NHS
Salisbury
NHS Foundation Trust

Trust Board Meeting in Public
Monday 4 December 2017
1.30pm – 4.45 pm
Board Room, Salisbury Foundation Trust

Timings	Agenda		SFT ref	Presenter	Page
1.30	**1.**	Patient/Staff Story		LW/Pres	
1.50	**2.**	Apologies and Declarations of Interest:/ Fit & Proper/ Good Character		NM	verbal
1:55	**3.**	Chairman's Business		NM	verbal
2:05	**4.**	Minutes of the Trust Board meeting held on 2 October 2017		NM/Enc	3
2:10	**5.**	Action Log and Matters Arising		NM/Enc	13
2:15	**6.**	Chief Executive's Report	SFT3952	CC-B/Enc	15
	Assurance and Reports of Committees				
2:30	**7.**	Workforce Committee Report – 27 November 2017	SFT3953	KM/Enc	21
2:35	**8.**	Clinical Governance Committee Report – 26 October 2017, 23 November 2017 and Annual Effectiveness Review	SFT3954	JR/MM/Enc	23 26 27
2:45	**9.**	Finance & Performance Committee Report – 6 and 27 November 2017	SFT3955	NM/Enc	35 37
2:55	**10.**	Integrated Performance Report (Month 7) • Operational Performance • Quality Indicators • Workforce Report • Safer Staffing • Finance Report • Wiltshire Health & Care	SFT3956	ALL/Enc	39

Timings	Agenda		SFT ref	Presenter	Page
	Quality and Risk				
3:30	**11.**	Board Assurance Framework	SFT3957	LW/Enc	91
3:40	**12.**	JBD Minutes evidencing presentation of Assurance Framework and Risk Register	SFT3958	CCB/Enc	127
3:55	**13.**	Risk Strategy 2018-20	SFT3959	LW/Enc	129
3:45	**14.**	Report of Director of Infection Prevention & Control	SFT3960	LW/Enc	151
4:10	**15.**	National Emergency Department Survey 2016	SFT3961	LW/Enc	185
4:15	**16.**	Emergency Planning and Resilience (EPRR) annual statement	SFT3962	AH/Enc	205
	Strategy and Development				
4:20	**17.**	Approval of Trust Strategy	SFT3963	LA/Enc	213
4:40	**Closing Business**				
	18.	Any Other Business			
	19.	Public Questions			
	20.	**Date of Next Meeting** Monday 5 February 2018 at 1.30 pm			

Salisbury NHS Foundation Trust

Minutes of the Public Board meeting held on
2 October 2017 in the Boardroom at Salisbury District Hospital

Board Members Present:

Dr N Marsden	Chairman
Ms T Baker	Non-Executive Director
Mr M von Bertele	Non-Executive Director
Dr C Blanshard	Medical Director
Mrs C Charles-Barks	Chief Executive
Mr P Hargreaves	Director of People and Organisational Development
Mr P Kemp	Non-Executive Director
Dr M Marsh	Non-Executive Director
Mrs K Matthews	Non-Executive Director
Prof J Reid	Non-Executive Director
Mrs L Thomas	Director of Finance
Ms L Wilkinson	Director of Nursing

Corporate Directors Present:

Mr L Arnold	Director of Corporate Development

In Attendance:

Sir R Jack	Lead Governor
Dr A Lack	Public Governor
Mr N Alward	Public Governor
Mrs L Taylor	Public Governor
Mr J Mangan	Public Governor
Mrs J Lisle	Public Governor
Mr M Wareham	Staff Side
Mr D Seabrooke	Secretary to the Board

Apologies:

Mr A Hyett	Chief Operating Officer

ACTION

2324/00 DECLARATIONS OF INTEREST AND FIT AND PROPER/GOOD CHARACTER

Members of the Board were reminded that they had 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.

2325/00 CHAIRMAN'S BUSINESS

Nick Marsden commented on the challenging times being experienced in the NHS at present and specifically on the Accident and Emergency Four Hour Target which the Secretary of State was expecting all Trust's to be meeting by March 2018.

ACTION

2326/00 MINUTES – 7 AUGUST 2017

The minutes of the meeting of the Public Board held on 7 August 2017 were approved as a correct record.

2327/00 ACTION LOG AND MATTERS ARISING

It was noted that reporting against the bed stock and occupancy reflecting escalation had not yet been included in the Integrated Performance Report. The Chairman reported that no Non-Executive Director appointment to the bed stacker company was required at this stage.

It was noted that the data warehouse cut over was due to take place in October and plans were in place with regards to the destruction of any data held.

The Older Peoples Board had launched on 29 September and would work towards improving this pathway. It was noted that the Genetics Tender had been received in recent days and that it would be timely to hold a seminar session in January 2018 to discuss the Trust's interests in this further. The proposed seminar on Getting it Right First Time had yet to be scheduled.

2328/00 REPORT OF THE CHIEF EXECUTIVE – SFT 3929 – PRESENTED BY CC-B

The Board received the report of the Chief Executive. Cara Charles-Barks highlighted key points from the written report. The Trust had delivered its Cancer Diagnostics and Referral to Treatment targets in August. A & E had achieved 91.4% of patients seen within four hours in August which she considered to be a failure in the local system of Health and Social Care. The Trust's financial position continued to be challenging and at this point in the year a recovery plan was being developed looking at short term actions, longer term transformation schemes and partnership working. Good progress was being made with the reduction of medical and nursing agency spend.

CC-B reported that the Eye Clinic had opened on 2nd October in its new location.

Work with departments on issues arising from the Lorenzo implementation of twelve months ago was continuing.

The Wiltshire Sustainability and Transformation Partnership had refreshed its priorities and was focusing on improvements to mental health provision and the Trust would be leading on a pilot in relation to the Older People's Pathway. Good progress had been made on emergency planning, resilience and response arrangements. CC-B highlighted the Trust's achievement in the Patient Led Assessment of the Care Environment (PLACE) assessments. The Trust was above the averages in five of the six areas covered with cleanliness and food quality rated by patients.

The seasonal flu campaign began on 2 October and the report described the established and new aspects of this year's promotion of the flu vaccinations. The Staff Survey for 2017 was launching today. Previous

surveys had led the Trust to improve on its on-site security and extended access to physiotherapy and psychological support for staff. The results of the survey would be published in spring 2018 and CC-B again confirmed that the survey was anonymous to the Trust.

The nominations for the 2017 Striving for Excellence Awards had opened and would close on 30 November. The Salisbury League of Friends had sponsored the awards ceremony which would be taking place at Salisbury Race Course on 2 February 2018.

At its August meeting the Trust had a Patient Story on breastfeeding and new mums linked to the Trust's Maternity Services were able to get support from peers in a number of local groups set up across the area.

Finally the achievement of the Procurement Department in winning a CIPS Supply Management award and awards for the Scan4Safety were highlighted. Nursing assistant Emma Ward had been nominated for a Kate Grainger award for compassionate care and Board members had had a brief presentation from Emma in person at an earlier meeting.

In relation to a question about additional resources in relation to the STP work it was noted that there was some project management support on offer.

The Board noted the Chief Executive's Report.

2329/00 ASSURANCE AND REPORTS OF COMMITTEES

The Board received reports of recent meetings of Board Committees as follows –

Audit Committee – 18 September 2017 – SFT 3930

Workforce Committee – 25 September 2017 – SFT 3931

Clinical Governance Committee – 28 September 2017 – SFT 3932

Finance and Performance Committee – 29 August and 25 September 2017 – SFT 3933

The Chairman invited the Chairs of the Committee to comment on the reports and the following principal points were made –

- Audit Committee – Paul Kemp noted that the newly appointed auditor BDO had attended their first meeting with the Trust. A deep dive had taken place on the administration of 18 Weeks/Referral to Treatment which was considered to be helpful. The Committee had carried out its semi-annual review of the Assurance Framework and was looking forward to the next review as the changes to the Assurance Framework currently being enacted would be in evidence.
- Workforce Committee – Kirsty Matthews highlighted the Committee's deep dive on sickness absence and the on-going work to improve the position on this. The use of agency had been reviewed. The Committee had had a useful update on changes to the Trust's arrangements for nurse training and the Board would have a seminar on all aspects of labour supply in the new calendar year.

- Clinical Governance Committee – Jane Reid highlighted the presentation given by Maternity and Gynae colleagues. Wiltshire Health and Care had attended the meeting to discuss Elderly Care. It was noted that the Mortality Review Policy was in place and published via ICID. A Task and Finish Group on children and young people's mental health service had been established which would report in March.
- Finance and Performance Committee – The Chairman highlighted the continuing work of the Committee in scrutinising operational and financial performance and initial review of the Financial Recovery Plan.

The Board received the reports of Committees.

2329/01 Integrated Performance Report Month 5 – SFT 3934 – Presented by LA

The Board received the Integrated Performance Report covering Operational Performance, Quality Indicators, Workforce, Finance and Safer Staffing.

Under local services CC-B reported that an upper limb Orthopaedic surgeon had been recently been appointed and this was expected to reduce waiting times in this area. Emergency pressures experienced by the Trust continued to fluctuate and the Trust had, in accordance with plan been operating with 30 less beds during August because of the reconfiguration. The Trust was receiving two to three days per week service on Interventional Radiology from University Hospital Southampton and this situation continued to be monitored.

The ward configuration was progressing for the end of December. A staffing issue had arisen in the Audiology Service which had subsequently been resolved. There continued to be outsourcing of MRI activity. There had been an Emergency Care Intensive Support Team visit in September which had raised some recommendations and an internal Urgent Care Steering Group was being formed in response. In response to a question from Tania Baker about cancer patients throughput, Cara Charles-Barks informed the Board that the capacity and demand in this area was being looked at in conjunction with the CCG.

In response to a question from Michael Marsh about the restoration of the Trust's bed base it was noted that the plan was to be down by ten beds by the end of 2017 and to have fully recovered by the end of February. The Chief Operating Officer would be procuring community beds to support the Trust in this regard.

In response to a question about theatre productivity from Jane Reid Christine Blanshard informed the Board that the approach was to change pathways and to secure capacity for planned procedures on a semi elective basis.

ACTION

Under specialist Services it was noted that the Trust was providing a melanoma service supporting Southampton and Portsmouth Hospitals. The funding of the Burns, Plastics and Spinal Specialities were being looked at as these were considered to be more expensive to provide than the income they generated. It was noted that a new Cleft Surgeon had been appointed.

The Trust was working in a consortium with Birmingham, Southampton and Oxford Hospitals in regard to the Genomics tender opportunities. Work continued towards securing a clinical lead for the Spinal Unit. It was noted in response to a question from Kirsty Matthews that Christine Blanshard was developing a combined staffing and operating plan for the Spinal Unit.

Tania Baker suggested that more information needed to be provided about the definitions behind some of the indicators featured in this part of the report.

In response to a question from Tania Baker, Christine Blanshard explained that the new Wessex Skin Service had been formed from the merger of the Dermatology, Laser and Plastics (Skin Service) following an increase in the establishment for Plastic Surgeons. This had been considered by the Executive as a business case which had considered the costs entailed.

Under innovation, Lisa Thomas informed the Board that the Laundry continued to win contracts and there was a need to expand the Laundry facility at Salisbury. Odstock Medical continued to progress research and development to promote the use of their products. The Trust continued to discuss with its STP Partnership insourcing further payroll work.

Under care, Christine Blanshard informed the Board that the HSMR to June was 112.5 and this had been declining over the past five months. A new Mortality Policy had been introduced. The SSNAP score had reduced due to capacity issues and the number of patients reaching the unit within the prescribed time and remaining there for the duration of their treatment.

Lorna Wilkinson informed the Board that there had been over 40 days of no falls resulting in moderate of serious harm. A full strategy was being implemented. Infection Control continued to perform well. There had been no mix sex breaches reported in the past six months. The Quality Indicator Report showed that quality had been maintained in August despite a pressured time. The Parliamentary and Health Service Ombudsman had completed a case review and the Trust had acknowledged a failure in a Urology case two years ago to recall the patient.

It was noted also that Wiltshire was an outlier for the carrying out of Best Interests Assessments. This continued to be escalated through the Safe Guarding Adults Board but the Trust continued to be able to deal with priority cases in a timely way.

ACTION

Christine Blanshard informed the Board that there had been an increase in mental health presentations by children and young people nationally. The Trust was seeing more patients under the age of 16. The Trust was discussing the service provided in this regard by Oxford Health. It was noted that a Mental Health Liaison Nurse had been appointed and a second post was being recruited. A gap in the administrative framework for dealing with children who were sectioned was being addressed by a Task and Finish Group.

Jane Reid asked about the rigour of the Mortality Review process. Christine Blanshard commented on the way in which the mortality review process operated and the difficulty of differing viewpoints among experts. Training had been provided for those involved in mortality and morbidity meetings. This was overseen by the work by the Mortality Surveillance Group who reviewed a sample of cases. Cases had also been reviewed externally. The work was estimated to take up around 40 person hours a week and at present the Trust did not identify many patients where problems in care was a contributing factor but there were learning points arising.

The weekend HSMR rate was broadly similar to that for weekdays but fluctuated slightly. The Trust continued to ensure that there was appropriate use of palliative care coding when patients came under staff groups who provided palliative care.

There were no issues to report on the handling of e-coli.

Under staffing, Paul Hargreaves highlighted work on improving the Trust's vacancy rates and controlling agency spend and reducing staff sickness. There had been an open day for nursing assistants which had resulted in a number of offers being made. Analysis of trained nurse interviews had indicated that 50% were not appointed and this was being investigated. Staff sickness hotspots were being investigated in terms of location and symptoms. The aim was to reduce sickness from 3.5 to 3%. The Trust was working with Loughborough University in analysing the reasons for absence.

In temporary staffing the Trust had brought down the demand for this and had reduced the spend on medical locums. The Trust however continued to work to ensure that these assignments were on cap.

In response to a question from Jane Reid about the rigour of the Trust's appraisal process it was accepted that some leaders had too many appraises. A values based approach was in place. Paul Kemp was concerned about the removal of the second sign off and while it was noted that senior managers had visibility of the appraisals of the next layer down, Paul Hargreaves undertook to consider whether the removal of the second sign off should proceed. PH

There was also work to improve the Trust's offer to prevent sickness absence and to provide support.

Under Effective which linked to the monthly Finance Report Lisa Thomas reported that the Trust had had a better August but was £2m away from plan year to date. Savings plans were behind at this stage in the year. With winter coming on it would be important to protect planned elective activity.

It was noted that the Trust may need to revise its current year end forecast of £7m deficit and that increased scrutiny from NHS Improvement could be expected. In response to this the Trust had launched the Outstanding Experience Every Time Board which was coordinating a number of strands of work in support of the Financial Recovery Plan.

Under Partnership it was noted that there was joint commissioning with the local authority for community placements. The Trust was working with the Salisbury Chamber of Commerce to promote the locality as an area for school leavers to gain employment, in this case via health and science careers.

The Early Supported Discharge and Home First initiatives had been delayed by staffing and recruitment problems.

It was noted that less bed days had been used up by Delayed Transfers of Care but the Trust needed to continue to monitor excess bed days.

In reflecting on the content of the report the Board felt that there was some instances where there was a lack of plans directly referenced to the identified challenge and that some indicators needed better definition and where possible to appear more frequently.

Under the Safer Staffing report, August had been a challenging month for fill rates. There had been greater use of band 3 and band 4 nursing staff. The Trust continued to manage this through the Safer Care processes and the twice daily staffing meeting. In relation to staffing on Breamore and Tamar Wards there had been no recorded impact on quality from staffing factors. The new model of supervision discussed by the Workforce Committee for nurse trainees had potential to increase trainee throughput.

2330/00 QUALITY AND RISK

2330/01 Customer Care Report – Quarter 1 – SFT 3935 – Presented by LW

The Board received the Quarter 1 report. 60 complaints had been received. There was good performance on initial acknowledgements and Customer Care where continuing to monitor complaints taking in excess of 25 days to resolve. The Emergency Department had been a complaints hot spot in Quarter 1. There was good improvement work on Winterslow Ward arising from complaints.

MSK Directorate had seen a significant reduction in their complaints through the use of a duty manager arrangement who would get involved in dealing with issues of complaint at early stage. Customer Care were looking to spread this practice to others if it proved to be successful in the longer term.

Surgery Directorate had seen an increase on bookings and appointments based complaints. Kirsty Matthews said that with the increase in pressures it was good to celebrate the reduced complaints and the positive comments that the Trust continued receive.

The Board received the Customer Care Report.

ACTION

2330/02 Review of Assurance Framework by JBD – SFT 3936 – Presented by CC-B

The Board received for information the minute extract from the Joint Board of Directors providing assurance of the on-going quarterly review of the relevant section of the Assurance Framework and Corporate Risk Register.

2330/03 Risk Management Annual Report 2017 – SFT 3938 – Presented by LW

The Board received the Annual Risk Management Report. Lorna Wilkinson highlighted the internal audit review of this area which had given reasonable assurance. Risk Management Policies were up to date and a positive reporting culture was in place. 90% of reported incidents were no or low harm. There continued to be positive feedback from staff. There was a high rate reported in the staff survey of incidents witnessed but not reported. This continued to be investigated. The number of Serious Incidents declared had increased and this was due mainly to falls. The Trust continued to be active in the Patient Safety Collaborative.

It was felt that the work of the Risk Department was clinically focused as was appropriate but that this needed to broaden out into other areas as necessary. Lorna Wilkinson undertook to reflect this in future strategies and the work of the Risk Management Team.

2330/04 Risk Management Strategy 2017/18 – SFT 3937 – Presented by LW

The Board received the Risk Management Strategy. The objectives for 2017/18 were set out. It was agreed that a two year strategy would be produced in future and that the work on the Assurance Framework would be reported back to the 4 December meeting of the Trust Board for approval.

2330/05 Clinical Governance Annual Report – SFT 3939 – Presented by CB

The Board received the Annual Quality Governance Report 2016/17 for assurance. Christine Blanshard highlighted the objectives of the Quality strategy and the work done on quality improvement following the CQC inspection reported in April 2016. The Quality Account set out work streams under safety effectiveness and experience. Future objectives would have a sharper focus on a narrow range of objectives.

The Board received the Annual Clinical Governance Report.

2331/00 STRATEGY AND DEVELOPMENT

2331/01 Major Projects Report – SFT3940 – Presented by LA

The Board received for information the Major Projects Report. On the Electronic Patient Record Laurence Arnold reported that there was a plan to come out of the stabilisation phase. There was a focus on prioritising the reporting capabilities for the organisation.

The report contained an update on the ward changes which had already been discussed along with Wiltshire Health and Care. Under Scan4Safety it was noted that phase three had been completed and the final stage of the implementation was in Theatres in late October.

In response to a question about the EPR switchover risks it was noted that this was considered to be a low level risk as a separate server which was already proven was going to be used.

In terms of the culture around the Electronic Patient Record, Laurence Arnold said that Lorenzo had not got a good name in the Trust since implementation and was frequently blamed for issues it had not generated. There was more work to do with users.

Paul Kemp acknowledged the progress made in the past year on Lorenzo. He was however concerned that the reporting capability it now offered was not in line with the original business case. It was noted that the Audit Committee at its December meeting was going to be looking in detail at the Lorenzo business case.

2331/02 Capital Development Report – SFT3941 – Presented by LA

The Board received the Capital Development Report for information. It was noted that under IT schemes, the functionality of the POET system was being increased. It was noted that the Trust was being moved by NHS Digital from the N3 national spine onto the Health and Social Care Network. The report highlighted the Infrastructure Refresh requirement and the procurement that was needed to replace IT infrastructure which was underway.

Electronic discharge summaries had been implemented across a number of areas of the Trust.

The Board received the Capital Development Report.

2331/03 Update on Strategy

Laurence Arnold showed slides setting out the top level objectives that were being proposed for the Strategy which would be discussed further at the 6 November development day and approved at the 4 December meeting of the Board.

Highlights included the Financial Recovery Plan, a consultation with the governors through the Strategy Committee, clinical strategies and further planning analyses.

2332/00 PERFORMANCE AND FINANCE

2332/01 Auditor Management Letter – SFT 3942 – Presented by CC-B

The Board received for information the Management letter presented to the July meeting of the Council of Governors by KPMG.

ACTION

2333/00 COMMITTEE MINUTES – FOR INFORMATION

The Board received for information the confirmed minutes of the Clinical Governance Committee 27 July and the confirmed minutes of the Finance and Performance Committee 26 June, 24 July and 29 August 2017.

2334/00 QUESTIONS FROM THE PUBLIC

- Lead Governor Raymond Jack commented positively on the opening of the Eye Clinic.
- Jenny Lisle asked about the additional support for Occupational Health which Paul Hargreaves said he would be looking at achieving.
- It was noted that the Trust was applying to the Charitable Trustees to support the implementation of Schwartz Rounds.
- It was noted in response to a question from John Mangan that the HSMR was just above the expected range.

2335/00 DATE OF NEXT MEETING

The next meeting of the Board would on Monday 4 December 2017 at 1.30 pm, in the Boardroom at Salisbury District Hospital.

Trust Board Part 1 Action log

Deadline passed. Completed Status = N	1
Deadline in future. Current progress made is updated. Completed status = 'N'	2
Completed status = 'Y'	3
Deadline in future. Current progress made is not updated	4

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
02 October 2017						
10/02/01	Genetics seminar	DS/CB/lA	04/12/17	Noted that draft tender specification now issued. January for seminar session in line with tendering timeframe	N	2
10/02/13	Risk Strategy - develop a two year strategy. Factor in the handling of non-clinical risk reporting	LW	04/12/17	On December Board agenda	Y	3

Report to:	Trust Board	Agenda item:	3952
Date of Meeting:	4 December 2017		

Report Title:	Chief Executive's Report			
Status:	Information	Discussion	Assurance	Approval
	X			
Prepared by:				
Executive Sponsor (presenting):	Cara Charles-Barks, Chief Executive			
Appendices (list if applicable):	None			

Recommendation:
None

Executive Summary:

This report provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers:

- **Performance –** update on current performance
- **Financial Recovery –** update on our financial recovery plan
- **Workforce –** update on workforce situation
- **Site changes –** update on plans for the site changes we are making to improve the management of emergency and non-emergency patients next winter
- **Trust escalation plans** - review of Trust escalation plans to improve access, consistency and clarity for staff
- **Fab Change Week** – initiative to celebrate work, share ideas and innovations and what can be done differently to improve care for patients.
- **Sustainability and Transformation Plans (STP) –** progress being made in our STP footprint
- **MRI Scanner** – New Stars Appeal campaign launched for second scanner
- **National A&E survey –** information on latest results of national A&E survey
- **Staff individual achievements** – staff do well in recent national awards
- **Trust achievements –** Breast Unit highly commended in national awards

Performance

We have maintained good performance across a number of areas – achieving the standards required for A&E, diagnostics and waiting times. This highlights the outstanding efforts made by our staff in A&E, which saw Salisbury's performance among the best in the country at times during October and early November. It also reflects the work of staff throughout the hospital who have worked hard to maintain the flow of patients at a time of continued pressure across the NHS. We continue to work closely with our partners in health and social care, as part of the national drive to ensure that all organisations within the system work collectively to improve the experience for patients attending emergency services. We are starting to see the number of delayed transfers of care reduce, which is encouraging and highlights the work we are doing with our partners. It is essential that we continue to provide good quality safe care and we are performing well against our main infection control targets, reflecting the work we are doing to maintain good infection control practices. We need to maintain our focus on all other quality indicators and more detailed information on our performance will be covered in the Trust Board.

Financial Recovery

The financial position continues to dominate our discussions both internally and with our regulators NHSI. We continue to develop our Outstanding Every Time Programme and schemes for the next two years are being developed into project charters, which will enable us to bridge the gap leading to a more sustainable financial position. However, the in-year position remains a key focus and challenge. Our likely deficit outturn is much higher than our plan, which is putting pressure on our services and the available cash we have to operate with. The Trust continues to work closely with our regulators on actions we can take to mitigate our position. As part of NHSI's investigation we are awaiting their decision on any future actions that may be needed. We will cover additional detail as part of the financial update at the Trust Board.

Workforce

Like most trusts across the country we are experiencing difficulties in recruiting the staff that we need to deliver our services, which is creating an over reliance on agency staff and a workforce overspend on temporary staff. We are working on an overall agency reduction plan and looking at our processes in order to improve our "offer" to new staff. We are also continuing to use local media campaigns, social media, recruitment events and national and international recruitment initiatives to boost recruitment. I acknowledge the day-to-day pressures that our staff are facing and the impact that this can have on sickness absence. We are providing additional support to departments with high sickness absence rates, as well as support for managers to manage sickness within their areas and see what additional support may be needed for staff to remain at work or return if they have short term sickness. This includes a detailed analysis of causes to see what further support we can provide through our developing health and wellbeing strategy. Reducing our reliance on agency staff, attracting staff to work permanently at the Trust and ensuring that existing staff have the support that they need are key priorities for the executive team.

Site changes update

As you are aware we are making a number of site changes that will put us in a better position to care for and manage emergency and non-emergency patients next winter and increase the number of medical beds available and we continue to make good progress on our plans. The new ophthalmology building (eye clinic) is now in place. The building has been designed with the help of patients and clinical teams to meet the specific needs of our eye patients. There are seasonal images throughout that are calming and relaxing. Each area is colour coded to help with wayfinding, and high contrast materials and large text signs have been used to help patients with visual impairment. The move of the eye clinic will now free up space for a the new Pembroke Ward and Suite and work has now started on this part of the project. Work on the new Acute Medical Unit (AMU) is nearing completion and this is scheduled to move to the former Farley Ward area in early December. The new AMU will be an expanded single-site medical and elderly care admission unit, which has been designed with the help of clinical staff so that it meets increasing demand now and in the future. The current Breamore Ward location will become the new Short Stay Surgical Unit, which will open in early Januaray and Breamore will move to the old AMU site. While the main aim is to improve the care we provide for both our emergency and elective patients, the site changes are also an important part of our plans to deliver our key performance targets and sustainability in the future.

Trust escalation plans

We have carried out review of all our Trust escalation plans to bring them together in one document for easy access and consistency. They now also include the national Operational Pressures Escalation Levels (OPEL) reporting framework. OPEL was introduced to remove variability in the management and reporting of winter pressures across all health systems and improve awareness and understanding among staff and the local community of the position and role they have to play in maintaining services during peak periods. This includes clear messages for local people on how best to use local health services. As part of our plan we will have designated escalation areas based on the OPEL level, with escalation triggers and an approval process at executive level. We had an excellent workshop with 37 representatives from across south Wiltshire testing our plans in preparation for winter. The aim is that these plans will also enable us to provide an effective response to pressures experienced throughout the year.

Fab Change Week

It is important that we are able to adapt and change to new ideas and thinking and last month we encouraged our staff to get involved in Fab Change Week. This enabled us to celebrate all the good things we are doing in hospital, share ideas and innovations and cast an eye on what we could do differently to improve the care we give to our patients. Theatres focused on turnaround times, with three theatres changing their daily practice during the week. Over 30 hospital and community staff looked at opportunities to improve discharges to community services and the booking clerks, across all areas, started to use the outpatient forward look tool, which helps improve clinic bookings and avoid delays. Over 30 staff and visitors also came along to listen to staff stories as part of Time in My Shoes' and we will be

looking at further opportunities to share their stories and experiences with hospital staff.

Sustainability and Transformation Plans (STPs)

The B&NES, Swindon and Wiltshire STP has now appointed Chris Bown as the new senior responsible officer. Chris has a strong leadership record within the NHS with executive level positions in Birmingham, Suffolk and Dorset. He will now be supporting the STP as it now moves forward at pace with a number of key priorities.

Service Improvement Awards

We have now held this years' Service Improvement Awards. This gave us an opportunity to hear about the fantastic work that is taking place across the hospital to improve services for our patients through a number of presentations and recognise and reward the best of these on the day. There were three award categories focusing on projects or areas for improvement that were identified by members of staff (Individual and Team Award), Trust projects taken forward by staff (Sponsored Project Award) and service improvement projects where staff been involved in supported learning through other mechanisms such as National Vocational Qualifications or Health Improvement Projects (Service Improvement Learning Award). It was great to see the innovation, creativity and high standards that have been set in all the presentations we saw on the day, and it's encouraging to know that this was just a small sample of the excellent projects and initiatives that are taking place in the hospital throughout the year. It's always difficult to single out individuals and teams, but I would just like to congratulate the winners Nadine Crook for her work on improving communication for stroke patients, the Older Persons Assessment and Liaison Team who provide additional therapy for older people in hospital, junior doctors Fiona Wu and Olivia Scott who designed and implemented a post falls assessment proforma and the Spinal Outpatient Service Team who won the judges' award for the way in which they worked together to improve patient services. I would also like to thank the team who have worked so hard to prepare such an enjoyable event. These achievements will now be publicised both internally and externally to ensure that our staff get the recognition that they deserve.

New MRI scanner

Our Stars Appeal charity has launched a major new campaign to raise £1.5 million for a second MRI scanner that will help around 10,000 people each year who need diagnosis and treatment for a range of conditions. Our existing MRI scanner is running at full capacity and an additional scanner will mean that patients who currently have their scans at other hospitals or in the mobile MRI van will be able to have these here. An additional scanner will also enable us to diagnose conditions faster using the very latest technology and techniques. Throughout the year we will be holding our normal fundraising activities, as well as a number of other activities to support this campaign. We are enormously grateful for the support and generosity that we have from our staff and local people and I would like to say thank you on behalf of the Trust Board and Governors, as we continue to put in place facilities that we and the local community can quite rightly be proud of here in Salisbury.

Patients rate A&E staff and services highly

I'm pleased to see that people needing emergency treatment have rated our A&E department as one of the best in the country, with a higher proportion of patients responding positively about the care they had received compared to other Trusts. When compared with most other Trusts in the survey, we were better in eight of the nine sections covered in the report. Communication of waiting times, length of visit, respect and dignity and overall experience were all areas where we were considered one of the best in the country. While we will always look to make improvements through our action plan, this is an excellent report which highlights the professionalism and commitment of our staff and the way in which they look after people who need emergency care.

National inpatient survey

We are making good progress against the actions identified in the national inpatient survey which was published earlier in the year. Salisbury scored 'about the same' as most other Trusts in England for the 11 sections and 'better' for patients having trust and confidence in the doctors treating them, and being told how an operation or procedure had gone in a way they could understand. There are individual ward and Trust-wide action plans that are monitored by the Clinical Governance Committee on behalf of the Board. Trust-wide actions centred mainly on issues related to pressure within the system and capacity such as use of escalation areas, changes in admission dates and waiting to get on a ward. These are being addressed mainly through the Trust site changes and the work we have been doing to review and test changes to our escalation plans, both of which have been mentioned earlier in my report.

Salisbury staff do well in awards

I want to say well done and a big thank you to staff who have done well in local and national awards. Anticoagulant nurse Nicola McQuaid and consultant haematologist Tamara Everington were part of a regional team that won a national Anticoagulation Achievement Award. They took part in the development of a patient education video and leaflet to improve the information available for patients starting anticoagulant drugs. Consultant surgeon Graham Branagan was commended for his leadership, recruitment metrics, depth and breadth of his work and multidisciplinary team approach by the team at the Cancer Research Excellence in Surgical Trials (NIHR CRN). These are just two examples of where our staff are recognised at the highest level, boosting our prominence and reputation across the country.

Breast Unit highly commended in Building Better Healthcare Awards

Our Stars Appeal funded Breast Unit has been highly commended in the Patients' Choice category of the Building Better Healthcare Awards. The national awards celebrate innovation in the design and build of NHS facilities, as well as suppliers of products and services to healthcare. Our ArtCare and Estates teams here worked closely with patients and staff to co-design and create a comfortable and calming, environment where patients and their families can come to terms with their diagnosis and get the care and treatment that they need in a sensitive and caring environment.

This is an excellent achievement and I want to thank them for all their efforts and the work that they have done to improve our patients' experience in this sensitive area of patient care.

Cara Charles-Barks
Chief Executive

Report to:	Trust Board	**Agenda item:**	**3953**
Date of Meeting:	4 December 2017		

Report Title:	Executive Workforce Committee Board Report	**Date:**	27 November 2017
Prepared by:	Kirsty Matthews, Non-Executive Director Paul Hargreaves, Director of OD and People		
Board Sponsor (presenting):	Kirsty Matthews, Non-Executive Director		
Appendices (list if applicable):			

Recommendation of items for escalation :

The Executive Workforce Committee focussed on three key areas of concern for the Trust, reviewing the current position for each using the Workforce KPI report and receiving assurance on current actions to improve the position:

Agency Spend
There has been a reduction in agency spend of £18,000 in month, with all clinical directorates, except Surgery, reducing their agency spend compared to last month. Surgery has, however, maintained a position of having no medical agency spend for the second consecutive month.

Recruitment
There has been an increase in recruitment this month; we have a strong on-going overseas recruitment campaign and the recent recruitment events in Australia have seen 33 offers made and a number of planned interviews booked. Whilst this is positive news, there was a good debate about not being reliant on overseas recruitment to close the vacancy gap as the conversion rate for previous campaigns has been around 20%. It was agreed to show this as separate activity in the workforce report until the overseas recruits were actually in post.

Sickness Absence
The sickness rate has reduced for both long and short term sickness this month (3.23%). The focused work on supporting areas to proactively manage sickness continues with the aim of further reducing sickness to below target.

The actions underway will ensure that these improvements continue and are sustained. Progress against the key performance indicators will continue to be managed through Directorate Performance Reviews.

The situation remains challenging; however it is clear that the focus of activity on the three key areas of pressure; agency spend, recruitment and sickness absence are starting to impact and we have seen early improvements in all of these areas this month.

The proposed People Strategy 2018-2022 was presented to the Committee. The four strategic areas (Resourcing & Talent Management, Business Partnering, Organisational Development & Engagement and Health & Wellbeing) and approach was agreed but further work is required on what will be delivered (short term v long term), by when and what the benefits will be. The next step is to prepare for Board Seminar January 2018.

The Freedom To Speak Up Guardians presented a progress report which demonstrated that these roles are a valuable access point for staff to raise concerns. There is a pre-meet now scheduled with the Director of OD & People ahead of the meeting with the Chief Executive. Assurance on this topic will be via the Executive Workforce Committee to the Board. Suggestion made to ensure that the Clinical Quality Committee receive an update going forward also for any patient related concerns.

Report to:	Trust Board	**Agenda item:**	**SFT3954**
Date of Meeting:	4 December 2017		

Report Title:	Clinical Governance Committee		**Date:**	26 October 2017
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness			
Sponsor (presenting):	Dr Michael Marsh, Non-Executive Director			
Appendices (list if applicable):	None			

Recommendation of items for escalation :
Items for escalation: • Awareness of GDPR training and consideration of implications for the Trust. • Positive assurance - HSMR has reduced over successive months, this is linked to improvement in palliative care and co-morbidity coding. Compliant with national mortality guidance. • Children and young people - significant improvement in CAMHS provision since the introduction of a clinical nurse specialist. Developmental improvement journey continues within the core service. Community service provision has increased risk temporarily with mitigation in place.

1. Business Undertaken

1.1 An internal audit report on the Friends and Family test recommended all 6 score measures should be reported. It was agreed it should remain as 4 measures in line with national reporting.

1.2 CAMHS – the legal and operational framework to detain children under the Mental Health Act needs to be confirmed in a service level agreement which is expected to be in place soon.

1.3 A discussion took place about the CGC terms of reference. A decision was deferred to November as to whether the Chief Operating Officer should be a member or in attendance.

1.4 CGC cycle of business – further work is required to balance the provision of reporting for Board assurance and sufficient time for debate. Meeting to be held outside of the CGC to agree standing agenda items and reporting schedule.

1.5 Effectiveness of CGC – agreed that the committee complied with its terms of reference.

1.6 Children and Young People core service presentation - positive assurance on improvements. The ward now provides the paediatric burns service. Ongoing discussions with Virgin Health care to ensure there are no gaps between the two services.Significant investment in nursing staff with a paediatric outreach team to respond to needs in ED, DSU and the ward.

1.7 Spinal Unit leadership – clinical leader post currently advertised.

1.8 Assurance – discharge pathway for patients from main theatre recovery has been changed and no direct discharges from recovery to home in October. Further improvements to be made in the pathway.

1.9 Quality indicators - area of concern is high risk TIA patients not all seen within 24 hours of referral. The CCG changed to an electronic referral process and some referrals were lost to first review. Patients now prioritised and no harm identified.

1.10 Mortality review report includes new mortality dashboard. Key themes emerging – advanced care planning, treatment escalation plans and community DNAR.

2 Items for escalation

2.1 Awareness of GDPR training and consideration of implications for the Trust.

2.2 Positive assurance - HSMR has reduced over successive months, this is linked to improvement in palliative care and co-morbidity coding. Compliant with national mortality guidance.

2.3 Children and young people positive assurance - significant improvement in CAMHS provision since the introduction of a clinical nurse specialist. Developmental improvement journey continues within this core service.

3 Key Risks Identified and Impact

3.1 High risk TIA patients lost to first review in the last 2 months. Patients now prioritised and no harm identified.

4 Key Decisions

4.1 None

5 Exceptions and challenges

5.1 None

6 Governance and Other Business

6.1 Post meeting note – In response to a Health Service Journal article that the NHS has been slow to address fire safety concerns following the Grenfell fire it should be noted that the Clinical Governance Committee received a report from the Fire Officer at

the July 2017 meeting. The Fire Officer provided assurance that the Trust's buildings have been inspected and are complaint with regard to cladding. He reported that a test evacuation of Farley ward was scheduled as part of our major incident plan. The CEO issued a broadcast to inform our staff of cladding compliance.

7 Future Business

7.1 Meeting in November 2017 with items agreed at the pre-meet.

Report to:	Trust Board	**Agenda item:**	**SFT3954**
Date of Meeting:	4 December 2017		

Report Title:	Report of Clinical Governance Committee (CGC)	**Date:**	23 November 2017
Prepared by:	Lorna Wilkinson, Director of Nursing		
Board Sponsor (presenting):	Jane Reid, Non-Executive Director		
Appendices (list if applicable):			

Recommendation of items for escalation :
Following the CGC meeting in November the following items were agreed for escalation: • Electronic Prescribing and Administration of Medicines. Acknowledging that this was part of the Lorenzo business case it is apparent that there is a significant delay in this module being available nationally. The Committee were concerned that this delay has implications for the Trust and its patient safety aspirations • Entonox levels in Maternity had been picked up on a safety walk and have been reported to Board previously. Despite historical work on this there is an ongoing concern and high levels recorded in some rooms on labour ward. A capital bid has been submitted for a phased approach to building work to ensure appropriate scavenging systems are in place

Report to:	Trust Board	**Agenda item:**	**SFT3954**
Date of Meeting:	4 December 2017		

Report Title:	Review of the effectiveness of the Clinical Governance Committee - September 2016 – July 2017			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness			
Sponsor (presenting):	Dr Michael Marsh, Non-Executive Director, Joint Chair Professor Jane Reid, Non-Executive Director, Joint Chair			
Appendices (list if applicable):				

Recommendation:
Recommendation - the report is presented for assurance that the Clinical Governance Committee is complying with its duties as set out in the terms of reference. **Assurance** – from March 2017 the Clinical Governance Committee had an agenda item for issues for escalation to ensure the Board is routinely sighted on and involved in the mitigation of key risks.

Executive Summary:
The review period totalled nine meetings held between September 2016 and July 2017. The report provides the Board with assurance that the CGC is effective in complying with its duties as set out in its terms of reference and items for escalation are reported to the Board after each meeting.

SALISBURY NHS FOUNDATION TRUST
REVIEW OF THE EFFECTIVENESS OF THE
CLINICAL GOVERNANCE COMMITTEE 2016 - 2017

1.0 Purpose

The purpose of this review is to provide assurance that the Clinical Governance Committee (CGC) is complying with its duties as set out in the terms of reference in 2016. The review period covers the last nine meetings from September 2016 to July 2017.

2.0 Background

The Framework for Integrated Governance indicates that clinical governance is the responsibility of the Board, supported by the CGC for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

The CGC's terms of reference detail its responsibility in providing assurance to the Board for the delivery of clinical governance and the quality agenda. The CGC does this by ensuring the supporting processes are embedded in directorates and the Trust wide groups promote learning, best practice and compliance with all relevant statutory duties.

3.0 Membership, attendance, quorum, frequency of meetings

All 9 meetings were quorate (appendix 1). The Chairman nominated a non-executive Director as chair for the May 17 meeting in the absence of the joint chairs.

4.0 Accountability and reporting arrangements

All 9 sets of minutes were presented at the subsequent public Board meeting. An annual Quality Governance report 2016/17 was presented at the June 17 CGC meeting.

5.0 Reporting arrangements into the Committee from Sub-Committees

Minutes from 8 sub-committees were presented to the CGC at the appropriate intervals except for the CQC steering group (appendix 2). Instead, a verbal update was given on the progress of the CQC action plan and preparedness of the organisation. From March 2017 all reporting committees, including the CGC, had an agenda item for items for escalation to ensure the Board is routinely sighted on and involved in the mitigation of key risks.

5.0 Duties on behalf of the Trust Board

5.1 Care Quality Commission

Progress of the CQC action plan has been reported quarterly on actions taken and completed and organisational readiness for a CQC inspection across core services. Positive assurance is that more of the core service actions have taken steps towards completion. Three remain at high risk – the surgical pathway and discharging patients from main theatres mitigated by a turn around plan, nursing documentation compliance – the Director of Nursing is leading on turn around and the paediatric emergency department area is still subject to building works. Some risk remains on patient flow due to the ward reconfiguration work.

The executive team have completed a self-assessment on the well-led framework and have a resulting action plan. The CQC inspection report also noted areas of weakness in governance, risk management and quality measurement in that the CGC minutes did not detail the roles of the people attending and not all actions were captured in the minutes. The CGC noted that the new Framework for Integrated Governance and Accountability Framework had pulled together an integrated performance report which enabled the Board to be routinely sighted on and involved in the mitigation of key risks. The CGC noted a lot of work had been undertaken to identify the key risk register along with the mitigation. A new Board and Committee handbook was introduced in October 2017. It sets out the duties of all staff involved in the preparation and

presentation of papers to the Board of Directors, its committees, the sub-groups of the management team and the management of those meetings and carrying out the actions that emanate from the Board and committee deliberations. The CGC have adopted them.

Patient Safety

5.2.1 Agree an annual safety plan and monitor progress

The CGC received three patient safety programme reports of year 2 of the Sign Up to Safety programme. Positive assurance was provided of the consistent use of the safety in theatre checklist procedure. The insertion and latterly ongoing catheter care bundles are now well imbedded. Areas of risk continue to be falls resulting in harm mitigated by the refreshed falls prevention strategy and multifactorial falls risk assessment. A new patient safety newsletter has been published to share learning.

5.2.2 Ensure risks to patients are minimised through application of a comprehensive risk management system in accordance with the Risk Management strategy and policy including:

- **To identify areas of significant risk, set priorities and agree actions using the Assurance Framework and risk register process.**
- **Monitor and review the clinical risks in the Assurance Framework and corporate risk register**

The assurance framework was reviewed quarterly with newly identified gaps in controls/assurance and positive assurances reported along with the relevant extract from the Trust's corporate risk register. The risk report card was reviewed quarterly and a risk annual report 2015/16 was received in September 2016 focusing on the progress that was made against the strategic goals and KPIs as set out in the Risk Management strategy (2015).

The NPSA National Reporting and Learning System (NRLS) data was presented twice during the period and showed the Trust rose to the highest 25% of reporters for acute (non-specialist) organisations for reporting of incidents. This increase is seen as a positive safety culture indicator.

The serious incident inquiry and clinical review report was reviewed quarterly and the CGC noted the good progress made in the completion of actions.

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

The CGC received quarterly reports on safeguarding children and adult safeguarding. By June 2017 positive assurance was received on safeguarding children Level 3 training compliance above 90%. An area of ongoing risk is that the local authority continues to be unable to meet the demand to complete the best interest and mental health assessments within the 7 day urgent authorisation period. CGC noted that the Wiltshire Safeguarding Adults Board had been challenged on this issue to find a solution.

5.3 Clinical Effectiveness/Clinical Outcomes

5.3.1 Agree the annual quality plan and monitor progress

The annual quality governance report 15/16 provided positive assurance that improving the quality of care had made good progress in the 'must do' elements of the CQC action plan. Risks remain in reducing falls that result in harm mitigated by a refreshed Trust wide falls action plan. Sustaining zero tolerance on mixed sex accommodation and maintaining patient flow during the site reconfiguration.

The quality account 2016/17 and the quality priorities for 2017/18 were approved in May 2017. An annual self-assessment against NHSI's Quality Governance Framework 2017/18 was presented to satisfy itself and patients that effective arrangements are in place to continuously monitor and improve the quality of care and areas that require improvement are effectively addressed. The CQC noted that the 2014/15 self-assessment had not included areas of weakness or areas in need of improvement. These were included in the last two self-assessments in September 2016 and 2017.

5.3.2 Ensure that care is based on evidence of best practice and national guidance

An annual NICE report 2016/17 provided assurance that the number of sets of guidance that are non-compliant for more than 12 months is 24 as at March 2017. There were 2 high risk actions outstanding which were subsequently completed by September 2017.

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

An annual report on professional registration was received in June 2017. The CGC were assured than no registrant was allowed to work unregistered.

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

A report on new procedures was presented in July 2017 to provide assurance that staff undertaking new procedures have complied with consent, audit and governance arrangements.

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

A quality indicator report was presented at all nine meetings and discussed quarterly. The CGC was assured by the actions taken to address areas where performance was not as expected.

5.3.6 Identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas in all specialities.

A number of core services inspected by the CQC presented to the CGC to provide assurance that their improvement plans were being completed. The CGC were assured by the approach.

Regular verbal updates were given of progress with a CQC enforcement notice related to a backlog of patients waiting for an outpatient follow-up appointment or video-urodynamic study. By April 17 the backlog had been cleared and the enforcement notice was met in full. However, there are continuing leadership concerns to be mitigated by a clinical therapy leadership model in the Spinal Unit.

An end of life care report provided assurance that significant progress had been made in the previous 12 months validated both by the 'good' rating from the CQC and significant improvements in the National Care of the Dying audit results. An annual dementia strategy report was presented by the clinical leads providing assurance that carer support had improved but further work is required to manage patients with delirium effectively. A learning disabilities report gave assurance that patients continue to receive good care with reasonable adjustments with good external engagement for the learning disabilities working group.

5.3.7 Ensure the research programme and governance framework is implemented and monitored

The research programme quarterly key performance indicators provided positive assurance. 3 of the 4 applicable indicators were met or exceeded. The risk of non-compliance with the 4th standard at year end is low and compliance is predicted to improve when the number of studies reviewed increases. An annual report 2016/17 provided assurance that the Trust recruited more participants into more studies across more specialities than the previous year. The hospital was ranked top for the number of studies and 4th recruiting small acute Trust nationally.

5.4 Patient experience

5.4.1 Agree the annual patient experience plan and monitor progress

An annual patient experience report 2016/17 provided assurance on lessons learnt and changes in practice as a result of patient feedback. However, further work is required to increase responsiveness to people's concerns.

The CGC noted the regular updates provided on the Spinal Unit leadership and the plans for a new leadership model.

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

The national inpatient survey results from 2016 provided assurance that the Trust scored 'about the same' as most other Trusts in England for the 11 sections and 'better' for patients having trust and confidence in the doctors treating them, and being told how an operation or procedure had gone in a way they could understand. Each ward identified its themes from all patient feedback and actions plans are in place.

Patient stories were told at two meetings along with a study of whether videoed stories would be an acceptable option to both patients and the committee members. The CGC decided patient stories should be told at the Board in 2017.

5.5 Learning from others

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

An annual external enquiries report which includes the Trust's response to national reviews, national confidential enquiries and external agency visits provided assurance that recommendations were acted upon until complete. The CGC were assured that an improvement notice of compliance with IR(ME)R regulations had been complied with by the deadline.

A raising concerns annual report 16/17 provided assurance that the Trust meets the requirements of the Freedom to Speak Up standards. The national staff survey 2016 put the hospital in the top 20% of all Trusts for staff feeling confident and secure in reporting concerns about unsafe clinical practice.

6.0 Items escalated to the Board

- Clinical leadership model for the Spinal Unit
- Research Strategy 2017 – 2022
- Leaks into the patient waiting area in Rheumatology
- CQC preparation
- Opportunities to improve triangulation of staff/management complaints

7.0 Summary

This paper serves to provide the Board with assurance that the CGC is effective in complying with its duties as set out in its terms of reference and items for escalation are reported to the Board to ensure it is sighted on and involved in the mitigation of key risks. The terms of reference are updated in October 2017.

8.0 Recommendation

The report is presented for assurance that the Clinical Governance Committee is complying with its duties as set out in the terms of reference.

Claire Gorzanski
Head of Clinical Effectiveness
17 October 2017
Updated 1 November 2017

Appendix 1

Clinical Governance Committee
Membership attendance

	Sept 2016	Oct 2016	Nov 2016	Jan 2017	Feb 2017	Mar 2017	May 2017	June 2017	July 2017	Number attended out of 9 meetings
Lydia Brown (Chair)	Yes	Yes								2/2 (100%)
Jane Reid (Chair)	Yes	No	Yes	Yes	No	Yes	No	No	Yes	5 (55%)
Michael Marsh (Chair)			Yes	Yes	Yes	Yes	No	Yes	Yes	6/7 (86%)
Steve Long (NED)	Yes	No	Yes	Yes	Yes	No				4/6 (66%)
Ian Downie (NED)	Yes	Yes	Yes	Yes	Yes	Yes				6/6 (100%)
Tania Baker (NED)	Yes	Yes	Yes	No	Yes	Yes	Yes (Chair)	Yes	No	7 (77%)
Michael Von Bertele					Yes	Yes	Yes	No	Yes	4/5 (80%)
Peter Hill (CEO)	No	Yes	Yes	Yes						3/4 (75%)
Cara Charles-Barks (CEO)				Yes	Yes	No	No	Yes	Yes	4/6 (66%)
Andy Hyett (COO)	Yes	Yes	Yes	Yes	No	No	Yes	No	No	5 (55%)
Dr Christine Blanshard (MD)	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	8 (89%)
Lorna Wilkinson (DoN)	No	No	Yes	Yes	Yes	Yes	No	No	Yes	5 (55%)
(DDoN)	Yes	Yes	Yes	Yes	No	No	Yes	No	Yes	6 (66%)
(Head of CE)	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	7 (77%)
(Head of CC)	Yes	No	Yes	Yes	No	No	No	No	Yes	4 (44%)
(Head of IA)	No	No	No	No	Yes	No	No	Yes	No	2 (22%)
(Chief Pharmacist or Deputy)	No	No	No	No	No	Yes	Yes	No	No	2/3 (66%) Attends 3 times a year
- (Governor)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	9 (100%)
(Junior doctor)	No	No	Yes	No	No	No	Yes	No	No	2 (22%)
(Junior nurse)	No	No	No	No	No					0/5 (0%)
(Junior nurse)							Yes	Yes	No	2/3 (66%)
Quorate	✓	✓	✓	✓	✓	✓	✓	✓	✓	

Quorum

Chairman (or Deputising Non-Executive Director) and three other Board Directors. In the absence of the Chair of the Committee, the Chair of the Trust Board will invite one of the other Non-Executive Directors to chair the meeting.

Appendix 2

Reporting arrangements into the Clinical Governance Committee from Sub-Committees

Committee	Sept 2016	Oct 2016	Nov 2016	Jan 2017	Feb 2017	Mar 2017	May 2017	June 2017	July 2017
CMB minutes	✓	✓	✓	✓	✓	✓	✓	✓	✓
IPCC minutes quarterly		✓		✓			✓		✓
Information Governance Steering Group minutes	✓	✓	No	No	✓	✓	✓	✓	✓
Clinical Risk Group minutes	✓	✓	✓	✓	✓	✓	✓	✓	✓
Children & Young People's quality and safety board minutes -- quarterly		✓		✓		✓			✓
Integrated Safeguarding Committee minutes – 3 times a year	✓		✓				✓		
CQC Inspection steering group minutes	No	No	No	No	No	No	No	No	No
Supervision of Midwives Assurance meeting minutes – quarterly		✓		No			✓		✓

Report to:	Trust Board – Public	**Agenda item:**	SFT3955
Date of Meeting:	04 December 2017		

Report Title:	Report of Finance & Performance Committee	**Date:**	06 November 2017
Prepared by:	Lisa Thomas, Director of Finance		
Board Sponsor (presenting):	Nick Marsden, Chairman		
Appendices (list if applicable):	None		

Recommendation of items for escalation :
The Board are asked to note the business conducted at the Finance & Performance Committee on 6 November.

Business Undertaken

The following business was discussed:

- The Trust's financial position and in-year financial recovery which was subsequently discussed at the November Private Trust Board

- The draft Financial Recovery Plan on which there is further work to be done to develop a deliverable plan

- The Trust's contracting position - The Committee were pleased to receive a report which will feature as a standing item going forwards

- An update on the Trust's winter planning and governance arrangements

- An update from the Outstanding Every Time Board including CIP delivery in-year, risks and mitigations in place

Key Risks Identified and Impact

- Draft Financial Recovery Plan - the scale of the recovery challenge will require transformational change and additional capacity to deliver.

- IT Infrastructure business case - the Committee considered a business case to modernise the Trust's data centre environment which goes out of support from July 2018. Investment in this business case will impact on next year's capital plan which the Committee requested further information on. It was agreed the business case should return to the Committee at its next meeting before proceeding for decision to the December Trust Board meeting.

Key Decisions

- No matters to report

Exceptions and Challenges

- No matters to report

Governance and Other Business

- No matters to report.

Future Business

In addition to the items mentioned above, regular agenda items are:

- Finance report from the relevant month
- Contracting
- Trust performance
- Productivity and benchmarking
- Update from the Outstanding Every Time Board

Report to:	Trust Board – Public	**Agenda item:**	SFT3955
Date of Meeting:	04 December 2017		

Report Title:	Report of Finance & Performance Committee	**Date:**	27 November 2017
Prepared by:	Lisa Thomas, Director of Finance		
Board Sponsor (presenting):	Nick Marsden, Chairman		
Appendices (list if applicable):	None		

Recommendation of items for escalation :
The Board are asked to note the business conducted at the Finance & Performance Committee on 27 November 2017.

Business Undertaken

The following business was discussed:

- The Trust's financial position and in-year financial recovery
- The draft Financial Recovery Plan on which there is further work to be done to develop a deliverable plan
- An update on the Trust's contract position
- Reviewing performance for Month 7
- Reviewing the allocated aspects of the new format Board Assurance Framework including local services, specialist services and resources
- Update from the Outstanding Every Time Board
- Consideration of an IT infrastructure business case
- Strategic estates developments which will progress to Board for consideration

Key Decisions

- Following a review by the EPR stabilisation group the Committee approved the recommendation to move out of the stabilisation phase. The project will come to a future Finance & Performance Committee meeting early in the new year with recommendations.

- The Committee agreed a commercial strategy which will strengthen the governance structure for commercial ventures and provide a framework against which to assess current and future ventures, improving transparency and informing decision making.

Exceptions and Challenges

- No matters to report

Governance and Other Business

- No matters to report.

Future Business

The following are regular items for the Committee:

- Finance report from the relevant month
- Contracting
- Trust performance
- Productivity and benchmarking
- Update from the Outstanding Every Time Board

Report to:	Trust Board	**Agenda item:**	**SFT 3956**
Date of Meeting:	4th December 2017		

Report Title:	Integrated Performance Report, October 2017			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Executive Directors			
Executive Sponsor (presenting):	Executive Directors			
Appendices (list if applicable):				

Recommendation:
To note the information contained in the integrated performance report

Executive Summary:
The Integrated Performance Report highlights key themes and issues across the organisation, attempting to make links between the various aspects of the Trust's business. As such it brings together themes from the: quality, people, performance and finance reports and seeks to set out the interlinking issues and plans to move forward the challenges faced. Also included are the latest performance and quality reports from Wiltshire Health & Care. The report reflects NHS Improvement expectations of the information to be reviewed at the Board.

