SALISBURY NHS FOUNDATION TRUST

TRUST BOARD

MONDAY 7 AUGUST 2017, 10.00 AM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
10.00am	**1**	**APOLOGIES FOR ABSENCE** Christine Blanshard, Tania Baker			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES** Public Board Meeting held on 5 June 2017			1
	4	**MATTERS ARISING**			
	5	**CHIEF EXECUTIVE**			
		1. Chief Executive's Report	CC-B	SFT 3908	11
10.30am	**6**	**INTEGRATED PERFORMANCE**		SFT 3909	17
		• Workforce Performance Report including Nurse Staffing (month 3)	PH/LW	SFT 3909a	(22)
		• Quality Indicator Report to 30 June (month 3)	CB/LW	SFT 3909b	(49)
		• Financial Performance to 30 June (month 3)	MC	SFT 3909c	(56)
		• Progress against Targets and Performance Indicators to 30 June (month 3)	AH	SFT 3909d	(65)
11.10am	**7.**	**REPORTS OF BOARD COMMITTEES**			
		1. Clinical Governance Committee minutes – 18 May and 22 June 2017	MM/JR	SFT 3910	71
		2. Finance & Performance Committee Minutes – 30 May	MC	SFT 3911	89
		3. Audit Committee minutes – 19 May 2017	PK	SFT 3912	93
11.30am	**8.**	**PATIENT CARE**			
		1. Customer Care Report – Quarter 4	LW	SFT 3913	97
		2. Skill Mix Review	LW	SFT 3914	109

11.50am **9.** **PAPERS FOR NOTING OR APPROVAL**

1.	Major Projects Report	LA	SFT 3915	147
2.	Annual Equality and Diversity Report	PH	SFT 3916	157
3.	Update on Progress of Medical Revalidation	CB	SFT 3917	185
4.	National In-Patient Survey Results	LW	SFT 3918	213
5.	Workforce Committee	PH	SFT 3919	Verbal
6.	Council of Governors draft minutes – 17 July 2017	NM	SFT 3920	-

12.20 **10.** **ANY OTHER URGENT BUSINESS**

11. **QUESTIONS FROM THE PUBLIC**

12. **NEXT MEETING**

The next public meeting will be held on Monday 2 October 2017, in the Board Room at Salisbury District Hospital starting at 1.30pm

SALISBURY NHS FOUNDATION TRUST

Minutes of the meeting of Salisbury NHS Foundation Trust Board Held on Monday 5 June 2017

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 A Hyett	Chief Operating Officer
	Mr P Kemp	Non-Executive Director
	Mrs K Matthews	Non-Executive Director
	Dr M Marsh	Non-Executive Director
	Ms L Wilkinson	Director of Nursing
Corporate Directors Present:	Mr L Arnold	Director of Corporate Development
	Mr M Collis	Deputy Director of Finance
	Mrs H Salisbury	Deputy Director of Human Resources
In Attendance:	Mr P Butler	Head of Communications
	Mr D Seabrooke	Secretary to the Board
	Mr P LeFever	Wiltshire Health Watch
	Mrs L Turner	Public Governor
	Mr N Alward	Public Governor
	Dr A Lack	Public Governor
	Dr J Lisle	Public Governor
	Sir R Jack	Lead Governor
	Mr R Polkinghorne	Appointed Governor
	Dr R Robertson	Public Governor
	Mr J Mangan	Public Governor
	Mr M Wareham	Staff Side
	Mr J Roberts	Cymbio Limited
	Mrs L Herklots	Public Governor
	Dr J Hemming	Consultant, Microbiology (for item SFT3892)
	Mrs F McCarthy	Senior Nurse, Infection Control (for item SFT3892)
	Mrs J Jarvis	Voluntary Services Manager (for item SFT3898)
	Dr J Barker	Guardian of Safe Working (for item SFT3903)
	Dr R Sykes	Guardian of Safe Working (Designate) (for item SFT3903)
Apologies:	Prof J Reid	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement

ACTION

2279/00 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.

2280/00 MINUTES – 3 APRIL 2017

A typographical amendment would be made to 2263/02 to remove a £ sign and to add a letter m after the figure in the penultimate paragraph of 2265/05.

To remove the words in 2263/01 ‘and a further ten were in the uk and’.

2281/00 MATTERS ARISING

2264/01 it was noted that the Board briefing on measures of mortality had been given.

2265/04 the business plan for Wiltshire Health and Care had been circulated.

2282/00 CHIEF EXECUTIVE’S REPORT - SFT 3889 – PRESENTED BY CC-B

The Board received the report of the Chief Executive. Cara Charles-Barks highlighted the continuing hard work by the staff and the instances of recognition shown in the report. The ‘Breaking the Rules’ initiative was designed to encourage patients and staff to share experiences of the application of a range of hospital policies and procedure and instances were these could be incompatible with good experiences and improvements to service. It was intended to understand and explore opportunities where change could be made.

A number of events for cares week were planned. The Trust had appointed three staff as Freedom to Speak Up Guardians who had direct access to the Chief Executive and staff could speak to any of them with any concerns around the quality of care, patient safety or issues affecting them or the wider hospital.

Finally she highlighted the annual Walk for Wards event taking place on Sunday 2 July at Wilton House.

The Board noted the Chief Executive’s report.

2283/00 STAFFING

2283/01 Workforce Performance Report including Nurse Staffing - SFT 3890 - Presented by HS & LW

The Board received the Workforce and Safer Staffing Report for month 1. Small improvements had been made in mandatory training compliance and there was some instances of sickness rates being over the local target.

Recruitment continued to be a focus and successes had meant less agency use in this area. The Trust was trailing a new app that would enable hospital staffing banks to share medical locums. In response to a question form Paul Kemp it was noted that the app included a number of standard checks and that there were assurances in built from other staffing banks that background checks on candidates had been completed. The Medical Director remained responsible for the suitability of all locum appointments and there would be suitable checking carried out.

75 job offers had been made through a recent recruitment trip to India with the first two appointees arriving in June.

The apprenticeship levy, of £0.5m in the Trust's case was highlighted and the opportunity to recover some of the value through relevant training was noted. Lorna Wilkinson undertook to provide further information about the Thames Valley and Wessex Leadership Academy training course which had been cited as an example. LW

In response to a question from Kirsty Matthews it was noted that the apparently high turnover of scientific staff detailed in the report was being investigated.

Michael von Bertele asked about changes to nurse student numbers arising from the withdrawal of the bursary. It was noted that hitherto the courses were oversubscribed and it was not yet known what the effect on Bournemouth University, which provided the majority of the Trust's nurse trainees, would be.

It was noted that sickness rates for six of the Trust's directorates were red rated and that executives continued to challenge each directorate via the performance reviews, how to get people back to work.

Safer Staffing Report

The Safer Staffing Report highlighted that nursing assistants were 119% due to overseas nurses working towards their International English Language Test qualification. It was expected that the number of staff shown as nursing assistants would reduce as qualified staff achieved the IELTS. Breamore Ward in particular was using its band 4 workforce flexibly.

It was noted in relation to a question from Michael Marsh that the two patients mentioned in the report requiring registered mental nurse support had been discharged.

The Board noted the report.

2284/00 PATIENT CARE

2284/01 Quality Indicator Report to 30 April 2017 – SFT 3891- Presented by CB and LW

The Board received the month 1 Quality Indicator Report. CB highlighted a new but unpopulated report on futile CPR attempts and the number of hospital cardiac arrests. There had been no cardiac arrests in March 2017.

Due to seasonal factors, the crude mortality rate in April had reduced. The Standardised Hospital Mortality Index was 104 to September 2016. Hospital Standardised Mortality Rate decreased to 116 which was higher than expected. New mortality measures would be reported to the Board in due course. The Trust best practice tariff for hip fractures in quarter four had improved to 90%. The Sentinel/National Stroke Audit Programme rated the Trusts as grade B in the latest assessment.

The Trust's escalation bed capacity reduced during April and there was a plan highlighted elsewhere in the agenda to reconfigure the Trust's bed base over the coming six months in preparation for winter 2017/18. This would see a temporary constraint in the number of available beds, presenting short term challenges.

LW reported that there had been no declaring single sex accommodation breaches for the second month running, there had been no falls resulting in fractures in April but some had occurred in May. Real time feedback for April was positive. Michael Marsh asked about the apparent fall off in the arrival of patients to the Stroke Unit within 4 hours and it was noted that work was ongoing to improve the time to first assessment but this had been challenging with patients arriving in the Emergency Department but the recent implementation of the Care Navigator was understood to have improved things. A dedicated stroke bed on Farley Ward was now in place.

In response to a question about the improvement to fractured neck of femur cases, it was noted that changes in the availability in trauma capacity have affected this indicator. The Trust was implementing a business case in relation to the separation of elective and orthopaedic surgery.

The Board noted the Quality Indicator Report.

2284/02 Report of Director of Infection Prevention Control - SFT 3892 – Presented by LW

The Board received the annual report giving information about the progress made against the 2016/17 annual action plan. The Chairman welcomed Fiona McCarthy and Julian Hemming to the meeting in support of this item.

It was noted that there had been no cases of MRSA bacteraemias and the 2016/17 outturn for C.Diff was 13 attributed cases against the ceiling of 19. There had been two periods of increased activity and one was declared as an outbreak. There had been ten MSSA cases and the team were focusing on improving device management. Out of 114 knee replacement procedures recorded one deep surgical site infection was identified using the Public Health England criteria.

The overall use of antibiotics in the hospital had improved. There had been reduced instances of problems with theatre trays and a good PLACE assessment. Training in infection control was just under the 85% target. Work continued with the Estates Team on water safety. The Clinical Management Board was reviewing the policy on Carbapenemase-producing Enterobacteriaceae and it was noted that precautions had been invoked.

In relation to the water safety there was a process of continual monitoring and opportunities would be taken to improve the infrastructure as part of the ward moves described earlier in the meeting.

The Board noted the report and acknowledged the responsibility of the Board for supporting the Director of Infection Prevention and Control.

2285/00 PERFORMANCE AND PLANNING

2285/01 Finance & Performance Committee Minutes – 27 March and 24 April 2017 – SFT 3893 Presented by NM

The Board received for information the confirmed minutes of the Finance and Performance Committee which had been focusing on the year end for 2016/17.

2285/02 Financial Performance to 30 April 2017 (Month 1) – SFT 3894 – Presented by MCo

The Board received the Financial Performance Report. It was noted that the Trust had reported a £1.1m deficit in month 1, which was behind the plan by £387,000. The finance and informatics teams were continuing to review the reported activity. Expenditure was on plan. The Trust's application for a Working Capital Facility had been acknowledged by the Department of Health. Wiltshire CCG had agreed to a £0.5m risk fund payment.

Out-patient activity (initial attendances and follow-ups) were both down against the previous year and against plan and it was noted that new IT systems and the Outpatient Transformation Plans were contributing towards this.

The report stated that the Cost Improvement Target for 2017/18 was £7.5m which included income generation schemes of £2.1m. £6.5m had been allocated as Cost Improvement Savings to the directorates and there was unidentified strategic savings of £1m back loaded to the last 3 months of the year. It was deemed necessary to seek a further £1m in savings due to unavoidable cost pressures identified for 2017/18 which meant a further savings requirement of was added.

It was noted that the Trust had approached Wiltshire CCG on a number of income related issues and discussions were continuing. Wiltshire CCG continued to support the Trust as it worked through reporting issues associated with the implementation of the new data warehouse and Lorenzo patient management system but Dorset CCG had started to raise concerns in this regard. West Hampshire CCG had issued a Contract Performance Notice in relation to delivery of Referral to Treatment, Emergency Department, Diagnostic and Cancer Wait Times for 2016/17. Discussions of this were continuing.

The Board noted the report.

2285/03 Progress Against Targets and Performance Indicators to 30 April (month 1) – SFT 3895 – presented by AH

The Board received the month 1 Performance Indicator Report and supporting information. It was noted that cancer performance had been good and continued to be affected by small numbers of patients. Data was still being validated. The 62 day cancer target had been delivered each quarter in 2016/17. Diagnostics was 97% against a target of 99% but was on trajectory. The Trust continued to seek additional suitable MRI scanning capacity to improve this indicator. Referral to Treatment standards were not being delivered at all sub specialty levels and as verification proceeded the Trust would continue to make secondary submissions in this regard. For ED the Trust had delivered the 95% target in April.

It was noted that the cancer figures included skin cancers. The Care Navigator was designed to signpost patients presenting at the Emergency Department to the type of care they required. The chart included in the supporting information showed variations in the numbers of 'green to go' patients who were assessed as not needing to be cared for in an acute hospital setting. Finally the need to be clear on the clinical governance of any outsourced MRI scanning activity was acknowledged.

The Board noted the report.

2285/04 Major Projects Report - SFT 3896 - Presented by LA

The Board received the Major Projects Report. LA reported that the data warehouse was now red rated due to delays in resolving this issue. The implementation of the ward reconfiguration would be starting in August with Laverstock Ward moving. Cara Charles-Barks would become the Trust's representative on the Wiltshire Health and Care Board. Wiltshire Health and Care were struggling to recruit sufficient therapy staff in to start their Early Supported Discharge Service in South Wiltshire. The Trust had offered to help in this regard.

The Board noted the Major Projects Report.

2285/05 Capital Development Report – SFT 3897 - Presented by LA

It was noted that the Trust had not been materially affected by the cyber-attacks that had occurred in May. The executive would be reviewing the cyber security arrangements. Principal schemes highlighted in the report included the transition to NHS mail and changes to the Trust's access to HSCN and a major IT infrastructure refresh. It was noted that Early Supported Discharge had been implemented in day surgery.

The Board noted the Capital Development Report.

.

2286/00 PAPERS FOR NOTING OR APPROVAL

2286/01 Voluntary Services Annual Report – SFT 3898 – Presented by HS

The Board received the Voluntary Services Annual Report and the Chairman welcomed Jo Jarvis, the Voluntary Services Manager in support of this item. Jo Jarvis reminded the Board of the role of the volunteers in adding to and enhancing patient care. There continued to be turnover of volunteers and an apprentice had been recruited recently to support the Voluntary Services Manager.

The 'stay with me' volunteers who were supporting patients with dementia were highlighted. The service was working with the Facilities Directorate towards staffing the desk in the main entrance.

In relation to a question from Cara Charles-Barks it was noted that the Trust supported the Duke of Edinburgh Awards at gold level. A recent refurbishment of courtyards around the Spinal Unit by young people was highlighted.

Finally the annual volunteer's day would be taking place on 7 July between 12 and 2 pm and all Board members were, as always, invited.

2286/02 Audit Committee Minutes – 13 March 2017 - SFT 3899 – Presented by PK

The Board received for information the confirmed minutes of the Audit Committee held on 13 March 2017. The Chairman of the Committee reported that there were no open matters arising from this meeting.

2286/03 Clinical Governance Committee Minutes – 23 March – SFT 3900 – Presented by MM

The Board received for information the minutes of the inquorate Clinical Governance Committee of 23 March 2017.

2286/04 Council of Governors – Draft Minutes 15 May 2017 – SFT 3901 – Presented by NM

The Board received for information the draft minutes of the Council of Governors held on 15 May 2017.

2286/05 Joint Board of Directors Minutes Evidencing Presentation of Assurance Framework and Risk Register – SFT 3902 – Presented by CC-B

The Board received for information the minute extract from the Joint Board of Directors.

2286/06 Guardian of Safe Working - Annual Report – SFT 3903 – Presented by CB

The Board received the first annual report to the Trust Board from the Guardian of Safe Working setting out the first few months of operation of the guardian arrangement. The Chairman Juliet Barker to the meeting in support of this item.

The Board was reminded that the Guardian role had been created under the 2016 junior doctors contract. At present 44 trainees were on the contract and the number was growing as more cohorts joined. A quarterly report on the exceptions reported to the Guardian was given to the Executive Workforce Committee and Joint Board of Directors.

Concerns had mainly arisen from Medical F1 doctors especially at times of escalation during the winter months and at times when there had been challenges on the recruitment of middle grade doctors. Concerns had arisen from Respiratory and Gastroenterology areas and a workforce review in Respiratory had taken place and had effectively reduced excess hours worked by trainees. There was flexibility at F1 level to use surgical F1s to cover medical patients if necessary.

It was felt the number of reports being made was in line with the Trust's strong reporting culture.

The Board noted the report.

2287/00 ANY OTHER URGENT BUSINESS

2288/00 QUESTIONS FROM THE PUBLIC

In relation to a question about appraisals compliance rates it was noted that work pressures continued to be a challenge in maintaining this.

In relation to a further question about the exit interviews and the number of outcomes categorised as 'other' it was not always possible to get interviewees to disclose reasons for leaving.

