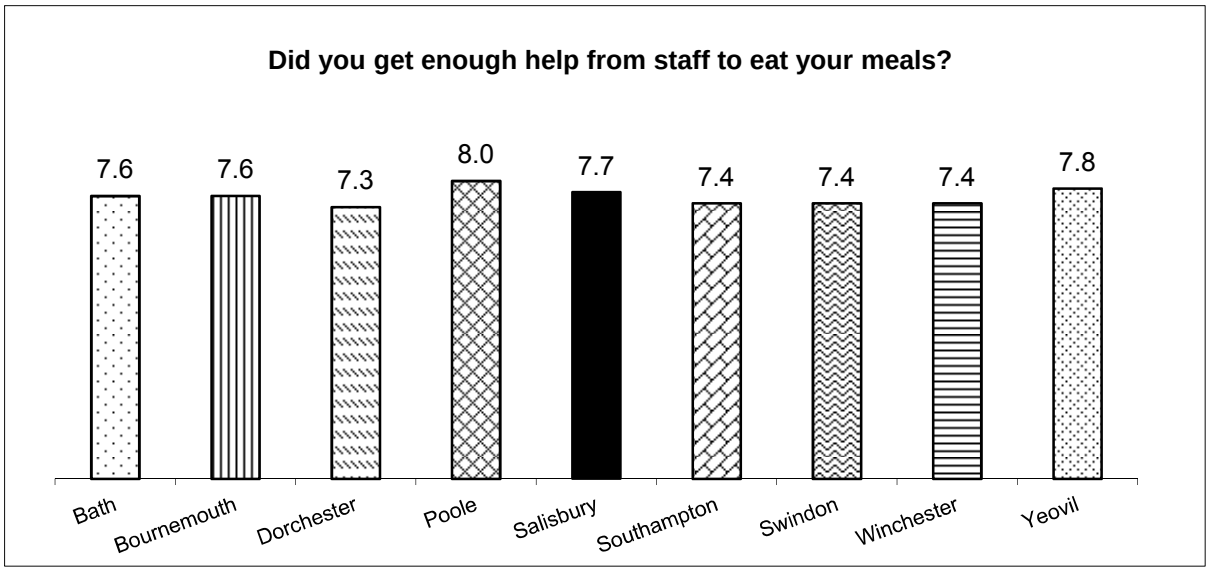
2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts







2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

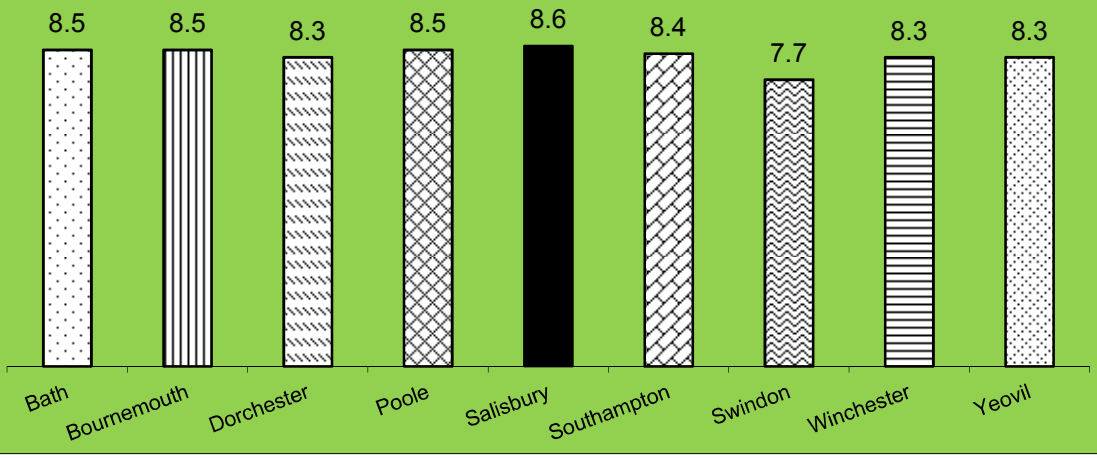


2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

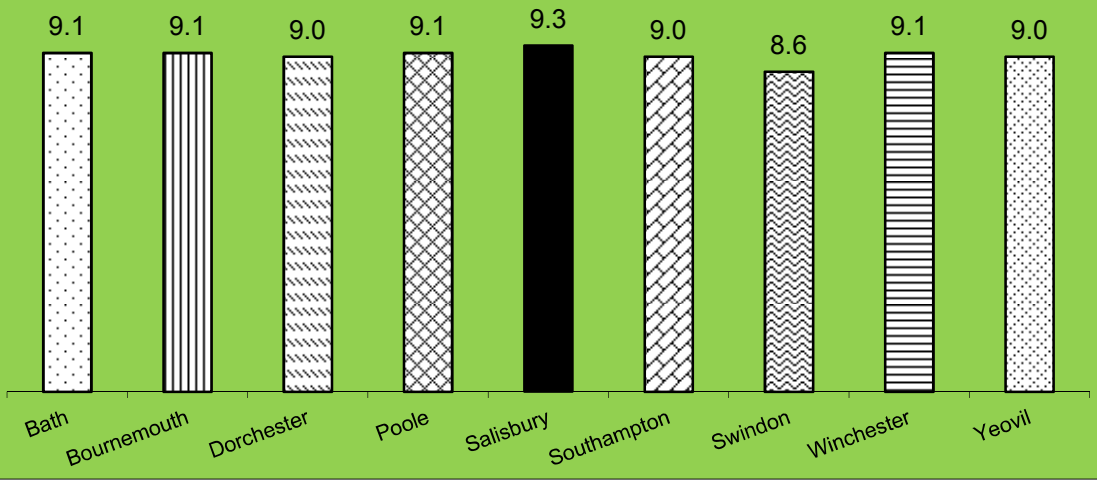
= SFT highest or joint highest score

= SFT lowest or joint lowest score

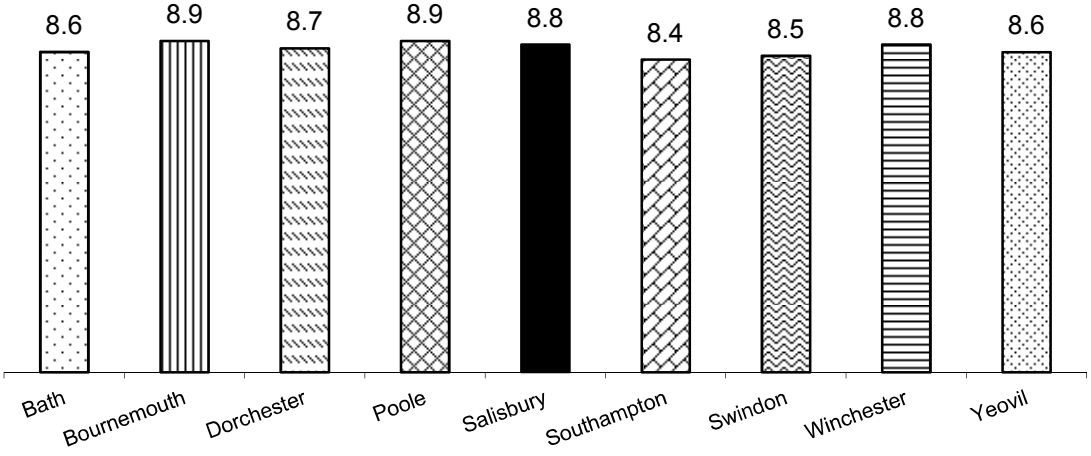
When you had important questions to ask a doctor, did you get answers that you could understand?



Did you have confidence and trust in the doctors treating you?



Did doctors talk in front of you as if you weren't there?



Gill Sheppard
Clinical Governance Administrator
June 2016

DOCTORS

2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

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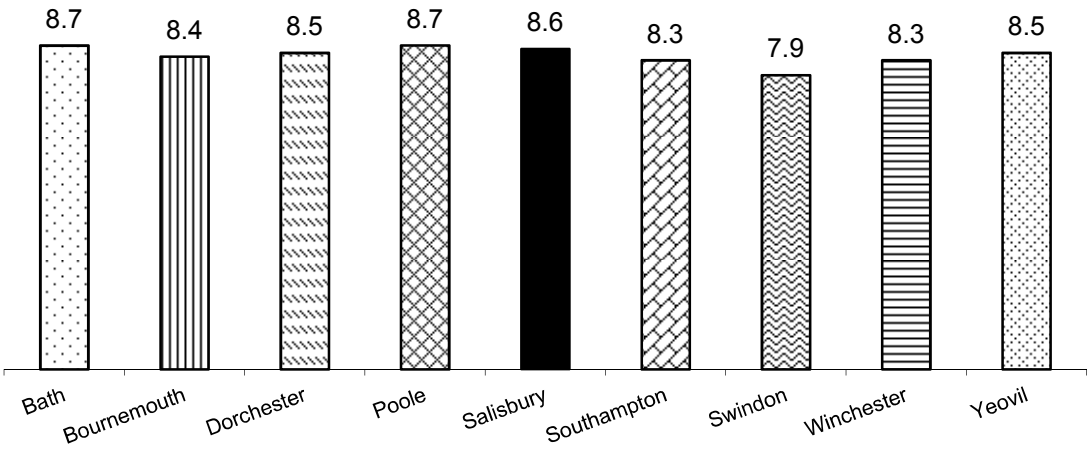
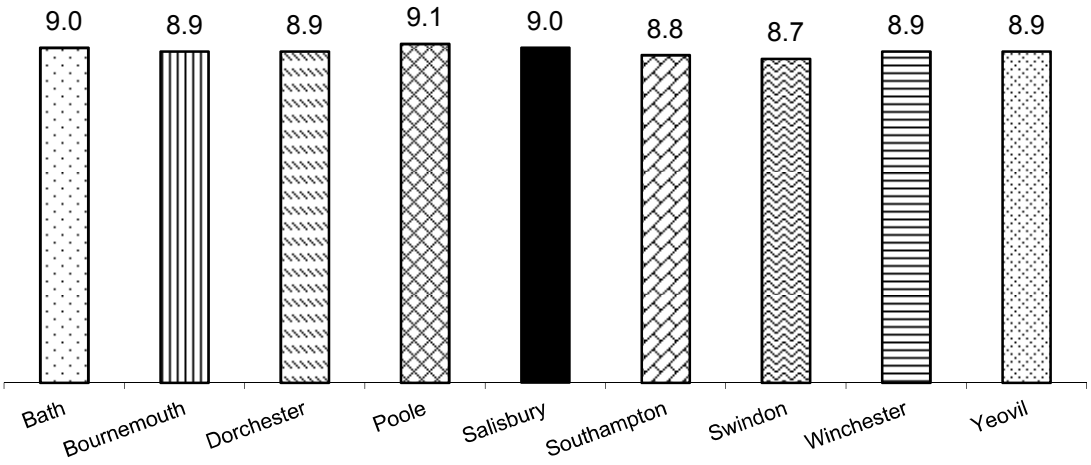
= SFT lowest or joint lowest score

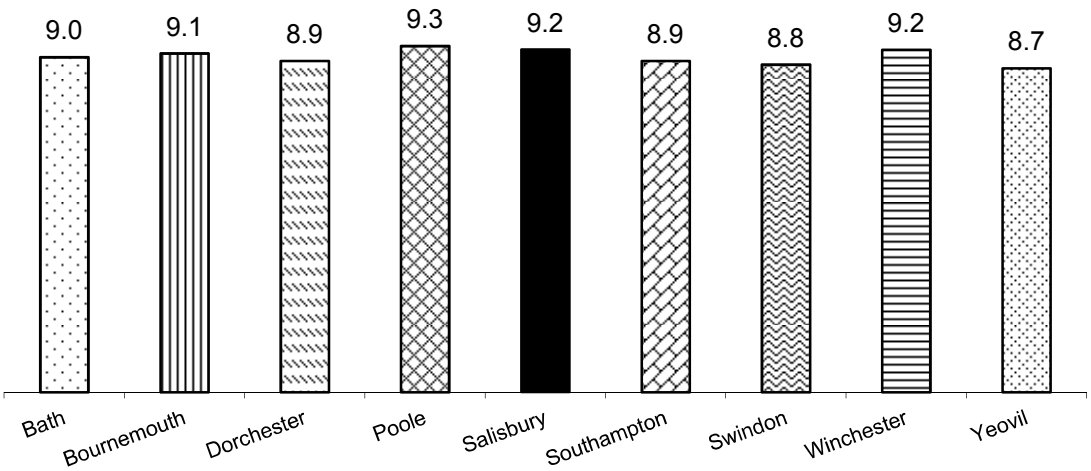
When you had important questions to ask a nurse, did you get answers that you could understand?



Did you have confidence and trust in the nurses treating you?



Did nurses talk in front of you as if you weren't there?



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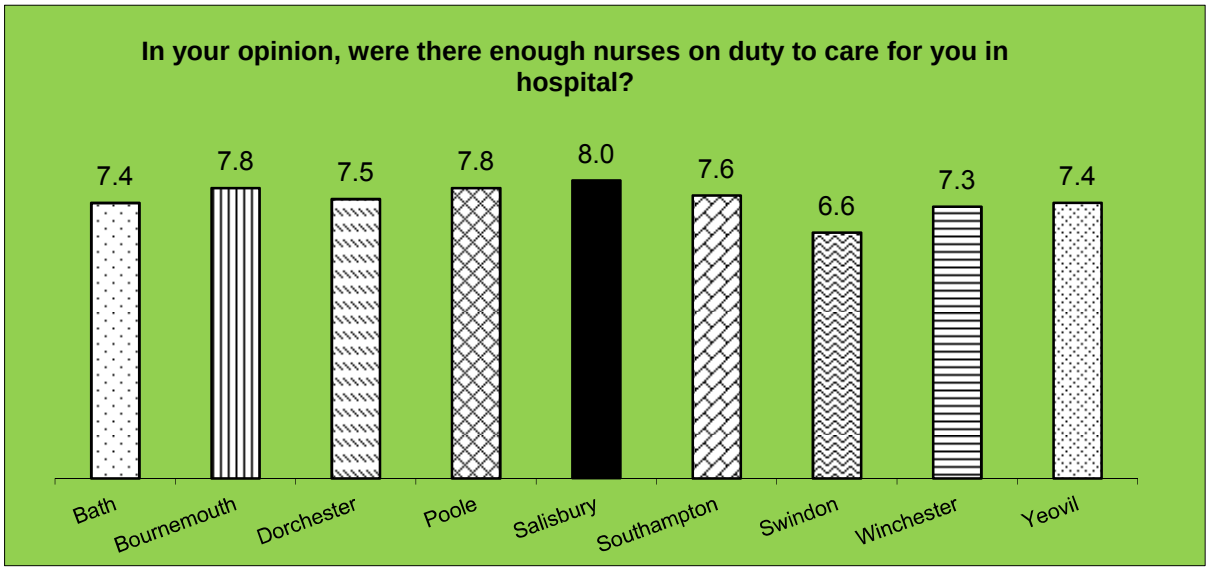
NURSES

2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts



2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

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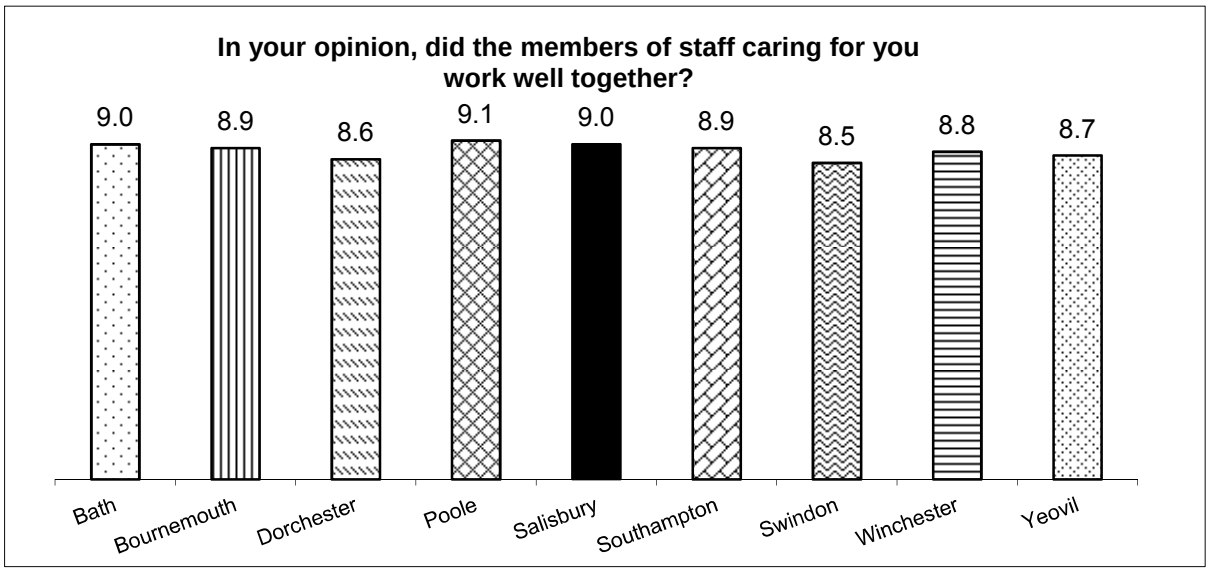