Performance Summary Narrative – October Performance, plus recent context

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
Local Services (COO)	• Trust achieved month end target of more than 92% of patients waiting for treatment having waited less than 18 weeks. • Reduced number of cancellations for non-clinical reasons	• Pressures on referral to treatment times in some sub-specialty areas often as a result of emergency pressures. • Particular challenge in terms of gastroenterology waiting times	• Directorates produced specialty level planning to determine capacity required to achieve 18 weeks. Undertaking additional lists to move this forward between now and the middle of January • Task and finish group established to review demand and capacity – additional clinics being set up (by end of January)
	• Diagnostic waits at >99% within 6 weeks • Improvements in backlogs in reporting times in radiology	• Diagnostic waits for MRI and audiology remain challenging • Longer term pressures for radiology in terms of ability to recruit consultants following retirements and growing demand for the service	• Outsourcing to other providers to maintain waiting times for MRI. Audiology additional capacity from December • Directorate to undertake a strategic review of the service – completes in Q4
	• Detailed planning for winter in place, with resilience meetings established to provide assurance regarding management of emergency pressures over the coming months • External funding agreed for extension of Older People Assessment Liaison project • Within the best performing Trusts in the country for ED performance for	• Emergency pressures fluctuate reflecting both changing levels of demand, including increased acuity, and internal and external capacity.	• Work with community providers to increase capacity (end Dec) • Ward reconfiguration to improve emergency flow. New MAU due to be operational on 6th December. Work on Pembroke ward started (Feb 18). • Steering group set up to lead the internal improvement of emergency clinical pathways (1st meeting in November)

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
	October at 96.3%		• Work underway to produce Trust escalation plan (completes December)
Local Services (COO)	• All cancer waiting time targets achieved. • Visibility of outpatient waiting list improved and are validating time to follow up appointments	• High levels of demand in a number of cancer pathways, eg breast	• National Cancer Improvement Team due to visit Trust (Q4)
Specialist Services (COO)	• Introduction of trauma surgeon of the day system in plastics – being piloted now • Development of MOHS service – specialist and technician employed to expand capacity		• Protected throughput of short stay surgical activity, including plastics, from early January
	• Cardiac catheter labs have now been repaired and operating	• Ongoing risk of operational failure due to age of equipment	• To be considered as a call on capital for 2018/19
	• Nurse-led outpatient clinic on spinal unit established and working well • Short stay inpatient assessment service for non-acute spinally injured patients established	• Leadership within the spinal unit • Value of the spinal contract with commissioners • Increased numbers of delayed	• Focussed piece of work underway, with recruitment continuing for a service lead for spinal unit (December). • Developing business case to specialist commissioners for spinal services to be completed following appointment of lead (Q4) • Step down facility being commissioned for spinal unit which will increase overall bed capacity – pilot being planned to commence December/January • Discharge of spinal patients now

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
		transfers of care	incorporated into integrated discharge bureau – embedding over next 6 months
Innovation (MD)	• Ongoing success of laundry contracts. • Live with GS1 tracking in theatres • Design of Breast Unit won highly commended award in Building Better Healthcare awards for contribution to improving patient experience and outcomes • Sterile Service performance improved over last month	• Capacity for expansion in laundry services requiring capital investment • Cash constraints on the Trust could place limits on the subsidiary companies ability to react to opportunities	• Opportunities for further laundry contracts. • Commercial development strategy approach outlined at F&P committee in November. Each of the Trust's subsidiaries will be reviewed in the context of strategic fit, opportunities and risks. (completed by March) • Working across the STP on back office functions. • Further contract review at executive level in January
Care (MD/DoN)	• HSMR continued to decline in latest figures. • Excellent performance continues in infection control – in upper quartile • Mixed sex breaches at 0 – for last 8 months • Positive result in recently-published children and young person's national survey • Since October, patients are no longer discharged home directly from main theatre recovery after surgery	• Mortality rate remains above expected • Stroke performance improved in September, operationally remains challenging • Periods of intense emergency pressure at times when staffing is equally challenged • Staffing remains challenging in a number of ward areas - see full	• Revised approach to mortality reviews. • See above for plans to manage urgent care demand and below for recruitment

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
		report in workforce paper re safer staffing	
Care (MD/DoN)	• RCEM audit of management of severe sepsis better than national average • NICOR heart failure audit – all metrics better than national average • • National Neonatal Audit – improvement in administration of antenatal steroids and outstanding breastfeeding rates • Excellent results in national dementia audit	• Need to improve documentation of septic patients receiving senior review before leaving ED • Ensuring all heart failure patients are admitted to Tisbury ward when outcomes are shown to be better • Improve communication with carers and patients with delirium or dementia • RCEM asthma audit shows poor performance compared to national standards	• ED working with new sepsis lead to develop improvement plan (Dec 17) • Will be a major focus for site co-ordination and will be facilitated by completion of ward moves (Feb 18). • Communication added to action plan of dementia steering group – ongoing in '18 • ED to appoint an asthma champion, undertake local re-audit and report to Clinical Management Board (May '18)
People (DoHR)	• Overseas nursing recruitment –cost effective and successful campaign in Australia • Introduced new approval form for new medical locum spend – to be signed off by three executive directors • Locum's nest – successful pilot and rollout in progress on flexible contract – locum staff at reduced rate • Rates of absence and agency spend have both fallen in month • 85 new starters in November	• Level of vacancies, especially in nursing, exacerbated by need for escalation**)** • Use of temporary staff high and unsustainable. High cost of medical agency. • Month 7 control total exceeded, but improving position • Staff survey returns at 35% • Flu take up rates are below CQUIN target – refreshing communications, data evaluation	• Longer term recruitment - "grow your own" plan, 10 month plan to achieve fill to 95% for ward based nursing. • Workforce pay control group to review temporary pay solution. Master vendor decision to be made in December. • Workforce controls group link nursing authorisation with medical authorisation and is overseeing temporary staffing costs going forward • Two week push on staff survey – high intensity on reminders, drop in sessions, prizes, T-shirts

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
People (DoHR)		to improve vaccination rate (end December)	
	• Trust absence below national benchmarking and fell in November	• Absence rate - high levels in theatres, causing capacity issues, a number of staff in informal stage	• Trust wide sickness group identified top 30 individuals to be supported back to work • Launch date of November for Health and wellbeing partnership with Loughborough University for study into factors causing absence
	• STP approach to joined up policies across organisations and HWB		• Workforce strategy phase 1 presented to Executive Workforce Committee on 27/11: recruitment and retention, diversity, health and wellbeing, business partnering
Resources (DoF)	• Slight improvement on financial performance in October. Increase in activity and income reflecting continued focus on utilising capacity appropriately. • Recovery plan development continues, significant progress has been made with procurement opportunities over the next 2 years.	• Year-end outturn forecast to be significantly off plan, NHSI investigation commenced, outcomes likely by end of December. • Recruitment and retention challenges continue to drive high agency spend. • Ongoing risks from Commissioner challenges places risk on the financial position. • Trust has borrowed £3m to date to support the underlying deficit position	• Forecast outturn position to be revised formally with NHSI at the end of Q3. • Directorates to formally agree individual savings programme by the end of December. • Turnaround Director support being identified to ensure next year's programme has traction and delivery (November).

Integrated Performance Summary Report

Salisbury NHS
NHS Foundation Trust

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			Last 3 Months				
	Metric Name	Target	Aug-17	Sep-17	Oct-17	Pts affected in Oct-17	YTD
LOCAL	A&E - 4 Hour wait from Arrival	95.0%	91.3% ↓	91.7% ↑	96.3% ↑	214	94.2%
	RTT - 18 Weeks from Referral to Treatment	92.0%	92.0% ↓	92.1% ↑	92.3% ↑	1,348	90.8%
	Cancer - 62 Day Wait for First Treatment from GP Referral	85.0%	91.9% ↑	91.2% ↓	82.9% ↓	10	87.1%
	Cancer - 62 Day Wait for First Treatment from Screening Referral	90.0%	100.0% →	100.0% →	0.0% ↓	1	81.8%
	Diagnostic - 6 Week Wait	99.0%	99.5% ↑	99.6% ↑	99.0% ↓	32	98.5%
	Diagnostic - 6 Week Wait - Compliance	10 out of 10	7 out of 10	9 out of 10	8 out of 10		

	Metric Name	Target	Jul-17	Aug-17	Sep-17	Reports outside RTG in Sep-17	
SPECIALIST Wessex Genetics Laboratory	Pre- + postnatal QF PCR + all molecular prenatal tests excluding Southern blotting		91.3% ↑	82.5% ↓	92.1% ↑	3	
	New-born screen for CFTR mutations (* working days)		66.7% ↓	73.3% ↑	100.0% ↑	0	
	Rapid oncology		100.0% →	100.0% →	80.0% ↓	1	
	Urgent postnatal		0.0% ↓	100.0% ↑	100.0% →	0	
	Prenatal array/karyotype + southern blot prenatal tests + urgent and predictive PCR-based molecular tests		79.5% ↓	79.7% ↑	75.9% ↓	13	
	Urgent oncology + molecular oncology testing in acute leukaemia		97.4% ↑	100.0% ↑	89.5% ↓	2	
	Routine oncology + routine PCR-based Haemato-oncology tests		97.7% ↑	96.7% ↓	94.7% ↓	18	
	Routine postnatal + routine PCR-based molecular tests		86.6% ↓	92.8% ↑	90.5% ↓	53	
	Mutation screening or tests which require Southern blotting + next generation sequencing of panels <10 genes		97.0% ↓	93.1% ↓	95.1% ↑	9	
	Mutation screening or tests which require Southern blotting + next generation sequencing of panels >10 genes		100.0% →	100.0% →	100.0% →	0	

	Metric Name	Target	Aug-17	Sep-17	Oct-17	Pts affected in Oct-17	YTD
CARE	Never Events	0	0 →	1 ↑	0 ↓		1
	Serious Incidents Rate		0 ↓	2 ↑	1 ↓		11
	Clostridium Difficile - notifications	19	0 →	1 ↑	1 →		3
	MRSA Bacteraemias - notifications	0	0 →	0 →	0 →		0
	% of births as emergency caesarean sections		10.7% ↓	8.4% ↓	8.1% ↓	17	12.0%
	% of harm-free care	95%	92.3% ↓	91.3% ↓	91.9% ↑	38	92.4%
	% of new harm-free care	95%	96.4% ↑	96.8% ↑	96.3% ↓	14	96.5%
	Venous thromboembolism (VTE) Risk Assessment	95%	99.6% ↓	99.3% ↓	99.1% ↓	9	99.4%
	Emergency re-admissions within 30 days following an elective or emergency spell at the Provider	TBC					
	Complaints - Total received	TBC	34 ↑	26 ↓	16 ↓		156
	Mixed Sex Accommodation breaches	0	0 →	0 →	0 →		0
	Inpatient Scores from Friends & Family Test - % Positive		96.4% ↓	97.1% ↑	96.9% ↓	242	96.9%
	A&E Scores from Friends & Family Test - % Positive		98.3% ↓	99.2% ↑	100.0% ↑	131	98.5%
	Maternity Scores from Friends & Family Test - % Positive		96.6% ↑	100.0% ↑	82.1% ↓	11	95.9%

	Metric Name	Target	2016-17 Q2	2016-17 Q4	2017-18 Q1 to date		YTD
CARE	Staff FFT - % Recommended for care or treatment		93.7% ↑	90.4% ↓	96.2% ↑		
				2015-16 YTD	2016-17 YTD		
	CQC Inpatient Survey - Overall Experience Score NEW!			8.4 ▪	8.2 ↓		

	Metric Name	Target	May-17	Jun-17	Jul-17		
CARE	Medication Errors - % Harmful Events NEW!						
	Patient Safety Incidents - % Harmful NEW!						
	Potential Under-reporting of Patient Safety Incidents NEW!						
	Central Alerting System Alerts Outstanding NEW!						
	Hospital Standardised Mortality Ratio	100	114	112	110		
	Hospital Standardised Mortality Ratio - Weekend	100	124	122	116		
	Summary Hospital Mortality Indicator	100					

	Metric Name (000s)	Target	Aug-17	Sep-17	Oct-17		YTD
STAFF	Total Staff Costs		£ 11,419,835	£ 11,552,535	£ 11,186,214		
	Temporary agency staff costs (£)	£ 513,000	£ 762,217	£ 804,575	£ 786,207		
	Temporary agency staff WTE		3.4% ↑	3.8% ↑	3.5% ↓		
	Temporary bank staff costs (£)		£ 582,156	£ 598,145	£ 523,734		
	Temporary bank staff WTE		6.3% ↑	6.5% ↑	6.4% ↓		
	Staff Absence	3.00%	3.50% ↓	4.03% ↑	3.23% ↓		
	Appraisals - Medical	85.0%	95.0% ↓	94.0% ↓	92.0% ↓		
	Appraisals - Non-medical	85.0%	81.9% ↓	82.1% ↑	81.3% ↓		
	Mandatory training (MLE)	85.0%	85.8% ↓	83.1% ↓	85.9% ↑		

	Metric Name		2016-17 Q3	2016-17 Q4	2017-18 Q1 to date		YTD
STAFF	Staff Turnover (Q)		2.7% ↓	3.6% ↑	3.0% ↓		
		Target		2014-15 YTD	2015-16 YTD		
	NHS Staff Survey	43%		31% -	35% ↑		

	Metric Name (000s)	Target	Aug-17	Sep-17	Oct-17	YTD plan	Variance
EFFECTIVE	Income & Expenditure - Surplus (+) / Deficit (-)	-£ 7,000	-£ 5,200 ↓	-£ 6,892 ↓	-£ 8,119 ↓	-£ 4,453	-£ 3,666
	Cost Improvement Plan	£ 7,500	£ 1,780 ↑	£ 2,290 ↑	£ 2,821 ↑	£ 3,421	-£ 600
	Cash Position	£ 2,009	£ 7,502 ↓	£ 6,580 ↓	£ 4,642 ↓	£ 4,365	£ 277
	Risk Rating	3	3 →	4 ↑	4 →		

	Metric Name	Target	Aug-17	Sep-17	Oct-17		YTD
PARTNERSHIP	Emergency admissions - Medicine & Elderly care (Over 65 years)		664 ↑	590 ↓	679 ↑		4,391
	Delayed Transfers of Care (DToC) - NHS	5	15 ↓	9 ↓	19 ↑		118
	Delayed Transfers of Care (DToC) - Social Services	11	10 ↓	15 ↑	9 ↓		87
	Bed days consumed by DToC each month		531 ↓	623 ↑	539 ↓		4672

- *denotes performance travel cannot be calculated due to a lack of figures in one of the months or quarters*

Acronyms

CFTR	Cystic fibrosis transmembrane conductance regulator	**RTG**	Reporting time guidelines
IBID	International Burn Injury Database	**SCIC**	Spinal Cord Injury Centre
QF-PCR	Quantitative Fluorescence-Polymerase Chain Reaction	**TAT**	Turn around time

Report to:	Trust Board	**Agenda item:**	**3956**
Date of Meeting:	4 December 2017		

Report Title:	Month 7 Operational Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Andy Hyett, Chief Operating Officer			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):				

Recommendation:
The Trust Board are asked to note the Trust Performance for Month 7

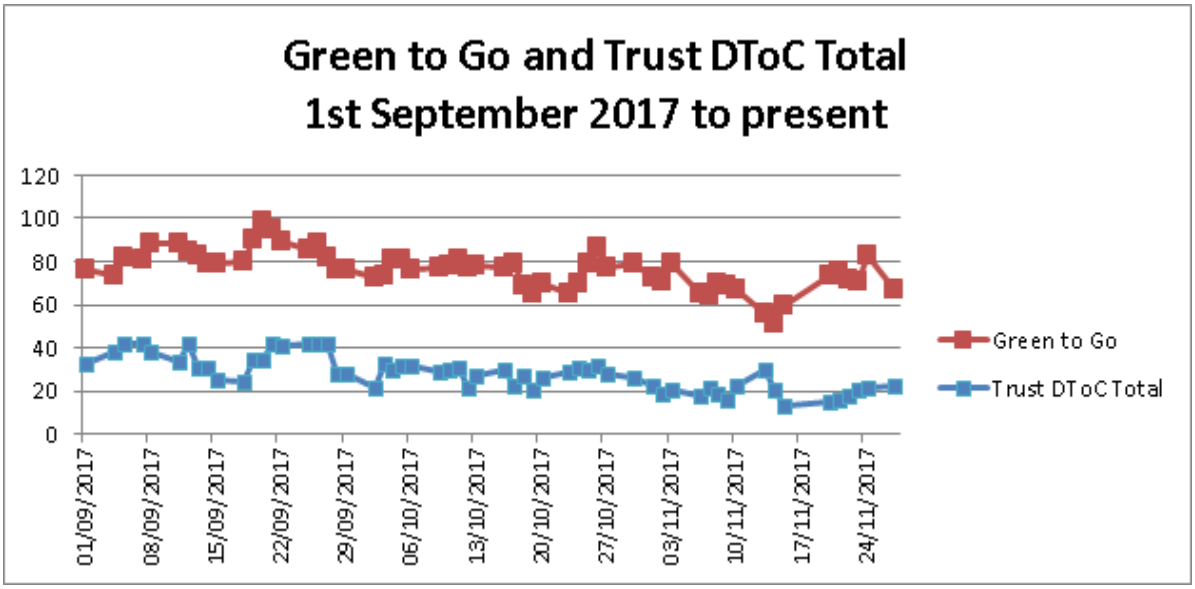
Executive Summary:
For Month 7 the trust successfully delivered the Referral to Treatment standard, the Diagnostic standard, the ED standards and Urgent operation cancelation standard. Unfortunately the trust is currently reporting non delivery of the 62 cancer standard however the validation period has not yet ended.

Emergency Pathway

4 hour performance for Month 7 was delivered at 96.3%.
Ambulance breaches - Total Breaches: 7, Breaches > 1hr: 0, Breaches < 1hr: 7.
There were no 12 hour trolley waits in October.

Time to Triage - Oct		
	All	Ambulance
Longest (minutes)	188	166
Median (minutes)	**10**	**7**

Time to treatment	
	October
Longest (minutes)	380
Median (minutes)	**58**



RTT

For October the trusts reported RTT performance of 92.3%.

5 specialties are not delivering to the standard, these are;

- General Surgery
- Trauma and Orthopaedics
- Oral Surgery
- Plastic Surgery
- Gastroenterology

Performance in these specialties is between 80% and 90%. Each area has prepared a plan for recovery which are currently being assessed.

Treatment function	Oct-17
General Surgery	80.33%
Urology	94.90%
Trauma & Orthopaedics	87.68%
Ear, Nose & Throat (ENT)	95.57%
Ophthalmology	98.67%
Oral Surgery	83.50%
Plastic Surgery	85.38%
General Medicine	100.00%
Gastroenterology	90.55%
Cardiology	100.00%
Dermatology	96.30%
Thoracic Medicine	94.50%
Rheumatology	100.00%
Geriatric Medicine	93.60%
Gynaecology	98.45%
Other	96.10%
Total	**92.25%**

Diagnostic

In October 99.05%% of patients were seen within 6 weeks. There were 32 breaches (30 MRI AND 2 Endoscopy).This is a worse position than month 6 due to an increase of 20 MRI waiters breaching.

November position is expected to be very similar.

Current wait times are 6 weeks in Radiology and 4-5 weeks in Endoscopy (with the exception of a small number of patients requiring a general anaesthetic).

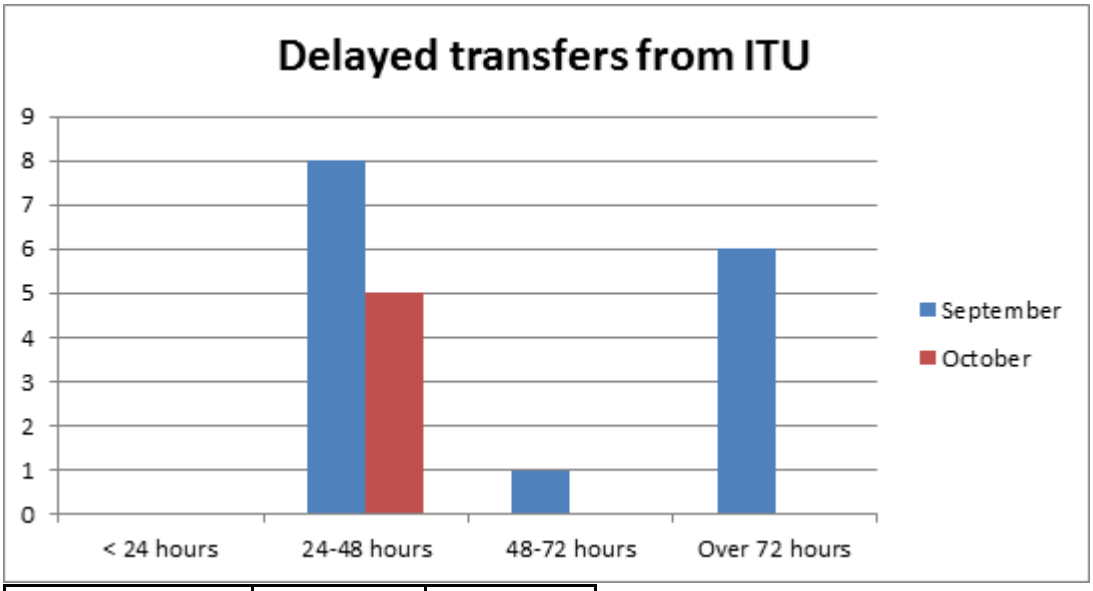
The position continues to be maintained by outsourcing MRI and Endoscopy tests, however outsourcing of Endoscopy tests is being reduced.

Cancer

All Cancer standards except the 62 day standard were delivered for October. Breast cancer, skin cancer and bowel cancer pathways remain areas on concern – breast cancer and skin cancer due to variation in referral numbers and bowel cancer due to capacity.

ICU

The graph below shows the number of delays in transferring patients from Intensive Care to downstream wards. The target is 24 hours however this is not always achieved due to availability of beds in specific specialties. This is managed through the daily bed meetings and an escalation process is in place for patients who are delayed beyond 24 hours.
In October 4 patients operations were cancelled due to a lack of ITU capacity



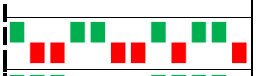
Delay period	September	October
< 24 hours	0	0
24-48 hours	8	5
48-72 hours	1	0
Over 72 hours	6	0
Total delayed	15	5
Total discharges	47	38
	32%	13%

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 – October 2017

Salisbury Hospital NHS Foundation Trust Board Report October 2017

			Reporting Month		Rolling 12 months
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Oct-17**	**Patients Affected in Oct-17**	**Trend Against National Standard**
Referral to Treatment Incomplete Performance	92%	STF = 92.0%	92.3%	1,348	
Referral to Treatment Incomplete Specialty Compliance	16 out of 16		11 out of 16		
Zero tolerance RTT waits > 52 weeks	0	0	0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Oct-17**	**Patients Affected in Oct-17**	**Trend Against National Standard**
A&E - 4 Hour wait from Arrival	95%	STF = 93.8%	96.3%	214	
A&E - 12 Hour Trolley Waits	0		0		
Diagnostics - Patients waiting less than 6 weeks	99%		99.0%	32	
Diagnostic Test Compliance***	10 out of 10		8 out of 10		
Urgent Ops Cancelled for 2nd time (Number)	0		0		
Mixed Sex Accommodation Breaches	0		0		
Infection control – Clostridium difficile (YTD)	19		YTD: 3	1	
Infection control - MRSA*	0		0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Oct-17**	**Patients Affected in Oct-17**	**Trend Against National Standard**
All Cancer two week waits	93%		94.7%	35	
Symptomatic Breast Cancer - two week waits	93%		98.9%	2	
31 day wait standard	96%		98.2%	2	
31 day subsequent treatment : Surgery	94%		100.0%	0	
31 day subsequent treatment : Drug	98%		100.0%	0	
62 day wait standard	85%		80.9%	11	
62 day screening patients	90%		0.0%	1	

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

***Only Diagnostic examinations carried out in the reporting month shown are counted

Report to:	Trust Board	**Agenda item:**	3956
Date of Meeting:	4 December 2017		

Report Title:	Quality indicator report – October 2017			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Christine Blanshard, Medical Director Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Quality indicator report – October 2017			

Recommendation:
To note the Trust quality indicators and actions being taken to improve.

Executive Summary:
Positive indicators reflect sustained good infection control practice and a culture of avoiding non-clinical mixed sex accommodation breaches. HSMR has reduced for the 4th data point in a row. Improvement in the stroke care indicators and a reduction in the number of complaints and concerns. Indicators of concern remain the high risk TIA performance anticipated to improve with twice daily clinics and the 3rd stroke consultant. We continue to focus on our falls reduction strategy.

1. Purpose

1.1 To provide the Board, Committees and Forums with the Trust's quality indicators

2.0 Background

2.1 The Accountability Framework sets out the performance function which oversees the delivery of all elements of Trust performance throughout the year, including service performance and quality of care linked to the delivery of the Trust's transformational and financial plans.

2.2 The Performance Framework sets out the metrics that each directorate will be held accountable for. The quality indicator report provides the metrics that the Trust uses to establish the quality of care provided by the Trust.

3.0 Quality indicator report

3.1 Readmission data, data for fractured neck of femur & multiple ward moves are now reported.

3.2 One serious incident requiring investigation commissioned.

3.3 One Trust apportioned C difficile.

3.4 One MSSA bacteraemia.

3.5 One E-coli bacteraemia.

3.6 HSMR decreased to 109.8 in July 17. In Q2, 97 (72%) deaths had an initial screen and 86 (42%) had a full case review. None had a greater than 50% chance of death due to problems in care. 18 learning points were noted for improvement action. The top 5 themes will be reported in Q3.

3.7 In October, there were two falls resulting in major harm (both fractured hips requiring surgery). The Trust falls reduction action plan is beginning to have a positive impact.

3.8 One patient who suffered a stroke as an inpatient failed to have a CT scan in 12 hours. Time to reach the stroke unit within 4 hours improved along with in-patients spending 90% of their stay on Farley ward – 3 patients were transferred to other wards to make way for new stroke patients. West Hampshire Clinical Commissioning Group undertook a stroke service assurance visit in November 17. SSNAP audit improved from D to C.

3.9 A reduction in the percentage of high risk TIA patients seen within 24 hours was due to the misdirection of referrals by the referral management centre. A new single point of access referral system is now in place and working well along with twice daily TIA clinics.

3.10 Escalation bed capacity remained high. Ward moves between 22.00 and 06.00 reported by month only. Phase one plan to reconfigure the bed base is on track with the opening of the new AMU expected in December.

3.11 No non-clinical mixed sex accommodation breaches for the 8th month in a row.

3.12 Real time feedback for patients rating the quality of their care improved. The Friends and Family test of patients who would recommend ED and the wards was sustained but the maternity service decreased. Care as a day case and outpatient was sustained. Q2 staff friends and family test improved.

4.0 Summary

Positive indicators reflect sustained good infection control practice and a culture of avoiding non-clinical mixed sex accommodation breaches. HSMR has reduced for the 4th data point in a row. Improvement in the stroke care indicators and a reduction in the number of complaints and concerns.

Indicators of concern remain the high risk TIA performance anticipated to improve with twice daily clinics and the 3rd stroke consultant. We continue to focus on our falls reduction strategy.

5.0 Recommendation

To note the Trust quality indicators and actions being taken to improve.

Claire Gorzanski, Head of Clinical Effectiveness, 13 November 2017

Salisbury NHS
NHS Foundation Trust

Trust Quality Indicators - October 2017

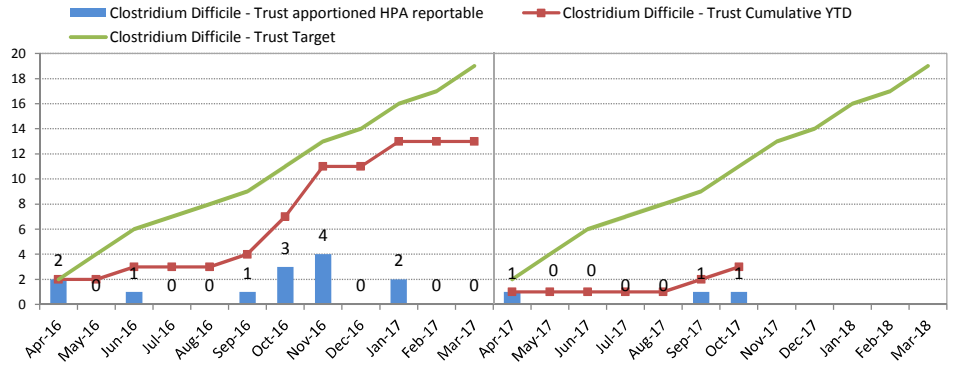
Quality Measures

Infection Control	*2016-17 YTD*	*2017-18 YTD*
MRSA (Trust Apportioned)	**0**	**0**

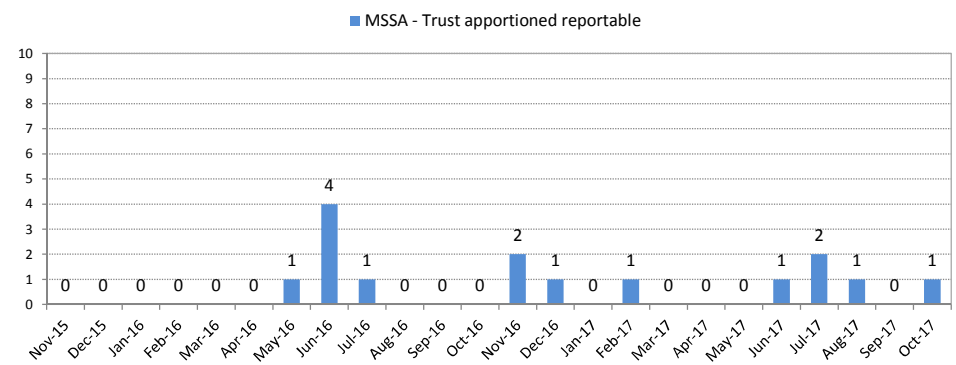
Trust Incidents	*2016-17 YTD*	*2017-18 YTD*
Never Events	**2**	**1**
Serious Incidents Requiring Investigation	**47 ***	**11**

* Of these commissioned, 1 has been downgraded following a formal agreement with the CCG, as it did not meet the SI definition

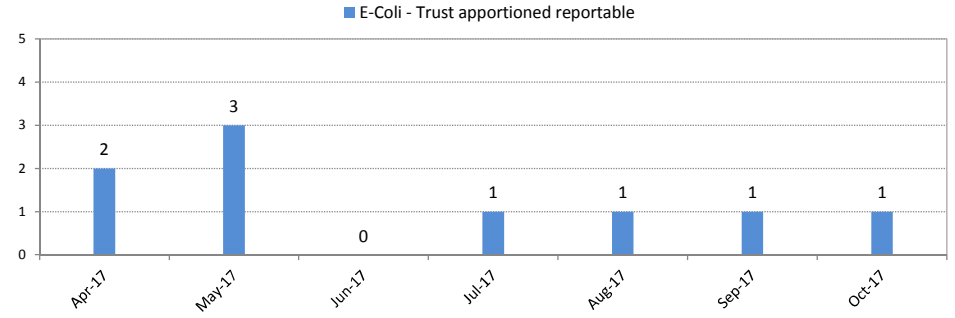
Clostridium Difficile - Trust Apportioned



MSSA - Trust Apportioned

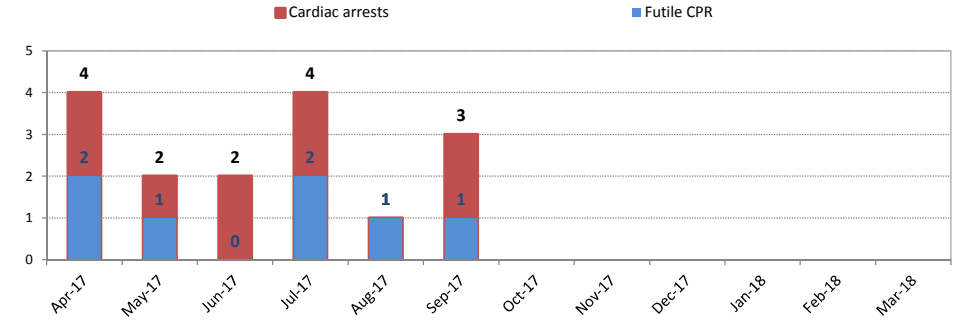


E-Coli - Trust apportioned reportable



Data from April 2017 onwards

In hospital cardiac arrests and futile CPR



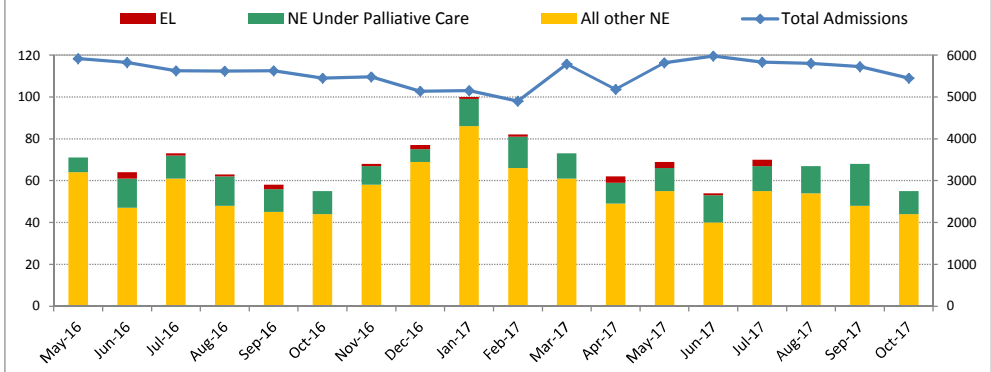
Please note cardiac arrests which occurred in ED, ITU, CCU and Paediatrics are excluded.
Data from March 2017 onwards

Salisbury NHS
NHS Foundation Trust

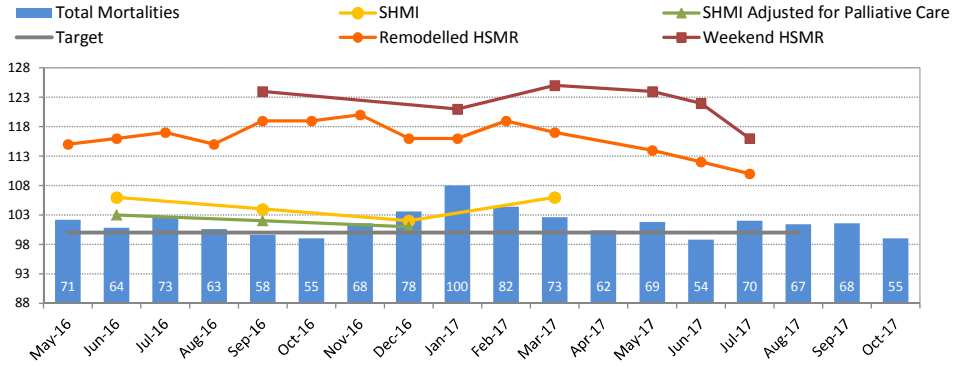
Trust Quality Indicators - October 2017

Quality Measures

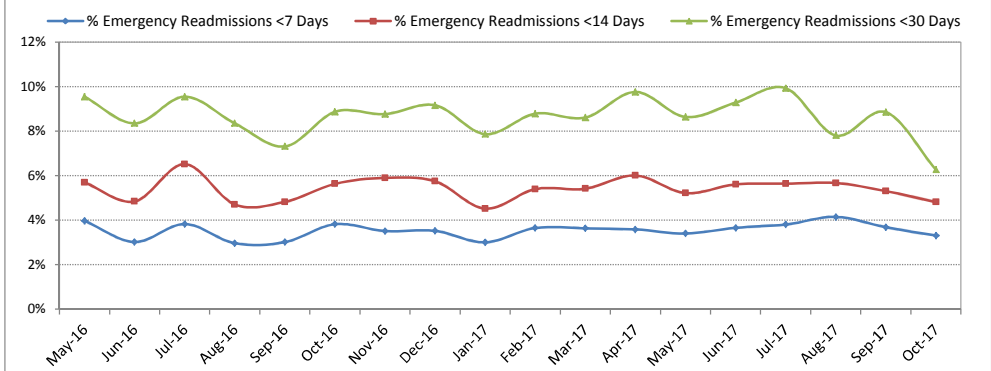
Hospital Mortalities



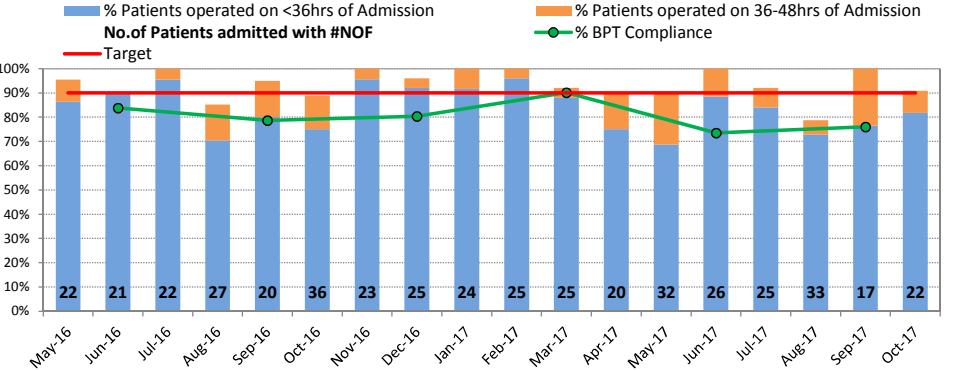
HSMR and SHMI



Emergency Readmissions within 7, 14 & 30 days of Discharge



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

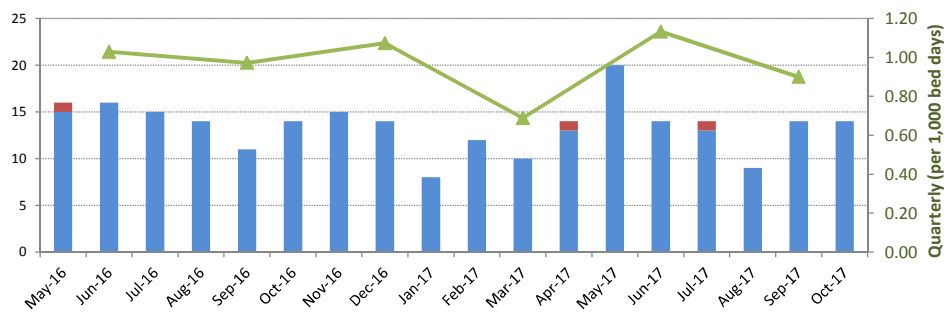


Salisbury NHS
NHS Foundation Trust

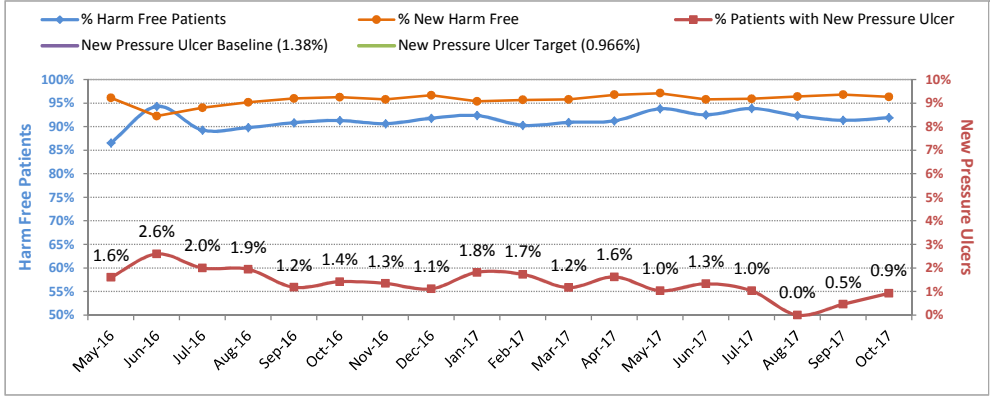
Trust Quality Indicators - October 2017

Quality Measures

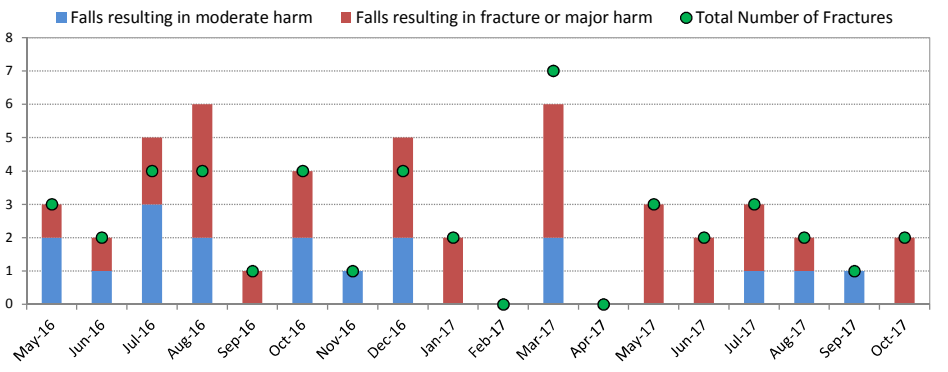
Pressure Ulcers



Safety Thermometer - One Day Snapshot per Month

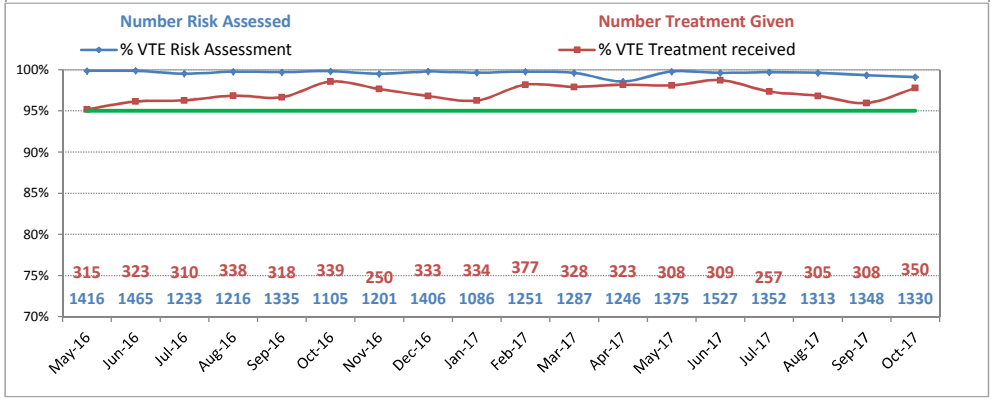


Patient Falls in Hospital



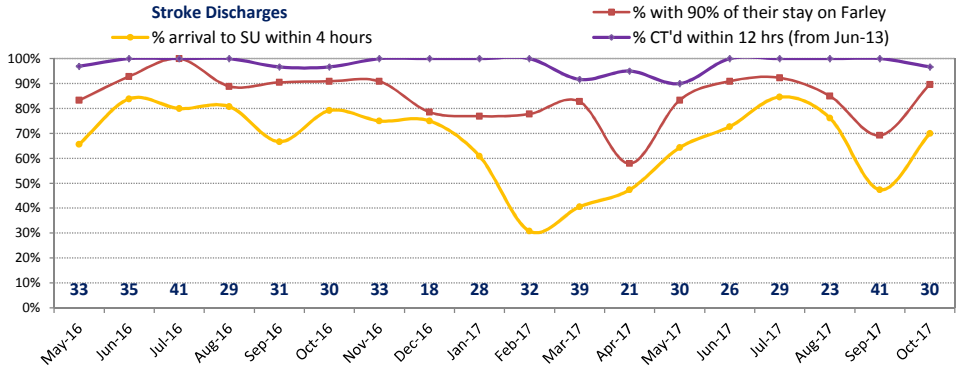
Please note, in Mar-17 1 patient has 2 fractures.

Venous Thrombous Embolism: Risk Assessment & Prophylaxis

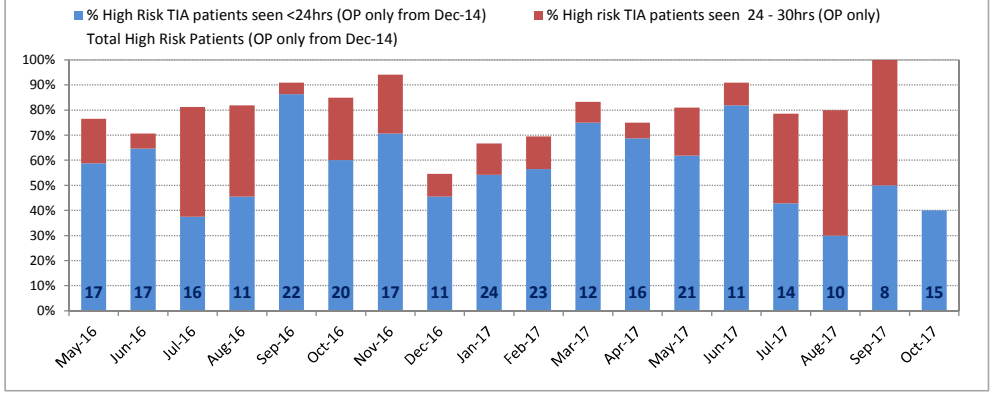


Please note, due to the time it takes to complete Clinical Coding, the current months Fracture Neck of Femur data will be subject to change over the following months.

Stroke Care



TIA Referrals



SSNAP Case Ascertainment Audit

Highest level = Grade A

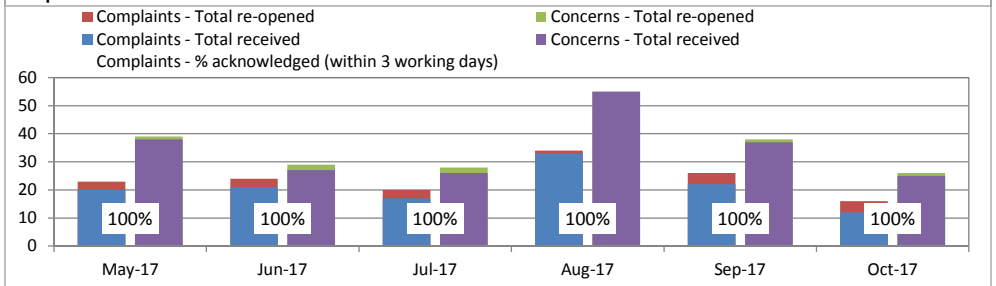
Lowest level = Grade E

Quarterly	Q1	Q2	Q3	Q4
2015-16	D	C	C	C

Tri-annually	Apr - Jul	Aug - Nov	Dec - Mar
2016-17	B	B	D
2017-18	C		

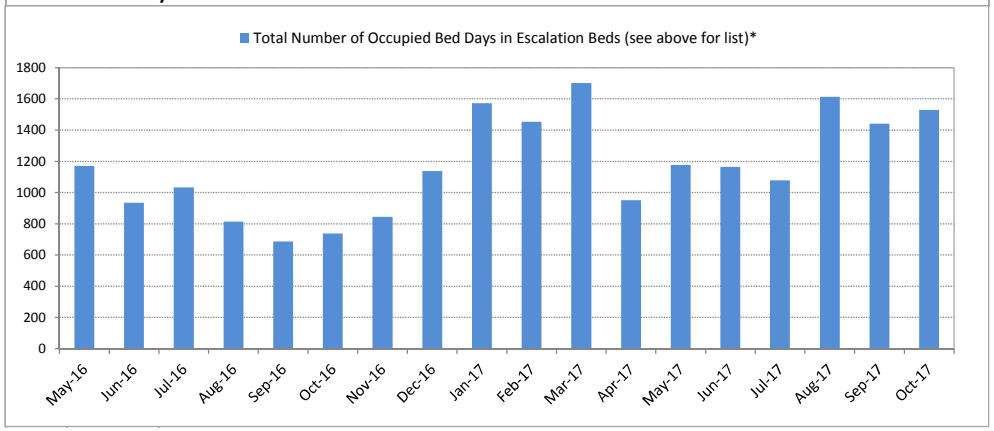
*From April 2016 escalation capacity includes beds on Breamore, DSU, Clarendon, Endoscopy, Avon, Britford SAU overnight stays, Whiteparish AMU overnight stays, Clarendon NHS, Pembroke Suite and Burns assessment room.

Complaints and Concerns

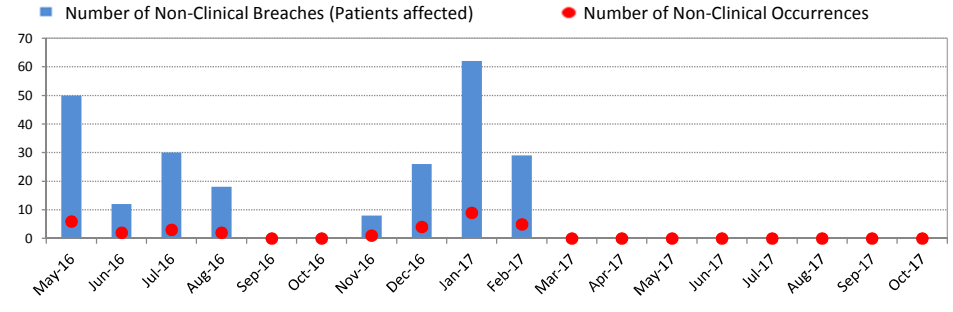


	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Complaints - Total received	20	21	17	33	22	12
Complaints - Total re-opened	3	3	3	1	4	4
Concerns - Total received	38	27	26	55	37	25
Concerns - Total re-opened	1	2	2	0	1	1

Escalation Bed Days

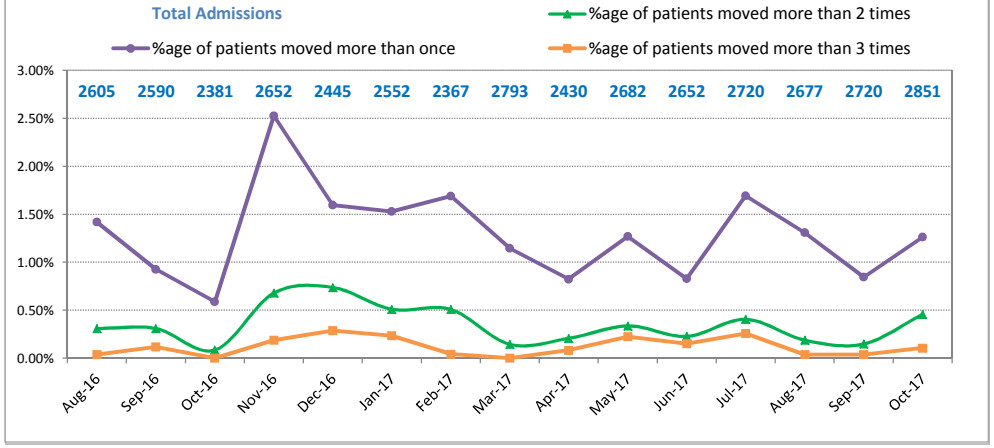


Delivering Same Sex Accommodation



	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
■	50	12	30	18	0	0	8	26	62	29	0	0	0	0	0	0	0	0
●	6	2	3	2	0	0	1	4	9	5	0	0	0	0	0	0	0	0

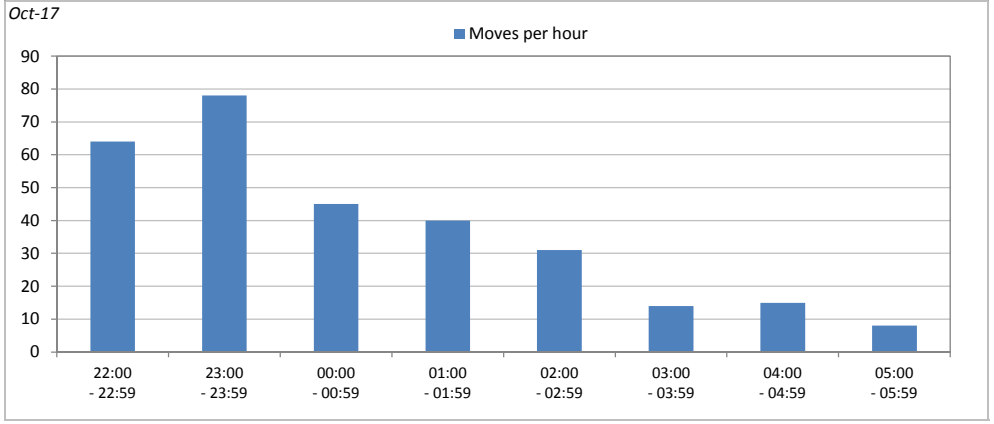
Patients moving multiple times during their Inpatient Stay



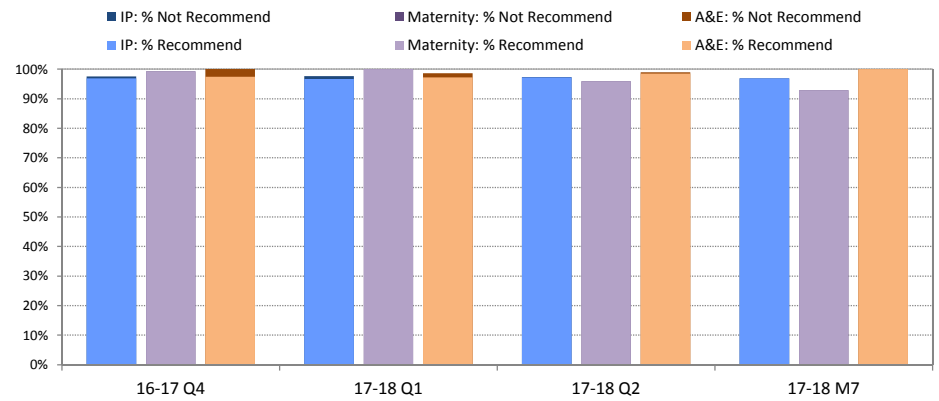
Please note, the number of Non-Clinical Breach Ocurrences is being reported from May 2016.

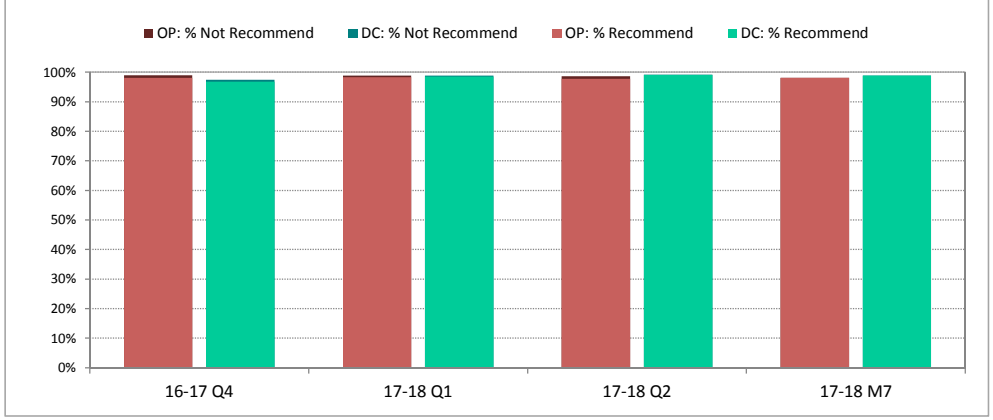
Ward moves between 22:00 and 06:00

Oct-17

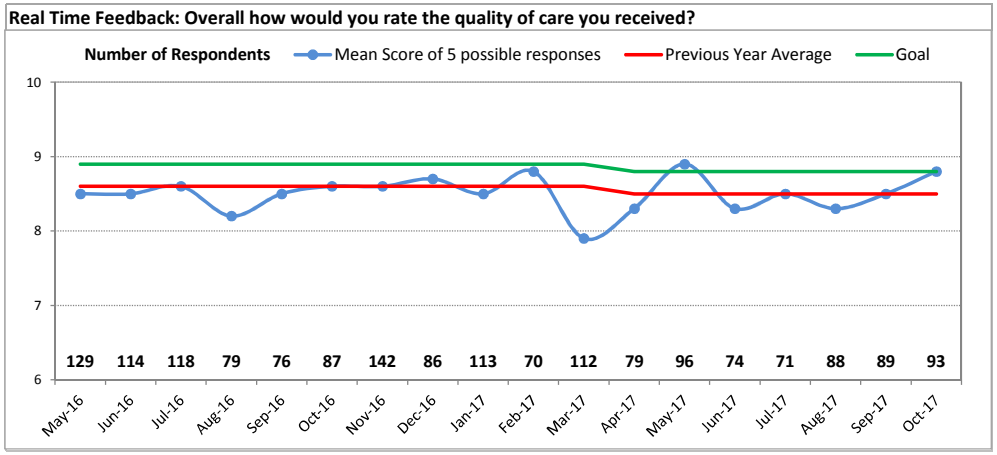


Friends & Family Test: Responses by Area

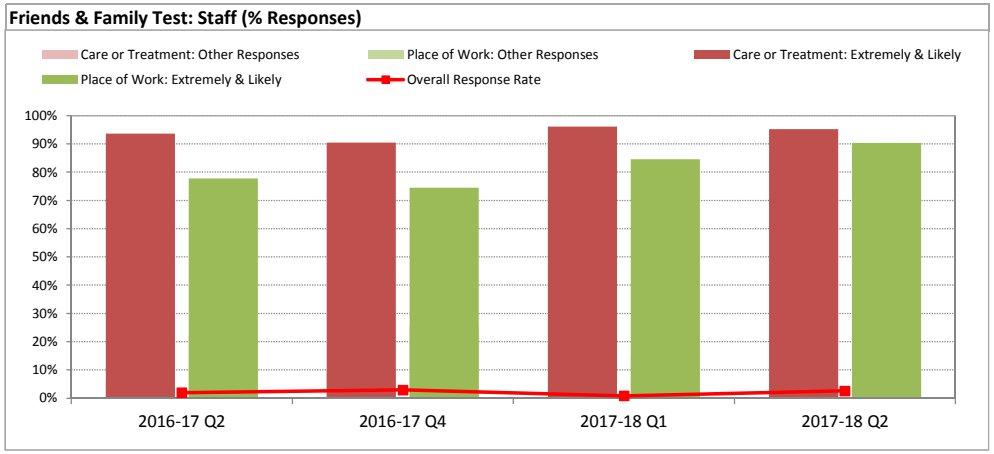




Real Time Feedback: Overall how would you rate the quality of care you received?



Friends & Family Test: Staff (% Responses)



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

Report to:	Trust Board	**Agenda item:**	3956
Date of Meeting:	4th December 2017		

Report Title:	Workforce Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Hilary Salisbury, Deputy Director of OD and People Helen Cridland, Deputy Director of OD and People			
Executive Sponsor (presenting):	Paul Hargreaves Director of OD and People			
Appendices (list if applicable):	Workforce KPIs Month 7 2017/18			

Recommendation:

It is recommended that the Board note the key areas of concern and actions that are in progress / planned.