In relation to a question about the Walk for Wards Cara Charles-Barks undertook to highlight the success of the may hospice walk which had been supported by 1500 people and to offer a thank you to the organisers. CC-B

In relation to a question about sickness rates targets it was noted that the sickness rates were set according to professional groups.

In relation to a question about water safety the practice of flushing water systems was considered the only reliable way of guarding against legionella infections developing

2289/00 DATE OF NEXT MEETING

The next public meeting of the Board would be held on Monday 7 August 2017 the Board Room.

Agenda Item	Action	Responsibility	Target	Outcome
2283/01	Lorna Wilkinson undertook to provide further information about the Thames Valley and Wessex Leadership Academy training course which had been cited as an example.	LW		
2288/00	In relation to a question about the Walk for Wards Cara Charles-Barks undertook to highlight the success of the may hospice walk which had been supported by 15000 people and to offer a thank you to the organisers.	CC-B		completed via CEO's message

Salisbury NHS Foundation Trust Board - 7 August 2017

SFT 3908

Title : Chief Executive's Report

Report from: Cara Charles-Barks

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:

- Sustainability and Transformation Plans – progress against the plans and NHS England's new rating system.
- Wiltshire Health and Care – update on Care Quality Commission (CQC) Inspection
- CQC – update on the new inspection methodology and a summary of the work taking place to prepare staff for re-inspection.
- Performance - an overview on current performance and thank you to staff
- Financial recovery – steps being taken by the Trust to manage the current financial situation
- Workforce issues – workforce challenges and actions being taken to address these
- Site changes - progress on plans to help relieve service pressures next winter
- Elevate programme – expansion of activities to help support children in hospital
- Information Standard – re-certification following successful assessment
- Staff BBQ - informal BBQ to thank staff for all their efforts

Proposed Action: To note the report of the Chief Executive

Chief Executive's Report

Supporting Information

1. Sustainability and Transformation Plans (STPs)

As part of the five year forward view all NHS organisations and local authorities are working in partnership within geographical areas (footprints) to develop STPs, which aim to transform health and care services over the next five years. Key priorities for our footprint centre on an increased focus on preventing ill health and promoting peoples' independence, the transformation of primary care, better use of technology and estates, the development of a workforce that meets changing needs and improved collaboration across our hospital Trusts. As part of its role in monitoring the progress of individual STPs across the country, NHS England has started to compile a dashboard indicating the relative starting points of STP footprints on the road to better care, together with a rating which will be updated annually. The ratings of 1 (Outstanding) 2 (Advanced) 3 (Making Progress) 4 (Needs most improvement) are based on a baseline assessment that takes into account a range of indicators including A&E waiting times, referral to treatment times, cancer care, mental health and the financial position of the organisations within the footprint. NHS England also took into account how well organisations are working together as part of their local STP. Our footprint has been given a rating of 2, giving a positive view of performance compared with other parts of the country and the way we are all working together to improve patient care across our geographical area.

2. Wiltshire Health and Care, Care Quality Commission (CQC) Inspection

At the end of June the CQC carried out a three day planned inspection of Wiltshire Health and Care. Although we do not have a confirmed date for publication of the report we expect this to take place in late September or early October. We will keep the Trust Board updated on the report when it becomes available.

3. CQC new inspection process

The CQC has published its new inspection methodology. They are moving towards an annual inspection for each healthcare provider, focusing on at least one of the eight core clinical areas and a review of Well Led. The core area inspections will be unannounced and we will not know when they are coming, or what they will look at. In terms of any future re-inspection in Salisbury this is a key priority for the Trust Board and progress against our action plan is monitored routinely at departmental, directorate and board level. To ensure that staff are well prepared for re-inspection we have been running a number of workshops for all the core services to gauge progress, identify any outstanding challenges and provide support where it may be needed. These are ongoing. I have also included updates in my regular staff message and highlighted the importance of ensuring that staff get the basics right and the value of ensuring that we consistently provide good quality care across all the core services.

4. Performance

Over the last year we have experienced considerable pressure on our services, which has had an impact on our overall performance against a number of key national indicators. I'm pleased to report that through a lot of hard work by our staff and management teams, we have seen a steady improvement in waiting times and the way in which we manage our patients stay across a number of services. This includes the four hour wait in Accident and Emergency, diagnostic waiting times and our overall 18 week referral to treatment target. This has a positive impact on access to services and our patients' experience of care and I would just like to use my Chief Executive's Report to thank our staff for all their hard work and their commitment in this area. Up-to-date figures will be included in the Performance Report.

5. Financial recovery

As the NHS looks to save around £30 billion over a five year period all Trusts are faced with significant financial challenges. Last year most Trusts across the country received one-off funding from the Department of Health if they met specific targets. In Salisbury we received a total of £7.8 million which enabled us to report a surplus of £4.5 million. While we have a strong tradition of sound financial management and are in a better position than many other hospitals across the country, we still have a challenging year ahead, with the need to make a further £8.5m of savings in order to deliver a deficit of £7 million. At the end of Quarter 1 we are considerably behind the management plan and the required savings that we need at this point in the financial year. We have a significant challenge ahead if we are to recover to our expected baseline position of a deficit of £7 million. In order to redress this we are currently working on a financial recovery plan, which will be discussed at our next finance committee meeting. The aim is that our plan will have two main strands. The first will focus on how the organisation can respond faster to current issues such as increased agency expenditure and ensure we use our capacity to the full. The second will have a longer term view, and looks at schemes that improve our efficiency and productivity in order to address the underlying deficit and put the organisation on a sustainable financial footing in the future. We are working closely with our regulator NHSI to ensure that we have a level of external scrutiny and support to ensure that we are maximising our opportunity to deliver against our financial plan. While it is important that we address the financial challenges, we will not compromise on the quality of care and this will remain the number one priority for our Trust.

6. Workforce challenges

Many Trusts across the country have a range of workforce challenges and are finding it harder to recruit staff to a number of clinical and non-clinical roles. This, and ongoing pressure within the health system, is also contributing to an increasing gap between the number of patients that are seen and the number of staff employed. This has an adverse effect on the use of agency staff, which is used by Trusts to maintain the required staffing levels. Some of the national challenges are mirrored in Salisbury and, as part of a wider review of our workforce strategy, we are looking carefully at our whole approach to recruitment, the information we provide and

campaigns that we run to attract staff and, crucially, retain them. A good example of this can be seen in a new and exciting campaign we are currently running to recruit additional staff as part of the site changes we are making. This includes greater use of social media, a more personal approach to our online campaign and better use of open days, where people can see first-hand the benefits of working at Salisbury. In terms of agency spend we are reviewing areas of high usage, continuing to work closely with our main provider for medical staff to help reduce usage in line with the requirements of the national cap and looking to boost the use of our internal bank for all disciplines. While our sickness absence rate is one of the lowest in the region, we value our staff and want to ensure that they have the support that they need. We are currently reviewing our health and wellbeing support to ensure that they continue to meet the needs of our staff. More information on these and other issues can be found in the Workforce Report.

7. Site changes

We are making good progress on our plans for the site changes we are making that will help relieve some of the pressure we have been facing over the past couple of years and put us in a better position to care for and manage emergency and non-emergency patients next winter. One of the biggest challenges we face is to maintain our existing services while we move wards and services around and we are running two projects in parallel with each other in order to minimise disruption and ensure that we get the right areas in the right place by the end of the year. The programme of moves started in mid-July and will continue throughout the autumn and early winter. We have worked closely with clinical teams on the design and layout of clinical areas to ensure that they will meet the needs of patients and staff once the programme is completed. We are also working closely with staff and providing general information to staff and patients through a number of communication channels. We have also held open staff briefing sessions, which has given all staff the opportunity raise any questions with the management team.

7. Elevate programme expands activities to children's ward

The success of our Elevate programme has resulted in the team being awarded additional funding from Arts Council England to commission Hoodwink Theatre Company to make a show especially for children on Sarum Ward. Elevate is one of a number of additional projects that we run that gives our patients extra support while they are in hospital and the majority of their creative activities help older people in hospital. This development enables the team to expand their activities to include a younger audience. This is an excellent achievement and another positive example of a team providing an innovative concept and, in the current economic climate, looking at other methods of funding to deliver it.

8. Information Standard

The Trust has been successfully re-certified for the Information Standard following an external assessment from NHS England. The standard is a voluntary scheme for organisations that produce healthcare information and ensures that information is clear, accurate, balanced, evidence-based and up-to-date. The standard also enables us to use the Information Standard logo. This logo, or kite mark, assures

anyone who uses, commissions or signposts that information, that it is of good quality and has been developed following an assured process.

9. Staff BBQ

Throughout the year there are a number of opportunities to celebrate the work of individual staff groups and professions such as International Nurses Day and formally recognise staff achievements through our awards ceremonies. Our staff and volunteers work hard throughout the year and we have invited all staff to a BBQ on the Green on Monday, August 7, to acknowledge their commitment and dedication. We accept that some staff may not be able to make it because of their clinical duties and we will also have a roving team taking round refreshments to wards and departments on the day. This is another way of thanking our staff and acknowledging their efforts and I know the Trust Board is looking forward to joining our staff on what should be an enjoyable and informal occasion.

Title: Integrated Performance Report

Report from: Laurence Arnold, Director of Corporate Development

Executive Summary:

The attached 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.

The report reflects NHS Improvement expectations of the information to be reviewed at the Board, but does still remain evolutionary and we will be adding to it over the coming months in particular to:

- Finalise all the data items
- Review the RAG ratings
- Undertake the work on the forecasting element
- Once the revised Trust strategy with associated actions and outcomes is agreed this will be reflected in the IPR.

Proposed Action: The Board is asked to comment on the integrated performance report

Supporting Information

Performance Summary Narrative – July

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans**
Local Services	• Improving ED performance • Reduced use of escalation • Appointment of stroke physician and ED consultant • Diagnostic waits >98% within 6 weeks • Successful IRMA (radiological) inspection • Incomplete waits at 90%	• Pressures on RTT as a result of emergency pressures • Delays in follow ups in dermatology • Diagnostic waits for MRI • Pressures on cancer waiting times – 62 day target • Cover for interventional radiology	• Ward reconfiguration to improve management of emergency patients and create short stay surgery ward. Work starts August • New ophthalmology outpatients. department – opens September • Outsourcing to New Hall – elective work over summer, MRI
Specialist Services	• Improvements in waiting times for diagnostic tests for spinal patients • Positive plastics deanery visit • Appointment of 2 new consultant plastic surgeons and locum	• Spinal unit improvements • High dependency burns patients – impact on clinical teams • Genomics tender – invitation to negotiate to be launched in November	• Developing business case to specialist commissioners for spinal services • Reconfiguration of burns/plastics/ orthopaedics template • Working with other genetics services to respond to tender
Innovation	• X3 licenses for new products being pursued • New business opportunities for laundry and payroll service • Good feedback on laundry, SDU, payroll, procurement services • My Trusty developments • Early implementer of urolift	• Healthcare solutions and PV not progressing at pace would like	• Looking at bids for innovation tariff
Care	• Excellent performance in infection control – best in the South West • Mixed sex breaches at 0 – for last 4 months • In Q1 improved stroke performance – time to CT and time on specialist ward • Positive audit results for mental health	• Mortality rate remains above expected • Number of complaints increased during winter escalation period and continuing into Q1 • Increased number of falls • Worsened SSNAP performance in Q4 • Pressure ulcers	• Revised approach to mortality reviews. Coding review • Embedding learning from reviews • CQC review planning work – all areas reviewing what has changed since December ’15. Learning from other

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans**
	liaison, inpatient and outpatient diabetes service		organisations
Staff	• Board changes • Good staff survey results • Overseas nursing recruitment • NHS Employers partner for diversity and inclusion • Good result in GMC junior doctors survey • Training posts rated green	• Level of vacancies, especially in nursing • Areas of concern from staff survey • Increased absence - above target. High levels in theatres, causing capacity issues • Use of temporary staff high and unsustainable. High cost of medical agency. In part caused	• Recruitment strategy and capacity • Action plan and engagement with staff survey issues • Review temporary staffing arrangements – to establish workforce control group. Reviewing master vendor arrangements. • Health and wellbeing initiatives to be developed
Effective	• Improvement in activity levels and income in June • Delivery of 16/17 year- end target • Positive meeting with NHSI and NHSE on financial position	• No resolution to control total for 17/18, with impact on ability to bid for other funds, risk around contract penalties • Challenging financial position – income overall down in first three months • CIP plans at 4% for 17/18, income based CIPs not being delivered • Contract discussions with West Hampshire	• Further discussions with NHSI/NHSE re financial sustainability, critical friend visit w/c 31/7 • Investigation underway into causes of income reduction • Recovery plans developed for all underperforming transformation schemes, external support to be secured • Financial recovery plan being developed, • Focus on reducing agency spend
Partnership	• 'Perfect weeks' – working with partner organisations to improve discharge • Annual review with WH&C	• High numbers of delayed patients though reducing • Delays in introducing early supported discharge for stroke due to recruitment issues within the community	• Promoting home first – go live in mid August • Commissioning community placements • PMO support to early supported discharge project

Integrated Performance Summary Report

Salisbury NHS
NHS Foundation Trust

			Last 3 Months					
	Indicator	Target	Apr-17	May-17	Jun-17	Total pts affected in Jun-17	2017-18 YTD	Forecast
LOCAL	A&E - 4 Hour Wait from Arrival	95.0%	95.0% ↑	93.1% ↓	95.7% ↑	184	94.6%	
	RTT - 18 Weeks from Referral to Treatment	92.0%	88.8% ↓	89.2% ↑	90.0% ↑	1,869	89.3%	
	Cancer - 62 Day Wait for First Treatment from GP Referral	85.0%	80.2% ↓	80.3% ↑	89.3% ↑	7	86.4%	
	Cancer - 62 Day Wait for First Treatment from Screening Referral	90.0%	42.9% ↓	81.8% ↑	100.0% ↑	0	81.8%	
	Diagnostic - 6 Week Wait	99.0%	97.0% ↓	96.9% ↓	98.4% ↑	4,127	97.4%	
	Diagnostic - 6 Week Wait - Compliance	10 out of 10	4 out of 10	7 out of 10	9 out of 10			

	Indicator	Target	2016-17 Q2	2016-17 Q3	2016-17 Q4	Benchmark		Forecast
SPECIALIST Burns Centre	% of adult resuscitation burns assessed by a consultant burns surgeon < 12 hours of admission	75.0%	No data	100.0%	100.0%	97.0%		
	% of adult inpatients receiving daily pain assessment	80.0%	73%	80.8%	63.0%	32.4%		
	% patients screened for psychosocial morbidity prior to discharge from burns ward	75.0%	100%	88.5%	100.0%	66.5%		
	% of patients screened for functional morbidity < 2 working days of admission	80.0%	100%	100.0%	100.0%	56.6%		
	Number of adult inpatients admitted to an inappropriate level of care according to National Burn Care Referral Guidance (2012)	0	0%	0	0	0		
	% IBID minimum dataset completed for adult inpatients		81.8%	86.4%	81.5%	56.2%		

	Indicator	Target	Oct-15 to Sep-16	Jan-16 to Dec-16	Apr-16 to Mar-17	Benchmark		Forecast
SPECIALIST Spinal Injuries Centre	Mean time from injury to referral (newly injured patients)		19.1	17.0	19.3	20.6		
	Mean time from referral to admission into SCI Centre		55.9	51.2	41.8	34.7		
	Mean LOS in acute phase for level of injury C1-C4		55.2	40.5	16.4	16.2		
	Mean LOS in acute phase for level of injury C5-C8		26.7	18.1	19.2	18.5		
	Mean LOS in rehab phase for level of injury C1-C5		125.9	106.0	113.5	94.4		
	Mean LOS in rehab phase for level of injury C5-C9		153.0	114.3	109.7	101.2		
	% of new injured patients receiving a face to face outreach visit from the SCIC outreach team <5 days of referral		95.0%	78.1%	85.3%	87.2%		
	% of newly injured patients who acquired a grade 3 or 4 pressure sore after admission to SCIC		0.0%	0.0%	0.0%	1.2%		

			2017-18 Q1					
	Indicator	RTG (calendar days)	Average TAT (calendar days)	Total Reports	Reports within RTG	% within RTG		Forecast
SPECIALIST Wessex Genetics Laboratory	Pre- + postnatal QF PCR + all molecular prenatal tests excluding Southern blotting	3	1.9	121	103	85.1%		
	New-born screen for CFTR mutations (* working days)	4*	3.0	54	50	92.6%		
	Rapid oncology	3	1.3	3	3	100.0%		
	Urgent postnatal	10	9.1	12	9	75.0%		
	Prenatal array/karyotype + southern blot prenatal tests + urgent and predictive PCR-based molecular tests	14	11.2	165	132	80.0%		
	Urgent oncology + molecular oncology testing in acute leukaemia	14	7.2	55	51	92.7%		
	Routine oncology + routine PCR-based Haemato-oncology tests	21	17.4	1086	1034	95.2%		
	Routine postnatal + routine PCR-based molecular tests	28	19.7	2015	1795	89.1%		
	Mutation screening or tests which require Southern blotting + next generation sequencing of panels <10 genes	56	35.4	631	568	90.0%		
	Mutation screening or tests which require Southern blotting + next generation sequencing of panels >10 genes	112	54.3	18	17	94.4%		