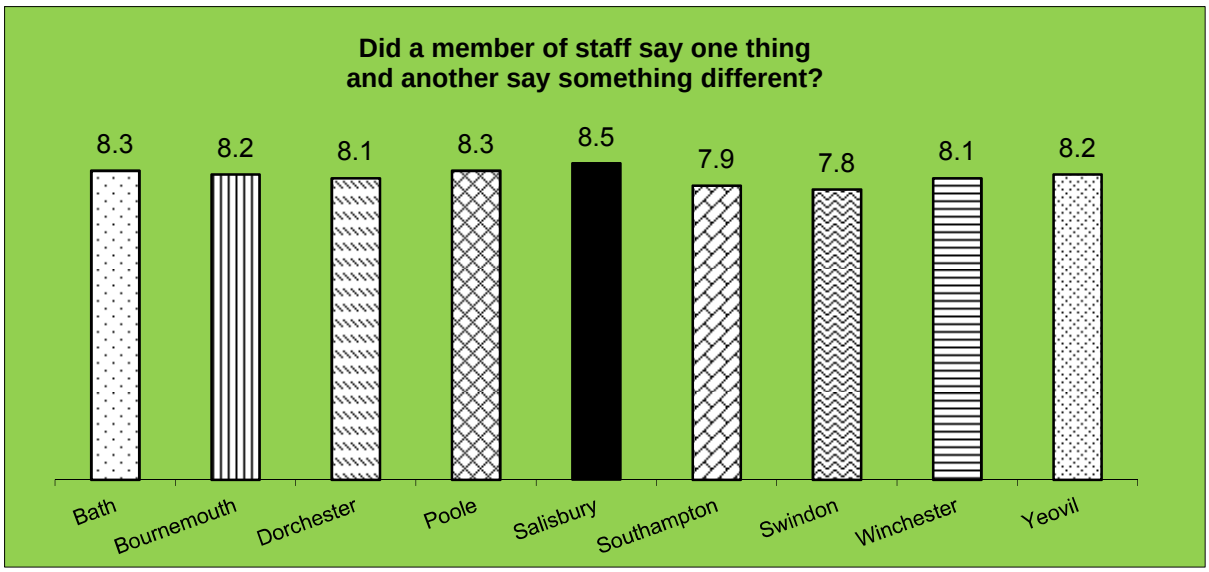

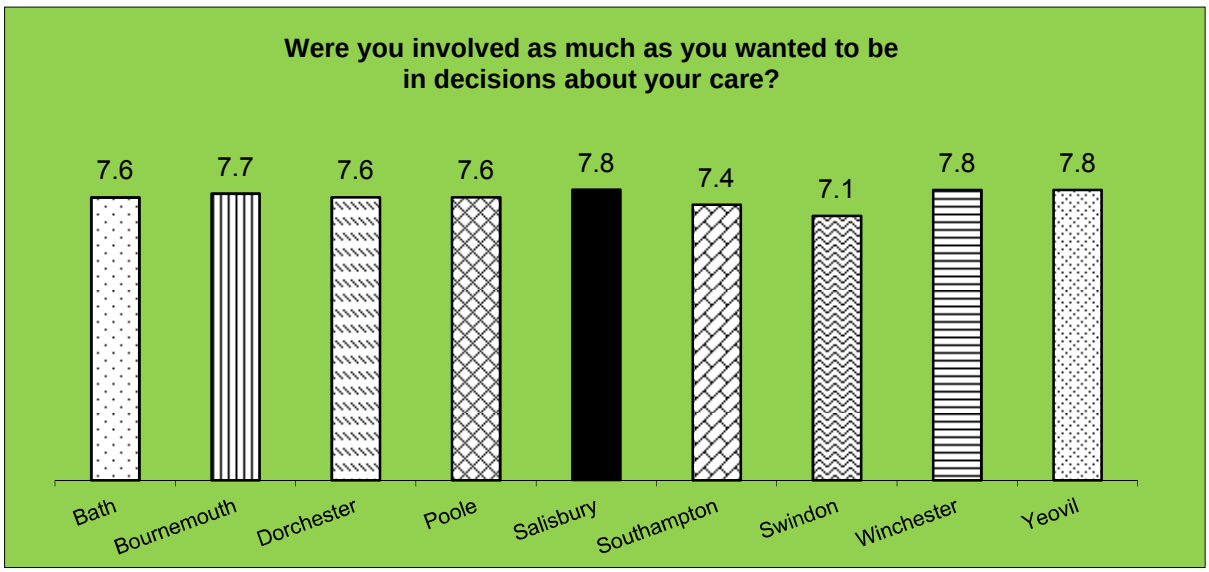

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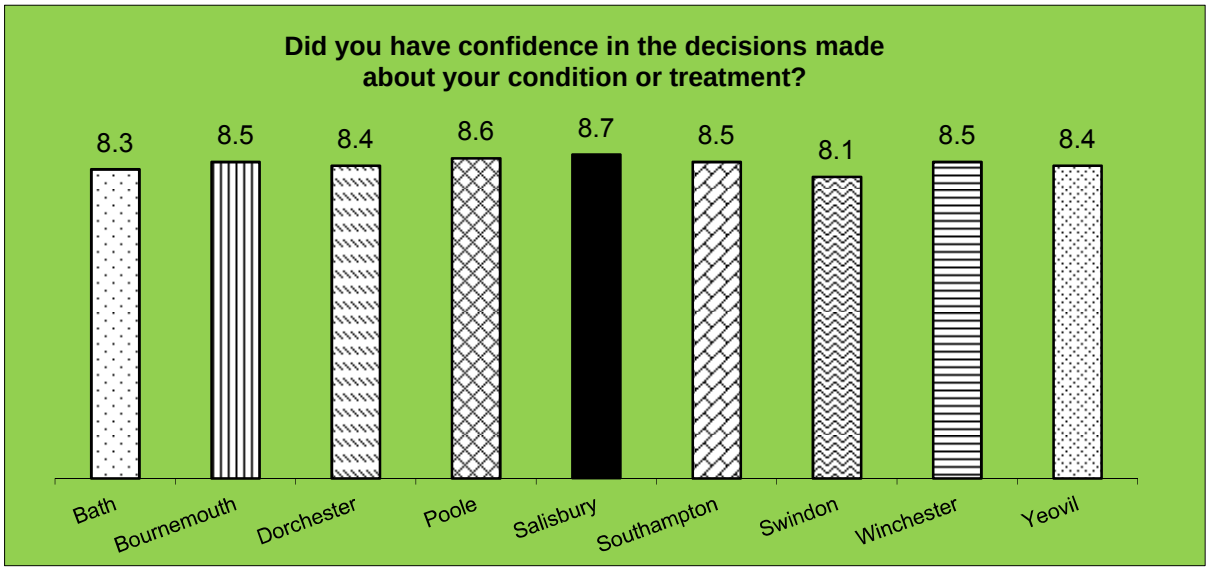
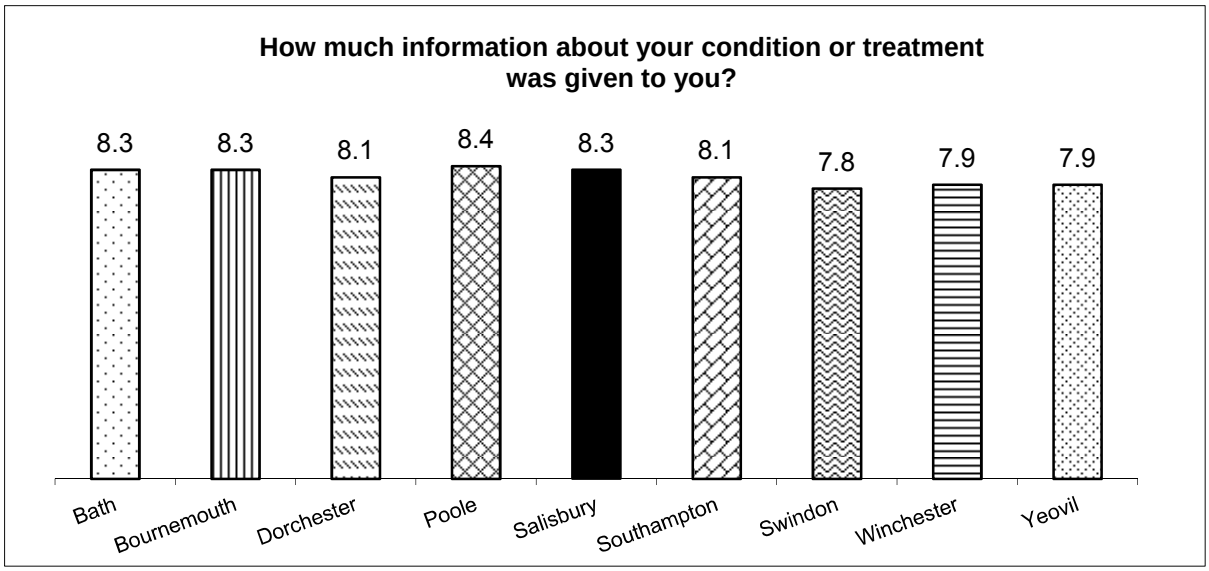
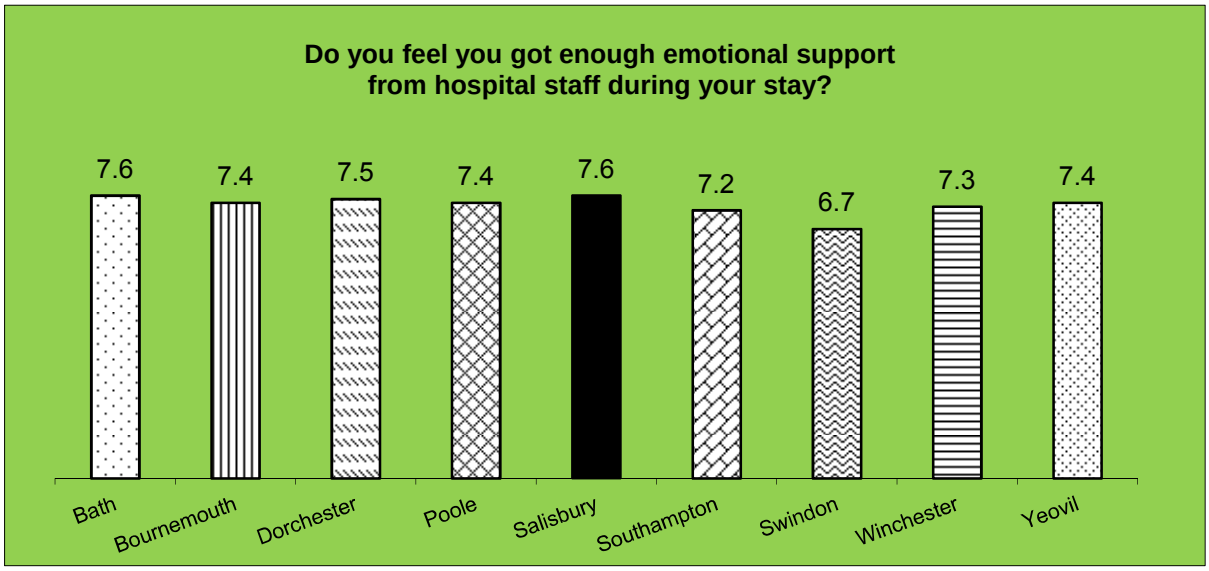
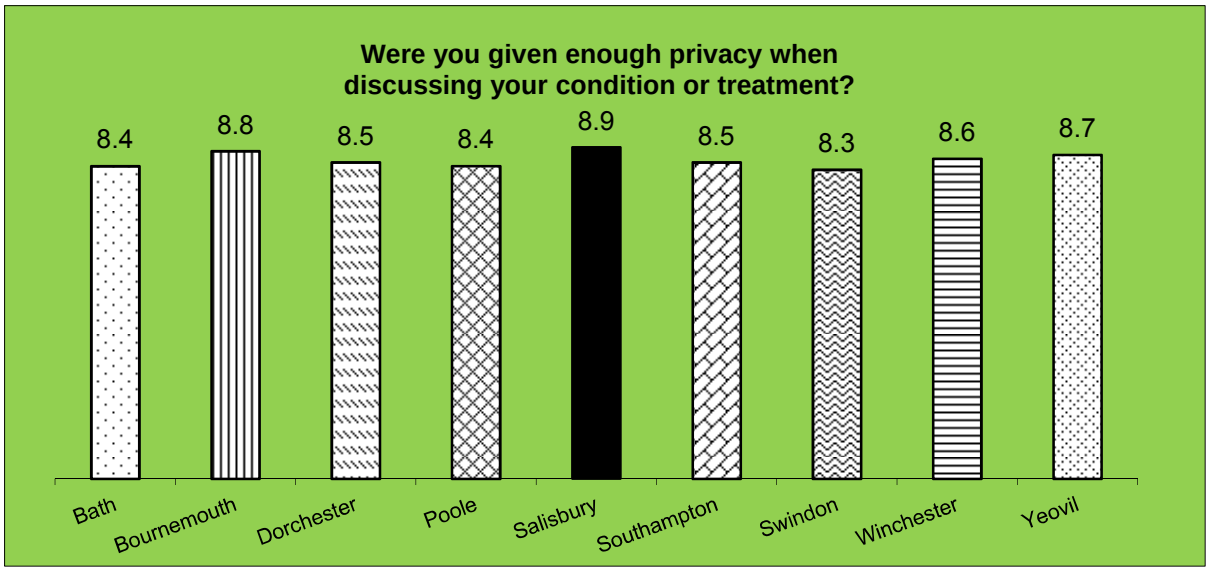
2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

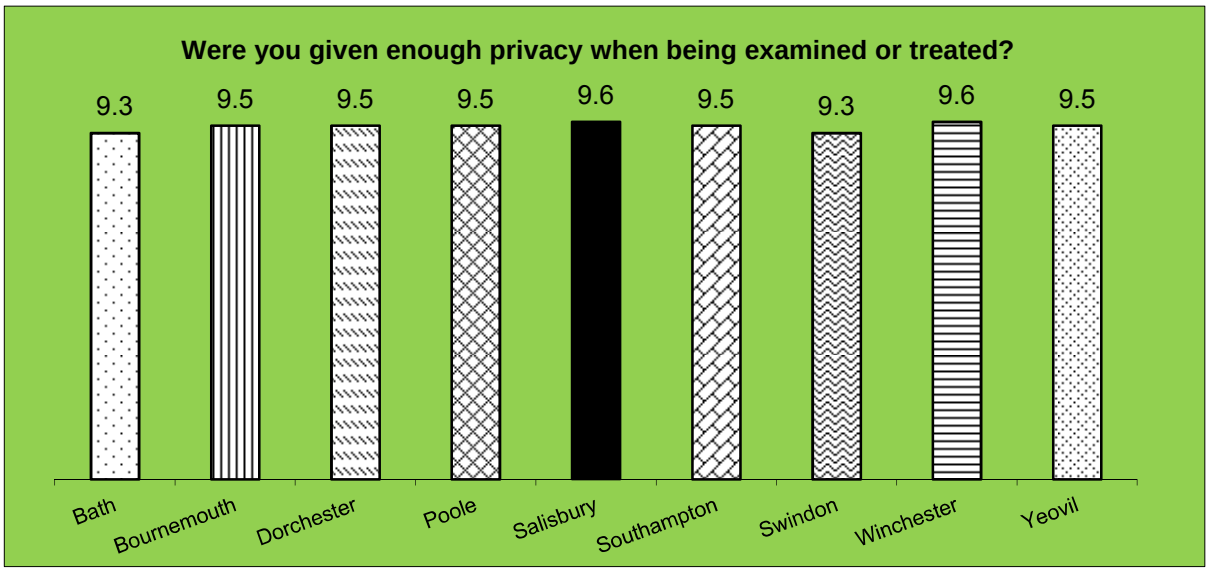




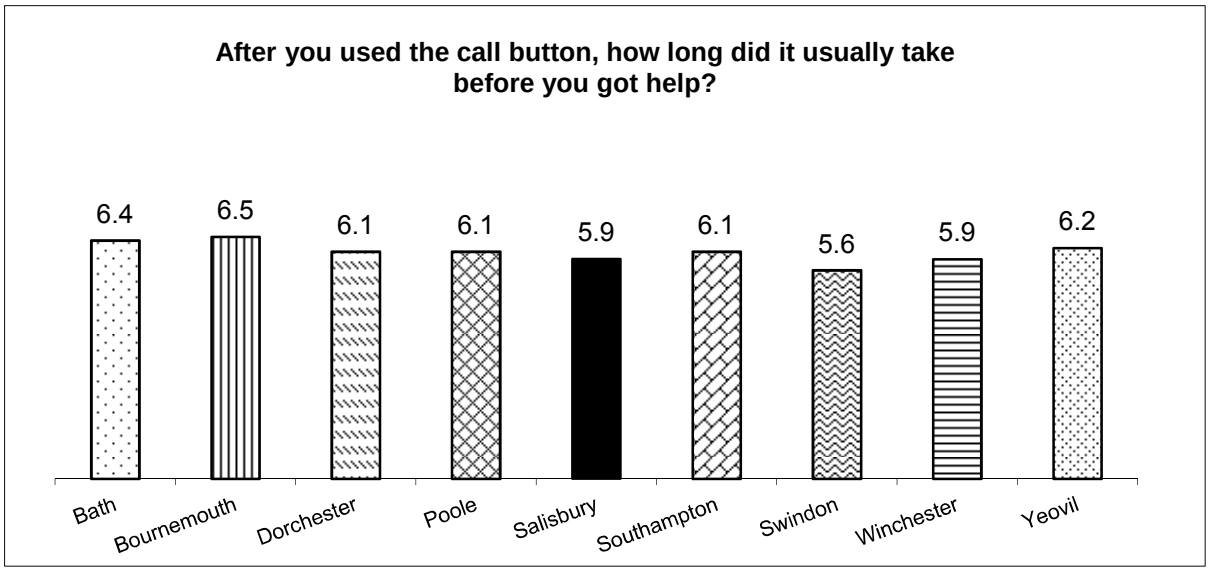
2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts







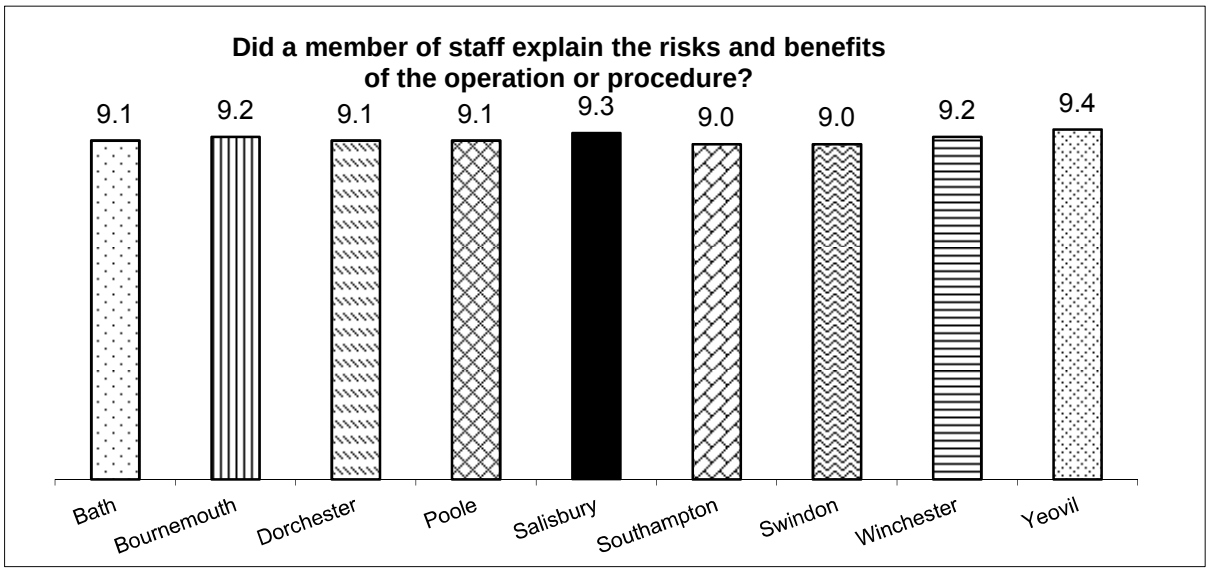
2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

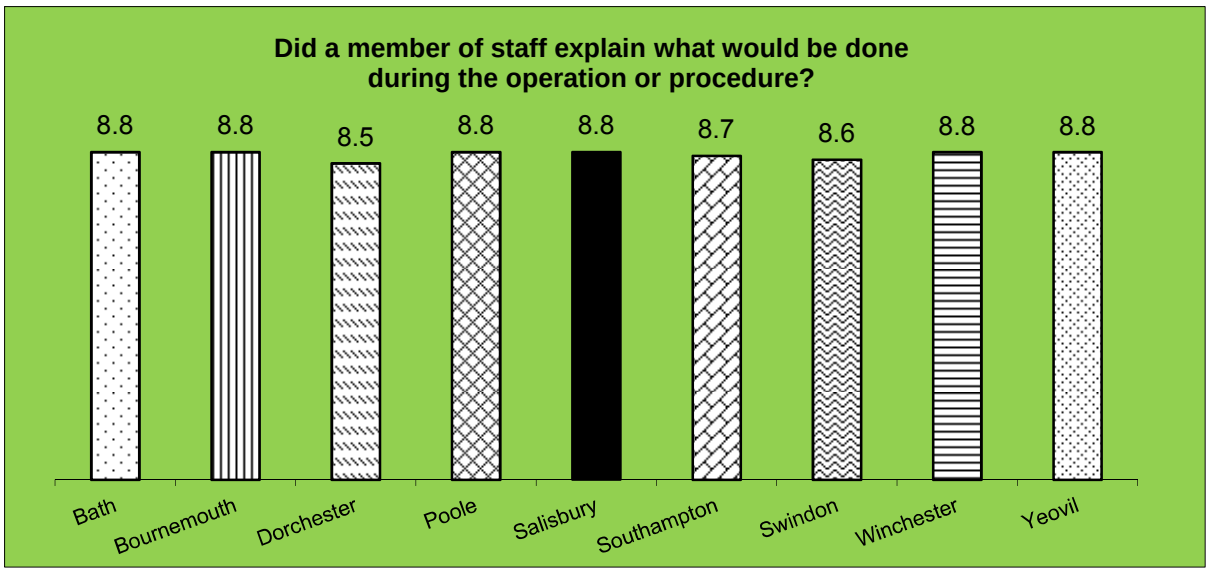


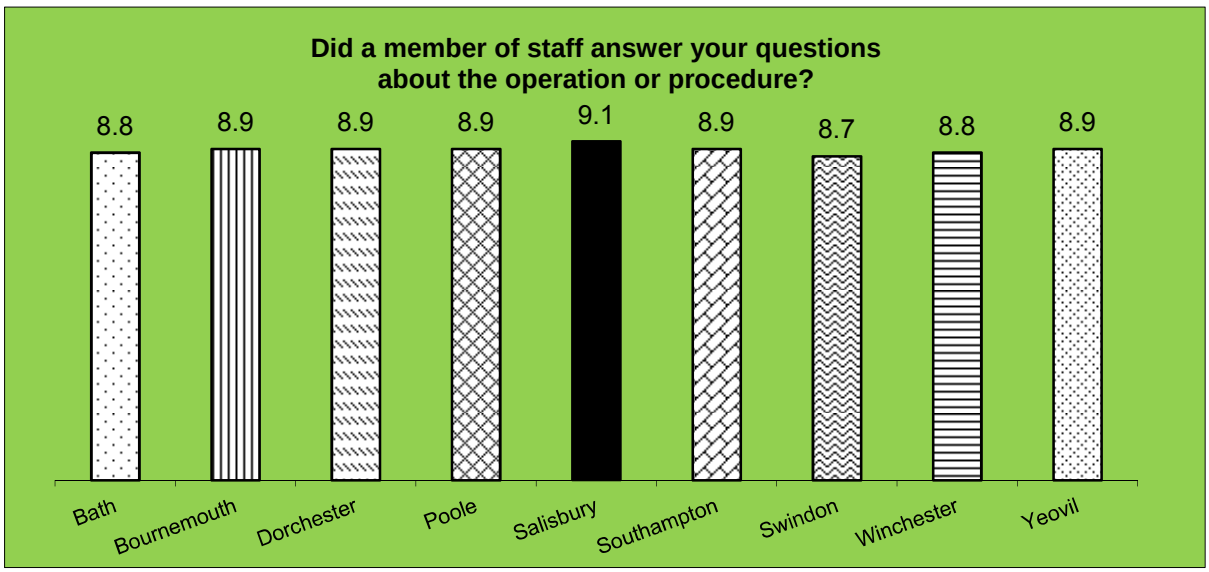
2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

= SFT highest or joint highest score

= SFT lowest or joint lowest score







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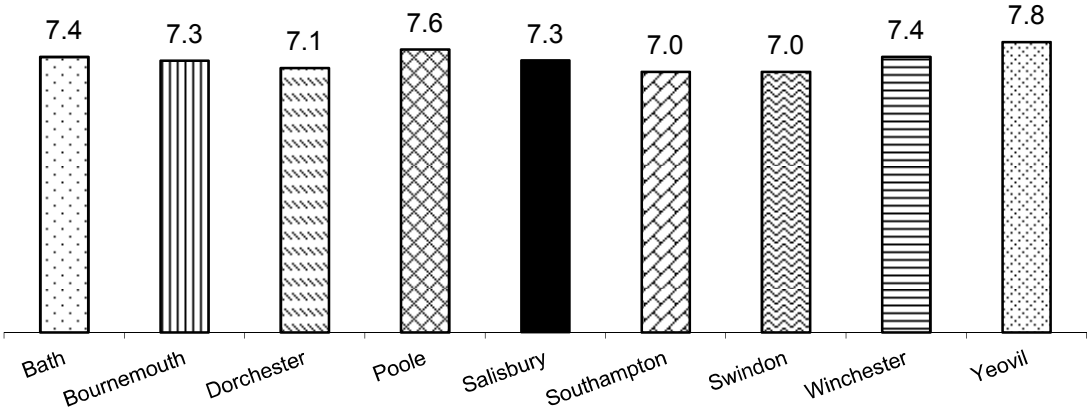
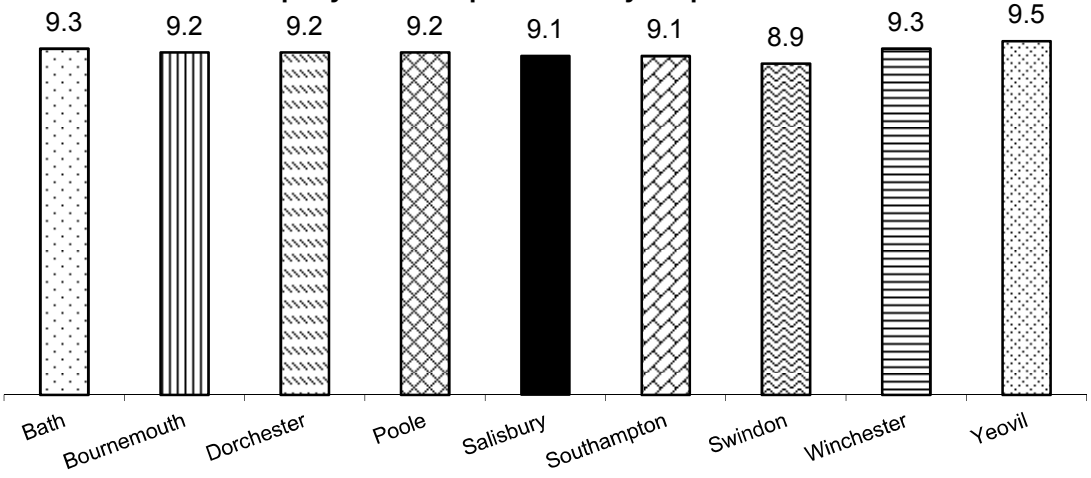
June 2016

2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

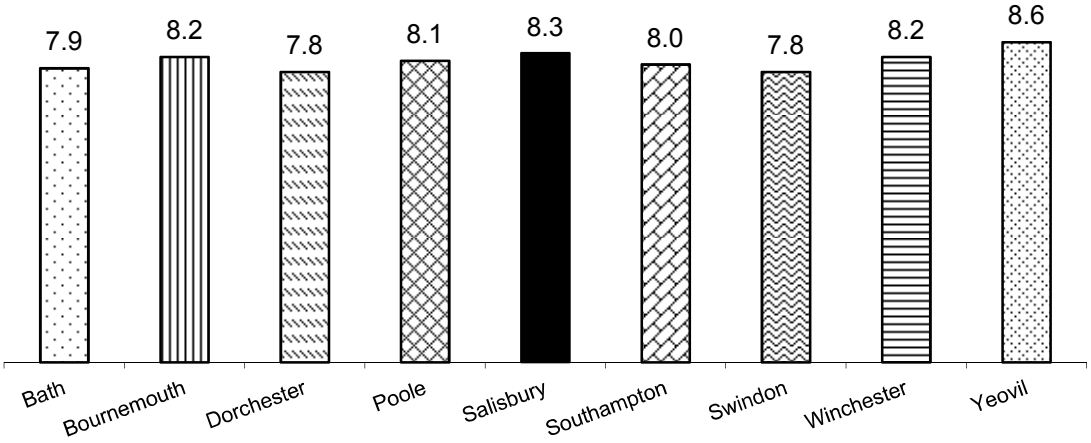
Were you told how you could expect to feel after you had the operation or procedure?