Executive Summary:

The Month 7 workforce dashboard (see appendix 1) details the Trusts performance against the key performance indicators: Of note this month:

A reduction in agency spend of £18,000 in month, with all clinical directorates except Surgery reducing their agency spend in comparison to last month. Surgery have however maintained a position of having no medical agency spend for the second consecutive month.

We have seen an increase in recruitment in month and are continuing to take proactive measures to recruit. We have a strong overseas recruitment campaign and the recent recruitment events in Australia have seen 33 offers made and a number of planned interviews booked.

The Trusts sickness rate has reduced for both long and short term sickness absence. The focused work on supporting areas to proactively manage sickness absence continues with the aim of further reducing sickness absence to below target.

1. Purpose

This report provides the workforce dashboard for month 7 which shows the performance against key performance indicators at Trust level, with trend analysis over time, and sets out actions underway or necessary to achieve targets and recover the position.

2. Background

The Month 7 data shows a £591k (0.75%) overspend on workforce year to date, which in part is due an over-reliance on agency as a result of recruitment difficulties and sickness absence levels. The overall vacancy rate has reduced slightly but remains high in some areas.

Sickness absence in month is red rated at 3.23%, but is below average for surrounding Trusts. Staff turnover is above target at 9.53% which is the second lowest (positive direction) rate among surrounding hospitals. Mandatory training compliance has increased this month and is back above target at 85.91%. Appraisal compliance for non-medical staff remains amber at 81.30%, whilst appraisal compliance for medical staff is above target at 92%.

3. Current position and actions

3.1 Sickness Absence

Whilst the Trust compares favourably to neighbouring Trusts, sickness absence is above the Trust target and has been for the last 18 months. Our current sickness absence rate of 3.23% represents a cost of £3.7m annually, based on an annual pay bill of £116m. A reduction in our sickness rate of 0.23% (to reach the 3% target) would mean a reduction in sickness by 6.65 FTE (£274k based on an average 2016/17 salary cost).

To bring sickness absence back to target **we are:**

- Providing support to managers to ensure that individuals whose sickness absence remains problematic (both short and long term) are managed in the appropriate manner which will either support their return to work or see them being managed through the Management of Attendance Policy.
- Revising the Management of Attendance Policy in consultation with staff side. Accompanying the new policy will be templates, training and guidance to support managers. Implementation is planned for January 2018.
- The Project Lead is working with managers, Payroll and the e-Roster team to review the processes linked to the accurate recording and subsequent reporting of sickness absence to understand some anomalies in the data. Resolution of this will be linked to the roll out of the revised policy from January 2018.
- Actively promoting health and wellbeing - the flu campaign has seen 53% of frontline staff (1447) vaccinated to Friday 17th November. Vaccinators continue to deliver vaccines across the organisation and to reach the target of 70% of frontline staff we require a further 525 staff to be vaccinated.
- Participating in a research project with Loughborough University who are conducting a health and wellbeing survey open to all staff (closes 1 December 2017). The results will help inform the health and wellbeing strategy currently under development. Take up has been low to date but we continue to promote completion through broadcasts, the flu campaign and Occupational Health.

3.2 Agency Spend

Agency spend has fallen in month, however trajectories show a year end position of £2.5m overspend against our £6.2m NHSI agency control, if agency spend levels to date were to continue. Agency spend in month accounted for 60% of total temporary expenditure, compared to a target of 40% (with 60% bank).

We aim to reduce our reliance on expensive agency staff. **We are**:

- Monitoring and controlling non-contractual pay spend across all staff groups, through our new Workforce Pay Control Group (fortnightly meeting). The initial focus is on harmonising and strengthening authorisation processes, Trust wide bank and rostering, and data cleansing.
- Workforce Pay Control Group have aligned processes for nursing and medical agency requests with the introduction of a revised medical agency request process from 20th November 2017 to ensure greater control and authorisation at Executive Director level.
- Performance managing our Master Vend agency supplier; as part of a recovery plan, the Trust is entering into a formal supplier relationship management programme with Total Assist which will involve a scorecard to measure performance of the contract. The aim is to improve supplier performance against agreed criteria. The key headlines will be reported back to the Workforce Pay Control Group.
- Growing our own temporary locum bank through Locums Nest. Since the trial commenced in July 2017, 100 doctors are now registered and an internal fill rate of 72% has been achieved (includes shifts up to May 2018). If this continues at the same level (albeit we should see an increase in numbers registered), the Trust could achieve a saving of £55,000 over the 12 month period July 2017 – July 2018. An evaluation of Locums Nest has been undertaken in November to inform whether the Trust continues using this method going forward. A paper was presented to the Workforce Pay Control Group on 17th November. Outcome to be confirmed week commencing 20th November.

3.3 Recruitment

We have seen an increase in budgeted wte this month, a large proportion of which (12 wte) is due to us now being the host employer for the GP trainees whilst they are on rotation in our region on behalf of HEE. There has been an increase in 3.0 wte psychiatrists which is a catch up adjustment. The remainder of the increase in budgeted establishment is due to skill-mix adjustments and cost pressure funding.

In terms of achieving our target of 95% fill rate for nursing, using the M7 baseline, it is currently predicted that it would take 10 months to achieve this.

We are:

- Creating our own route into Nursing via apprenticeships, using a "grow your own" approach.
- Attending careers fairs and events and holding open days for potential recruits (45 Nursing Assistants are joining the Trust in November and December as a result of recent open days).
- Recruiting Nurses and middle grade Doctors Internationally - We had Skype interviews for Applicants from UAE on 8 and 9th November and have made 18 offers of employment to date.
- Nursing recruitment mission to Australia, with 33 offers made to candidates from Melbourne, Brisbane and Sydney, with circa 15 to be followed up by Skype interviews. Exploring opportunities for an additional event in Perth.
- Improving our marketing via social media, including a recruitment Micro Site go-live at the end of November, using Skype interviews and advertising on a Park and Ride bus.
- Re-launching our "refer a friend" initiative in December.

- Following attendance at the Health Sector Jobs Dublin Fair and the Health Care Science event at Southampton University we are actively promoting vacancies to the contacts we gathered.

4. Conclusion

The situation remains challenging; however it is clear that the focus of activity on the three key areas of pressure; agency spend, recruitment and sickness absence are starting to impact and we have seen early improvements in all of these areas this month.

The actions described in section 3 will ensure that these improvements continue and are sustained and progress against the key performance indicators will continue to be managed through Directorate Performance Reviews.

Whilst we are continuing to focus on the day to day, we are developing a people strategy (subject to approval from Executive Workforce Committee) that will deliver a sustainable workforce for the future.

Paul Hargreaves
Director of Organisational Development and People

Salisbury NHS Foundation Trust Workforce Dashboard

	Strs/Lvrs		Turnover (FTE)			Vacancies				Temporary Spend					Sickness							Training	Appraisal		Employee Relations - Formal						
	Starters *(head count in month)*	Leavers *(head count in month)*	Average Heads *(in year)*	Number of Leavers *(in year)*	Turnover *(rolling year)*	Budget Wte (Ledger)	Staff In Post Wte *(Ledger - month end)*	Vacant Wte	Vacancy Rate	spend on Agency	% Temp Spend on Agency *(in month)*	spend on Bank	Total Temp Spend	Agency Budget	Long Term Sick WTE lost *(in month)*	%	Short Term Sick WTE lost *(in month)*	%	Total WTE lost to Sickness *(in month)*	Sickness Rate		Mandatory Training	% Complete Medical Staff	% Complete non-medical staff	Performance	Short Term Sick	Long Term Sick	Disciplinary	Grievance	Bullying and Harassment	Totaql Caseload
YTD Trend	*Data excludes: Docs in Training & Tupe Transfers. Data includes: Bank Staff*																														
Month Trend																															
Target		29		240	8.50%			154.06	5.00%	£ 516,667	40.00%								84.70	3.00%		85.00%	85.00%	85.00%							0
Apr-17	71	43	2,827	250	8.85%	3,081.27	2,823.20	214.76	6.97%	£ 513,765	41.61%	£ 720,840	£ 1,234,605	Under	52.11	59%	36.92	41%	89.03	3.20%		84.12%	91.00%	80.40%	-	-	-	3	-	-	3
May-17	59	54	2,824	243	8.61%	3,078.73	2,777.53	268.47	8.72%	£ 692,515	53.84%	£ 593,693	£ 1,286,208	Over	56.60	58%	40.26	42%	96.86	3.54%		84.76%	93.00%	81.00%	2	-	-	-	-	-	2
Jun-17	52	56	2,822	257	9.09%	3,078.14	2,786.46	261.33	8.49%	£ 746,142	58.41%	£ 531,232	£ 1,277,374	Over	56.51	62%	35.28	38%	91.79	3.40%		85.14%	93.00%	81.40%	3	5	4	-	-	-	12
Jul-17	67	46	2,820	256	9.07%	3,052.55	2,782.64	269.91	8.84%	£ 731,460	57.20%	£ 547,400	£ 1,278,860	Over	60.94	62%	36.85	38%	97.79	3.59%		86.63%	95.00%	81.90%	3	7	8	3	2	1	24
Aug-17	54	55	2,816	266	9.45%	3,075.03	2,778.67	296.36	9.64%	£ 762,217	56.70%	£ 582,156	£ 1,344,373	Over	60.84	61%	38.49	39%	99.34	3.50%		85.79%	95.00%	81.90%	1	8	6	4	1	2	22
Sep-17	62	49	2,814	274	9.73%	3,045.93	2,807.27	238.66	7.84%	£ 804,575	57.36%	£ 598,145	£ 1,402,720	Over	73.43	65%	39.67	35%	113.10	4.03%		83.07%	94.00%	82.10%	1	3	2	2	3	1	12
Oct-17	85	44	2,816	268	9.53%	3,113.36	2,872.77	240.59	7.73%	£ 786,207	60.02%	£ 523,734	£ 1,309,941	Over	67.67	73%	25.65	27%	93.32	3.23%		85.91%	92.00%	81.30%	1	4	-	2	4	-	11
Nov-17																															
Dec-17																															
Jan-18																															
Feb-18																															
Mar-18																															
totals	450	347		Average	9.19%			Average	8.32%	£ 719,554									Average	3.50%		85.06%			11	27	20	14	10	4	86

NB reported rates may change slightly due to receipt of additional returns

Month 7 position shows an overspend on workforce of £591k (0.75%) year to date. Recruitment difficulties in some areas have lead to the Trust's agency spend trajectory exceeding its NHSI agency control total target. The vacancy rate has decreased slightly this month but vacancies remain high in some areas. Staff sickness is red rated at 3.23%, which is average for the surrounding Local Acute hospital Trusts. Staff Turnover is above target at 9.53%, the second lowest (best) rate among surrounding hospitals. Mandatory training compliance levels have improved this month and are above target (green). Appraisal compliance has slightly decreased and remains amber at 81.30%. Key areas identified for action include :

Staff Sickness – We aim to bring sickness absence back to target. **We are :**

- Working with departments to identify those individuals whose sickness absence remains problematic (both short and long term).
- Ensuring the above individuals are managed in an appropriate manner which will either support their return to work or see them being managed through the Management of Attendance Policy.
- Working with Managers across the Trust to understand some of the challenges that are faced when managing sickness absence.
- Using the feedback obtained to help inform the development of a refreshed Health and Wellbeing Strategy**.**
- Working with Managers, Payroll and the e-Roster team to review the processes linked to the accurate recording and subsequent reporting of sickness absence to understand if the data robust and if not, why not and how do we rectify.

Agency Spend - We aim to reduce our reliance on expensive agency staff, and to meet our £6.2m NHSI Agency Spend Control Total. **We are**:

- Monitoring and controlling non-contractual pay spend across all staff groups, through the new Workforce Pay Control Group. The initial focus is on harmonising and strengthening authorisation processes, Trustwide bank and rostering and data cleansing.
- Performance managing our mastervend agency supplier; as part of a recovery plan, the Trust is entering into a formal supplier relationship management programme with Total Assist which will involve a scorecard to measure performance of the contract with the aim to improve supplier performance against agreed criteria. The key headlines will be reported back to the Workforce Pay Control Group.
- Growing our own temporary locum bank through Locums Nest. Following a trial period, an evaluation of Locums Nest will be undertaken this month to inform whether the Trust continues using this method going forward.

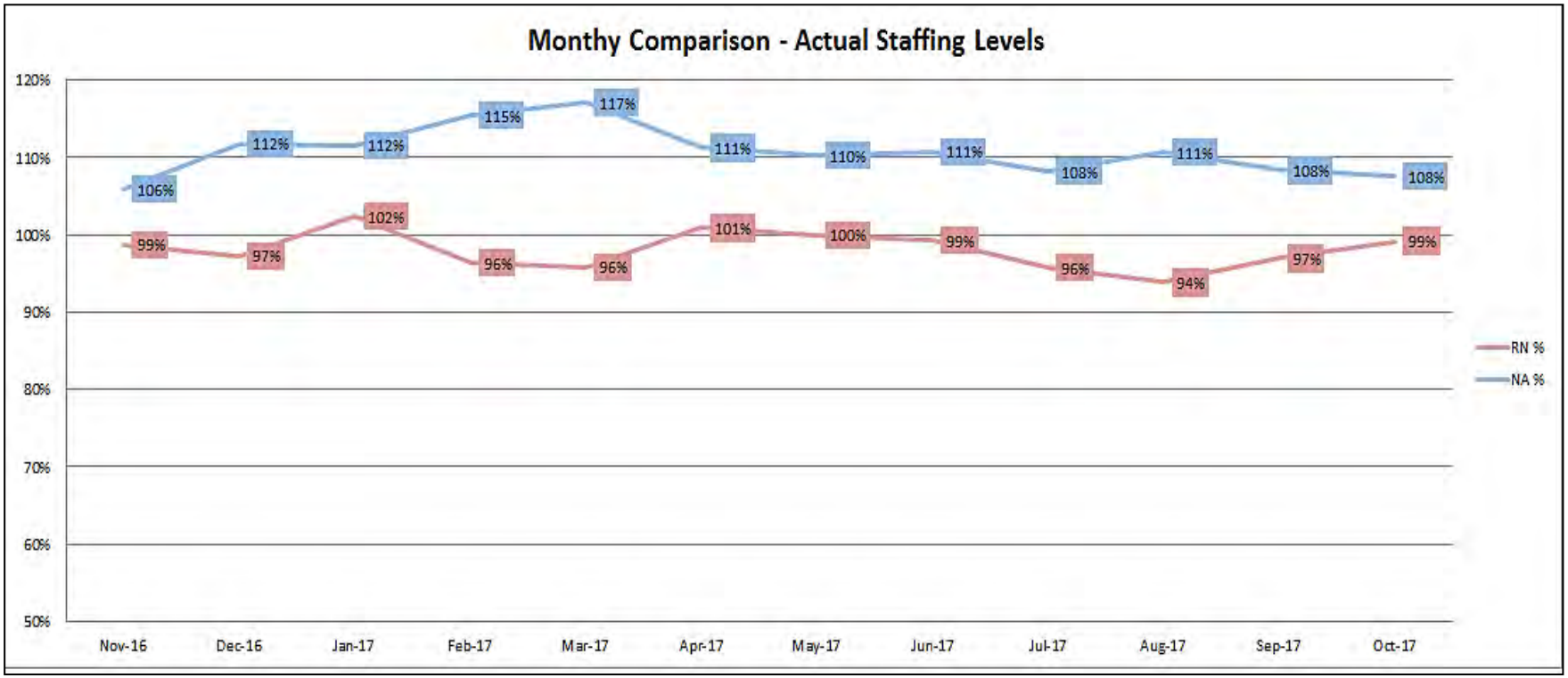
Recruitment - We aim to ensure we stabilise the workforce and reduce agency spend to an absolute minimum. **We are:**

- Creating our own route into Nursing via apprenticeships, using a "grow your own" approach.
- Attending careers fairs and events and holding our own open days for potential recruits (37 Nursing Assistants are joining the Trust in November and December as a result of recent open days).
- Recruiting Nurses and middle grade Doctors Internationally - We had Skype interviews for Applicants from UAE on 8 and 9th November and have made 18 offers of employment to date.
- On a Nursing recruitment mission to Australia, with 22 offers made to candidates from Melbourne and Brisbane, with a number to be followed up by Skype interviews. One more event is planned for Sydney.

Safe Staffing NQB Report – October 2017

Monthly Comparisons – Actual Staffing Levels

	Registered Nurses			Nursing Assistants			Combined			Skill Mix	
Month	Planned hours	Actual Hours	%	Planned Hours	Actual Hours	%	Planned Hours	Actual Hours	%	RN	NA
Oct-17	59035.0	58569.2	99%	33207.4	35716.3	108%	92242.3	94285.4	102%	62%	38%



↑
Review of coding overseas nurses

Overview of Nurse Staffing Hours – October 2017

Day	RN	NA
Total Planned Hours	34608.7	21037.42
Total Actual Hours	33957.62	22636.25
Fill Rate (%)	98.1%	107.8%

Night	RN	NA
Total Planned Hours	24426.25	12169.95
Total Actual Hours	24611.53	13080.03
Fill Rate (%)	100.8%	107.5%

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	Day RN Planned	Day RN Actual	Day RN Fill Rate	Day NA Planned	Day NA Actual	Day NA Fill Rate
Medicine	**14427.18**	**14091.10**	**97.9%**	**10286.00**	**11520.25**	**112.7%**
Breamore	1076.75	994.00	92.3%	859.00	1271.50	148.0%
Durrington	1093.50	1009.42	92.3%	870.00	1044.00	120.0%
Farley	2110.50	1937.75	91.8%	1526.00	1628.00	106.7%
Hospice	904.50	914.00	101.1%	657.00	724.00	110.2%
Pembroke	775.00	793.75	102.4%	765.50	821.50	107.3%
Pitton	1764.75	1652.50	93.6%	1197.50	1249.08	104.3%
Redlynch	1500.98	1547.98	103.1%	1123.50	1197.00	106.5%
Tisbury	2037.70	1865.20	91.5%	706.00	699.17	99.0%
Whiteparish	1707.00	2069.00	121.2%	1012.00	1166.00	115.%
Winterslow	1456.50	1307.50	90%	1569.50	1720.00	109.6%
Surgery	**7231.75**	**7486.25**	**105.5%**	**2678.42**	**2878.92**	**109.9%**
Britford	1998.00	2031.50	101.7%	1104.50	1304.00	118.1%
Downton	1277.50	1243.00	97.3%	946.50	883.00	93.3%
Radnor	3345.25	3486.00	104.2%	357.92	309.92	86.6%
DSU Inpatient Ward	611.00	725.75	118.8%	269.50	382.00	141.7%
MSK	**7482.80**	**7101.47**	**94.6%**	**6694.00**	**6879.08**	**108.3%**
Amesbury	1609.25	1958.00	121.7%	1391.75	1392.25	100.0%
Avon	1545.75	1134.83	73.4%	1945.33	1597.75	82.1%
Burns	1461.38	1389.88	95.1%	746.50	990.25	132.7%
Chilmark	1575.50	1435.50	91.1%	1098.00	1410.00	128.4%
Tamar	1290.92	1183.25	91.7%	1512.42	1488.83	98.4%
CSFS	**5466.97**	**5278.80**	**98.8%**	**1379.00**	**1358.00**	**100.5%**
Maternity	3191.22	2960.80	92.8%	1022.25	981.50	96.0%
NICU	1115.50	1104.50	99.0%	0.00	0.00	100.0%
Sarum	1160.25	1213.50	104.6%	356.75	376.50	105.5%
Grand Total	**34608.70**	**33957.62**	**98.7%**	**21037.42**	**22636.25**	**109.5%**

Key:	Less than 80%	Between 80 - 90%	Between 90 - 115%	Greater than 115%

Nursing Hours by Night Shifts

Row Labels	Night RN Planned	Night RN Actual	Night RN Fill Rate	Night NA Planned	Night NA Actual	Night NA Fill Rate
Medicine	**9823.50**	**9935.33**	**101.2%**	**5761.45**	**6369.53**	**110.2%**
Breamore	713.00	736.00	103.2%	713.00	700.00	98.2%
Durrington	701.50	759.00	108.2%	713.00	793.50	111.3%
Farley	1069.50	1079.75	101.0%	713.00	747.50	104.8%
Hospice	589.00	589.25	100.0%	416.45	420.20	100.9%
Pembroke	713.00	701.50	98.4%	356.50	425.00	119.2%
Pitton	1069.50	1055.83	98.7%	713.00	1032.33	144.8%
Redlynch	1069.50	1069.50	100.0%	713.00	747.50	104.8%
Tisbury	1426.00	1437.50	100.8%	356.50	322.00	90.3%
Whiteparish	1414.50	1483.50	104.9%	355.00	434.00	122.3%
Winterslow	1058.00	1023.50	96.7%	712.00	747.50	105.0%
Surgery	**5278.50**	**5845.75**	**116.5%**	**1782.50**	**1926.25**	**102.7%**
Britford	1058.00	1080.00	102.1%	713.00	780.25	109.4%
Downton	713.00	724.50	101.6%	713.00	722.00	101.3%
Radnor	2978.50	3227.00	108.3%	356.50	356.50	100.0%
DSU Inpatient Ward	529.00	814.25	153.9%	0.00	67.50	100.0%
MSK	**4248.00**	**4113.50**	**97.0%**	**3545.00**	**3740.00**	**105.7%**
Amesbury	1069.50	1169.50	109.4%	713.00	747.50	104.8%
Avon	900.00	690.75	76.8%	910.00	900.00	98.9%
Burns	1069.50	1023.50	95.7%	713.00	851.00	119.4%
Chilmark	589.00	598.50	101.6%	589.00	610.00	103.6%
Tamar	620.00	631.25	101.8%	620.00	631.50	101.9%
CSFS	**5076.25**	**4716.95**	**94.4%**	**1081.00**	**1044.25**	**230.8%**
Maternity	2845.75	2564.25	90.1%	1069.50	986.75	92.3%
NICU	1069.00	1053.00	98.5%	0.00	0.00	100.0%
Sarum	1161.50	1099.70	94.7%	11.50	57.50	500.0%
Grand Total	**24426.25**	**24611.53**	**102.1%**	**12169.95**	**13080.03**	**124.2%**

Key:	Less than 80%	Between 80 - 90%	Between 90 - 115%	Greater than 115%

Reporting Amendments

The following amendments have been made to this months submission:

Farley is currently located on Winterslow ward. To keep specialties in line this is reported as Farley.

***Winterslow* has moved to Laverstock (and for roster purposes is known as Laverstock 2.)**

For specialty reasons this is still named as *Winterslow* in this report

Overview of Areas with Red

(Internal rating below 80%)

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	Avon	73%	√		Day	There was a decrease in demand for respiratory patients requiring care over the month resulting in a reduction of patient acuity levels within the unit and the ward was safely run with less nursing staff.
Red		77%	√		Night	The process to remove /cancel shifts that were unrequired had not been strictly followed. The Ward Leader is now aware and will correct this for future reporting.

Overview of Areas with Amber

(Internal Rating 80-90%)

Flag	Ward	%	RN	NA	Shift	Mitigation
Amber	Avon	82%		√	Day	As above
Amber	Radnor	87%		√	Day	Unfilled shifts were due to sickness. Small numbers of staff involved exaggerate the percentage of unfilled shifts.

- All Unfilled shifts are reviewed and risk assessed at twice daily operational staffing meetings in conjunction with patient acuity and demand.
- Shifts are reassessed if the patient acuity and demand alters.

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

Mitigation of Risk for Red/Amber

The gap between RN and NA staffing demonstrates a further reduction this month almost matching November 2016.

Evidence shows a further increase in RN staffing during October by 2% from 97% to 99% and an overall 5% increase from 94% in August 2017 . NA overstaffing has remained static for a second month at 108%.

The skill mix supports this with a continued increase from 61/39 % (RN/NA) to 62/38% alongside a sustained upward trend for both RN day and night fill rates despite the vacancy and recruitment challenges.

2017	RN Days	RN Nights
August	92.5 %	95.9%
September	95.5%	99%
October	98.7 %	102.1%

This has resulted in only 1 area flagging in Red status for a second month and a reduction in understaffed areas flagging Amber from 10 units to 2.

Avon has flagged Red for RN days and nights and Amber for NA days. This unit has not had the expected number of respiratory patients and so these shifts were not required.

SafeCare is used daily on an operational basis.

Using the SafeCare system, patient acuity and dependency is assessed at least three times a day on a shift by shift basis with any further risk assessments taking place at the twice daily operational staffing meetings

Overview of Overstaffed Areas >115%

Ward	%	RN	NA	Shift	Comments
Breamore	148%		√	Day	The ward is staffed for 20 beds but has been running as a 24 bedded unit therefore requiring increased support in staffing levels with the unit using NA staff rather than RN to do this.
Durrington	120%		√	Day	Overstaffing was for patients with enhanced 1:1 care needs deemed at risk of falls or with confusion/mental health needs
Amesbury	121%	√		Day	New RN staff on supervision increased the percentage of RN day shifts
Chilmark	128%		√	Day	This is due to enhanced 1:1 care for patients deemed at risk of falls or with confusion /mental health needs .
Pembroke	119%		√	Night	This was overnight 1:1 enhanced care needs as above
Pitton	145%		√	Night	Additional B 2 staff were used for 1:1 enhanced care for patients deemed at risk of falls or with confusion /mental health needs .
Whiteparish	121%	√		Day	Overstaff is due to new staff . 4 x new Band 2's and 5 x new band 5's all starting from middle of September onwards. All have had anything from 2 to 5 weeks of supernumery shifts depending on experience
Whiteparish	122%		√	Night	
Burns (Laverstock, Burns & Plastics)	133%		√	Day	On patient required 1:1 enhanced care for 48 hours. Extra NA staff were used to assist with discharges (from Recovery) via the unit. As per Avon, some unrequired shifts had not been cancelled resulting in skewed data figures
Burns (Laverstock, Burns & Plastics)	119%		√	Night	
Sarum	500%		√	Night	A recent agreed increase in staffing levels for nights has resulted in shifts being temporarily covered by extra NA staff .

Overview of Overstaffed Areas >115%

Ward	%	RN	NA	Shift	Comments
Britford	118%		√	Day	SAU in escalation so NA cover increase on twilight shifts which come into day time reporting
DSU Inpatient	119%	√		Day	Extra staffing is to cover the flexing needs for beds. The commissioning of extra beds (an increase from 11 to 18 beds) within the downstairs area of the unit occurred again this month.
DSU Inpatient	142%		√	Day	
DSU Inpatient	154%	√		Night	

Over-staffing

The two main reasons for Overstaffing remain unaltered and were for:

1. Enhanced 1:1 care for patients at risk of falls, mental health needs or confusion
2. Flexing bed stock and staffing levels to meet fluctuating patient demands.
3. New staff who are additional to a ward during local induction

Breamore :- As per previous months. The unit has extra 4 beds within their capacity and this results in a need for an extra NA to support the extra patient demand. The unit moves in December to become Whiteparish and the change in bed stock will accommodate the extra capacity within the current unit. This should be reflected in the reporting from January 2018.

Actions taken to mitigate risk

The nurse-in-charge of individual wards in discussion with the DSN/ADSN review the following on a shift by shift basis.

- The accounting of the staff skills set when deciding on the band of staff needed.
- All shifts are gauged with staff 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.

Report to:	Trust Board	Agenda item:	3956
Date of Meeting:	4th December 2017		

Report Title:	Finance Report Month 7			
Status:	Information	Discussion	Assurance	Approval
			X	
Prepared by:	Mark Collis- Deputy Director of Finance			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):	None			

Recommendation:
The Board is asked to note the financial position for October 2017, the key risks and the actions being taken to mitigate them.

Executive Summary:
The purpose of this report is to set out the Trust's financial performance for the period to 31st October 2017. The Financial position has shown an improvement in month, however whilst parts of this relate to an increase in activity and income, the position has also improved due to the pay costs of IM&T projects having been capitalised this month which have improved the position. Underlying, the cost of outsourcing activity is offsetting the increase in income and pay costs remain a growing concern. The key focus needs to be controlling pay costs, particularly medical staffing which is an area which has continues to grow. Conversations have taken place at all directorate performance review meetings as to what additional actions can be taken between now and March, and whether any savings programmes can be bought forward to achieve in quarter 4. The workforce pay controls group is focusing on agency and locum spend, and ensuring all actions are in place to reduce spend.

Executive Summary of Key Financial Performance - October 2017

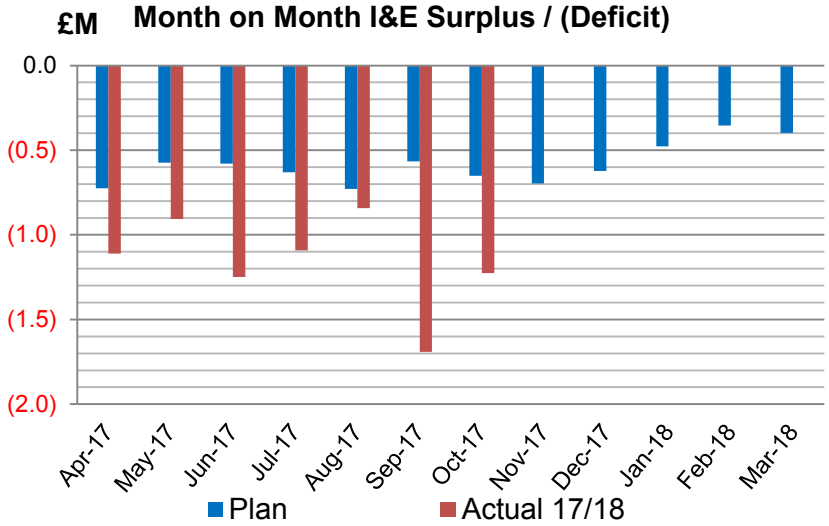
Page	Area of Review	Key Highlights	Status
1	Income & Expenditure	**In Month:** The in-month deficit was £1,227k which was an adverse variance against the plan of £576k this was an improvement on last month's position. The improvement was mainly the result of increased NHS income and a retrospective capitalisation of pay costs . **Year to Date:** The main cause of the YTD deficit relates to under delivery of NHS clinical income (£3,665k behind the plan). This reflects that not all savings are being being fully delivered and 43% were non-recurring to date.	RED
2	NHS Clinical Income	**In Month:** There was a notable improvement in NHS clinical income for planned care and outpatients due to increased activity. **Year to Date:** The most significant areas of underperformance relate to outpatients and elective work. Excluded drugs and devices were behind plan but offset by lower expenditure.	RED
3	Workforce	**In Month:** Overall pay has decreased when compared to the previous month as a result of capitalising staff working on IT projects which was consistent with the previous year's adjustments. **Year to Date:** Pay costs have exceeded plan and the adverse variance against the agency control total remains a concern. Laundry pay spend was £377k more than plan but was matched by additional income.	AMBER
4	Non Pay	**In Month:** Non pay was overspent across most areas including drugs and clinical consumables and this was partly due to increased activity. **Year to Date:** Non Pay spend overall remains behind plan. This was in part was due to lower levels of activity than planned. The Trust continues to deliver the procurement savings plan.	GREEN
5	Efficiency - Better Care at Lower Cost	**In Month:** Actual savings were slight behind plan and this was due to income generation schemes in Medicine and Surgery not being delivered. **Year to Date:** Savings were behind plan due to income generation schemes not delivering in line with plan.	RED
6	Use of Resources rating	The Trust's overall risk rating score remains unchanged at 4 under the new single oversight framework. A score of 4 will mean that a provider is subject to financial special measures. NHSI have completed their investigation and provided feedback to the Trust. The Trust is in the process of reviewing the feedback and developing a recovery plan.	RED
7	Cash Management	**In Month:** The Trust has made a further drawdown of cash from the DoH to support its deficit position. Cash is close to the planned figure. **Year to Date:** The Cash position is being carefully monitored, however the Trust has now borrowed £3.4m to support its working capital position, all of which is repayable and will impact on future years investment plans.	AMBER
8	Capital Expenditure	**In Month:** Spend was ahead of plan due payment of the new eye clinic facility. **Year to Date:** Although there was some in-year slippage on the capital programme the year end position is expected to be in line with the current revised plan.	GREEN

Page 1 - Income & Expenditure

Status	Position	Trend

Income & Expenditure

	YTD (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s
Operating Income			
NHS Clinical Income	109,662	106,724	(2,938)
Other income	17,494	17,431	(63)
Total income	**127,156**	**124,155**	**(3,001)**
Operating Expenditure			
Pay	80,552	81,104	(552)
Non Pay	42,737	42,595	142
Total Expenditure	**123,289**	**123,699**	**(410)**
EBITDA	**3,868**	**456**	**(3,412)**
Financing Costs	8,322	8,575	(253)
Surplus/(Deficit)	**(4,454)**	**(8,119)**	**(3,665)**



Variation & Action

In Month: The in-month deficit was £1,227k which was an adverse variance against the plan of £576k which was improvement on last month. This was mainly attributable to increased NHS income and a retrospective capitalisation of pay costs to reflect a similar adjustment undertaken at the end of the last financial year.

Year to Date: The main cause of the YTD deficit was NHS clinical revenue being behind the plan. Spend on agency staff and in particular doctor costs continues to be of concern. The key areas of focus continue to be workforce controls and maximising our resources to recover our income position.

Action: There continues to be on-going dialogue with the relevant commissioners to resolve contractual issues. Directorates are focusing ensuring workforce controls are embedded to reduce the reliance on agency spend, and that CIP plans are being developed to mitigate any shortfall.

Page 2 - NHS Commissioner Income

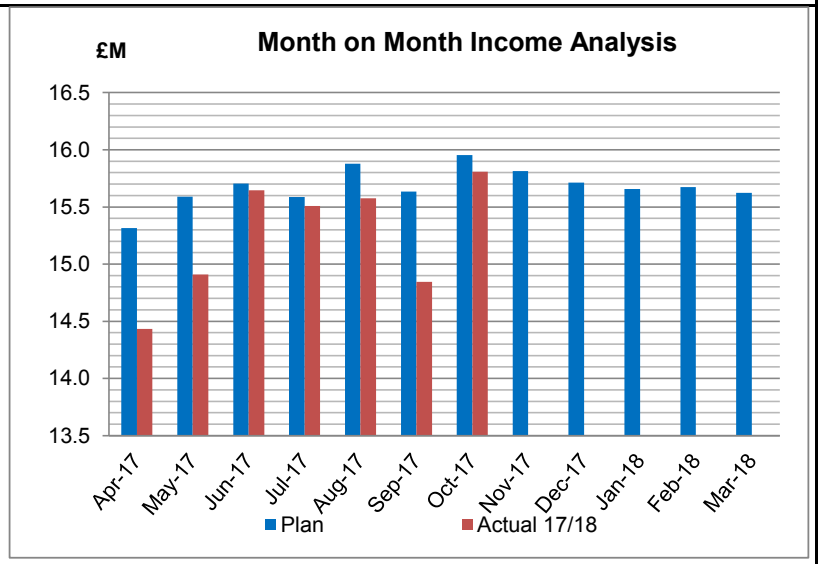
Status	Position	Trend

NHS Clinical Income

By Point of Delivery	YTD (Cumulative) Plan £000s	Actual £000s	Variance £000s
Day Case	10,308	10,140	(168)
Elective inpatients	9,521	9,273	(248)
Non Elective inpatients	36,342	36,582	240
Outpatients	15,984	14,471	(1,513)
Excluded Drugs & Devices	10,364	9,583	(781)
Other	27,143	26,675	(468)
TOTAL	**109,662**	**106,724**	**(2,938)**

SLA performance			
Wiltshire CCG	55,304	55,965	661
Dorset CCG	11,752	12,956	1,204
Hants CCG	9,042	8,945	(97)
Other CCGs	19,021	10,492	(8,529)
Specialist Services	14,543	18,366	3,823
TOTAL	**109,662**	**106,724**	**(2,938)**

By Point of Delivery - Activity	YTD (Cumulative) Last Year	This Year	Variance £000s
Elective - EL	3,009	2,900	(109)
Day case - DC	12,879	12,645	(234)
Non Elective - NEL	15,784	16,365	581
Outpatients	121,839	132,650	10,811
A&E	28,270	27,680	(590)



Outpatient activity was above last year but a significant amount is currently not chargeable due contractual arrangements for counting & coding changes and block arrangements. We are in discussion with the CCGs.

Variation & Action

In Month: Overall activity levels have improved in recent months. however the underlying position however still shows the Trust overall is still not achieving the income plan in full, and elective and outpatients continues to drive the underperformance. The Trust has a number of contract challenges it is still validating and there is further £0.8m risk to the YTD position should these issues not be resolved.

Year to Date: Income continues to be significantly behind plan and the overall, planned inpatient activity was lower when compared to the same period last year.

Action: There continues to be on-going dialogue with the relevant commissioners to resolve funding issues and will form the basis of our discussions with NHSI with regards to the overall recovery plan. Clearly this is important to ensure clarity of our expected year end position.

Page 3 - Workforce

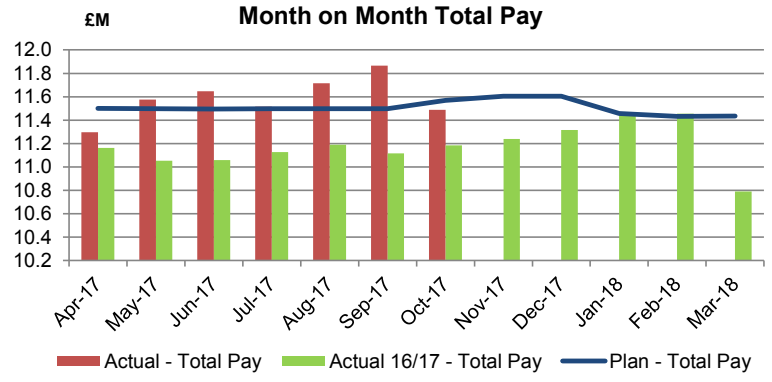
Status	Position	Position

PAY

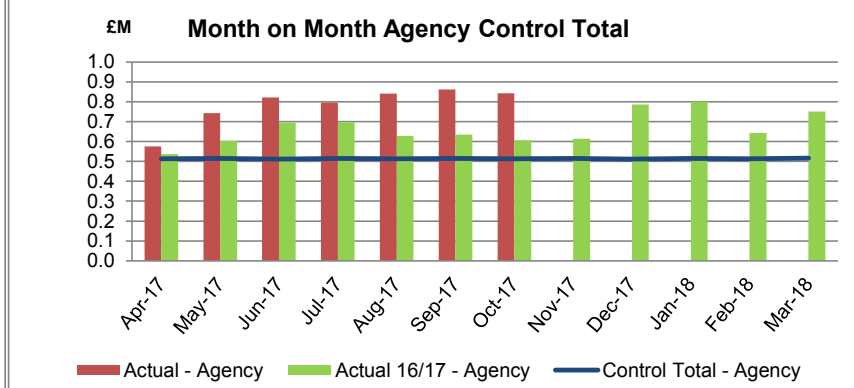
	YTD (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	72,586	71,537	1,049
Pay - Bank	4,374	4,091	283
Pay - Agency	3,592	5,476	(1,884)
TOTAL	**80,552**	**81,104**	**(552)**
Medical Staff	22,246	23,069	(823)
Nursing	22,229	21,064	1,165
HCAs	8,472	9,218	(746)
Other Clinical Staff	10,595	10,823	(228)
Infrastructure staff	17,010	16,930	80
TOTAL	**80,552**	**81,104**	**(552)**

Full Time equivalent	YTD		
	Plan FTEs	Actual FTEs	Variance FTEs
Pay - In Post	2,984.09	2,917.88	66.2
Pay - Bank	170.50	200.89	(30.4)
Pay - Agency	83.28	118.14	(34.9)
TOTAL	**3,237.87**	**3,236.91**	**0.96**
Medical Staff	359.87	379.65	(19.8)
Nursing	900.66	849.43	51.2
HCAs	578.96	624.29	(45.3)
Other Clinical Staff	402.95	418.01	(15.1)
Infrastructure staff	995.43	965.53	29.9
TOTAL	**3,237.87**	**3,236.91**	**0.96**

Trend



Trend



Variation & Action

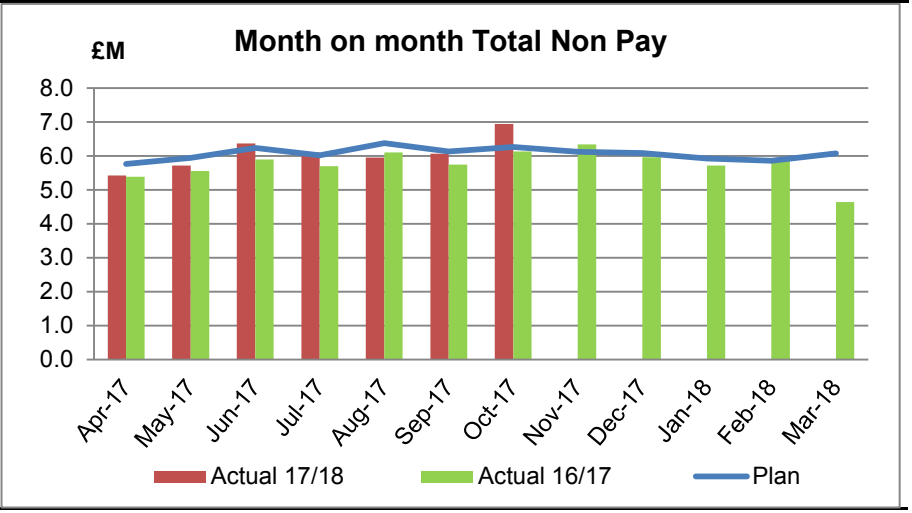
In Month: The spend on pay has decreased when compared to the previous month. This was entirely due to a retrospective adjustment for the capitalisation of costs to reflect a similar adjustment undertaken at the end of the last financial year.

Year to Date: Pay costs are exceeding plan and the adverse variance against the agency control total remains a concern. The Trust has two key issues to address one of volume of agency shifts representing value for money and quality risks, and the price of agency shifts in terms of capped rates.

Action: The Trust has instigated an additional workforce controls group, to ensure all aspects of pay expenditure are reviewed. This group is reviewing agency spend, recruitment trajectories, sickness levels and additional payments, to ensure oversight and standardisation across all of the workforce.

Page 4 - Non Pay Expenses (excluding Finance Charges & Depreciation)

Status	Position				Trend
		YTD (Cumulative)			
		Plan £000s	Actual £000s	Variance £000s	
Non Pay	Drugs	11,980	12,022	(42)	
	Clinical Supplies	12,505	12,005	500	
	General Supplies	3,049	2,987	62	
	Outsourced healthcare	2,558	2,750	(192)	
	Other Non Pay expenses	12,645	12,831	(186)	
	TOTAL	**42,737**	**42,595**	**142**	



Variation & Action

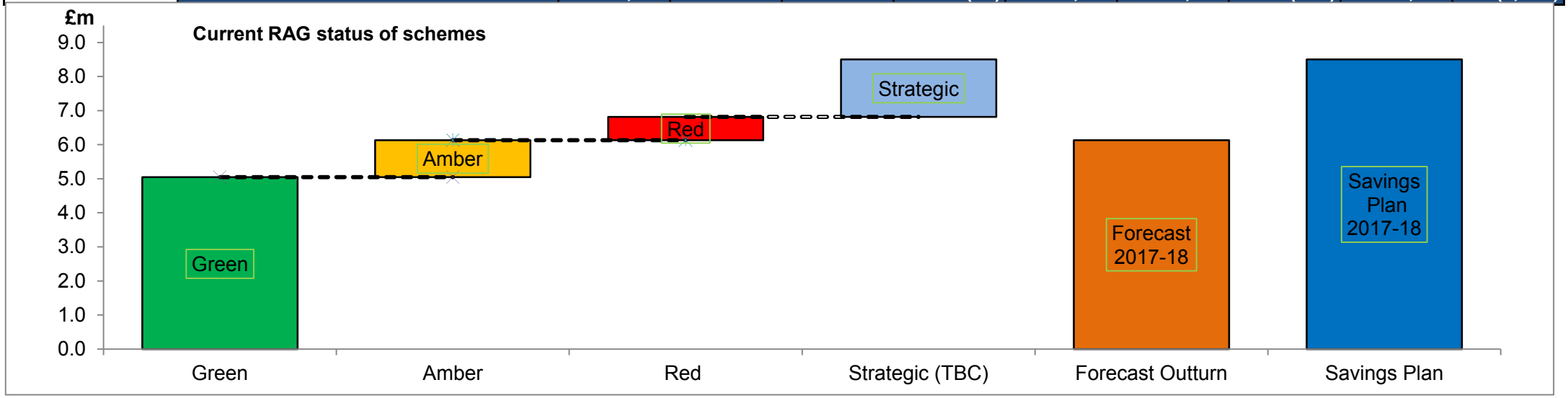
In Month: Overall non pay costs have increased when compared to the previous month, the main drivers of additional spend were drugs and clinical supplies which was partly attributable to the higher levels of activity in month.

Year to Date: Non Pay spend remains underspent against plan overall. The Trust year to date has an adverse variance of £192k on outsourcing clinical activity to external providers for mainly endoscopy and orthopaedics activity.

Action: Procurement have identified a number of additional initiatives and are working closely with Directorates.

Page 5 - Efficiency - Better Care at Lower Cost

Status	Position								
	Directorate	Annual Plan £000s	In Month			Year to Date			Forecast	
			Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Outturn £000s	Variance £000s
Efficiency	Medicine	1,089	96	39	(57)	592	164	(428)	404	(685)
	Musculo Skeletal	933	110	117	7	458	465	7	1,015	82
	Surgery	1,425	156	56	(100)	749	334	(415)	918	(507)
	Clinical Support & Family Services	1,823	155	171	16	1,011	872	(139)	1,830	7
	Corporate Services	1,230	126	114	(12)	659	892	233	1,649	419
	Strategic Schemes	2,000	-59	16	75	-48	94	142	316	(1,684)
	TOTAL	**8,500**	**584**	**513**	**(71)**	**3,421**	**2,821**	**(600)**	**6,132**	**(2,368)**



Variation & Action

In Month: Actual savings were slightly behind plan this month mainly in Medicine and Surgery and relate to the non-delivery of income generation schemes.

Year to Date: Overall savings were behind plan due to income generation schemes not being delivered. Of the YTD savings delivered 43% were reported as non-recurring.

Action: The main risk to the savings programme is £2m of strategic schemes profiled to be achieved in quarter 4, which do not have fully worked up plans to achieve. This combined with the non achievement of the income schemes year to date mean the risk to the Trust's year end position is significant. The Directorates are looking at schemes identified for next financial year, and how these schemes might be brought forward to deliver in this financial year.

Page 6 - Use of Resources

Status	Description	Position			
		Metric	Definition	YTD Plan Number	YTD Actual Number
Use of Resources	NHSI measures an organisation use of resources on a scale of 1-4 with 4 being the highest risk and 1 the lowest risk	Capital service cover rating	Degree to which income covers financial obligations	4	4
		Liquidity rating	Days of operating costs held in cash	2	2
		I&E margin rating	I&E surplus/deficit / total revenue	4	4
		I&E margin: distance from financial plan	YTD actual I&E surplus/deficit compared to YTD plan		4
		Agency rating	Distance from cap	1	4
		Risk rating after overrides			4

Variation & Action

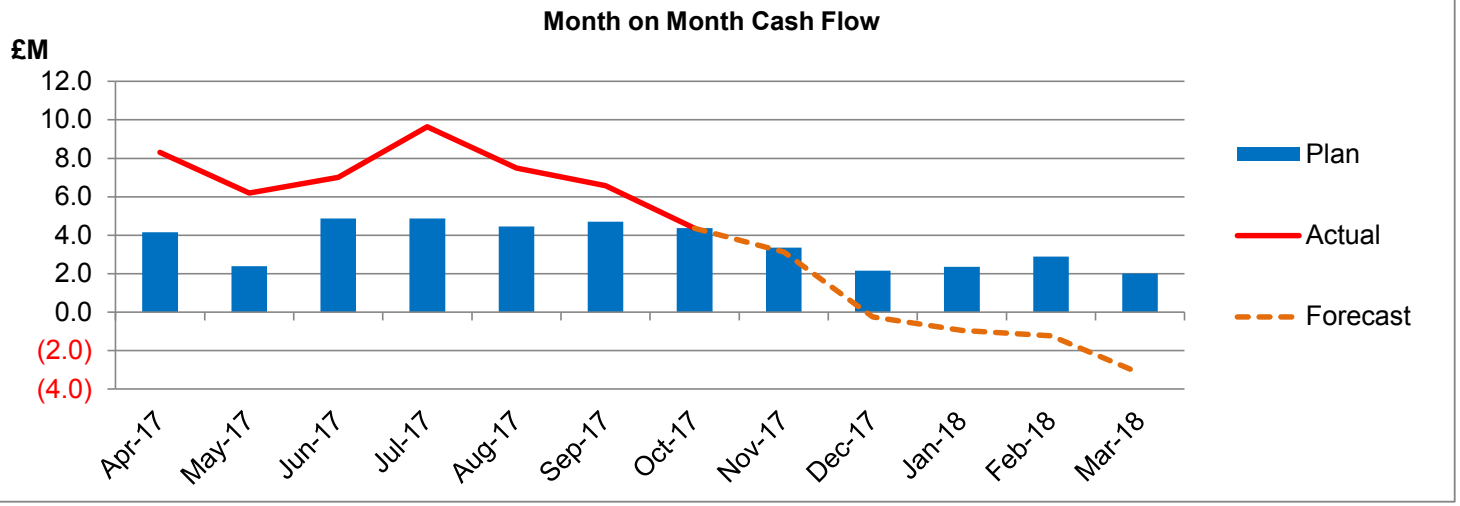
The Trust's overall risk rating score has changed to a 4 under the new single oversight framework, 1 being the highest score with maximum autonomy. A score of 4 will mean that a provider will require support from NHSI. The level and type of support is predicated on a number of items, including what the associated circumstances are, whether the Trust understands the issue and utlimately the plan to to address the issue.

NHSI have completed their investigation and provided feedback to the Trust. The Trust is in the process of reviewing the feedback and developing a recovery plan.

Page 7 - Cash & Working Capital

Status	Position						Variation & Action
Cash & Working Capital		Opening Balance April 2017 £000s	Plan £000s	Current Month Balance £000s	Variance £000s	Actual In Year Movement £000s	**In Month:** The Trust's cash position was assisted by the drawdown of a further £164k revenue support loan in the month, which is repayable in October 2020. **Year to Date:** Monthly cash flows are being submitted to the NHSI highlighting cash flow requirements for a three month period moving forward. Close scrutiny is being undertaken on the cash position to ensure sufficient funds are available to meet the Trust's requirements. Revenue support loans of £3,441k have been received to date with further borrowings required moving forward. **Action:** Cash requirements to be monitored
	Inventories (Stock)	4,950	2,950	5,516	2,566	566	
	Debtors	14,968	12,949	13,035	86	(1,933)	
	Cash	7,660	4,365	4,642	277	(3,018)	
	TOTAL CURRENT ASSETS	**27,578**	**20,264**	**23,193**	**2,929**	**(4,385)**	
	Creditors	(20,515)	(17,010)	(19,823)	(2,813)	692	
	Borrowings	(1,140)	(1,159)	(1,140)	19	0	
	Provisions	(344)	(214)	(344)	(130)	0	
	TOTAL CURRENT LIABILITIES	**(21,999)**	**(18,383)**	**(21,307)**	**(2,924)**	**692**	
	TOTAL WORKING CAPITAL	**5,579**	**1,881**	**1,886**	**5**	**(3,693)**	

Trend

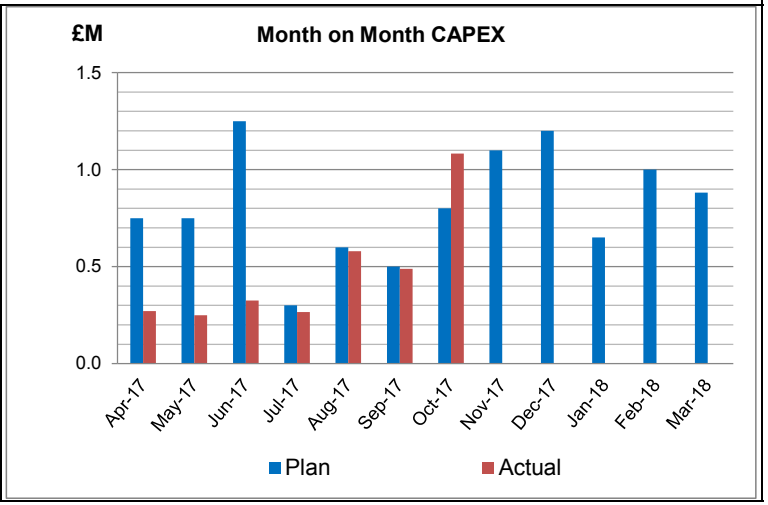


Other Indicators

BPPC % of bills paid in target	Current Month	Previous Month	Movement
- By number	81.8%	81.3%	0.5%
- By value	85.2%	85.3%	(0.1%)
Creditor days	65	61	4
Debtor days	22	21	1

Page 8 - Capital Expenditure

Status	Position						
		Annual	YTD (Cumulative)				
	Schemes	Plan £000s	Plan £000s	Actual £000s	Variance £000s	Forecast £000s	Variance £000s
Capital Expenditure	Breast Unit	89	88	85	3		89
	Other	79	79	79	0		79
	Donated: TOTAL	**168**	**167**	**164**	**3**	**0**	**168**
	Estates - Ward Relocation Project	2,364	1,576	1,049	527		2,364
	Other Estates Projects	1,328	718	386	332		1,328
	Estates: TOTAL	**3,692**	**2,294**	**1,435**	**859**	**0**	**3,692**
	IM&T - EPR / Data Warehouse	2,356	1,479	694	785		2,356
	IM&T - Other	1,496	591	353	238		1,496
	IM&T: TOTAL	**3,852**	**2,069**	**1,047**	**1,022**	**0**	**3,852**
	Medical Equipment: TOTAL	**1,353**	**297**	**229**	**68**		1,353
	Other: TOTAL	**561**	**123**	**387**	**(264)**		561
	Contingency	**155**	**0**	**0**	**0**		155
	TOTAL	**9,781**	**4,950**	**3,262**	**1,688**	**0**	**9,781**



Variation & Action

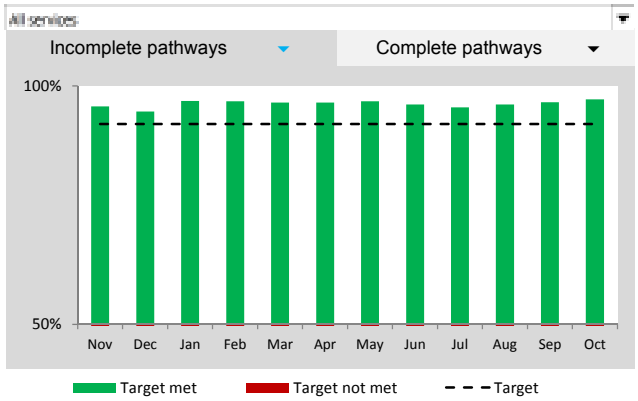
In Month: Capital expenditure increased by £1,082k in the month. Although work is underway on the different elements of the ward relocation projects, these are slightly behind the original planned estimate of spend. Expenditure is expected to increase in the coming months as invoices are received.

Year to Date: All Managers responsible for larger capital schemes have been requested to revisit the future cash flows connected with these projects to determine the timing of cash requirements up to the year end and to identify whether any slippage is likely into 2018-19. Current slippage against plan is expcted to be approx. £1m but this will continue to be monitored on a monthly basis.

Action: The Trust will continue to monitor monthly the programme via the Capital Control Group, to mitigate slippage. Any deterioration in the financial position is likely to have a direct impact on the availability of cash to support the capital programme. The Trust is currently looking to identify a longer term 3-5 year capital programme to capture the current level of risk and backlog associated with limited capital funds historically. This will allow the Trust to prioritise and plan for the longer term and ensure the capital programme is targeted at the areas with the greatest risks.

Performance Dashboard October 2017

RTT

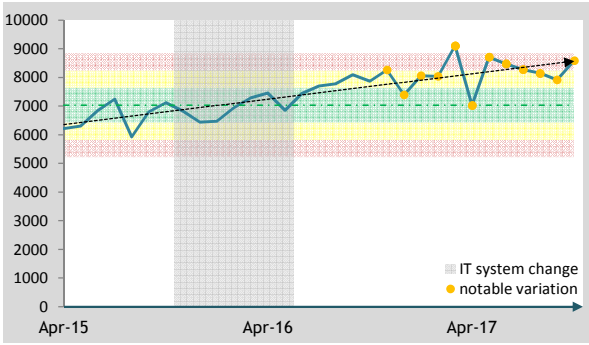


Incomplete pathways month end position

	% under 18 weeks	Breaches
Community Teams	93%	57
Continence - Adult	99%	3
LD	72%	11
Outpatient Physio	98%	100
Podiatry	100%	0
Wheelchair service	95%	7
WON	96%	23

LD service remains an area of concern - previously flagged to commissioners.

Activity



Referrals ↑ 14% Contacts ↑ 8%

Notable movers

Neurology Specialists	↑ 44%
Community Teams	↑ 27%
Speech and Language Therapy	↑ 20%
Fracture Clinic	↓ -8%
Inpatient Therapy	↓ -6%
Orthotics	↓ -1%

LD and Wheelchair services data excluded in this view of overall activity as not comparable pre and post system migration. Trend logic has been adjusted from previous years' reports. See explanatory notes for notable variation guidance.