	Indicator	Target	Apr-17	May-17	Jun-17	Travel	2017-18 YTD		Forecast
CARE	Never Events	0	0	0	0	→	0	G	
	Clostridium Difficile - notifications	19	1	0	0	→	1	G	
	MRSA Bacteraemias - notifications	0	0	0	0	→	0	G	
	Serious Incidents Rate		1	4	2	↓	7		
	Emergency C-section Rate **NEW!**								
	Percentage of Harm Free Care	TBC	91.2%	93.8%	92.5%	↓			
	Percentage of New Harm Free Care	TBC	96.8%	97.1%	95.8%	↓			
	VTE Risk Assessment	95%	98.6%	99.8%	99.6%	↓			
	Emergency re-admissions within 30 days following an elective or emergency spell at the Provider	TBC							
	Complaints - Total received	TBC	13	23	24	↑	60		
	Mixed Sex Accommodation Breaches	0	0	0	0	→	0	G	
	Staff Friend & Family Test - % Recommended (Q)		93.0% Q1	93.7% Q2	90.4% Q4	↓			
	Inpatient Scores from Friends & Family Test - % Positive		96%	98%	97%	↓			
	A&E Scores from Friends & Family Test - % Positive		95%	98%	97%	↓			
	Maternity Scores from Friends & Family Test - % Positive		100%	100%	100%	→			
	CQC Inpatient Survey - Overall Experience Score **NEW!**		8.4 2015	8.2 2016		↓			

	Indicator	Target	Jan-17	Feb-17	Mar-17			Forecast
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	116	119	117			
	Hospital Standardised Mortality Ratio - Weekend **NEW!**	100	121		125			
	Summary Hospital Mortality Indicator	100						

	Indicator	Target	Apr-17	May-17	Jun-17		2017-18 YTD		Forecast
STAFF	Staff Absence	3.00%	3.18%	3.15%	2.67%		3.08%	R	
	Appraisals - Medical	85.0%	91.0%	93.0%	93.0%				
	Appraisals - Non-medical	85.0%	80.4%	81.0%	81.4%				
	Mandatory Training	85.0%	84.1%	84.8%	85.1%				
	Staff Turnover (Q)	8.2% 2016-17	2.7% Q3	3.6% Q4	3.0% Q1				
	NHS Staff Survey	43%	31% 2015	35% 2016					

	Indicator (000s)	Target (per month)	Total Pay (£)	WTE (%)	Total Pay (£)	WTE (%)	Total Pay (£)	WTE (%)			Forecast
STAFF Costs	Total Staff Costs		£ 10,997		£ 11,348		£ 11,258				
	Use of Temporary Staff - Bank		£ 721	6.9%	£ 594	6.0%	£ 531	5.9%			
	Use of Temporary Staff - Agency	£ 513	£ 514	2.8%	£ 693	3.4%	£ 746	3.3%			

	Indicator (000s)	2017-18 Target	Apr-17	May-17	Jun-17	2017-18 YTD Plan	Variance	
EFFECTIVE	I&E Surplus (+) / Deficit (-)	-£ 7,000	-£ 1,112	-£ 2,017	-£ 3,267	-£ 1,877	-£ 1,390	
	Cost Improvement Plan	£ 7,500	£ 199	£ 522	£ 923	£ 1,304	-£ 381	
	Cash Position	£ 2,009	£ 8,318	£ 6,196	£ 7,018	£ 4,874	£ 2,144	
	Risk Rating	3	N/A	3	3			

	Indicator	Target	Apr-17	May-17	Jun-17		2017-18 YTD	Forecast
PARTNERSHIP	Emergency admissions - Medicine & Elderly care (Over 65 years)		1003	1008	1004		3,015	
	Delayed Transfers of Care - NHS		28	32	9		69	
	Delayed Transfers of Care - Social Services		15	14	10		39	
	Bed days consumed by DToC each month		648	881	821		2350	

Last printed: 31/7/2017 11:8

Title: Trust Board Workforce Report

Report from: Paul Hargreaves, Director of Organisational Development and People

Executive Summary: This report describes the key workforce performance metrics for the Trust and the actions undertaken to address those metrics. The report also provides a narrative across all of the presented metrics, with trend analysis.

Proposed Action: The Executive Workforce Committee is asked to note the report and request further actions as appropriate

Supporting Information : See month 3 Trust Board Workforce Report attached

State of play:

The Trust is currently overspending on workforce due to a combination of long term unfilled vacancies, exacerbated by skills shortages, with a diminishing programme of mitigation, e.g. overseas recruits (both in EU and further afield) to compensate for the gap. Increasing sickness has led to an over reliance on agency as the bank (both nursing and medical) struggle to meet rising demand.

The metrics in the attached document describe the current position at month 3, and we are developing a workforce strategy to address the urgent and immediate requirements for workforce and build sustainably for the future workforce incorporating an Organisational Development programme.

Immediate actions:

- **Deep dive in total workforce spend, focus on high cost agency, both medical and nursing and eliminating admin agency. Review of process, activity in directorates and current providers**
- **Working groups on tackling sickness absence**
- **Creation of a Health and well-being strategy**
- **Recruitment strategy including infrastructure, social media and micro-site development, developing apprenticeship pathways with internal process review.**

Salisbury NHS
NHS Foundation Trust

Workforce Report
M3
2017-18

Summary

Salisbury NHS
NHS Foundation Trust

- The Trust vacancy rate has decreased to 8% this month. We are developing a workforce strategy to address the urgent and immediate requirements for workforce and build sustainably for the future workforce incorporating an Organisational Development programme.
- Mandatory training compliance has increased slightly again this month from 84.8% to 85.1%, which is on target (85%).
- Appraisal compliance for non-medical staff has slightly increased this month from 81.0% to 81.4%. Medical staff appraisal compliance has remained at 93% this month.
- Staff sickness for the last year remains above target at 3.4%. This compares favourably with latest NHS sickness rate of 4.24%. The reasons for this rise are being monitored and action being taken by Directorate teams.
- The Trust's Turnover rate in month 3 is 9.6%. Reasons for turnover are being monitored and initiatives taken forward at Trust and Directorate level. The Trust's turnover rate is in line with or better than other Hospitals locally.
- **Note : The use of "FTE" in this report denotes "Full Time Equivalent"**

Achievements in Month

Salisbury NHS
NHS Foundation Trust

- Locums Nest (a booking management system to grow our internal Locum staff bank and help reduce the Trust's agency spend) goes live on Monday 24th July. www.locumsnest.co.uk
- Our first 3 overseas nurses have successfully passed their Objective structured clinical examination (OSCE).
- A further international nurse is due to arrive this week, with a further 6 due to arrive in August
- We have launched a landing page to support our recruitment campaign whilst the microsite is developed http://nhscreative.org/salisburynhsjobs/index.html
- We have held 2 open evenings, with a further open day to be held this month.
- We have successfully made a Substantive Consultant appointment to Emergency Department.
- The Nurse Education Supervisors team have been successful in developing new areas for student nurse placements with specialist nursing teams within the trust.
- The Trainee Nursing Associates have completed their first placement.
- A new model of supporting learners in practice is being trialled on Whiteparish AMU.

Directorate Headlines M3

Salisbury NHS Foundation Trust

Directorate Health Score		
Clinical Support & Family Services	3 Green, 1 Amber, 1 Red	AMBER
Facilities	2 Green, 1 Amber, 1 Red	AMBER
Medicine	2 Green, 1 Amber, 2 Red	AMBER
Musculo Skeletal	2 Green, 1 Amber, 2 Red	AMBER
Surgery	2 Green, 2 Amber, 1 Red	AMBER
Corporate	3 Green, 2 Amber, 1 Red	AMBER
Quality	3 Green, 1 Red	GREEN

Clinical Support and Family Services	M1	M2	M3	
Agency Spend	£90,975	£96,376	£113,177	RED
Stat/Mad Training % Compliance	87	85	85	GREEN
Appraisals % Non Medical	83	82	83	AMBER
Appraisals % Medical	87	90	89	GREEN
Sickness %. Target 2.50%	2.53	2.26	2.09	GREEN

Facilities	M1	M2	M3	
Agency Spend	£10,759	£5,045	£7,948	AMBER
Stat/Mad Training % Compliance	92	94	96	GREEN
Appraisals % Non Medical	98	97	98	GREEN
Sickness %. Target 3.50%	4.04	4.89	5.02	RED

Medicine	M1	M2	M3	
Agency Spend	£255,248	£369,914	£455,464	RED
Stat/Mad Training % Compliance	77	78	79	AMBER
Appraisals % Non Medical	68	70	70	RED
Appraisals % Medical	92	96	92	GREEN
Sickness %. Target 3.40%	3.06	3.17	2.96	GREEN

Musculo Skeletal	M1	M2	M3	
Agency Spend	£94,814	£97,528	£120,910	RED
Stat/Mad Training % Compliance	86	87	87	GREEN
Appraisals % Non Medical	76	76	78	AMBER
Appraisals % Medical	95	95	95	GREEN
Sickness %. Target 2.75%	3.07	3.02	2.91	RED

Surgery	M1	M2	M3	
Agency Spend	£58,608	£91,279	£75,379	AMBER
Stat/Mad Training % Compliance	85	85	86	GREEN
Appraisals % Non Medical	80	82	82	AMBER
Appraisals % Medical	89	92	95	GREEN
Sickness %. Target 3.40%	4.31	4.35	4.41	RED

Corporate	M1	M2	M3	
Agency Spend	£3,361	£469	£0	GREEN
Stat/Mad Training % Compliance	79	84	81	AMBER
Appraisals % Non Medical	80	81	82	AMBER
Sickness % Finance/Procurement. Target 1.90%	2.45	2.36	2.37	RED
Sickness % HR &OD. Target 2.00%	1.51	1.87	1.88	GREEN
Sickness % Corporate Dev. Target 3.00%	2.81	2.59	2.47	GREEN

Quality	M1	M2	M3	
Agency Spend	£0	£0	£0	GREEN
Stat/Mad Training % Compliance	92	94	97	GREEN
Appraisals % Non Medical	87	88	88	GREEN
Sickness %. Target 3.00%	4.49	2.94	3.16	RED

Additional Notes

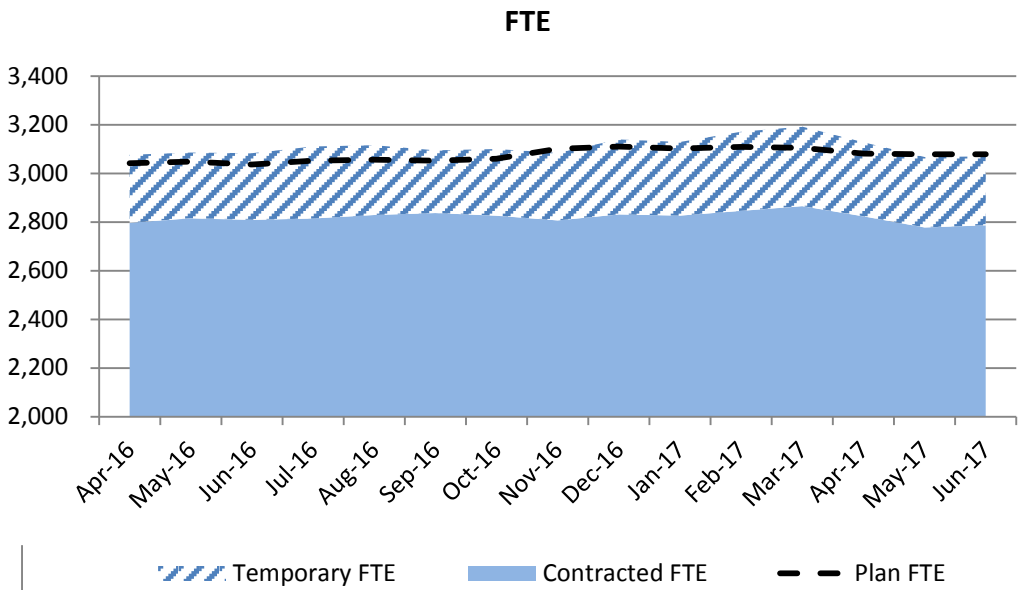
1. RAG ratings show where extra support is being provided to Directorates through the Directorate performance management structure.
2. Worsening trend and below Trust "Red" RAG rating threshold = RED. Improving trend, or above Green RAG rating threshold = GREEN. Otherwise = AMBER. Sickness worse than target = Red, Sickness better than target = Green

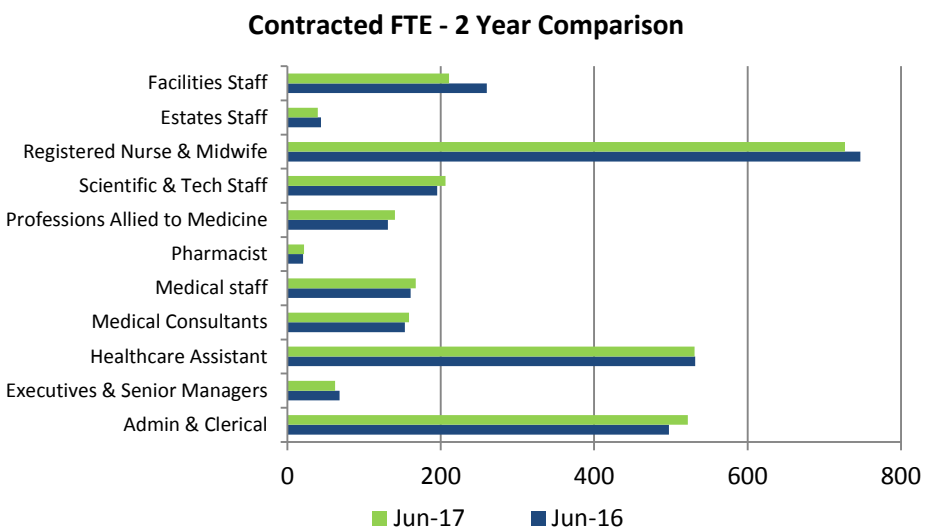
Workforce M3

Salisbury NHS Foundation Trust

June 17

Contracted Total FTE
2,786
(June 16 - 2,808)





Additional Notes

1. Overall staffing numbers are slightly under plan this month. The use of temporary staff is seen mainly in registered nursing and nursing assistants.

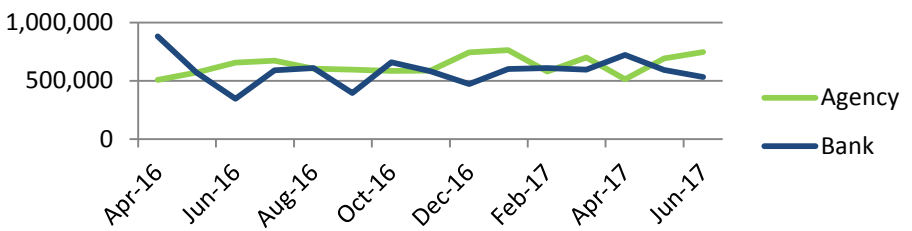
2. There has been a decrease in the number of contracted staff (FTE) down by 22 FTE compared with June 2016, mainly due to the transfer of SDU and Day Nursery Staff.