Did the anaesthetist explain how he or she would put you to sleep or control your pain?



Afterwards, did a member of staff explain how the operation or procedure had gone?

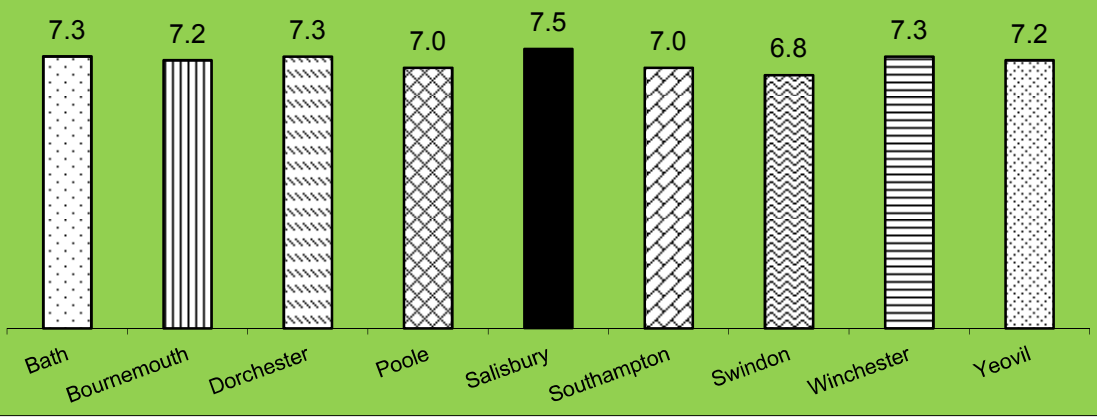


2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

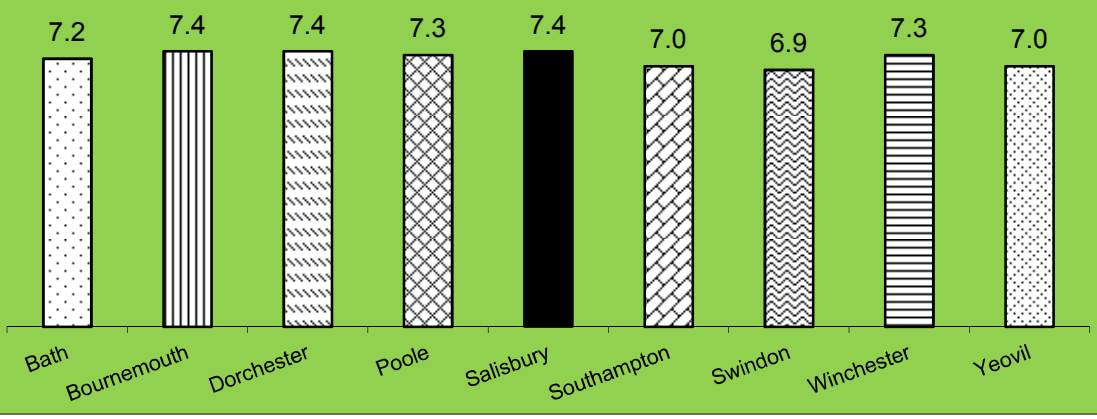
= SFT highest or joint highest score

= SFT lowest or joint lowest score

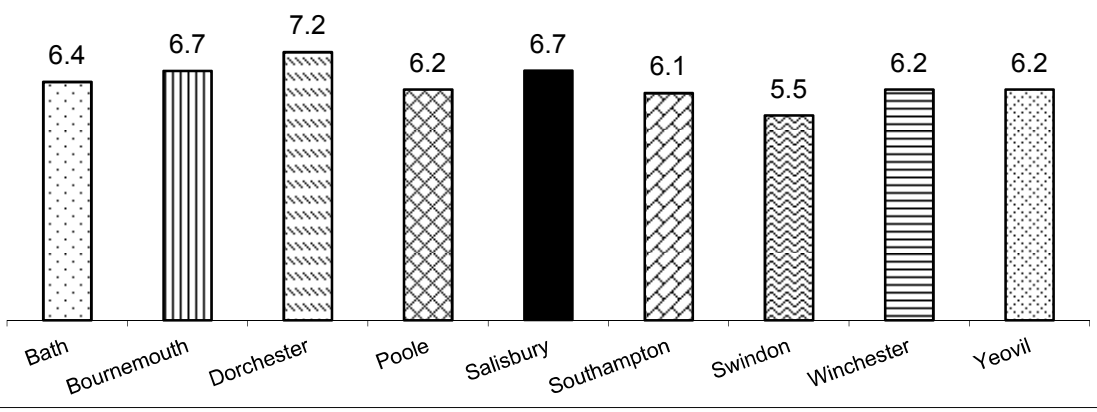
Did you feel you were involved in decisions about your discharge from hospital?



Were you given enough notice about when you were going to be discharged?



Discharge delayed due to wait for medicines/ to see doctor/for ambulance



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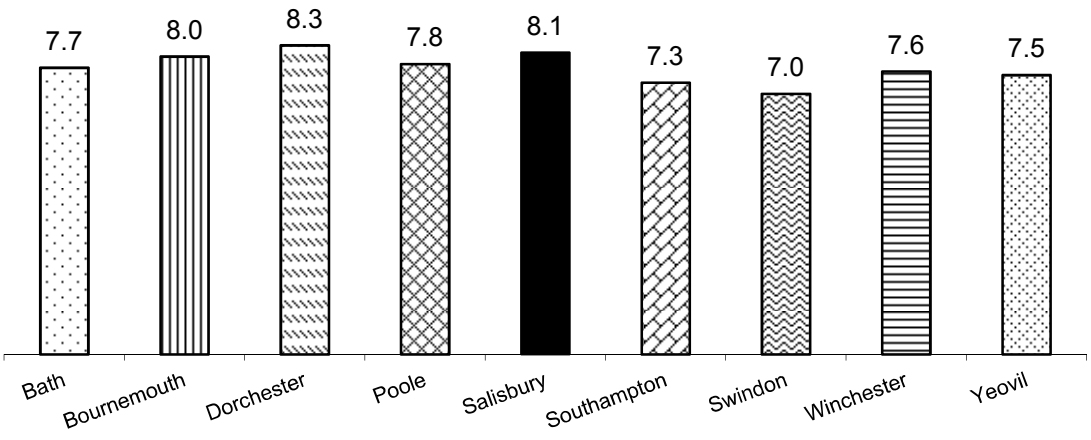
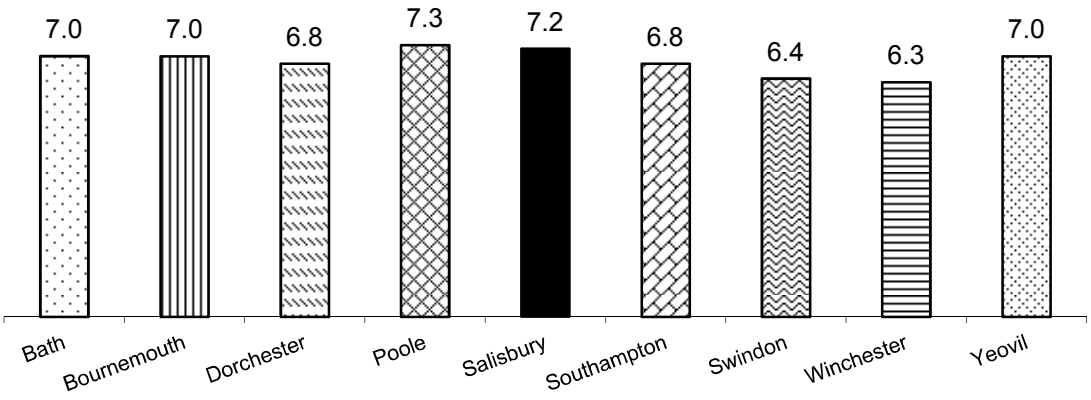
2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

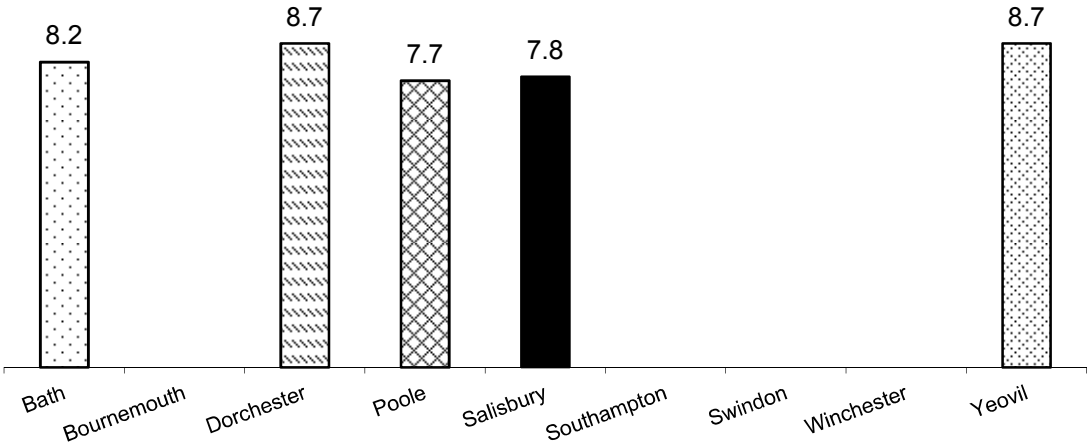
How long was the delay to discharge?



Did you get enough support from health or social care professionals to help you recover and manage your condition?



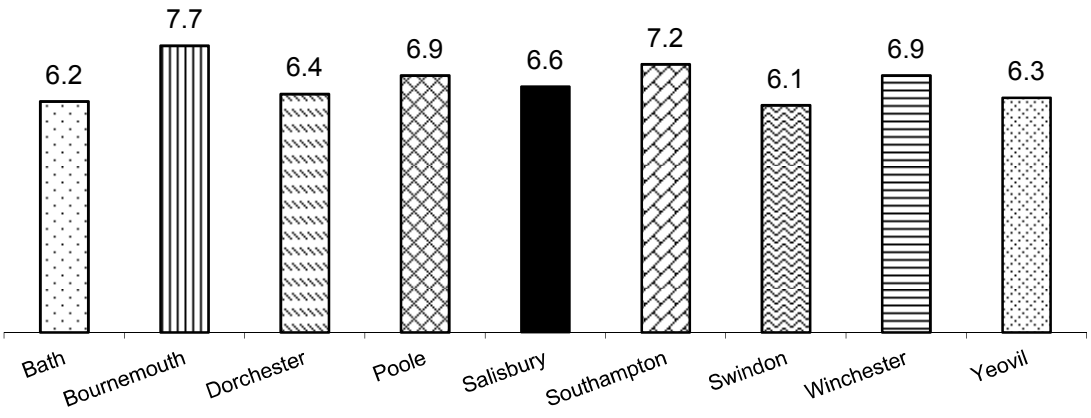
When you transferred to another hospital or went to a nursing or residential home, was there a plan in place for continuing your care?



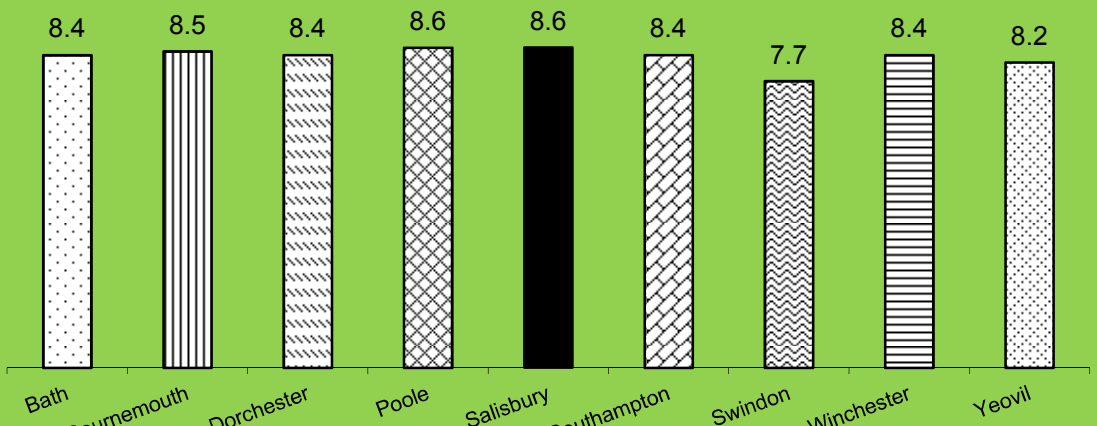
No data = less than 30 respondents

2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

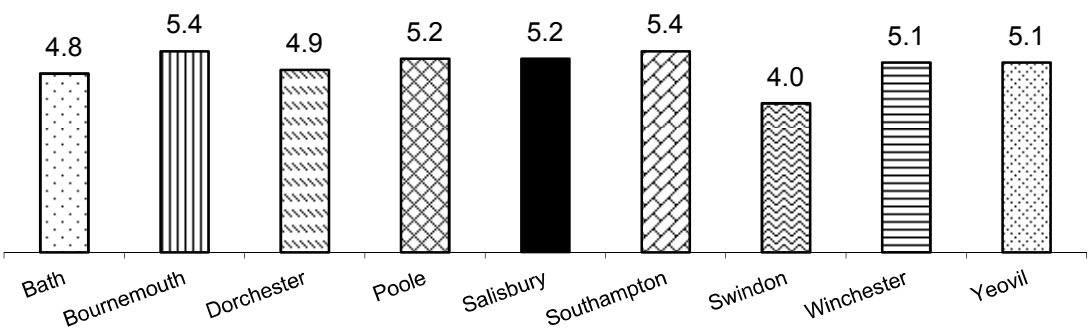
Before you left hospital, were you given any written information about what you should or should not do after leaving hospital?



Did hospital staff explain the purpose of the medicines you were to take at home in a way you could understand?

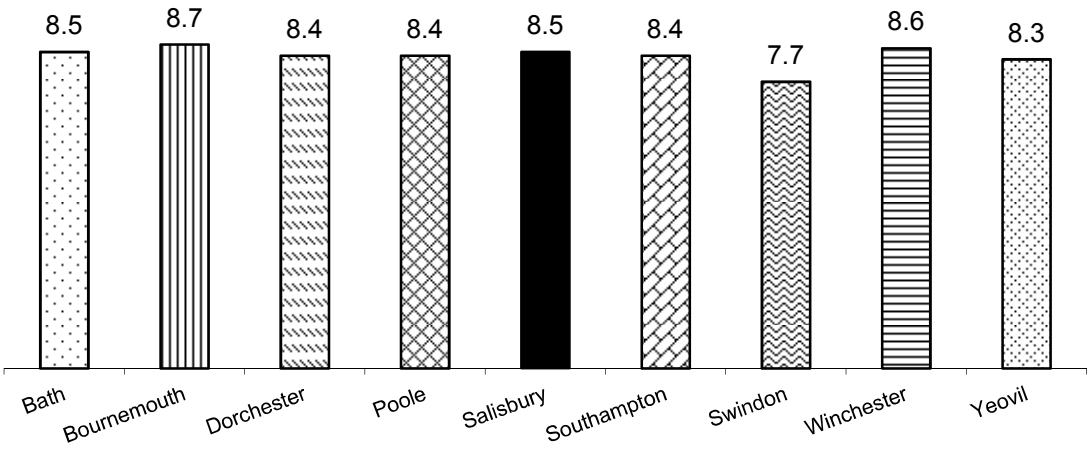


Did a member of staff tell you about medication side effects to watch for when you went home?

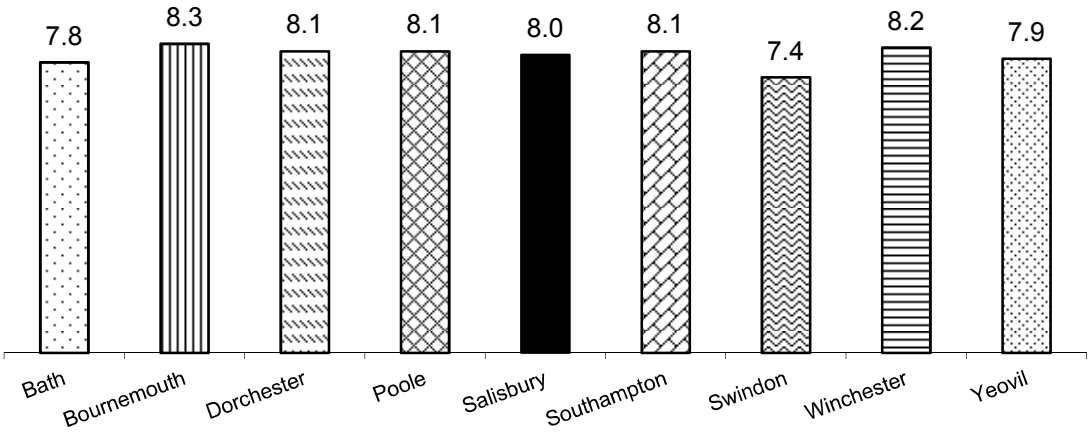


2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

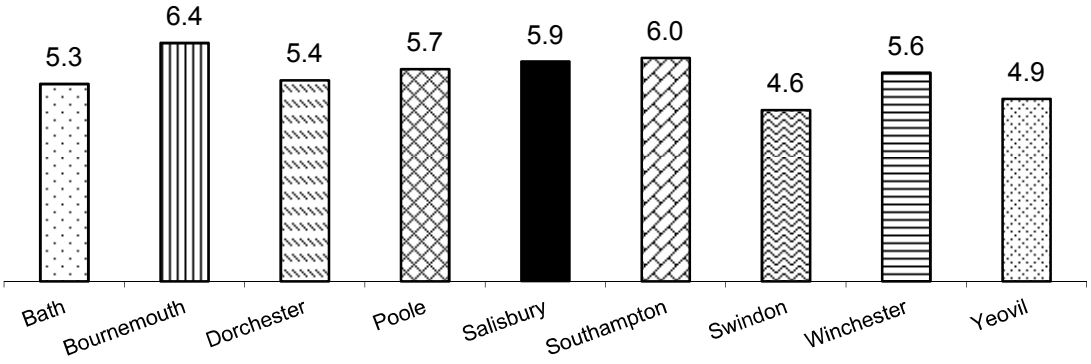
Were you told how to take your medication in a way you could understand?



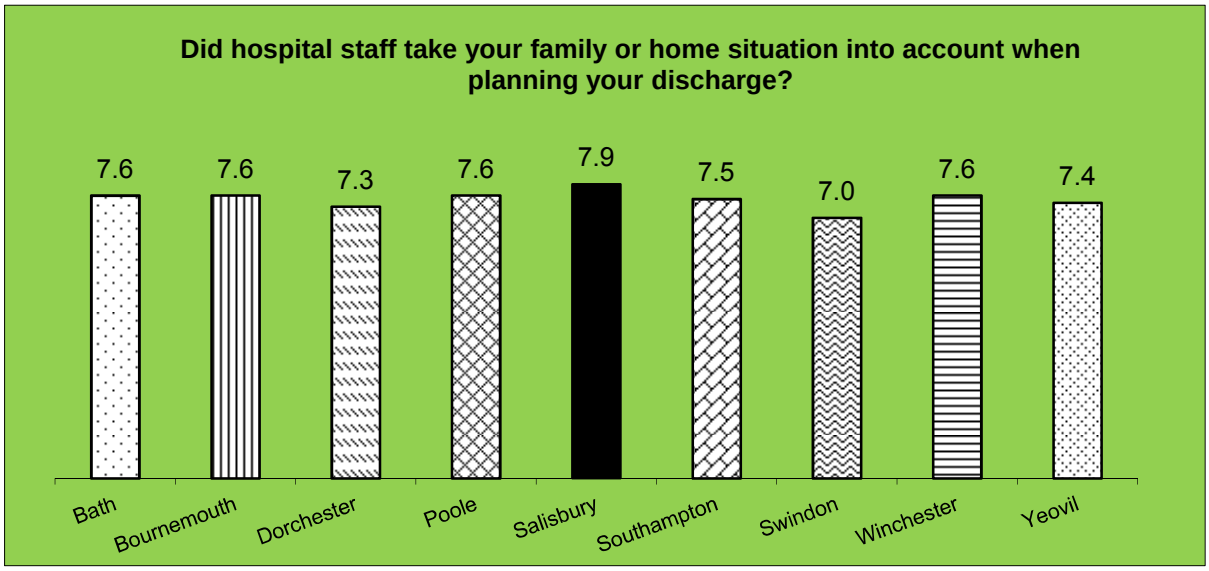
Were you given clear written or printed information about your medicines?