Inpatient assessments

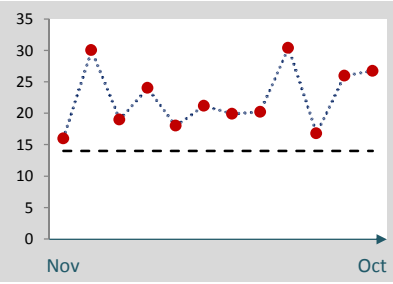
All wards

MRSA	✓ 96%
VTE	✓ 100%
VTE prophylaxis	✓ 100%
MUST	✓ 96%
PURAT	✓ 99%
Falls	✓ 99%
Dementia	✓ 94%

Overall targets met

Mean Inpatient Length of Stay

Ailesbury, Cedar, Longleat	31.7
Mulberry	53.0
Step up	29.6
Step up excluding delays	26.7



LoS heavily influenced by delayed days which routinely account for more than 20% of our ward capacity. For more detail around our LoS see the inpatient data sheet.

Discharge timings

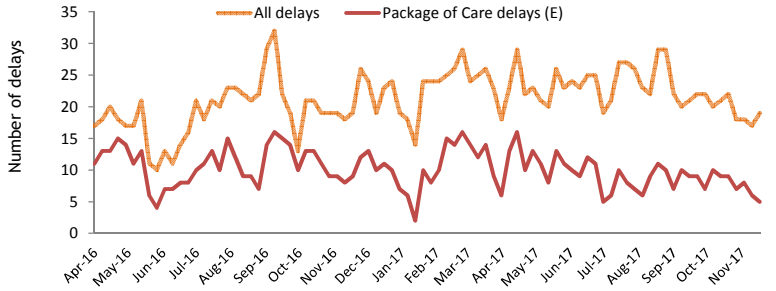
34% midday

7% weekend

excludes transfers to hospital and deaths

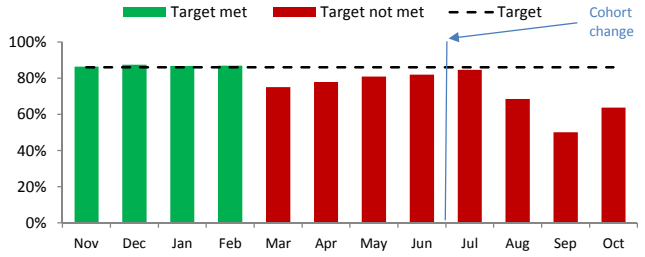
Care providers including homes are reluctant to take patients at weekends.

Delayed Transfers of Care



POC (E) delays now shown separately in trend data above. We are still awaiting acute delay data for Wiltshire patients from CCG/CSU to further assess impact of Home First pathway. Following DToC counting workshop we may see increase in POC (E) delays that would previously have counted as Housing delays.

Community teams 90 day reablement



In month 64% FYTD 78%

Patients still at home 90 days after referral to team

Data quality concerns

It is an ongoing challenge to identify the correct cohort for this data - now looking at Home First patients. Very small numbers in cohort - expecting numbers to increase in coming months.

End of life support

In month	FYTD
100%	95%

This month

15 of 15

patients were supported by the community teams to die in their place of choice

Strong performance year to date

Funding reviews*

	In month	FYTD
CHC 3 month		
Completed	0	N/A
Due	0	
CHC Annual		
Completed	0	N/A
Due	0	
FNC		
Completed	0	N/A
Due	0	

CHC and FNC reporting delayed this month

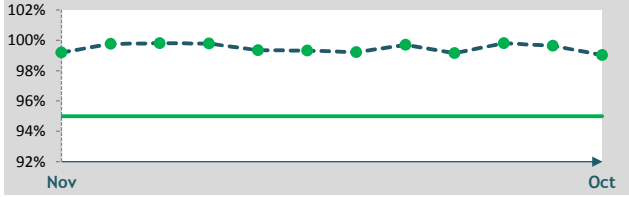
MIU waiting times

median 20 minutes

95th centile 124 minutes

MIU performance

Arrival to departure 4 hour stay	Left without being seen	Transfers to acute
99%	5%	5%



Performance on 4 hour stay and patient feedback remains strong. Data challenges remain around patients left without being seen and transfers to acute. Significant operational pressures are not reflected in the data.

Explanatory notes for our summary measures

RTT

RTT is the Referral to Treatment waiting times period for patients accessing our services.

Complete pathways are waiting periods that have ended in the month. Our target is to see at least 95% of patients within 18 weeks of their referral.

Incomplete pathways are waiting periods that are still ongoing at the end of the month. Our target is to have at least 92% of patients waiting under 18 weeks.

Activity

We routinely monitor two activity measures.
1. The number of patient contacts for each service
2. The number of referrals into each service.

Patient contacts are contacts involving direct contact with the patient - either face to face or by telephone. Our services will often record other activity relating to the patient's care that does not involve direct patient contact. These contacts are excluded from these measures.

The percentage growth shown is calculated from the slope of the trend line. The three services with the highest growth rate, and three with the lowest growth rate are shown as notable movers.

Control logic is used on the chart to indicate when variation is significant.
Coloured horizontal bands on the chart represent multiples of standard deviation (sd) from the mean. The green band represents the mean ±1 sd, amber represents the mean ± 2 sd ,and red represents the mean ± 3 sd.
Points of interest are shown on the chart when they meet at least one of the following criteria:
7 or more consecutive points above the mean, 1 point beyond 3 sd from the mean, 2 of 3 consecutive points greater than 2 sd above or below the mean, 4 of 5 consecutive points greater than 1 sd above or below the mean.

Inpatient assessments

We aim to complete a number of assessments for our inpatients within a certain time from admission.

Our targets are as follows:
MRSA: 95% of inpatients to be assessed within 24 hours
VTE: 95% of inpatients to be assessed for Venous Thromboembolism risk within 24 hours of admission, and to receive prophylactic treatment where appropriate.
MUST: Malnutrition Universal Screening Tool to be completed within 24 hours of admission.
PURAT: 95% of inpatients to be risk assessed for Pressure Ulcers within 2 hours of admission.
Falls: 95% of inpatients to be assessed for falls risk within 4 hours of admission. We report all the above as a % of inpatient admissions in the month.
Dementia: 90% of inpatients to be receive dementia screening within 72 hours of admission. We report this as a % of inpatients discharged in the month.

Mean inpatient length of stay

The average length of stay (in days) for those patients being discharged in the month.
We have 4 community wards. Our three rehabilitation wards Ailesbury (Savernake hospital), Cedar (Chippenham) and Longleat (Warminster) have an average length of stay target of 20 days. Our specialist stroke ward, Mulberry (Chippenham hospital), has an average length of stay target of 30 days.

Ailesbury and Longleat ward also admit 'step-up' patients - these are patients referred from their GP, A&E or ambulance service rather than on discharge from another hospital. We have a target average length of stay of 14 days for these patients. We also report the average length of stay for these patients adjusted to exclude and days for which the patients was a delayed discharge.

Discharge Timings

Here we report the percentage of patients discharged from our inpatient wards before midday against a target of 50%, and the percentage of weekend discharges against a target of 15%.

We only include 'onward' discharges in this data - we exclude deaths and those being transferred back to acute hospitals.

The data shown is for the most recent reporting month only.

Delayed Transfers of Care

A delayed transfer of care occurs when an inpatient is ready to leave hospital but is still occupying an inpatient bed. We report the reason for the delay as categorised by NHS England.

In line with national requirements, we report two measures:

1. The number of delays at midnight on the last Thursday of each month (target is to have delayed patients occupying less than 20% of total ward capacity)

2. The number of bed days lost in the month to these delayed patients.

Community reablement

This measure looks at the residence of a patient 90 days after referral in to our community teams for short term support following a discharge from hospital. It helps quantify the effectiveness of the Community teams in supporting patients to stay in their homes.

We currently have a target of 86% for this measure.

End of Life support

We report the percentage of end of life patients supported in the community that have died in their place of choice.

Funding reviews

Each month we are asked to complete a number of Continuing Health Care (CHC) and Funded Nursing Care (FNC) assessments on behalf of Wiltshire CCG. Here we report how many are completed within 28 days of the due date. We report this measure one month in arrears.

MIU waiting times

The median (middle) wait in minutes from arrival at the Minor Injury Unit to the time of being seen.

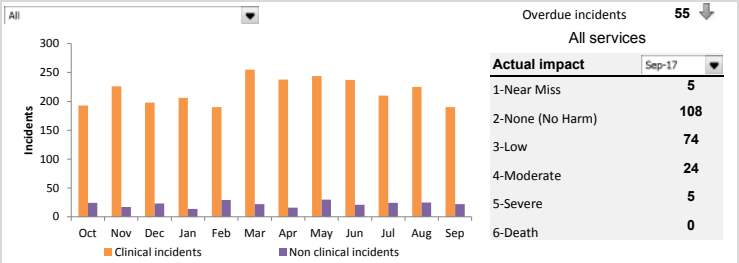
The 95th centile shows the maximum time that 95% of attendees had to wait.
Both measures for the current reporting month only.

MIU performance

We have two Minor Injury Units - one in Chippenham and one in Trowbridge.
We measure the time between each patient's arrival at the Minor Injury Unit and the time they depart. We report the percentage of patients that have an arrival to departure time of under 4 hours against a target of 95%.
We report the number of patients leaving the unit without being seen as a percentage of all attendances. We have a target of no more than 1.9% for this.
We report the number of patients transferring to an acute hospital as a percentage of all attendances. We have a target of no more than 5% for this.

Quality Dashboard September 2017

Incidents

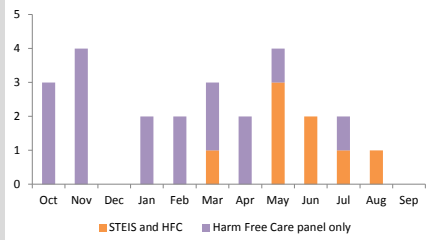


Overdue incidents 55

All services

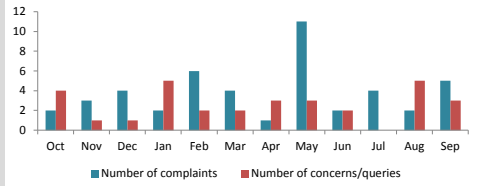
Actual impact	Sep-17
1-Near Miss	5
2-None (No Harm)	108
3-Low	74
4-Moderate	24
5-Severe	5
6-Death	0

SIRIs excluding pressure ulcers



Complaints/Concerns

Response compliance 100% Open ombudsman cases 0



No overdue responses in September. Complaints routinely below benchmark level

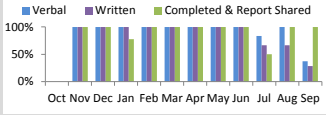
RIDDOR

Financial Year to Date

2

RIDDOR report(s)

Duty of Candour compliance

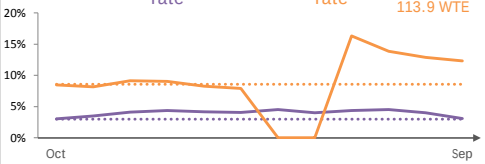


National Mandatory Audits - 1 completed in month

	Completed	Missed
Audit uploads	100%	0

Sickness/Vacancy

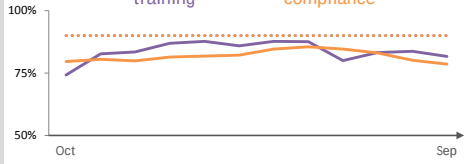
Sep-17 Sickness rate 3.09% Vacancy rate 12.33% 113.9 WTE



Sickness is 1% above same time last year. This is due to management of long term sickness.

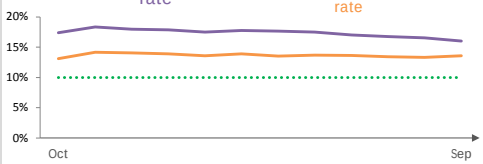
Training/Appraisals

Sep-17 Mandatory training 82% Appraisals compliance 79%



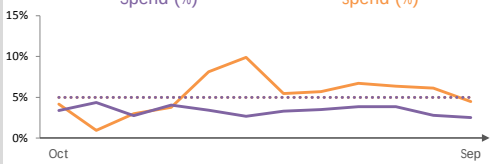
Turnover

Sep-17 Turnover rate 16.03% Voluntary turnover rate 13.58%



Bank/Agency spend %

Sep-17 Bank Staff Spend (%) 2.51% Agency staff spend (%) 4.49%



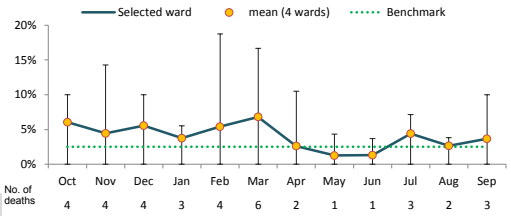
Infection Prevention & Control

All wards	In month	Prev 12 months
MRSA incidence	0	0
C diff incidence	0	0
E coli incidence	0	0
Bed days lost to norovirus	0	17

Compliant with all targets. Bed days lost to norovirus were on Ailesbury ward in October 2016. For information there has been x1 C.Diff incidence reported in October - this

Deaths

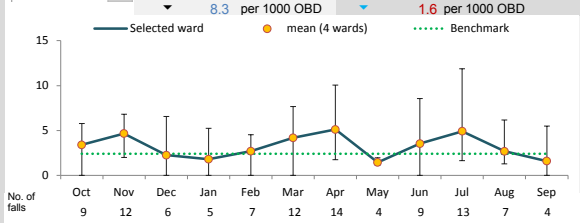
All wards 3 death(s) in month 3.7% of discharges



Palliative care deaths are excluded from Apr 17 (in line with National benchmarking definition)

Falls

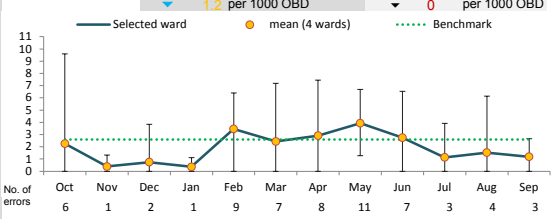
All wards 21 fall(s) in month 8.3 per 1000 OBD 4 Fall(s) with harm 1.6 per 1000 OBD



The Quality team undertook a deep dive into the 40 falls reported in April. The key findings will be published this month.

Medication errors

All wards 3 error(s) in month 1.2 per 1000 OBD 0 Harmful error(s) 0 per 1000 OBD

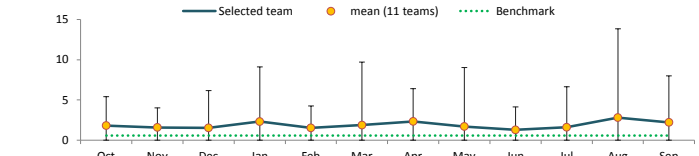


Please note: There is no benchmarking value for medication errors with harm

Medication errors now included on the community teams and specialist services sections within this dashboard.

Avoidable Pressure Ulcers

All teams 15 avoidable pressure ulcers acquired in month 2.21 per 1000 caseload

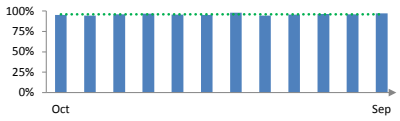


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
No. of pressure ulcers (all)	12	10	10	15	10	13	16	12	9	11	19	15
Category III	1	1	1	2	1	1	0	0	0	2	1	1
Category IV	0	0	0	2	0	0	1	1	1	0	2	1

This graph shows the total verified Category III and IV avoidable pressure ulcers.

Safety Thermometer

Percentage of Harm Free Care (new harms)

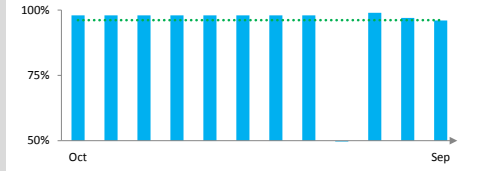


Community Wards	100.00%
Community Teams	96.22%
Wards and Teams combined	**97.42%**

Improvement in return for September - see community teams and inpatients tabs. The quality team continue to work with teams to improve compliance.

Friends and Family Test

Show response numbers



96%

recommend score

There is an increase in the number of responses, however a drop of 1% in the recommended score in September The quality team are scoping new ways of collating feedback to improve the response rate, i.e. mobile working. There has been no resolution to the reporting error in June;

Inpatient assessments

All wards	Aug-17	Sep-17
Early Warning Score	100%	95%
VTE assessment	100%	99%
VTE prophylaxis	100%	100%
Hospital Acquired Thrombosis	0	0
Falls assessment	94%	92%
MUST assessment	100%	99%

Report to:	Trust Board	Agenda item:	3957
Date of Meeting:	4 December 2017		

Report Title:	Board Assurance Framework			
Status:	Information	Discussion	Assurance	Approval
				X
Prepared by:	Fenella Hill, Head of Risk			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Revised BAF v12 TB December 2017 Front sheet Corporate Risk Register Summary for new BAF Corporate Risk Register TB December 2017			

Recommendation:

Approval –

- for the Board to approve the revised Board Assurance Framework.
- for the Board to agree the reporting frequency at Board level whilst this BAF is being further developed

Executive Summary:

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

The Trust Board carries out an annual review of the Board Assurance Framework (BAF) process to ensure that the risks described are the most valid and the document remains fit for purpose to be managed and monitored via the Assurance Committees. The BAF was reviewed during a Trust Board workshop in October 2017 and agreement was made to adopt a revised version.

The revised BAF is attached for Trust Board agreement as an appropriate document for the Board and Assurance Committees to monitor risks against the Trust's Strategic Priorities.

The aims of the revised BAF are to:

- Ensure there is clear alignment between the Trust's Strategy, BAF and Corporate

Risk Register;
- Enable the Board to be able to clearly see progress / deterioration of risks on the Corporate Risk Register and where required request further assurance / deep dive;
- Support the updating of actions against gaps in one place

Supporting Documentation:
- The Corporate Risk Register (CRR) will be presented alongside the BAF at each committee or board review;
- A summary sheet will support the CRR, tracking the risk over the previous 6 months and detailing date of addition to risk register, Lead Executive and whether the risk is an internal or external risk. Updates can also be requested and tracked through this summary sheet.
- It is clear from the summary sheet that our highest risk areas are:
    - Local Services: ensuring capacity to meet demand – ward reconfiguration project on track
    - Resources: higher than planned deficit position. Currently working with NHSI and BCG on financial recovery plan
    - People: continuing challenges in recruitment, particularly Registered Nurses

Next Stages:
- Risks on the Corporate Risk Register to be reviewed by Executive Lead to ensure they are representative of the actual current risk;
- Going forwards we will need to demonstrate grip in the mitigation of risks with the corporate risk register reflecting a direction of travel
- Further work is needed to ensure that all gaps identified on the BAF are trackable either through relevant risks on the risk register or further development of this template;
- Internal Audit to consider using the evidence within the BAF to align the audit plan with gaps identified and support the Trust where there is insufficient Level 3 Assurance currently available.

Salisbury
NHS Foundation Trust

Board Assurance Framework
2017/18

Date: **v1.14**

Trust Vision: An Outstanding Experience for Every Patient

Delivery of our vision and the strategic objectives is underpinned by our Trust Values and Behaviours: Patient Centred and Safe, Professional, Responsive, and Friendly. A drive to be 'outstanding every time.' It is also recognised (as illustrated above) that woven throughout the delivery of the strategy is the need to successfully develop and work across partnerships and collaborations which is why the Corporate Risk Register highlights both internal and external risks to delivery of our objectives.

Strategic Priorities

Local Services – We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

Care – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm

People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

Resources – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources

Board Assurance Framework – Glossary

Strategic priority	Executive Lead and Reporting Committee	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver	Executive lead for the risk The assuring committee that has responsibility for reporting to the Board on the risk.	What management controls/systems we have in place to assist in securing delivery of our objective	Where we gain independent evidence that our controls/systems, on which we are placing reliance, are effective.	What evidence demonstrates we are reasonably managing our risks, and objectives are being delivered **Level 1 Assurance** – Internally generated report or information which describes the effectiveness of the controls to manage the risk. For example – the Integrated Performance Report, self-assessments. **Level 2 Assurance** – Semi-independent reports or information. For example – Non-Executive Director walk arounds, Internal Audits **Level 3 Assurance** – Independent reports or information which describes the effectiveness of the controls to manage the risk. For example – External Audits, regulator inspection reports/reviews.	Where do we still need to put controls/systems in place? Where do we still need to make them effective?	Where do we still need to gain evidence that our controls/systems, on which we place reliance, are effective?

Key for progress against objectives

	Completed
	On schedule and full delivery expected within timeframe
	Work ongoing with risks to full delivery within timeframe
	Not started, and/or high risk of not achieving within timeframe

Risk Score Key

Low Risk	Moderate Risk	High Risk	Extreme Risk
1-3	4-6	8-12	15-25

Strategic Priority:

> **Local Services –** We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

Executive Lead: Chief Operating Officer **Reporting Committee:** Finance and Performance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Frail Elderly** - Development of an integrated frail elderly service	COO	April 2018	
2. **Emergency Care** - Implement new systems to manage the flow of emergency patients	COO	April 2018	
3. **Delayed Discharge** - Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need	COO	April 2018	
4. **Access** - Improving access to core services to support prompt, responsive care	COO	April 2018	

Corporate Risk Register Principal Risks

Likelihood \ Consequence	5	4	3	2	1
5		**4682**	**3919**		
4			**5220**		
3					
2					
1					

4682 - Non elective admissions, DTOCs and 'Green to go' patients and impact on elective capacity

5220 - Delay in radiology reporting

3919 – Capacity planning – required number and range of facilities

Further risks to be added:
Financial sustainability and impact on delievery of local servcie
Integrated partnerships to enable delivery of older peoples pathway

Key Controls	Assurance on Controls
• Established performance monitoring and accountability framework (WTAG/OMB/JBD) • Access policy • Accountability Framework • Ward reconfiguration governance structure • Engagement with commissioners and system (EDLDB)	• Integrated performance report • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes.

Key Headlines - Objectives

Objective	Positive Assurance	1	2	3	Gaps in Control / Assurance
1. Development of an integrated frail elderly service	• Performance against quality metrics including increase number of discharges within 48 hours • Identifying opportunities for improved flow out of ED • Patient ward moves reduced (Getting the patient to the right place, first time)	x x x			• Unsuccessful recruitment of acute physicians. • Agreeing pathways from ED/AMU to frailty. • Capacity within AMU/Durrington footprint managed locally. • Singe bed base (Acute Frailty Unit) to ensure seamless movement of patients within available capacity.
2. Implement new systems to manage the flow of emergency patients	• Performance against national standards and internal quality metrics (improving length of stay and flow of patients) • Positive quality metrics • Good progress with new build, project on track - Ophthalmology open, AMU and short stay surgery units on schedule. Pembroke move on track for Q4	X X x			• Unsuccessful recruitment of acute physicians - gaps in senior clinical posts effecting regular senior ward rounds • Reliance on agency staff effecting ability to embed new ways of working • Accurate data entry at ward levels. • OPEL Status approval at ED Local Delivery Board Level.
3. Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need	• Decreased number of non DTOC delays	x			• Community/voluntary sector funding and capacity. • Staff availability to identify and develop opportunities to improve pathways and discharge

4. Improving access to core services to support prompt, responsive care	• Delivering national access standard • Reports seeing current performance and waiting list now delivering • RTT waiting list has stabilised • Clarity as to what capacity is required to clear backlogs	x			• Consultants job plans currently do not allow accurate capacity and demand modelling • Follow up waiting list still being validated • Additional short term capacity required to clear backlogs – concern about affordability and whether deliverable delivered

Strategic Priority:

> **Specialist Services –** We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

Executive Lead: Chief Operating Officer **Reporting Committee:** Finance and Performance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Spinal Centre –** Service improvement initiatives within Spinal Cord Injury Centre	MD	April 2018 (Phase 1)	
2. **Plastics** - Delivery capacity to separate elective and emergency care. Lead provision of plastic surgery network across Wessex	COO		
3. **Partnership Working** - Work with our partners in networks to develop care pathways for specialist services which improve effectiveness and patient experience (eg burns, cleft lip, genomics)	MD/COO/DoCD	June 2018 (Phase 1)	

Corporate Risk Register Principal Risks

Likelihood \ Consequence	5	4	3	2	1
5					
4					
3	**5100**	**3322** **5047**			
2					
1					

3322 - Genetics National reconfiguration

5047 - Vacant Lead Clinician Post (spinal)

5100 - Inability to provide robust activity & income performance reports

Key Controls	Assurance on Controls
• NHS England contract standards • Access Policy • Work with key network partners in Plastic Surgery - Solent Alliance/Plastics Venture Board	• Integrated Performance Report • Specialist Services dashboards

Key Headlines - Objectives

Objective	Positive Assurance	1	2	3	Gaps in Control / Assurance
1. Service improvement initiatives within Spinal Cord Injury Centre	• Reducing the delay to admission and acceptance of admissions. • Reducing LoS by introducing intense rehab and standardisation of care, whilst also introducing a step down facility for rehab. • Ensuring a sustainable outpatient model, with every patient being recorded. • Improve inpatient decision making • Ensuring appropriate and reduce unnecessary diagnostic tests • Improve therapy collaborative working across patient pathway, including inpatient and outpatient services	x	x		• The historical and cultural national referral process restrictions. • Recruitment of a clinical lead to support change within the teams. Financial modelling has been completed and a project plan drafted. • Workforce gaps in staffing levels and conflicting priorities. • Implement and embed multi-disciplinary ward round, including support from respiratory and neurology. • Cultural practice of clinicians requires discussion with medical staff. • Levels of therapy engagement resulted in pilot work being stopped. New approach from lead therapist to be worked through.
2. Plastic Surgery: Deliver capacity to separate elective and emergency care. Lead provision of plastic surgery network across Wessex	• Theatre timetables have been redesigned to ensure that elective and emergency capacity is separated. • Support to PHT to become sustainable out of hours • Network approach to Plastic surgery service provision	x			• The current re-modelling and configuration of DSU. • The proposed model of 1:8 on call at UHS is being scoped and costed, this o/c would be in addition to SFT. Proposal with options being written. • Currently it's a short-term agreement between PHT and SFT, on how SFT can facilitate OOH services for PHT. SLA to be produced and formalised in December 2017.
3. Work with our partners in networks to develop care pathways for specialist services which improve effectiveness and	• Cleft appointed new consultant cleft surgeon, who is also rotated on the plastic surgery O/C rota. • Work continues with Oxford and Southampton in ensuring the appropriate site is available for cleft surgery	x			• Questions re tariff for complex plastics and burns work. A review of SLR coding/funding/tariff for Burns and Plastic is being undertaken with a report due in December 2017.

patient experience (eg burns, cleft lip, genomics)					

Strategic Priority:

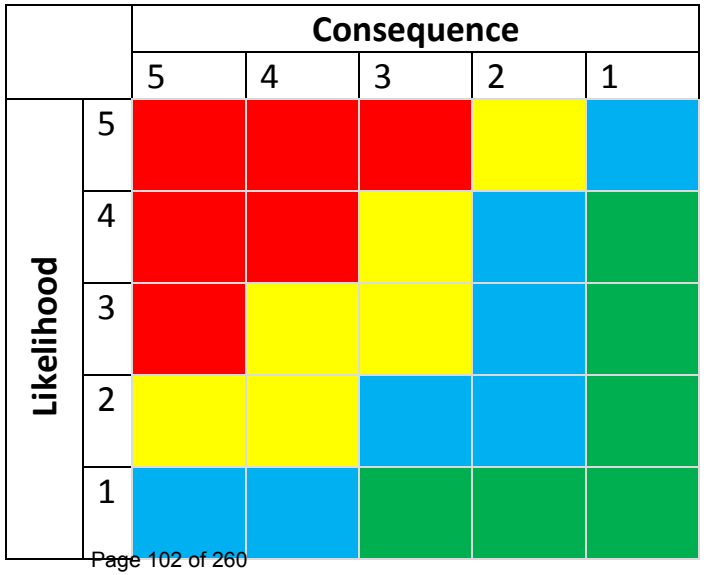
Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

Executive Lead: Medical Director **Reporting Committee:** Clinical Governance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Research -** Deliver an increased range of high quality research which directly benefits patient care and increases the level of research income earned	MD	April 2019	
2. **Improvement -** Build a culture of innovation and continuous improvement adopting a consistent QI methodology	COO	Jan 18	
3. **Innovation -** Introduce innovative processes, pathways and to change how we deliver our services to improve effectiveness of our services and to bring additional benefit for our patients	MD/COO	April 2018	
4.	DoO&D		

Corporate Risk Register Principal Risks



Risks to be added:

Ability to develop the QI capability and culture to transform services

Key Controls	Assurance on Controls
• Outstanding Every Time Board • QI training and coordination via PMO • Research Governance Framework	• Model Hospital benchmarking • NIHR Wessex

Key Headlines - Objectives

Objective	Positive Assurance	1	2	3	Gaps in Control / Assurance
1. Deliver an increased range of high quality research which directly benefits patient care and increases the level of research income earned	• Attaining recruitment target • Increased number of departments are research active • Good progress in recruiting to time and target • Team won national Research Excellence Award	X		X	
2. Build a culture of innovation and continuous improvement adopting a consistent QI methodology	• Business case developed setting out future QI approach	x			• Historically there has been no consistent approach to QI. Improvement on this will be dependent on business case being approved • Fragmented capture of QI work within the Trust
3. Introduce innovative processes, pathways and to change how we deliver our services to improve	• Trust weighted activity unit benchmark in top 10% of country as per the Model Hospital tool. • Consistently approving introduction of new procedures • GROW programme – 78% reduction in stillbirth rate • New ambulatory gynaecology service	X		X	• Surgical pathway requires improvement to reduce pre-surgery bed days • Fractured neck of femur pathway needs improvement

effectiveness of our services and to bring additional benefit for our patients	• Introduction of virtual fracture clinic and patient initiated follow up • Roll out of email advice service				

Strategic Priority:

Care – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm

Executive Lead: Medical Director and Director of Nursing **Reporting Committee:** Clinical Governance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **CQC** - Achieve a CQC rating of Good	DoN	March 18	
2. **Safety -** Deliver on the local and national safety priorities	DoN	March 18	
3. **Infection -** Maintain our focus on reducing rates of infection	DoN	March 18	
4. **End of Life Care -** Review process to establish learning and improvement	MD	March 18	
5. **Patient Experience -** Work with our patients to plan and improve the services we provide to ensure the care delivered meets patients' needs	DoN	March 18	

Corporate Risk Register Principal Risks

Likelihood \ Consequence	5	4	3	2	1
5		3914			
4			**3925** **3924**		
3		**4977**	**5078**		
2					
1					

4977 – Inpatient fall resulting in harm
5078 – Mortality (HSMR) Ratio higher than expected range

Linked workforce risks (see People section)
3914 – Failure to recruit adequate numbers of nursing staff
3924 - Failure to recruit to vacant posts could result in an inability of the organisation to deliver excellence to all patients
3925 - Failure of staff to maintain updated statutory /Mandatory Training

Further Risks to be added:
External - Changing population, social care capacity

Key Controls	Assurance on Controls
• Quality Governance Framework • Integrated Governance Framework • Accountability Framework • Policies and procedures • Patient and user feedback mechanisms / patient stories at Board • Contract Quality Review Meeting / contractual monitoring • Annual audit programme • Safety programme • Infection Prevention and Control Governance Framework and plan	• Internal reporting processes to Committees and Board • External reporting and benchmarking mechanisms • Internal audit programme • CQC inspection regime • Patient Surveys/Friends and Family Test/Real Time Feedback • Executive Board safety Walks • Well led review commissioned for December 2017

Key Headlines - Objectives

Objective	Positive Assurance	1	2	3	Gaps in Control / Assurance
1. Achieve a CQC rating of Good	• Positive CQC Insights report on key benchmarks • Improvement delivery on Must do/ Should do's	x		X	
2. Deliver on the sign up to safety work streams	• Quarterly reports show most workstreams on track • Positive NRLS report re reporting culture	X		x	• Falls continues to be biggest risk within the work streams • Improvement needed in local Mortality and Morbidity meetings
3. Maintain our focus on reducing rates of infection	• Trust in the upper quartile for reportable infection rates in the South West in Q1 and Q2			X	
4. Review process to establish learning and improvement	• Mortality review reports show low levels of avoidability • HSMR showing decline		x	X	• HSMR still above expected
5. Work with our patients to plan and improve the services we provide to ensure the care delivered meets patients' needs	• Mixed sex breaches at 0 for last 6 months • ED patient survey amongst best in the country • Cancer survey benchmarks positively • High satisfaction shown in Friends and Family Test and Real Time Feedback • Positive Patient and Public involvement in ophthalmology build	X x	 x 	X x 	

Strategic Priority:

People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

Executive Lead: Director of Organisation and People **Reporting Committee:** Executive Workforce Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Resourcing and Talent Management -** Deliver a cohesive plan to attract, deploy, retain and reward a flexible workforce	DoODP	March 2019 (phase 1)	
2. **Business Partnering** - Establish effective partnerships to align business and HR strategies	DoODP	March 2019 (phase 1)	
3. **Health and Wellbeing** - Improve the health and wellbeing of staff	DoODP	March 2019 (phase 1)	
4. **OD and Engagement** - Develop a diverse and inclusive culture where staff feel engaged	DoODP	March 2019 (phase 1)	
5. **Leadership -** Develop strong leadership capability across all levels of the organisation to support an innovation culture	DoODP		

Corporate Risk Register Principal Risks

Likelihood	Consequence 5	4	3	2	1
5		**3914**	**(A)**		
4			**5220 3925 3924**		
3		**(B)**	**(C)**		
2					
1					

A - Failure to recruit staff as a result of:

- Government pay cap
- IELTS
- Brexit

Will result in SFT being unable to deliver safe, sustainable services for patients

B - Failure to deliver excellence for all patients if the workforce is not appropriately skilled and staffed to the right level changing agenda education - 3 year programme for ODPs, bursary funding, apprenticeship model.

C - Failure to achieve an outstanding experience for every patient because staff do not feel valued and able to contribute fully to work as a consequence of low morale

(A, B and C new risks yet to be added to Risk Management System)

5220 - Covering Radiology services and workload due to staffing shortages

3914 - Failure to recruit adequate numbers of substantive nursing staff

3924 - Failure to recruit to vacant posts could result in an inability of the organisation to deliver excellence to all patients and places additional responsibility on existing staff to manage services.

3925 - Failure of staff to maintain updated statutory /Mandatory Training

Key Controls	Assurance on Controls
• Executive Workforce Committee (EWC) • Health and Wellbeing Board • People Strategy Programme Group (not yet established) • HR Policies • Directorate Performance meetings • Trust values and behaviours • Workforce Pay Control group • Safer Staffing Group • Equality, Diversity and Inclusion Steering Group (under review) • Health and Safety Committee • Integrated Performance Report at Board • Monthly Workforce Dashboard • Executive Safety Walks	• Staff Survey • Staff Friends and Family Test • External Audits • CQC Well Led Domain • NHSI temporary spend caps

Key Headlines - Objectives

Objective	Positive Assurance	1	2	3	Gaps in Control / Assurance
1. Deliver a cohesive plan to attract, deploy, retain and reward a flexible workforce	• Staff turnover remains steady (reported through EWC) • Growing medical locum bank (Locums Nest trial) • Engaged with regional streamlining work stream • Engaged with STP Agency cap and control work stream.	X X X x			• Impact of Brexit not yet clear • Impact and delay of IELTS / OSCE for international recruits • Recruitment data not easily reportable • No retention strategy and associated resource • Feedback gaps (candidate/ starter/ leaver) • Potential for shortage areas to be removed from Shortage Occupation list (e.g. Nursing) • Pay constraints
2. Establish effective partnerships to align business and HR strategies	• Development of new Workforce KPI Dashboard •	X			• Lack of management training and toolkits on key people management topics • Lack of accessibility and transparency of key workforce data (workforce dashboards)
3. Improve the health and wellbeing of staff	• Staff sickness benchmarks well at approx. 3.5% as an average. • Shape up at Salisbury offering for staff well supported.	X x			• Staff sickness remains above 3% target • Sickness absence management not effective • Sickness absence reporting processes and data not robust

4. Develop a diverse and inclusive culture where staff feel engaged	• Staff survey results in best 20% of Acute Trusts for 18 of 32 key findings. • Staff Friends and Family Test results are positive. • In HSJ top 100 places to work			X X x	• Mandatory Training compliance remains below target of 85% • Appraisal rates for non-medical staff remain below target of 85% • Ongoing cuts to funding for education & training
5. Develop strong leadership capability across all levels of the organisation to support an innovation culture	•				

Strategic Priority:

Resources – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources

Executive Lead: Director of Finance **Reporting Committee:** Finance and Performance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Financial Recovery Plan -** Deliver on financial recovery plan to secure financial sustainability	DoF	March 2019	
2. **Campus Scheme** - Develop a financially viable scheme to rejuvenate and improve the utilisation of the estate	DoCD	April 2021	
3. **Digital Strategy -** Develop and implement a digital strategy which will enable the delivery of more effective care through the use of technology	DoCD	April 2021	
4. **Service Reviews -** Undertake reviews of core services to ensure ongoing plans for sustainability and delivery of key objectives	MD	March 2018	

Corporate Risk Register Principal Risks

Likelihood \ Consequence	5	4	3	2	1
5			**5099**		
4		**5104**	**5105 3809**		
3	**5100**				
2					
1					

3809 - Failure of move to Data warehouse

5100 - Inability to provide robust activity & income performance reports due to problems with data warehouse and EPR system.

5104 - Potential monies at risk through non delivery of some of the CQUIN targets in 17/18

5105 - Inflationary & local unavoidable cost pressures greater than plan.

5099 - NHSI offer a control total which requires the Trust to make more cost savings which are not achievable.

Key Controls	Assurance on Controls
• Finance and Performance Committee • Accountability Framework – Directorate Performance Reviews • Contract monitoring systems • Contract performance meetings with commissioners • INNF Policy Distributed • OETB • Capital control group • Budget setting process • Internal Audit Programme • Investment Committee	• Internal Performance reports to Trust Board • Audit Committee Reports

Key Headlines - Objectives

Objective	Positive Assurance	1	2	3	Gaps in Control / Assurance
1. Deliver on financial recovery plan to secure financial sustainability	• Outstanding Every time Board established with CEO chairing fortnightly. • Additional capacity procured to support the development and delivery of the recovery programme (BCG). • Internal communication plan launched • Initial plan developed with high level savings opportunities.		X		• Engagement with STP and Commissioners on SFT recovery plan. • Capability and capacity across the organisation to deliver change at pace. • Recruitment challenges across the organisation limit delivery of the plan.
2. Develop a financially viable scheme to rejuvenate and improve the utilisation of the estate	• Additional management capacity with experience in delivering similar projects secured • National schemes are coming on line which offer potential frameworks for development • Support from Wiltshire Council and commissioners for proposed scheme • Potential funding via joint venture arrangement will enable master planning to begin • Positive early clinical engagement.		X		• Link into wider Trust strategic estate plans needs strengthening • Reliance on private sector investment, agendas/timescales may not align • Lack of communication expertise for a project that will have a significant PR element
3. Develop and	• Early draft of document developed to begin consultation				• Delay in subsequent phases of EPR, delivery against business case

implement a digital strategy which will enable the delivery of more effective care through the use of technology	• Foundation of an integrated patient record system exists which can be linked to other systems • Strong engagement from some clinical quarters, eg nursing • Some signs of STP wide solutions which may benefit the Trust		X		• System supplier engagement • Because of usability issues, risk around engagement • Lack of capital funds to invest (potential national funds will be allocated by the STP) • Need to redefine the role of ISSG in taking forward the digital strategy
Undertake reviews of core services to ensure ongoing plans for sustainability and delivery of key objectives	• Outstanding Every time Board established with CEO chairing fortnightly to oversee programme. • Additional capacity procured to support the development and delivery of the recovery programme- core services one element. • Use of Model hospital and GIRFT to support pathway change in place.		X		• Timeliness of publication of relevant benchmarking information to support decision making. • Capacity to undertake reviews then implement change at pace.

Corporate Risk Register Summary – November 2017

Risk Score Key

Low Risk 1-3	Moderate Risk 4-6	High Risk 8-12	Extreme Risk 15-25

Internal (I) or External (E) Risk	Risk Detail			Current Scoring		Score Trend			Date Risk added
	Risk (Datix) Ref	Risk Title	Exec Lead	Current Score	Target Score	Prev. Month	3 months ago	6 months ago	
	Strategic Priority - **Local Services** – We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.								
	5220	Covering Radiology services and workload due to staffing shortages	Chief Operating Officer	12	12	12	12	n/a	June 2017
	3919	Capacity planning – required number and range of facilities	Chief Operating Officer	15	6	15	15	15	May 2015
	4682	Delayed transfers of care (DToC) and 'Green to go' patients - negative impact on capacity.	Chief Operating Officer	20	8	20	20	20	July 2016
	Summary/Update of actions agreed at XXXXX • ID XXXX –								
	Strategic Priority - **Specialist Services** – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.								
	3322	Genetics National Reconfiguration	Medical Director	12	6	12	12	12	August 2013
	5047	Spinal Unit Clinical Leadership – post vacant	Medical Director	12	4	12	12	12	February 2017
	5100	Inability to provide robust activity & income performance reports	Director of Finance	15	5	15	15	15	March 2017
	Summary/Update of actions agreed at XXXXX • ID XXXX -								

	Strategic Priority - **Innovation** – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered								
	Summary/Update of actions agreed at XXXXX • ID XXXX -								
	Strategic Priority - **Care** – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm								
(I)	4977	Inpatient fall resulting in harm	Director of Nursing	12	8	12	12	12	January 2017
(I)	5078	Mortality (HSMR) ratio	Medical Director	9	3	9	9	9	March 2017
(E/I)	3914	Failure to recruit adequate numbers of nursing staff	Director of Organisation and People	20	9	20	16	16	May 2015
(I)	3924	Failure to recruit to vacant posts could result in an inability of the organisation to deliver excellence to all patients	Director of Organisation and People	12	9	12	12	12	May 2015
(I)	3925	Failure of staff to maintain updated statutory /Mandatory Training	Director of Organisation and People	12	9	12	12	12	May 2015
	Summary/Update of actions agreed at XXXXX • ID XXXX -								
	Strategic Priority - **People** - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams								
(E)	XXXX	Failure to recruit staff as a result of: Government pay cap, IELTS, Brexit will result in SFT being unable to deliver safe, sustainable services for patients	Director of Organisation and People			NEW	NEW	NEW	Not yet written
(I)	XXXX	Failure to deliver excellence for all patients if the workforce is not appropriately skilled and staffed to the right level	Director of Organisation and People			NEW	NEW	NEW	Not yet written
	5220	Covering Radiology services and workload due to staffing	Chief Operating	12	12	12	12	12	June 2017

		shortages	Officer						
	3914	Failure to recruit adequate numbers of substantive nursing staff	Director of Nursing	20	9	20	16	16	May 2015
	3924	Failure to recruit to vacant posts could result in an inability of the organisation to deliver excellence to all patients and places additional responsibility on existing staff to manage services.	Director of Organisation and People	12	9	12	12	12	May 2015
	3925	Failure of staff to maintain updated statutory /Mandatory Training	Director of Organisation and People	12	9	12	12	12	May 2015
	Summary/Update of actions agreed at XXXXX • ID XXXX -								
	Strategic Priority - **Resources** – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources								
	3809	Failure of move to Data warehouse	Director of Corporate Development	12	12	12	12	12	March 2015
	5105	Inflationary & local unavoidable cost pressures greater than plan.	Director of Finance	12	12	12	12	12	March 2017
	5099	NHSI offer a control total which requires the Trust to make more cost savings which are not achievable.	Director of Finance	15	6	15	15	15	March 2017
	5100	Inability to provide robust activity & income performance reports due to problems with data warehouse and EPR system.	Director of Corporate Development	15	5	15	15	15	March 2017
	5104	Potential monies at risk through non delivery of some of the CQUIN targets in 17/18	Director of Finance	16	8	16	16	16	March 2017
	Summary/Update of actions agreed at XXXXX • ID XXXX -								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Synopsis	Due date	Done date	Action lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5078	Quality Directorate	All clinical areas	08/03/2017	Clinical Governance	9	Due to a consistently higher than expected HSMR there is a risk to the Trusts reputation as patients and the public potentially could perceive it as a negative indicator of care. The rising trend in HSMR also has the potential to attract additional scrutiny from the CQC, commissioners and NHSI.	May recur occasionally	Moderate	9	Implement the recommendations of the Mortality and Morbidity meetings review.	30/06/2017	08/08/2017	Gorzanski, Claire	Clinical Governance Committee	30/11/2017	3		Clinical Governance Committee, Trust Board (Corporate Risk Register)	Medical Director
										Pilot screening of all deaths for avoidable harm by junior doctors presenting each case to a consultant.	30/06/2017	08/08/2017	Cornforth, Dr Belinda						
										Any deaths with a suboptimal pathway or adverse event to receive a second review by the speciality M&M meeting to determine and share learning points.	30/06/2017	08/08/2017	Cornforth, Dr Belinda						
										CUSUM and other alerts to be reviewed by the Mortality Surveillance Group and learning points disseminated.	30/06/2017	08/08/2017	Cornforth, Dr Belinda						
										Publish a monthly 'mortality matters' newsletter. Email to all medical staff.	30/06/2017	10/03/2017	Cornforth, Dr Belinda						
										Introduce a system for tracking implementation of lessons learned.	30/06/2017	08/08/2017	Cornforth, Dr Belinda						
										Develop a mortality dashboard for reporting to the Mortality Surveillance Group.	30/09/2017		Mortimore, Martin						
										Implement the recommendations of the national mortality review using the structured judgement review.	30/09/2017	01/08/2017	Blanshard, Dr Christine						
										Use the Datix platform to record death reviews once available and in the meantime continue to use the Trust's electronic recording mortality tool.	30/09/2017		Cornforth, Dr Belinda						
										West of England AHSN to hold a local event to train the trainers in the new structure judgement review process.	30/12/2017		Blanshard, Dr Christine						
										Identify deaths of patients with learning disabilities and notify the LeDeR programme of the death and input to the review of the circumstances leading to the death.	30/04/2017	08/08/2017	Cornforth, Dr Belinda						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Synopsis	Due date	Done date	Action lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5105	Finance and Procurement	Trustwide	27/03/2017	Trustwide risk assessment	12	Inflationary & local unavoidable cost pressures greater than plan.	Will probably recur, but is not a persistent issue	Moderate	12	Executive review & agreement of cost pressures.	30/03/2018		Collis, Mark	Finance Committee	29/09/2017	6		Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance
										Review whether to continue service driving the cost pressure.	30/03/2018		Collis, Mark						
										Renegotiation of prices with suppliers and use of cheaper alternative products. Seek to mitigate through negotiation and look at alternative solutions.	30/03/2018		Collis, Mark						
										Maximise shift to biosimilar/biologics.	30/03/2018		Collis, Mark						
										Staff outside Procurement not to agree price increases. Any notified price increase to trigger new market test (subject to Procurement resource availability).	30/03/2018		Collis, Mark						
										Review price increase notifications across the STP, regional collaborative and analytics platforms.	30/03/2018		Collis, Mark						
5220	Clinical Support and Family Services	Radiology	26/07/2017	Directorate risk assessment	12	There is currently a difficulty in covering the workload in the Radiology Department. This is due to increasing workload in the context of retirements and a national shortage of Radiologists. The risk to the Trust is that there will be an increasing delay in diagnosis and specifically that important pathologies such as cancer are not diagnosed in a timely manner.	Will probably recur, but is not a persistent issue	Moderate	12	[26/07/2017 18:42:28 Henry Wilding] Scope external reportig agencies to gauge current capacity and ability to accept additional work	23/08/2017		Lloyd-Jones, Graham	Joint Board of Directors	23/08/2017	4		Joint Board of Directors, Trust Board (Corporate Risk Register), Finance Committee	Chief Operating Officer
										[26/07/2017 18:44:55 Henry Wilding] Ensure all agencies and locums within current tier have been explored as to potential locum availability. Escalate to COO for approval for off framework agencies/locum if no success with above	02/08/2017		Lloyd-Jones, Graham						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Synopsis	Due date	Done date	Action lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
3924	Human resources	Trustwide	26/05/2015	Trustwide risk assessment	12	[26/05/2015 15:22:29 Fenella Hill] Recruitment Failure Failure to recruit to vacant posts could result in an inability of the organisation to deliver excellence to all patients and places additional responsibility on existing staff to manage services. Identified specialities are not recruited to establishment and therefore there is a reliance on a temporary workforce such as bank and agency. This has an impact on reputation, quality and financial aspects of the organisation. Posts identified include specialist Medical Posts (i.e. Dermatology, Community Geriatricians, Gastroenterology, Opthalmology) where this is a national recruitment problem and nursing post (particualrly medicine) where this is a supply problem	Will probably recur, but is not a persistent issue	Moderate	12	Recruitment initiatives such as 'refer a friend', European Recruitment, job fairs	31/03/2017	05/04/2017	KINGSC	Executive Workforce Committee	29/09/2017	9	3.2	Joint Board of Directors, Trust Board (Corporate Risk Register)	Director of Organisational Development and People
										Working with training institutions to raise the profile of Salisbury and attendance at careers fairs such as university or national.	31/03/2017	05/04/2017	KINGSC						
										Liaison with University to assess and promote student experience to ensure students consider SFT a positive place to work.	31/03/2017	05/04/2017	KINGSC						
										Use of other medias including social media (Facebook and Twitter) to promote Trust	31/03/2017	05/04/2017	KINGSC						
										'Branding' of Salisbury to promote reputation.	31/03/2017	05/04/2017	KINGSC						
										Focus on retention of current staff - Developing of 'fresh eyes' approach for new staff - Reviewing Exit Interview to increase update and learning	29/09/2017		Salisbury, Hilary						
										Monitoring of vacancies	31/03/2017	05/04/2017	KINGSC						
										Monitoring agency usage via 'Reducing Agency Spend' group.	31/03/2017	05/04/2017	Wilkinson, Lorna						
										Use of head hunting agencies to secure medical locums	31/03/2017	05/04/2017	KINGSC						
										Transitioning work with Army - making links with the groups moving back onto the plain - promoting careers at Salisbury with Army spouses	31/12/2017		Holt, Sharon						
3925	Human resources	Trustwide	26/05/2015	Trustwide risk assessment	12	Failure of staff to maintain updated Statutory/Mandatory Training There is a high rate of completion of statutory and mandatory training by staff on entry to the Trust. However there is a failure amongst some staff to update with regards to these modules. There is a risk that staff may be practising without having completed updates - this is identified as a low risk from a patient safety perspective as staff will have knowledge from initial completion, however it has implications for regulation activity and organisational reputation.	Will probably recur, but is not a persistent issue	Moderate	12	Raise staff awareness of their individual and professional responsibilities in relation to training.	31/03/2017	05/04/2017	KINGSC	Executive Workforce Committee	29/09/2017	9	3.2	Joint Board of Directors, Trust Board (Corporate Risk Register)	Director of Organisational Development and People
										Monitor staff training records with individuals through appraisal.	31/03/2017	05/04/2017	KINGSC						
										Appropriate sanctions to be managed with staff where evidence of non completion i.e. failure of pay progression	31/03/2017	05/04/2017	KINGSC						
										Monitoring of training records through Directorate Performance Meetings	31/03/2017	05/04/2017	KINGSC						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Synopsis	Due date	Done date	Action lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
3322	Clinical Support and Family Services	Genetics	29/08/2013	Organisational risk assessment	12	Risk: National reconfiguration of genetic services planned. Potentially a major threat to the future of genetic lab services in Salisbury. Risk ongoing, tender expected after General election in June 2017 Action: Tender expected 2017/18	May recur occasionally	Major	12	A genomics strategy group, co-chaired by Christine Blanshard (MD), has been established that involves University Hospitals Southampton and the University of Southampton. A pilot project is planned for 2015 and will formulate a regional strategy once details of the proposed reorganisation are known. This was not released until Nov 2016 These meetings have restarted with additional parties due to the updated project named "re-procurement" Genomic tender meetings occurring regularly between UHS and SFT including Trust representative. Partnership negotiations begun for a wider partnership bid.	01/04/2018		Blanshard, Dr Christine	Trust Board	30/11/2017	6		Clinical Governance Committee, Finance Committee, Trust Board (Corporate Risk Register)	Medical Director
3809	Corporate Development	Information Technology	02/03/2015	Other assurance not listed	12	UPDATED 09/05/2016 - To align with Project risks - loss of functionality during move to new warehouse facility will adversely affect the Trust. Although this is likely to be a one off event, the impact would be catastrophic [02/03/2015 10:29:39 Christopher Dodgson] Loss of data warehouse would have an adverse impact on financial stability, booking process, communication with patients (sms), service improvement processes, commissioning etc. 17-10-2017 AC The data warehouse is now the main operational tool for reporting - it sits on "unsupported" technology - namely Windows Server 2003 and SQL Server 2005 which means no additional patches will be applied in terms of security patching. Best practice would dictate that it is moved to a more modern operating system and database but there is a longer term project to replace it.	Will probably recur, but is not a persistent issue	Moderate	12	Plnns in place to develop data warehouse - work is ongoing and data warehouse mostly established. The project is focusing on the delivery of reports needed at go live. Reports will then be developed from the InView data warehouse as reporting deadlines are reached.	30/10/2016	27/10/2016	Cowling, Andrew	Not known	30/11/2017	4	4.1	Joint Board of Directors, Trust Board (Corporate Risk Register), Finance Committee	Director of Corporate Development
										[19/07/2017 15:55:30 Andrew Cowling] Strategy for new data warehouse platform to be defined to enable the risk to be eliminated	30/11/2017		Mortimore, Martin						
										Schedule and perform a controlled failover of the data warehouse cluster	10/11/2017		Gibson, Richard						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Synopsis	Due date	Done date	Action lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
4977	Quality Directorate	Trustwide	03/01/2017	Incident reports	12	There is a recognised national risk of in-patients falling, slipping or tripping whilst in hospital care. There has been an increase in falls resulting in high harm within SFT. In addition to this, we have increasingly frail patients and high ward acuity. Bed capacity within the Trust has become challenging due to an increase in non-elective admissions and patients who are fit for discharge but awaiting care packages or placements. This results in patients being occasionally nursed in areas which are not ideal for their needs, increasing their risk of falling. Harm ranges from psychological, such as loss of confidence and fear of falling (thus reducing their rehabilitation opportunities) to physical injuries such as minor cuts, bruises or more serious injuries such as fractures or head injuries. Rarely injuries from falls can be fatal. Those for whom rehabilitation is limited, may require on-going care needs which may be a litigation risk for the organisation.	May recur occasionally	Major	12	HImP team developing stickers to use in patient notes. The stickers are designed to ensure a systematic assessment takes place and follows NICE guidance.	31/07/2017	29/06/2017	Cox, Dr Christina	Falls Group	14/12/2017	8		Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing
										Create a sticker to use by nursing staff to assist with triaging patients, ensuring appropriate assessments and escalation are made following a fall.	31/07/2017	29/06/2017	Mooney, Vanessa						
										National Falls Audit 2015 identified Lying and Standing Blood pressures as a key area for improvement nationally. Trust compliance with this is poor and need to agree a process we can use in key areas at SFT.	31/07/2017	31/05/2017	Benson, Rebekah						
										The National Falls Audit in 2015 identified some gaps in our current falls assessment compared to national recommendations. SFT had only recently introduced a revised assessment and agreed to embed this, then look to incorporate the additional recommendations with future revisions.	29/12/2017	31/05/2017	Hill, Fenella						
										Development of the role of falls links nurses (undertaking data collection for SU2S work stream) into falls Champions for their area.	31/07/2017	25/07/2017	ROEL						
										Need to develop consistent training programme for ward staff.	31/07/2017	31/05/2017	Hill, Fenella						
										Incorporate key falls prevention measures into daily management plans currently being revised	31/07/2017	05/07/2017	Ford, Maria						
										Ensure clear guidelines for staff regarding appropriate imaging when patients have fallen and a head injury is suspected (or can not be excluded)	17/07/2017	13/07/2017	ROEL						
										RCA template to be adapted to support ward staff when investigating and provide assurance to the CCG in relation to the SI Framework	27/01/2017	31/05/2017	Lowe, Tarah						
										Set up 'Share and Learn' sessions for ward staff to present their RCA's and facilitate sharing of good practice	18/12/2017		ROEL						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Synopsis	Due date	Done date	Action lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
										Double grip slipper socks to be implimented on adult inpatient wards Trust wide.	21/08/2017	01/10/2017	ROEL						
										Falls reduction strategy and action plan to be approved at CMB.	28/06/2017	08/06/2017	ROEL						
										SBAR handover of care stickers to be trialled on Whiteparish and Durrington Wards.	28/06/2017	19/06/2017	ROEL						
										[05/07/2017 15:20:26 Louise Roe] Action leads for falls action plan to be identified in order to drive forward revised action plan.	31/07/2017	10/07/2017	ROEL						
										[05/07/2017 15:22:39 Louise Roe] Roll out SBAR handover stickers across the Trust	28/08/2017		Lowe, Tarah						
										[05/07/2017 15:23:36 Louise Roe] Multifactorial falls risk assessment and interventions form to be approved with plan for roll out to be decided.	28/08/2017	13/07/2017	ROEL						
										[05/07/2017 15:26:20 Louise Roe] Nursing post falls assessment to be trialled	31/07/2017		Mooney, Vanessa						
										[05/07/2017 15:30:52 Louise Roe] Medical post falls assessment form to be trialled.	11/09/2017		ROEL						
										[25/07/2017 10:16:43 Louise Roe] New multifactorial falls risk assessment and interventions form to be trialled for 1 month. 18/10/17: Assessment trialled, currently being incorporated into new nursing assessment document as part of documentation work stream.	28/08/2017	18/10/2017	Ransby, Katie						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Synopsis	Due date	Done date	Action lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5047	Musculo-Skeletal	Spinal Unit	15/02/2017	Care Quality Commission, Specialty Risk assessment	12	There is currently no lead Clinician in post for the Spinal Unit and no suitable clinician identified to adopt role. Clinical Director and Deputy Clinical Director for Musculo-Skeletal Directorate have taken on the responsibilities as part of the Care Quality Commission recovery plan. Peer review raised serious concern relating to lack of clinical leadership on the SIU. Action plan in place and managed through existing meeting structure. Executive meetings with DMT Monthly Increased CD PA's as part of new assurance framework	May recur occasionally	Major	12	Continue with intensive support and increased Clinical Leadership from MSK Clinical Director & Deputy	30/09/2017		Swayne, Dr Philippa	Care Quality Commission	31/10/2017	4	2.4	Finance Committee, Trust Board (Corporate Risk Register)	Medical Director
										Produce business case for increased Medical support to centre	30/09/2017		Swayne, Dr Philippa						
										Therapy workforce review to be presented at EWDC in May 17 exploring opportunities for potential service level AHP leadership roles	31/05/2017		Mulshaw, Cris						
										Use expert SME's for pathway redesign and improvements	30/09/2017		Wright, Jonathan						
										Overarching Business case to CCG	01/07/2017		Wright, Jonathan						
3919	Operations Directorate	Trustwide	22/05/2015	Trustwide risk assessment	12	[22/05/2015 10:22:19 Samantha King] Effective capacity planning to ensure that the Trust has the required number and range of facilities and staff to deliver the services.	Will undoubtedly recur, possibly frequently	Moderate	15	Review capacity planning model outputs regularly with operational staff. Capacity and Demand modelling using IMAS model. Starting with Endoscopy and MRI capacity.	31/12/2015	10/01/2017	Hyett, Andy	Joint Board of Directors	31/10/2017	6	3.2	Joint Board of Directors, Trust Board (Corporate Risk Register), Finance Committee	Chief Operating Officer
										Review of outpatient capacity	31/03/2017	12/04/2017	Hyett, Andy						
										Business cases for reconfiguration of the hospital approved. Moving to implementation plan.	31/10/2017		Hyett, Andy						
5099	Finance and Procurement	Trustwide	27/03/2017	Trustwide risk assessment	15	NHSI offer a control total which requires the Trust to make more cost savings which are not achievable. Open to fines and penalties Inability to access central capital funding.	Will undoubtedly recur, possibly frequently	Moderate	15	Develop & Implement a finance strategy which delivers a financial sustainable organisation for the future.	30/03/2018		Collis, Mark	Finance Committee	31/03/2018	6		Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance
										Only agree a control total which is honestly deliverable and doesn't jeopardise the safety of services.	30/03/2018		Collis, Mark						
										Secure STF funding to support delivery of control total.	30/03/2018		Collis, Mark						
										Ensure all income due is received including obtaining full reimbursement for non-PbR services.	30/03/2018		Collis, Mark						
5100	Finance and Procurement	Trustwide	27/03/2017	Trust Board, Trustwide risk assessment	15	Inability to provide robust activity & income performance reports due to problems with data warehouse and EPR system. This could result in commissioners not paying for any growth in activity or under-performance of QIPP schemes.	May recur occasionally	Catastrophic	15	Engage with STP commissioners to agree reasonable funding including a fair year end settlement.	30/03/2018		Arnold, Laurence	Finance Committee	29/09/2017	5		Finance Committee, Trust Board (Corporate Risk	Director of Finance
										EPR Stabilisation Programme	13/11/2017		Arnold, Laurence						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Synopsis	Due date	Done date	Action lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5104	Finance and Procurement	Trustwide	27/03/2017	Trustwide risk assessment	16	[26/06/2017 17:22:35 Claire Gorzanski] Potential monies at risk through non delivery of some of the CQUIN targets in 17/18. Generally, some targets are difficult to achieve. 1a - improvement of health and wellbeing of NHS staff - improvement of 5% over 2 years in 2 out of 3 questions in the staff survey. Responses to all 3 questions decreased between 2015 & 2016 survey. £85K at risk. 1C - Improving uptake of flu vaccine for front line staff - no opt out for West Hampshire CQUIN (£23k at risk). Partial payment if 60 - 70% uptake achieved. 2 - Supporting discharge - 2.5% increase in discharging patients to usual place of residence. £205K at risk. 3 - Sepsis - achievement of 90% screening and treatment and reduction in 2 of the 3 antibiotic groups on 2016 baseline. £162K at risk. 4 - Reducing mental health frequent flyers in A&E - 20% reduction in attendances of selected cohort. £205K at risk. Total monies at risk of non delivery of CQUIN targets £475K - £680K	Will probably recur, but is not a persistent issue	Major	16	Baseline position currently being established.	30/03/2018	08/08/2017	Wilkinson, Lorna	Finance Committee	31/10/2017	8		Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance
										Exec lead, SRO and working group oversight.	30/03/2018		Wilkinson, Lorna						
										CCG meeting 27th Feb to agree interpretation of scheme and evidence required.	30/03/2018	08/08/2017	Wilkinson, Lorna						
										[26/06/2017 17:28:36 Claire Gorzanski] Reduce the level of work related stress and MSK work related problems in groups of staff who have the highest rates. Target high risk groups for action through work led by DD of HR and staff & health wellbeing group.	31/03/2018		Salisbury, Hilary						
										[26/06/2017 17:31:36 Claire Gorzanski] Increase the uptake of the flu vaccine of front line staff by running a comprehensive flu campaign based on learning in 16/17 and from other Trusts.	31/03/2018		Lewis, Heidi						
										[26/06/2017 17:35:44 Claire Gorzanski] Increase discharges to usual place of residence through the existing programme of work related to patient flow, the LDB and multi-agency partnerships to reduce stranded patients.	31/03/2018	17/11/2017	Knight, Sarah						
										[26/06/2017 17:39:17 Claire Gorzanski] Improve the screening of inpatients by adding a sticker to the EWS escalation section 'could the patient have an infection'. Continue current ward based CCOT education programme. Provide regular feedback on timeliness of screening and IV antibiotics audit. Monitor progress through the Sepsis working group.	31/03/2018		Ford, Maria						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Synopsis	Due date	Done date	Action lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
										[26/06/2017 17:43:26 Claire Gorzanski] Reduce the consumption of all antibiotics, carbapenem and piperacillin/tazobactum through AMR stewardship ward rounds, education and feedback to individual clinicians and teams on practice. Take part in antibiotic awareness week. Agree protocol changes at the Infection Prevention and Control Group.	31/03/2018		Williams, Louise						
										[26/06/2017 17:46:43 Claire Gorzanski] Ensure all patients in the identified cohort of ED frequent attenders have a personalised care plan agree with them. For relevant patients agree a multi-agency plan with police, ambulance service, AWP, primary care. Monitor attendance of the cohort and target ongoing frequent attenders.	31/03/2018		Davies, Dr Stephen						
										[26/06/2017 17:49:52 Claire Gorzanski] Agree and implement a plan for 35% of specialties to offer advice and guidance by Q4 17/18. Open negotiations with the CCG and agree a local tariff for A&G.	31/03/2018	08/08/2017	Barrett, Jessica						
										[26/06/2017 17:53:31 Claire Gorzanski] Map existing clinics to the Directory of Services on eRS so they are made available to GPs. Prioritise the specialties the CCG have said will not be available to GPs unless they refer using eRS. Monitor progress monthly and report to the OPD PMB.	31/03/2018	08/08/2017	Stephens, Mrs Davina						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Synopsis	Due date	Done date	Action lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
3914	Quality Directorate	Trustwide	20/05/2015	Other assurance not listed	16	[20/05/2015 12:18:15 Samantha King] Failure to recruit adequate numbers of substantive nursing staff with the following implications: Quality and safety concerns at ward level Poor patient experience High agency spend - financial risk to the Trust	Will undoubtedly recur, possibly frequently	Major	20	Continue recruitment initiatives within UK	01/04/2016	29/04/2016	Wilkinson, Lorna	Executive Workforce Committee	31/01/2018	9	3.2	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing
										Overseas recruitment planned for 2015/16 (50 RNs)	31/03/2016	18/03/2016	Harvey, Ian						
										Participate in Workforce Productivity and Efficiency Programme (DH) - 1 of 22 participating Trusts	31/03/2016	18/03/2016	Wilkinson, Lorna						
										Participate in the implementation of the Monitor/TDA Staffing tool kit. Launch being held in June 201	24/12/2015	15/10/2015	Wilkinson, Lorna						
										Skill mix review to be carried out twice per year	31/12/2016	28/12/2016	Wilkinson, Lorna						
										Explore strengthening of controls around use of expensive agency	31/07/2015	15/10/2015	Wilkinson, Lorna						
										Specials project - design and implement PDSA cycles linked into Lord Carter work, develop sitting service (volunteers)	30/06/2016	30/06/2016	MART						
										Robust review of roster perform metrics at monthly safer staffing meeting	31/03/2016	18/03/2016	Hyett, Fiona						
										Development of sensitive KPIs for PSG with clear outcome criteria to show how agency premia s being reduced	31/08/2016	28/12/2016	Hyett, Fiona						
										To implement the agency rules and caps this year.	29/04/2016	30/06/2016	Wilkinson, Lorna						
										Implementation of 2016/17 recruitment strategy	31/03/2017	24/05/2017	Wilkinson, Lorna						
										Continue local recruitment campaigns Develop micro site	30/01/2018		Wilkinson, Lorna						
										Overseas recruitment to continue EU, non EU	30/01/2018		Wilkinson, Lorna						
										Ensure exit interviews carried out for all leavers	31/03/2017	24/05/2017	Wilding, Henry						
										Continue controls around use of expensive agency	30/04/2016	30/04/2016	Wilkinson, Lorna						
										Ensure exit interviews carried out for all leavers	30/09/2017	29/11/2016	DENNIN						
										Ensure exit interviews carried out for all leavers	30/03/2018	24/05/2017	Harvey, Ian						
										Ensure exit interviews carried out for all leavers	31/03/2017	24/05/2017	JONJ						
										Develop apprenticeship and Nursing associate opportunities	01/03/2018		Hyett, Fiona						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Synopsis	Due date	Done date	Action lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
										Full recruitment of NA staff	01/03/2018		Hyett, Fiona						
										Performance management of agency contrscts	01/03/2018		Hyett, Fiona						
										Focus on Retention collaborative actions (NHSI)	01/06/2018		Hyett, Fiona						
4682	Operations Directorate	Trustwide	22/07/2016	Trustwide risk assessment	20	Due to the increased demand of non elective patients, delayed transfers of care (DToC) and 'Green to go' patients there has been a negative impact on capacity. As a result there is an on-going need to cancel elective patients. This will result in: * negative impact on performance targets * reduced patient satisfaction * increased complaint numbers * additional distress to patients/carers * Patients waiting for extended periods for procedures to be undertaken * some specialties and patients being impacted repeatedly. * negative impact on Trust reputation.	Will undoubtedly recur, possibly frequently	Major	20	Operational standards for flow	31/12/2016	10/01/2017	Hyett, Andy	Trust Board	30/09/2017	8	1.1	Joint Board of Directors, Trust Board (Corporate Risk Register), Finance Committee	
										Reducing DTOCs and G2G bed days	30/09/2017		Hyett, Andy						
										Implement E-whiteboard	31/12/2016	10/01/2017	Hyett, Andy						
										Set predicted day of discharge	30/06/2017	07/07/2017	Hyett, Andy						
										Embed whiteboard	31/03/2017	12/04/2017	Hyett, Andy						
										Delivery of Trusts actions as part of EDELDB	31/03/2018		Hyett, Andy						
										Business cases for reconfiguration of the hospital approved. Moving to implementation plan.	31/10/2017		Hyett, Andy						
										[07/07/2017 14:39:34 Samantha King] Revised patient flow transformation scheme	31/03/2018		Hyett, Andy						
										[07/07/2017 14:40:18 Samantha King] reconfiguration of the hospital.	01/01/2018		Hyett, Andy						