Temporary Workforce
M3

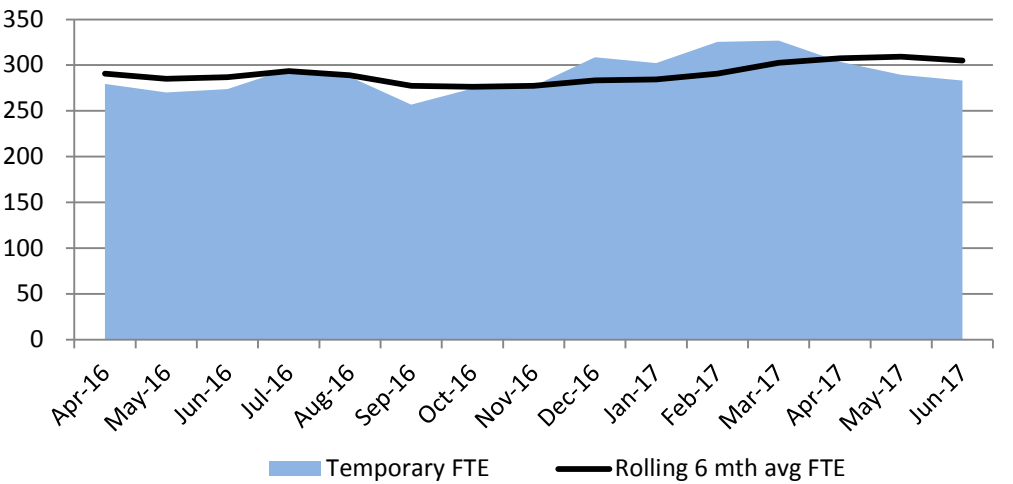
Salisbury NHS
NHS Foundation Trust

Temporary FTE 283
(June 16 - 274)

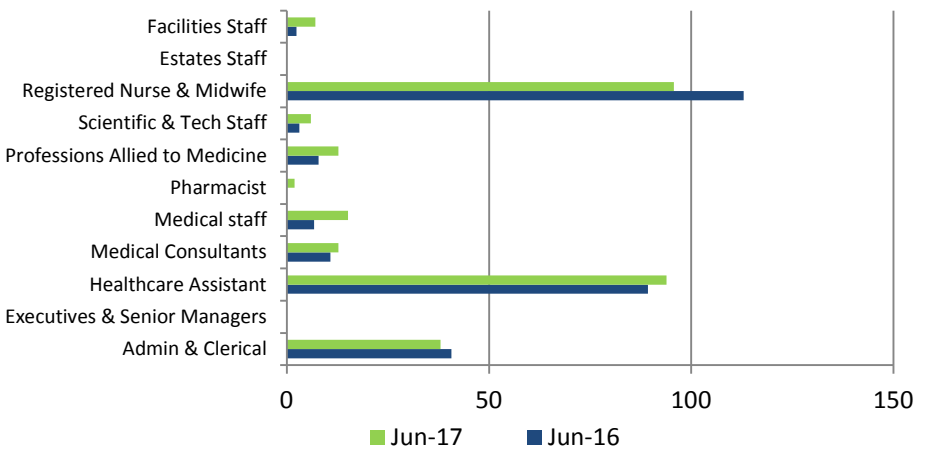
Agency and Bank Spend



Temporary FTE



Temporary FTE - 2 Year Comparison



Additional Notes

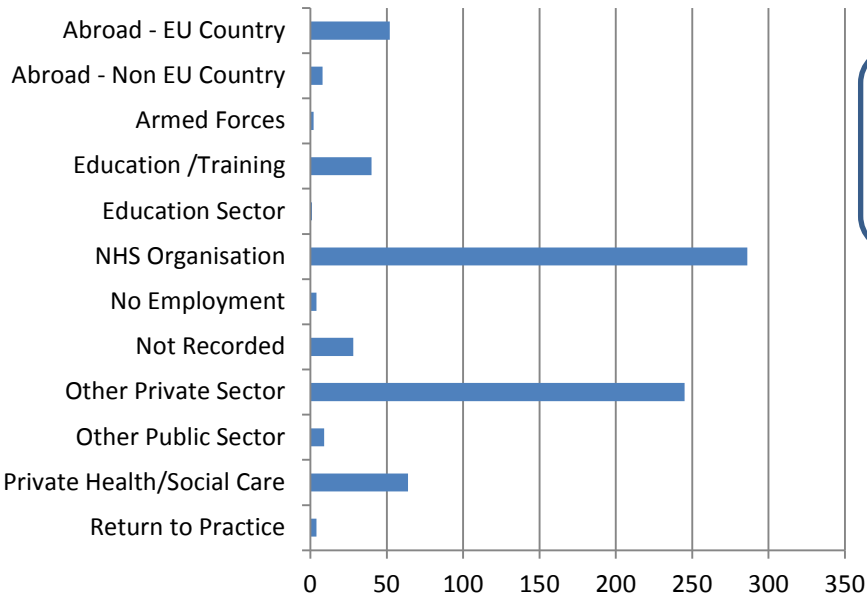
1. **Agency costs for the year to date stood at £2.0m, compared to £1.7m for the same period in 2016/17. Agency costs for June showed an increase of £54k compared to the previous month.**

Note: Temporary FTE includes bank and agency staff.

Starters – Source of Recruitment M3

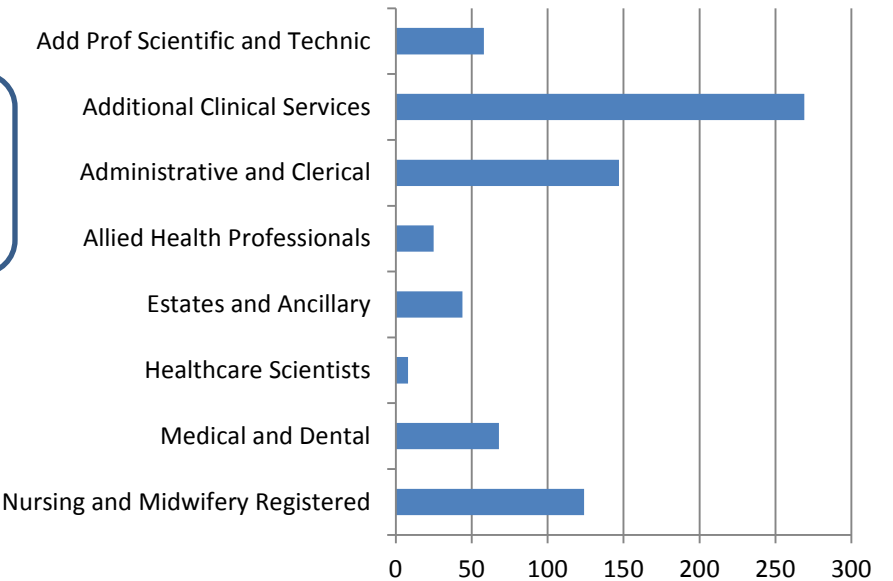
Salisbury NHS Foundation Trust

Number of Starters by Source of Recruitment



Number of M3 Starters 52

Number of Starters by Skills Group



Additional Notes

1. **There were 52 starters in month 3 compared to 63 in month 2.**
2. **As last month, the most common source of recruitment to the Trust was from other NHS Organisations; with the most popular NHS organisations being Royal Bournemouth and Christchurch Hospitals NHS Trust, followed by Southampton University NHS Trust, Basingstoke and Dorset Healthcare NHS Trust, and Great Western NHS Foundation Trust.**
3. **The skills group with the greatest number of starters was "Additional Clinical Services". This group includes Nursing and Therapy assistants.**

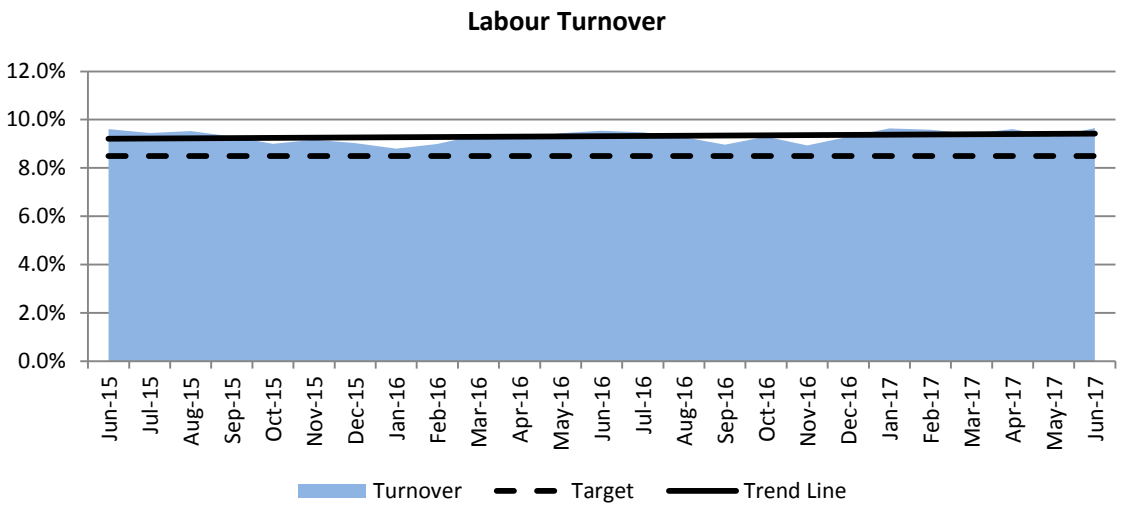
Figures are based on previous 12 months data and exclude trainee medical staff.

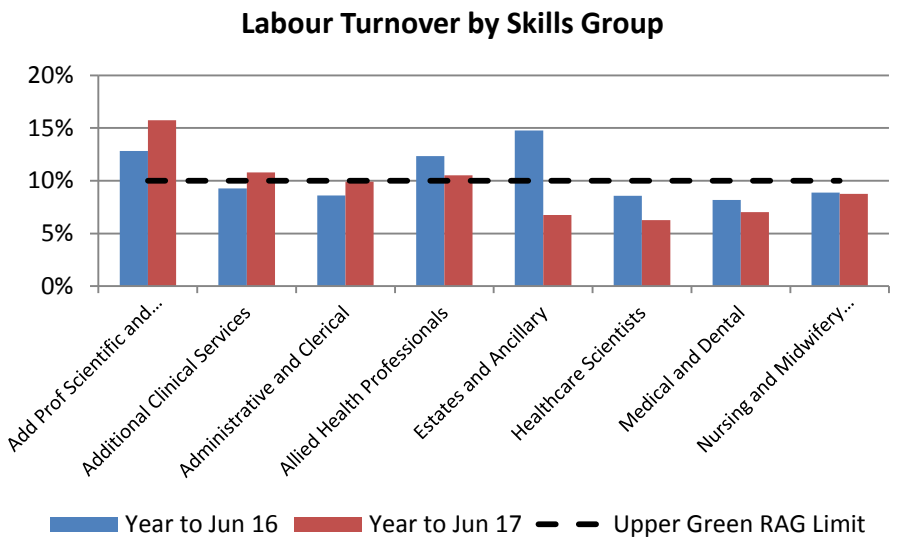
Labour Turnover
M3

Salisbury NHS Foundation Trust

June 17

9.6%
(June 16 – 9.7%)





Additional Notes

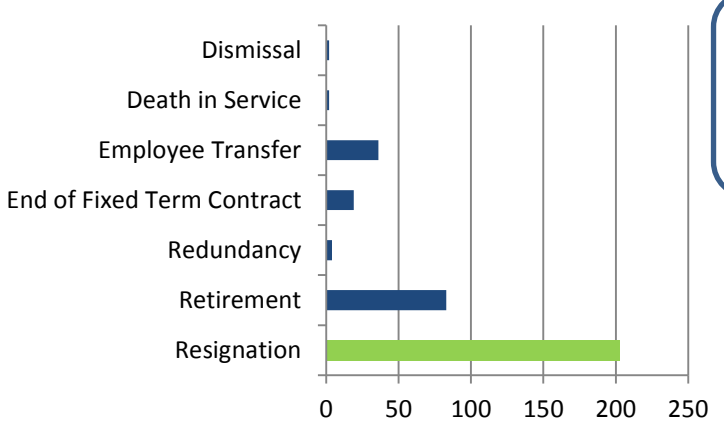
Note: Turnover figures are based on previous 12 months, and exclude bank staff, foundation and training doctors and Tupe Transfers.

1. **Turnover in the year to June 2017 stood at 9.6% compared to 9.7% in the year to June 2016.**
2. **Groups with turnover higher than the Trust's 7-10% green Red/Amber/Green rating are being monitored closely at Directorate level and actions taken as appropriate.**
3. **The overall turnover trend is being closely monitored at Trust and Directorate performance meetings.**
4. **The Trust is conducting a review of the Exit Questionnaire process to encourage uptake and identify themes.**

Leavers
M3

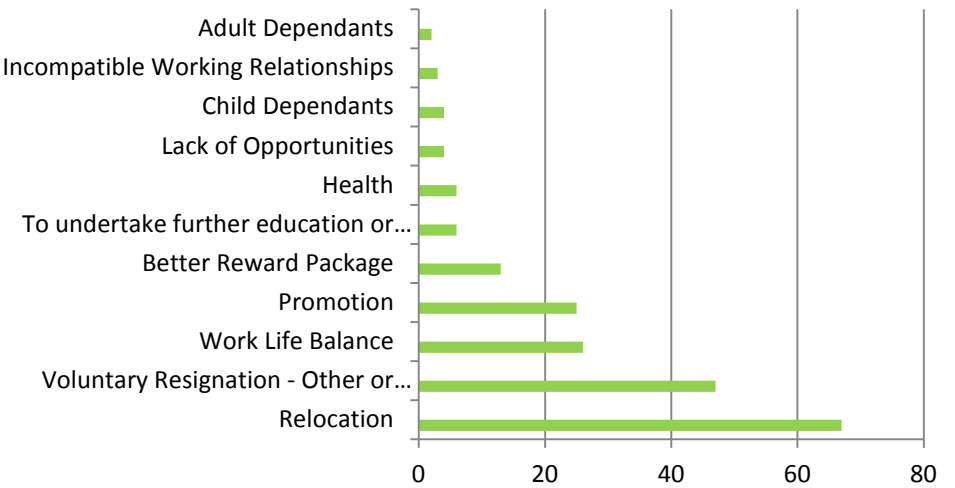
Salisbury NHS
NHS Foundation Trust

Number of Leavers by Reason

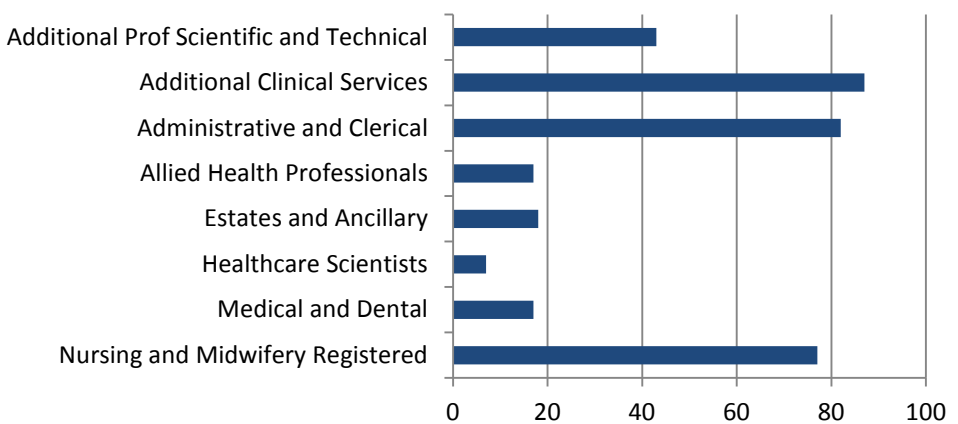


Number of M3 Leavers
27
(June 2016 - 21)

Number of Resignations



Number of Leavers by Skills Group



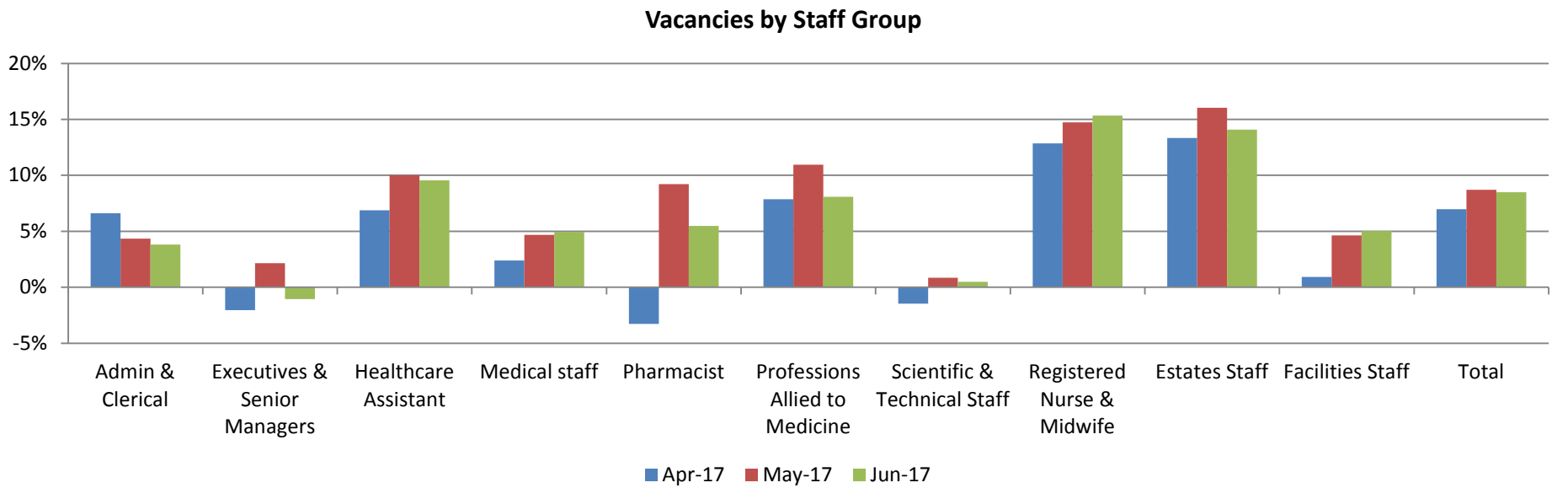
Additional Notes

1. **The most common reason for resignation was 'Relocation' which includes: family relocation due to re-basing of military partners.**
2. **All leavers can access an Exit Questionnaire or Interview. The Trust is conducting a review of the Exit Questionnaire process to encourage uptake and identify themes. These themes are fed back to managers for action.**

Note: Figures based on previous 12 months data.