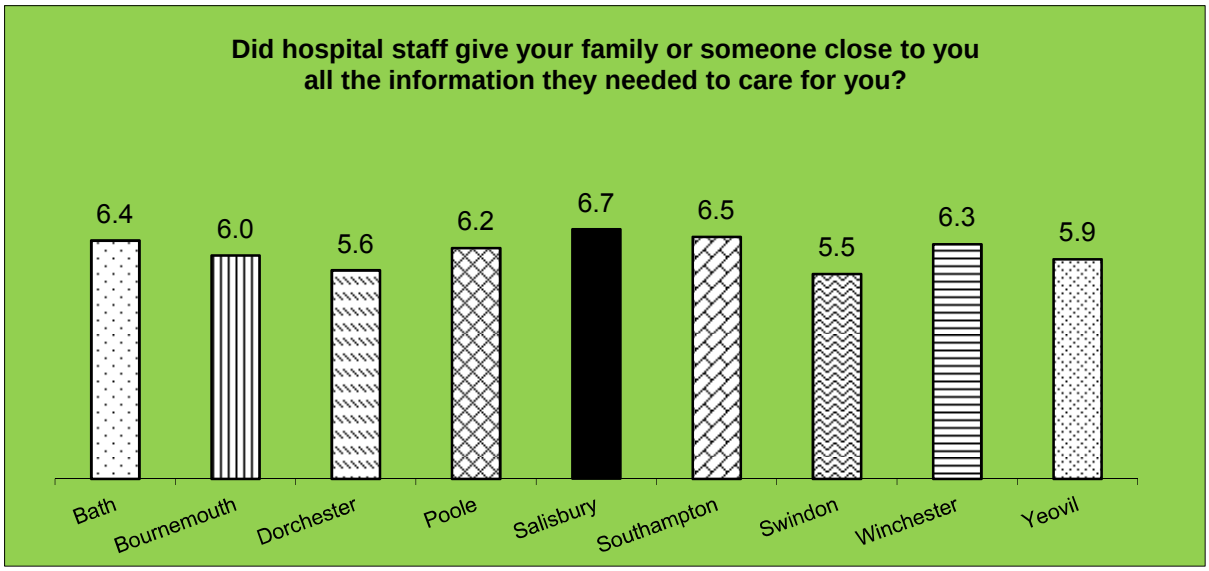


Did a member of staff tell you about any danger signals you should watch for after you went home?

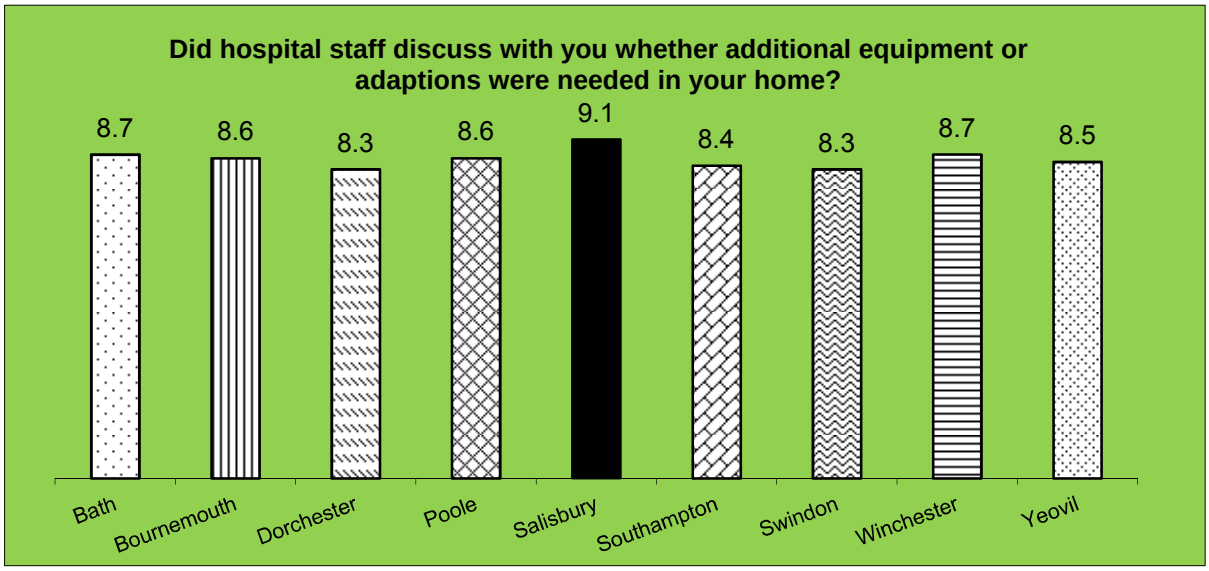


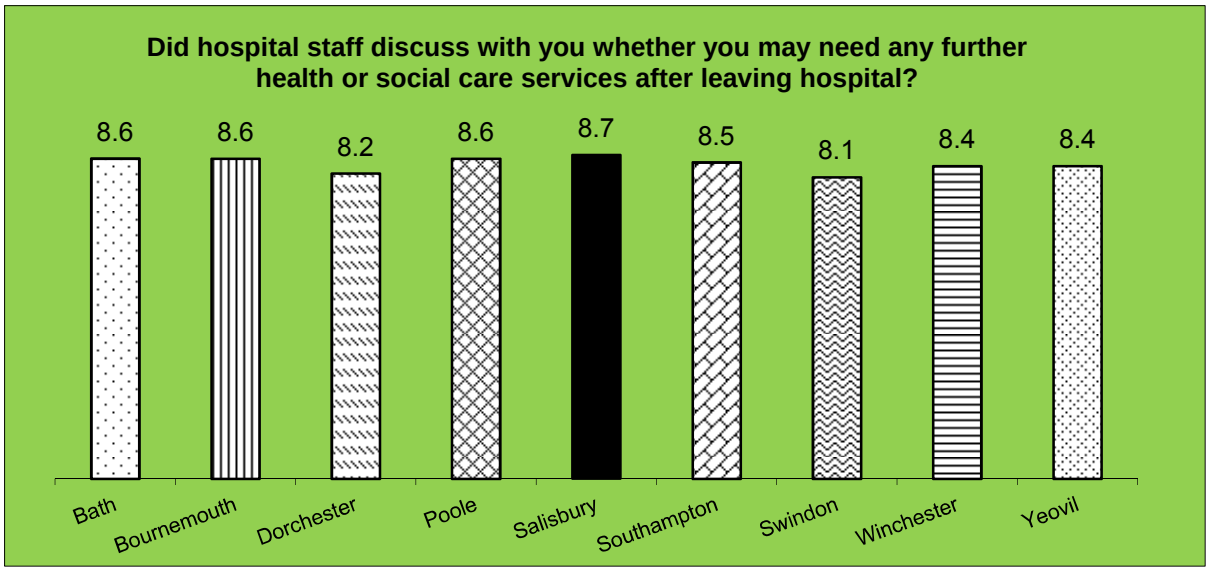
2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts





2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts



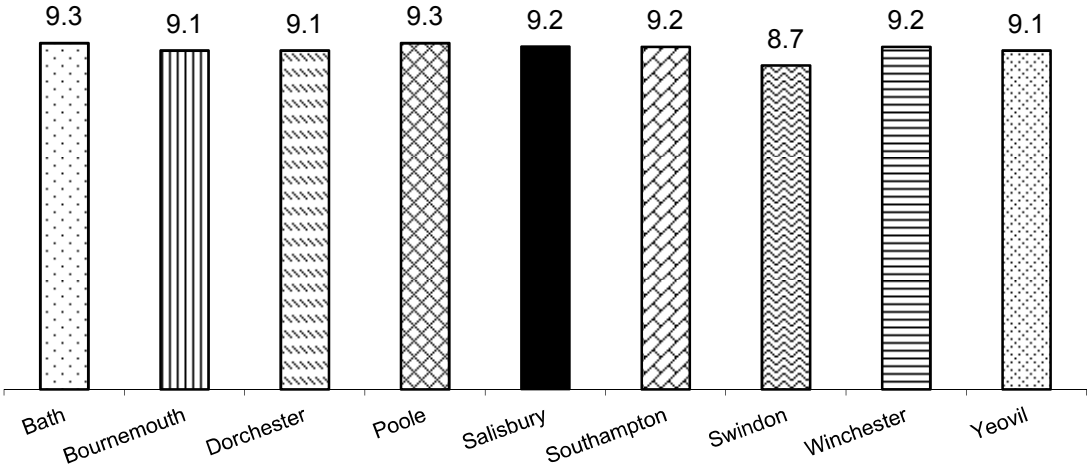


2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

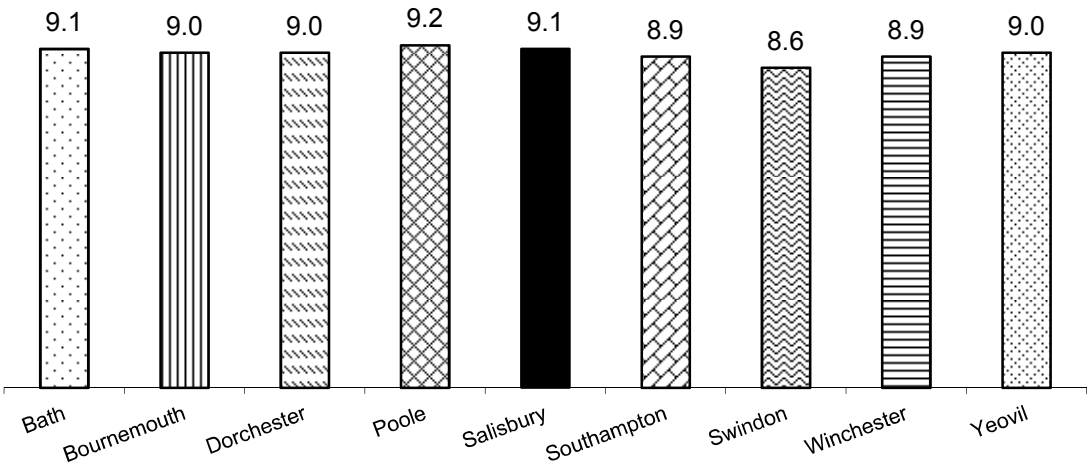
= SFT highest or joint highest score

= SFT lowest or joint lowest score

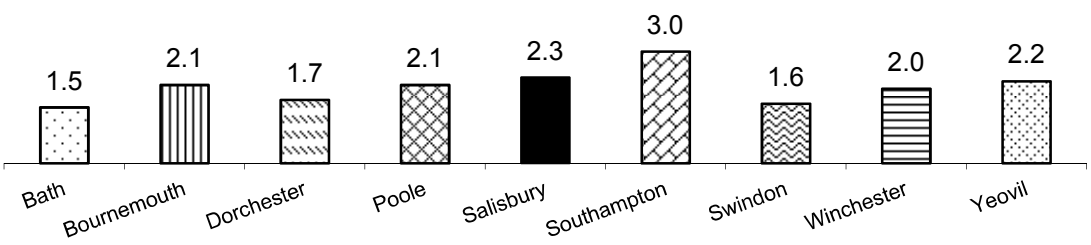
Did you feel you were treated with respect and dignity while you were in the hospital?



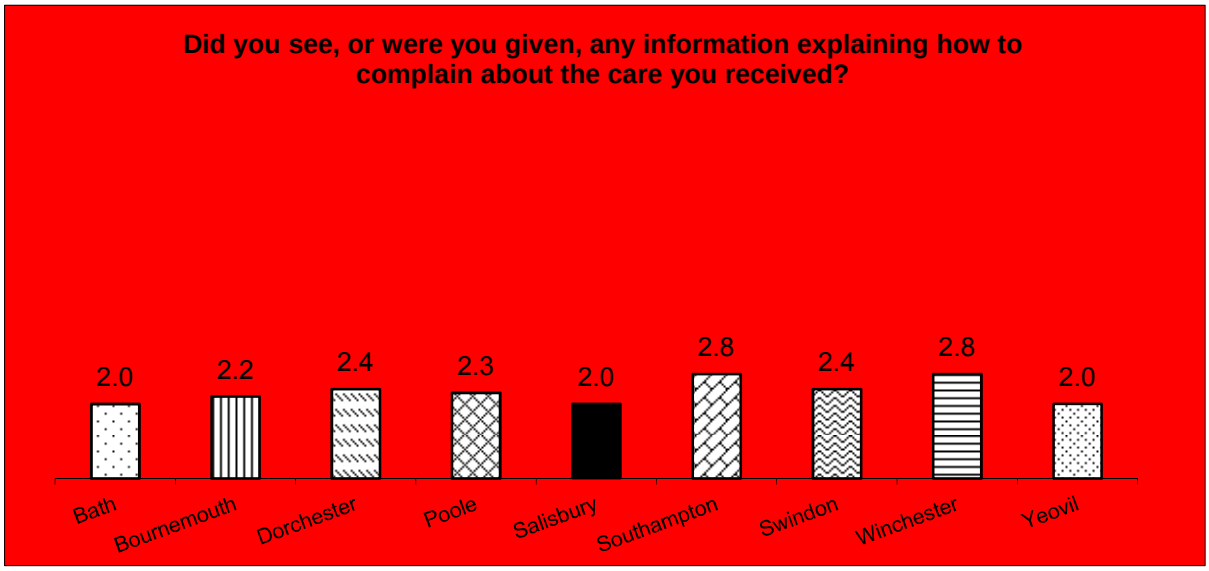
During your time in hospital did you feel well looked after by hospital staff?



While in hospital, were you ever asked to give your views on the quality of your care?



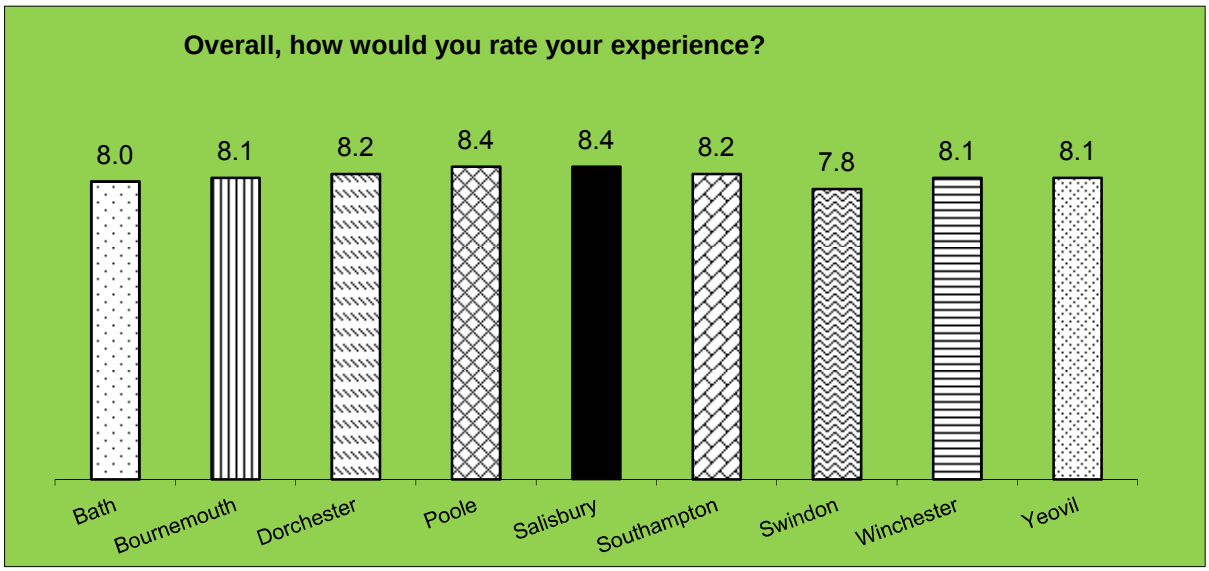
2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts



2015 INPATIENT SURVEY RESULTS
Comparisons with Neighbouring Trusts

= SFT highest or joint highest score

= SFT lowest or joint lowest score



Gill Sheppard
Clinical Governance Administrator
June 2016

OVERALL EXPERIENCE

PAPER: SFT 3796

PAPER TITLE: Annual Revalidation Report

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

MAIN ISSUES:

- The Trust has sufficient trained appraisers supported by an appraisal lead, regular workshops and peer support
- Appraisal compliance rate 96%
- Sixty four doctors were revalidated this year. The whole of the Trust's medical workforce has now been revalidated once.
- In no case this year was revalidation was deferred due to ill health, maternity leave or delayed appraisal
- One case of non-engagement notified to GMC with a satisfactory outcome
- Three fitness to practice referrals made by the RO
- Policies for appraisal, remediation and handling concerns require updating
- Quality assurance for appraisal on hold pending appointment of new chair of the QA Board

ACTION REQUIRED BY THE BOARD:

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

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

The Board is asked to support the appointment of a non-executive director to chair the appraisal quality assurance board

AUTHOR: Dr Christine Blanshard

TITLE: Medical Director and Responsible Officer

Revalidation - Annual Board Report

1. Executive summary

In April 2014 NHS England published a framework for quality assurance for revalidation which requires Responsible Officers to produce their annual report on revalidation for the Board of their Designated Body in a prescribed format, and the chairman or chief executive to sign a statement of compliance to be submitted to the level 2 Responsible Officer. This report describes the number of doctors with a prescribed connection to the Trust, the number of completed appraisals within the appraisal year 2015-16, the appraisal quality assurance process and any issues with the revalidation process and an action plan.

2. Purpose of the Paper

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

3. Background

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

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

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

4. Governance Arrangements

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

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

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

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

She is also required to:

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

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

She is line managed in this respect by her "second level responsible officer" who is currently the Medical Director of NHS England South, and appraised with regard not only to her performance as an RO, but on the whole of her practice, by an NHSE appointed appraiser. Her annual appraisal was completed in March 2016.

The RO has received appropriate training for the role and is engaged in the regional responsible officer network which provides updates and support. She has attended 80% of the regional RO network meetings.

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

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

In addition she acts as a source of expert advice for difficulties encountered in the appraisal process, signposting where necessary appraisers and appraisees to further advice and guidance. She works with appraisers and appraisees on continuously improving the value of the appraisal process.

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

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

Appraisers are responsible for:

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

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

Progress with appraisals is monitored by the RO and administrator at a monthly meeting, and any doctors who have not completed their appraisal by the anniversary of their previous appraisal are sent a reminder. If there is no further progress they are offered a face-to-face appointment with the administrator to support them in completing their portfolio; if this fails the appraisal lead will contact the doctor and offer more intensive support, and the RO will remind the doctor that participation in an annual appraisal process is a requirement to retain a licence to practice medicine. As a last resort the GMC can be informed of non-engagement with the appraisal process.

a. Policy and Guidance

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

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

For the appraisal year 2015-2016:

204 doctors had a prescribed connection to the Trust (increased form 192 in the previous year) comprising 168 consultants, 12 SAS doctors and 24 temporary or short-term contract holders (trust locums and junior doctors not in a training post)

157 consultants, 11 SAS doctors and 24 temporary contract holders completed their annual appraisal within the prescribed time. Four doctors were excused due starting in-year, maternity leave or long-term sickness absence. One consultant completed her appraisal, which was more than a year overdue, only after the GMC were informed of her non-engagement with the process. Eight doctors did not complete their appraisal within the year despite repeated reminders. Thus the overall compliance rate for appraisal for revalidation is **96%**. This year a number of SAS doctors left the trust and 100% of the remainder had a timely appraisal, well above the national level. At the time of writing the most overdue appraisals are for two consultants whose last appraisal was in October 2014 and December 2014 respectively. Their previous appraisals have been satisfactory and I have no concerns about their fitness to practice.

Sixty-five doctors were due for revalidation during the course of the year and a revalidation recommendation was made by the due date in 58 cases. In seven cases the recommendation was made up to two days late, mainly due to late sign-off of documents but in a three cases due to sickness absence of the RO. This did not impact on the practitioner's registration. In 64 cases a positive recommendation was made; in one case the GMC was advised of non-engagement, but this doctor was successfully revalidated within six months. This year no doctor had their revalidation deferred, due to maternity leave, sick leave or insufficient evidence.

No doctors were involved in a remediation process as a result of issues identified at appraisal. However some concerns about the practice of seven doctors were identified by our governance processes.

One doctor has been excluded due to concerns about his conduct, and referred by the RO to the GMC. He has appeared before a GMC interim orders panel which has placed restrictions on his practice and a GMC investigation is ongoing.

Three doctors have been subject to formal disciplinary processes for misconduct, one of whom was also referred by the RO to the GMC. The case was closed with advice.

One former employee was referred to the GMC by a subsequent employer with concerns about his capability. We had identified similar concerns and managed them via supported practice. The GMC did not find his fitness to practice was impaired.

One consultant is subject to a restriction on her practice and a formal remediation programme with the support of the National Clinical Assessment Service. She is also subject to an ongoing GMC investigation.

The RO has communicated with a former employee's new RO some concerns about his capability and advised limited/supported practice.

Three doctors have removed themselves from the medical register with the agreement of the RO following retirement from clinical practice.

The RO meets quarterly with her GMC employer liaison officer to discuss ongoing and potential fitness to practice concerns.

b. Appraisers

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

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

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

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

c. Quality Assurance

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

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

Following resignation of the NED chair of the AQA board, this year's meeting has been delayed awaiting the appointment of a new chair.

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

d. Access, security and confidentiality

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

e. Clinical Governance

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

6. Recruitment and engagement background checks

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

7. Risk and Issues

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

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

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

A small number of doctors are struggling to engage with the process and there is a risk that they will lose their licence to practice; however this is unlikely as compliance increases markedly as the revalidation date draws close. The difficulty will be keeping these doctors engaged in appraisal once they have been revalidated, and this is beginning to be apparent as most doctors have now been revalidated (the system was set up to revalidate most doctors in the first three years of a five year cycle)

8. Next Steps

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

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

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

9. Recommendations

The Board is asked to note this report and agree for it to be shared with the Second Level Responsible Officer.

The Board is further requested to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations

The Board is asked to support the appointment of a non-executive director to chair the appraisal quality assurance board

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Version 4, April 2014

THE NHS CONSTITUTION

NHS England INFORMATION READER BOX		

Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	01142
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, **Annex E - Statement of Compliance**
Author	NHS England, Medical Revalidation Programme
Publication Date	4 April 2014
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees
Description	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	Replaces the Revalidation Support Team (RST) Organisational Readiness Self-Assessment (ORSA) process
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers (ROCR approval applied for).
Timings / Deadline	**From April 2014**
Contact Details for further information	england.revalidation-pmo@nhs.net http:// www.england.nhs.net/revalidation/

Document Status

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Annex E – Statement of Compliance

Designated Body Statement of Compliance

The board/executive management team – [delete as applicable] of [Insert official name of designated body] has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments:

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments:

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments:

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments:

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments:

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments:

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments:

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments:

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Comments:

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments:

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

SALISBURY NHS FOUNDATION TRUST

Notes of the Finance & Performance Committee
Held on 31 May 2016

SFT 3797

Present	Dr N Marsden	Chairman
	Mr I Downie	Non-Executive Director
	Mr P Hill	Chief Executive
	Mr M Cassells	Director of Finance and Procurement
	Mr A Hyett	Chief Operating Officer
In Attendance:	Mr P Kemp	Non-Executive Director
	Mrs K Matthews	Non-Executive Director
	Mr D Seabrooke	Head of Corporate Governance
	Mr R Webb (for item 5)	Associate Director of Procurement Commercial Services
	Mr P Casson (for item 7)	Odstock Medical Limited
Apologies	Dr L Brown	Non-Executive Director

1. FINANCE AND PERFORMANCE COMMITTEE MINUTES – 21 MARCH AND 25 APRIL 2016

The notes of the meeting of the Committee held on 21 March 2016 were accepted as a true record and the notes of the meeting held on 25 April 2016, which wasn't quorate, were noted.