Report to:	Trust Board	**Agenda item:**	3958
Date of Meeting:	4 December 2017		

Report Title:	Assurance Framework – Quarterly Review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	David Seabrooke, Head of Corporate Governance			
Executive Sponsor (presenting):	Cara Charles-Barks, Chief Executive			
Appendices (list if applicable):				

Recommendation:

To note the quarterly review of the allocated aspect of the Assurance Framework by the Joint Board of Directors

Executive Summary:

Extract from 18 October JBD minutes

JBD received the Assurance Framework and Risk Register.

- It was noted that work is underway to bring the Assurance Framework in line with the Trust's corporate strategy and corporate risk register to ensure the three align. This will enable the Board to clearly see the risks identified against the strategic objectives
- Work is underway to review the corporate risk register and to ensure top risks are captured. Adjustments to the process will ensure the corporate risk register is closed down at the first week of every month, enabling a check and challenge review at relevant meetings. The process to agree new items to go onto the corporate risk register will also be adjusted to ensure decisions are taken via JBD or directorate executive performance meetings. Ownership for items on the corporate risk register will also be clarified. This revised process will go forward from December.
- The new format Assurance Framework is being prepared to go to the December Board meeting.

Report to:	Trust Board	Agenda item:	SFT3959
Date of Meeting:	4 December 2017		

Report Title:	Risk Management Strategy 2017			
Status:	Information	Discussion	Assurance	Approval
				X
Prepared by:	Fenella Hill, Head of Risk Management			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Risk Management Strategy 2017 RMS Appendix A RMS Appendix B RMS Appendix C			

Recommendation:

Approval – The Trust Board is asked to approve the revised Risk Management Strategy 2017.

Executive Summary:

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

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place which will assure the Trust Board that as a Foundation Trust it is discharging its responsibilities.

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

The Strategic Objectives and Key Performance Indicators (KPIs) have been updated for 2017/18 and include:

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

- Ensuring compliance with ‘Duty of Candour’ requirements

The following KPI’s are also in place:

- Achieve compliance with regulations and requirements as determined by NHSI
- Maintain full registration with the Care Quality Commission, aiming for good;
- To be above average reporters of incidents when benchmarked against Trusts of a similar size (NRLS Report);
- Participation in the national and regional patient safety campaigns;
- Maintain a culture where staff feel risk management processes are fair and responsive, evidenced through the annual Staff Survey;
- Compliance with contractual requirements associated with the reporting and management of Serious Incidents;
- Evidence of shared learning from incidents through newsletters, departmental feedback, Executive Performance Meetings etc.
- Clear identification and mitigation of risks associated with delivery of the Workforce Strategy Key Performance Indicators via the Risk Register and Board Assurance Framework.
- Clear identification and mitigation of risks associated with financial recovery plan via the Risk Register and Board Assurance Framework.

Risk Management Strategy

Directorate Responsible for Strategy:	Quality Directorate
Name of responsible board/committee:	Trust Board
Post Holder Responsible for Strategy:	Head of Risk Management
Contact Details:	Risk Management 01722 336262 x2496
Date Written:	September 2017
Approved and Ratified by:	Trust Board
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Date Strategy Becomes Live:	December 2017
Next Due for Review:	December 2018

VERSION INFORMATION

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

Version No.	Updated By	Updated On	Description of Changes
2.4	Denise Major	September 2011	• Section 1 updated reference to DoH,11/12 Operating Framework. DoH,'Liberating the NHS', 2010. • Monitor, Compliance Framework 2011. • The National Quality Board: Maintaining and improving quality during the transition: safety, effectiveness, experience. 2011. • KPIs, section 7, p9 and 10 • Updated Head of Risk working with CEO and Head of Clinical Effectiveness, section 11.2, p14 • Updated terms of reference for the Assurance Committees, Appendix A, p16-24 • Updated references, p26
2.5	Fenella Hill	September 2012	Section 1, p5 updated reference to DoH 12/13 Operating Framework 'Liberating the NHS' (November 2011) and Monitor Compliance Framework 12/13 (March 2012). Section 4, p8 Statement of Internal Control changed to Annual Governance Statement. Section 7, p10 KPIs updated
2.6	Fenella Hill	September 2013	Section 1, p5 updated NHS Outcomes Framework 2013/14. Monitor Compliance Framework. P6 updated Monitor requirements and licensing. Section 7, p10 updated KPI's
2.7	Fenella Hill	September 2014	Section 1, p5 Re-written Section 2, p6 Re-written Section 3, p6 new addition All other sections amended and updated.
2.8	Fenella Hill	October 2015	Addition of Section 3, p6 Responsibility for Risk Management Section 9, p9 Re-written to reflect strategic objectives for 2015/16 Appendix E, p22 updated. All sections minor updates to reflect correct processes.
2.9	Fenella Hill	August 2016	All sections minor updates to reflect correct processes. Appendix B – updated to reflect current committee structure Appendix C – updated to reflect current Risk Management Team structure.
3.0	Fenella Hill	August 2017	All sections minor updates to reflect correct processes. Section 6 – updated to reflect current practice with Board assurance Framework. Section 7 – updated to reflect current practice including changes within the

			Executive Performance review process. Section 9 – Risk management strategic objectives reviewed. KPIs updated to include Finance and Organisation and People Section 10 – amendments to roles and responsibilities. Appendices updated

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Salisbury NHS Foundation Trust

Risk Management Strategy

1) Introduction

1.1 Risk Management is an integral part of Salisbury NHS Foundation Trust's (SFT) management activity and is a fundamental pillar in embedding high quality, sustainable services for the people of Salisbury and the surrounding area. As a complex organisation delivering a range of services in a challenging financial environment we accept that risks are inherent part of the everyday life of the trust. Effective risk management processes are central to providing Salisbury NHS Foundation Trust (SFT) Board with assurance on the framework for clinical quality and corporate governance.

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

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

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

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

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

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

1.8 As part of the Annual Governance Statement, SFT will make a public declaration of compliance against meeting risk management standards. The Trust currently has good systems and process for risk management in place as evidenced by internal and external audit opinion.

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

2) Purpose of the Risk Management Strategy

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

3) Responsibility for Risk Management

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

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

4) Promoting a Fair and Open Culture

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

5) Strategic Goals

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

5.2 Continued development of the Board Assurance Framework (BAF) to ensure that organisation wide strategic risks are identified. The BAF enables the Board to

demonstrate how it has identified and met its assurance needs and is also the vehicle for informing the Annual Governance Statement.

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

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

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

5.5 To further develop the organisational safety culture and its effectiveness through implementation of local, regional and national Patient Safety interventions.

5.6 To ensure that the Trust can demonstrate compliance with the statutory Duty of Candour ensuring that it maintains a consistent open and honest culture, involving patients and families in investigations where appropriate.

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

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

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

6) Compliance and Assurance

6.1 NHSI have implemented a 'Single Oversight Framework' to ensure there is a clear compliance framework which ensures that all Trusts are able to demonstrate that they are remaining within their agreed provider licence. It is therefore imperative that the Trust is aware of any risks (e.g. associated with new business or service changes) which may impact on its ability to adhere to this framework.

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

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

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

identified, translated onto the Board Assurance Framework and remedial action agreed.

6.5 The Board Assurance Framework is reviewed bi-monthly, in its entirety, by the Trust Board. The Framework identifies the principal risks facing delivery of the Trust's strategic objectives and informs the Trust Board how each of these risks is being managed and monitored effectively. Every risk on the BAF is assigned to an Executive Director who is responsible for reporting on progress to the Board of Directors. An Assurance Committee is also identified for each principal risk to assure the Trust Board that it is being monitored, gaps in control and assurance are identified, and processes put into to place to minimise the risk to the organisation.

6.6 The designated Assurance Committees of the Trust Board are the Clinical Governance Committee (Clinical Risk), the Finance and Performance Committee (Financial and Performance Risk), and the Executive Workforce Committee (Workforce and Health and Safety Risk). The Audit Committee monitors the Assurance Framework process overall biannually.

6.7 It is the responsibility of the Assurance Committees to report to the Trust Board, any new risks identified and gaps in assurance/control, as well as positive assurance on an exception basis. If a significant risk to the Trust's service delivery or gap in control/assurance is identified then this should be reported immediately via the Executive Directors (see Appendix C).

6.8 The Board Secretary shall work closely with the Executive Lead for Risk (Director of Nursing), Medical Director, Chief Operating Officer, Director of Finance, Director of Organisational Development and People, Director of Corporate Development and Head of Corporate Governance to ensure that the BAF remains dynamic and is integral to the Business Planning cycle.

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

7) The Trust Risk Register

7.1 Each Department will continue to carry out risk assessments which are held on Datix. A single framework for the assessment, rating, and management of risk is to be used throughout the Trust; this process is described in detail within the Risk Management Policy and Procedure (intranet), alongside how department risk registers are escalated, where appropriate to the directorate risk register.

7.2 Each Directorate will continue to maintain a comprehensive risk register, which will be formally reviewed in full at quarterly intervals, with key headlines and top risks presented monthly, through the Executive Performance Meetings. At these meetings the directorates will be expected to report on their directorate risk register (risks scoring 12 or above that require executive knowledge and support), highlight any new or emerging risks that threaten their service delivery or Directorate objectives and present action plans for minimising and managing these risks. The performance meeting should identify those departmental risks which also pose a corporate threat and so require escalation to the Trust's Corporate Risk Register. The risk register should be seen as a dynamic process as ranking/prioritisation of risks that will change as risk reduction practices take place. The Directorate Management

Committee (DMC) has responsibility for ensuring that all risks within the Directorate are appropriately graded and have sufficient actions in plan to mitigate/reduce the risk.

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

7.4 There is a requirement to detail for every risk on the risk register the plan for the ongoing management of the risk i.e. accept, tolerate or mitigate the risk. Where a decision is made to accept or tolerate the risk it needs to be documented where the decision was made and agreed. Risks that require mitigation must have an action plan.

8) Risk Management Policy

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

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

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

9) Risk Strategic Objectives 2017/18

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

- Monitoring of incidents to highlight trends and areas requiring further investigation/action
    - Provision of monthly incident report card at Clinical Risk Group to support theming of all incidents and monitoring of high harm incidents.
    - Support to Directorates to enable them to monitor themes and trends in reporting within their directorate, departments and specialties' and take remedial action, evidence learning and support enable wider sharing.
    - Working with departments to evidence learning from incidents and feedback to team. Linking with complaints and Litigation team to look at broader themes and learning.

- Embedding risk management at all levels of the organisation – creating a safety culture

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

- Leading and supporting staff and promoting reporting
  - Ensure all staff are aware of their responsibility for reporting incidents.
  - Utilise both formal and informal opportunities with staff for teaching.
  - Participation in local meetings, M&M meetings, Clinical Governance Sessions.
  - Monitor reporting patterns to identify areas/groups of staff who may not be reporting and investigate whether reporting patterns are reflective of risk activity.
  - Introduction of 'Patient Safety Drop-in Sessions' and wall mounted 'Comments Boxes' to support feedback from staff about safety concerns and potential resolutions.
  - Board Safety Walkrounds to focus on staff safety concerns and seeking resolution.

- Ensuring there is appropriate provision of training
  - Review existing in-house training provision in relation to risk management to identify gaps in training provision.
  - Review current availability of training opportunities both internal and external
  - Continued development of bi-monthly case study based RCA training with Customer Care for staff at all levels of the organisation.
  - Delivery of Department/Directorate specific training to enhance the user experience of Datix and showcase functionality.

- Ensuring compliance with 'Duty of Candour' requirements
  - Ensure all staff are aware of their responsibilities through cascade of the Duty of Candour and Being Open Policy.
  - Appropriate and responsive training as required in liaison with the Head of Legal Services.
  - Monitoring of incidents to ensure that graded appropriately
  - Where Duty of Candour triggered liaise with clinicians to ensure they are aware of the correct notification and follow up procedures, feeding back to DMC's and teams where gaps identified.
  - Monitoring of duty of Candour compliance at directorate Executive Performance Meetings

The following KPI's are also in place:

- Achieve compliance with regulations and requirements as determined by NHSI
- Maintain full registration with the Care Quality Commission, aiming for good;
- To be above average reporters of incidents when benchmarked against Trusts of a similar size (NRLS Report);
- Participation in the national and regional patient safety campaigns;
- Maintain a culture where staff feel risk management processes are fair and responsive, evidenced through the annual Staff Survey;

- Compliance with contractual requirements associated with the reporting and management of Serious Incidents;
- Evidence of shared learning from incidents through newsletters, departmental feedback, Executive Performance Meetings etc.
- Clear identification and mitigation of risks associated with delivery of the Workforce Strategy Key Performance Indicators via the Risk Register and Board Assurance Framework.
- Clear identification and mitigation of risks associated with financial recovery plan via the Risk Register and Board Assurance Framework.

10) Accountability and Responsibility Arrangements

10.1 The Chief Executive

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

10.2 Executive and Non-Executive Directors

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

The Executive and Non Executive Directors are responsible for ensuring that they are adequately equipped with the knowledge and skills to fulfil this role. Risk Management training sessions can be accessed via the Risk Department but as a minimum the Risk Manager and Executive Lead for Risk will co-ordinate an annual workshop and update for Trust Board members.
The Executive Directors are accountable and responsible for ensuring that the Corporate Directorates are implementing the Risk Management Strategy and related policies. They also have specific responsibility for managing the Trust's principal risks, which relate to their Directorates. For example:

- The Director of Finance for managing the Trust's principal risks relating to ensuring financial balance,
- Director of Nursing for managing the principal risks relating to clinical quality, nursing workforce and infection control as DIPC.
- Director of Organisational Development and People is responsible for managing the Trust's principal risks relating to Health and Safety and Workforce planning.
- The Medical Director is responsible for managing risks associated with Medical Workforce planning and clinical effectiveness.
- Chief Operating Officer for operational performance related risks.

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

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

10.3 Head of Risk Management

The Head of Risk Management is responsible for:

- Maintaining and updating appropriate Risk Management Policies and procedures;
- Working with the Board Secretary to ensure there is a clear and dynamic link between the Board Assurance Framework and Corporate Risk Register;
- Ensuring the Trust has a comprehensive and dynamic Risk Register and working with Directorate Management Teams to ensure that they understand their accountability and responsibilities for managing risks in their areas;
- ensuring that Directorates know how to access their incident data;
- ensuring information is provided on incident data to the Clinical Governance Committee, and Trust Board;
- Presenting risk reports at the CCG Clinical Quality Review Meeting (CQRM) in line with contract requirements;
- Producing and coordinating Risk Management training programmes in conjunction with the Patient Safety Facilitator and other departments such as Customer Care.
- Collaborating with external stakeholders' key to Risk Management e.g. Commissioners, CQC, NHSI and other Trusts.
- Ensuring that there is an appropriate and named point of contact for patients and families during the Serious Incident review process.

10.4 Board Secretary

The Board secretary is responsible for:

- Co-ordinating the update of the Board Assurance Framework with the Executive Team to ensure that it is reviewed at the Assuring Committees and Trust Board.

10.5 Specialist Areas

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

10.6 Directorate Management Committees

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

- Work proactively to achieve the Trusts Key Performance Indicators for Risk Management.
- Understand and implement the Risk Management Strategy and related policies.
- Ensure that appropriate and effective risk management processes are in place within their delegated areas.

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

10.6 Departmental Managers / Clinical Leads

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

- Ensuring that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility as per this Strategy and related Risk Management Policies.
- Adverse Events are reported, reviewed and investigated thoroughly and in a timely way.
- Staff receive feedback about incidents reported, remedial actions put in place, are encouraged to engage in the resolution of problems and sharing learning wider.
- Ensuring that the grading of incidents are appropriate and regulated actions taken where Duty of Candour is triggered
- Disseminating learning and implementing recommendations made as a result of incident investigations, clinical reviews, and serious incident inquiries within their area of responsibility.
- Monitor and report on the implementation and progress of any recommendations made which fall directly within their area of responsibility i.e. within the Department.
- Maintaining a dynamic departmental risk register

- Ensuring that where high or extreme risks are identified these are brought to the attention of the Directorate Management Team for inclusion onto the Directorate Risk Register.
- Ensuring that all staff are made aware of these risks within their work environment and are aware of their individual responsibilities for raising concerns.
- Ensuring that all staff have appropriate information, instruction, and training to enable them to work safely.
- Ensuring that all new staff attend Trust Induction, receive a departmental induction and are released for mandatory training.

10.7 All Staff

All Staff are required to:

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

11) Organisational Arrangements and Risk Management Structure

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

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

12) Ensuring Compliance with National Standards

12.1 The Risk Team is responsible for facilitating and ensuring compliance with core risk standards.

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

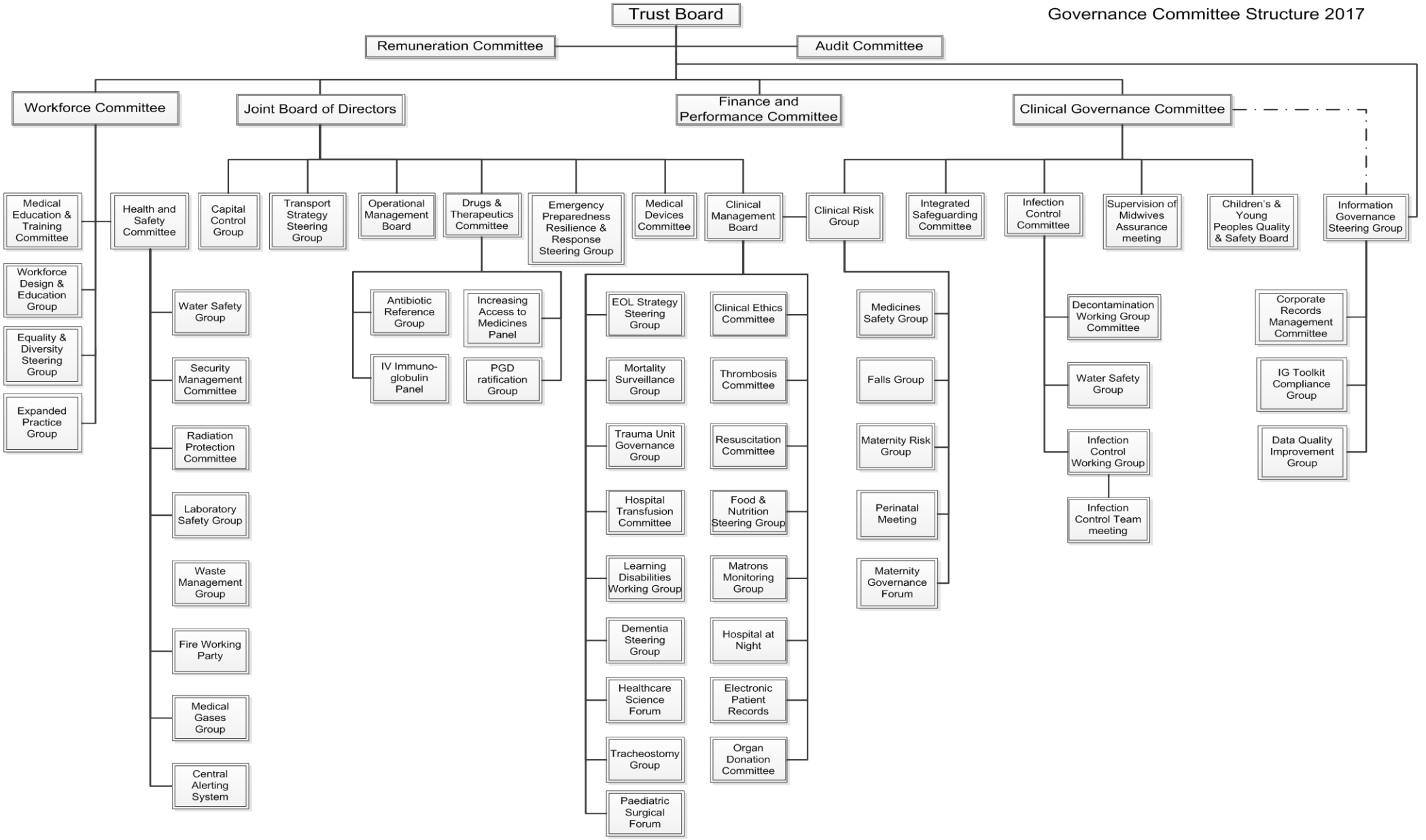
12.3 The Patient Safety Facilitator works in collaboration with the Health and Safety Committee to ensure compliance with Health and Safety Standards

13) Monitoring and Review

This strategy shall be reviewed annually by the Trust Board.

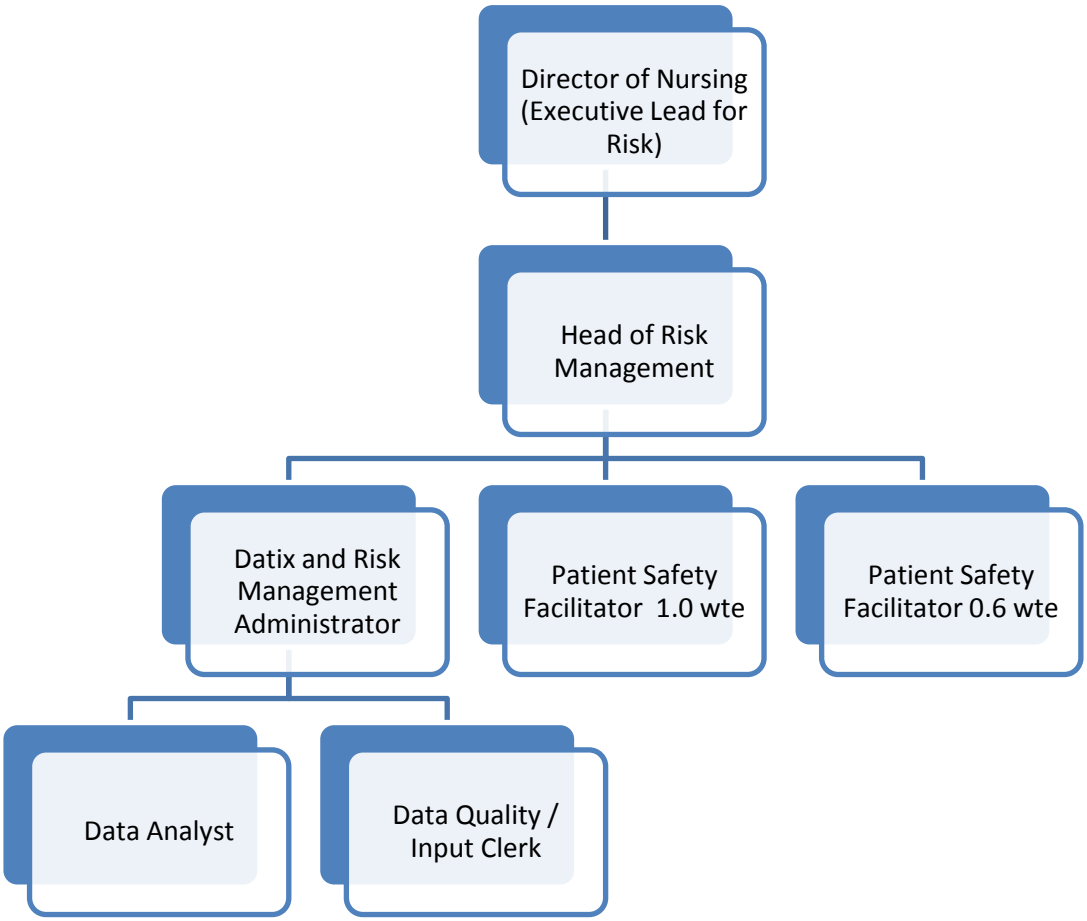
The Head of Risk shall monitor that the process for managing risk locally is being complied with as per this Strategy and the Risk Management Policy and Procedure; this shall be reported at the Directorate performance meetings and within the annual report.

The overall implementation of this strategy shall be monitored through the annual internal audit review.


Governance Committee Structure 2017
Trust Board
Remuneration Committee
Audit Committee
Workforce Committee
Joint Board of Directors
Finance and Performance Committee
Clinical Governance Committee
Medical Education & Training Committee
Workforce Design & Education Group
Equality & Diversity Steering Group
Expanded Practice Group
Health and Safety Committee
Water Safety Group
Security Management Committee
Radiation Protection Committee
Laboratory Safety Group
Waste Management Group
Fire Working Party
Medical Gases Group
Central Alerting System
Capital Control Group
Transport Strategy Steering Group
Operational Management Board
Drugs & Therapeutics Committee
Antibiotic Reference Group
IV Immuno-globulin Panel
Increasing Access to Medicines Panel
PGD ratification Group
Emergency Preparedness Resilience & Response Steering Group
Medical Devices Committee
Clinical Management Board
EOL Strategy Steering Group
Mortality Surveillance Group
Trauma Unit Governance Group
Hospital Transfusion Committee
Learning Disabilities Working Group
Dementia Steering Group
Healthcare Science Forum
Tracheostomy Group
Paediatric Surgical Forum
Clinical Ethics Committee
Thrombosis Committee
Resuscitation Committee
Food & Nutrition Steering Group
Matrons Monitoring Group
Hospital at Night
Electronic Patient Records
Organ Donation Committee
Clinical Risk Group
Medicines Safety Group
Falls Group
Maternity Risk Group
Perinatal Meeting
Maternity Governance Forum
Integrated Safeguarding Committee
Infection Control Committee
Decontamination Working Group Committee
Water Safety Group
Infection Control Working Group
Infection Control Team meeting
Supervision of Midwives Assurance meeting
Children's & Young Peoples Quality & Safety Board
Information Governance Steering Group
Corporate Records Management Committee
IG Toolkit Compliance Group
Data Quality Improvement Group

APPENDIX B

Organisation Chart for Risk Management Team



APPENDIX C

Assurance Framework Report to Trust Board

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

3. New Risks Identified for Inclusion onto Assurance Framework

Risk:
Executive Lead:

4. Newly Identified Gaps in Control/Assurance

Details of gap:
Remedial Actions agreed:

5. Newly Identified Positive Assurances

Please detail the assurance and the linked risk:

6. Risk Register – Newly Identified Extreme Risks

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

Report to:	Trust Board	**Agenda item:**	**3960**
Date of Meeting:	Monday 4th December 2017		

Report Title:	Director of Infection Prevention & Control (DIPC) Six Monthly Update Report 2017/18			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Lorna Wilkinson			
Executive Sponsor (presenting):	Lorna Wilkinson			
Appendices (list if applicable):	Included within the report (Pages 25 – 30)			

Recommendation:

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

The Board are required to note the report and how the contents relate to Board assurance and minute that the Board continues to acknowledge their collective responsibility as described above and detailed within the DIPC report.

Executive Summary:

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

The purpose of the DIPC 6 monthly Report is to inform the Trust Board of the progress made against the 2017/18 Annual Action Plan, to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The reported 6 month period has been a busy time for Infection Prevention & Control but the Trust has achieved good outcomes to date with no reported Trust apportioned MRSA bacteraemias, and 2 reported Trust apportioned Clostridium difficile cases against a trajectory of <19 for 2017/18. Concerted effort continues with antimicrobial stewardship and continued decreases in consumption can be seen in Section 11. Other achievements to note can be seen in the improved Patient Led Assessment of the Care Environment (PLACE) scores (Section 15) and the robust decontamination audit plan (Section 12).

The report has detailed the progress against the Action Plan for 2017/18 in reducing HCAI rates for the Trust and the key priorities have included:

- Continued focus on the reduction of all reportable Trust HCAIs and ensure preventable infections are avoided.
- Ongoing reinforcement to improve compliance with hand hygiene practices and behaviours.
- Continued focus on antimicrobial stewardship.
- Monitor and manage decontamination services.
- Sustain progress with education, training and audit relating to infection control practices and policies.
- Monitor and manage water safety.
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

Key challenges

- Mandatory training compliance which, although improving slowly remains below the Trust target of 85%.
- Comprehensive work continues (along with independent advice) on the water safety agenda (Legionella and Pseudomonas). However, working with such a large and complex water system poses challenges, and positive counts have been identified during this 6 month reporting period. There are robust monitoring and mitigation activities in place.
- There is an increasing occurrence of complex multi-resistant organisms, which the IPC team through the described assurance framework, will keep pace with.

NHS
Salisbury
NHS Foundation Trust

Director of Infection Prevention & Control (DIPC)

6 monthly update Report 2017/18

Lorna Wilkinson
DIPC

November 2017 (Final v.2)

1. Introduction

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

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

The purpose of the DIPC 6 monthly Report is to inform the Trust Board of the progress made against the 2017/18 Annual Action Plan (Appendix 1), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

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

The reported 6 month period has been a busy time for Infection Prevention & Control but the Trust has achieved good outcomes to date with no reported Trust apportioned MRSA bacteraemias, and 2 reported Trust apportioned Clostridium difficile cases against a trajectory of <19 for 2017/18. Concerted effort continues with antimicrobial stewardship and continued decreases in consumption can be seen in Section 11. Other achievements to note can be seen in the improved Patient Led Assessment of the Care Environment (PLACE) scores (Section 15) and the robust decontamination audit plan (Section 12).

2. Governance Arrangements

The work towards achieving the objectives of the Annual Action Plan 2017/18 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC), which completes the governance arrangements (Appendix 2).

3. Infection Control Arrangements

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

The IPCT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (w.t.e) ICNs and secretary (0.6 w.t.e). In addition, there are 2 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead.

4. Assurance Activity

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

- Agree an annual infection control programme and monitor its implementation

- Oversee the implementation of infection control policies and procedures
- Monitor and review the incidence of HCAI
- Develop and review information regarding infection prevention and control
- Monitor the activities of the IPCT
- Benchmark the Trust's delivery of control of infection standards in various accreditation systems, and against CQC Regulations
- Monitor the implementation of infection prevention and control education
- Receive regular updates from the Antibiotic Reference Group (ARG)
- Receive regular updates from the IPCWG
- Monitor compliance and formal reporting on Legionellosis and Pseudomonas water management, via the Water Safety Group (WSG)
- Receive regular reports from the Decontamination Working Group (DWG)
- Provide regular assurance reports to the CGC

5. Budget Allocation for Infection Prevention & Control Nursing Team

The total budget for the Infection Prevention & Control nursing team is £160K comprising:

Pay

Nursing	£140K
Administrative	£18K

Non-Pay

Non- staff	£3K

Income - £1k

Training

Training budgets are held centrally in the Trust.

6. HCAI Management and Statistics

6.1 HCAI

The investigation and management of communicable and hospital acquired infections in the Trust is the role that is most often associated with infection control and is an important and visible function of the service.

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

The Trust is also required to record these incidents on the strategic executive information system (STEIS) in line with the Serious Incident Framework: Supporting learning to prevent recurrence (NHS England, 2015), and the Health Protection Agency HCAI Operational Guidance & Standards (2012), Health Protection Agency now Public Health England (PHE) from 1st April 2013.

During quarters 1 and 2 of 2017/18, the Trust has had **no** declared outbreaks of:

- Viral gastroenteritis (Norovirus)
- Clostridium difficile (C.difficile)
- Staphylococcus aureus, including Methicillin Resistant Staphylococcus aureus (MRSA)
- Methicillin Sensitive Staphylococcus aureus (MSSA)
- Carbapenemase producing enterobacteriaceae (CPE)
- Invasive Group A Streptococcus (iGAS)

- Multi-drug resistant Acinetobacter baumannii (MDRAB)
- Chickenpox (Varicella zoster)
- Extended Spectrum Beta Lactamase (ESBL) producers
- Pertussis
- Respiratory Syncytial Virus (RSV)
- Influenza
- Vancomycin Resistant Enterococcus (VRE)
- Tuberculosis (TB)

The ICNs provide clinical teams with infection control advice, support and education on a daily basis to all inpatient areas. The management of patients admitted with suspected and known alert organisms is discussed, and risk assessments undertaken. The Isolation Risk Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway have been developed and implemented to assist staff competency and confidence in the management of cases.

The availability of sideroom facilities across the Trust site to isolate infected patients can be limited at times when demands on capacity are high. In such instances, risk based decisions are necessary. Patients with alert organisms can be safely managed either within cohort bays, or isolation nursed in a bed space. The ICNs continue to review patients nursed in siderooms on a daily basis to prioritise high risk patients. Information and guidance is communicated to the ward nursing and medical teams and the Clinical Site Coordinators, with additional written documentation provided to support staff in the ongoing management of these patients.

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

6.2 Viral gastroenteritis (Norovirus)
The Trust has experienced a fairly consistent level of activity associated with patients experiencing diarrhoea and/or vomiting. This included patients admitted with symptoms of diarrhoea and/or vomiting and isolated in a sideroom from admission, and patients who were nursed in a bay environment and developed symptoms during their admission period.

During quarters 1 and 2 of 2017/18, the level of diarrhoea and/or vomiting activity continued with the closure of one inpatient area (Breamore Ward) and 16 bays in 10 clinical areas across the medical, surgical and musculoskeletal directorates at different times. All occurrences were managed as per policy and from inpatient sampling by the Laboratory, there were 3 confirmed Norovirus cases.

6.3 MRSA
During quarters 1 and 2 of 2017/18, there has been no requirement to close beds or bays as a direct result of MRSA.

6.4 Carbapenemase Producing Enterobacteriaceae (CPE)
Following the increase in the number of cases of CPE infection identified at other regional hospitals, the ICNs have provided advice in relation to the safe transfer of patients to the Trust from other countries or UK hospitals with a known higher prevalence of CPE.

The Trust continues to implement the PHE toolkit published in December 2013, for the early detection, management and control of CPE across the inpatient and outpatient clinical areas. The Trust policy has been revised during quarter 2, with new screening admission assessment documents created for the general inpatient ward areas and the Intensive Care Unit (ICU). No new cases of CPE have been identified for inpatients from screening undertaken.

6.5 Invasive Group A Streptococcus (iGAS)

During quarter 2 of 2017/18, there has been one case of invasive Group A streptococcal infection identified from a blood culture taken for a patient within an outpatient department (OPD) setting. The patient was not admitted to the Trust.

6.6 Multi-drug resistant Acinetobacter baumannii (MDRAB)
As previously reported, during quarter 4 of 2016/17, a patient who had transferred from another Trust to a ward within the musculoskeletal directorate was identified with a resistant Acinetobacter species from extensive transfer screening. This patient had previously been identified to have MDRAB in a number of sites and other resistant organisms whilst at the other Trust.

As the patient was a planned transfer, the ICNs were able to communicate with the clinicians involved in the patient's care, Consultant Microbiologists, ward team, and IPCT at the previous Trust, in order to safely manage this patient on transfer. The ICNs have continued to support the ward team in the ongoing management of this patient, whom remains an inpatient and continues to be strictly isolated during their inpatient care episode.

During quarter 1 of 2017/18, a patient nursed within the musculoskeletal directorate was identified to be MDRAB positive from a wound swab. The patient was moved to a sideroom facility on the ward for strict isolation nursing, with further screening undertaken on instruction from the Consultant Microbiologist. No patient contacts were identified and the patient was discharged from hospital with follow up arranged in the OPD.

6.7 Influenza
Patients have continued to be admitted to the Trust with respiratory illnesses and 'flu-like' symptoms, although the incidence has markedly decreased during these two quarters.

When required, patients have been isolated within sideroom facilities on admission; some patients were managed within the bay setting. In both situations, patient contacts were identified for follow up. When a positive influenza result is confirmed, appropriate antiviral prophylaxis is provided as per PHE guidance. The IPCT provide support and guidance to staff groups within the ward teams in the ongoing management of identified patients, including the wearing of personal protective equipment (PPE).

During quarters 1 and 2 of 2017/18, a total of 5 inpatient influenza cases were identified (Influenza A and B) from in-house testing with no cases of RSV.

6.8 Vancomycin Resistant Enterococcus (VRE)
During quarters 1 and 2 of 2017/18, new unrelated cases of VRE have been identified, with a number of patients also identified to be VRE positive either in the community, or on admission to the Trust.

When inpatient cases have been identified, required actions were agreed following discussion with a Consultant Microbiologist. These have included strict isolation precautions, the completion of additional environmental and equipment cleaning, and where indicated screening of identified patient contacts, with the continuation of antibiotic stewardship.

Patients previously VRE positive require isolation in a sideroom facility on admission wherever possible, and risk assessments undertaken to identify those patients suitable to be safely managed within bays. Although currently there is no plan to cohort VRE positive patients, this may be a consideration for the future.

6.9 Tuberculosis (TB)
During quarter 1 of 2017/18, a patient who attended the Respiratory OPD was identified to be pulmonary TB positive. The patient was not admitted to the Trust and any required follow up for close contacts was undertaken within the community setting.

7. Mandatory Surveillance

7.1 Surgical Site Infection Surveillance (SSIS)

Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends. The ICNs coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust.

Where orthopaedic surgical procedures are performed, Trusts are required to undertake mandatory SSIS every year. This must be for a minimum of a three months surveillance period or until a cohort of 50 cases has been achieved, in at least one of these categories listed below:

- Hip (prosthesis) replacement
- Knee (prosthesis) replacement
- Repair of neck of femur
- Reduction of long bone fracture

The Trust complies with this annual requirement to undertake SSIS.

- The category for hip replacement surgery was commenced on 1st April 2017, and by 30th June 2016 the required number of new patients undergoing hip replacement surgery had been achieved. However, a decision was made to extend the data collection period to the end of quarter 2 (2017/18), in order to achieve a comparable cohort.
- The final cohort for quarter 1 of 2017/8, consisted of 72 patients and identified 1 deep incisional infection, as defined by the criteria set by PHE. The data was submitted to PHE within the agreed timeframe.
- During quarter 2 (2017/18), the ICNs completed active surveillance data collection and follow up for patients who had undergone hip replacement surgery during the previous quarter.
- Data collection will be finalised during quarter 3 of 2017/18, with end of category result updates for hip replacement surgery being presented at the IPCC meeting in January 2018.

Formal reports outlining progress with SSIS were presented at the IPCC meetings and disseminated to relevant Trust personnel.

The commencement and facilitation of the SSIS process is dependent on the availability of web reports from the Informatics Department (IT). Due to the data warehouse issues, there was a delay in activating this system for quarter 1 of 2017/18 and data was collated manually by the ICNs. However, this issue has now been resolved.

7.2 Methicillin Resistant Staphylococcus aureus (MRSA)

The PHE Mandatory enhanced MRSA bacteraemia surveillance scheme (updated March 2016), is used to measure the effectiveness of infection prevention and control practices in all NHS Trusts. The rationale for the surveillance is that it is sometimes difficult to distinguish between colonisation and true infection caused by MRSA, but culture of the bacterium from blood almost always represents significant infection.

The Trust has continued to report MRSA screening rates for all elective and emergency admissions to ensure continued improvement in reducing infections. These screening compliance rates are monitored by the Directorate Management Teams (DMTs) and reported as a KQPI. The ICNs undertake a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit. Feedback is provided to DMT's about compliance rates and any identified missed screens for follow up actions and outcomes are reported to the Matrons Monitoring Group (MMG).

The Trust continues to review MRSA screening options to potentially reduce the number of screens for patients **not** admitted to identified 'high risk' areas, as per Department of Health (DH) guidance (2015). During quarter 2 of 2017/18, it was agreed by the IPCWG that compliance of screening for 'high risk' patients and areas is identified from the emergency screening data. This will form a baseline to indicate whether these patients are being screened appropriately.

The Trust reports mandatory enhanced surveillance in line with PHE requirements onto the national HCAI Data Capture System (DCS) website. The Trust adheres to the classification of cases in accordance with the set definitions. This is applicable to MRSA bacteraemia cases and C.difficile cases, and differs from previous classification reporting formats. Results are provided in the summary below, and include the definitions of 'Trust apportioned' cases and 'non-Trust apportioned' cases. The Trust's MRSA Trust apportioned cases target for 2017/18 is zero.
MRSA Bacteraemia Trust apportioned cases include patients that are –

1. Inpatients, day patients and emergency assessment patients; **AND**
2. have had a specimen taken at an acute Trust; **AND**
3. specimen is **3 or more** days after date of admission (admission date is considered day '1').

Non-Trust apportioned cases include all cases that are **NOT** apportioned to the acute Trust.

Table 1: Breakdown of total number of Trust cases recorded April to September 2017 (Figures in brackets show number of cases recorded April to September 2016)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**0 (0)**	**0 (0)**	**0 (0)**	**0 (0)**	**0 (1)**	**0 (0)**							**0 (1)**
Non Trust apportioned cases	0 (0)	0 (0)	0 (0)	0 (0)	0 (1)	0 (0)							**0 (1)**
Trust apportioned cases	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)							**0 (0)**

7.3 Clostridium difficile

The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

7.4 Monitoring and diagnostic C.difficile testing

The Trust continues to apply DH guidance for C.difficile testing and the previously agreed revised C.difficile testing and reporting algorithm. All C.difficile positive stool samples that test toxin positive are reportable to PHE. (Of note: from April 2017, changes were made regarding the mandatory reporting requirements for Trusts. This is in relation to the classification of C.difficile cases with a focus on previous healthcare interactions/episodes. Following further clarification from PHE, the definition of Trust apportioned and non-Trust apportioned cases has not changed).

In accordance with PHE definitions, C.difficile Trust apportioned cases include patients that are –

1. Inpatients, day patients and emergency assessment patients; **AND**
2. have had a specimen taken at an acute Trust; **AND**
3. specimen is **4 or more** days after date of admission (admission date is considered day '1').

Non-Trust apportioned cases include all cases that are **NOT** apportioned to the acute Trust.

All patients with a stool sample confirming the presence of C.difficile require the implementation of strict infection control measures and practices e.g. isolation nursing in a sideroom facility, the completion of terminal and enhanced cleaning by Housekeeping and a review by the relevant clinicians to determine if C.difficile treatment is indicated. The formal reporting process to PHE is managed by the ICNs under direction of the DIPC and ICD, and has had an impact on the team's workload.

Table 2 below relates to the breakdown of all inpatient reportable cases of C.difficile and **Table 3** relates to the total reportable cases of C.difficile recorded by the Trust.

Table 2: Breakdown of reportable cases recorded for all inpatients April to September 2017 (Figures in brackets show number of inpatient reportable cases April to September 2016)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**1 (2)**	**1 (0)**	**2 (1)**	**0 (0)**	**0 (0)**	**2 (1)**							**6 (4)**
Non Trust apportioned cases	0 (0)	1 (0)	2 (0)	0 (0)	0 (0)	1 (0)							**4 (0)**
Trust apportioned cases	1 (2)	0 (0)	0 (1)	0 (0)	0 (0)	1 (1)							**2 (4)**

Table 3: Breakdown of total number of reportable C.difficile cases recorded April to September 2017 (Figures in brackets show total number of reportable cases recorded April to September 2016)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Inpatients	**1 (2)**	**1 (0)**	**2 (1)**	**0 (0)**	**0 (0)**	**2 (1)**							**6 (4)**
Community Hospitals	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)							**0 (0)**
General Practitioners (GPs)	1 (2)	2 (2)	2 (0)	0 (1)	1 (0)	0 (1)							**6 (6)**
Residential/Nursing Home	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)							**0 (0)**
Other (e.g. Coroner, Private Hospital, Day Attender, ED, Outpatient)	0 (0)	0 (1)	1 (0)	0 (1)	0 (0)	0 (0)							**1 (2)**
Total	**2 (4)**	**3 (3)**	**5 (1)**	**0 (2)**	**1 (0)**	**2 (2)**							**13 (12)**

(Of note: In a single patient, a positive test occurring after a previous positive test is considered a new episode after 28 days).

For quarters 1 and 2 of 2017/18, the Trust has reported 2 Trust apportioned C.difficile cases, which does not exceed the target set for the Trust by NHS England of <19 for the full year. For each inpatient episode, an infection control incident investigation is completed using a 'SWARM' approach. This process has been led by the ICNs, with the increased involvement of nursing and medical staff in the relevant clinical areas and the Antimicrobial Pharmacist (or area Pharmacist), to complete the required documentation.

Key findings and learning are identified and reported by the staff teams involved, with an appropriate action plan for implementation. Actions taken include patient education and completion of High Impact Intervention (HII) auditing, to ensure the safe management of these patients. Action is taken when non-compliance with Trust policy is identified.

Multidisciplinary C.difficile ward rounds have continued by the ICD and/or Consultant Microbiologist and ICNs, with the involvement of the Antimicrobial Pharmacist when required. Attendees can include the DIPC, Deputy DIPC and Medical Director. These rounds provide an opportunity to formally review and assess the patient's progress and management in relation to C.difficile. The group members also ensure that information is shared with the ward teams and this is supported by an entry within the patient healthcare records. The membership of this group has been reviewed, and a Gastroenterologist and Dietician will be involved as required.

During quarters 1 and 2 of 2017/18, no Trust apportioned cases have been submitted to the 'Appeals Panel Process' for the relevant CCG.

7.5 Methicillin Sensitive Staphylococcus aureus (MSSA)

The Trust continues to report MSSA bacteraemia cases via the HCAI DCS website. Currently, there is no national guidance for data definition of MSSA bacteraemia cases for targets to be set. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either Trust apportioned or non-Trust apportioned.

Table 4: MSSA bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April to September 2017 (Figures in brackets show number of cases recorded April to September 2016)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**2 (5)**	**2* (4)**	**1 (6)**	**6 (5)**	**1 (4)**	**1 (0)**							**13* (24)**
Non Trust apportioned cases	2 (5)	2 (3)	0 (2)	4 (4)	0 (4)	1 (0)							**9 (18)**
Trust apportioned cases	0 (0)	0 (1)	1 (4)	2 (1)	1 (0)	0 (0)							**4 (6)**

*May 2017 – 2 additional MRSA bacteraemia cases noted: one identified from blood cultures whilst the patient was attending Salisbury Dialysis Unit and later admitted to the Trust via ED, and one identified from blood cultures taken whilst the patient was attending an outpatient clinic, and later admitted to the Trust from the clinic.