Vacancies by Skills Group
M3

Salisbury NHS
NHS Foundation Trust



Additional Notes

1. The overall vacancy rate has decreased to 8%, with some small changes within the workforce.

2. 75 job offers have been made following the recruitment trip to India.

3. Nursing excludes Corporate Staff and includes those with direct clinical care only.

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

5. Some areas shown over establishment do not have a budgeted establishment as such, but earn income to cover staff costs. Others may be as a result of staff movements to cover projects, for example in Informatics, or overlap of staff for handover reasons.

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

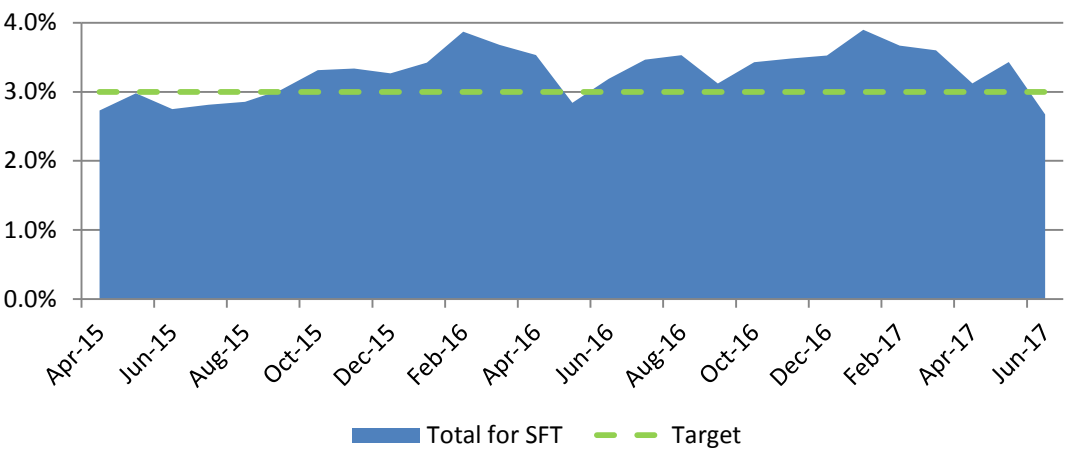
Sickness
M3

Salisbury NHS
NHS Foundation Trust

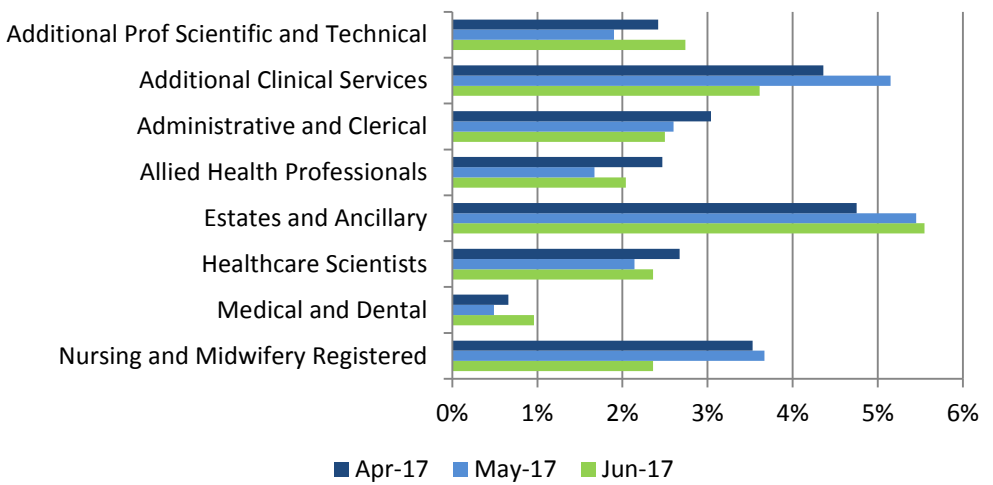
June 17

Percentage
3.41%
(June 16 – 3.26%)

Sickness Absence vs Target



Sickness Absence by Skills Group



Additional Notes

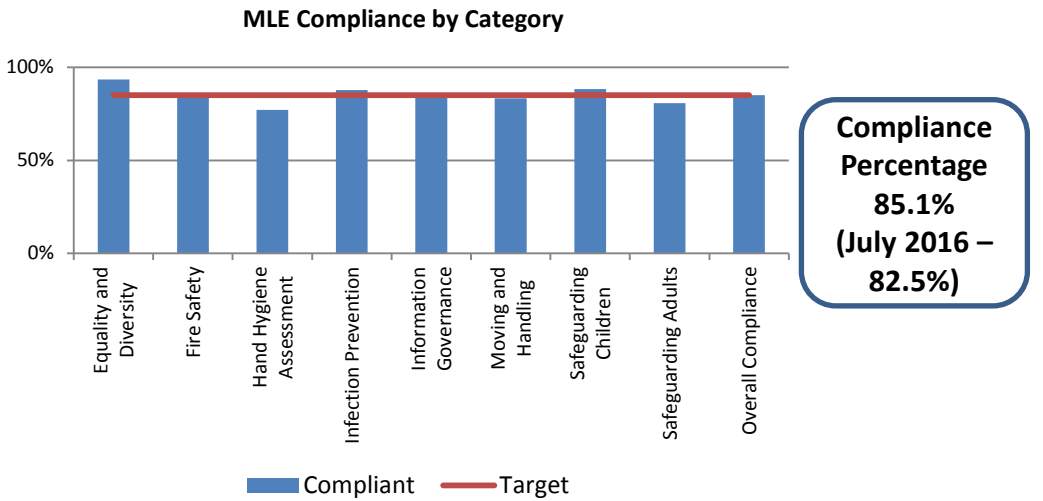
1. Each directorate has a set maximum tolerance for sickness and this is regularly monitored at performance meetings.

2. The most common reasons for sickness this month were, 'Anxiety, stress, depression, other psychiatric illnesses' and 'Injury, fracture'. Occupational Health form regular discussions at Operational Management Board.

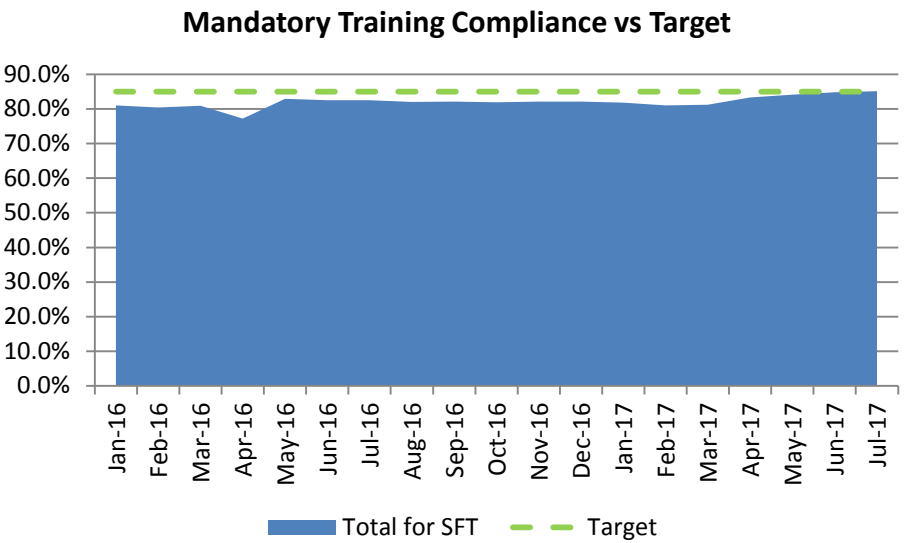
3. The skills group with the highest sickness rate was "Estates and Ancillary" with 5.6%, followed by "Additional Clinical Services" with 3.6%, which compare with the national NHS average sickness rates for these groups of 6.4% and 6.2% respectively.

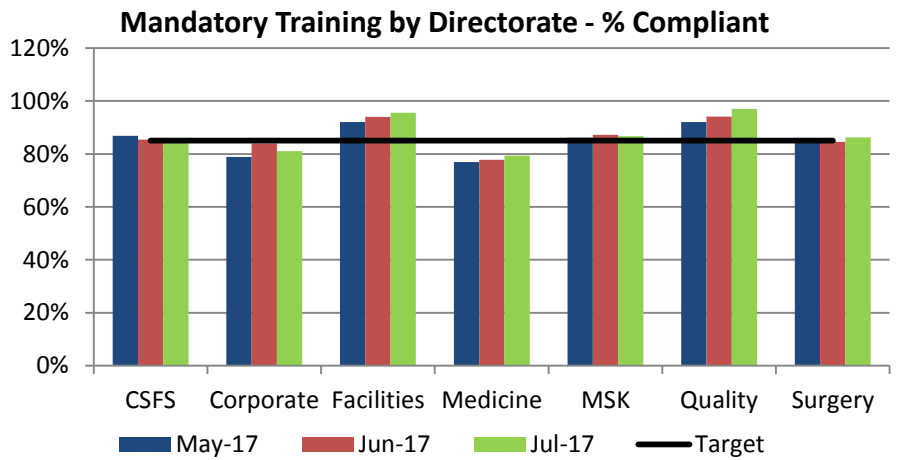
Mandatory Training
M3

Salisbury NHS Foundation Trust



Compliance Percentage 85.1% (July 2016 – 82.5%)





Additional Notes

1. The percentage of staff up to date with their mandatory training has increased this month from 84.8% to 85.1% against a target of 85%.
2. The directorate with the highest compliance rate was Quality with 97.0%, and the directorate with the lowest compliance rate was Medicine at 79.3%.
3. Highest compliance is in Equality and Diversity, currently at 93.5%, lowest compliance is in Hand Hygiene training, this is now being recorded in live time to give an up to date picture, currently at 77.2%.

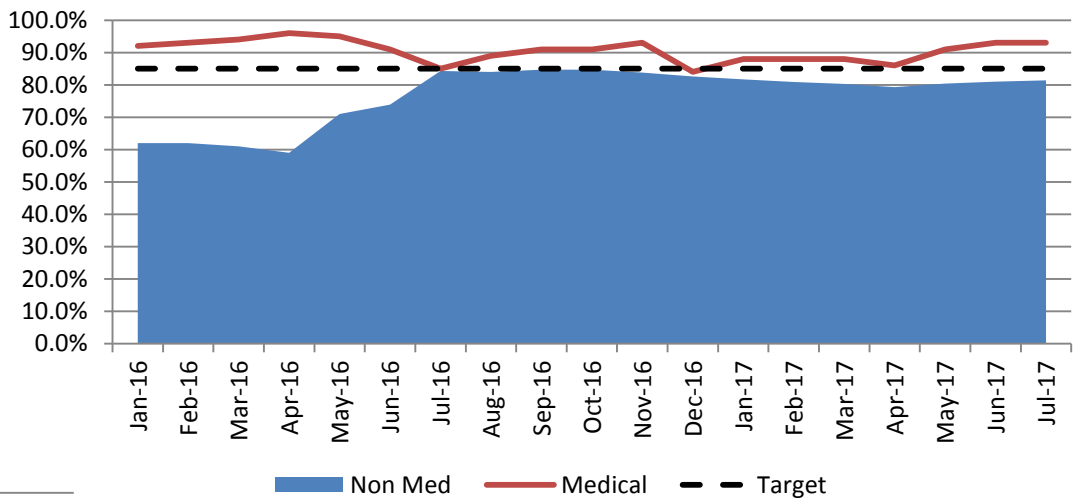
Appraisals
M3

Salisbury NHS
NHS Foundation Trust

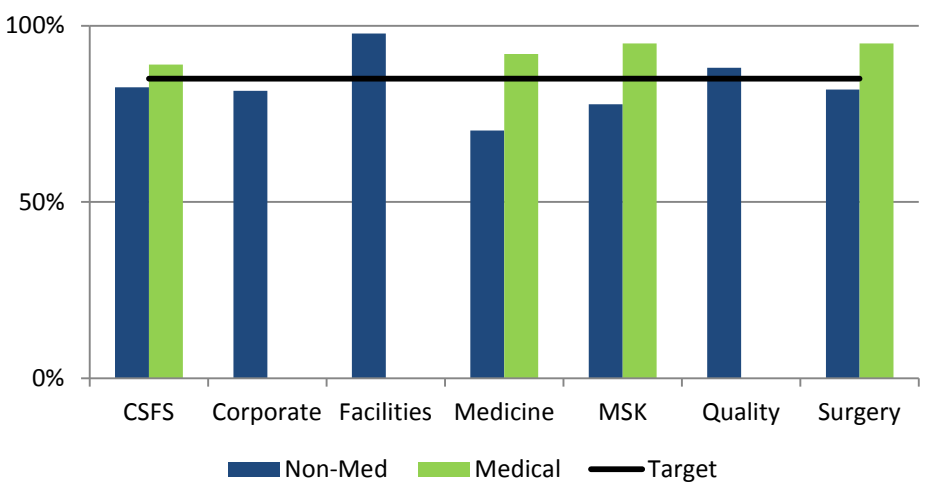
July 17

Compliance percentage - 81.4% non medical, 93% medical.

Appraisal Compliance vs Target



Annual Appraisal by Directorate - % Compliant



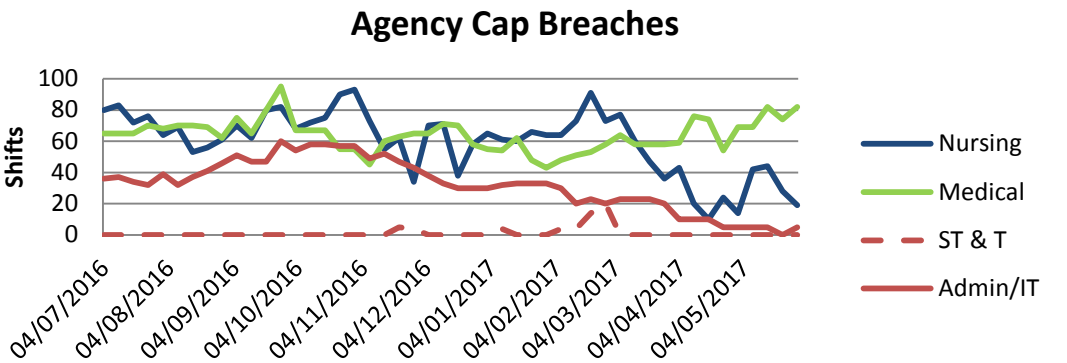
Additional Notes

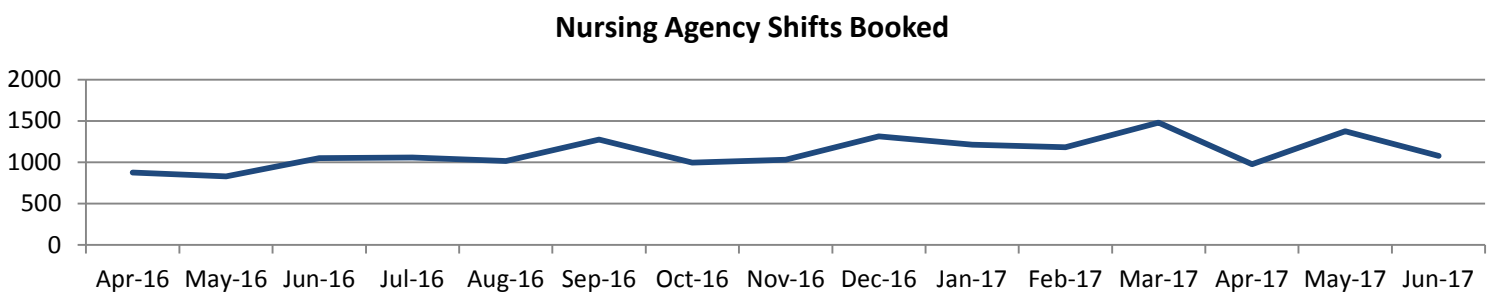
1. **Appraisal compliance for non-medical staff has slightly increased from 81.0% to 81.4% this month. Data is taken from a 13 month window to more accurately reflect activity. Detailed non-compliance reports are now live and available to managers (providing the names of non-compliant individuals) for further action.**
2. **The percentage of Medical staff with an annual appraisal in the last 12 months has remained at 93% this month.**