2. MATTERS ARISING

There were no matters arising.

3. CQUIN 2016/17

PH gave a brief update on progress with agreeing CQUINs with West Hampshire CCG. It was agreed that this item would now revert to quarterly monitoring.

4. FINANCE REPORT TO 30 APRIL (MONTH 1)

The Committee received the Finance and Contracting Report to 30 April 2016. It was noted that the Trust had made a deficit £382,000 which was a favourable variance of £224,000 against the plan. The phasing of the plan includes Sustainability and Transformation funding in the months when it is paid without accruals. £525,000 had therefore been accrued in the actuals in arriving at the deficit figure.

A contract with Wiltshire CCG has been signed and Heads of Agreement with West Hampshire CCG and Dorset CCG have been signed. A financial baseline with the specialised commissioner had been agreed on the basis that this contract was likely to over-perform early in the financial year and the commissioner has been made aware of this and accepts liability for excess activity.

It was noted that progress was being made on establishing the new Joint Venture Company (Sterile Supplies Ltd) to take over SDU services with a target date of 1st July 2016. The new board would commence in June and the Trust's representatives were David Taylor and Ron Burrows with both appointments to be reviewed in a year's time.

It was also noted that the Trust had applied to the ITFF for a £6m loan to support the costs of implementing the EPR system.

It was noted that elective in-patient activity continued to be down on plan and against the preceding year and non-elective in-patients were up against the preceding year and against the plan.

It was noted that on 27 May there were 49 Delayed Transfers of Care patients in the hospital, of this number roughly a quarter are Social Services patients. AH was following up with the agencies that attended the Quality Summit and there were individual stakeholder meetings planned to discuss the continuing issue with Delayed Transfers of Care. Discussions would continue with a view to ensuring that an appropriate forum was in place to drive forward action with partners.

There was concern that the implementation of the Electronic Patient Record in October would have an adverse effect on the Trust's capacity and it was on that basis that the Trust had been prioritising waiting lists in the lead up to the implementation.

5. PROCUREMENT AND COMMERCIAL SERVICES DEPARTMENT – ANNUAL REPORT 2015/16

The Chairman welcomed Rob Webb to the meeting.

The following principal points arose from the report that was circulated:

- The service had generated £1.1m of savings and had a further £1m savings target in 2016/17.
- The value of capital spend through Single Tender Actions had increased during the year – work continued to address this with the Departments concerned.
- The criteria set out in the Standing Financial Instructions for competition were considered to be reasonable.
- The Service had done considerable work on standardising the arrangements for medical locums and on meeting the nursing agency capping arrangements.
- The Trust had, following Procurement advice, withdrawn from the Crown Commercial Services Energy Scheme and this had resulted in savings during 2015/16 of £300,000.
- Work on the GS1 (Scan 4 Safety) project was continuing to improve inventory management, purchase to pay, and arrangements for product recall.

On behalf of the Committee the Chairman offered his congratulations to Procurement for its achievements during 2015/16.

6. TRANSFORMATION AND COST IMPROVEMENT

The Committee received the PMO report for Month 1 and noted that savings (and income generation) of £6.5m were being targeted from Directorates with a further £3m necessary from more strategic schemes. 83% of the £6.5m savings attributed to the Cost Improvement Programme had been identified at this stage although it was noted that around 10% of what had been identified was currently Red rated. There would be continued work on the Theatre Transformation Scheme valued at £630,000, which was the biggest single initiative.

There was concern that not all of the £6.5m base had been identified so far and none of the additional £3m.

7. ODSTOCK MEDICAL LTD UPDATE

The Committee received the report of Odstock Medical Limited and the Chairman welcomed Phil Casson to the meeting. It was noted that revenue for 2015/16 had been just over £2m and that a profit of £55,000 achieved. The total payments to the Trust and its charity were £266,000.

Sales of the Stimustep had been affected by supplier availability throughout the year. The company had been affected by the departure of its clinical lead during the year. Revenue had been derived from the provision of monthly courses, treatments and product sales. The company continued to aim to grow by at least 10% per annum and to ensure its position as a market leader for FES systems. Following the purchase of a 3D printer and expansion in staffing the company was facing space constraints.

The Chairman thanked Phil Casson for the report and the continued success of Odstock Medical was noted.

8. REPLICA 3D UPDATE

It was noted that the shareholder letter had been issued and a further report would be made to the June meeting of the committee.

9. OPERATIONAL PERFORMANCE - MONTH 1

The Committee received the Month 1 Performance Report. It was noted that 18 weeks incomplete performance was 91.1% for April against a trajectory of 90.45%. Delays were occurring in Orthopaedics and Ophthalmology. All Cancer metrics had been delivered in April.

ED performance in April was 90.5% and was likely to be below the 95% threshold in May. It was noted that recruitment for a new clinical lead was underway and that challenges included ensuring prompt first doctor assessment and bed availability across the hospital.

The Committee noted the Performance Report.

10. CORPORATE GOVERNANCE STATEMENT AND NHSI LICENCE COMPLIANCE RETURN

The Committee received drafts of the annual returns for Licence Compliance and the Corporate Governance Statement. These were approved for submission to NHS Improvement.

11. DATE OF NEXT MEETING

Monday 27 June 2016 at 9.30 am.

SALISBURY NHS FOUNDATION TRUST

Notes of the Finance & Performance Committee
Held on 27 June 2016

Present	Dr N Marsden	Chairman
	Mr I Downie	Non-Executive Director
	Mr P Hill	Chief Executive
	Dr L Brown	Non-Executive Director
	Mr A Hyett	Chief Operating Officer
	Mr M Collis	Deputy Director of Finance
In Attendance:	Mr P Kemp	Non-Executive Director
	Mr D Seabrooke	Head of Corporate Governance
	Mr R Drag	Procurement Manager (for item 3)
	Mr R Webb	Associate Director of Procurement Commercial Services (for item 3)
Apologies	Mr M Cassells	Director of Finance and Procurement
	Mr L Arnold	Director of Corporate Development

1. FINANCE AND PERFORMANCE COMMITTEE MINUTES – 31 MAY 2016

The notes of the meeting of the Committee held on 31 May 2016 were accepted as a true record.

2. MATTERS ARISING

There were no matters arising.

3. SCAN 4 SAFETY

Rob Drag and Rob Webb attended for this item. The Committee received a report detailing the inventory management system under Scan4Safety that was being introduced. The system brought benefits around accurate patient level costing, data capture at point of use, demand-lead management, better stock control and supply chain management and improved registration and product recall for implanted devices.

The Trust would be investing in a new inventory management system, Genesis VMI which would cost £659,000 over five years. £27,000 was supported by the Scan4Safety budget allocated by the Department of Health in respect of years one and two and the Trust would be required to fund the remaining £331,450 from years three to five. The business case was supported by a return on investment factor of x 1.3 and this business case was supported by the Committee.

4. WILTSHIRE HEALTH AND CARE

Following informal discussion by the Board earlier in the month the committee had been asked to finalise the Member's Agreement in relation to Wiltshire Health and Care LLP. Appended to the membership agreement was the Wiltshire Health and Care Business Plan 2016/17.

It was noted that Laurence Arnold would be the Trust's representative on the Board of the LLP.

The committee agreed that the membership agreement should be entered into and that the Chairman should sign on the Trust's behalf.

It was also noted that the business plan would be adopted by Wiltshire Health and Care at its first Board meeting.

5. FINANCE REPORT TO 31 MAY 2016

The committee received the Month 2 Finance Report. It was noted that the income and expenditure position at Month 2 was a year to date deficit of £295,000 (after adjusting for donated income and Sustainability and Transformation funding). This was a favourable variance against the plan of £895,000 and was a small operating surplus. This was due to income for emergency care activity being significantly higher than expected although this had an adverse impact on elective activity. Pay expenditure had been less than plan as controls on temporary staff and the monitoring of permanent appointments was strengthened and non-pay expenditure had been controlled by a successful drive to achieve savings in this area.

The A & E activity had been highest on record. Referrals into the hospital were increasing and the Trust was challenged in delivering this activity. There was no additional ward capacity available. The possibility of the Trust purchasing home care beds continued.

MCo undertook to analyse how changes to the Trust's management of non-elective admissions could be profiled. MCo

The committee noted the Month 2 Finance Report.

6. TRANSFORMATION AND COST IMPROVEMENT

The Committee received the Transformation Plan Tracker Report for Month 2. In relation to the CIP target of £6.5m, 94% of savings had been identified. £529,000 of savings, mainly from MSK and CSFS were Red rated and a total of £1.65m were Amber rated at this stage. Benefits were arising from the Theatres and Outpatient Transformation Programmes with good leadership from the directorates.

Some income generation schemes were included as non-recurrent CIP. 42% of the schemes were listed as non-recurring.

The report indicated that the remaining £3m savings plan had yet to be identified.

The Committee noted the report.

7. OPERATIONAL PERFORMANCE REPORT

The Committee received the Month 2 report. Infection Control performance was on track, but the RTT/Incomplete Target had not been delivered in Month 2 but was ahead of the trajectory provided to regulators and commissioners and this was in part due to the junior doctors strike. Figures on 62 Day Cancer Waits were subject to verification but were indicating this had not been met in Month 2. The Trust had delivered 94.1% in relation to the ED Four Hour Target.

The committee noted the Performance Report.

8. REPLICA 3D UPDATE

It was noted that progress continued to be made in the sale of Replica 3D shares back to the Trust.

9. REVIEW OF TERMS OF REFERENCE AND EFFECTIVENESS

The Committee received the Terms of Reference which were considered to be appropriate.

10. AOB – FINANCIAL POSITION 2016/17

A paper for discussion at the July Trust Board Seminar Day had been circulated by MCa and comments back to MCo were requested.

11. DATE OF NEXT MEETING

Monday 25 July 2016 at 9.30 am.

TRUST BOARD

FINANCE & CONTRACTING REPORT TO 30th June 2016

SFT 3798

1. Introduction

This paper outlines the main drivers behind the SFT Group consolidated financial position for the period ending 30th June 2016.

The Income & Expenditure (I&E) position was a Year-to-Date (YTD) deficit of £83k (after adjusting for donated income and 'sustainability & transformation' funding), a favourable variance against the plan of £1,403k, and an in-month surplus of £212k.

Summary of Key Financial Information	Year to Date (YTD)			
	Plan £000s	Actual £000s	Var £000s	Var %
Income	51,044	51,850	806	1.6%
Expenditure	50,500	50,111	389	0.8%
EBITDA	**544**	**1,739**	**1,195**	**219.7%**
Finance and Depreciation Costs	3,605	3,525	80	2.2%
I+E Surplus /(Deficit) excl donated income & STF	**-3,061**	**-1,786**	**1,275**	**41.7%**
Donated Asset Income Adjustment	0	128	**128**	
Sustainability & Transformation Fund	1,575	1,575	**0**	
I+E Surplus /(Deficit)	**-1,486**	**-83**	**1,403**	**94.4%**
Favourable Variances are shown as +ve				

The main reasons for the favourable variance were:-

- The continued over-performance on NHS commissioner contracts particularly for non-elective activity, outpatient attendances and critical care days. There was one exceptional patient who was discharged in June and had accrued an excess bed day charge of £88k.
- A donation of £128k for capital purchase which was not anticipated until September.
- However, there was an increase in agency spend which has resulted in the Trust exceeding its YTD control total by £224k (14%). This was as a result of continuing significant operational pressures and the need to keep open all escalation beds.

2. Sales

NHS activity revenue was £44,664k (excluding sustainability & transformation funding) which was £532k above the plan. Resilience funding from Wiltshire CCG has been included in this position although no formal agreement has yet been signed.

Contract Activity Performance 2015/16 (June 2016)	Actual 2015-16	Actual 2016-17	Plan 2016-17	Year on Year Variance	Plan Variance
Elective inpatients	1,407	1,312	1,327	-95	-15
Elective PSDs/day attenders	5,594	5,702	5,629	108	73
Regular Day Attenders	1,852	2,351	1,693	499	658
Non Elective Inpatient	6,551	6,899	6,511	348	388
Outpatient initial attendances	16,577	17,530	15,111	953	2,419
Outpatient follow-up attendances	27,428	28,975	25,430	1,547	3,545
Outpatient procedures	8,839	9,243	8,360	404	883
A&E attendances	11,451	11,896	11,509	445	387
Favourable Variances are shown as +ve					

- Elective spells were up by 15 against plan but down on the year on year comparison by 95, with notable reductions in Plastics and Gynaecology. The under-performance was due to a lack of capacity with procedures being cancelled due to non-elective pressure on beds.
- Day Cases were up by 74 against plan and by 108 year on year mostly in Urology, Colorectal surgery Trauma & Orthopaedics and Ophthalmology.
- Non-Elective activity has over-performed by 388 spells against plan with activity up against A&E, General Medicine, Trauma & Orthopaedics and Gynaecology.
- Overall Outpatient attendances were up by 2,904 against when compared to last year.
- A&E activity was up against plan by 387 attendances.

Other income was ahead of plan by £273k due partly to the reclassification of NHS Clinical income to non-NHS clinical income.

3. Cost of Sales including indirect costs

The total YTD net expenditure for all Directorates was £43,702k, resulting in an adverse variance of £98k. The position is summarised below:

Directorates	In Month			Year to Date		
	Plan	Actual	Var	Plan	Actual	Var
	£000s	£000s	£000s	£000s	£000s	£000s
Medicine	3,742	3,808	(66)	10,773	11,015	(242)
Musculo Skeletal	2,559	2,469	90	7,351	7,185	166
Surgery	3,113	3,115	(2)	9,048	9,169	(121)
CSFS	3,227	3,267	(40)	9,643	9,746	(103)
Facilities	373	360	13	1,132	1,038	94
Corporate	1,776	1,802	(27)	5,657	5,549	108
TOTAL	**14,790**	**14,821**	**(32)**	**43,604**	**43,702**	**(98)**

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 main drivers of the overall Directorate's adverse variance are:-
- Non delivery of target savings.
- The premium cost of agency staff to cover vacancies.

4. Cost Improvement Plan

After three months of the financial year the Trust achieved YTD savings and Income Generation schemes of £1,290k against a plan target of £1,221k a favourable variance of £69k. It is recognised the CIP programme is back loaded and therefore on a straight line basis the Trust would be £1,085k (54%) below where it should be.

At the time of preparing this report, unidentified schemes relating to the £6.5m distributed target amount to £449k (6.9%). Clinical Directorates & Corporate Services continue to work on developing schemes and finalising the deliverability of key project milestones and the monthly phasing of savings.

5. Statement of Financial Position

Overall the working capital position (current asset less liabilities) was better than plan by £3,873k mainly due to a higher than expected cash balance and lower than expected creditors.

6. Cash

The consolidated cash position at the end of the first quarter was ahead of plan by £2m. This is primarily due to the consolidation of the £2.25m held in the SSL bank account, which was included as an investment in the plan on the basis that a joint venture agreement would be in place at this time.

The Trust's cash flow forecast excludes any sums for subsidiary companies or joint venture with SSL. The cash reflects the actual position for the first three months of the year and a forecast for the remaining nine months. It is based on a number of assumptions; some of the key ones are as follows:-

- NHS income is based on contract values and no extra income has been included for additional activity which may be received in the year.
- It is assumed the Trust will receive the full £6.3m Sustainability and Transformation Fund, which will be paid in July, October, January and March.
- Although the Trust has applied to the ITFF for a £6m loan towards the EPR project, this funding has yet to be approved and no income is included for this loan.
- Expenditure is based on known figures wherever possible and best estimates if these are not available.
- Capital expenditure for the year is forecast to exceed the source of funding available if the loan from the ITFF is not available.

The Trust will continue to monitor the cash flow position on a daily basis to highlight any potential requirements for additional funding.

7. Capital Expenditure

Expenditure was £1,981k which was ahead of plan by £258k although expected to be on plan by the end of the year.

8. NHS Commissioner Contracts

The contracts for Wiltshire and Dorset CCGs have been signed and the CQUIN schemes have now been finalised.

The contract with West Hampshire and Associates has not been signed. Local CQUINs remain an area of discussion.

The Trust has signed the Specialised Services contract but discussions are ongoing with regards to elements of the information schedule. The CQC recommendations in relation to the Spinal service have been reflected in the contract with an agreement to jointly review the service.

The Trust issued Wiltshire CCG with an Activity Query Notice in relation to A&E and non-elective activity which is significantly above the contracted level. A meeting was held on 19th July. A 14 point action plan has been agreed with the commissioner. A follow up meeting between executives of both organisations and senior management from the Local Council will take place within the next month.

A similar notice has been served on West Hampshire CCG due to overperformance and the meeting is due to be held shortly. In both cases the intent is to comply with the contract and ensure that any overperformance is paid for.

The April and May activity challenges have been recently received. The Interventions Not Normally Funded (INNF) challenge equates to a value of £95k, of which £12k relates to the use of Botox in Urology where prior approval has not been sought and this will now be a loss of income for the Trust. There remains an issue surrounding the management of skin excisions within the Plastics and Dermatology services which still has not been fully resolved.

The NHS England impact assessment exercise which has now been completed and will be used to develop a shadow performance monitoring tool that is due to be published at the end of September. The impact assessment for the Genetics service was submitted by the deadline but it raises more questions than answers.

9. Risks

The Trust's key financial risks for 2016/17 can be summarised as follows:

- Deliver the CIP target of £9.5m; this is the greatest financial challenge;
- Deliver performance trajectories to secure Sustainability & Transformation funding;
- Meet contractual obligations and avoid penalties;
- Delivery of CQUIN targets;
- Unplanned growth of non-elective activity which has a detrimental impact on elective work:
- Matching capacity to demand in the most cost effective way in order to avoid losing work to local competitors.

10. Other Issues

NHSI is consulting on a replacement for the Risk Assessment Framework and has issued a document called the 'Single Oversight Framework' for consultation. There are a large number of questions about how this will work in practice but the aim is to have one framework covering: quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability. By the time of the meeting a response to the consultation will have been submitted.

A separate substantial document has also been received from NHSI called 'Strengthening Financial Performance and Accountability in 2016/17' which is a reaction to the deteriorating financial position of the provider sector. The document reiterates responsibilities and covers a number of issues such as:

- Targeting areas for savings such as: pay-bill growth, back office and pathology consolidation, and the consolidation of unsustainable services.
- Introduction of capital controls which may further restrict Trust freedoms.
- Reiteration of control totals and confirmation of whether they are agreed.
- Operational performance trajectories.
- Access critieria for obtaining money from the Sustainability and Transformation Fund.
- Tackling financial failure through special measures

The Trust has responded as required and will work on the paper's requirements with other partner organisations.

11. Conclusions

The Group reported position for June was a deficit of £83k giving a favourable variance of £1,403k against plan.

The Trust's risk rating score is currently 3.