During quarters 1 and 2 of 2017/18, there have been 4 Trust apportioned cases identified. The ICNs undertake an infection control incident investigation for all Trust apportioned inpatient cases, in conjunction with relevant staff from the clinical area concerned. Emphasis has been placed on the need for continued monitoring of invasive devices by staff, adherence to the relevant Trust

policies relating to the taking of blood cultures and skin disinfection/decontamination and maintaining the required care documentation.

7.6 Gram-negative bloodstream infections (GNBSIs)

7.6.1 Escherichia coli (E.coli)

The Trust continues to input enhanced surveillance data for E.coli bloodstream infections (BSI) in accordance with current guidance from the DH and PHE. From 1st April 2012, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the E.coli bacteraemia cases recorded within the Trust. This allows the cases to be classified as either Trust apportioned or non-Trust apportioned.

Table 5: E.coli Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April to September 2017
(Figures in brackets show total number of cases recorded from April to September 2016)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**9 (11)**	**9 (6)**	**10 (8)**	**8 (13)**	**9 (8)**	**9 (12)**							**54 (58)**
Non Trust apportioned cases	7 (10)	6 (5)	10 (5)	7 (9)	8 (7)	8 (12)							**46 (48)**
Trust apportioned cases	2 (1)	3 (1)	0 (3)	1 (4)	1 (1)	1 (0)							**8 (10)**

Following the identification of a positive blood culture result for E.coli, a Consultant Microbiologist completes a PHE mandatory enhanced surveillance form. In consultation with the relevant clinician, key patient factors are considered in order to establish if the case is likely to be healthcare related. However, it may not be possible to determine.

Of the 8 Trust apportioned cases identified during quarters 1 and 2 of 2017/18, 3 were unknown or unclear source of infection and the remaining 5 cases had a source of infection identified. Of these unrelated 5 cases, the sources of infection were:

- hepatobiliary (related to a surgical intervention)
- urinary tract (including lower)
- gastrointestinal (related to a surgical intervention).

The Trust recognises the importance of continuing improvement work with the appropriate recognition and treatment of infections and adherence with NICE guidelines. This data was entered onto the HCAI DCS website. Where concern is highlighted by the Microbiologist for an individual case, further investigation is undertaken. For these Trust apportioned cases, no further follow up was identified.

The Trust will continue to work towards reducing the incidence of these GNBSIs. The ICNs are working collaboratively with the relevant CCGs who are leading on achieving the Quality Premium (from April 2017, for 2 years), aiming to reduce all E.coli BSIs by 10% in year 1.

7.6.2 Klebsiella sp. and Pseudomonas aeruginosa

From April 2017, the incidence of GNBSIs for Klebsiella sp. and Pseudomonas aeruginosa reported at the Trust now requires enhanced investigation and data entry onto the PHE DCS website. This work has been undertaken by the IPCT.

Table 6: Klebsiella sp. Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April to September 2017

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**0**	**0**	**2**	**2**	**0**	**1**							**5**
Non Trust apportioned cases	0	0	2	2	0	1							**5**
Trust apportioned cases	0	0	0	0	0	0							**0**

Table 7: Pseudomonas aeruginosa Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April to September 2017

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**0**	**3**	**0**	**1**	**1**	**0**							**5**
Non Trust apportioned cases	0	2	0	1	1	0							**4**
Trust apportioned cases	0	1	0	0	0	0							**1**

7.7 Infection in Critical Care Quality Improvement Programme (ICCQIP)

From April 2017, the Trust has participated in the surveillance of BSIs in patients attending the ICU and Neonatal Unit (NNU). Data collection and submission is coordinated by the Lead ICU Nurse, with the support of the ICNs and involvement of the NNU staff. From the data submitted, no further updates have been provided by PHE.

8. Hand Hygiene

All inpatient and outpatient clinical areas are required to undertake monthly hand hygiene audits. Compliance rates are calculated, and individual tables are produced for each area within the directorates. These are provided to clinical leaders, DMTs and DIPC via the monthly MMG meetings.

To promote hand hygiene best practice, a Uniform Policy and Workwear Guidance including 'Bare Below the Elbow' (BBE) policy remains in place. Compliance with the policy and audit results is monitored by the DMTs and feedback provided to the DIPC.

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the directorates of measures implemented to improve non- compliance. This target is reflected in the clinical leaders and DSNs personal objectives, with ongoing work required by the DMTs to sustain improvements. To promote hand hygiene compliance the ICNs continue to train and update the Infection Control Link Professionals (ICLPs) to undertake hand hygiene assessments for staff in their own areas. This has proved successful in raising the profile of hand hygiene behaviour and compliance with BBE. It also provides an alternative opportunity for staff to complete their annual mandatory hand hygiene assessment. The directorates are encouraged to share successes within individual areas at the MMG meetings.

Analysis of the hand hygiene audit data demonstrates that the key factors influencing the compliance scores are:

- Non completion of audits by areas
- Non-compliance with hand decontamination by other staff groups, lowering the overall score for the area concerned
- Audit delegated to a staff member(s) unfamiliar with the audit process

When compliance is poor the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results continue to be disseminated according to staff groups for each area. This action has provided evidence to strengthen the feedback process for the directorates to take the necessary action.

The ICNs have continued to facilitate the completion of hand hygiene audits by an external auditor, the Healthcare Manager for GOJO Industries, across selected clinical areas. The external auditor utilised the World Health Organisation (WHO) hand hygiene audit tool, and assessed the hand hygiene practices of all staff groups against the '5 moments for hand hygiene':

- Moment 1: Before patient contact
- Moment 2: Before a clean/aseptic procedure
- Moment 3: After body fluid exposure risk
- Moment 4: After patient contact
- Moment 5: After contact with patient surroundings

For quarters 1 and 2 of 2017/18, the overall compliance rate from external auditing of 12 inpatient areas was 79.02%. This is a slight decrease on the previously reported overall compliance of 78.6% from auditing of 7 inpatient clinical areas during quarters 1 and 2 of 2016/17.

Detailed analysis was undertaken to identify the key areas of non-compliance, which was predominantly staff missing moment number 5, handwashing after contact with patient surroundings. The results were reported via the DIPC and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in practice. Additional education and support has been provided by the ICNs to staff groups focusing on the audit findings.

The 'Red, Amber and Green' rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised and the impact of these measures is being monitored by the IPCWG, DMTs and MMG.

9. Audit

In line with the requirements of the Health and Social Care Act 2008, a programme of infection prevention and control audits is illustrated in the annual audit programme (Appendix 3). The programme ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust.

The ICNs have been involved with the following audit work during quarters 1 and 2 of 2017/18, including the follow up and outcomes from auditing against infection control policies:

- Dirty Utility Room Standard
- BBE & Uniform Policies and Workwear guidance
- Use of the MRSA pathway and IRAT *(data collection in progress)*
- 2% Chlorhexidine Gluconate (CHG) in 70% Alcohol Isopropyl Wipes *(data collection in progress)*

Final reports are generated for each completed audit and resulting action plans approved by the IPCWG before submission to IPCC and Clinical Management Board (CMB).

The ICNs continue to undertake additional observational audits of staff practices within clinical areas. Feedback is provided at the time of the audit to the nurse in charge, and where non-compliance has been identified this is addressed with the individual staff member. Feedback is provided to the relevant Clinical Leader. Practice observations have included application of standard precautions, isolation nursing precautions, commode cleanliness, dirty utility room standards and linen management.

The monthly audit programme for the safe use of mattresses continues and is led by the Medical Devices Management Services (MDMS), with six monthly reporting to the MMG.

All approved audit reports generated by the ICNs are uploaded on to the Clinical Audit electronic database system, accessible via the Trust intranet site. This ensures the opportunity for all staff groups to access this important audit work.

10. Innovations

The IPCWG continue to lead the review of technologies and innovations related to the reduction of HCAIs, with the involvement of key personnel across the Trust site. This has been incorporated as a standing agenda item at the IPCWG meetings, with innovations measured against the best practice evidence/research available, which has included DH recommendations.

The IPCWG continue to strive to ensure that the Trust implements only those technologies and innovations that have been peer reviewed and appropriately approved. The Trust has agreed for this winter season, influenza and RSV testing can be performed as a 'point of care' test on the new Acute Medical Unit (AMU) when relocated to the new Level 2 template. This work is being overseen by Microbiology and AMU staff will be appropriately trained to use this kit and undertake testing. The Trust has also agreed to implement polymerase chain reaction (PCR) Norovirus testing within the Laboratory, leading to improved sensitivity and specificity.

11. Antibiotic Prescribing *(information for this section has been provided by Louise Williams, Principal Pharmacist Antibiotics)*

The ARG meets monthly to maintain oversight of the issues relating to antimicrobial use in the Trust. The group advise and promote good practice, review audit results and ensure up to date evidence based guidelines.

11.1 Guideline development/review

The ARG continually works to ensure policies on the Trust guidelines database are easily accessible and up to date.

Guidelines recently reviewed:

- Ear, Nose & Throat (ENT)
- Oral and Maxillofacial
- Antifungal guidelines
- Respiratory infection – chronic obstructive pulmonary disease (COPD)
- Respiratory – community acquired pneumonia (CAP)

Guidelines currently under review:

- Respiratory infection – hospital acquired pneumonia (HAP)

- Penicillin Allergy Prescription Sticker Awareness Policy
- The prevention of infection in Asplenic and Dysfunctional Spleen Patients

Future guidelines for review:
- Endocarditis – Prophylaxis Against Infective Endocarditis
- Ophthalmology guidelines for Keratitis (adults)
- Gentamicin conventional multiple dosing (adults)
- Gentamicin: high dose 5mg/kg daily (adults)

11.2 Audit

Regular Antimicrobial Stewardship Audits

The Lead Antimicrobial Pharmacist and a Consultant Microbiologist carry out fortnightly antimicrobial stewardship audits on the wards, auditing wards in turn on a rolling programme. Interventions are made as necessary during the audits as well as staff education. We are focusing on whether the antibiotic has been reviewed within 72 hours and the outcome of the review.
The audit reviews:
- Whether the indication is recorded on the drug chart and in the healthcare records (HCRs)
- Whether a stop/review date has been recorded on the drug chart or in the HCRs
- Whether the treatment is in line with local policy/as per microbiology and, if not, there is clear documentation why
- If there is evidence of review within 72 hours and, if so, the outcome of the review

The results of these audits are fedback via e-mail to the Clinical Lead for the area, Directorate Senior Nurse (DSN), IPCT, Ward Pharmacist, Senior Pharmacist, DIPC, Medical Director and Quality Lead, plus all Consultants with patients seen during the audit, and all Consultant Microbiologists.

C.difficile – Antibiotic treatment review & ward rounds

All cases of C.difficile are reviewed by a member of the Pharmacy Team, to ascertain whether past or current antibiotic treatment may have been a contributory factor. Other medications which may impact upon the patients clinical conditions are also noted and reviewed i.e. use of laxatives, antimotility drugs, proton pump inhibitors (PPIs).

A designated Senior Pharmacist attends the multidisciplinary ward rounds, as required. This is undertaken by a Consultant Microbiologist together with the ICNs. It provides an opportunity to review the treatment and management of inpatient C.difficile cases, and is also a forum to discuss any management issues or concerns. In addition, the group will liaise with the appropriate clinicians/nursing staff for the patient if required, and an entry is made within the healthcare records.

Antibiotic Awareness Week

'Antibiotic Awareness Week' is 13th – 19th November 2017, with antibiotic awareness day on Saturday 18th November. The Trust annually plan a campaign to raise awareness of the need to use antibiotics responsibly and this year will be planning a range of actions to promote awareness, including the use of posters throughout the hospital, the Pharmacy team engaging with staff on the wards and via e-mail broadcast messages.

11.3 Risk Management

Any concerning incident reports (DATIX) relating to or involving antibiotics are highlighted at the ARG to identify any trends.

11.4 Defined daily doses (DDD)

As recommended in the DH document 'C.difficile – How to deal with the problem' (2008, section 3 updated June 2013), a mechanism for capturing DDD data is in place. This is necessary to ensure cost effective use of antimicrobials and it also allows the Trust to monitor drug usage and compare it to that of other Trusts.

The following drug usage reports are provided to the ARG every six months:

- Cephalosporins, Ciprofloxacin, Clindamycin and Co-amoxiclav
- Ceftazidime, Cefalexin and Cefaclor
- Daptomycin, Vancomycin, Teicoplanin and Linezolid
- Imipenem, Meropenem, Ertapenem and Tazocin
- Clindamycin, Clarithromycin and Doxycycline

11.5 National Antimicrobial Commissioning for Quality & Innovation (CQUIN) 2017/19

For 2017/18, a national CQUIN around 'Antimicrobial Resistance and Sepsis' has been agreed. This differs from last year in that the focus is on patients with a diagnosis of sepsis, and the standards are as follows:

CQUIN 2c – Antibiotic review

Assessment of clinical antibiotic review between 24 – 72 hours of patients with sepsis who are still inpatients at 72 hours.
Local audit of 30 patients per quarter.
Milestones set for the CQUIN as follows:

- Q1 – 25%
- Q2 – 50%
- Q3 – 75%
- Q4 – 90%

CQUIN 2d – Reduction in antibiotic consumption per 1000 admissions (3 parts)

1) 2% reduction of total antibiotic consumption per 1000 admissions.
2) 1% reduction in total consumption of Carbapenems per 1000 admissions.
3) 2% reduction in total consumption of Piperacillin/Tazobactam per 1000 admissions>

The information collected regarding the review is also more detailed that last year's CQUIN. Data submitted includes who the review was undertaken by and the outcome of that review i.e. stop, switch to oral, outpatient parenteral antimicrobial therapy (OPAT), continue with no review date, continue with new review date, escalate to broader spectrum antibiotic, de-escalate to narrower spectrum antibiotic or change antibiotic (as a result of blood culture result). Information is also required regarding blood culture results and whether these have been acted on and if not, that a reason has been documented.

This year the baseline against which reductions are required is the calendar year of 2016. The results for quarters 1 and 2 of 2017/18 are as follows:

2c – Antibiotic review

- Our target of 25% in quarter 1 was attained with 100% of prescriptions having a documented review between 24 – 72 hours.
- 96% of the prescriptions audited in quarter 2 had a documented review thus meeting the milestone of 50% for this quarter.

2d – Reduction in antibiotic consumption per 1000 admissions

Table 8: Salisbury NHS Foundation Trust (SFT) estimated percentage reduction/increase in antibiotic use in quarter 1 of 2017/18 compared to 2016

	DDD/1000 admissions 2016	DDD/1000 admissions quarter 1 (2017/18)	% year-year
All antibiotics	5032	5074	+0.8
Piperacillin/Tazobactam	166.4	81.2	-51.2

Carbapenems	49.9	45.7	-8.4

Table 9: SFT estimated percentage reduction in antibiotic use in quarter 2 of 2017/18 compared to 2016

	DDD/1000 admissions 2016 (baseline year)	DDD/1000 admissions quarter 2 (2017/18)	% change
All antibiotics	5032	4862	-3.4
Carbapenems	166.4	67.1	-59.7
Piperacillin-Tazobactam	49.9	47.6	-4.6

The above data shows we have met the target reductions in all areas in quarter 2. We now need to continue to focus on good practice ensuring appropriate antimicrobials are being used within the Trust with regular reviews. The Lead Antimicrobial Pharmacist also plans to start to conduct ward reviews of patients to try and target patients on extended courses of antimicrobials or those with poor documentation of the indication. The ward Pharmacists will be asked to flag up patients needing review and microbiology will be referred to when needed.

12. Decontamination *(information for this section has been provided by Sarah Jennings, Medical Device Safety Officer (MDSO) and Decontamination Lead (DL)*

Progress against Decontamination Strategy

The Decontamination Strategy has been updated with regard to 2016 Health Technical Memorandum (HTM) guidance and a review of decontamination in terms of Essential Quality Requirements (EQR) and Best Practice (BP) is ongoing. Key objectives are reviewed at the DWG meetings. Risk assessments are monitored and updated when necessary. Decontamination was reviewed through a Trust TIAA audit and was graded as providing “reasonable assurance”. A work plan is in place to meet the recommendations established from the audit.

12.1 Activity to promote compliance with decontamination arrangements

- The Decontamination Policy is current and has been rewritten to reflect the joint venture, Salisbury Sterile Services (SSL), and new HTM regulations.
- Local decontamination audits and standard operating procedures (SOP) development continues.
- Tray tracking for instrumentation is in place and software for endoscope traceability is being developed for potential implementation in quarter 4 of 2017/18.
- Wraps have changed from linen to paper although there are still a number of holes being reported. An audit is taking place in October 2017 looking at practice through from SSL to receipt/storage and use in the Main Theatres Department (MTD) to identify if there are any trends in damaged wraps.
- Instrument inventory review continues with tray rationalisation in orthopaedic theatres. It is hoped that a new post, Surgical Instrument Coordinator, will be able to carry on with this work.
- SSL are laser marking individual instruments for tracking purposes.
- SSL continue to process flexible endoscopes as per HTM 01-06. The 5 endoscope washer disinfectors (EWDs) have all been out of use at one point due to failures and high total viable count (TVC) levels. This is largely due to the age of the machines and the constant use of them; more so when one or more is out of use. Contingency plans and actions to maintain the service is being discussed as it will be a year until the new SSL facility is operational.

12.2 Decontamination Audit plan

- Audits performed during quarter 2 have been in Breast Care, Dermatology Unit, Endoscopy Suite, Laser Clinic, Obstetric Theatres, Pembroke Oncology Ward & Suite, MTD and Day Surgery Unit (DSU). Some areas have provided good assurance for compliance and other areas have been asked to provide additional evidence for their local decontamination processes.
- SOPs are also in use or in progress for a number of other areas performing local decontamination of devices including Spinal pressure clinic, Dermatology Unit, ENT Department and Vascular OPD.
- Work continues to standardise the post procedure endoscope clean. This has been accepted as an SOP by Endoscopy Suite. The focus is now on MTD, DSU and ENT to adopt this.
- Standards for the decontamination of semi-invasive ultrasound probes used intra cavity or on broken skin have been discussed with Vascular and Radiology Departments. A SBAR for the automated decontamination of probes using Trust owned Trophon units has been shared with Radiology staff and their Directorate Manager for action. The Lead for Radiology Ultrasound has now raised this with Finance in order to resurrect the Trophons and secure an ongoing revenue budget for consumables.

12.3 Maintaining a fully compliant sterilisation facility (SSL)
The DL continues to attend a monthly SSL Operational Management Board (OMB) and also meets weekly with SSL to discuss any issues arising. The DL has made a case for provision for a STERRAD low temperature sterilisation facility and for SSL to also purchase and manage dry storage cabinets (DSC) once in their new facility. Implementation of HTM guidance for endoscope process challenge checks and residual protein testing of instrumentation will be managed between SSL and Estates Technical Services (ETS) during the next quarter.

12.4 The Decontamination Working Group
The DWG met in June and will next meet in October. Terms of Reference including membership have been reviewed in light of recommendations from the TIAA audit. The DWG reports up to the IPCC.

13. Education and Training Activities
It is widely recognised that ongoing education in infection control is required in order to improve health care worker compliance with infection prevention and control practices. The ICNs undertake a number of induction and educational updates to a wide range of key staff within the Trust. The ICNs keep attendance data from these sessions and supports the Trust in its delivery of mandatory education for all staff. The infection prevention and control (IPC) computer based learning (CBL) package is accessible for all staff on the management learning environment (MLE) via the Trust intranet site.

During quarters 1 and 2 of 2017/18, the ICNs have been working with the Education Department to review the compliance data generated from the MLE system for both hand hygiene assessments and IPC CBL modules. Further cleansing of the data has been stipulated by the DIPC and this is currently being progressed with the Education Department.

The ICNs have continues to focus on the promotion of opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical directorates facilitated the completion of hand hygiene assessments for staff by utilising a ultra-violet (UV) light box for rotation through their directorate areas and departments.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. These include core induction sessions in addition to specific topic requests. The facilitation of learning has also involved members of staff shadowing of the ICNs in addition to the monthly scheduled ICLP meetings. Details of education opportunities provided are available from the ICNs.

14. Water Safety Management *(information for this section has been provided by Terry Cropp, Responsible Person (RP) for Water and Head of Estates)*

This section summarises the water safety management precautions that the Trust has taken over quarters 1 & 2 of 2017/18. This includes monitoring and remedial action that has been taken in respect of the management of the water systems.

The Trust manages the safety of water systems in line with the HTM 04-01 (Pt B) Safe Water in Healthcare Premises and HTM 04-01 (Pt C) Pseudomonas (guidance for augmented care units), together with the technical guidance document HSG274 part 2.

The Trust WSG has been active during 2017 in response to the management of events involving the water systems on site. The WSG is formed of technical and non-technical staff that can recommend, change and enforce issues relating to water safety across the Trust. The WSG includes representatives from all of the high risk areas identified in the policy and the Trust's independent advisor – Mr Daniel Pitcher, Authorising Engineer (AE) of the Water Hygiene Centre.

To assist the management process in respect of the water systems across the site, regular meetings of teams Responsible and Deputy Responsible Person (for Water Systems) from ETS and FES Limited (PFI maintenance contractor) are held on a monthly basis, to review progress with planned preventative maintenance (PPM) and actions in respect of water safety.

The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution in the challenge of Legionella control. The water systems within hospitals are complex; therefore the testing and controls we have in place are designed to mitigate the risks to our patients and staff.

14.1 Annual routine water sampling results (Legionella)

Emergency review meetings have taken place in the Trust as a result of elevated sample results, the actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of emails as events occur, and as regular reports to the WSG and IPCC. Local actions taken have included the cleaning and disinfection of outlets, with temperature checks and increased flushing where necessary.

2016/17 round of sampling is complete, continued follow up is required in areas (as per Table 10 below) on the basis of counts identified through this surveillance programme. The 2017/18 round of routine sampling commenced on the 3rd of October.

	Ward/Department	Location	DATIX
1	Emergency Department (ED)	Level 3 Sector 1	97579 + 98071
2	Nunton Unit	Level 2 Sector 1	97776
3	Durrington Ward	Level 2 Sector 2	98069
4	Post Natal Ward	Block 67	1015956
5	Fertility	Block 05	23068

All of the areas listed have continued monitoring and mitigation in place as per policy.

- **Post Natal Ward** (Block 67) the affected outlets were decontaminated and taken out of use immediately. Subsequently a decision has been made by key members of the WSG to remove a sink in the main ward area, and a shower in room 67.18 due to lack of use or inappropriate use of these outlets, this should reduce the risk of future counts in this area.
- **Durrington Ward** major changes to the pipe work for the hot and cold water systems on Durrington Ward are being completed as part of the work (2017 Site Re-configuration) on the Level 2 Sector 2 template, for the new Acute Medical Admissions (AMU) facility. The

wards will then have separate systems to improve circulation and temperature. These systems will be commissioned and chlorinated as part of these works.
- Re-sampling following localised action and in line with policy is being completed (x 3 pre & post) in the **ED, Nunton** and **Fertility**.

14.2 Routine water sampling results (Pseudomonas)
Routine sampling (six monthly of 250 + outlets) for Pseudomonas is completed in the following augmented areas:
- Avon Ward
- Plastics & Burns Unit
- NNU
- ICU (Radnor Ward)
- Pembroke Ward

The routine sampling for Pseudomonas commenced on 5th October 2017, there are currently no live counts from the sampling completed to date.

14.3 Flushing
The flushing of all outlets in clinical areas across the hospital continues, with the total percentage of flushing for quarters 1 and 2 of 2017/18 at 54.5%. Low figures are as a result of staff shortages within ETS and operational pressure in other areas. However, in an effort to improve compliance, the resource that completes this work will have protected time moving forward. (Note: ETS will, when there is limited time/resource available for flushing target the outlets/areas that have previously had high counts to ensure compliance in these high risk areas).

14.4 Copper/Silver Ionisation Plant
No recorded issues. Regular maintenance continues on the Silver/Copper ionisation plant serving the Spinal Unit and Central areas of the hospital supporting the overall management of Legionella.

14.5 Independent advice
The Trust AE is Mr Daniel Pitcher of the Water Hygiene Centre. The Trust has extended the contract with Water Hygiene Centre to June 2018.

14.6 Drain Blockages
Though we have seen improvements in the area we have a recent spate of blockages which have affected both wards (Whiteparish AMU/Downton Ward) and OPD areas (Physiotherapy Department). It is clear that the message must not be lost in our management of the drainage system, regular broadcast e-mails are sent advising staff of the 'do's and don'ts' to prevent blockages. Reminders have also been cascaded to staff (at MMG meetings) with regard to the correct procedure in the event of a flood/spillage, and the locations of spill kits which should be used in the event of a flood.

15. Cleaning Services *(information provided by Michelle Sadler, Facilities Manager)*
This section summarises the key components of the Trust's cleaning programme, to ensure the provision of a safe clean environment for patients and their relatives, visitors and staff. This ongoing work is provided by the Housekeeping Department and Facilities directorate.

15.1 Patient led assessment of the care environment (PLACE) internal audits
The Trust has developed and implemented a programme of PLACE audits for 2017/18 and plans to undertake 56 internal PLACE assessments between June 2017 and March 2018 using the new PLACE criteria.

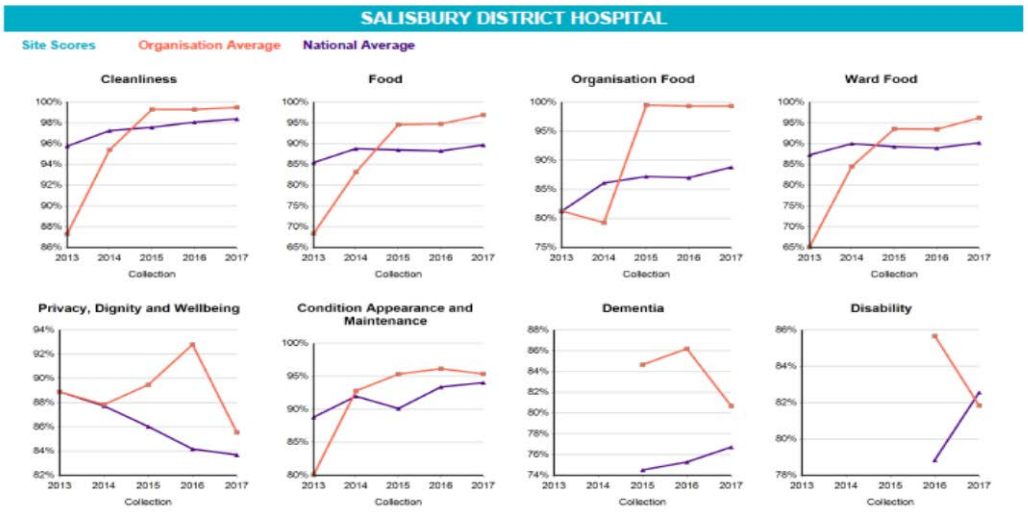
We continue to achieve active engagement and good support from Governors, Volunteers and the local Health Watch representatives to undertake the audits. Each ward produced their own action plans and reported progress via the monthly MMG meetings. Focus is given to themes from the ward or department and learning that can be shared with other areas.

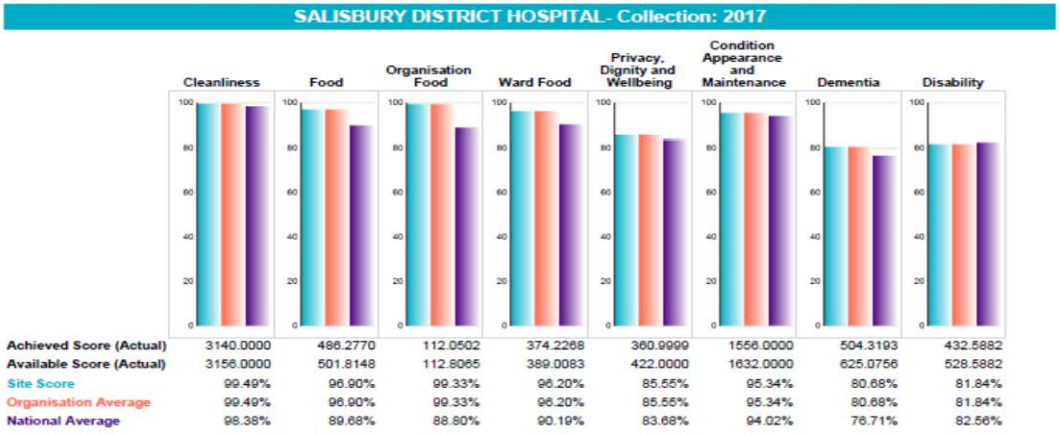
The PLACE internal audits have produced evidence that supports capital bids and decorating programmes so funds are appropriately allocated. The Dementia Lead for the Trust has also engaged with the PLACE programme, with a joint approach to environmental aspects to ensure this patient group is well supported within these criteria. A table top PLACE exercise is now also being undertaken at the planning stage, with ETS and ArtCare, for any new or refurbished departments/wards to better ensure that consideration is given to the criteria prior to its building completion. The results of each assessment are submitted using the PLACE 'Lite' tool linked to the Health and Social Care Information Centre.

15.2 National PLACE

The Trust participated in the National PLACE assessment on March 2nd 2017. A total of 10 wards and ED were visited, 4 food assessments undertaken, 6 OPD areas as well as external spaces and communal areas were also assessed as required under the PLACE criteria. The results reflect improvements have been made in most areas with the Trust score being published in August 2017.

The results from PLACE are analysed and key themes form the basis of improvement plans within the Trust. Below are the Trust scores against the national average for 2017.





	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3140.0000	486.2770	112.0502	374.2268	360.9999	1556.0000	504.3193	432.5882
Available Score (Actual)	3156.0000	501.8148	112.8065	389.0083	422.0000	1632.0000	625.0756	528.5882
Site Score	99.49%	96.90%	99.33%	96.20%	85.55%	95.34%	80.68%	81.84%
Organisation Average	99.49%	96.90%	99.33%	96.20%	85.55%	95.34%	80.68%	81.84%
National Average	98.38%	89.68%	88.80%	90.19%	83.68%	94.02%	76.71%	82.56%

Table 11 below demonstrates the audits undertaken and the scores linked to the level of findings.

Area of Focus	KPI	APR 2017	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR 2018	Total *(To date)*
Cleaning	Total audits	96	96	112	96	111	95							606
	Passes	56	53	60	50	60	55							334
	Qualified Passes	40	43	52	46	51	40							272
	Fails	0	0	0	0	0	0							0

Area of Focus	KPI	APR 2016	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR 2017	Total
Cleaning	Total audits	93	93	109	93	94	110	96	112	96	96	96	112	1200
	Passes	51	47	55	48	52	63	54	59	52	47	57	57	642
	Qualified Passes	42	46	54	45	42	47	40	53	44	49	39	55	556
	Fails	0	0	0	0	0	0	0	0	0	0	0	0	0

15.3 Terminal enhanced and double cleaning

Table 12 below illustrates the additional cleaning undertaken in clinical areas between April 2016 and September 2018 (excluding the deep clean planned programme).

Month/Year XX –Highest XX- Lowest	2016/17 Number of Terminal/ Post Infection Cleans	2016/17 Enhanced cleaning hours	2016/17 Double cleans in hours	2017/18 Number of Terminal/ Post Infection Cleans	2017/18 Enhanced cleaning hours	2017/18 Double cleans in hours
April	393	67	83.50	428	21	114.25
May	363	63.75	64	447	51.75	128
June	342	35.50	59.75	457	71.50	104.75
July	299	52.75	63.50	573	57	115
August	380	43.75	120	460	79.75	68.50
September	397	57.75	69.25	457	82.50	117.25
October	411	63.25	90.50			
November	416	67.5	105.5			
December	500	64.5	180.25			
January	476	52.75	185			
February	433	55.75	91.25			
March	365	52	130.25			
Year to Date total	**4775**	**676.25**	**1242.75**	**2822 @ 6 months**	**363.50 @ 6 months**	**647.75 @ 6 months**
Totals for Year	**6694**			**4481.00 @ 6 months**		

15.4 Deep clean programme/rapid response team

The deep clean and decorating programme commenced in April 2017 *(a copy of the programme is available from the Housekeeping Department).* A monthly review of this plan is undertaken at Matrons Monitoring Meeting (MMG) and discussed with the ICNs and DSN's at weekly meetings. Concerns have been raised that the Housekeeping Team cannot access a number of bays and siderooms due to bed pressures.

For those areas that are not deep cleaned, a contingency "scrub" plan of action has been agreed. This contingency scrub plan will continue to be monitored to better ensure all areas have a level of annual deep clean. These areas will be prioritised should they become available and the deep clean and GLOSAIR disinfection will be undertaken.

In addition to the deep clean programme, the demand on the GLOSAIR 400 room decontamination system remains high and reflects the robust measures in place to ensure appropriate infection control.

Table 13 below reflects the GLOSAIR 400 room decontamination activity in 2016/2017 and 2017/2018 to date.

2017/18 MONTH	APRIL	MAY	JUNE	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
GLOSAIRS (Not including Deep Clean Plan)	19	35	44	43	13	38						
Total to date	192											
2016/17 MONTH	**APRIL**	**MAY**	**JUNE**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
GLOSAIRS (Not including Deep Clean Plan)	64	31	21	18	22	17	28	22	35	34	23	10
Total to date	325											

15.5 Housekeeping resource

Housekeeping were awarded additional funding, following a paper that was presented by the Head of Facilities (with a value of £171k) to the Executive Directors (January 2016) The Executive Directors agreed to fund a proportion of the paper with a value of £76,582 from October 2016.

This has enabled the Housekeeping department to extend their operational hours to include 20.00hrs to 23.45hrs every day, extend the weekend cover between the hours of 12noon to 16.00hrs, and increase the supervisors on shift to accommodate these extra operational hours. This change has seen an increase in the Housekeeping Department's ability to respond to post infection clean requests late into the evening (enabling quicker bed turnaround time), an ability to undertake deep clean and GLOSAIR disinfection at the weekend with staff on shift throughout the day.

If the demand on post infection cleans at these times are low, the resource is distributed to the deep clean plan or OPD areas. This extended service better ensure that cleaning resources can meet the demands on the service and ensure national cleaning standards and infection control needs are met.

Table 14 below shows the average number of cleans in extended hours (20.00hrs – 23.45hrs)

Type of clean	Day of week	Average number of cleans at this time/per month
Terminal cleans	Monday – Friday after 20.00hrs	**43**
	Saturday after 20.00hrs	**8**
	Sunday after 20.00hrs	**6**
Deep cleans & GLOSAIR	Monday – Friday after 20.00hrs	**23**
	Saturday after 20.00hrs	**3**
	Sunday after 20.00hrs	**6**

Housekeeping Services continue to strive to work in a multidisciplinary team way, communicating well and being responsive to the needs of our patients.

15.6 Improvement Work Projects

Housekeeping management team have undertaken a gap analysis review to identify what actions/changes would be required to fully implement the cleaning management tool advocated by the British Standards Institute (BSI). This was presented at the Joint Board of Directors on 20th September 2017 by Head of Facilities and General Manager Housekeeping, Staff Club, Porters

and Linen Services. It was agreed, that this funding, would be requested as a cost pressure for 2018/2019.

A capital bid was submitted for two new decontamination units in 2016/2017. Funding was approved for one replacement unit and a further capital bid was submitted in for 2017/2018 for the remaining machine. This specification for these replacement machines now sit with procurement for tendering.

16. Summary

This six monthly update report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust.

The report has detailed the progress against the Action Plan for 2017/18 in reducing HCAI rates for the Trust and the key priorities have included:

- Continued focus on the reduction of all reportable Trust HCAIs and ensure preventable infections are avoided.
- Ongoing reinforcement to improve compliance with hand hygiene practices and behaviours.
- Continued focus on antimicrobial stewardship.
- Monitor and manage decontamination services.
- Sustain progress with education, training and audit relating to infection control practices and policies.
- Monitor and manage water safety.
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

Appendix 1

Infection Prevention & Control – Annual Action Plan 2017/18

Please note: The numbering **does not** depict the order of priority for the Trust, but reflects the numbered duties within the Hygiene Code.

Domain and Key Actions	Who By	Status
1 Management, Organisation and the Environment **1.1 General duty to protect patients, staff and others from HCAIs** **1.2 Duty to have in place appropriate management systems for Infection Prevention and Control**		
Continue to promote the role of the DIPC in the prevention & control of HCAI	Chief Executive	Continuous
DIPC as Chair of the Infection Prevention and Control Committee	Chief Executive	In place
Lead infection prevention & control in the Trust and provide a six monthly public report to the Trust Board	DIPC	In place
Monitor and report uptake of mandatory training programme	IPCT	In place
Continue contribution to implementation of the Capacity Management policy	DIPC	In place
Ensure a programme of audit (incorporating Saving Lives High Impact Interventions) is in place to systematically monitor & review policies, guidelines and practice relating to infection prevention & control	IPCWG/IPCC	Monthly
Continue to review staffing levels via Workforce Planning	DDIPC	Continuous
Complete bedpan washer replacement and dirty utility room upgrade programme within the Trust (for inpatient clinical areas), including the Spinal Unit.	DIPC/RW	Complete
1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks		
Maintain the role of DIPC as an integral member of the Trust's Clinical Governance & risk structures (including Assurance Framework)	Chief Executive	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these	DIPC/JH/IPCT	In place
Active Surveillance & Investigation:		
Continue implementation of mandatory Surveillance Plan for HCAI & produce quarterly reports for IPCC	ICNs	In place
Review implementation of 'alert organism' & 'alert condition' system	JH/SC/PR	Continuous
Use comparative data on HCAI & microbial resistance to reduce incidence & prevalence	JH/SC/PR	In place
Promote liaison with Public Health England (PHE) for effective management & control of HCAI	DIPC/JH/IPCT	Continuous

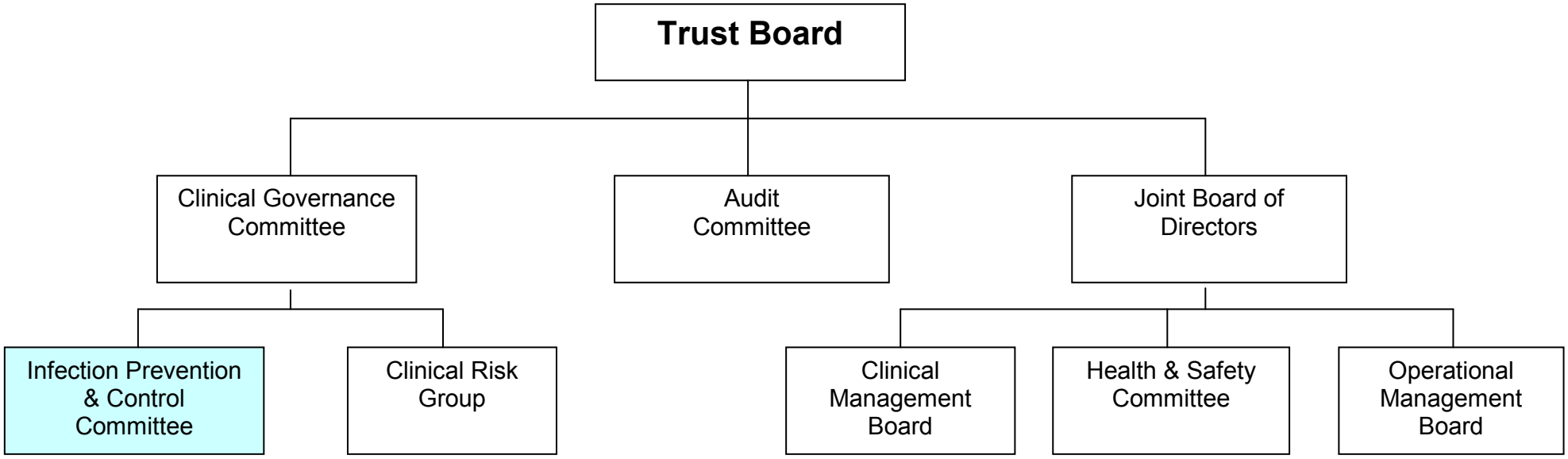
Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/IR/MS	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/IR/MS/ Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	IPCT	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	TC	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/SJ	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	IR	Continuous
Ensure adherence to the uniform and BBE policies and workwear guidance through audit and formal reporting via the monthly Matrons Monitoring Group meetings	DIPC/DSNs	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit	DSNs/IPCT	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation	JH/SC/PR	Continuous

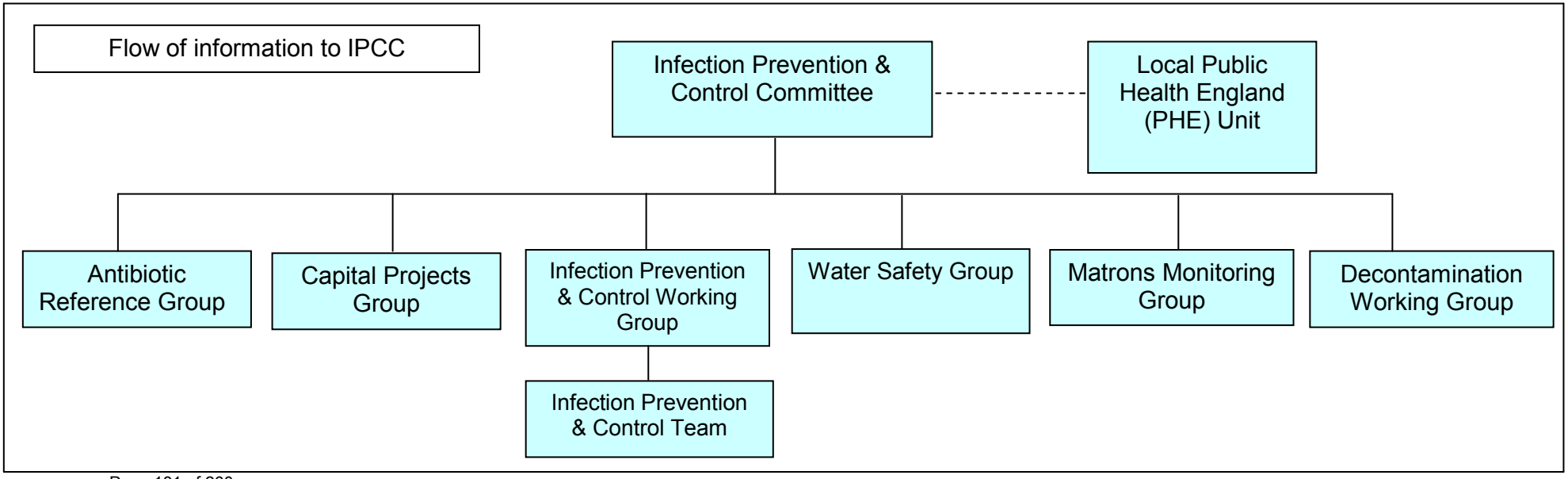
Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	In place
Isolation of patients	JH	In place
Safe handling and disposal of sharps	PK/GL	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	HL	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)	JHo/SK	In place
Disinfection policy	MS	In place
Antimicrobial prescribing	JH/ET	In place
Mandatory reporting HCAIs to the HPA	JH	In place
Control of infections with specific alert organisms; MRSA and C. difficile	IP&CT	In place
Additional policies:		
Transmissible Spongiform Encephalitis (TSE)	JH	In place
Glycopeptide Resistant Enterococcus (GRE)	JH	Included in
Acinetobacter species	JH	Isolation
Viral Haemorrhagic fever (VHF)	JH	Policy
Prevention of spread of Carbapenem resistant organisms	JH	In place
Diarrhoeal infections	JH	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	JD	In place
Infection control measures for ventilated patients	MF	In place
Tuberculosis	JH	In place
Legionellosis risk management policy and procedures, including pseudomonas	TC	In place
Strategic Cleaning Plan & Operational Policy	MS	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	TC	In place
Waste Management Policy	PJ	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	SJ	In place

Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs.		
Ensure all staff can access relevant occupational health & safety services (OHSS)	PH	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	HL	Continuous
Continue the provision of infection prevention and control education at induction	IPCT	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPCT	Continuous
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals	DSNs/ICNs	Continuous

Appendix 2

Formal Trust Reporting Structure





Appendix 3

Infection Prevention & Control Annual Audit & Policy Review Programme 2017/18

No	Aim	Audit	When by/How	Person(s) responsible/main author
1	Active surveillance & investigation.	Mandatory SSIS - Orthopaedic Surgery	Yearly, with minimum data set of 50 cases and/or 3 month period.	Facilitated by ICNs, including key personnel from relevant areas.
		Root Cause Analysis (RCA)/Post Infection Review (PIR)/incident investigations/SWARM meetings – • Mandatory alert organisms (MRSA, MSSA & E.coli bacteraemias & C.difficile infection) • Outbreaks e.g. Norovirus, C.difficile • PII e.g. C.difficile • Targeted others e.g. Tuberculosis, VRE	As required, within agreed timeframes.	Led by the ICD, DIPC and ICNs, including key personnel from affected areas.
2	Reduction of infection risk from the use of catheters, tubes, cannulae, instruments & other devices.	Patient Safety Work – ongoing implementation of care bundles e.g. central line & peripheral vascular devices.	Work continues to progress within the clinical areas.	Clinical Leaders/DSNs and educational support from key staff, with support from ICNs.
		Saving Lives: High Impact Interventions (HII).	• Priorities & timescales agreed with DIPC. • Plus, targeted audits.	Clinical Leaders/DSNs IPCT
3	Reduce the reservoirs of infection.	Environmental & equipment cleanliness	• Priorities & timescales agreed with DIPC. • Plus, targeted audits.	Clinical Leaders/DSNs IPCT
		In house Patient Led Assessment of the Care Environment (PLACE) visits.	Programme led by Facilities Directorate.	Facilities/Housekeeping Manager with the involvement of DMTs.
4	High standards of hygiene in clinical practice.	Hand hygiene, including Isolation nursing and use of personal protective equipment (PPE).	• Priorities & timescales agreed with DIPC. • Plus, targeted audits.	Clinical Leaders/DSNs IPCT

No	Aim	Audit	When by/How	Person(s) responsible/main author
5	Prudent use of antibiotics.	Antibiotic prescribing & usage.	Action Plan agreed & monitored by the Antibiotic Reference Group (ARG).	Chief Pharmacist & Antimicrobial Pharmacist
6	Management & organisation – • Policy, guideline & information development & review programme (review dates according to ICID or SDH intranet site).	Patient information leaflet – Acinetobacter.	Review January 2018.	ICNs.
		Microbiology/Infection Control Alerts Policy.	Review February 2019.	Deputy ICD.
		Aseptic procedure.	Under review October 2017.	ICNs.
		Central Line Policy	Review June 2019.	Sarah Clark (Radnor Ward).
		Clostridium difficile Policy.	Review February 2018.	ICD.
		Patient information leaflet – C.difficile.	Review February 2018.	ICNs.
		Contractors/Procurement information leaflet – infection prevention in hospital.	Review June 2018.	ICNs.
		Creutzfeldt Jakob Disease (CJD) Policy.	Review May 2019.	Decontamination Lead & ICD.
		Decontamination Policy.	Review April 2018.	Decontamination Lead.
		Patient information leaflet – ESBL.	Review April 2020.	ICNs.
		Glove Usage Policy & Chart.	Under review 2017.	ICNs.
		Patient information leaflet – Group A Strep (GAS).	Review February 2019.	ICNs.
		Staff information leaflet – Hand Hygiene.	Review January 2018.	ICNs.
		Infection Control Policy.	Under review 2017.	ICNs.
		Infection Prevention & Control Practice in the Operating Department.	Under review 2017.	Lucinda Pluck (Main Theatres Department)
		Inpatients with diarrhoea algorithm.	Review October 2018.	ICNs.
		Isolation Policy (including diarrhoeal infections & other alert organisms).	Review March 2019.	ICD.
		Hand Hygiene Policy.	Under review 2017.	ICNs.
		Patient information leaflet – Invasive GAS Disease.	Review February 2019.	ICNs.
		Linen Management Policy.	Review February 2020.	ICNs.
		Legionellosis Management & Water Safety Policy.	Review February 2019.	Terry Cropp.
		Clinical Management of MRSA Policy.	Review November 2018.	ICD.

No	Aim	Audit	When by/How	Person(s) responsible/main author
6	Continued	Patient information leaflet – MRSA your questions answered.	Review January 2018.	ICNs.
		Patient information leaflet – MRSA Contact.	Review November 2019.	ICNs.
		Patient information leaflet – MRSA Screening.	Review July 2018.	ICNs.
		Outbreak Management Policy.	Review July 2020.	IPCT.
		Norovirus Management & Outbreak Policy.	Review July 2020.	IPCT.
		Patient information leaflet – Norovirus.	Review February 2019.	ICNs.
		Patient information leaflet – 'Now that I am in Isolation – some practical advice'.	Review November 2019.	ICNs.
		Prevention of Occupational Exposure to Blood Borne Virus Policy.	Review November 2019.	ICNs.
		Prevention of Spread of CRO Policy.	Review July 2020.	ICD.
		Patient information leaflets – CPE C3 – Colonised. C4 – Carrier. C5 – Contact.	Review July 2020.	ICNs.
		Peripheral Venous Cannulation Policy.	Review November 2017.	ICNs.
		Patient information leaflet – Having a 'drip' (peripheral venous cannula)	Review February 2019.	ICNs.
		Standard Precautions Policy.	Review November 2018.	ICNs.
		Surveillance Policy.	Review January 2019.	ICNs.
		Taking Blood Cultures Policy – Adults.	Review May 2020.	IPCT.
		Tuberculosis Infection Control Policy.	Review December 2017.	ICD.
		Ebola & other VHFs Policy.	Reviewed 2017.	ICD.
		Control of GRE Policy.	Review July 2020.	ICD & Deputy ICD.
		Patient information leaflet – GRE.	Review September 2018.	ICNs.
		Patient information leaflet – Hygiene advice for patients about controlling spread of infections.	Review November 2018.	ICNs.
		Staff information – MERs CoV.	Review September 2018.	ICD.

Report to:	Salisbury NHS Foundation Trust Board	**Agenda item:**	**SFT 3961**
Date of Meeting:	4 December 2017		

Report Title:	National Emergency Department Survey 2016 Analysis of Care Quality Commission Benchmark Report and Local Action Plan			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Hazel Hardyman, Head of Customer Care Gill Sheppard, Clinical Governance Administrator			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Appendix A: Care Quality Commission Benchmark Report for Salisbury NHS Foundation Trust			

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

Executive Summary:

Salisbury NHS Foundation Trust (SFT) participated in the sixth national Emergency Department survey between October 2016 and March 2017. The sample size was 1,250 and 495 patients responded.

Details are available at: http://www.cqc.org.uk/publications/surveys/emergency-department-survey-2016. The benchmark report for SFT is attached to this report (Appendix A).

Comparisons with other Trusts

- SFT scored 'better' than most other Trusts in eight of the nine sections overall. Two of these were the highest scoring of all Trusts (doctors and nurses; respect and dignity).
- SFT was at the top end of 'about the same' for the remaining section.
- SFT scored 'better' than most other Trusts for 16 of the 35 individual questions. Three of these were the highest scoring of all Trusts (staff available to help if needed; different staff not saying different things; treated with respect and dignity in ED).
- SFT was at the higher end of 'about the same' for 13 of the remaining 19 questions.

Comparisons with Neighbouring Trusts

Work has been undertaken to compare SFT's results with its neighbouring Trusts at Bath, Bournemouth, Dorchester, Poole, Southampton, Swindon, Winchester and Yeovil.

- SFT had the highest or joint highest score within this group for six of the nine main sections (Waiting times; Doctors and nurses; Tests; Hospital environment and facilities; Leaving the Emergency Department; Respect and dignity)
- SFT had the highest or joint highest score for 17 of the 35 individual questions and scored favourably for the remaining 18.

Comparisons with our own unweighted results in 2014
Local analysis of the unweighted 2016 results show that they are on par with those of 2014. The main downward movement of scores has been in the length of time patients had to wait before they first spoke to a nurse or doctor. Work to address this has been included in the department's action plan.

Action Plan
The Emergency Department have identified areas where improvements could be made and have drawn up an action plan accordingly. Progress will be monitored via the Trust's Clinical Management Board and Clinical Governance Committee.

1. PURPOSE

This report provides analysis of the Care Quality Commission (CQC) benchmark report for Salisbury NHS Foundation Trust (SFT), together with comparisons of scores with neighbouring Trusts. It also provides information on the actions to be taken by the Emergency Department (ED) to improve services where required.

2. BACKGROUND

2.1 Salisbury NHS Foundation Trust (SFT) participated in the sixth national Emergency Department survey between October 2016 and March 2017. Questionnaires were sent to 1,250 randomly selected patients who had attended the Emergency Department at Salisbury District Hospital during September 2016. A total of 495 patients responded.

2.2 The Care Quality Commission (CQC) has benchmarked the results based on the scores of all participating Trusts, weighted by age and gender, and has published reports on their website for each individual Trust. Details are available at: http://www.cqc.org.uk/publications/surveys/emergency-department-survey-2016. The benchmark report for SFT is attached to this report (Appendix A).

3. ANALYSIS OF BENCHMARK REPORT

3.1 Mean Scores

3.1.1 SFT scored 'better' than most other Trusts in eight of the nine sections overall. Two of these were the highest scoring of all Trusts as indicated in **bold** text in the table below:

SECTION	SFT SCORE	LOWEST TRUST SCORE	HIGHEST TRUST SCORE
Arrival at the Emergency Department	8.5	6.6	8.8
Waiting times	6.5	5.0	6.7
Doctors and nurses	**8.8**	7.5	**8.8**
Care and treatment	8.4	7.0	8.5
Tests	9.0	7.6	9.1
Hospital environment and facilities	8.9	7.3	9.0
Respect and dignity	**9.4**	7.9	**9.4**
Experience overall	8.5	7.2	8.6

3.1.2 SFT was at the top end of 'about the same' for the remaining section:

SECTION	SFT SCORE	LOWEST TRUST SCORE	HIGHEST TRUST SCORE
Leaving the emergency department	7.1	5.1	7.4

3.1.3 SFT scored 'better' than most other Trusts for 16 of the 35 individual questions. Three of these were the highest scoring of all Trusts as indicated in **bold** text:

ISSUE	SFT SCORE	LOWEST TRUST SCORE	HIGHEST TRUST SCORE
Told waiting time to be examined	4.9	1.8	5.6
Length of visit to ED	7.9	6.0	8.2
Enough time to discuss problem	9.0	7.7	9.2
Clear explanation of condition/treatment	8.7	7.3	8.8
Family/friend able to talk to doctor	8.4	6.8	8.6
Sufficient information provided on condition/treatment	9.2	7.8	9.3
Staff available to help if needed	**8.7**	6.8	**8.7**
Different staff not saying different things	**9.5**	8.0	**9.5**
Clear explanation of tests required	9.0	7.3	9.1
Test results provided before leaving ED	8.8	7.1	9.3
Clear explanation of test results	9.2	7.9	9.4
Suitable food or drinks available in ED	7.8	5.1	8.2
Told when usual activities could be resumed	6.7	3.3	7.0
Home situation taken into account before patient left ED	6.2	2.9	6.6
Treated with respect and dignity in ED	**9.4**	7.9	**9.4**
Overall experience	8.5	7.2	8.6

3.1.4 SFT was at the higher end of 'about the same' for 13 of the remaining 19 questions:

ISSUE	SFT SCORE	LOWEST TRUST SCORE	HIGHEST TRUST SCORE
Wait with ambulance crew before handover to ED	9.1	6.1	9.5
Privacy at reception desk	7.8	6.2	8.2
Doctors and nurses listening to patient	9.2	8.1	9.3
Opportunity to discuss anxieties or fears	7.8	6.2	8.3
Confidence and trust in doctors and nurses	9.0	7.9	9.3
Inclusion in discussions between doctors and nurses	9.2	7.6	9.5
Privacy during examination or treatment	9.3	8.2	9.6
Involvement in decisions about care and treatment	8.5	6.9	8.7
Provision of pain relief medication	6.8	4.2	7.7
Pain control	8.2	6.4	8.8
Cleanliness of ED	9.1	7.4	9.5
Not threatened by other patients or visitors	9.8	8.8	9.9
Provision of contact details if concerned after leaving ED	7.9	5.5	8.3

3.1.5 Scores for the final six questions were as follows:

ISSUE	SFT SCORE	LOWEST TRUST SCORE	HIGHEST TRUST SCORE
Waiting time to speak to doctor/nurse	6.6	4.3	7.5
Waiting time for examination	6.7	5.3	7.3
Reassurance from staff	6.9	5.1	7.9

Purpose of medication clearly explained	9.2	8.1	9.9
Explanation of medication side effects to watch for	5.9	3.7	7.2
Explanation of danger signals to watch for	6.5	4.1	7.4

3.2 Comparisons with National Response Rate and Demographic Characteristics

3.2.1 The national response rate was 28% compared to SFT's response rate of 41%.

3.2.2 Age group responses were generally in line with the national picture (16-35 = 11%; 36-50 = 15%; 51-65 = 28%; 66 and older = 45%).

3.2.3 The split between male and female respondents was in line with the national split (male = 46%, 45% nationally; female = 54%; 55% nationally).

3.2.4 Responses from other ethnic groups were lower at 2%, compared with 10% nationally.

3.3 Comparisons with Neighbouring Trusts

3.3.1 Work has been undertaken to compare SFT's results with its neighbouring Trusts at Bath, Bournemouth, Dorchester, Poole, Southampton, Swindon, Winchester and Yeovil.