Agency Cap Breaches
M3

Salisbury NHS
NHS Foundation Trust

Agency Nursing Shifts 1079
Agency Nursing Cap Breaches 98 (9%)
Agency Medical Shifts 386
Agency Medical Cap Breaches 356 (92%)





Additional Notes

1. **The data shows the trend on agency usage since April 2016 . The breaches of the NHS Improvement caps reveals that the cost of agency is not reducing across all shifts and that the cost for agency, when it is used last minute, can be considerably high.**
2. **A "Mastervend" contract has been implemented for the supply of locum Medical staff, and efforts are being made to recruit to hard to fill vacancies, to reduce reliance on agency.**

Key Risks/Assurances

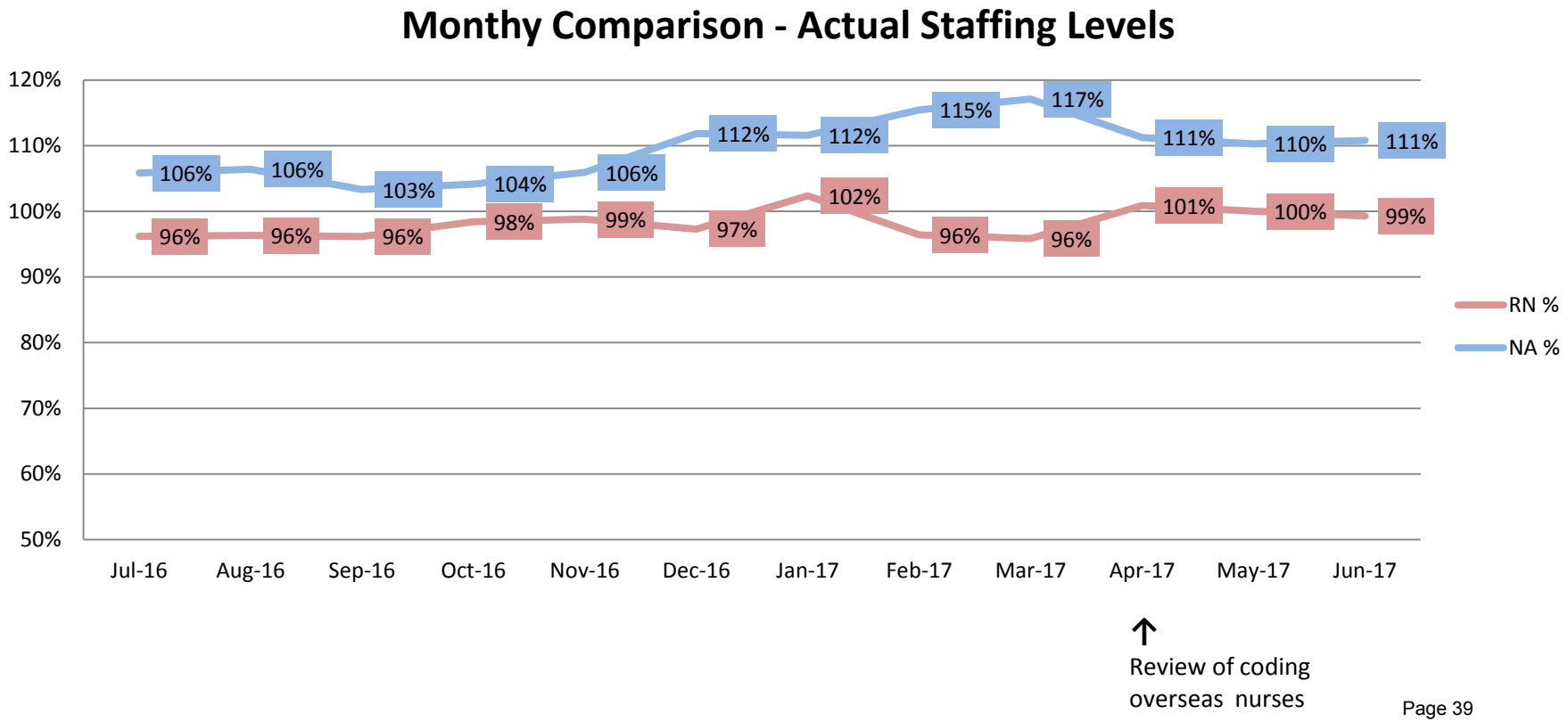
Salisbury NHS
NHS Foundation Trust

- Recruitment – we are developing a workforce strategy which will address our workforce requirements and build sustainably for the future. A number of work streams are in place, looking at hard to fill gaps across the Trust, using agencies to recruit overseas doctors, and introducing a co-ordinated approach to ensure safe staffing levels.
- Appraisal compliance has increased again slightly this month and is just below target. Information is accessible to managers allowing for transparency and better targeted action.
- Directorates are scrutinising spend and looking at alternatives. A "Mastervend" contract has been implemented for the supply of locum Medical staff, and efforts are being made to recruit to hard to fill vacancies, to reduce reliance on agency. We are developing our own internal bank for the supply of locum medical staff and have implemented standardised Trust medical locum rates.
- NHS Improvement cap breaches for the supply of Nursing agency shifts have reduced, with a number of new contracts successfully negotiated with agencies for the supply of agency staff. Booking of all agency locum staff has been re-sited in the bank office so there is more resilience around identifying and supplying agency shifts.
- Turnover has remained steady over the last 2 years excluding Tupe Transfers. This trend is being closely monitored at Trust and Directorate performance meetings which focus on specific hot spots.

Safe Staffing NQB Report – June 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
June-17	56487.4	56092.5	99%	33225.4	36805.7	111%	89712.8	92898.2	104%	60%	40%



Overview of Nurse Staffing Hours – June 2017

Day	RN	NA
Total Planned Hours	33629.44	21313.40
Total Actual Hours	32814.83	23429.98
Fill Rate (%)	**97.6%**	**109.9%**

Night	RN	NA
Total Planned Hours	22858	11912
Total Actual Hours	23277.67	13375.67
Fill Rate (%)	**101.8%**	**112.3%**

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	**14299.45**	**13860.40**	**97.8%**	**10320.17**	**11966.31**	**116.0%**
Breamore	1038.00	1001.75	97.0%	859.67	1126.17	131.0%
Durrington	1037.00	1087.20	105.0%	886.00	1125.00	127.0%
Farley	1891.75	1892.75	100.0%	1467.75	1810.25	123.0%
Hospice	869.00	895.75	103.0%	638.50	607.00	95.0%
Pembroke	796.50	797.00	100.0%	387.50	485.00	125.0%
Pitton	1703.00	1700.25	100.0%	1167.75	1127.58	97.0%
Redlynch	1467.45	1418.45	97.0%	1125.50	1151.48	102.0%
Tisbury	1983.00	1876.75	95.0%	690.50	917.58	133.0%
Whiteparish	1739.50	1661.00	95.0%	1059.00	1090.50	103.0%
Winterslow	1774.25	1529.50	86.0%	2038.00	2525.75	124.0%
Surgery	**5916.50**	**6170.33**	**105.0%**	**2370.00**	**2457.58**	**101.3%**
Britford	1948.00	1931.00	99.0%	1105.50	1158.83	105.0%
Downton	1188.50	1324.00	111.0%	917.00	975.00	106.0%
Radnor	2780.00	2915.33	105.0%	347.50	323.75	93.0%
MSK	**8582.32**	**7998.76**	**92.3%**	**7247.48**	**7758.17**	**113.0%**
Amesbury	1607.75	1686.50	105.0%	1374.00	1341.50	98.0%
Avon	1475.50	1274.58	86.0%	1897.92	1857.67	98.0%
Burns	1311.90	1211.93	92.0%	550.50	921.00	167.0%
Chilmark	1447.50	1391.00	96.0%	1082.75	1164.00	108.0%
Laverstock	1591.67	1499.33	94.0%	900.48	842.50	94.0%
Tamar	1148.00	935.42	81.0%	1441.83	1631.50	113.0%
CSFS	**4831.17**	**4785.34**	**100.7%**	**1375.75**	**1247.92**	**95.3%**
Maternity	2735.25	2610.75	95.0%	1030.75	911.25	88.0%
NICU	1067.42	1134.42	106.0%	0.00	0.00	100.0%
Sarum	1028.50	1040.17	101.0%	345.00	336.67	98.0%
Grand Total	**33629.44**	**32814.83**	**97.7%**	**21313.40**	**23429.98**	**110.4%**

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	**9512.00**	**10037.50**	**105.6%**	**5577.00**	**6632.67**	**113.8%**
Breamore	690.00	690.00	100.0%	690.00	701.50	102.0%
Durrington	690.00	770.50	112.0%	690.00	724.50	105.0%
Farley	1035.00	1082.50	105.0%	690.00	827.50	120.0%
Hospice	560.50	560.50	100.0%	405.00	415.50	103.0%
Pembroke	683.00	684.00	100.0%	0.00	230.00	100.0%
Pitton	1035.00	1263.75	122.0%	690.00	721.00	104.0%
Redlynch	1035.00	1012.00	98.0%	690.00	747.50	108.0%
Tisbury	1380.00	1357.00	98.0%	345.00	540.17	157.0%
Whiteparish	1380.00	1353.25	98.0%	342.00	368.00	108.0%
Winterslow	1023.50	1264.00	123.0%	1035.00	1357.00	131.0%
Surgery	**4116.50**	**4128.50**	**100.7%**	**1712.00**	**1779.75**	**103.3%**
Britford	1035.00	1023.50	99.0%	690.00	747.75	108.0%
Downton	690.00	701.50	102.0%	688.50	700.00	102.0%
Radnor	2391.50	2403.50	101.0%	333.50	332.00	100.0%
MSK	**4726.00**	**4745.75**	**100.3%**	**3542.00**	**3860.00**	**115.8%**
Amesbury	1035.00	1014.00	98.0%	690.00	690.00	100.0%
Avon	888.50	886.75	100.0%	900.00	910.00	101.0%
Burns	690.00	692.00	100.0%	345.00	701.50	203.0%
Chilmark	569.50	571.00	100.0%	570.00	532.00	93.0%
Laverstock	943.00	982.00	104.0%	437.00	426.50	98.0%
Tamar	600.00	600.00	100.0%	600.00	600.00	100.0%
CSFS	**4503.50**	**4365.92**	**98.0%**	**1081.00**	**1103.25**	**124.7%**
Maternity	2433.50	2291.67	94.0%	1035.00	1022.75	99.0%
NICU	1035.00	1047.75	101.0%	0.00	0.00	100.0%
Sarum	1035.00	1026.50	99.0%	46.00	80.50	175.0%
Grand Total	**22858.00**	**23277.67**	**102.5%**	**11912.00**	**13375.67**	**114.4%**

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

Overview of Areas with Red/Amber

Flag	Ward	%	RN	NA	Shift	Mitigation
Amber	**Avon**	86%	√		Day	Avon has 4.66 WTE vacancies and Tamar 3.38 WTE. The patient acuity and skills set of the staff on shift are reviewed daily with lead nurse and DSN. Staff from spinal outpatients are utilised to assist on the wards during busy periods and the lecture practitioner works clinically across both wards to support nursing numbers.
Amber	**Tamar**	81%	√		Day	
Amber	**Maternity**	88%		√	Day	These were unfilled due to sickness. There were unsuccessful attempts to cover with bank staff . The unit ensured safety by escalating to the community when activity dictated and utilising non clinical staff to support workflow in non clinical tasks
Amber	**Winterslow**	86%	√		Day	B5 Shifts are sometimes covered with a Band 4 which affects the RN %

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 skill mix (60/40) and staffing levels (RN /NA 99% /111%) have remain stable since May 2017

Higher NA levels demonstrate the on-going requirement to provide safe 1:1 enhanced care for patients at risk across the Trust particularly in Medicine and Burns.

There are no wards flagging Red for unfilled shifts this month. There are moderately fewer wards at Amber compared with May 2017 (3 x medical wards) with only 1 medical ward flagging this month.

- **Tamar & Avon:-** Both Tamar & Avon are carrying RN vacancies. Both lead nurses of Tamar and Avon work together to ensure all shifts for both wards are staffed safely. Unfilled shifts are always send to nurse bank, on cap agency, and staffing demands in other areas across the Trust are reviewed. If the shift remains unfilled and patient acuity is high, the shift will be escalated to DSN who will submit an agency request to prevent any staffing gaps ensuring there is no compromise on patient safety.
- **Winterslow:-** RN day shifts were bolstered by other staff cohorts being utilised (i.e. band 4, AHPs and ward leaders) who supported peak patient demand times permitting extra RN provision to be available at night at a time when a large cohort of patients required enhanced care.
- **Maternity:-** Sickness was the overriding factor for unfilled shfits with the inability to cover with local bank staff. If high levels of patient acuity and demand require these shifts to be covered there are multiple processes in place. Escalation can be to the Community, to a midwifery supervisor on 24 hour call (who will assist with escalation and support) and in addition, during the day , managers and non-clinical staff are deployed as necessary.

Overview of Overstaffed Areas >115%

(Medical Directorate)

Ward	%	RN	NA	Shift	Comments
Breamore	131%		√	Day	The ward is staffed for 20 beds but has been running as a 24 bedded unit therefore requiring some increase in staffing levels which is provided through an additional NA
Durrington	127%		√	Day	Extra staffing was all for large numbers of patients requiring enhanced care due to confusion, or at risk of harm from falls. At one point 18/21 ward patients were at very high risk of falls
Farley	123%		√	Day	Several patients throughout the month required enhanced care due to confusion, or at risk of harm from falls.
Farley	120%		√	Night	
Pembroke	125%		√	Day	These are to cover 4 extra capacity beds with an extra NA within the numbers. This increase in establishment will align from September reporting as and when used.
Winterslow	124%		√	Day	All overstaffing was for either 1:1 care needs or enhanced care for patients due to confusion, or at risk of harm from falls. Extra staffing was provided by NA staff where possible and deemed safe to do so. RN staff were re-deployed from days to RN nights was to cover the "extra" approved nocturnal Band 5 post due to increased acuity.
Winterslow	131%		√	Night	
Winterslow	123%	√		Night	
Pitton	122%	√		Night	Extra cover is used for increased levels of patient acuity due to patient needs based on risk assessments and acuity levels. This was for 1:1 RN care for high acuity tracheostomy patients.
Tisbury	133%		√	Day	20 shifts were additional shifts for enhanced care needs for patients with enhanced care needs or those who were acutely ill . Staffing numbers were bolstered to ensure safe staffing levels against patient acuity demand
Tisbury	157%	√		Night	5 patients had high acuity demands for several nights requiring extra RN support

Overview of Overstaffed Areas >115%

(MSK & Surgery)

Ward	%	RN	NA	Shift	Comments
Burns	167%		√	Day	Both shifts are for extra NA staff to provide 1:1 enhanced care for a patient with mental health needs. This is on-going with currently no known end date.
Burns	203%		√	Night	
Sarum	175%		√	Night	There was only one shift with an additional NA. This was to support only 2RN on shift when 3 RN are budgeted for. A locally skilled NA was redeployed to nights as deemed to offer more consistent quality care than a more expensive external agency nurse unfamiliar with the environment.

Over-staffing

Where possible, information was extracted from supporting narrative entered within the SafeCare data census records for June 2017.

Burns

- There is an on-going need to provide extra NA support for both night and day shifts for a patient with mental health needs. Overstaffing for this unit has reduced significantly this month compared to May where 1:1 RMN care was also required 24/7.

Farley/Durrington/Winterslow

All wards had increases in NA cover for 1:1 enhanced care for patients deemed at risk to meet the demands of patient safety .

- Winterslow RN understaffing reflects the exact amount of overstaffing on RN night shifts evidencing flexible rostering to cover the extra night time Band 5 post approved due to high activity

Pitton :- 1:1 RN care was required for tracheostomy patients.

Tisbury:- There were several patients over the month who had high levels of acuity resulting in the need to bolster shift numbers .

Sarum:- The small numbers involved grossly exaggerate the numbers. Only one shift was overstaffed but is reflected as 175% overstaffing as NAs are not usually rostered for nights

Breamore and Pembroke:- Both units have extra 4 beds within their capacity to be used as escalation and this results in a need for an extra NA to support the extra patient demand.

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.