12. Recommendation

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

Malcolm Cassells
Director of Finance
29 July 2016

Appendix A - SUMMARY STATEMENT OF COMPREHENSIVE INCOME

	In month			YTD (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Operating Income						
NHS Clinical Income	13,896	13,706	(190)	40,328	40,684	356
High cost drugs income	1,268	1,431	163	3,804	3,981	177
Other Clinical Income	399	659	260	1,768	1,729	(39)
Research & Development & Education	541	544	3	1,599	1,635	36
Other (Excluding Donated Asset income)	1,155	1,351	196	3,545	3,821	276
TOTAL INCOME	**17,259**	**17,691**	**432**	**51,044**	**51,850**	**806**
Operating Expenditure						
Pay - In post (includes bank & locums)	10,537	10,364	173	31,801	31,441	360
Pay- Agency	535	695	(160)	1,611	1,835	(224)
Drugs	1,576	1,713	(137)	4,731	4,691	40
Clinical Supplies & purchase of healthcare	2,149	2,083	66	6,007	6,004	3
Non-Clinical Supplies	540	564	(24)	1,659	1,563	96
Other (incl PFI unitary charge)	1,539	1,535	4	4,691	4,577	114
TOTAL EXPENDITURE	**16,876**	**16,954**	**(78)**	**50,500**	**50,111**	**389**
EBITDA (Earnings Before Interest, Tax, Depreciation & Amortisation)	**383**	**737**	**354**	**544**	**1,739**	**1,195**
Financing Costs	1,204	1,178	26	3,605	3,525	80
SURPLUS / (DEFICIT) excluding donated income & STF	**-821**	**-441**	**380**	**-3,061**	**-1,786**	**1,275**
Donated Asset Income	0	128	128	0	128	128
Sustainability & Transformation Fund	525	525	0	1,575	1,575	0
SURPLUS / (DEFICIT)	**-296**	**212**	**508**	**-1,486**	**-83**	**1,403**

Appendix B - CAPITAL EXPENDITURE

Project Name / Category	Approved Annual Plan 16/17 £000s	Agreed Changes 2016/17 £000s	Slippage to 2017/18 £000s	Revised Annual Plan 2016/17 £000s	YTD spend (June 2016) £000s	Anticipated Under/(Over) spent on Projects £000s
Donated Assets						
Bariatric Bed	11,140	0	0	11,140	0	
Clinical Radiology 2 x Ultrasound	17,700	0	0	17,700	0	
Orthodontics & Oral Surgery Cone Beam CT Scanner	110,000	0	0	110,000	0	
Small Donated Additions	0	127,772	0	127,772	127,772	
Donated Assets - Totals	**138,840**	**127,772**	**0**	**266,612**	**127,772**	**0**
Phase 3 Building Schemes						
Breast Unit enabling	10,194	0	0	10,194	160,153	(149,958)
CT Scanner Building and Enabling	9,013	0	0	9,013	0	
Laverstock Ward (Decant Ward Project)	354,720	0	0	354,720	474	
SAU Refurb (Decant Ward Project)	88,147	0	0	88,147	75,122	
Maternity development	354,712	0	0	354,712	16,488	
Radnor Ward Development	12,594	0	0	12,594	0	
SDU Development	30,338	0	0	30,338	2,676	
Springs entrance development	1,228,718	-1,228,718	0	0	0	
Ward changes - Dementia Patient Care	1,457	0	0	1,457	81	
Building Schemes - Totals	**2,089,894**	**-1,228,718**	**0**	**861,176**	**254,993**	**(149,958)**
Building and Works						
Accommodation H&S Work	40,000	0	0	40,000	0	
Accommodation Boilers (Wylye House & Victoria Drive)	80,000	0	0	80,000	0	
Accommodation replacement of kitchens and bathrooms	46,850	0	0	46,850	20,910	
Accommodation Roof Repairs (Compton & Langley)	60,000	0	0	60,000	0	
AHU replacement yr 4 (2016/17) of 7	170,596	0	0	170,596	43,744	
Asbestos management	17,776	0	0	17,776	0	
Avon and Bourne Boiler Replacement	52,000	11,532	0	63,532	0	
BMS upgrade	44,023	0	0	44,023	0	
Car park machinery replacement	10,071	37,000	0	47,071	0	
Catering Changing Area	19,000			19,000	0	
Catering Dishwasher	49,066	0	0	49,066	0	
Catheter Suite - Rebalance of Heating System	6,048	0	0	6,048	0	
Central booking relocation - block 79 (Wilton ward)	101,439	0	0	101,439	26,332	
DSU Roof Repairs	5,822	0	0	5,822	0	
DSU Salto	13,668	0	0	13,668	890	
Ductwork & Fire Damper Cleaning Whole Site	129,483	0	0	129,483	7,564	
Electricity at Work Regulations Compliance	84,239	0	0	84,239	3,554	
Estates health and safety	4,725	0	0	4,725	1,910	
Estates - Oracle software interface	24,000	0	0	24,000	0	
Fertility Centre Upgrade	15,000	0	0	15,000	0	
Fire compartmentation SDH north - remedial works	18,271	0	0	18,271	0	
Fire Door Compliance	40,000	0	0	40,000	0	
Flooring Replacement	40,534	0	0	40,534	0	
General laboratory replacement autoclave and Mortuary Disinfector	54,075	0	0	54,075	44,225	
Genetics Cooling	36,000	0	0	36,000	0	
Genetics Modular cold room	0	0	0	0	0	
Helipad Temporary Parking	0	17,870	0	17,870	0	
Hillcote Sale Costs	0	0	0	0	0	
Hospice and Finance Fire Alarms	45,295	0	0	45,295	350	
Lab Medicine Cold Room	0	0	0	0	2,049	(2,049)

Project Name / Category	Approved Annual Plan 16/17 £000s	Agreed Changes 2016/17 £000s	Slippage to 2017/18 £000s	Revised Annual Plan 2016/17 £000s	YTD spend (June 2016) £000s	Anticipated Under/(Over) spent on Projects £000s
Level 4 Bed space Power Sockets	41,610	0	0	41,610	0	
Lifts overhaul - year 3 (2014/15) of 3	40,488	0	0	40,488	3,392	
Main boiler burners	5,549	-5,549	0	0	0	
Main Entrance L3 Upgrade	5,807	0	0	5,807	0	
Maternity Obstetric Theatre Refurbishment	1,030	0	0	1,030	0	
Maternity Post Natal Upgrade	6,437	0	0	6,437	0	
Mattress Laundering	2,521	0	0	2,521	0	
Medical Gas Hoses 2nd year of 2 (2015/16)	147,000	0	0	147,000	0	
MSK Notes Preparation	6,500	0	0	6,500	0	
Nurse Call System Upgrade - SDH North & Maternity - 2nd year of 2	123,167	0	0	123,167	0	
OHSS replacement windows	5,270	0	0	5,270	2,055	
Old GUM Clinic Demolition	10,449	0	0	10,449	0	
Pathology - air tube upgrade	4,119	0	0	4,119	0	
Pathology - conversion of computer room to office	12,000	0	0	12,000	0	
Pathology Reception	6,370	0	0	6,370	0	
Pharmacy Cold Room	10,000	0	0	10,000	0	
Powered Door Curtains Level 2	30,000	-15,000	0	15,000	0	
Productive Operating Theatres	18,542	0	0	18,542	0	
Public & Staff WCs L5,L4,L3	53,357	0	0	53,357	97	
Public Spaces Fund	12,441	0	0	12,441	0	
Roads and paving repairs	214,259	0	0	214,259	0	
Sarum Ward Play deck	0	7,000	0	7,000	0	
SDH North Drain Survey	4,999	0	0	4,999	0	
Server Rooms - Air Conditioning	16,890	0	0	16,890	0	
Shower Cubicle Drainage Improvements	17,693	0	0	17,693	5,383	
Site Signage	7,517	0	0	7,517	287	
Spinal Boiler Replacement & Associated Pipework	5,983	-5,983	0	0	0	
Spinal treatment centre refurbishment	16,306	0	0	16,306	3,865	
Spinal Unit Doors and Locks	4,282	0	0	4,282	59	
Springs servery upgrade - floor and freezers only	75,000	0	0	75,000	0	
Taps & IPS panels - site wide	48,056	0	0	48,056	3,314	
Water Safety	42,000			42,000	0	
Water tanks access - main tanks only	30,000	0	0	30,000	0	
Building Projects/Building and Works Totals	**2,233,620**	**46,870**	**0**	**2,280,491**	**169,978**	**(2,049)**
Information Technology						
Alternative to Microsoft products - review	75,000	0	0	75,000	0	
Blades	193,000			193,000	0	
Blood Tracking Phases 1 - 3	185,945	0	0	185,945	46,677	
BMS Network Upgrade	987	0	0	987	1,771	(784)
Brocade Switch Replacement	5,004	0	0	5,004	0	
CALS	200,000			200,000	0	
Catering Cash Register Replacement	4,400	0	0	4,400	460	
Citrix Support	102,276	0	-68,184	34,092	0	
Community Midwifery system trial	29,244	0	0	29,244	0	
Connectivity Upgrade for Warminster & Shaftesbury	19,023	0	0	19,023	13,647	
Data Warehouse (16/17 bid)	175,000	0	0	175,000	0	
EEG Neurophysiology Review Software	5,000	0	0	5,000	0	
Electronic Letters	14,617	0	0	14,617	0	
EPMA	405	0	0	405	0	405
EPR Contingency	0	0	0	0	83,866	(83,866)

Project Name / Category	Approved Annual Plan 16/17 £000s	Agreed Changes 2016/17 £000s	Slippage to 2017/18 £000s	Revised Annual Plan 2016/17 £000s	YTD spend (June 2016) £000s	Anticipated Under/(Over) spent on Projects £000s
EPR Lines	11,000	0	0	11,000	0	
EPR Network Resilience	0	87,000	0	87,000	20,882	
EPR Implementation Costs	-170,248	1,891,500	0	1,721,252	363,007	
EPR Hardware	-188,526	650,000	0	461,474	243,370	
EPR Data Warehouse	0	224,200	0	224,200	36,600	
EPR Supplier Costs	0	1,570,200	0	1,570,200	0	
EPR Scanning	0	932,000	0	932,000	0	
Genetics - software upgrade	7,836	0	0	7,836	0	
Genetics High Spec Analysis Equipment & Software	29,405	0	0	29,405	0	
Histopathology Hardware	10,773	0	0	10,773	0	
IBD register	8,951	0	0	8,951	0	
In-house development team - applications, databases and Dashboards (subject to bus case)	101,465	0	0	101,465	24,887	
Maintenance renewal - estimate	38,034	0	0	38,034	28,410	
Mobile Computing	8,772	0	0	8,772	936	
Mortuary module	52,000	0	0	52,000	0	
Network Unsupportable	24,000	0	0	24,000	0	
Network Upgrade Consultancy	129,774	0	0	129,774	14,386	
Ophthalmology System	140,926	0	0	140,926	39,330	
Order Comms (includes System Admin Bid & Sexual Health Bid)	15,265	0	0	15,265	0	
PACS	116,873	-54,000	0	62,873	0	
PACS ED Machines	0	54,000	0	54,000	0	
Palliative Care EPR	39,437	0	0	39,437	0	
PAS 2016 Replacement - Consultancy Costs	780	0	0	780	0	
Patient Observations Monitoring and Decision Support/Early Warning System/POET	0	0	0	0	1,515	(1,515)
Radiology - OrderComms	36,117	0	0	36,117	0	
Replace 6509x3 network hubs	67,479	0	0	67,479	0	
Reporting System	3,570	0	0	3,570	0	
Results System in GP Practices 'Review' System	10,079	0	0	10,079	0	
SAN Storage	210,000	0		210,000	0	
SBAR Cardiology DICOM Migration	45,100	0		45,100	0	
SBAR for PAS	2,476	0	0	2,476	0	2,476
SBAR re NACS Update to ED Symphony	7,500	0	0	7,500	0	7,500
SBAR re UPS Replacement (formerly UPS Replacement - Room based for Computer Rooms)	21,150	0	0	21,150	0	
Telecoms Voice Over IP - invest to save (non clinical areas - subject to a telephony strategy)	189,543	0	0	189,543	35,460	
Telepath enhancements	3,505	0	0	3,505	0	
Telepath to CSCLims (Phase 3 / Year 4 of 4 2016/17)	150,000	0	0	150,000	0	
TMG-UAG	15,000			15,000	0	
UPS Replacement Programme	34,132	0	0	34,132	2,160	
Whiteboards	208,320	0	0	208,320	34,216	
XML for Pathology COSD Submission	11,900	0	0	11,900	0	
Information Technology Totals	**2,402,290**	**5,354,900**	**-68,184**	**7,689,006**	**991,580**	**(75,784)**
Medical Devices						
ANC Ultrasound (GROW Programme)	80,000	0	0	80,000	0	
Bariatric Bed (2016/17 bfwd)	346	-346	0	0	0	
BED replacement programme - 4th (2016/17) yr of 4	58,996	0	0	58,996	0	
Cone Beam CT Scanner Enabling Works	0	43,402	0	43,402	0	

Project Name / Category	Approved Annual Plan 16/17 £000s	Agreed Changes 2016/17 £000s	Slippage to 2017/18 £000s	Revised Annual Plan 2016/17 £000s	YTD spend (June 2016) £000s	Anticipated Under/(Over) spent on Projects £000s
DSU Camera Stack	98,000	0	0	98,000	0	
DSU Ophthalmic Microscope	120,000	0	0	120,000	0	
General x-ray machine - Westbury - radiology	99,000	0	0	99,000	0	
Genetics DNA Extractor	77,000	0	0	77,000	0	
Genetics Cytology Ozone Free Hood	0	21,500	0	21,500	19,036	
Grouped Items 2015/16	1	0	0	1	6,477	(6,476)
Grouped Items 2016/17	100,000	0	0	100,000	28,426	
Maternity Theatre Equipment	26,014	0	0	26,014	0	
Medical Equipment <£50k 14/15	26,400	0	0	26,400	0	
Medical Equipment <£50k 15/16	11,635	0	0	11,635	0	
Medical Equipment <£50k 16/17	231,780	0	0	231,780	72,671	
Powered Patient Trolleys	0	0	0	0	0	
Radiology Lead Aprons	30,000	0	-20,000	10,000	0	
Radiology Room 2 Replacement	228,000	0	0	228,000	0	
Radiology Room 11 Ultrasound Replacement	80,000	0	0	80,000	79,824	
Refrigerated Centrifuge	444	-444	0	0	0	
Rigid hysteroscopy x 4 plus stack	3,561	0	0	3,561	0	
Ringwood Ophthalmology Equipment	50,000	0	0	50,000	0	
Scopes	32,153	0	0	32,153	0	
Spinal Hoists	37,574	0	0	37,574	0	
Static and Pressure Relieving Mattresses	22,209	0	0	22,209	0	
Theatre Instrumentation Replacement Programme	773,355	0	0	773,355	199,771	
Thermometer Data Loggers	12,958	0	0	12,958	12,444	
VAC Therapy Machines	3,600	0	0	3,600	3,600	
Video scopes x2 - main theatres	50,000	0	0	50,000	0	
Medical Equipment Totals	**2,253,026**	**64,112**	**-20,000**	**2,297,138**	**422,249**	**(6,476)**
Other						
Bed Stacking	36,494	0	0	36,494	13,759	
Car Park Machinery	37,000	-37,000	0	0	0	
Catering Boiling Pan	15,000	0	0	15,000	0	
Cold Servery Counters	70,000	0	0	70,000	0	
Demand Response Generator Conversion	178,920	0	0	178,920	0	
Efficiency schemes	222,170	-109,000	0	113,170	0	
Finance systems	90,000	0	0	90,000	0	
LED Lighting	30,737	0	0	30,737	0	
Lightning Repairs	0	0	0	0	0	
Outpatient Kiosks	65,953	0	0	65,953	0	
Photovoltaics' / Solar thermal PV	17,683	0	0	17,683	0	
Portering Bed Movers	0	0	0	0	0	
Procurement Tug 2015/16	2,050	0	0	2,050	0	
Project costs	25,529	0	0	25,529	0	
Scan4Safety (GS1)	0	109,000	0	109,000	0	
Security	40,000	0	0	40,000	525	
Telecoms Trunk Lines	8,280	0	0	8,280	0	
Theatres Storage and Trolleys	2,580	0	0	2,580	0	
Ward Waste Bins	60,643	0	0	60,643	0	
Other Totals	**903,040**	**-37,000**	**0**	**866,040**	**14,284**	**0**
Trust Totals	**10,020,711**	**4,327,936**	**-88,184**	**14,260,463**	**1,980,856**	**(234,267)**

Trust Board meeting

SFT 3799

MONTH 3 OPERATIONAL PERFORMANCE REPORT

Date: 2nd August 2016

Report from: **Andy Hyett, Chief Operating Officer**

Presented by: **Andy Hyett, Chief Operating Officer**

Executive Summary:

Operational pressures resulted in the trust failing to deliver the referral to treatment standard and ED standard for Month 3. Infection control and diagnostic standards were met.

Emergency Pathway

The trust failed to deliver the ED standard in Month 3, with 92.8% of all patients being admitted or discharged within 4 hours.

During this period escalation capacity was opened to manage emergency flow and clinical teams in ED and AMU reported an increase in the acuity of patients presenting in addition to high numbers of attendances. This is reflected in the attendance numbers with 3940 patients attending in June compared to 3806 in the same period last year and more significantly 674 patients attending through the Majors pathway compared to 499 for the same period last year.

Actions to increase capacity and decrease demand outlined at the previous board meeting are being followed through

RTT

In order to manage the significant increase in non elective admissions a high number of elective procedures have been cancelled. This has directly resulted in the failure of the RTT incomplete standard delivering 90.1% against a standard of 92%.

Diagnostic

The trust is continuing to work to decrease diagnostic waiting times further. The trust has seen a significant increase in request for diagnostic tests and particularly imaging. However the trust has maintained delivery of the diagnostic standard

Cancelled Operations

Unfortunately a high number of elective procedures have been cancelled as a direct result of the impact of high medical admissions. All attempts are being made to limit this impact and all cancelations are being managed by clinical priority.

Cancer

Whilst the trust failed to deliver the Symptomatic Breast Cancer two week wait standard in June all standards were delivered for Q1. Of the 22 patients that breached 18 were due to patient choice.

Links to Assurance Framework/ Strategic Plan:

Choice – Ensuring deliver key of performance targets to encourage patients in choosing to be treated locally at SFT as a provider of high quality care and ensuring that intervention by regulators is not required

Appendices: Appendix 1. Trust Board Performance Report – June 2016

Salisbury Hospital NHS Foundation Trust Board Report June 2016

			Reporting Month		Rolling 12 months
Metric Name	**National Ceiling / Standard**	**Local Trajectory**	**Jun-16**	**Patients Affected in Jun-16**	**Trend Against National Standard**
Referral to Treatment Incomplete Performance	92%	92.01%	**90.1%**	1,362	
Referral to Treatment Incomplete Specialty Compliance	16 out of 16		**9 out of 16**		
Zero tolerance RTT waits > 52 weeks	0	0	0	0	
A&E - Time in A&E department	95%	95.18%	**92.8%**	310	
12 Hour Trolley Waits	100%		100%	0	
Diagnostics - Patients waiting longer than 6 weeks	99%	99.5%	99.0%		
Diagnostic Test Compliance	14 out of 14		**9 out of 14**		
Urgent Ops Cancelled for 2nd time (Number)	0		0		
Mixed Sex Accommodation Breaches	0		**12**		
Infection control – Clostridium difficile (YTD)	6		Total for Fiscal Year = 3	1	
Infection control - MRSA*	0		0		
Metric Name	**National Ceiling / Standard**		**Jun-16**	**Patients Affected in Jun-16**	**Trend Against National Standard**
All Cancer two week waits	93%		93.9%	42	
Symptomatic Breast Cancer - two week waits	93%		86.0%	22	
31 day wait standard	96%		99.1%	1	
31 day subsequent treatment : Surgery	94%		97.1%	1	
31 day subsequent treatment : Drug	98%		100.0%	0	
62 day wait standard	85%	92.5%	90.5%	6	
62 day screening patients	90%		91.3%	1	
62 day patients waiting first definitive treatment after Consultant upgrade	85%		100.0% (Mar-16)	0 (Mar-16)	
Cancer 104 Day Waits**	0		0	0 (Apr-16)	

Cells with black dotted outlines indicate provisional data

*Please note: MRSA is no longer monitored by Monitor

**This excludes patients transferred to another Provider and now exceed 104 days

Major Projects Report

Date: August 2016

Report from: **Laurence Arnold, Director of Corporate Development**
Presented by: **Laurence Arnold**

Executive Summary:

The Major Projects Report reflects the complexities of a number of the key projects which the Trust is currently engaged in. It describes the nature of four transformational projects which cover:

- **IT/technology (EPR and GS1) and the adaptive impact on the organisation**
- **a joint venture to improve the responsiveness and efficiency of sterilisation services, and**
- **Wiltshire Health & Care went live on 1st July and the first formal Board meeting took place on 21st July**

Proposed Action:
To note the report.

Links to Assurance Framework/ Strategic Plan:
Value – "We will be innovative in the use of our resources to deliver efficient and effective care, eg be[ing] innovative in our use of technology to make the organisation more effective."
Choice – "provide a comprehensive range of high quality local services enhanced by our specialist centres"

Appendices:

Supporting Information

Introduction

The Trust is engaged in a number of high profile and organisational wide projects which will consume considerable resources during the next twelve months. The purpose of this paper is to provide the Board with assurance around how those projects are progressing and to ensure the intended deliverables are being realised. The projects included are:

- Electronic Patient Record
- The GS1 initiative
- Wiltshire Health and Care management of community services – now operational
- Joint venture to provide a sterilisation and disinfectant unit (SDU)
- Organisational development impact – a draft strategy and action plan has been discussed at Executive Workforce Committee in June and the Board in July

Summary

Salisbury NHS Foundation Trust

Project	Lead	Status	Workstreams	Summary
EPR	LA	Improving at Amber	7 x green 5x amber	**Go live due weekend of 28/10 – currently on track.** Detailed planning underway – configuration moving into testing. Increasing communication around the organisation. Improving progress with data warehouse
Scan for Safety	MC (LW)	Stable at Green	4 x green	Phase 1 completed and Phase 2 in Progress – Implementation to start for August
Wiltshire Health & Care	LA	Stable at Green		New service operational from 1st July
SDU	MC	Improving at Green	3 x green	Positive engagement with private provider. Initial consultation with SDU staff now ended. Subject to final agreement of commercials and confirmation of service specification staff transfer will proceed on 1st September

Salisbury NHS
NHS Foundation Trust

Electronic Patient Record (EPR)

To provide an electronic record of patient activity, visible across the organisation allowing real-time interaction and ensuring that information can be acted on immediately, improving efficiency and safety of care provided.

Workstream	Status	Trend	Actions
Infrastructure	Amber	Improving	Infrastructure roll catching up with schedule.
Configuration	Amber	Stable	Significant work underway on letter templates
Integration	Amber	Stable	Good progress continues, with majority in place for testing. Work starting on R&R interface development
Data migration	Green	Stable	Trial load 2 validation generally positive
Data warehouse	Amber	Improving	Good progress continues with additional workforce

Electronic Patient Record (EPR)

Salisbury NHS Foundation Trust

Workstream	Status	Trend	Actions
Business change	Green	Stable	Communication activity significantly increased. Operational processes for training non-substantive staff underway
Benefits	Green	Reducing	Further interim 'Benefits Review' to reflect impact of delay in R&R and phase 2 modules
Role based access	Green	Improving	Card issued to just over 50% of total of about 2,900 staff
Training	Green	Stable	Developing training materials and detailed plan. Courses now being booked
Requests & Results	Amber	Stable	Catalogue loaded, interface being tested
Validation	Green	Stable	Testing of trial load 2 complete. Business process validation starts August
Cutover planning	Green	Stable	High level plans in place. Resource requirements identified. Costings being prepared.

Scan for Safety

Salisbury NHS Foundation Trust

To introduce GS1 standards to provide a consistent means of identifying and tracking patients, equipment, medications, equipment and locations across the Trust.

Workstream	Status	Trend	Actions
Global location numbering	Green Phase 1 Complete	Stable	4411 (84% of Trusts') GLNs now assigned. GLN summary document completed. 'Locations Group' set up on monthly basis
Catalogue management	Green Phase 1 Complete	Stable	Detailed gap analysis complete and recommendations made. Work underway with other demonstrator sites to develop this further Master Data Management
Patient identification	Green Phase 1 Complete	Stable	Mio device selected and in development for scanning use with POET/Blood hound. 'Safer Care' workshops booked in July with key SFT clinical stakeholders to map points of possible patient ID
Purchase to pay/Inventory	Green Phase 1 Complete	Stable	Review of 'as-is' P2P processes now complete, all areas across SFT visited and final processes being verified and signed off by key stakeholders in these areas.

SFT, together with RUH Bath and GWH Swindon Trusts, has successfully tendered to be the provider of adult community services across Wiltshire. A limited liability joint venture will be established to enable the three organisations to manage the services and to aid the integration of services across acute and community settings. The service went live 1st July.

- The inaugural Board meeting took place on 21st July
- WH&C have identified 6 priorities for 16/17:
  - ❶ Higher intensity care managed in the community
  - ❷ Early supported stroke for stroke patients
  - ❸ Health coaching
  - ❹ Musculo-skeletal physiotherapy provision in the community
  - ❺ Development of urgent care centres
  - ❻ Mobile working
- Detailed planning underway for ❶ and ❷with good engagement from SFT clinical staff
- Developing clinical and operational links within the southern locality
- Reporting links into Board to be via the Finance Committee with reports to other Board sub-committees as appropriate

SDU Joint Venture

To establish a joint venture to provide sterile services with a private provider from a standalone facility on SDU South to develop as a local market leader in the provision of sterile services.