3.3.2 SFT had the highest or joint highest score within this group for six of the nine main sections:
- Waiting times
- Doctors and nurses
- Tests
- Hospital environment and facilities
- Leaving the Emergency Department
- Respect and dignity

and was only slightly below the highest score for the remaining three:
- Arrival at the Emergency Department
- Care and treatment
- Experience overall

3.3.3 SFT had the highest or joint highest score for 17 of the 35 individual questions and scored favourably for the remaining 18.

3.3.4 Full details of the comparison scores are available upon request.

3.4 Comparisons with our own unweighted results in 2014

3.4.1 Local analysis of the unweighted 2016 results show that they are on par with those of 2014. Where there has been a downward movement of scores, the shifts have been generally small; the main shift being the length of time patients had to wait before they first spoke to a nurse or doctor (6.6 in 2016 compared with 7.1 in 2014). Work to address this has been included in the department's action plan.

3.5 Action Plan

3.5.1 The Emergency Department has carefully considered the results of the 2016 survey in conjunction with all other patient feedback received through the Friends and Family Test, complaints and concerns, and have identified areas where improvements could be made. An action plan has been drawn up accordingly. Progress will be monitored via the Trust's Clinical Management Board and Clinical Governance Committee.

4. SUMMARY

4.1 The survey results were very positive. Where improvements can be made, the Emergency Department is acting accordingly.

5. RECOMMENDATION

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

Lorna Wilkinson
Director of Nursing

APPENDIX A

Patient survey report 2016

Emergency Department Survey 2016

Salisbury NHS Foundation Trust

NHS patient survey programme
Emergency Department Survey 2016

The Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and we encourage care services to improve. Our role is to register care providers and to monitor, inspect and rate services. If a service needs to improve, we take action to make sure this happens. We speak with an independent voice, publishing regional and national views of the major quality issues in health and social care.

Emergency Department Survey 2016

To improve the quality of services the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences.

The sixth survey of emergency department patients involved 137 acute and specialist NHS trusts with a Type 1 accident and emergency department[1]. Forty nine of these trusts also had direct responsibility for running a Type 3 department[2] and patients from these departments were included within the survey for the first time in 2016. Responses were received from 45,597 people, a response rate of 27%.

Patients were eligible for the survey if they were aged 16 years or older, had attended an emergency department during September 2016 and were not staying in hospital during the sampling period. Full sampling criteria can be found in the survey instruction manual (see further information section).

Trusts responsible for only Type 1 departments drew a random sample of 1,250 patients. Trusts that also directly ran Type 3 departments sampled 950 patients from Type 1 departments and 300 patients from Type 3 departments. Questionnaires and reminders were sent to patients between October 2016 and March 2017.

Similar surveys of emergency department patients were carried out in 2003, 2004, 2008, 2012 and 2014. Due to the change in sampling month, results from 2016 are not comparable with previous years.

The emergency department survey is part of a wider programme of NHS patient surveys, which covers a range of topics including adult inpatients, children and young people's inpatient and day-case services, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

The Care Quality Commission will use the results from this survey in our regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of CQC Insight, which provides inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health will hold them to account for the outcomes they achieve. NHS Improvement will use the results to guide its work to improve the quality of care provided by NHS Trusts and Foundation Trusts.

[1] A Type 1 department is a major, consultant led A&E Department with full resuscitation facilities operating 24 hours a day, 7 days a week

[2] A Type 3 department is an A&E/minor injury unit with designated accommodation for the reception of accident and emergency patients. The department may be doctor or nurse-led, treats at least minor injuries and illnesses and can be routinely accessed without appointment.

Interpreting the report

This report includes Type 1 department results only[3] and shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part.

It uses an analysis technique called the '**expected range**' to determine if your trust is performing 'about the same', 'better' or 'worse' compared with other trusts. For more information, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

A 'section' score is also provided, labelled S1-S9 in the 'section scores'. The scores for each question are grouped thematically and broadly in line with their order in the questionnaire, for example ‘Doctors and nurses’ and ‘Tests’.

This report shows the same data as published on the CQC website (http://cqc.org.uk/emergencydepartmentsurvey). The CQC website displays the data in a simplified way, identifying whether a trust performed 'better', 'worse' or 'about the same' as the majority of other trusts for each question and section.

Standardisation

Trusts have differing profiles of people who use their services. For example, one trust may have more male inpatients than another trust. This can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of people.

To account for this, we standardise the data. Results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-sex-admission type profile reflects the national age-sex-admission type distribution (based on all of the respondents to the survey). Standardisation therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess trust performance. For example, they may be descriptive questions such as Q6 which asks respondents if they had previously visited the same emergency department about the same condition. Alternatively they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q29 “Were you in any pain while you were in the emergency department?”

For full details of the scoring please see the ‘Survey Technical Document’ (see further information section).

Graphs

The graphs in this report show how the score for the trust compares to the range of scores achieved by all trusts taking part in the survey. The black diamond shows the score for your trust. The graph is divided into three sections:

- If your trust's score lies in the orange section of the graph, its result is 'about the same' as most other trusts in the survey.

[3]Benchmark reports for Type 3 department results have not been produced.

- If your trust's score lies in the red section of the graph, its result is 'worse' compared with most other trusts in the survey.
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey. If there is no text the score is 'about the same'. These groupings are based on a rigorous statistical analysis of the data, as described in the following 'methodology' section.

Methodology

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the '**expected range**' which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust and the scores for all other trusts. If the trust's performance is outside of this range, it means that it performs significantly above/below what would be expected. If it is within this range, we say that its performance is 'about the same'. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance.

In some cases there will be no red and/or no green area in the graph. This happens when the expected range for your trust is so broad it encompasses either the highest possible score for all trusts (no green section) or the lowest possible for all trusts score (no red section). This could be because there were few respondents and / or a lot of variation in their answers.

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (or the corresponding section). This is because the uncertainty around the result is too great. A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see further information section).

Tables

At the end of the report you will find tables containing the data used to create the graphs. These tables also show the response rate for your trust and background information about the people that responded.

Results for 2016 have not been compared with the previous survey as due to changes in sampling month, any change in results could be attributed to differences caused by patients being seen at different times of the year than in previous surveys.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
http://cqc.org.uk/emergencydepartmentsurvey

The results for the emergency department surveys from 2003, 2004, 2008, 2012 and 2014 can be found at:
http://www.nhssurveys.org/surveys/296

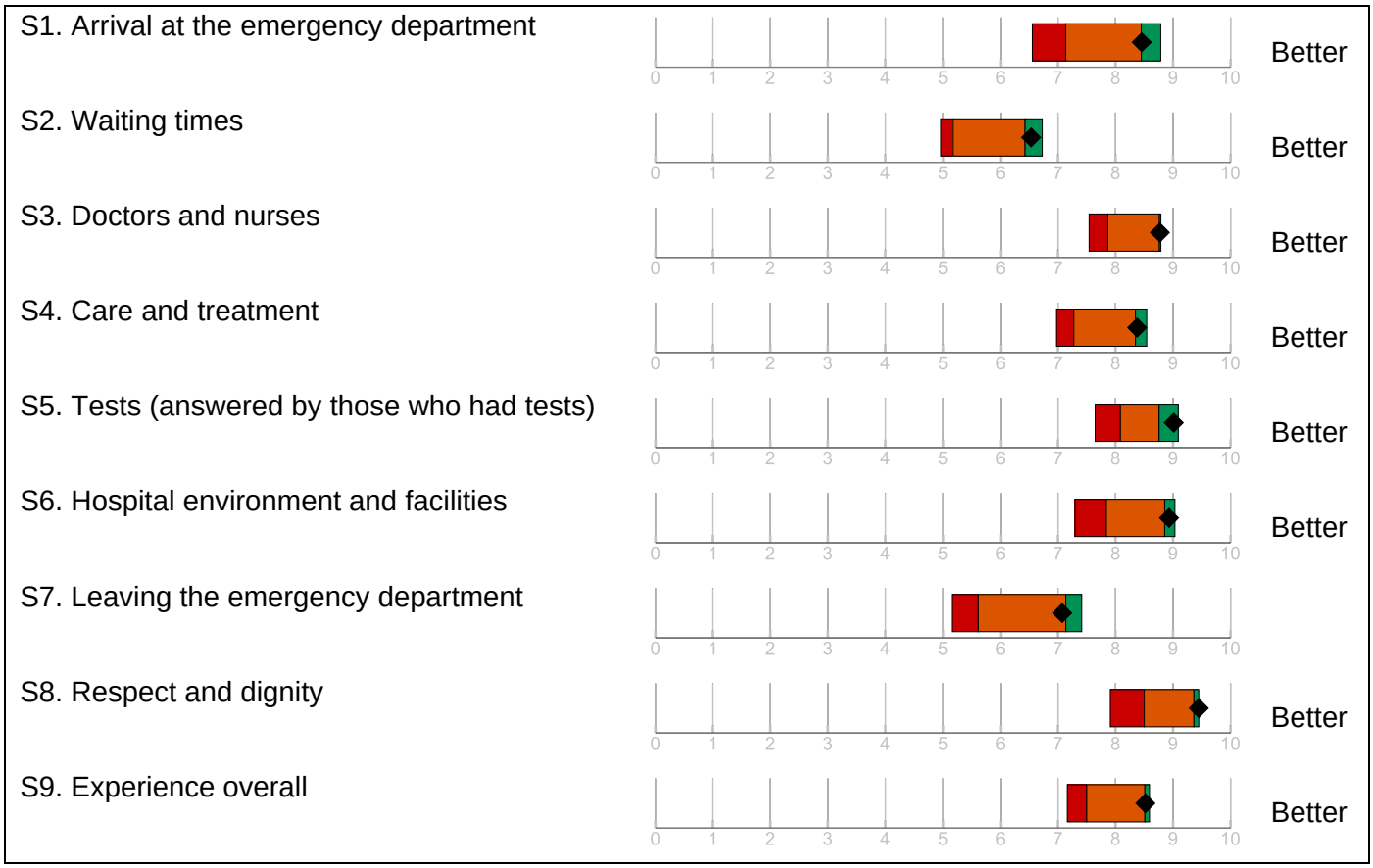
Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/957

More information on the programme of NHS patient surveys is available at:
http://www.cqc.org.uk/content/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/content/monitoring-nhs-acute-hospitals

Emergency Department Survey 2016
Salisbury NHS Foundation Trust

Section scores

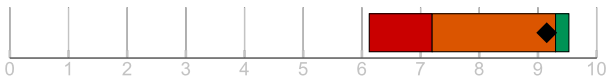


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Emergency Department Survey 2016
Salisbury NHS Foundation Trust

Arrival at the emergency department

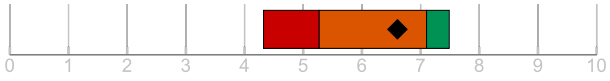
Q5. How long did you wait with the ambulance crew before your care was handed over to the emergency department staff?



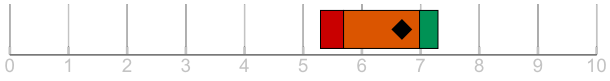
Q7. Were you given enough privacy when discussing your condition with the receptionist?

Waiting times

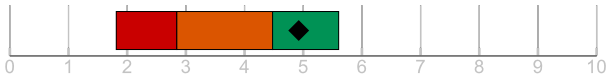
Q8. How long did you wait before you first spoke to a nurse or doctor?



Q9. How long did you wait before being examined by a doctor or nurse?



Q10. Were you told how long you would have to wait to be examined?



Better

Q11. Overall, how long did your visit to the emergency department last?

Better

Doctors and nurses

Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?

Better

Q13. Did a doctor or nurse explain your condition and treatment in a way you could understand?

Better

Q14. Did the doctors and nurses listen to what you had to say?

Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?

Q17. Did doctors or nurses talk to each other about you as if you weren't there?

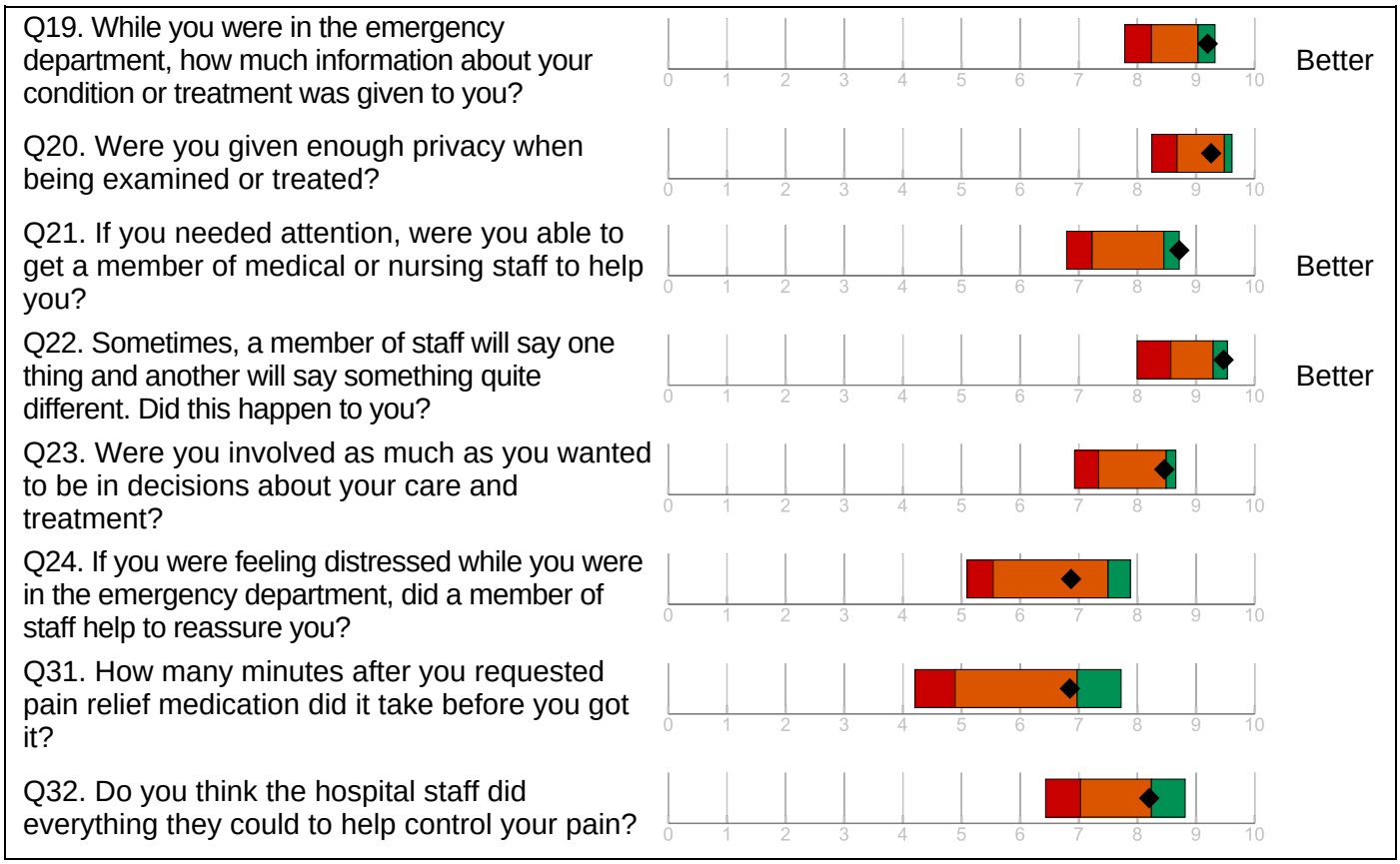
Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

Better

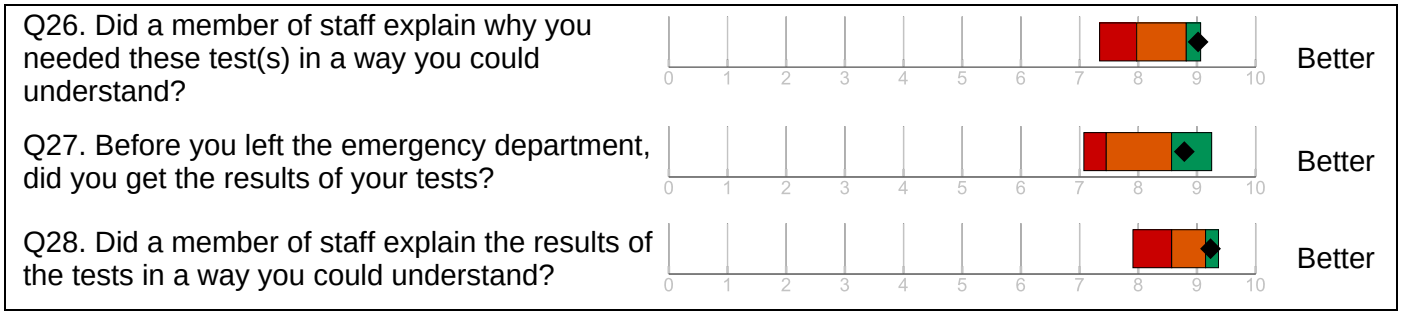
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

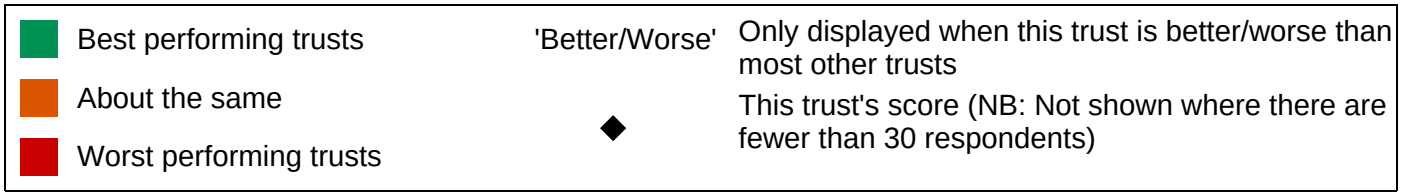
Emergency Department Survey 2016
Salisbury NHS Foundation Trust

Care and treatment



Tests (answered by those who had tests)





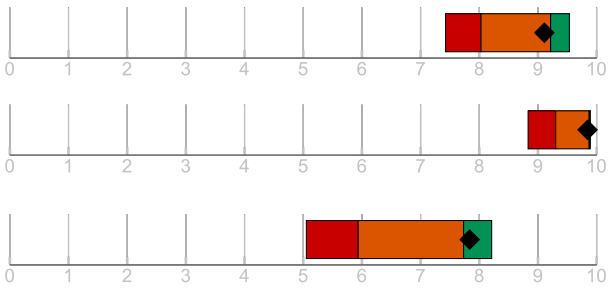
Emergency Department Survey 2016
Salisbury NHS Foundation Trust

Hospital environment and facilities

Q33. In your opinion, how clean was the emergency department?

Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?

Q35. Were you able to get suitable food or drinks when you were in the emergency department?



Better

Leaving the emergency department

Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?

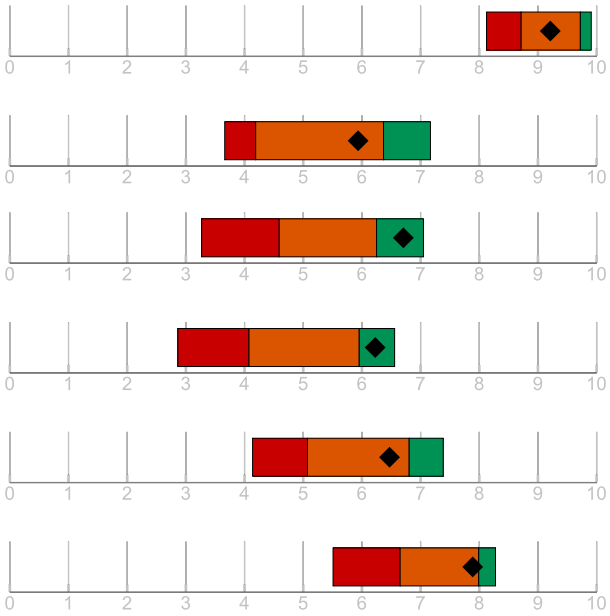
Q39. Did a member of staff tell you about medication side effects to watch for?

Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?

Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?

Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?

Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?



Better

Better

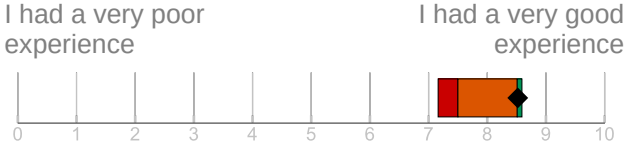
Respect and dignity

Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?

Better

Experience overall

Q45. Overall...



Better

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
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Worst performing trusts		

Emergency Department Survey 2016
Salisbury NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)
Arrival at the emergency department					
S1	Section score	8.5	6.6	8.8	
Q5	How long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	9.1	6.1	9.5	157
Q7	Were you given enough privacy when discussing your condition with the receptionist?	7.8	6.2	8.2	382
Waiting times					
S2	Section score	6.5	5.0	6.7	
Q8	How long did you wait before you first spoke to a nurse or doctor?	6.6	4.3	7.5	473
Q9	How long did you wait before being examined by a doctor or nurse?	6.7	5.3	7.3	457
Q10	Were you told how long you would have to wait to be examined?	4.9	1.8	5.6	370
Q11	Overall, how long did your visit to the emergency department last?	7.9	6.0	8.2	473
Doctors and nurses					
S3	Section score	8.8	7.5	8.8	
Q12	Did you have enough time to discuss your health or medical problem with the doctor or nurse?	9.0	7.7	9.2	484
Q13	Did a doctor or nurse explain your condition and treatment in a way you could understand?	8.7	7.3	8.8	462
Q14	Did the doctors and nurses listen to what you had to say?	9.2	8.1	9.3	482
Q15	If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.8	6.2	8.3	309
Q16	Did you have confidence and trust in the doctors and nurses examining and treating you?	9.0	7.9	9.3	485
Q17	Did doctors or nurses talk to each other about you as if you weren't there?	9.2	7.6	9.5	485
Q18	If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	8.4	6.8	8.6	289

Emergency Department Survey 2016
Salisbury NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)
Care and treatment					
S4	Section score	8.4	7.0	8.5	
Q19	While you were in the emergency department, how much information about your condition or treatment was given to you?	9.2	7.8	9.3	479
Q20	Were you given enough privacy when being examined or treated?	9.3	8.2	9.6	485
Q21	If you needed attention, were you able to get a member of medical or nursing staff to help you?	8.7	6.8	8.7	291
Q22	Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?	9.5	8.0	9.5	486
Q23	Were you involved as much as you wanted to be in decisions about your care and treatment?	8.5	6.9	8.7	463
Q24	If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?	6.9	5.1	7.9	159
Q31	How many minutes after you requested pain relief medication did it take before you got it?	6.8	4.2	7.7	71
Q32	Do you think the hospital staff did everything they could to help control your pain?	8.2	6.4	8.8	272
Tests (answered by those who had tests)					
S5	Section score	9.0	7.6	9.1	
Q26	Did a member of staff explain why you needed these test(s) in a way you could understand?	9.0	7.3	9.1	325
Q27	Before you left the emergency department, did you get the results of your tests?	8.8	7.1	9.3	287
Q28	Did a member of staff explain the results of the tests in a way you could understand?	9.2	7.9	9.4	248
Hospital environment and facilities					
S6	Section score	8.9	7.3	9.0	
Q33	In your opinion, how clean was the emergency department?	9.1	7.4	9.5	468
Q34	While you were in the emergency department, did you feel threatened by other patients or visitors?	9.8	8.8	9.9	487
Q35	Were you able to get suitable food or drinks when you were in the emergency department?	7.8	5.1	8.2	248

Emergency Department Survey 2016
Salisbury NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)
Leaving the emergency department					
S7	Section score	7.1	5.1	7.4	
Q38	Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.2	8.1	9.9	84
Q39	Did a member of staff tell you about medication side effects to watch for?	5.9	3.7	7.2	66
Q40	Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	6.7	3.3	7.0	199
Q41	Did hospital staff take your family or home situation into account when you were leaving the emergency department?	6.2	2.9	6.6	134
Q42	Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	6.5	4.1	7.4	218
Q43	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	7.9	5.5	8.3	321
Respect and dignity					
S8	Section score	9.4	7.9	9.4	
Q44	Overall, did you feel you were treated with respect and dignity while you were in the emergency department?	9.4	7.9	9.4	481
Experience overall					
S9	Section score	8.5	7.2	8.6	
Q45	Overall...	8.5	7.2	8.6	458

Emergency Department Survey 2016
Salisbury NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	495	41941
Response Rate (percentage)	41	28

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	46	45
Female	54	55
Age group (percentage)	(%)	(%)
Aged 16-35	11	12
Aged 36-50	15	14
Aged 51-65	28	25
Aged 66 and older	45	49
Ethnic group (percentage)	(%)	(%)
White	98	90
Multiple ethnic group	0	1
Asian or Asian British	0	3
Black or Black British	0	2
Arab or other ethnic group	0	0
Not known	1	4
Religion (percentage)	(%)	(%)
No religion	21	19
Buddhist	0	0
Christian	74	72
Hindu	0	1
Jewish	0	0
Muslim	0	2
Sikh	0	0
Other religion	1	1
Prefer not to say	3	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	96	93
Gay/lesbian	1	1
Bisexual	1	1
Other	0	1
Prefer not to say	3	5

Report to:	Trust Board	Agenda item:	3962
Date of Meeting:	Monday 4th December 2017		

Report Title:	Emergency Preparedness Resilience & Response (EPRR)			
Status:	Information	Discussion	Assurance	Approval
			X	
Prepared by:	Ian Robinson – EPRR Lead			
Executive Sponsor (presenting):	Andy Hyett – EPRR Accountable Officer			
Appendices (list if applicable):	None			

Recommendation:

The Trust Board is asked to support the ongoing work required to fulfil our EPRR duties and responsibilities, and to sign off this annual EPRR assurance report as part of the NHS England assurance process.

Executive Summary:

Purpose of Report:
To provide assurance to the Trust Board as part of the National EPRR Assurance process. The Trusts self-assessment against the National EPRR Core Standards has been confirmed by Wiltshire CCG and approved by NHS England, as delivering FULL assurance.

This report, through a summary of EPRR activity, including the assurance process and training and exercising demonstrates our compliance.

Background:
The Trust is defined as a category 1 responder under the Civil Contingencies Act and is subject to civil protection duties discharged through the EPRR assurance process.

Based on the National RAG status for EPRR compliance SFT have been rated by Wiltshire CCG and NHS England as 'Full' compliance and were commended for the work that has been undertaken in the last year. As a category One responder we are meeting our civil protection duties under the Civil Contingencies Act (2004).
Full compliance means that arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve.

1. Purpose

This paper provides an annual report on the Trust's emergency preparedness in order to meet our statutory requirements of the Civil Contingencies Act (CCA) (2004) and the NHS England Emergency Preparedness Resilience and Response (EPRR) Framework 2015 and NHS England Business Continuity Framework.

2. Background & Statutory Framework

The Civil Contingencies Act outlines a single framework and establishes clear roles and responsibilities. SFT are defined as a category 1 responder in the CCA and is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place Emergency Plans;
- Put in place Business Continuity Arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with local responders to enhance co-ordination;
- Co-operate with other local responders to enhance coordination

3. National EPRR Framework & Core Standards

The NHS England EPRR Frameworks contain principles for health emergency planning for the NHS in England and the NHS Core Standards for EPRR provides the minimum standards that an NHS organisation must meet.
It is expected that that the level of preparedness will be proportionate to the role of the organisation and the services provided:

- SFT must meet the minimum core standards and provide evidence these standards are being met
- SFT must identify an Accountable Office (Chief Operating Officer) who is responsible for ensuring these standards are met

4. Wiltshire and Swindon EPRR Assurance process 2017-18

The responsibility for undertaking the local assurance process for SFT was undertaken by the Wiltshire Clinical Commissioning Group (CCG). SFT provided the CCG with a core standard spreadsheet with each standard RAG rated with supporting evidence to support this rating, together with an improvement plan summarising actions against any non-compliant action/s with deadlines for completion and an overall statement of our self-assessment.
Our self-assessment stated (July 2017): As part of the national EPRR assurance process for 2017/18, Salisbury NHS Foundation Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 52 of the core standards which are applicable to the organisation, Salisbury NHS Foundation Trust:

- is fully compliant with 52 of these core standards; - the overall rating is 'Full'

The Salisbury NHS Foundation EPRR work plan, detailed how the core standards will be maintained and enhanced during the next twelve months.

The CCG conducted the 'confirm and challenge' meeting on 4th August 2017 and the CCG informed NHS England that based on the National RAG status for EPRR compliance that SFT are rated in the 'Full' category. See figure 1 below for compliance levels:

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A workplan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A workplan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

Figure 1:

The CCG informed NHS England that based on the National RAG status for EPRR compliance and the SFT self-assessment that SFT are rated in the Full compliance category. Further to this no EPRR monitoring will be required this year through the contract meetings.

5. Training & Exercising

Statutory requirement set out that the Trust will undertake:

- Live Exercise – Every 3 years
- Table Top Exercise – Yearly
- Communication Test – Every 6 months

A variety of training and exercising and live events have taken place in the last 8 months see tables below in relation to training and awareness and exercises and live incidents:

Table 1:

Type of Training/Awareness	Audience/Description	Date
Loggist (New)	4 volunteers Trust wide who have expressed an interest in the loggist role	4th April 2017 & 3rd July 2017
Loggist (refresher)	5 loggists undertook refresher training	6th April & 3rd July 2017
CBRN & PRPS	6 volunteers for the Rapid Response Team trained in May & a further 14 volunteers in November	5th May 2017 17th November 2017
EPRR Mandatory On-Call Training	11 Duty Managers and Heads of Service 3 ETS on call staff 3 ETS on call staff	26th April 2017 25th August 2017 26th September 2017
EPRR Overview including Run, Hide Tell and It's OK to Say – Staff Club	12 Staff Club members	10th July 2017
EPRR Overview including Run, Hide Tell and It's OK to Say – Therapy Team	50 members of the Therapy team	27th July 2017
Fit Test Train the Trainer	6 staff undertook the train the trainer for FF3 fit testing	9th August 2017
EPRR Overview including Run, Hide Tell and It's OK to Say – Housekeeping	45 staff	4th August 2017
Counter Terrorism Awareness Sessions	152 attended the hourly sessions run by the Counter Terrorism Intelligence Unit (CTIU)	6th September 2017
LRF Executive visit to Porton Down	Attended by Executive Director	15th September 2017
CBRN Workshop – Tidworth	2 staff Attended	26th & 27th October 2017
NPAG – Resilience Group	1 member of staff attends	13th June 2017 7th November 2017
Cyber Crime Awareness Session	Attended by Informatics Team	25th October 2017
EPRR Awareness Session for Clinical Site	5 attended	13th November 2017
PREVENT (WRAP)	Monthly and ad-hoc specialty sessions 180 trained to date	Monthly and ad-hoc as requested

Table 2:

Type of Exercise/Live	Audience/Description	Date
Exercise Shadow – Radiology Business Continuity Table Top	Table top exercise based around business continuity failure in severe weather impacted by loss of utilities	19th April 2017
SWAST MI Everbridge Cascade test / Exercise Connecting	Switchboard & Duty Manager	Weekly until July 2017 Now quarterly no notice exercise
Project Argus	Counter Terrorism Table Top exercise – 44 staff participated	10th May 2017
Internal Incident – Escaped Prisoner	Internal Incident Plan activated	31st May 2017
Theatre 7 & 8 Evacuation Exercise	15 Theatre staff undertook evacuation exercise	6th June 2017
Ward Evacuation Fire Exercises	219 staff participated over three days across all four clinical directorates	1st – 3rd August 2017
Exercise Alchemic	41 staff participated in the CBRN live exercise of the wet decontamination process, from ED and from the Rapid Response Team peer reviewed by CCG, NHS England and other Acute Trust	14th September 2017
Exercise Arthurs Shield	MOD Tactical Exercise based on a plane crash at Boscombe Down, multi-agency – attended by one member of the IMT to represent health with NHS England	31st October 2017
Internal Incident – Lorenzo Outage	Internal Incident Plan activated	1st November 2017
Exercise Little Problem	Paediatric Critical Care network Mass Casualty table top (7 attended)	8th November 2017
Eye Clinic Outpatient Fire Evacuation Exercise	30 staff attended	21st November 2017

All exercises and live events are debriefed so lessons learnt and action plans can be captured, and plans updated/modified as required.

6. 2018 Exercising Schedule – dates planned

Live Exercises	Table Tops	Communications Test	Training
CBRN Exercise 13th June 2018 – follow up exercise to Exercise Alchemic Sept 2017	Cyber Crime Table Top	SWAST Exercise Connecting January 2018	PREVENT WRAP – Scheduled January – March 2018
	Major Incident Response – Mass Casualty 1st March		Loggist Refresher Training and Loggist new 6 sessions in 2018
	Major Incident Response – Mass Casualty Recovery 19th April & 7th June		CBRN & PRPS Training 3 sessions in 2018
			Counter Terrorism Awareness Sessions 11th April 2018

7. Partnership Working

Externally the Trust is embedded in multi-agency planning through the Wiltshire & Swindon Local Health Resilience Partnership LHRP. This ensures a proactive and coordinated approach to planning and sharing of best practice. The Trust participates on a regular basis on the Everbridge SWAST communications cascade as well as regular Health Community Response Plan activities such as Exercise Bugle, and actively works on the LHRP task and finish groups where appropriate. In 2017 we further engaged our partnership working through peer reviews at the live CBRN exercise and with Dorset, Wiltshire Fire & Rescue during our ward evacuation exercises in August and with the coordinated planning of the modular response tool iRespond which is being implemented across the Health economy in Wiltshire.

8. Identified Gaps in EPRR portfolio & Next Steps

Gaps	Action	Date
Testing of our internal cascade procedures	Commence once the bleep system has been commissioned	February 2018
Maintain our volunteer pool for Loggists and the Rapid Response Team	Ensure we have scheduled regular refresher training sessions	Sessions booked throughout 2018
Update our MI Plan, Burns Plan & Pandemic Flu Plan	All plans are currently live and have a planned extension on the live date – work required to complete the updates following the reconfiguration works	Complete by March 2018

FFP3 Fit Testing – formal records and compliance difficult to review	Now being reviewed through the Winter Resilience Assurance Group	
Maintain compliance against the core standards and improve on these minimum standards	To ensure we maintain full compliance at the next Core Standards CCG Confirm and Challenge meeting	August 2018
Continued roll out of iRespond (modular planning & response tool)	Cascade to Wards now to expand to all departments	April 2018
Forge links with the Wessex network of the LHRP, to ensure a consistent approach for response to an incident linking the Trauma Centre and Units	Continued participation in regional exercising, building on links with partners at other organisations	2018

9. Summary

Based on the National RAG status for EPRR compliance SFT have been rated by Wiltshire CCG and NHS England as 'Full' compliance and were commended for the work that has been undertaken in the last year. As a category One responder we are meeting our civil protection duties under the Civil Contingencies Act (2004).
Full compliance means that arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve.

10. Recommendation

The Trust Board is asked to support the ongoing work required to fulfil our EPRR duties and responsibilities, and to agree this full compliance statement by signing off this annual EPRR assurance report as part of the NHS England assurance process.

Report to:	Trust Board	**Agenda item:**	**SFT 3963**
Date of Meeting:	4th December 2017		

Report Title:	Trust Strategy			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Director of Corporate Development			
Executive Sponsor (presenting):	Director of Corporate Development			
Appendices (list if applicable):				

Recommendation:
The Board are asked to consider the final draft of the Trust's strategy which will then form the basis for the Trust's future planning

Executive Summary:
The latest version of the strategy includes: 1. The main strategy document 2. Examples of the detailed plans to be completed 3. Proposed governance approaches, ie quarterly updates on progress to Boards, with individual sub-committees reviewing progress on projects more frequently

Introduction

In an extremely challenging environment for healthcare, Salisbury NHS Foundation Trust has to change and adapt to ensure that it is adequately equipped to face the challenges of the next five years. We have written this strategy document, *Shaping the Future*, to set out how we see Salisbury NHS Foundation Trust will work with other partners to respond to the many changes and challenges facing local health services and to set out what our ambitions and priorities are in taking forward our ultimate aim of delivering

An Outstanding Experience for Every Patient

In seeking to deliver an outstanding experience, patient safety must be and will be our first priority providing safe, high quality care to our patients which meets their individual needs and expectations and which values theirs and their relatives' time. We want every patient to have an **outstanding experience every time**.

Meeting the needs of the local populations requires all healthcare organisations to work effectively together. Underpinning our strategy is a belief that SFT must progress in partnership with others – with primary care providers, with social services, with other hospitals and with those that oversee the delivery of care and above all by listening to our patients themselves. We will work with other organisations to take a 'population view', managing patients across organisations to achieve the best outcomes both for individual patients and for the population as a whole.

We are privileged to have a high quality and committed workforce. Sustaining that workforce in terms of numbers and quality will be vital over the next five years. We hope to see more of our staff working across care pathways that would be recognisable to our patients, and particularly in and close to our patients' homes. This will mean a workforce that can work across organisations with more staff from other organisations working on the hospital site. That way we can share skills, expertise and understanding of the wider health and social care system.

As both a care provider and the biggest employer in South Wiltshire we recognise our importance to the community and our responsibility to serve it and contribute to its prosperous development.

We have an immediate financial challenge that we must address, and we must tailor our aspirations accordingly. We are undertaking a major financial review to ensure that we can achieve financial sustainability in the longer term. This strategy document describes what we aspire to do, but also what we must do to ensure that we have a sound future financially. That will involve some transformational change projects which will fundamentally alter the way services are provided, how we approach our business and how we use our resources.

We hope that you find this document instructive. In the meantime Salisbury NHS Foundation Trust is on an important journey with its partners to deliver the ambitions and aspirations outlined in Shaping the Future. We hope you will support us on that journey.

Chairman CEO

Our Vision and Values

Our Vision

Our vision for Salisbury Foundation NHS Trust is to provide:

An Outstanding Experience for Every Patient

We will deliver our vision through **collaborative partnerships**, working with other organisations to deliver high quality services that improve the health of the community we serve through:

- A relentless commitment to safety in all the care that we provide
- Achieving a *Good* rating from the CQC, working towards an *Outstanding* rating
- Formulating and delivering on a plan for financial sustainability
- Developing a clear vision for how we will transform health care locally with our partners
- Recruiting and retaining the highest quality staff and developing them to work in effective teams
- A focus on quality improvement – giving all clinical staff the tools and the freedoms to improve services at a local level. **Outstanding every time** will be our watchword.
- Developing a plan to transform the estate to meet the needs of clinical services more effectively, with a focus on providing facilities for the frail elderly, reducing the impact of emergency care on planned services and using our land in the most productive way for the organisation and the whole community
- Using technology to assist patients to manage their health and designing systems which promote the sharing of clinical information and add value to clinicians
- Helping patients to manage their health and be responsible for their own wellbeing
- Achieving the best outcomes for our patients efficiently and effectively within the available resources Always learning – from others, from ourselves, and from where we get it right…and where we don't
- Fostering enjoyment at work – health care is a vocation for our staff, and we want staff to value and be valued for the contribution they are making
- Being more consistent - getting it right the first time and every time
- But above all, a sustained focus on patient experience – personalised care that values our patients' wishes and is tailored to their needs

Our Values

We have an established set of values and behaviours which were developed with our staff. They describe the characteristics we want Salisbury FT to be known for and represent the foundations on which we seek to deliver on our vision and strategic priorities.

There are four core values each of which describes behaviours that demonstrate those values and are what our staff, our patients and the Trust as a whole, would be expecting to see in practice:

Patient Centred and Safe – Our focus here is on patient safety, team work and continuous improvement.

Professional – Our focus is on being open and honest, efficient and acting as a good role model.

Responsive - Our expectation is that staff will be action orientated, with a "can do" attitude and that they innovate, take personal responsibility and listen and learn.

Friendly - We expect our staff to be welcoming, treat people with respect and dignity and value others as individuals.

Equality & Diversity

We support the local Equality and Human Rights charter and value the diversity of local communities. Our aim is to provide services that recognise, understand and respond to the experiences and needs of all our diverse populations so that there is equality of opportunity to access and benefit from co-ordinated and appropriate services.

Salisbury Foundation Trust adheres to the standards set out in the Workplace Race Equality Standard (WRES) national guidance. We produce and publish our baseline WRES data and have an updated action plan that is annually reviewed. The Trust publishes its data and action plan every August under the Equality, Diversity and Inclusion hospital website pages, in a transparent and easy to access template. This area of work is led by the Trusts Head of EDI (Equality, Diversity and Inclusion), supported by the Trust's EDI Strategic Committee, which reports directly to the Trust Board.

Partnership working

If we are to address the challenges facing the whole health economy we will need to work effectively with others. We have to work as a system, not as a series of loosely connected separate organisations or individuals. We must reach out to work with partners within a system which cares for a patient in the place most appropriate to their needs. We must link up with other acute hospitals to provide services which have sufficient highly skilled staff to be sustainable and resilient. And beyond that we should work with health and social care providers to develop people, providing staff with attractive opportunities which enthuse them and which will encourage them to remain in the locality.

In summary

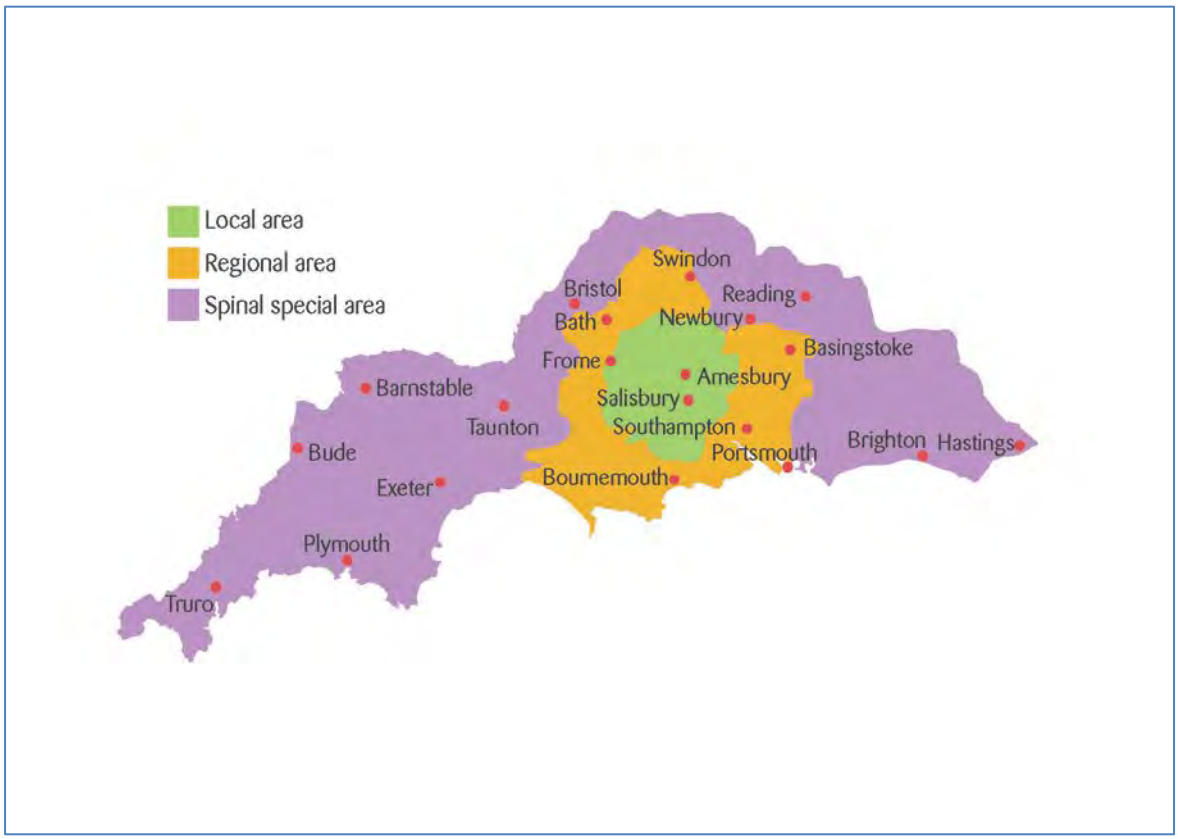

An outstanding experience for every patient
Local services
We will meet the needs of the local population by developing new and improved ways of working which always put patients at the centre of all that we do
Specialist Services
We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population
Innovation
We will promote new and better ways of working always looking to achieve excellence and sustainability in how our services are delivered
Care
We will treat our patientsand their families with care, kindness and compassion and keep them safe from avoidable harm
People
We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams
Resources
We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources
Outstanding every time
Patient centred & safe
Responsive
Friendly
Professional

Strategic Context

Salisbury NHS Foundation Trust

Salisbury NHS Foundation Trust (SFT) is a well-established acute Trust with a track record of high quality care and delivery of performance targets. It provides a broad range of acute district general hospital (DGH) services for the local population alongside a portfolio of specialist services, such as burns and plastic surgery, the Duke of Cornwall Spinal Injuries Unit and the Wessex Genetics Laboratory, to a wider catchment. This service mix distinguishes SFT - at one level SFT is a local acute hospital service embedded in the local community, yet its specialist services enjoy a national reputation and reach which extends across much of southern England. The two elements are interdependent – neither are able to prosper without the contribution of the other.

The Trust has a core catchment population of around 250,000 people to whom district general hospital (DGH) services are provided. Our specialist services as a provider of regional services to a population of two million and supra regional services extend to a population of approximately eleven million people.



The Local Context

About two-thirds of SFT's patients come from Wiltshire. The population of Wiltshire is growing markedly – it is expected to increase by about 6% (from a figure of 492,000 currently) by 2030. The 2016 joint strategic assessment estimates that between 2014 and 2023 the number of people living in Wiltshire aged over 65 will increase by a quarter and the over 85 population is predicted to grow

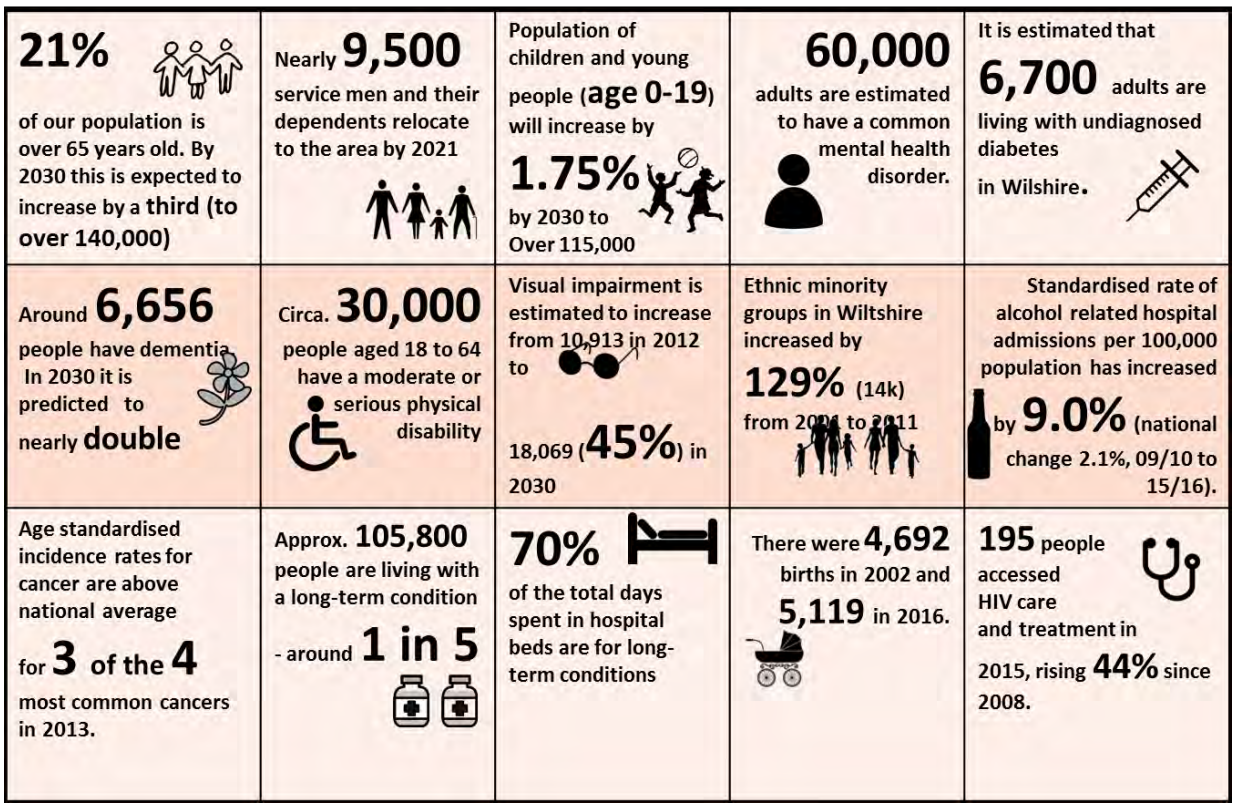
by one third. The Wiltshire population is already older than the England average - there are 0.8% more people aged over 75 years than the national average. This gap is expected to widen because the population of people aged over 65 is growing at a faster than average England rate; between 2016 and 2026 there will be a 27.3% increase in the number of people aged 65. By 2026 the number of people over 65 years old will account for 22.5% of the total Wiltshire population compared to 18.9% at the current time.

In younger age groups, the expectation is that the number of children (under 19) will remain largely constant over the next decade with the exception of a one off increase as a result of the army relocation (see below). The population in the 30-55 bracket is expected to reduce over the next decade.

This trend indicates a continuing shift in demand for older persons medicine with a focus for community services in targeting areas such as cardiology, respiratory and infections including urinary tract infections to mitigate the risk of increased admissions, and SFT's strategy, in working with its partners, will need to reflect this.

The total population and the age of the local population is changing, but as people live longer it is a major challenge to health services, and to the population, to ensure they live longer in better health. Health promotion and the prevention of illness have to become a bigger focus for health services, with incentives developed to enhance healthy living and healthy lifestyles.

The extent of the challenge already is underlined by the graphic below which summarises a number of indicators for the population of Wiltshire:



Military Population

In 2019 there will be a substantial increase in the local military population and their dependents as service personnel return from bases in Germany to return to Wiltshire, particularly in Tidworth and Ludgershall. The current predictions are that the following numbers will relocate to Wiltshire:

5,180 service personnel

1,813 spouses

2,357 dependents.

The moves will happen in July 2019 and therefore are expected to have no impact until the following year. However in 2020/21 and subsequent years the impact projected by Wiltshire CCG and Wiltshire Council is quite marked (this data is being tested and challenged):

Table 1 – projected impact on SFT activity from Wiltshire CCG arising from the military rebasing

SFT overall impact	Baseline Activity 17/18	Growth 17/18-19/20	Overall Percentage Change	Annual Growth
A&E Attendances	34,693	1,642	4.73%	2.37%
OP 1st Attendances	53,155	1,782	3.35%	1.68%
OP Fup Attendances	89,916	2,976	3.31%	1.65%
OP Procedures	31,454	855	2.72%	1.36%
Day Case Spells	15,056	467	3.10%	1.55%
IP Elective Spells	2,994	119	3.97%	1.99%
Emergency Spells (Excl Maternity)	15,640	1,083	6.92%	3.46%
Regular Day Case	6,840	93	1.36%	0.68%
Maternity	4,310	186	4.32%	2.16%

The National Context

In the NHS Five Year Forward View (5YFV) and the subsequent document setting out the next steps for the 5YFV, a clear sense of the national priorities is outlined:

Urgent & Emergency Care

To ensure urgent and emergency care services are available 24 hours a day, 7 days a week at a time of growing demand. In response to this challenge, the priority is on ensuring that community reablement allows for more patients to be discharged from hospital beds to allow for effective emergency patient flow. In addition more alternatives for attendance at ED will be developed, with a particular focus on the development of urgent care hubs and alternative handling of urgent and emergency calls.

General Practice

Placing a focus on ensuring that patients can secure a convenient and timely appointment, the emphasis is on recruiting sufficient primary care staff, including GPs and nurses, but also pharmacists and mental health therapists.

Cancer Treatment

To ensure that patients receive timely care, the emphasis is particularly on the early detection and identification of cancer. Greater use of genomics will enable both early identification of those at risk of developing cancer and for determining the best treatment options for a patient's particular type of tumour.

Mental Health

Ensuring parity of esteem for mental health services is an important priority and will see an expansion in provision of psychological therapies for common mental health conditions and in the provision of mental health liaison teams in secondary care, as well as more therapists in primary care.

Care of the Frail Elderly

Given the demographic changes described elsewhere, it is clear that helping frail and older people to stay healthy and independent is a massive challenge and should form an important part of the Trust's strategy. The national focus is on ensuring better integration of services – around GP, community health, mental health and hospital services, and linking in more effectively with care providers and care homes.

Service Integration

Increasingly there is a challenge to integrate services and integrate funding to deliver greater benefit for patients and deliver more value for the public purse. This will see commissioners and providers, as well local authorities and the voluntary sector working together to take a population view of local health needs and working in an integrated fashion to meet those needs.

Efficiency and Effectiveness

As the NHS seeks to meet the challenges described above, there remains the further challenge to ensure that services continue to improve in terms of efficiency and of effectiveness. As such the 5YFV sets out a ***NHS 10 Point Efficiency Plan***:

1. Free up to 2000 to 3000 hospital beds
2. Reduce costs from temporary staffing costs and improve productivity
3. Use the NHS' procurement clout
4. Secure best value from medicines and pharmacy
5. Reduce avoidable demand and meet demand more appropriately
6. Reduce unwarranted variation in clinical quality and efficiency
7. Better use of estates, infrastructure, capital and clinical support
8. Reduce the costs of corporate and administrative services
9. Collect income the NHS is owed
10. Financial accountability and discipline for all NHS organisations

Sustainability and Transformation Plans

The Bath & North East Somerset, Swindon and Wiltshire (BSW) STP covers a population of c.0.9m people, living within the three unitary council areas. The STP established as a vehicle for accelerating progress at the level that delivers the best outcomes and experience for our citizens. Only those challenges that are most effectively dealt with at a footprint level will be addressed through the STP. The STP has determined that it will focus on 5 key priorities for change:

1. The development of locality-based integrated teams supporting primary care
2. Shifting the focus of care from treatment to prevention and proactive care
3. Redefining the ways we work together to deliver better patient care
4. Establishing a flexible and collaborative approach to workforce
5. Further enabling acute collaboration and sustainability

Within this overall context, the STP will particularly focus on care of the frail elderly and mental health, aiming to ensure parity of esteem.

Within neighbouring STPs, Hampshire and Isle of Wight's plan highlights the need to reduce delays in discharging patients from hospital, the need to ensure people live longer in good health by focusing more on health promotion and giving people more information on their health conditions and the role that lifestyle plays. In Dorset, similarly, there is an intent to deliver on a Prevention at Scale programme to help people stay healthy, with the development of integrated community services to provide access to local high quality services with a One Acute Network programme to deliver the more specialist care across the county.

Our Challenges

The biggest challenges the local health economy faces are demographic, whilst for SFT the most significant challenge by far is ensuring a return to financial stability whilst maintaining the quality of care. The emerging financial recovery plan is described below, whilst other challenges impacting on our strategic priorities include:

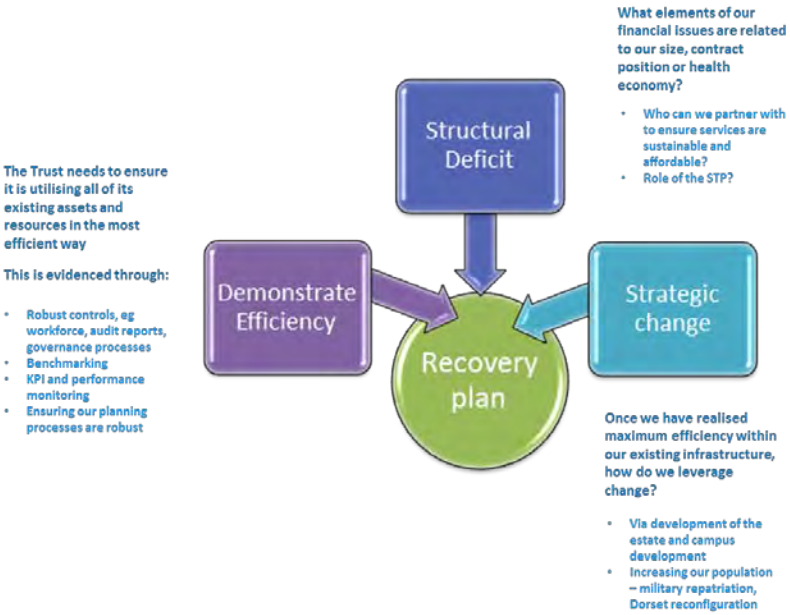
- Our ability to recruit the staff we need, particularly in light of projections for newly trained staff, as we begin to feel the impact of Brexit, the difficulties recruiting from abroad and the changes to bursary entitlements
- Challenges within primary care, with increasing workload and recruitment difficulties
- Social care challenges – availability of sufficient provision in the community, eg reablement services, domiciliary care, nursing and residential care capacity
- Increased regulation resulting in higher overhead costs
- Providing services which can be sustainably delivered to a consistently high standard

Financial Recovery Plan

Salisbury NHS FT's financial situation has been deteriorating over a number of years, which is reflected by the underlying position which sees an underlying deficit of £10m or approximately 5% of turnover. In recent years the Trust has relied on a number of non-recurrent actions and technical

adjustments to deliver on its annual financial plan, and these one-off solutions are now largely exhausted.