Salisbury NHS Foundation Trust Board - 7 August 2017

SFT 3909b

Title: Quality indicator report – June 17 & Q1 2017/18

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

Executive Summary: **Please note: the readmission data & data for fractured neck of femur (except best practice tariff compliance) & multiple ward moves is unable to be extracted from the data warehouse currently.**

- No MRSA bacteraemias in Q1. One Trust-apportioned MSSA bacteraemia in Q1 which is still being investigated.
- No Trust apportioned C. difficile cases in June. A total of 1 in Q1.
- 2 new serious incident inquiries commissioned in June. A total of 7 in Q1.
- 2 in-hospital cardiac arrests in May 17, of which 1 had a futile CPR attempt.
- A decrease in the crude mortality rate in June 17. SHMI decreased to 102 and to 101 adjusted for palliative care to December 2016. HSMR decreased to 117 in March 17 and is higher than expected. In April, 27 (43.5%) of 62 deaths were reviewed. None were considered avoidable. There were 5 learning points. Mortality newsletter drafted and will be published at the end of July 17.
- A decrease in Q1 of hip fracture patients being operated on within 36 hours. Those that waited beyond 36 hours were waiting for theatre (17) and for medical review/further investigations (2). Best Practice Tariff compliance decreased to 73% in Q1.
- A decrease in grade 2 pressure ulcers this month. There was one suspected deep tissue injury but the patient died before it could be staged. Share and learning meetings continue to drive improvements.
- In June 17 there were 2 falls resulting in major harm (both fractured hips requiring surgery). In Q1 there were 5 falls all resulting in major harm (all fractured hips/femur requiring surgical repair). A new falls reduction strategy and action plan was reported to the Clinical Risk Group and our commissioners in June 17.
- 100% delivery of CT scan within 12 hours and an improvement in stroke patients spending 90% of their stay on the stroke unit. Patients arriving on the stroke unit within 4 hours improved but remains below the national benchmark – clinical reasons account for most exceptions (2 went to ITU, 1 delayed due to deteriorating condition & 1 no reason given). SSNAP case ascertainment decreased from a B to D (Dec 16 to March 17) – due to timeliness of transfer to the stroke unit, therapy and consultant vacancies & data quality issues. In response to this, ring fenced access bed agreed, therapy vacancies filled, 3rd consultant recruited.
- An increase in the percentage of high risk TIA patients seen within 24 hours.
- Escalation bed capacity decreased slightly in June. Ward moves between 22.00 and 06.00 reported by month only. The plan to reconfigure the bed base over the next 6 months in preparation for next winter has commenced.
- In Q1 there were no non-clinical mixed sex accommodation breaches and this is the 4th month in a row.
- Real time feedback for patients rating the quality of their care decreased slightly in June. The Friends and Family test of patients who would recommend ED, wards, the maternity service and care as a day case and outpatients was sustained.

Proposed Action: 1) To note the report.

Supporting Information: Quality indicator report to June 2017

Salisbury NHS
NHS Foundation Trust

Trust Quality Indicators - June 2017

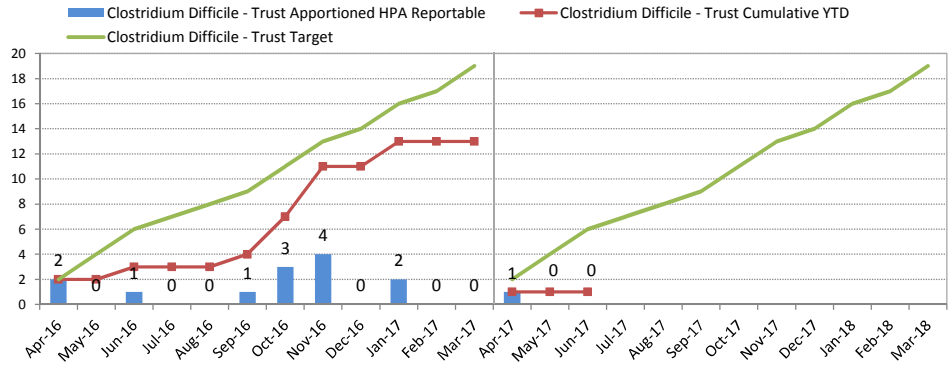
Quality Measures

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

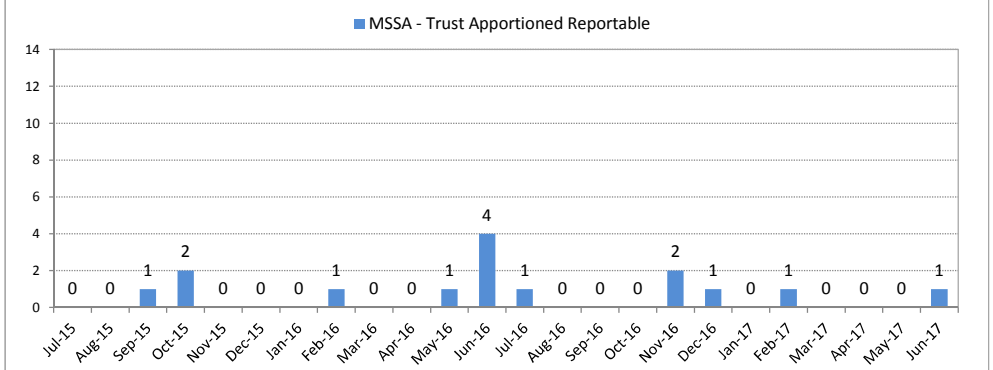
Trust Incidents	2016-17 YTD	2017-18 YTD
Never Events	2	0
Serious Incidents Requiring Investigation	47 *	7

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

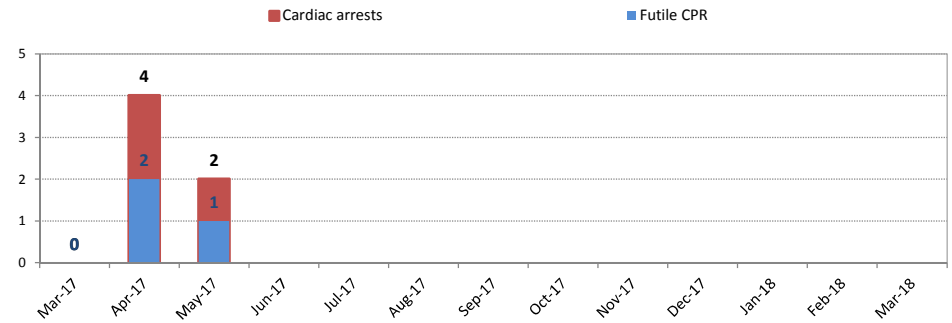
Clostridium Difficile - Trust Apportioned



MSSA - Trust Apportioned

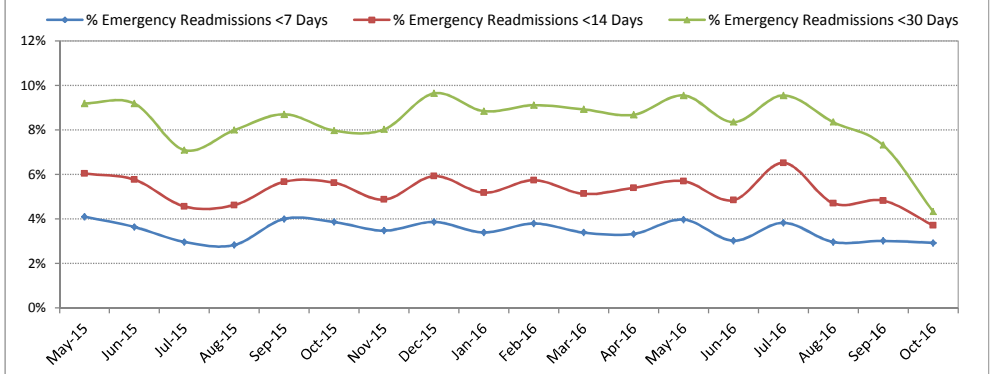


In hospital cardiac arrests and futile CPR

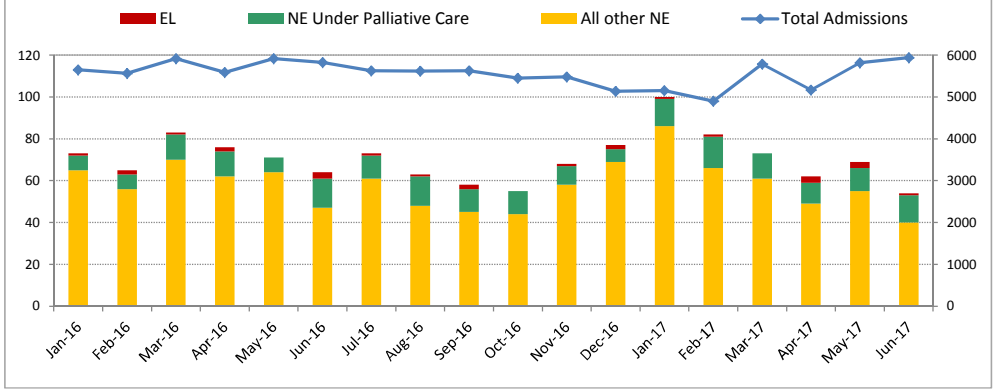


Please note cardiac arrests which occurred in ED, ITU, CCU and Paediatrics are excluded.
Data from Mar-17 onwards

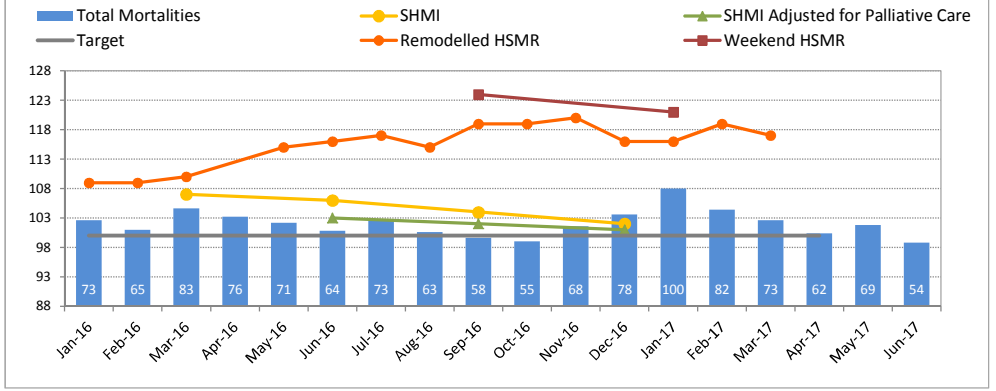
Emergency Readmissions within 7, 14 & 30 days of Discharge



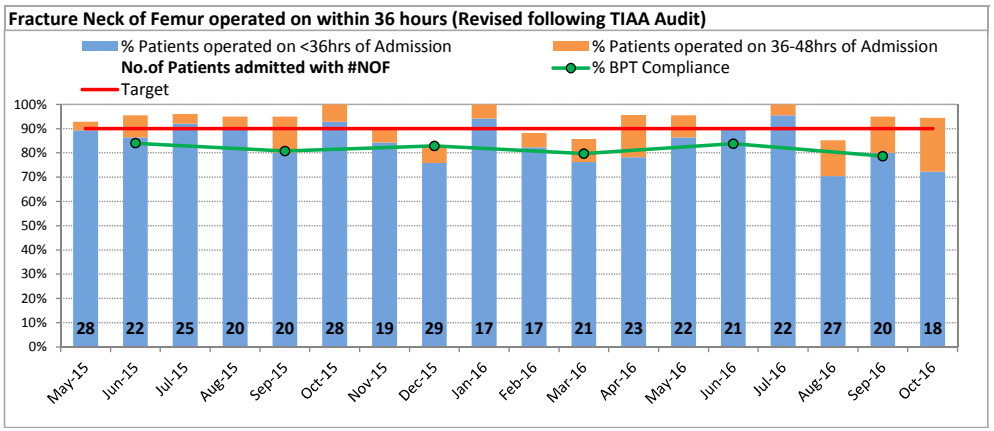
Hospital Mortalities



HSMR and SHMI



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

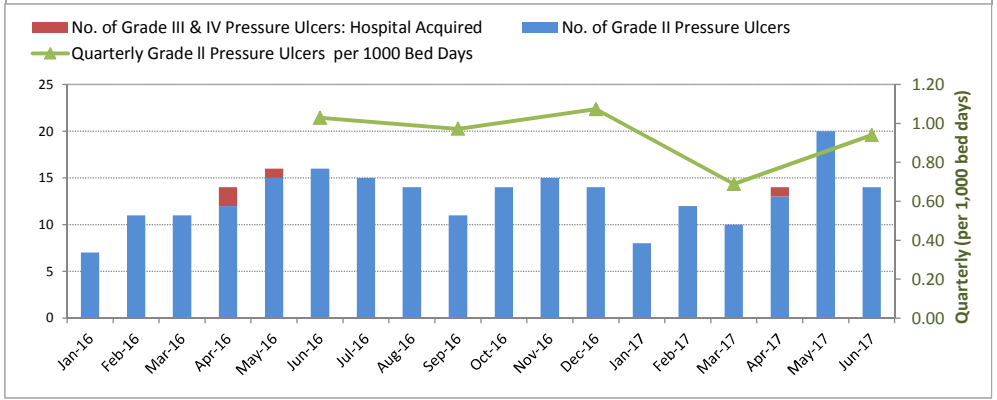


Salisbury NHS
NHS Foundation Trust

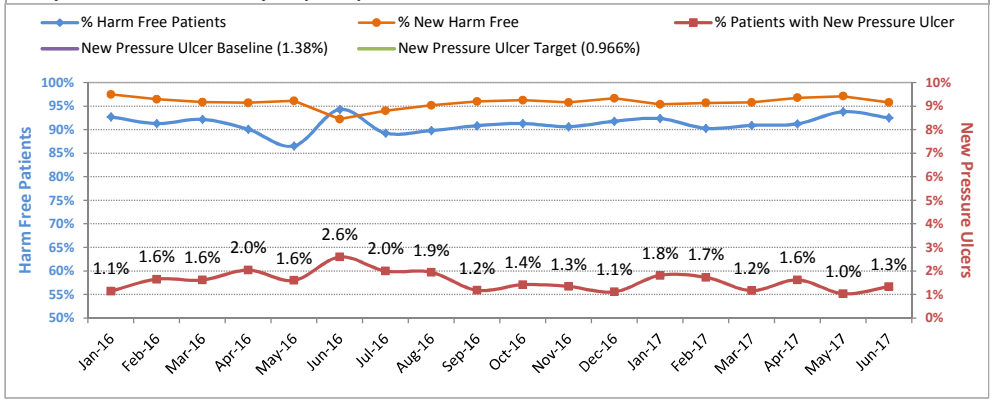
Trust Quality Indicators - June 2017

Quality Measures

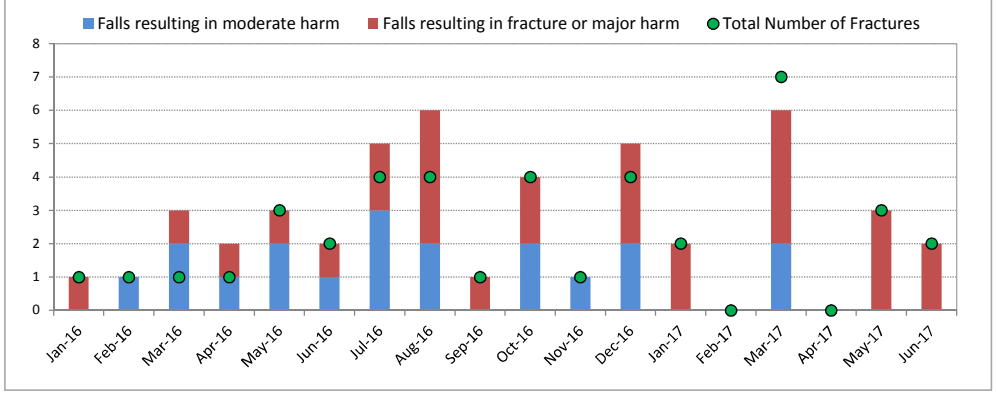
Pressure Ulcers



Safety Thermometer - One Day Snapshot per Month

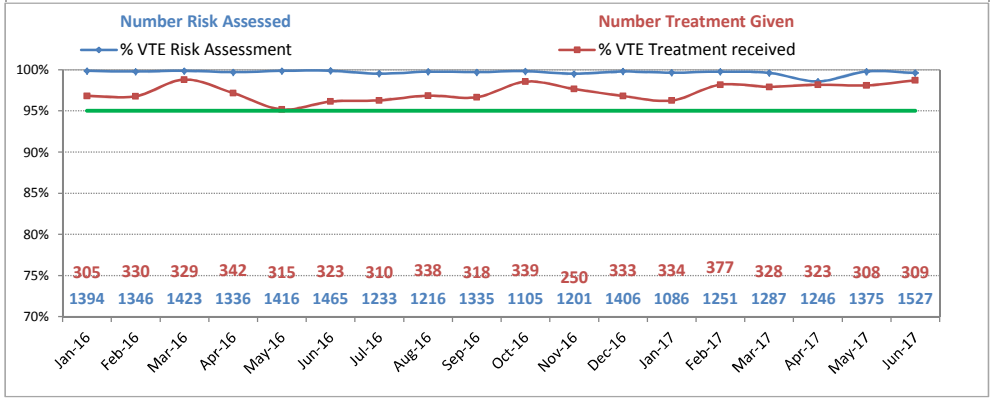


Patient Falls in Hospital



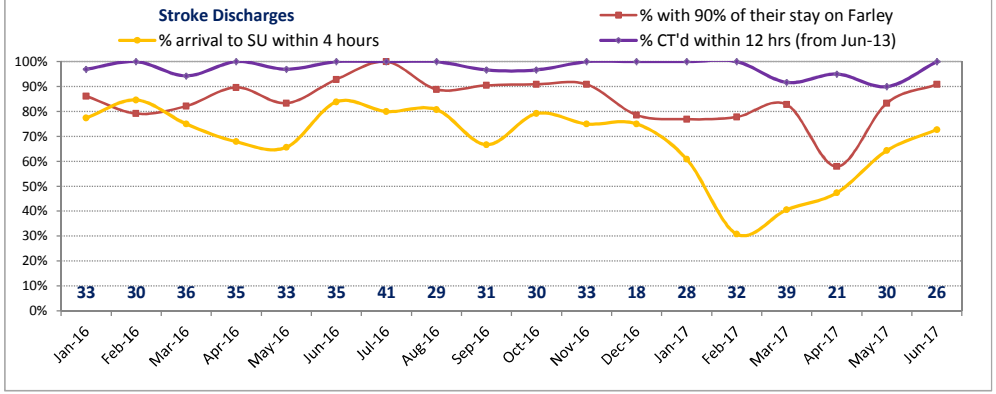
Please note, in Mar-17 1 patient has 2 fractures.