Workstream	Status	Trend	Actions
Commercial	Green	Improving	JV agreement , leases and service contract being finalised with the signing due by mid August
Workforce	Green	Stable	Consultation with staff completed and went well. Transfer of staff – aiming for 1st September subject to commercial agreement
Facility design	Green	Stable	Space being freed up ready for expected demolition to begin in mid September

Annual Report of the Remuneration Committee 2015/16

This is the 20th annual report on the work of the Remuneration Committee and covers the period 1 July 2015 to 31 July 2016. The report describes the process agreed by and followed by Committee and presents any noteworthy points from the year's activity. Additional detail is included in the Remuneration section of the Annual Report 2015/16.

The Code of Governance states that remuneration "should be sufficient to attract, retain and motivate directors of quality and with the skills and experienced required…"

The Committee reviews all the Executive Directors' pay bands annually in relation to national benchmarks. Individual pay-points are reviewed in the light of exceptional performance.

The reward packages, as reviewed by the Committee, offered by the trust to executives benchmark economically against national comparators. In practice the Trust has been able to recruit executive directors on this basis. The Trust's policy is to engage its executive directors on permanent contracts of employment.

New director appointments are normally made at the bottom of the pay band. The Remuneration Committee has established a policy of giving a 3% increment to new entrants after two satisfactory years in post.

Executive Directors' individual business objectives are drawn from the Trust's Annual Plan and these are reviewed in totality by the Remuneration Committee.

The Chief Executive conducts the individual executive appraisals and reports to the Committee on each individual's director's performance and on any development initiatives. The Chief Executive withdraws from the Remuneration Committee meeting when the Chairman discusses the results of his appraisal.

In 2015./16, the committee has agreed a 1% pay increase for the executives for 2016/17 in line with the national Agenda for Change pay award. One executive director became eligible for consideration for the 3% increment, as described above, and this has been agreed. The processes described above have been carried out across three meetings and there are no other matters to bring to the board's attention.

SALISBURY NHS FOUNDATION TRUST
Minutes of the Audit Committee
Held on: 20 May 2016

SFT 3802

Present: Mr P Kemp (Chairman and Non-Executive Director)
Mr I Downie (Non-Executive Director)
Dr L Brown (Non-Executive Director)

In Attendance: Mr J Oldroyd (KPMG)
Mr J Brown (KPMG)
Mr D Seabrooke (Head of Corporate Governance)
Mr M Cassells (Director of Finance and Procurement)
Mr M Stabb (TIAA)
Ms A Nash (KPMG)
Mr A James (Financial Controller)
Ms L Wilkinson (Director of Nursing) for item 4
Mrs K Matthews (Non-Executive Director) - Observer

Apologies:

ACTION

1. MINUTES – 14 MARCH 2016

The minutes of the meeting of the Committee held on 14 March 2016 were agreed as a correct record.

2. MATTERS ARISING

The item on pre-employment checks would be brought to the 17 October meeting. **DS**

MC would be writing to staff to remind them of appropriate use of car parking payment mechanisms. **MC**

3. SUMMARY INTERNAL AUDIT PROGRESS REPORT

The Committee received the report giving details of the progress with the 2015/16 Annual Plan for Internal Audit.

The Committee noted the following completed reports and findings;

- Assurance Framework and Risk Management – reasonable assurance
- Temporary Staffing (nurse bank) – reasonable assurance
- Firewall Security – reasonable assurance
- Contract Income Management – substantial assurance
- Statutory Duty of Candour – substantial assurance
- Odstock Medical Limited – substantial assurance
- Controlled Drug and Drug Fridge Management – limited assurance

In relation to on-going audits the Committee noted that the update of the Patient Moneys and Property Policy would be completed by 31 August 2016.

The Estates Strategy would be renewed in February 2017. Committee Members had received a note from management setting out progress with the appointment of authorised persons and engineers in relation to the work of the Estates Department. It was agreed that at the July meeting there would be a general review of progress with internal audit recommendations. **DS/LA**

In relation to the Controlled Drug and Fridge Management Report it was noted that the field work had found inconsistencies with the record forms and their usage, in two instances the wrong type of fridge, some lack of knowledge on the part of ward staff as to the purpose and importance of recording and checking drugs fridges and in a number of cases gaps in the record of the daily check. It was noted also that the Clinical Governance Committee had discussed this issue.

There was disappointment that the report had found inconsistencies in the regular completion of the recording of temperatures. Lorna Wilkinson informed the Committee that the issues were being picked up via the Nursing and Midwifery Forum and that the Directorate Senior Nurses were undertaking weekly spot checks of temperature recording. The forms were being updated and redistributed as a reminder. The non-compliant fridges were being replaced. It was suggested that the importance of the daily checks were emphasised in local ward inductions for new starters. It was noted that the Clinical Governance Committee would continue to monitor progress.

The Committee noted the report.

4. ANNUAL AUDIT REPORT AND HEAD OF INTERNAL AUDIT OPINION

The Committee received the Internal Audit Annual Report. This was in summary providing reasonable assurance as to the adequacy and effectiveness of the Trust's internal control environment.

The report was noted.

5. EXTERNAL AUDIT REPORT (ISA 260) AND LETTER OF REPRESENTATION

The Committee received the External Audit Report and Jon Brown highlighted the following principal points –

- There was an unqualified audit opinion on the accounts
- There was a clean limited assurance opinion on the content of the Quality Report.
- There was one unadjusted audit difference relating to income from Great Western NHS Foundation Trust
- There were no public interest issues the auditors wished to raise.

In relation to the Limited Assurance Review of the performance indicators in the Quality Account the findings in relation to the Referral to Treatment Indicator and the supporting information were discussed. Testing had shown some issues around the accuracy of the data. The auditor was not able to provide a limited assurance opinion for the Referral to Treatment Within 18 Weeks because a number of variances were identified between the data record and the underlying source.

These differences were not considered to be material and where concerns had arisen the patient record had been reviewed in detail to provide assurance that no harm had arisen.

The Limited Assurance Opinion had been given in relation to A&E data and falls data.

In relation to recommendations raised and followed up recommendations one and two had been implemented and recommendations three and four had not been.

The Committee reviewed the Letter of Representation in connection with the Quality Report and the Director of Finance and Procurement confirmed that having regard to the statements contained in the letter, it could be signed and provided to the auditors.

6. DRAFT CONSOLIDATED FINANCIAL STATEMENTS FOR THE YEAR TO 31 MARCH 2016

The Draft Financial Statements had been circulated to the Trust Board and there were no issues arising from them in this meeting.

7. EXTERNAL ASSURANCE ON THE TRUST'S QUALITY REPORT 2015/16

The Draft Quality Report had been circulated in full to the Trust Board. The Audit Opinion was circulated to the Committee and was noted.

8. LOSSES AND COMPENSATION REGISTER

The Losses and Compensation Register was signed by the Chairman.

9. DATE OF NEXT MEETINGS

The next two meetings of the Audit Committee will be held on Monday 11 July 2016, and Monday 17 October 2016 at 10 am.

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 19th May 2016, 10am-12pm
Boardroom, Salisbury District Hospital

SFT 3803

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair) - Non-Executive Director
Dr Christine Blanshard - Medical Director
Claire Gorzanski – Head of Clinical Effectiveness
Hazel Hardyman – Head of Customer Care
Fiona Hyett - Deputy Director of Nursing
Steve Bleakley – Chief Pharmacist
Andy Hyett – Chief Operating Officer
Ian Downie - Non-executive Director
Samuel Williams – F1

In attendance:

Kate Williams	Minute taker
Jan Sanders	Governor
Gill Cobham	CGC051605 & CGC051617
Judy Cronan – Stroke Co-ordinator	CGC051607
Kirsty Anderson – Senior Sister, Farley Stroke Unit	CGC051607
Sarah Paterson – Physiotherapist, Farley Stroke Unit	CGC051607
Fenella Hill – Head of Risk Management	CGC051614, CGC051615, CGC051619 & CGC051620

CGC051601 Apologies:

Peter Hill - Chief Executive Officer
Lorna Wilkinson - Director of Nursing
Mark Stabb – Head of TIAA
Steve Long - Non-executive Director
Hollie Foreman – Staff Nurse, Laverstock

Welcome:

Steve Bleakley – Chief Pharmacist
Samuel Williams – F1

CGC051602 – Minutes of the meetings held on 25th February 2016 and 24th March 2016

The minutes were approved by the committee.

CGC051603 – Matters Arising / Action Tracker

Action Tracker items are either on today's agenda or are scheduled to be heard at a future meeting.

CGC051604 – Action Tracker – Nursing, Midwifery and AHP Strategy update – Fiona Hyett

- The Nursing, Midwifery and AHP Strategy was approved by the Clinical Governance Committee in 2015. This was a revised document with changes made following feedback from staff.
- The Strategy has since been widely disseminated and printed in an A5 leaflet with copies for all staff
- The report provides key headlines on progress with the agreed 2015/16 priorities
- All action areas are making progress although many workstreams are long term hence

most areas currently amber
- Individual team and department progress against the Strategy will be celebrated once again through a Pride in Practice event in March 2017
- A national Nursing Strategy is being launched on May 18th by the CNO and this will inform the 2016/17 priorities

Copies of the A5 leaflet will be made available to the committee.

CGC051605 – Action Tracker – Learning Disabilities end of Year Report – Gill Cobham

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Key achievements:

- LD Audit demonstrated good care, with reasonable adjustments being made
- Safeguarding Champions launched
- LD Workshop

GC reported on progress made in this area. There has been a real success in flagging patients with a learning disability on PIMS. The working group in January this year was well attended. A checklist to support admissions is to be developed in 2016/17. There are still challenges regarding communication but this is being addressed. A workplan has been put together for 16/17. CB requested that an improved system for obtaining the historical records of patients with a learning disability be put in place to assist in necessary reviews. There will be a crossover of learning between pharmacy / dementia care / learning disability care.

LB noted that progress in this matter will be tracked throughout the year.

CGC051606 – Action Tracker – Cancelled operations – process and learning (verbal update) – Andy Hyett

AH reported that cancellation of operations presents a continual challenge. From a planning point of view, difficult decisions are taken whenever an operation has to be cancelled. We expect the EPM system to be switched on in the next few weeks which will provide another pathway. AH gave assurance that cancellations are based on clinical prioritisation and if the patient can be booked back in within 28 days. There is a focus on 'on the day' cancellations. During the Junior Doctors' strike there were 3 days of non-elective surgery cancelled. It was found that thereafter services were improved due to the necessary resetting.

STRATEGY

CGC51607 – Core Service presentation – Stroke Medicine – Judy Cronan, Kirsty Anderson, Sarah Paterson

A presentation was given by JC regarding the achievements and challenges of the Stroke unit.

Improvements have been made in discharge planning with community teams visiting the wards each week. A new SSNAP score is awaited. In order to improve the hospital's score continuing efforts are being made to ensure that standards are maintained during staff changeovers. Plans are also in place to meet the criteria for reviews to be made 7 days per week by a stroke consultant. There are new RCP guidelines due out in the Autumn.

The early supported discharge scheme is working well with improved communications with community teams. The committee asked the Stroke team to find out the expected time limits for a stay in hospital for each type of stroke patient so that the team could work towards matching those expectations.

The committee noted that the team worked very positively and proactively during a recent Norovirus episode.

A discussion took place during which it was agreed that the team would provide information regarding the number of patients who could be moved from an acute ward if ESD could provide support. It was also agreed that the target for a scan to be completed within 1 hour needs to be reinforced in the induction for F1's.

LB thanked JC, KA and SP for their presentation and commented that she was very impressed with the unit during a recent Executive Walkround.

CGC051608 - Hot Topic – 7 Day Service Plan

- The NHS Services, Seven Days a Week Forum was established in February 2013 to consider how NHS services could be improved to provide a more responsive and patient centred service across 7 days. As a first stage, the Forum focused on urgent and emergency care services and their supporting diagnostic services.
- The Forum's review points to significant variation in outcomes for patients admitted to our hospitals at the weekend in England. This variation is seen in mortality rates, patient experience, length of stay and re-admission rates. The Forum set ten clinical standards to improve clinical outcomes and patient experience at weekends, all of which were intended to be in place by March 2017.
- In February 2016, NHSE decided that four clinical standards were to be prioritised for implementation, as taken together would mean patients needing urgent or emergency hospital care would receive the same quality of assessment, diagnosis, treatment and review on any day of the week. By March 2017, a quarter of the population must have access to the four standards, rising to half of the population by 2018 and complete coverage by 2020. UHS is in the first wave of Trusts that must deliver the standards by March 2017.
- The Trust has met 3 of the standards on shift handover, mental health provision and quality improvement since 2013/14.
- NHSE commissioned all Trusts to take part in a 280 prospective case notes audit of patients admitted as an emergency between 30 March to 5 April 16 against the 4 priority clinical standards. The results show:
  - Time to consultant review within 14 hours – 74% across the 7 day period.
  - Diagnostic access – 100% for patients with critical needs, 98.6% for patients with urgent needs.
  - Intervention/key services - access to consultant-delivered interventions are available on site during the week for all relevant services. Formal network arrangements are in place for PCI, interventional radiology and radiotherapy.
  - Ongoing review – Twice a day for ITU/HDU patients – 100% for ITU. For patients in AMU - 76% weekday, 69% at weekends, SAU – 52% weekday, 50% at weekends and CCU – 29% weekday, 50% at weekends were reviewed twice a day. Daily review on a general ward - 60% were reviewed at least once every 24 hours. Those who did not receive a daily review were stable patients whose greatest needs were therapy, nursing or specialist nursing input.
- The Trust has continued to work to improve the remaining 3 standards related to patient experience, MDT review within 14 hours and transfer to community, primary and social care through the Transformation programme.

CB presented the progress being made in the 7 Day Service plan. It was agreed that this matter would be reported back to the committee in 1 year. **CB / CGz**

The committee noted the report.

CGC051609 - Spinal Unit Leadership (verbal update) – Christine Blanshard

CB reported that job plans have been changed for the spinal consultants and these are now in place; there is additional capacity in outpatients; and progress is being reported on a monthly basis to NHSE and CQC. The mortality surveillance group will be reviewing the notes of relevant spinal patients.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC051610 – CQC Inspection Report December 2015 and action plan

- A comprehensive CQC inspection took place in the Trust in December 2015. Overall, the Trust was rated as 'Requires Improvement', however many areas of outstanding practice were recognised, and a rating of 'Good' was given in 27 out of 39 core service areas examined. The spinal unit was rated as 'Good' for caring and 'Requires Improvement' overall.
- A Quality Summit was held in April and focused on four principal themes: mental health liaison and support for adults and for children, patient flow into the hospital, patient flow out of the hospital and the Trust's internal issues. The action plan is focused primarily on the actions that the Trust can take forward within the hospital; it refers to actions discussed in the Quality Summit, which require multi-agency working.
- The aim of the action plan is to improve quality, address the findings of the report and thereby move the rating of Requires Improvement to Good via a re-inspection. A Trust-wide plan captures cross departmental issues that are further developed and detailed as necessary by the

nine core areas of service that were inspected.

- The delivery of the action plan will be monitored and managed via the following routes:
  - At the monthly Directorate Performance Reviews – where each Directorate Management Teams will be held to account on delivery of their core service improvement actions.
  - Oversight of the action plan as a whole and delivery of the Trust-wide actions through a dedicated CQC Steering Group, chaired by the Director of Nursing.
  - Board oversight of progress is through the Clinical Governance Committee.
  - Both the CGC and the Joint Board of Directors have a programme of core area presentations, starting in May to enable them to hear direct from the services on progress with their improvement plans.
- A Warning Notice was received in January in relation to the management of outpatient follow-ups and video urodynamics in the Spinal Unit. A separate action/improvement plan is in place as a direct response to the detailed concerns raised. The same governance applies to delivery of this plan with an added layer of scrutiny in that executive team members are meeting with Directorate Management team on a 2 weekly basis to ensure pace of improvement.

The committee requested that a report is made to the committee on key issues in 3 months and a full report in 6 months. **LW**

CGC051611 – National Inpatient Survey 2015 – CQC Benchmark Report and Local Action Plans

This report has not been published yet and will be presented at the June Clinical Governance Committee meeting.

ASSURING CLINICAL EFFECTIVENESS

CGC051612 – Quality Indicator including DSSA – discussion – Christine Blanshard

- 2 cases of Trust apportioned C Difficile.
- A decline in the elective MRSA screening rate. Directorates are investigating each case.
- 4 new serious incident inquiries commissioned in April.
- A decrease in the crude mortality rate in April 16 associated with a decrease in admissions. SHMI is 109 and 104 adjusted for palliative care to September 2015. HSMR decreased to 109 in January 16 and is higher than expected.
- The number of grade 2 pressure ulcers remain static. Share and learn meetings on-going. Two grade 3 pressure ulcers, one was a particularly complex patient. Full investigations underway.
- Safety Thermometer – 96% 'new harm free care'.
- There were 2 falls, 1 resulting in major harm (fractured elbow requiring internal fixation) and 1 moderate harm (head injury).
- CT scan within 12 hours was sustained at 100% for stroke patients. An improvement in patients spending 90% of their time on the stroke unit. Patients arriving on the unit within 4 hours declined due to bed pressures but most who breached the target arrived minutes after the 4 hours.
- A significant reduction in high risk TIA patients being seen within 24 hours due to clinic availability (industrial action and consultant leave). However, 90% were seen within 30 hours.
- Escalation bed capacity remains at a high level with a significant number of delayed transfer of care and 'green to go' patients. Ward moves remain at a low level.
- In April 16 there were no non-clinical mixed sex accommodation breaches.
- Real time feedback improved in April for patients rating the quality of their care. The Friends and Family test response rate for inpatients and ED declined as did the Maternity Services response rate. Day case response rates improved but outpatient response rates remained consistent with previous months. Q4 staff FFT showed an improvement in recommending the

hospital as a place to work and to receive care and treatment.

The committee noted the report.

CGC051613 – Final Quality Account – Christine Blanshard

- Overall, the Trust has made good progress in improving the quality of care in 15/16 but there is still work to do. The report describes progress with last year's improvement priorities: keeping patients safe from avoidable harm; ensuring patients have a positive experience of care; working with our partners and patients to prevent ill health; providing patients with high quality care seven days a week and providing co-ordinated care across the whole health community.

- Five quality priorities have been selected for 16/17 following a wide consultation. The five priorities are:

Priority 1 Continue to keep patients safe from avoidable harm.

Priority 2 Ensure patients have an outstanding experience of care

Priority 3 Actively work with our community partners, patients and carers to prevent ill health and manage long term conditions

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

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

- The draft quality account has been reviewed by three members of the Readership Panel and the majority of their suggested amendments made. One member commented 'I have read the report right through twice and think it is excellent, the format fine, content comprehensive and in a logical order and I had no problems with jargon.'

- KPMG have completed a review of the account and audit two mandated indicators – 1) The Emergency Department 4 hour wait was compliant 2) Referral to treatment (RTT) incomplete pathways – a number of records were not compliant – actions to improve data quality are highlighted on page 50 and referred to in the Director's responsibility section on page 70. KPMG also audited falls resulting in a fracture or serious harm selected by the governors. The falls audit was fully compliant.

CB reported that good progress was being made in Safety, with continuing improvements in catheter-associated urinary tract infection, dementia screening and the prevention agenda.

CGz stated that this report had been sent out to Healthwatch, local commissioners, council members and governors and has been audited by KPMG. KPMG have picked up a minor data anomaly but have been generally complimentary overall.

The report was approved by the committee.

ASSURING SAFETY

CGC051614 – Risk Report Card Q4 – Fenella Hill

- 1871 incidents reported over the quarter
- 1 major incident due to fractures within the quarter
- 1 new Clinical Review commissioned within the quarter
- No new Non-clinical Reviews commissioned within the quarter
- 5 new Serious Incident Inquiries commissioned within the quarter
- No new Local Reviews commissioned within the quarter

The committee noted the report.

CGC051615 SII/CR report Q4 – Fenella Hill

Updates to outstanding recommendations:

- SII 144, SII 160, SII 162, SII 176, SII 169, SII 173, SII 174, SII 178, SII 180, SII 182, SII 183, SII 186, SII 187, SII 188, SII 189, SII 184, SII 185

- **Reviews with outstanding recommendations:**

- SII 160, SII 176, CR 113, SII 182, SII 187, SII 188, SII 185

- **New Recommendations since January 2016 CGC**

- SII 169, SII 173, SII 174, SII 178, SII 180, SII 182, SII 183, SII 186, SII 187, SII 188, SII 189, SII 184, SII 185

- **Serious Incident Inquiry/Clinical Review for Closure**

- SII 144, SII 162, SII 169, SII 173, SII 174, SII 178, SII 180, SII 183, SII 186, SII 189, SII 184

FHi reported that good progress is being made. Some items are still in progress and staff have really engaged in getting these signed off.

CGC051616 – Safeguarding Children Q4 report – Fiona Hyett

FHy presented the report detailing the activity and performance relating to the safeguarding of children.

The committee asked that Angela Conway confirm what plans are in place for a named doctor for safeguarding. GC confirmed that training of relevant staff members has started. **AC**

CGC051617 – Safeguarding Adults Q4 report – Gill Cobham

GC presented the report detailing the activity and performance relating to the safeguarding of adults. There has been learning from a recent SII incident in how to protect and support staff members when an allegation has been made against them. The DoLS checklist has helped staff significantly in correctly identifying patients who need to be on a DoLS. From April, Levels 1 and 2 Safeguarding training has been available on MLE – work is ongoing to map staff to ensure they undertake the correct level of training which will impact on compliance in the short term.

CGC051618 – Medication Safety annual report including missed doses – Steve Bleakley

SB presented the achievements and challenges concerning medication safety. TIAA audited the security of drugs and this was generally positive, with few issues. Trustwide learning needs to be encouraged following incidents. The Workplan for Medicines Safety Officer EPMA project improves safety including missed doses. Fridge monitoring on the wards has been highlighted and staff made aware of the need to remain vigilant. Ward pharmacists provide valuable interventions in the matter of missed doses.

CGC051619 – NPSA NRLS Organisation Patient Safety Incident report – Fenella Hill

During this reporting period, all patient safety incidents are uploaded to the NRLS from the Trust once the investigation is closed, this has been in effect since July 2005. From April 2011 all incidents have been submitted as open and are updated when they are closed.
Key items to note are:

- Reporting rate per 1000 bed days shows the Trust to be in the top of the middle 50% of the cluster group. This demonstrates a further rise in our position within this cluster since the last report. We are now reporting a rate of 41.44 incidents per 1000 bed days compared to 33.58 for the previous 6 month reporting period. This increase is seen as a positive safety culture indicator.