Given the scale of the financial challenge facing the Trust, a financial recovery plan is being developed to put the organisation on a sustainable financial footing. It will have two main strands. Firstly it will focus on how the organisation can best deal with current issues such as increased agency expenditure and how we ensure we use our capacity to the full. Secondly there will be a longer term view examining schemes by which we can transform the ways services are delivered to improve our efficiency and productivity and improve on the safety and quality of care provided. As a result some of the developments proposed in this strategy, where there is an ongoing financial impact, may either be delayed until the financial position has rebalanced or will require supporting reductions in expenditure elsewhere.



To help guide the Trust in its long-term approach a high-level benchmarking analysis has been completed which provides a clear view of where we may look to meet the challenge most effectively. A level of potential opportunity has been identified and this is now being assessed in more detail to determine which schemes are developed further. The main areas include:

Initiative	Key issues	Scale of Opportunity
Inpatient flow	Reducing length of stay across a range of specialties, enabling the reduction of the bed base	£3m
Improved theatre utilisation	Increasing theatre utilisation across all theatres and improving booking of theatre lists	£2.5m
More detailed coding	Greater interaction between clinicians and coders to ensure that the full range of coding, including all co-morbidities, is captured	£0.5m

Initiative	Key issues	Scale of Opportunity
Improving clinic efficiency	Refining booking processes to improve clinic utilisation rates, reducing the number of patients not attending for clinic by improving information provided	£3m
Temporary workforce reductions	Reduce the number of agency staff employed across all disciplines	£5m
Estates	Reduce the cost of managing the whole estate	£1m
Corporates	Reduce the cost of managing the organisation, increasing income into the hospital (eg laundry, payroll, procurement)	£4m
High cost medicines	Bring the cost of high cost drugs down in line with benchmarks	£0.6m
Shared pathology network	Working collaboratively across the Wessex region	£1m?
Radiology opportunities	Improved utilisation, impact of 2nd MRI scanner	£1m
Therapies	Therapy led changes	£0.5m
Procurement gains	Further improvements to the Trust's ability to reduce costs through its purchasing power	£5m

All these schemes are being worked up in more detail to determine the exact level of opportunity, but where opportunities exist for immediate financial and operational benefit, these are being adopted. The Board is committed that these opportunities will contribute to, rather than have an adverse impact on, the quality of services being provided. Many of the schemes described in outline above are consistent with the priorities described in the rest of this document. For all schemes quality impact assessments will be undertaken to ensure that quality of care is maintained.

In Summary

The table below summarises an analysis of the Trust's strategic position in the form of a Strengths Weaknesses Opportunities Threats (SWOT) analysis highlighting our strengths and weaknesses as an organisation, and setting out some potential opportunities and threats.

Strengths	Weaknesses
Strong local community support –positive reputation locally, great warmth shown to hospital, support for Stars, large number of volunteers **Organisational culture and values** – positive culture identified and valued, eg CQC **Financial control** – low Relative Cost Index (RCI) **Specialist services** – plastics, burns, spinal injuries, genetics, rehabilitation underpin DGH with catchment extending across Southern England **Performance benchmarks** – national audits, 7 day working, performance in upper quartile for many standards **Research & development** – high recruitment to trials for hospital of our size **High quality staff** – good engagement, low turnover **Innovative practice** – deployment of new techniques and approaches as reflected at *Pride in Practice* event. Examples include: HOLEP, FISH, GS1 **Entrepreneurial approach** – willingness to engage in areas outside of typical NHS activities to improve services for patients and increase income.	**Catchment population** – mid-sized acute Trust in rural setting, clinical and financial sustainability **CQC Assessment** – Trust classified as *requires improvement* **GP Relations –** increasingly challenging as reflects pressures in primary care **Demographic shifts** – leading to large increases in emergency demand **Stranded patients** – large numbers of patients staying in hospital longer than their clinical need warrants **Low income growth** – income recovery for work undertaken (eg plastics), impact of reducing tariff **Rural location** – transport / time for patients (and staff) to travel to main hospital **Recruitment** – ability to recruit new staff across a range of groups **Talent management** – perceived that limited opportunities for development, identifying future senior leaders **Technology** – not securing sufficient leverage from new technologies
Opportunities	**Threats**
Clinical networks – enhance our role and develop closer links with other organisations (Southampton, WH&C) and emerging LETBs/AHSNs **Increasing partnership development** – work with other providers to deliver services more effectively, eg health & social care integration, WH&C **ACS /STPs** – working with other partners to secure health economy wide benefits, eg to manage whole pathways more effectively **Specialist services** – enhance services, extend catchment, develop rehabilitation **Improve care pathways** – esp. elderly patients, integrated care **New leadership team** – establishment of Board, clinically led leadership model. **Patient engagement** – working with local residents to co-produce new services. **Site changes** – re-use of estate, reconfiguring the bed based to support new ways of work **Improve CQC rating** – reputational and morale impact of an improved assessment	**Financial challenges** –overall income reduction, leading to underlying deficit with limits on cash and ability to use capital to achieve change. **Clinical sustainability** – commissioning changes re designation, ability to staff on-call rotas **UK departure from EU** – impact on recruitment and the increasing cost of goods **Impact of national changes on recruitment** – loss of bursaries, new contractual arrangements leading to inability to recruit **Workforce planning** – lack of suitably qualified staff, especially clinical, given the Trust's ageing workforce. **Genetics tender** – potential impact on local laboratory **CQUIN targets** – increasingly challenging standards with consequent risk for income and reputation if not achieved **Different landscape** - impact of 5YFV on future direction for DGHs

Future Capacity Requirements

Bed Modelling Requirements

An initial, high level view of the bed requirements which will be required over future years has been undertaken. Using data from April 2014 to August 2017, the model forecasts future bed requirements based on previous seasonality and expected changes in population, especially in the light of substantial house rebuilding to the north of Salisbury. At the current time, it includes assumptions for the projected increase in demand arising from the military rebasing, and assumes the same level of growth has experienced over the last two and a half years. It does not, as yet, make any assumptions about changing operational delivery methods, for example as a result of the ward reconfiguration projects.

Table 2 – Projected Acute Bed Capacity Requirements

Financial Quarter	Demand	Capacity	Variance
Q1 18/19	364	377	13
Q2 18/19	339	377	38
Q3 18/19	349	377	28
Q4 18/19	367	377	10
Q1 19/20	380	377	**-3**
Q2 19/20	356	377	21
Q3 19/20	372	377	5
Q4 19/20	392	377	**-15**
Q1 20/21	383	377	**-6**
Q2 20/21	362	377	15
Q3 20/21	383	377	**-6**
Q4 20/21	404	377	**-27**

Table 2 shows that there will, on current demand projections, be a growing need for acute beds, especially acute medical beds. The Trust will need to plan to expand by at least one further acute medical ward by the winter of 2019/20 unless care models can be developed which reduce demand for non-elective admissions and provide for substantial reductions in length of stay. More detailed bed modelling and hospital planning will be undertaken in 2018 as part of the hospital redevelopment programme described below.

Our Priorities

Introduction

In the pursuit of delivering on our commitment to offering an outstanding experience, we have agreed on three strategic priorities which describe what we must do and three enabling priorities which will help us in creating an organisation capable of delivering on our vision. For each priority we describe what we are trying to achieve, the key areas we believe will contribute to delivering the priority area and the measures by which we will judge our success. In Appendix 1 we define in more detail the steps we will be taking to deliver on the priorities outlined in this section.

Strategic Priorities

We have agreed three strategic priorities reflecting our **commitment to delivering an outstanding experience for every patient** which will allow us to transform the services we offer, linking more effectively with other services patients are receiving to deliver a real health gain for the communities we serve.

Those strategic priorities are:

Local Services

Our Priority

Our aim is to meet the needs of the local population by developing new and improved ways of working which always put the patient at the centre of all that we do.

What we mean by this?

We will provide a comprehensive range of **local** general hospital services which reach out into the local communities we serve. We will manage the care of patients with long term conditions in teams which span across the community – working with GPs, community health and social care teams to keep patients out of hospital unless admission is absolutely essential, and working with the same teams to discharge patients effectively when they no longer need to be in hospital.

We will care for patients as close to their homes as possible and as linked teams – the patient need neither know nor care which organisation staff work for, only that the **local** service is caring for them with a clear treatment plan and that all staff know the next steps in that plan.

We will ensure that our services evolve to meet future needs. We are reconfiguring our wards to ensure that there is sufficient capacity for medical patients to reflect demographic changes. We are looking to separate elective and emergency care so that the peaks of emergency cases do not impact so significantly on planned workload. Only by improving flow through the hospital can we ensure that we meet the needs of our patients for access to prompt, responsive and safe care.

We will do this by:

- Working with our partners to evolve new care pathways across organisations which manage patients according to their clinical needs in the location and manner most appropriate for those needs with an early focus on the frail elderly and patients with long term conditions
- Development of community based frailty services which manage patients care through specialist multi-disciplinary team community services
- As part of the long term campus project creating a step down unit for frail elderly patients who no longer require acute care
- Implementing new systems in the Emergency Department to improve flow, with an emphasis on early intervention and senior decision making.
- Making our acute emergency services more responsive and enabling clinicians to prevent admissions by expanding the ambulatory capacity on our medical assessment unit, by increasing the proportion of emergency care provided by general acute and elderly care physicians, and by offering more rapid access clinics, by creating a community hub at the hospital which will work to avoid admission to acute care
- Develop with partners a series of initiatives that has an absolute imperative that patients stay no longer in hospital than their clinical needs require
- Reducing access times for urgent and planned services so that patients receive prompt, responsive care. To include reduced waiting times for follow up appointments.
- Offering more care on an ambulatory basis – reducing need for patients to stay in hospital overnight, eg planned emergency surgery, ambulatory gynaecology, use of intravenous sedation and regional blocks
- Providing more flexible outpatient services, eg one stop clinics, virtual clinics, communications via technology rather than face to face consultations, evening clinics
- More outpatient clinics provided on an outreach basis in the community, eg in response to the increasing military population. Support the development of GPs with special interests in a number of specialities, eg in cardiology to provide increased medical resource and senior decision making to the acute service and the community service as it develops
- Improving access to our specialists for primary care – provision of advice and guidance services, greater joint working,

Patient Story

Doreen has Parkinson's disease. She had been in hospital for some time but when it was agreed that she no longer needed medical care her family and healthcare professionals felt that the best place for her to be discharged to was an intermediate care bed in a residential home. Doreen was determined that she did not want this and that she wanted to go home, so a trial period at home was agreed to assess her needs. Initially the hospital Early Supported Discharge (ESD) team bridged the gap for morning care then handed over to the community team - Help to Live at Home. Doreen remained at home with 24 hour care. The ESD team undertook joint visits with the community therapists and her GP to coordinate her ongoing needs.

Subsequently the ESD team supported Doreen's husband in his own hospital admission. He was very pleased to see the team during his admission as he found the familiar faces extremely re-assuring. Doreen and her husband were determined that they wanted her to remain at home. By working with Doreen and her family across the boundaries of our local organisations we were able to join up her care and support and empower Doreen's family to ensure that her care needs were assessed and met in her chosen environment.

Six months later Doreen had to come back into hospital but because she was well known to the teams they knew Doreen's usual condition and her, and her loved ones' aspirations for her to return home. Doreen was discharged home with ESD support quickly improving her mobility and working with her GP, the community teams and Age UK to manage her at home, including trips to the local lunch club.

How will we recognise success?

- 60% of medical patients discharged directly from the acute medical unit and acute elderly unit
- Delayed transfers of care reduced to 5% of the total bed base
- Average length of stay for non-elective admissions reduced by 2 days
- Reduction in cancelled operations back to 15/16 baseline (10 cases per month)
- Main access targets delivered (ED, RTT, cancer), reductions in waiting times for follow up appointments
- Planned orthopaedic activity increased by 10%
- An agreed plan for the development of the estate with a clear funding route
- Reduction in readmission rates by 5%
- Increased discharges to patients' normal place of residence – as more patients are cared for in the community

Specialist Services

Our Priority

We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population – more than 11 million across Southern England for the Spinal Centre and over three million for patients across Wessex for burns and plastics, cleft lip and palate, genomics and specialist rehabilitation services.

What we mean by this?

Our ambition is to build on decades of outstanding regional and supra-regional services which remain an essential element of the portfolio of services provided at Salisbury. The level of expertise and specialism is second to none with outstanding microsurgical techniques, management of patients with serious burns, cancer care, reconstructive surgery (eg cleft lip), care of the spinally injured and the provision of a genetics services as part of a wider collaborative. In particular the plastic surgery service plays a vital role in the major trauma service for Wessex, with a surgeon present on site in Southampton every day to provide reconstructive input for major trauma cases. In addition the specialist services allow our local services to provide a level of care beyond the remit of a typical local hospital eg complex cancer reconstructive surgery, urology treatments for patients with spinal cord injuries, the close working relationships with tertiary colleagues from University Hospitals Southampton (eg for paediatrics).

Our focus will be on

- Delivering the capacity to allow the plastic surgery service to keep elective and trauma work separate to ensure that all aspects of care are provided to patients quickly and effectively
- Taking the lead for provision of plastic surgery across the Wessex area, playing the lead surgical reconstructive role for the major trauma centre
- Development of the Salisbury Skin Service providing outstanding care across dermatology and plastic surgery to manage increasing demand for skin cancer treatment
- Building up the reconstructive service provided to military personnel who have suffered major traumatic injury
- Developing new care pathways for babies with cleft lip and palate and their families to improve experience ensuring timely interventions and improved experience
- Reconfiguring the care pathway for spinal cord injured patients
- Subject to a Board approved business case, bidding with other genomics providers as a collective to be a genetics central hub laboratory

Patient Story

Earlier this year, Jo suffered a serious burn injury when her clothing caught alight after coming in to contact with a gas fire in her home. She was brought to the Emergency Department at Salisbury District Hospital. This was to be the beginning of a 6 month journey to recovery that involved the entire burns multi-disciplinary team.

Jo had sustained deep burns that covered 26% of her body. After a short period of stabilisation in the Emergency Department, Jo was taken to the Plastics and Burns Unit where specialist burns nurses cleaned her burns and applied dressings. Her condition was monitored closely by doctors from intensive care and the burns and plastics team. Jo required skin grafts to help her burns heal. Over the months that followed, she met the physiotherapists and occupational therapists who supported her with her first steps to recovery. The dietician ensured she received nutritional support to enable her wounds to heal. The pain team helped to ensure she was comfortable. The psychologist supported Jo through her treatment and fears for the future.

Just over 5 months after her injury, Jo was discharged home with support from her local district nurse and the rehabilitation team. She continues to attend the burns dressing clinic and has been referred to the scar management team for on-going management.

How will we recognise success?

- Reduced access times for both planned plastic surgery cases and for trauma cases
- Take the lead the delivery of a network based plastic surgery service across Wessex
- Compliance with national burns standards
- An agreed care pathway for spinally injured patients with patients clear on rehabilitation outcomes and the next steps to achieve those outcomes
- Reduced length of stay within the Spinal Centre
- Agreed investment plan for reconfiguring the Spinal Centre
- Continuing to support the delivery of supra-regional genetics services through collaborative partnerships
- Patients and families have a clear understanding of their clinical pathway/s including key interventions, timescales and desired outcomes for the treatment of cleft lip and palate.

Innovation

Our priority

We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered making a positive contribution to the financial position of the Trust.

What we mean by this?

We will listen and learn from clinical evidence and best practice engaging in national initiatives and programmes and participating in clinical research to benefit our patients offering them access to new and better treatments. We will be innovative in how we develop commercial services which provide a financial benefit to the organisation.

We will

We will ensure that opportunities for delivering excellence is at the forefront of what we do and is reflected in our programme of quality improvement. We will equip our workforce with the skills for participating in, and leading, quality improvement and innovation programmes consistently at scale. We will continue to look for opportunities to develop ways of increasing non-clinical services at the Trust where they will benefit us financially.

We will ensure opportunities for innovative new clinical pathways are provided for locally, to ensure improved outcomes for patients. For example the management of enlarged prostate through a new laser technique which requires far less invasive surgery and extending the early supported discharge services which are helping patients return home more quickly.

We will continue to seek out best practice from other parts of the NHS which can be adopted in our hospital, for example the use of colour coded mobility aids to provide the correct assistance more quickly; participation in national initiatives such as *end PJ paralysis* which helps our patients get up and get dressed to assist their recovery; the use of biosimilars which combine effectiveness and value for money, and Breaking the Rules, inviting our staff, patients and carers to help us to remove systems and processes which hinder an outstanding experience.

We will adopt new practices to transform our services improving patient safety, increasing clinical productivity and driving operational efficiency. The transformation agenda will touch all areas of our business as we review all that we do to ensure that every activity undertaken is required, that it is carried out by the most appropriate member of staff, at the right time in the correct sequence to provide an outstanding experience and outcome.

We will continue to invest in the creation of new products and equipment developed by our staff supported by our innovations team.

Innovation Example

The Trust is one of six hospitals across the country introduce GS1 standards to provide a consistent means of identifying and tracking patients, equipment, medications, equipment and locations across the organisation. Here is what one clinician said about the system:

> "Knowledge is power – not only does this provide us with a level of data and insight that can be used to better challenge clinical practice and variation, helping us to reduce inefficiencies and improve patient experience and outcomes – more importantly it ultimately helps to safeguard our patients from avoidable harm. In the event of a product recall, we can now easily and quickly track an affected product to the right patient."

How will we recognise success?

- Agreed programme of care pathways designed locally with others (GPs, community teams, social care) using evidence on best practice to improve the care provided
- Reviewing our business processes to ensure that they are effective, and that they make best use of our resources, especially scarce clinical resources
- A consistent approach to quality improvement used by all levels of the organisation with measurable outputs
- Identifying and developing leadership talent
- Outcome measure for research
- Increased contribution from commercial activities, eg My Trusty, Laundry, Scan 4 Safety consultancy
- Implementing the new prosthetic treatment for nasal speech for children with cleft lip and palate
- New innovative procedures in place, eg systems to prevent pneumonia, arterial connecting systems, point of care testing introduced for identifying more rapidly conditions such as flu and norovirus, introduction of improved test for bowel cancer screening programme
- Fewer patients coming to clinic to be seen – more managed in primary care, more virtual outpatients, conversations between clinicians to manage patients differently. Also reducing follow ups – see and treat services, patients managed post treatment in liaison with primary care, use of technology to manage patients remotely (eg plans within urology for PSA tracker software)
- Explore the possibility of computer assisted diagnosis and image interpretation within radiology
- Development of ultrasound guided regional anaesthesia.
- Staff are individually recognised for their innovative work within the wider NHS
- Achievement of innovations tariff where a positive business case can be made

Our Three Enabling Objectives

There are three enabling objectives which provide the structure on which the Trust is able to deliver on its key strategic priorities – an absolute focus on high quality, safe care; working with our staff to develop as individuals and as teams; and providing services as effectively as possible.

Care

Our Intent

We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm.

What we mean by this?

First and foremost we will prioritise patient safety, reducing harm and protecting the most vulnerable. We want to provide services which reassure patients about their quality and standards of care and which are delivered with warmth, kindness and compassion at every point in the patient journey. Patients remember how they were treated, how they were spoken to, how they were made to feel safe. We must treat each patient as an individual, and the care they receive be personal and personalised. And we must value our patients' time in hospital – every minute must add value, no patient should spend more time in hospital than they need to. We will work with patients to understand their needs and preferences so that we can offer services that work for them. We will constantly seek feedback from our patients and that feedback drives how we develop what we do.

We will place a much greater focus on health promotion and prevention supporting staff to educate and empower local people to know how to keep themselves well and when to access services.

Early in the life of this strategy we will have another CQC review and our intent is to improve the rating that this hospital receives.

We will achieve this by:

- A safety first approach with a sustained focus on reducing avoidable harm through the *Sign up to Safety* initiative, with particular emphasis on reducing harm from pressure ulcers,

catheter associated urinary tract infections and from falls, and fully embedding the GROW programme within maternity

- Improving the care of the frail elderly with a focus on better identification and management of needs through the comprehensive geriatric assessment (CGA) and develop personalised care plans accordingly. Emphasis will be placed on reducing the deconditioning in our elderly patients which happens in hospital.
- Reviewing a percentage of all in-hospital deaths to establish whether they could have been avoided by problems in care, ensure learning is achieved and improvements made
- Sustaining reductions in hospital acquired infections
- Providing person centred and personalised care: with patients as equal partners in planning, developing and monitoring their care to make sure it meets their needs
- Improving our approaches to the treatment of cancer – diagnosing patients within 4 weeks of referral, improving how we care for patients who have had their primary treatment
- Promoting 7 day services where viable to do so
- Increase the range of services provided to children within the Sarum unit, and develop outreach service for children cared for in ED and Day Surgery
- Creating a culture of continuous learning and improvement – outstanding every time
- Develop a midwife-led birthing unit to provide increased choice on birth options for local families
- Delivering on our Quality Account priorities and CQUIN targets

Patient Story

Alice was admitted requiring treatment for a medical condition. She had a learning disability but at home she'd lived independently with a strong and supportive network of friends and her church. Alice's condition meant that she had difficulty understanding why she was in hospital and she refused to eat or drink. The nurses tried everything they could to help her eat; finding out from her friends what she liked to eat and making mealtimes a sociable event with friends coming in from her village to eat with her. The nurses also tried hard to make her time in hospital as fun and non-clinical as possible, taking her to the chapel and out for walks. Eventually Alice started to eat and her condition improved. Getting her home again was challenging and the multi-professional teams in hospital and the community worked closely together and she was discharged back to her own home. Recently Alice became unwell again and was re-admitted to another ward in the hospital. As soon as the original team heard this they quickly arranged for her to be transferred back to them as they knew that the relationships they had built up with her would help her recovery. It did.

We will measure success by

- Achieving a *Good* CQC rating and then working towards an *Outstanding*
- Being in the lowest decile for patient harm
- Reducing levels of hospital acquired infection rates
- Sustain below 1% the percentage of deaths where there was a 50% chance or more of death being due to problems in care.
- Measuring the outcomes of each our patient safety programme workstreams.
- Patient feedback in the top quartile as measured by national surveys and the friends and family feedback
- Having no patients waiting in hospital for discharge when they no longer need acute care
- Sustain the reduction in the number of still births and neonatal deaths

People

Our Intent

We will make SFT an outstanding place to work where everyone feels valued, supported and engaged and are able to develop as individuals and as teams'

What we mean by this?

To provide consistently high standards of care SFT must have a flexible workforce which is motivated, feels valued and empowered and shares the same values as the organisation. We will improve our workforce planning and recruitment processes to ensure we have sufficient resources when and where we need them most. Strong leadership across all levels of the organisation is crucial to maximise our potential. We must give individuals and teams the scope to grow and develop and feel empowered to transform how services are provided and make the contribution we need to deliver this strategy. We must contribute to making our workforce healthy and well at work, but above all we want them genuinely to enjoy coming to work every day.

We will achieve this by:

- Implementing a resourcing strategy which sets the direction and the proactive actions to ensure we are able to attract, recruit, deploy, retain and reward the workforce we need to deliver outstanding patient experience both now and sustainably into the future.
- Improving our use of the temporary workforce to make it more financially sustainable and responsive to the needs of the organisation.
- Establishing effective partnerships with directorates to ensure business and HR strategy are aligned.
- Delivering effective and efficient HR transactional services with streamlined and consistent processes and policies.
- Implementing support for managers through self-service with guidance and toolkits.
- Creating centres of excellence which provide leading edge, innovative HR solutions.

- Delivering a health and wellbeing strategy which focusses on proactive interventions to improve physical, mental, spiritual and financial wellbeing.
- Creating a diverse and inclusive culture where everyone feels engaged, valued and empowered and are committed to delivering excellent care.
- Developing our staff, offering opportunities to take on extended roles, enhance their skills and making sure they have excellent learning opportunities and a clear development path allowing us to develop talented individuals within the workforce. We will use talent mapping tools and techniques to identify high potential members of staff.
- Supporting staff to access development opportunities across the health system whereby staff work for the health system, not for one organisation.
- Developing clinical leadership across the Trust.
- Engaging and communicating with our workforce on the future delivery of services and their role
- Taking the time to celebrate with our staff the achievements we make and the successes we have

Member of staff story

Ever since I completed my degree in (BSc) Nursing in India, I realised I have a very strong calling and passion toward this profession. It became my dream to explore the field of nursing to extract the best out of it. I came to UK in 2006, and initially I preferred to work in community nursing homes - to start with, as those were the best opportunities to get to know the changes in practice and of course the cultural differences. Working as a staff nurse, I was always determined to make my work place the very best. To begin with raising my three musketeers and looking after my ill husband were the only targets I was focusing on.

I consider every challenge as an opportunity to take me to a place where I can advocate my ideas for improving the care I offer. Joining SDH in 2015 was a milestone in my professional life. I was helped to identify and work on my own potential to develop further. Soon I realised it was the right time for a change, came out of my comfort zone, and I believe I gracefully carried out my new role with confidence and made an impact. Never stopping for a moment since then, I became a band 6 sister for the older persons' unit within 3 months, and then stepped up to band 7 role after a further 5 months. And finally, here I am ready to open a new ward too…Achieving things which you never imagined of achieving makes you feel successful in life.

We will measure success by

- Achieving the key deliverables through the People Strategy in four areas: resourcing and talent management, health and wellbeing, business partnering and organisational development and engagement.
- Increase staff in post to ensure we spend our pay bill effectively and minimise spend on temporary workforce.
- Developing workforce plans for each Directorate to ensure effective deployment of staff and pro-active management of future workforce needs.
- Maintain staff turnover rates at between 7 to 10%
- Reduce staff absence to 3% or below
- To achieve top level staff survey rates with 80% of scores being in the top 20% or better than average and with no scores being in the worst 20%
- To achieve appraisal compliance rates in excess of 90%, and reporting in the top 20% in the annual NHS Staff Survey.
- Improve the quality of appraisals, ensuring they reflect staff development aspirations and reflect delivery of key organisational targets
- To increase statutory/mandatory training compliance rates year on year to a level of 90%
- Ensuring all managers and leaders are trained through Trustwide leadership programmes.

Resources

Our Intent

We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources.

What we mean by this?

We must ensure that we secure maximum value for the public funds for which we are custodians. We must spend wisely, minimise waste and seek to deliver the greatest amount of health gain. We will manage budgets for a population providing care where it delivers the most benefit and encouraging better value for money for the whole health economy.

SFT currently has a substantial financial deficit. By early 2018 we will have in place a plan to manage that financial position into a sustainable position over the next two years. This will involve us doing things differently, reducing demand for services and their cost and working towards a completely different financial regime of population based budgets.

We will achieve this by:

- Constructing a financial plan which describes how the Trust will secure financial sustainability, reducing its financial deficit over time
- That financial plan to be underpinned by a transformation strategy devised with a clear vision of the business change we want to achieve and how we can deliver that change
- Reduce agency spend within all staff groups

- Achieve financial savings from the introduction of new technology
- Our estates transformation scheme will unlock the potential for reducing the cost of delivering services and also generate new sources of income
- Harnessing digital technologies to make the delivery of care more effective, eg use of System1 to increase knowledge about patients' health and care outside of hospital, expanding the usage of GS1 technologies, moving towards replacing paper notes with electronic data recording, sharing data between organisations more effectively
- Undertake a series of service reviews in light of model hospital, service line reporting, the *Getting It Right First Time* initiative to determine plans for ensuring sustainability of services and maintaining high standards of care
- Extend the range of services being provided on an ambulatory basis eg upper limb trauma in orthopaedics, day case prolapse and hysterectomy procedures particularly with the new 23 hour day unit.

Improving Our Use of Resources Example

In Salisbury we have worked on a project to allow complex reports that are normally only available on paper to be visible on the PACS system. Reports of tests such as heart ultrasounds (transthoracic echocardiograms) and reports of vascular ultrasounds are now available alongside more traditional radiological reports such as CTs and MRIs. Patients with certain illness need to have their treatment options discussed at multi-disciplinary team (MDT) meetings. At these meeting it is very important that all information such as images and reports and blood test results are available to make the best possible treatment plan. MDT co-ordinators can now save time when preparing for MDTs as these results are visible on the PACS system and can easily be shown to the whole team. This has also saved the valuable time of consultants and nurses who can see these reports whenever and wherever they need to. Previously one of our chest consultants would have to send a nurse to the cardiology department multiple times during every clinic to retrieve paper copies of her patients' reports, whereas now she can see them in the system she uses all the time.

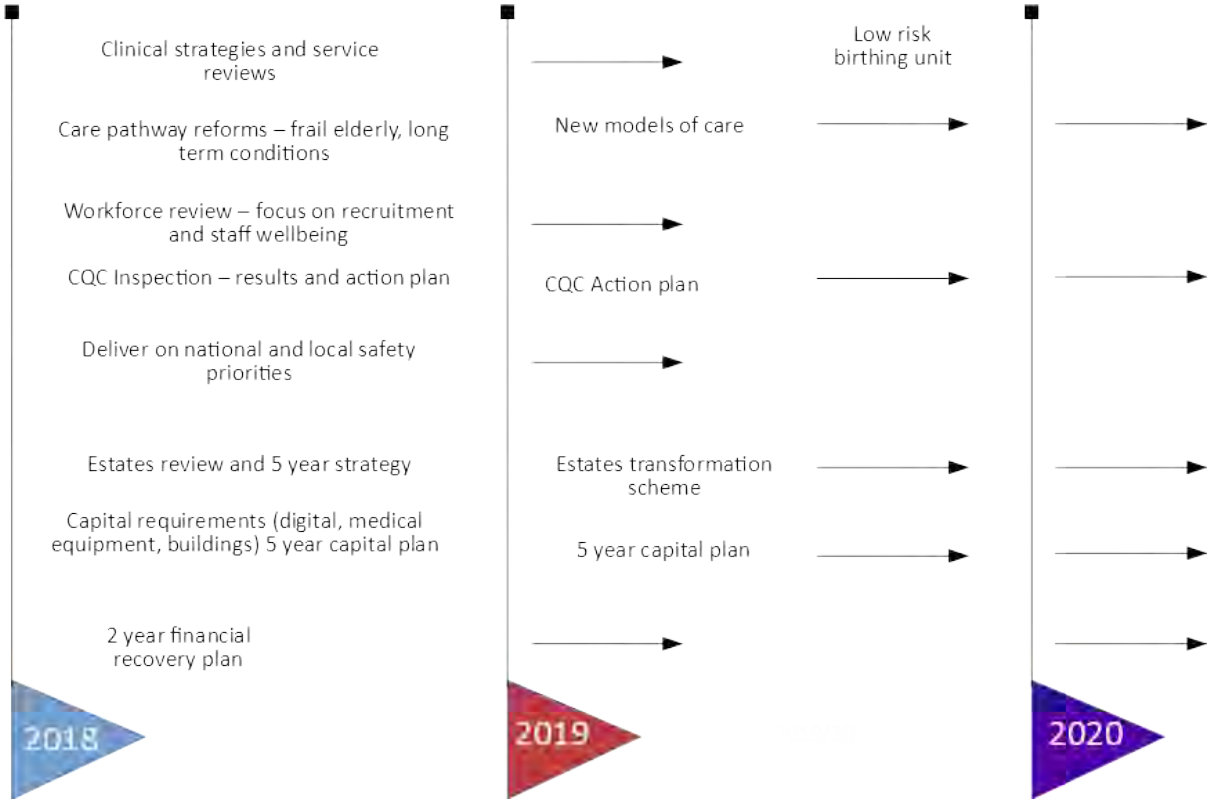
We will measure success by

- Achieve financial balance by 2020
- Weighted cost of our services substantially below the national level
- Trust services delivered more effectively than national Carter metrics
- Services reviewed against the *Getting It Right First Time* criteria and all services to be assessed against Model Hospital standards and using the outputs from service line reporting
- Outcomes from estate transformation scheme
- An agreed digital strategy setting out how the Trust will use technology to improve the quality of care, support good clinical practice, help patients manage their care and enhance the efficiency of our services

Progressing the Strategy

Governance

The full list of priority and enabling objectives are listed in Appendix A. The Trust Board will monitor progress against delivery of the strategy receiving quaterly reviews based on the detailed plans described in Appendix C. Executive Directors will report to Board sub-committes more frequently on progress as per the listing in Appendix B. The Trust's annual operational plans will be firmly based on moving forward the strategic priorities within this document.



Conclusion

This strategy seeks to set out a sustainable future for Salisbury NHS Foundation Trust. In order to manage the demand from a growing local catchment population, the services delivered by SFT must be both clinically and financially sustainable. This will not be possible without close, mutually beneficial co-operation with other local providers and with all our commissioning and regulatory bodies. In line with the *Five Year Forward View* we believe that budgets will need to be managed jointly across organisations and we will work with others in an open and transparent way to achieve this. In the first instance, however, it is essential that we establish a solid financial base and the first two years of this strategy will emphasise this. At the same time we will be working across organisations to refine and improve care pathways to provide the safest and most effective care for our local and specialist services.

Appendix A - Priority objectives

Salisbury NHS

Priority	Objective			Exec sponsor
LOCAL (FINANCE & PERFORMANCE) We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	Frail Elderly	1.1	Development of an integrated frail elderly service	COO
	Emergency Care	1.2	Implement new systems to manage the flow of emergency patients	COO
	Delayed discharge	1.3	Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need	COO
	Access	1.4	Improving access to core services to support prompt, responsive care	COO
SPECIALIST (FINANCE & PERFORMANCE) We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	Spinal Centre	2.1	Reconfiguration of spinal cord injury (SCI) pathway	MD
	Plastics	2.2	Delivery capacity to separate elective and emergency care. Lead provision of plastic surgery network across Wessex	COO
	Partnership working	2.3	Work with our partners in networks to develop care pathways for specialist services which improve effectiveness and patient experience (eg burns, cleft lip, genomics)	MD/COO/DoCD
INNOVATION (CLINICAL GOVERNANCE) We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	Research	3.1	Deliver an increased range of high quality research which directly benefits patient care and increases the level of research income earned	MD
	Improvement	3.2	Build a culture of innovation and continuous improvement adopting a consistent QI methodology	COO
	Innovation	3.3	Introduce innovative processes, pathways and to change how we deliver our services to improve effectiveness of our services and to bring additional benefit for our patients	MD/COO

Appendix A - Enabling Objectives

Salisbury NHS

Priority	Objective			Exec sponsor
CARE (CLINICAL GOVERNANCE) We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	CQC	4.1	Achieve a CQC rating of Good	DoN
	Safety	4.2	Deliver on safety priorities, both local and national	DoN
	Infection	4.3	Maintain our focus on reducing rates of infection	DoN
	End of Life Care	4.4	Review process to establish learning and improvement	MD
	Patient experience	4.5	Work with our patients to plan and improve the services we provide to ensure the care delivered meets patients' needs	DoN
PEOPLE (WORKFORCE) We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	Resourcing	5.1	Deliver a cohesive plan to attract, deploy, retain and reward a flexible workforce	DoODP
	Business Partnering	5.2	Establish effective partnerships to align business and HR strategies	DoODP
	Health & Wellbeing	5.3	Improve the health and wellbeing of staff	DoODP
	OD & Engagement	5.4	Develop a diverse and inclusive culture where staff feel engaged	DoODP
	Leadership	5.5	Develop strong leadership capability across all levels of the organisation to support an innovation culture	DoODP
RESOURCES (FINANCE & PERFORMANCE) We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	Financial recovery plan	6.1	Deliver on financial recovery plan to secure financial sustainability	DoF
	Campus Scheme	6.2	Develop a financially viable scheme to rejuvenate and improve the utilisation of the estate	DoCD
	Digital Strategy	6.3	Develop and implement a digital strategy which will enable the delivery of more effective care through the use of technology	DoCD
	Service Reviews	6.4	Undertake reviews of core services to ensure ongoing plans for sustainability and delivery of key objectives	MD

Appendix B - Governance

Quarterly Board review

LOCAL (F&PC)	SPECIALIST (F&PC)	INNOVATION (CGC)	CARE (CGC)	PEOPLE (WORKFORCE)	RESOURCES (F&PC)
Frail Elderly	Spinal Centre	Research	CQC	Resourcing	Financial recovery plan
Emergency Care	Plastics	Improvement	Safety	Business Partnering	Campus Scheme
Delayed discharge	Partnership working	Innovation	Infection	Health & Wellbeing	
Access			End of Life Care	OD & Engagement	Digital Strategy
			Patient experience	Leadership	Service Reviews

Operational Plan | Clinical Strategies

Appendix C – Plans on a Page

Objective 1.1 Frail Elderly

Development of an integrated frail elderly service

Exec Sponsor: COO

What will be different in 5 years?

Improved link between all providers of pathways for the Frail and Elderly

Underlying plan detail

Domain	Deliverables	Year 1 Milestones	Year 2 Milestones	Year 3 Milestones onwards
Acute Frailty Unit (ACU)	- Reduced Length of stay and patient ward moves - A combined Acute Frailty Unit (ACU) operational	- Implement MSAM score on AMU to improve flow of patients - Attend post-take ward rounds	- Increase number of GP practices virtual ward rounds	Ongoing management of patient pathways
Staffing	- Business Case approved by DMC for medicine. - Recruitment for 2 elderly medicine consultants	- CSFS DMC approve therapies element of business case. - Funding allocation identified. - Job descriptions prepared	7 day OPAL service operational	7 day OPAL service operational
Documentation	Patients transferred directly to Acute Frailty Unit avoiding SSEU, following successful implementation of SAM score within ED.	Increase the number of patients directly admitted to the Acute Frailty Unit	Ongoing review of documentation and pathways	Ongoing review of documentation and pathways
Data systems	- CDC forms available on Lorenzo. - CGA proforma to include wider staff input	- IT systems in place - ED checklist in place	- IT systems in place and monitoring/reporting functions available	… Ongoing review and monitoring

Objective 1.2 Emergency Care

Implement new systems to manage the flow of emergency patients

Exec Sponsor: COO

What will be different in 5 years?	Improve access to Emergency treatment and seamless flow between services

Underlying plan detail

Domain	Deliverables	Year 1 Milestones	Year 2 Milestones	Year 3 Milestones onwards
4 hourly safety board round	All identified staff attending on a daily basis	- Implement 4 hourly board rounds between 08.00-23.59 - Introduce electronic recording	Implement 4 hourly board rounds 24/7	Ongoing monitoring and development
ED Navigator post	- Funding identified - Robust data sources for reporting developed	- Business case for continuation of post approved - Data capture confirmed	- Post review to identify additional opportunities - Data available for reporting	Data available for reporting and monitoring
Review pathways from ED to specialities	Speciality discussions between ED and clinical leads	- ED/Rheumatology pathway set-up - Gynae pathways identified	- Identification and set-up of additional pathways - Ongoing monitoring	- Identification and set up of additional pathways. - Ongoing monitoring
AMU re-configuration	Data demonstrates increased number of 24 and 48 hour discharges.	Increase number of discharges from AMU as per business case	Increase number of discharges from AMU as per business case	Increase number of discharges from AMU as per business case
Development of Short stay surgical Unit (SSSU)	Direct streaming from ED for surgical pathways Reduced length of stay	SSSU pathways agreed for admission Increase number of patients streamed to SAU	Increase number of patients streamed to SAU	Increase number of patients streamed to SAU
Implement SAM Score in ED and AMU	- Patients arrive in correct ward area - Patients arrive with an EDD set automatically	- SAM score identified in ED and AMU - Electronic recording available	Ongoing monitoring of SAM score and EDD	Ongoing monitoring of SAM Score and EDD

Objective 1.3 Delayed Discharges

Salisbury NHS

Improve partnership working to reduce delayed transfers (DTOC) of care and patient length of stay (LOS) to ensure stability in bed compliment and financial balance

Oversight Committee:

Exec Sponsor: COO

What will be different in 5 years?	**Plans and processes will be in place with all organisation to support the Trust running with zero DToC and reduce LoS**

Underlying plan detail

Domain	Deliverables	Year 1 milestones	Year 2 milestones	Year 3 milestones
Clinical Pathways	Streamline existing pathways Relaunch the Wiltshire wide Choice Policy Task & Finish Group Daily validation Face to Face senior decision makers weekly meetings Increased focus on green to go patients	All clinical pathways in place, and reviewed. Outcome measures in place	▪ Regular review of pathways, informed by improved outcome data ▪ DToC reduce to 14	
Capacity	Extending Home from hospital linked with Age UK Regular urgent care net work meetings	Ensure additional 9 beds through the Better Care Fund are maximised		
CHC Process	Moving CHC patients out of the acute Trust for the CHC assessment to be completed in the community	▪ CHC patients reduced LoS ▪ No more than 15% of CHC checklist done in the acute Trust		
Finance		▪ Increased discharges to patient own home by 2.5%	Increased discharges to patients own home by 7%	▪ Review of service provision

Objective 1.4 Access

Oversight Committee: Finance & Performance

Exec Sponsor: COO

What will be different in 5 years?	Improving access to core services to support prompt, responsive care

Underlying plan detail

Domain	Deliverables	Year 1 milestones	Year 2 milestones	Year 3 milestones
Modelling	To model capacity & demand	Implement modelling in ENT, Gastro, Orthopaedics & Plastics	Complete modelling for remaining services	Regular updating of models to ensure they are up to date and used for service management and planning
Performance Improvement	To improve performance against all constitutional standards	Produce recovery plans for all areas under reporting	To implement plans	Monitor performance with predictions of future performance
Monitoring	To continually monitor performance to predict performance deteriorating and respond ahead of time	All pre existing reports operational and monitored through Delivery Group	All Dashboards and reports used daily / weekly	All Dashboards and reports used daily / weekly

Objective 2.2 Plastic Surgery

Salisbury NHS

Develop and implement a digital strategy which will enable the delivery of more effective care through the use of technology

Oversight Committee:

Exec Sponsor: COO

What will be different in 5 years?	**Provision of a sustainable outcome driven plastic surgery service across Wessex, ensuring timely treatment is provided in an effective and efficient way at the most appropriate location**

Underlying plan detail

Domain	Deliverables	Year 1 milestones	Year 2 milestones	Year 3 milestones
Clinical Pathways	Network approved clinical pathways for emergency and elective care ▪ Care is provided in the correct location	▪ Network action plan in place with priority pathways agreed ▪ Outcome data used to inform pathways	▪ All clinical pathways in place, and reviewed. Outcome measures in place	▪ Regular review of pathways, informed by improved outcome data
Capacity	▪ 24/7 on call provision for emergency care ▪ Achievement of emergency care and RTT targets ▪ Robust demand and capacity plan in place with commitment from Network to resource	▪ Demand and capacity plans implemented ▪ Appropriate treatments in appropriate environment ▪ RTT compliance ▪ Emergency care measure compliance	▪ A review of inpatient capacity ▪ Network review of capacity	▪ A review of inpatient capacity ▪ Network review of capacity
Workforce	▪ A network wide workforce in place to deliver all elements of service provision ▪ A well led team motivated and focused on good outcomes ▪ Staff are supported by hosting organisations to deliver high quality care	Workforce review across network ▪ Clear, sustainable workforce plans in place ▪ Evidence of improved retention in all staff groups	▪ Business case / implementation of recommendations	▪ Review implementation ▪ Skills assessment
Finance	▪ Agreed activity is ▪ provided with in financial contract	▪ Information captured to allow accurate coding ▪ Accurate SLR information ▪ Accurate reference costs ▪ Financially viable SLA's in place	▪ Network wide financial ▪ review of service to ensure equitable financial balance and provision	▪ Review of service provision

Objective 3.2: Improvement

Build a culture of innovation and continuous improvement adopting a consistent QI methodology

Exec Sponsor: COO

What will be different in 5 years?	The Trust will have implemented a single approach to improvement; developed the capacity and capability for continuous improvement and embedded a culture which empowers its workforce to drive bottom up change to strive for an outstanding experience for every patient.

Underlying plan detail

Domain	Deliverables	Year 1 milestones	Year 2 milestones	Year 3 milestones
Quality Improvement methodology	Implement and embed a single and consistent QI approach Trust-wide	Develop a single QI approach supported by a standardised suite of improvement methodologies.	Continue to implement and embed the use of the QI approach within the organisation.	Sustain.
QI training programme	Implement a programme of QI training with progressive levels of learning for all staff.	Develop and commence delivery of a four level improvement training programme; 1. Introduction to QI (online e-course) 2. Bronze level (online e-course) 3. Silver level (face to face training) 4. Gold (face to face training)	Continue programme delivery Year 1 cohorts engagement in future change opportunities. …	Evaluation of course impact developed
Develop staff to deliver improvement	Develop a workforce skilled to use a standardised improvement approach with time out to work in teams to resolve problems	15% of workforce trained (638 staff)	40% of workforce trained (1702 staff).	75% of workforce trained (2340 staff). .
Infrastructure	Establish a QI Academy and develop a team of QI facilitators and coaches to deliver face to face training and support staff through delivery of improvement projects.	25 QI coaches and 9 trainers recruited and trained.	45 QI coaches and 10 trainers recruited and trained.	65 QI coaches and 11 trainers recruited and trained
Governance	Developed a governance framework to oversee and monitor implementation of the improvement programme	QI academy reference group established. Programme Implementation Plan in place. Robust reporting established.	Monitoring	

Objective 4.1 CQC

Salisbury NHS

Achieve a CQC rating of Good

Exec Sponsor:
DoN
Clinical Governance Committee

What will be different in 5 years?	Trust has as a minimum a CQC overall rating of 'Good'

Underlying plan detail

Domain	Deliverables	Year 1 milestones	Year 2 milestones	Year 3 milestones
Planning	Comprehensive CQC preparation plan that closes down all previous must do's	▪ CQC action plan in place ▪ All previous 'must do's' identified as actioned and embedded ▪ Staff clear on improvement journey and inspection requirements ▪ Well led review ▪ Engagement with core services on key improvement areas		
Inspection	CQC inspection completed 2018 with resulting judgement of 'good'	▪ Inspection successfully managed ▪ Draft inspection report fully assessed and responded to		Reinspection
Post Inspection	Improvement plan in place post inspection	▪ Post inspection review of report with each core service ▪ Agreed improvement plan	Improvement plan in place and all core services engaged with plan to improve on rating at next inspection	

Objective 4.2 Safety

Deliver on the local, regional, and national patient safety initiatives

Exec Sponsor: DoN

What will be different in 5 years?	The Trust will have an embedded track record on improving safety with tangible improvements for patients

Underlying plan detail

Domain	Deliverables	Year 1 milestones	Year 2 milestones	Year 3 milestones
Reduced patient harm	▪ 10% reduction in falls resulting in serious harm ▪ Sustained reduction in stillbirths and neonatal deaths ▪ Reliable application of sepsis care bundle ▪ Reduced never events	▪ Implementation of the GAP/GROW programme ▪ Involvement in national maternity collaborative ▪ Improving compliance with sepsis 6 interventions ▪ Human factors training across theatres ▪ Implementation of falls reduction strategy	▪ Future initiatives determined by local priorities and national initiatives	▪ Future initiatives determined by local priorities and national initiatives
…			…	

Objective 4.5 Patient Experience

Salisbury NHS

Work with our patients to plan and improve services we provide to ensure the care delivered meets patients needs

Exec Sponsor: DoN

What will be different in 5 years?	Involving patients and our public will be considered mainstream to everything we do and consider

Underlying plan detail

Domain	Deliverables	Year 1 milestones	Year 2 milestones	Year 3 milestones
Development of PPI Strategy	Robust PPI strategy What's in it at the moment that can use	▪ Review of PPI strategy to ensure fit for future purpose ▪ Complete ward reconfiguration work with patient involvement in design of services ▪ Patient stories in public board ▪ Patient involvement in improving appointment letters ▪ Involvement in the design of new facilities	…	
PPI Strategy Delivery			▪ Implementation of PPI strategy	▪ Implementation of PPI strategy

Objective 4.3 Infection

Maintain our focus on reducing rates of infection

Exec Sponsor: DoN

What will be different in 5 years?	The Trust will have low levels of Healthcare Associated Infections and be able to show excellent antimicrobial stewardship

Underlying plan detail

Domain	Deliverables	Year 1 milestones	Year 2 milestones	Year 3 milestones
Infection prevention and control	Low levels of HAIs	▪ Implementation of the IPC work plan ▪ Involvement in system wide work on gram negative reductions ▪ Reporting gram negative sepsis via PHE	▪ Year 2 below trajectory HAIs ▪ Gram negative reduction work in place	▪ Year 3 below trajectory HCAI ▪ System wide reductions in gram negative bacteraemias ▪ Continued focus on antimicrobial stewardship
Robust and reliable processes for anti-microbial stewardship	Prompt review of antimicrobial Presciptions Sustained reductions in antimicrobial use across the Trust Achieve CQUIN	▪ Monitoring of antimicrobial prescriptions <72 hours with feedback and education to clinical teams ▪ Programme of review of all antimicrobial policies	▪ Monitoring of antimicrobial prescriptions <72 hours with feedback and education to clinical teams ▪ Programme of review of all antimicrobial policies	
	…		…	

Objective 5.1: Resourcing

Salisbury NHS

Deliver a cohesive plan to attract, deploy, retain and reward flexible workforce

Oversight Committee:

Exec Sponsor:

What will be different in 5 years?

We will have a flexible workforce which is motivated, feels valued and empowered and shares the same values as the organisation. We will improve our workforce planning and recruitment processes to ensure we have sufficient resources when and where we need them most.

Underlying plan detail

Domain	Deliverables	Year 1 milestones	Year 2 milestones	Year 3 milestones
Attract	Strong employer brand Comprehensive incentives and benefits package	Media campaign Incentives package		
Select and recruit	Values Based Recruitment Process New Recruitment System	Values Based Recruitment implemented Recruitment system implemented Managers trained Reporting on recruitment key metrics	…	
Orientation	Revised induction programme Feedback from new starters on recruitment and orientation process	Revised induction programme 30/100 day questionnaires implemented		
Deploy	Trust-wide implementation of e-Roster Directorate level workforce plans Integrated resourcing function (recruitment, temporary staffing, rostering)	Implementation plan agreed for roster roll out Workforce plans developed Resourcing function integrated	…	
Retain & Reward	Grow our own strategy	Nursing apprenticeship programme developed		

Objective 5.3: Health and Wellbeing

Salisbury NHS

Improve the health and wellbeing of staff

Oversight Committee:

Exec Sponsor:

What will be different in 5 years?	We will contribute to making our workforce healthy and well at work, and genuinely enjoy coming to work every day.

Underlying plan detail

Domain	Deliverables	Year 1 milestones	Year 2 milestones	Year 3 milestones
Physical	Onsite staff facilities Fast track access to OH services Health promotions (flu, smoking)	- Draft health and wellbeing strategy (covers all domains) - Communication of one stop shop for physical health and wellbeing opportunities - Calendar of health promotions communicated - Re-launch 'Shape up at Salisbury'	…	
Mental / Spiritual	Resilience / stress programme Mediation service	- Resilience /stress training delivered to staff and managers - Employee Assistance Programme implemented		
Financial	Salary Sacrifice schemes Staff discounts / benefits	- Salary Sacrifice schemes and staff discounts/benefits communication plan		
Family	Flexible Working policy and process On site day nursery	- Flexible working policy re-launched as part of health and wellbeing strategy	…	

Objective 6.1 Financial Recovery Plan

Salisbury NHS

Deliver on Financial Recovery plan to secure financial sustainability

Exec Sponsor: DoF

What will be different in 5 years?

The Trust will be in a financial sustainable position, with an ongoing process in place and the skills across the organisation, to develop new innovative ideas in responding to the financial challenges that may lie ahead.

Underlying plan detail

Domain	Deliverables	Year 1 milestones	Year 2 milestones	Year 3 milestones
Planning & Delivery	• Fully developed plan of initiatives to reduce cost base/increase productivity. • Plans profiled and metrics to monitor agreed. • Resource identified to support delivery. • Governance process to monitor success embedded in the organisation. • Long term financial model completed to support financial strategy.	• Delivered the savings programme identified for the year. • Secured resource to delivered programme. • Outstanding Every Time Board established to drive delivery & progress.	• Delivered the savings programme identified for the year. • 2 year planning cycle in place for transformation schemes.	• Delivered the savings programme identified for the year.
Capability & Capacity	• Transformation scheme pipeline in place for future schemes • Strengthened PMO in place to deliver transformation schemes. • Wider systematic review of benchmarking information to input into the transformation programme.	• PMO structured and resourced to deliver transformation programme. • Transformation Director in place. • Systematic review of GIRFT & Model hospital opportunities.	• Permanent structure for supporting transformation in place. • Transformation Director no longer required.	

Objective 6.2: Campus Development

Salisbury NHS

Develop a financially viable scheme to rejuvenate and improve the utilisation of the estate

Oversight Committee: F&PC

Exec Sponsor: DoCD

What will be different in 5 years?	Site masterplan agreed and local authority approved which underpins Trust clinical strategies and health & wellbeing aspirations. Has a clear funding and cashflow plan and an implementation plan with a number of enabling projects commenced.

Underlying plan detail

Domain	Measures of Success	Deliverables	Year 1 Milestones	Year 2 Milestones	Year 3 Milestones onwards
Site Planning	Site masterplan developed in line with clinical and health & wellbeing strategies.	▪ Evaluation of current site condition and space utilisation. ▪ Linkage with adjacent landowners plans. ▪ Agreed vision and site masterplan.	▪ 6 facet survey completed. ▪ Space utilisation reviewed. ▪ One Public Estate bid submitted and approved. ▪ Local stakeholder engagement and input.	▪ Planning approved site masterplan, for all development categories required. ▪ Agreed planning linkage with adjacent landowners scheme.	▪ Ongoing individual projects submitted for detailed planning as part of the agreed and approved masterplan.
Financial Scheme	• Secure funding for development activity. • Defined cashflow projections. • Generate incremental revenue. • Robust governance arrangements.	▪ Required MOU's signed. ▪ Funding sources identified. ▪ JV structures agreed. ▪ Business cases developed. ▪ NHSI approvals secured. ▪ Revenue and cashflow models agreed.	▪ Fund sources agreed and commercial structures approved. ▪ JV structures legally completed. ▪ NHSI approvals secured. ▪ Revenue projections incorporated into Trust LTFM.	▪ Early revenue assumptions pressure tested. ▪ Cashflow models refined as more agreements are established. ▪ Progressing JV and partnership agreements to delivery on site.	▪ Revenues from early enabling projects start landing into the financial model. ▪ Operational and productivity impacts to be analysed as a result of early progress of the Campus plans.
Enabling works	Agreed plan with clear understanding of funding implications, Trust fixed points, interdependencies and new commercial opportunities.	▪ Fixed points established and agreed. ▪ Commercial opportunities sequencing agreed. ▪ Preliminary works identified and progressed to design phase/ implementation phase.	▪ Fixed points established and Board approved. ▪ Commercial opportunities reviewed and approved for progression. ▪ Full enabling programme established and progressing to implementation.	▪ Early projects to commence and complete on site, which unlock land take and improve patient and staff experience. eg. decked car parking and new Welcome Centre. ▪ Progression of new clinical adjacency activity as part of overall plan.	▪ Progression on site of new Elective Centre, incorporating Private Patient Unit and Rehabilitation. ▪ Progression of added value projects such as Education, Patient Hotel and Older Peoples Residential.

Objective 6.3: Develop Digital Strategy (detail will change)

Salisbury NHS

Develop and implement a digital strategy which will enable the delivery of more effective care through the use of technology

Oversight Committee: F&PC

Exec Sponsor: DoCD

What will be different in 5 years?	Digital strategy agreed that has led to the development of digital tools which have delivered improved ease of use for staff, have reduced the reliance on paper documentation and have increased the ability of the Trust's services to work across care settings.

Underlying plan detail

Domain	Measures of success	Deliverables	Year 1 milestones	Year 2 milestones	Year 3 milestones
Strategy Development	…Board approved strategy developed in line with clinical strategies that has had wide consultation and input	▪ Approved strategy with clear deliverables, timescales and indicative costs ▪ Substantial clinical engagement including process change required.	▪ First draft developed with wide engagement ▪ Consultation on draft with subsequent amendments ▪ Final version to Board with indicative 5 year financial plan. Workplan for the department	▪ Regular review of progress at Board	▪ Regular review of progress at Board ▪ Update strategy in light of progress and changes in strategic context
Governance	…revised governance structure put in place to deliver on the strategy	▪ Robust programme management approach ▪ Good user involvement and engagement ▪ Approved business cases for all major schemes outlining clear rationale, incl benefits and realistic view of all costs and risks	▪ Programme Board established with clinical engagement ▪ Clinical Reference Group in place ▪ Programme of business cases established		
EPR Development	…deliver on the priorities outlined within the strategy	▪ Electronic recording of information first time is the default ▪ Information is safely shared between organisations to improve patient care ▪ Staff are assisted by technology to deliver care	▪ Nursing documentation ▪ Electronic correspondence ▪ Windip replacement ▪ POET rollout, incl scanning	▪ Order comms ▪ Theatres	▪ Electronic prescribing ▪ Shared care record ▪ Technology is used to manage patient care in their homes
Infrastructure	…a robust and efficiently maintained infrastructure is in place to support the organisational needs	▪ Infrastructure is resilient, promotes mobility ▪ Compliant with legislation	▪ Infrastructure refresh ▪ Dashboards ▪ Website ▪ NHSMail ▪ HSCN ▪ Improving remote access ▪ GDPR (May 25th)	▪ Intranet ▪ ICID replacement ▪ Data warehouse	▪ Windows10