- Patient accidents continue to be the top reported incident at SFT (18.4% against the cluster reporting 18%).

- Nationally 72% of reported incidents result in no harm. We reported 89.7% of incidents as

resulting in no harm, compared to 75.1% for the remainder of the cluster.

- Incidents reported in 6 of the 6 months 1 April – 30 September 2015

FHi reported that SFT has good reporting, openness and transparency. Weekly reports are gathered and this may become daily. DATIX is monitored regularly and responses made to individuals who have reported, if necessary.

The committee noted the report.

CGC051620 – Annual CLIP report – Fenella Hill

The report aggregates and distils the reporting processes from Risk, Customer Care and Litigation throughout the year. The report identifies any cross cutting themes for the organisation and the available information can be used for current service planning. The report covers the period from April 2015 – March 2016.

FHi reported that this is being used to plan how to go forward from a learning perspective. CB commented that the DMT's now include a discussion during quality performance meetings on what learning has been made following claims previously made.

The committee noted the report.

PAPERS FOR NOTING

CGC050621	Clinical Management Board meeting minutes (March, April 2016)	Noted
CGC050622	Information Governance Group meeting minutes (February 2016)	Noted
CGC050623	Clinical Risk Group meeting minutes (March 2016)	Noted
CGC050624	Integrated Safeguarding Committee (November 2015, January 2016)	Noted
CGC051625	Infection, Prevention and Control Committee (January 2016)	Noted
CGC051626	Supervision of Midwives Assurance meeting (April 2016)	Noted

CGC051627 - ANY OTHER BUSINESS

There were no additional items.

NEXT MEETING

2016 dates will be Thursdays, 10am-12pm in the Boardroom – 23rd June, 21st July, 22nd September, 20th October, 24th November. No meetings in April, August or December.

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 23rd June 2016, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair) - Non-Executive Director
Peter Hill - Chief Executive Officer
Lorna Wilkinson - Director of Nursing
Dr Christine Blanshard - Medical Director
Claire Gorzanski – Head of Clinical Effectiveness
Fiona Hyett - Deputy Director of Nursing
Steve Bleakley – Chief Pharmacist
Andy Hyett – Chief Operating Officer
Mark Stabb – Head of TIAA
Dr Samuel Williams – F1
Steve Long - Non-executive Director

In attendance:

Kate Williams	Minute taker
Jan Sanders	Governor
Mr Neal Jacobs – Consultant Orthopaedic Surgeon	CGC061604
Katie Ransby – Senior Sister, Chilmark Ward	CGC061604
Dr Sarah Bartram – Consultant Rheumatologist	CGC061604
Katrina Glaister – Clinical Effectiveness Facilitator	CGC061605
Patient 'LN'	CGC061605
Gill Sheppard – Clinical Governance Administrator	CGC061609 & CGC061614
Dr Stef Scott – Head of Research and Development	CGC061615
Victoria Downing-Burn – Deputy Director of Human Resources	CGC061618

Observing:

Denise Major – Directorate Senior Nurse, MSK
Jo Jones – Deputy Directorate Senior Nurse, MSK

CGC061601 Apologies:

Hollie Foreman – Staff Nurse, Laverstock Ward
Hazel Hardyman – Head of Customer Care
Ian Downie - Non-executive Director

CGC061602 – Minutes of the meeting held on 19th May 2016

The minutes were approved by the committee.

CGC061603 – Matters Arising / Action Tracker

LW requested that additional dates be added to the CQC Inspection Report updates. **KW (completed)**

STRATEGY

CGC061604 – Core Service presentation – Orthopaedics – Neal Jacobs / Katie Ransby

A presentation was given by NJ to provide the CGC with assurance that the Orthopaedic department are progressing actions identified as in need of improvement in the surgical core service during the CQC inspection.

As part of the surgical core service the Orthopaedics department were rated as good in terms of

effectiveness, caring and leadership; with requires improvement in safety and responsiveness.

In response to CQC findings, the staff rota has been improved and further appointments are being made to the department. Regular reviews of complications, incidents and mortality are being held at departmental meetings.

SL and LB sought reassurance from the department that challenges relating to sterilisation of equipment were being dealt with. AH confirmed that the sterilisation process has been changed in response to the recent issue. LW requested that the Risk Register be embedded into the regular departmental meetings.

NJ confirmed that current trainees were very satisfied with their training. There will be less time available for the next round of trainees but strategies are in place to deal with supervision during clinics. Virtual fracture clinic training is a possibility for the future.

LB thanked NJ and KR for their presentation.

CGC061604 – Core Service presentation – Rheumatology – Sarah Bartram

A presentation was given by SB to provide the CGC with assurance that the Rheumatology department as part of the outpatient core service were progressing their action plan where areas of improvement were identified in the CQC inspection report..

As part of outpatients the Rheumatology department were rated as good in all areas with challenges relating to waiting times for some clinics, and water leaks in the department (which are being investigated).

Rheumatology has been rated as the best department in the South of England for numbers seen within 3 weeks of referral, and in the top 5 for referrals made from primary care within 3 working days. A Fracture Liaison Service was launched in March 2016.

PH noted that the department continues to provide a great service, and that the team are highly regarded.

LB thanked SB for her presentation.

CGC061605 – Patient Story – facilitated by KG

The patient recounted experiences of being admitted to SDFT hospital with septic arthritis of the knee.

The patient was very impressed that having been admitted at 1.00am, many tests were completed and by 10.00am the next day surgery was undertaken. There was a long wait in recovery due to a lack of available beds but the patient was on the ward by 3.00pm

The patient felt that the level of care on the ward was excellent, with friendly, supportive and caring staff. Friends and family felt they were given appropriate information. The spouse was offered an appointment with a consultant in order to be fully updated but did not feel the need to accept this. The patient was in a side room but did not feel isolated as staff ensured that they checked on her regularly.

The patient became ill during this time, requiring a PIC line to be removed and further tests to be taken – she felt that this was dealt with very quickly. Due to the need to have a second PIC line inserted, the patient's return home was delayed but some day leave was arranged which was very helpful. One reason for the delay in returning home was that there were not enough community staff who could assist with the PIC line. Occupational Therapists and Physiotherapists ensured that sufficient care / medication / dressings were available for the patient's return home.

The patient suggested that more prompt information regarding medical complications would have been welcome. The patient further suggested that handover conversations should not be held in the corridor as patients could overhear. A further suggestion was that consultants visit patients more regularly.

Overall, the patient was very happy with her treatment and felt that the ethos of Chilmark Ward and the hospital was very positive.

KR stated that it was necessary to undertake the handover in the corridor for several reasons and

that the patient's room was particularly near to the discussions.

AH noted that many patients were delayed due to the ongoing issue of dealing with IV antibiotics in the community.

CB noted that consultants should do ward rounds once a week and this was in their job plans. CB to ask Dr Philippa Swayne to check this. **CB**

ASSURING A QUALITY PATIENT EXPERIENCE

CGC061606 – Annual Food and Nutrition Report 15/16 – Fiona Hyett

We continue to receive positive RTF comments regarding food and food services and received an improved score in the Patient Led Assessment of the Care Environment (PLACE) audit. One 'food' or 'nutrition' related complaint was received by the Trust during the year.

The Groups Terms of Reference have been reviewed to ensure both the membership and work plan remain appropriate.

The Trust continues to support the work led by Lord Carter, with efficiencies identified for this year's savings plan. Work has commenced on the Food and Nutrition CQUIN and on a Trust Food and Nutrition Strategy.

CB queried the level of attendance as the TOR only lists 19 people. FHy stated that many people receive notification of the meetings and attend where possible.

CGC061607 – Q4 Complaints Report – Lorna Wilkinson

84 complaints were received in quarter 4 compared to 66 complaints in quarter 3 and 74 complaints for the same period in the previous year. The activity from comments, concerns and enquiries has decreased from 491 in Q4 last year to 433 in Q4 this year.

The main issues from complaints are:

- Clinical treatment (31), 9 more than Q3 - sub-themes were 22 unsatisfactory treatment across15 different areas, 3 correct diagnoses not made, 2 pain management, 2 inappropriate treatment, and 1 each for consent to treatment and further complications. The Emergency Department received 5 complaints about clinical treatment with 2 relating to missed fractures. Ophthalmology had 4 complaints relating to clinical treatment with no themes.
- Communication (16), 12 more than Q3, - sub-themes were 6 lack of communication across 6 different areas, 5 wrong information; 3 delay in receiving/sending information; and 1 each for insensitive communication and letter sent incorrectly.
- Appointments (14), 1 less than Q3 (15) – sub-themes were 6 cancelled appointments, 3 appointment date required, and 2 appointment delays and 1 each for unsatisfactory outcome, wrong information and appointment system procedures, across 10 different specialties.
- Staff attitude (12), 1 less than Q3 (13) – 5 related to medical staff, 4 nursing staff, and 3 administrative across 11 different areas.

There was one new request for independent review by the Parliamentary and Health Service Ombudsman. A total of 372 inpatients were surveyed for real time feedback in the quarter. They made 250 positive and 260 negative comments with the main negative issues being level of service at weekends, noise and food and nutrition on the wards.

The main area of concern from the Friends and Family Test was waiting times. There were 4 new requests to undertake Patient and Public Involvement projects. NHS Choices received 23 comments in Q4 with 20 positive and 3 negative.

LW reported that the hospital was under increased pressure in terms of numbers of patients. Work is being done around letters to patients and appointments. I complaint has been referred to PHSO after a great deal of work being done on it at the Trust.

CGC061608 – Complaints Dip Sampling Report – Steve Long

The dip sampling exercise for this quarter focused on complaints relating to the Plastics Dept. The dip sampling suggests that responses tended to focus on the action needed as a consequence of the complaints rather than the identification of what led to the complaint. Additionally it is suggested that a more personal response in addition to a letter would improve the successful resolution of a complaint.

LB suggested that this could be a topic covered in a Clinical Governance ½ day.

CGC061609 – National Inpatient Survey 2015 – CQC Benchmark Report and Local Action Plans – Gill Sheppard

Salisbury NHS Foundation Trust participated in the 13th national inpatient survey between September 2015 and January 2016. The sample size was increased from 850 to 1,250 patients to provide more robust data nationally. The survey contained 63 questions which could be analysed, grouped into 11 sections.

Comparisons with other Trusts
SFT scored 'better' than most other Trusts in 1 of the 11 sections and 6 of the 63 individual questions.

- Waiting to get to a bed on a ward
- For the remaining sections and questions, SFT scored 'about the same' as most other Trusts.

Comparisons with its own 2014 benchmark results
SFT had significantly improved in 7 areas:-

- Time to get to a bed on a ward after arrival
- Same sex sleeping areas
- Nurses involving patients in discussions
- Staff availability to discuss worries and fears
- Privacy when discussing condition or treatment
- Pain control
- Taking family or home situation into account when planning discharge

Local Results Analysis

- 448 comments were received on things that were good.
- 330 comments were received on things that could be improved.
- The main area where more negative than positive comments were received related to discharge.

Comparisons with Neighbouring Trusts

- Salisbury has the highest or joint highest mean score in 7 of the 11 overall sections and 27 of the 63 individual questions when compared with other Trusts in the area.
- Salisbury had the lowest or joint lowest score in 2 of the individual questions:-
  Did you ever share a sleeping area with patients of the opposite sex?
- Did you see, or were you given, any information explaining how to complain about the care you received?

The Next Steps

- Each ward has identified its themes from the national patient survey, real-time feedback, Friends and Family Test, concerns and complaints.
- Action plans have been drawn up. These will be reviewed in three months' time when completed actions will be removed and new actions added based on themes arising from more current feedback. This exercise will form a three-month rolling programme.

The committee noted the report.

<u>ASSURING CLINICAL EFFECTIVENESS</u>

CGC61610 – Quality Indicator including DSSA – Tabled only – Christine Blanshard

- One MSSA bacteraemia due to chest sepsis. Not device related.

- A decline in the non-elective MRSA screening rate. Directorates have raised the importance of screening at their monthly meetings and investigated individual cases.

- 7 new serious incident inquiries commissioned in May.

- A decrease in the crude mortality rate in May 16 with an increase in admissions. SHMI increased to 112 to December 2015 and remains as expected. HSMR is 109 to February 16 and is higher than expected. Dr Foster report with details of mortality reviews presented to CGC and a response completed on a CQC outlier alert for deaths due to COPD and bronchiectasis. In April and May, 72 structured case note reviews were completed and there was 1 potentially avoidable death of a patient with a long lie at home.

- An increase in the number of grade 2 pressure ulcers. One grade 3 pressure ulcer. Share and learn meetings on-going.

- Safety Thermometer – 96% 'new harm free care'.

- There were 3 falls, 1 resulting in major harm (fractured hip requiring surgery) and 2 resulting in moderate harm (fractured wrists managed with casts).

- CT scan within 12 hours was achieved for all except one stroke patient. A decrease in patients spending 90% of their time on the stroke unit – 4 patients transferred to other wards awaiting discharge to make way for new stroke patients. Patients arriving on the unit within 4 hours declined for a variety of reasons – in the main arriving 10 minutes after the breach time from ED and patients being admitted to AMU and SSEU rather than the stroke unit (bed pressures). In Q4, SNNAP was a grade C.

- An improvement in high risk TIA patients being seen within 24 hours. 7 patients not seen within the timeframe due to lack of morning clinic availability (3), MRI not undertaken in under 24 hours (2) and delayed primary care referrals (2).

- Escalation bed capacity remains at a high level with a significant number of delayed transfer of care and 'green to go' patients. Ward moves remain at a low level.

- In May 16 there were 6 non-clinical mixed sex accommodation breaches affecting 50 patients all on AMU, all for a short period of time to enable timely access to medical care, and all due to bed capacity issues and patient acuity.

- Real time feedback declined in May for patients rating the quality of their care. The Friends and Family test response rate for inpatients improved and ED, Maternity Services and outpatient response rates remained the same. Day case response rates declined. Q4 staff FFT showed an improvement in recommending the hospital as a place to work and to receive care and treatment.

The committee noted the report.

CGC061611 – Annual Clinical Governance Report 15/16 – Christine Blanshard

- The report is structured around the Quality Governance Framework and the work needed to ensure compliance with the NHS Outcomes Framework 2016/17.

- The Quality Account is the key driver for improvement and overall the Trust has made good progress in improving the quality of care in 15/16. Nevertheless, there are still improvements to be made which are reflected in the quality priorities and work streams for 16/17.

- The CQC Trust wide action plan is also a key driver for improvement and is robustly monitored to ensure progress is made and sustained in practice.

CB reported that Duty of Candour is being implemented. The Trust has a good rating for openness and transparency. Morbidity / mortality reviews are being undertaken by CB and CGz.

Following the recommendations in the CQC report, the minutes of the Clinical Governance Committee will now contain a summary of 'areas of challenge' raised during meetings. **KW (Completed)**

CGC061612 – Major Issues Report – Christine Blanshard

- A national Healthcare Safety Investigation Branch (HSIB) will be set up and in place by the summer.
- The NHS Outcomes Framework 2016 – 2017 sets out improvement areas for the year.
- The Kings Fund – Improving quality in the English NHS – A strategy for action
- NHS England business plan 2016 -2017 set to deliver the Five Year Forward View.
- A national framework for nursing, midwifery and care staff is launched by Jane Cummings.
- CQC inspection report published along with the Trust wide and core service action plans.
- The latest Learning from Mistakes League table published by NHS Improvement places the Trust in the top five hospitals in the country for openness and transparency.
- Staff rated the Trust as one of the best places in the NHS to work and receive treatment as part of the latest national staff survey published in Feb 16.
- Highest number of patients recruited into clinical research trials.

The committee noted the report.

CGC061613 – Annual Clinical Audit report (including proposed audit programme 16/17) – Christine Blanshard

- Clinical audit is a requirement of the CQC effective domain and was rated as good in the CQC inspection. The clinical audit plan is a prioritised list of audits that the Trust takes part in each year. Many of the audits are required to be published in the Quality Account.

- This end of year report provides assurance that the Trust has delivered the clinical audit plan almost in full. Interventions are in hand for audits not on target.

- Examples are given to show how clinical audit has improved patient outcomes.

- Priorities for improvement in 2016/17 are set out in the report.

CGz noted that the report now contains information on how clinical audit has improved outcomes. 30% of audits have been re-audits.

The committee noted the report.

CGC061614 – Annual NICE Report 15/16 – Gill Sheppard

NICE guidance published between 1 April 2015 and 31 March 2016

A total of 164 sets of guidance have been published. The current status is as follows:-

Compliant	41
Working towards compliance	50
Awaiting feedback	12
Non-applicable to SFT	61

Progress towards compliance with guidance outstanding more than 12 months

A total of 35 sets of guidance have been outstanding for more than 12 months. Risk assessments indicate these are low or moderate with actions to mitigate.

The committee noted the report.

CGC061615 – Annual Research and Development Report – Stef Scott

Clinical research is a vital part of the work of the NHS, and a commitment to conduct, promote and use clinical research to improve patient care is part of the NHS England Constitution. Dr Jonathan Sheffield, the chief executive of the National Institute of Health Research Clinical Research Network (NIHR CRN) has a vision “for participation in a clinical research study to be a treatment option for all patients, no matter where they are treated or what condition they have”. The Annual Report

describes the contribution that the Trust has made towards the NIHR CRN high level objectives. We are pleased to report an extremely successful year for Trust research. Highlights for the Trust during 2015/16 include:

- Recruiting 1789 study participants into NIHR CRN portfolio studies (and increase of almost 900% compared to 2008/09);
- 3rd highest recruiting small acute trust nationally;
- In the top 100 (at 100!) recruiting Trusts nationally for the first time;
- Meeting the following targets on time or ahead of schedule:
    - Increased recruitment into commercial contract portfolio research;
    - Reduced the median time taken to issue NHS permission to proceed (11 days);
    - Recruitment of the first study participant within 70 days for 100% of eligible interventional studies;
    - Improved recruitment to time and target for commercial studies.
- Targets have been set for 2016/17 relating to:
    - consolidation of the above,
    - identification of potential cost-savings; and
    - writing a new Trust Research Strategy for 2017 onwards.

SS reported that it has been a very good year. The Trust is now in the top 100 recruiters in the country. The action plan for 16/17 included examination of possible costs savings associated with research projects. AH suggested that Louise Arnett could assist in this. CB noted that this would aid transparency in costs savings.

The committee approved the report.

CGC061616 – Research Support Service Framework – Stef Scott

This item has been deferred until November 2016.

CGC061617 – Dr Foster Report and Mortality Reviews – Christine Blanshard

- SHMI is 109 and 104 when adjusted for palliative care and is as expected to June 2015. HSMR is 109 to February 16 and is higher than expected. Deaths in low risk diagnosis groups are as expected. Deaths by day of admission are as expected on weekdays and weekends.

- Care Quality Tracker - for the period March 2015 to February 2016 our overall risk is 4 which is lower than the national median and there is one elevated risk and two risks.

- CQC mortality outlier alert for COPD and bronchiectasis – for the period January to September 2015 detailed analysis showed no evidence of avoidability and a number of learning points.

- CUSUM alerts – 3 new diagnosis groups for the period February 2015 to January 2016. An assessment of avoidability and learning points are given where these groups have been investigated.

- In response to the Southern Health investigation we have reviewed deaths of all patients with learning disabilities.

CGz noted that a COPD care bundle will be introduced.

ASSURING SAFETY

CGC061618 – Annual Report for Professional Registration 15/16 – Victoria Downing-Burn

All registered staff are checked at appropriate intervals to ensure their registration is maintained and current. If registration should lapse and they are not able to work in a registered capacity and fail to become re-registered then formal action will be taken. All medical and dental staff registrations are also checked to ensure they are registered and licenced and the Trust is working to implement all the requirements of revalidation. All new recruits who require professional registration have their registration status checked via the regulators web site, GMC, HPC and NMC by the HR administrative team.

VD-B reported that there has been a significant change regarding nurse revalidation and that the Trust had a good process to support staff. The report noted some breaches which had been resolved. The process is being managed appropriately.

CB stated that a process is in place for doctors to relinquish their licence to comply with GMC requirements.

CGC061619 – Q4 Sign Up To Safety Programme Report – Lorna Wilkinson

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

Workstream One – Reducing Harm in Frailty
1a) Reducing falls resulting in injury
1b) Reducing harm from pressure ulcers
1c) Reducing harm from catheter associated urinary tract infections (CAUTIs)
1d) Transfers of care (Collaboration with Wessex Academic Health Science Network)

Workstream Two – Deteriorating Patient
1a) Reducing harm from sepsis
1b) Reducing harm from acute kidney injury

Workstream Three – Perioperative Safety
1a) Reducing perioperative harm through use of safety checks and briefings
1b) Reducing surgical site infections through implementation of the surgical site infection bundle

Workstream Four – Maternity Safety
1a) Reducing still births through improved recognition of growth issues in the unborn.

LW reported good achievements last year with reductions in many areas. The online audit tool is well received. The use of checklists is currently undergoing evaluation. LB stated that it was important to emphasise to anaesthetists / surgeons the need to sign off checklists.

LW reported that the GAP programme is ongoing with encouraging preliminary information that low birth weight babies are being identified. CGz noted that there has been a reduction in stillbirths, although there are very small numbers involved.

Challenges

Item	Challenge	Action
Core Service Presentation : Orthopaedics	Assurance that water leaks / holes in drapes / litmus paper and issues with the radiology service in the operating theatre are resolved.	
Patient Story	Orthopaedic consultants need to ensure that they are completing 1 ward round per week in accordance with their job plan.	CB to ask Dr Philippa Swayne – Clinical Director for MSK – to ensure that this is happening.
Customer Care Report	More evidence is needed that patients are being contacted in person as soon as a complaint is received to truly understand the nub of it. An improvement in learning from the themes arising is required.	Hazel Hardyman to discuss with DMT's. Hazel Hardyman.

PAPERS FOR NOTING

CGC061620	Clinical Management Board meeting minutes (May 2016)	Noted
CGC061622	Information Governance Group meeting minutes (April 2016)	Noted
CGC061623	Clinical Risk Group meeting minutes (April 2016)	Noted

CGC051627 - ANY OTHER BUSINESS

There were no additional items.

NEXT MEETING

2016 dates will be Thursdays, 10am-12pm in the Boardroom – 21st July, 22nd September, 20th October, 24th November. No meetings in April, August or December.