Venous Thrombous Embolism: Risk Assessment & Prophylaxis

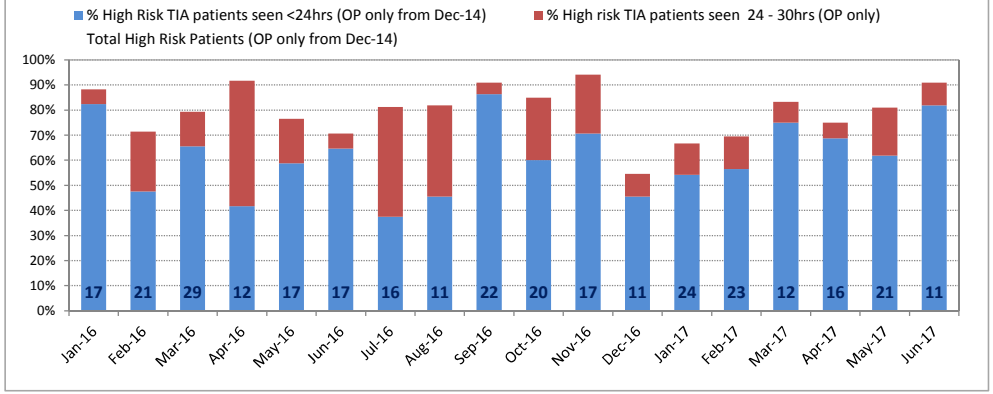


Please note, due to the time it takes to complete Clinical Coding, the current months Fracture Neck of Femur data will be subject to change over the following months.

Stroke Care



TIA Referrals



SSNAP Case Ascertainment Audit

Highest level = Grade A

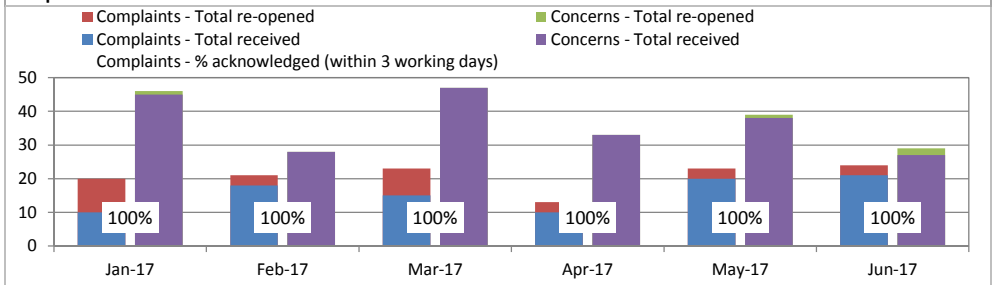
Lowest level = Grade E

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

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

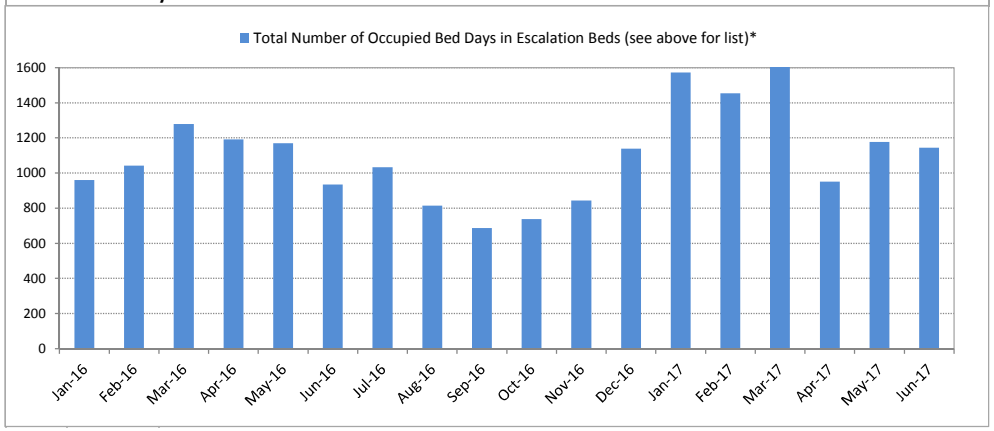
*From April 2016 escalation capacity includes beds on Breamore, DSU, Clarendon, Endoscopy, Avon, Britford SAU overnight stays, Whiteparish AMU overnight stays, Clarendon NHS, Pembroke Suite and Burns assessment room.

Complaints and Concerns

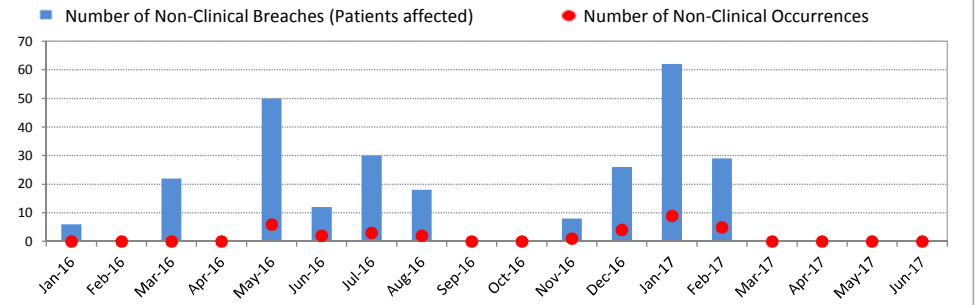


	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Complaints - Total received	10	18	15	10	20	21
Complaints - Total re-opened	10	3	8	3	3	3
Concerns - Total received	45	28	47	33	38	27
Concerns - Total re-opened	1	0	0	0	1	2

Escalation Bed Days

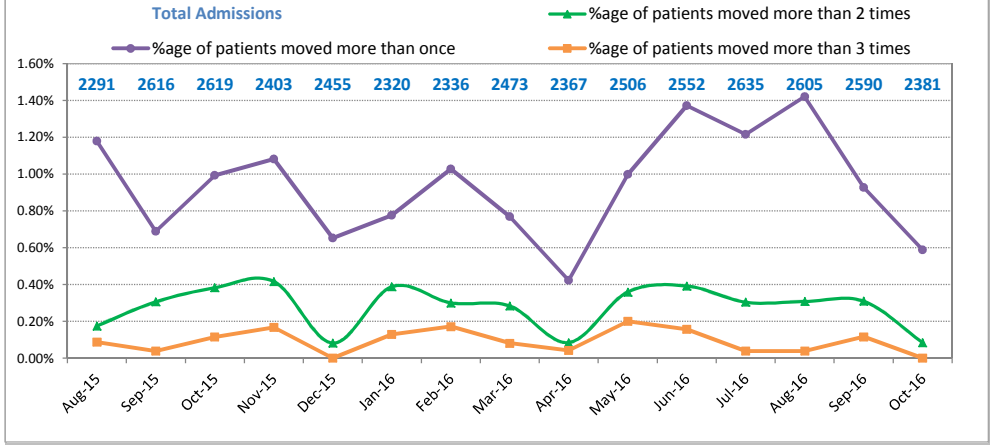


Delivering Same Sex Accommodation



	Jan-16	Feb-16	Mar-16	Apr-16	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
■	6	0	22	0	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

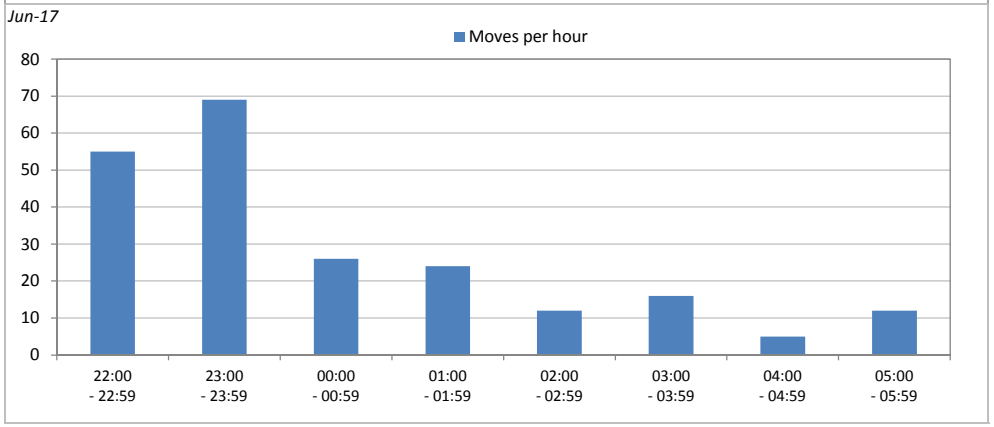
Patients moving multiple times during their Inpatient Stay



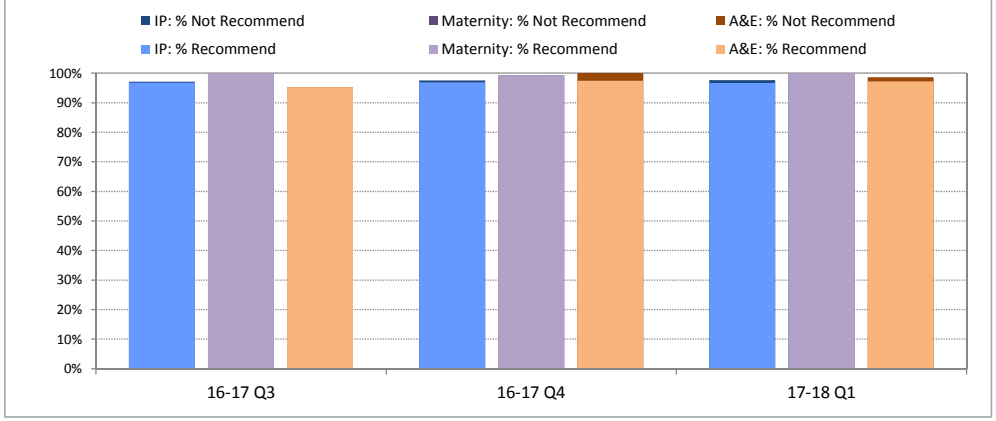
Please note, the number of Non-Clinical Breach Ocurrences is being reported from May 2016.

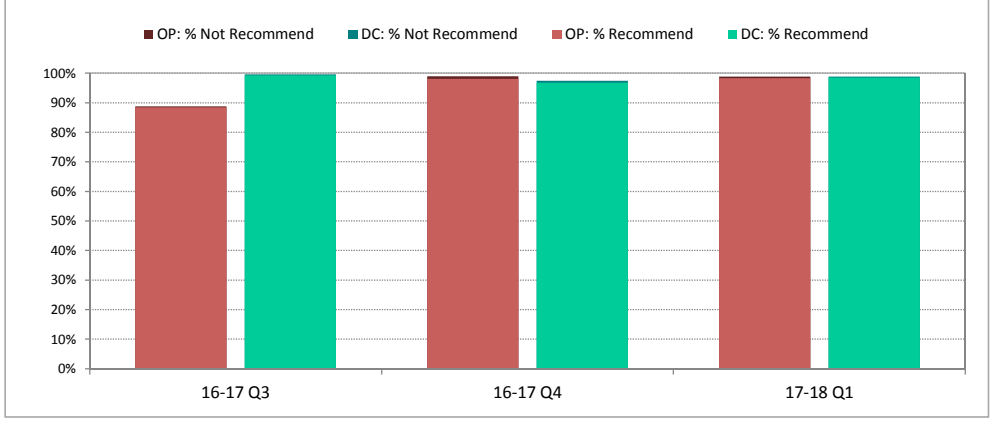
Ward moves between 22:00 and 06:00

Jun-17

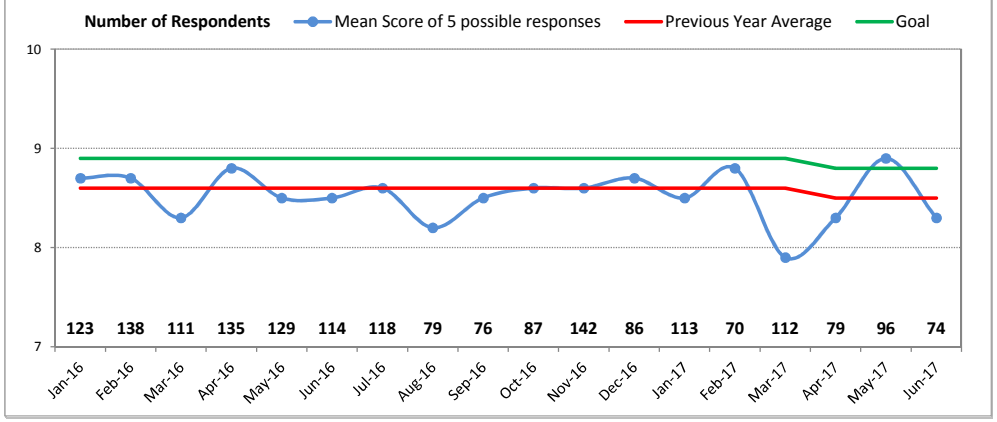


Friends & Family Test: Responses by Area

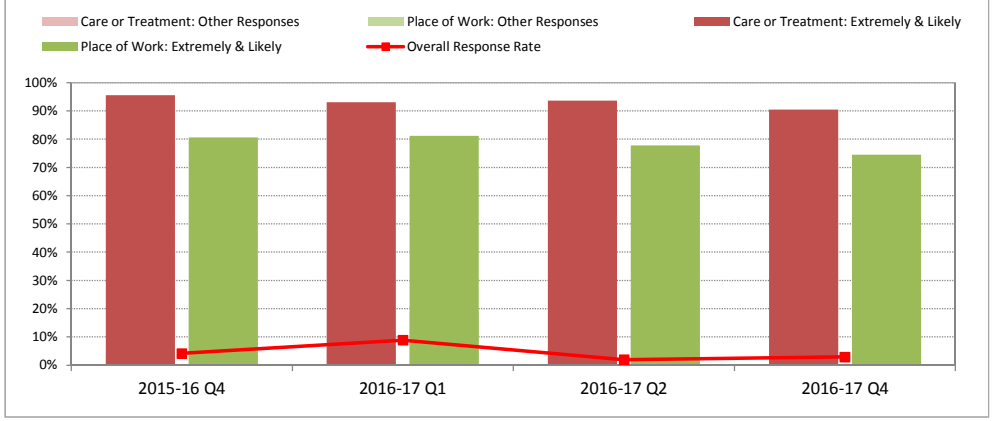




Real Time Feedback: Overall how would you rate the quality of care you received?



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.

Trust Board

SFT 3909c

FINANCE & CONTRACTING REPORT TO 30th June 2017

1. Introduction

This paper outlines the main drivers behind the consolidated financial position for the period ending 30th June 2017.

The Income & Expenditure (I&E) position for June was a year to date deficit of £3,267k which results in adverse variance against the plan of £1,390k (see Appendix A). As the Trust is targeting a deficit of £7m for the year on a straight line basis it could be expected that after three months the deficit would be £1,750k. The in-month deficit was £1,250k which was an adverse variance against the plan of £671k.

Summary of Key Financial Information	Year to Date			
	Plan £000s	Actual £000s	Var £000s	Var %
Income	53,956	52,328	-1,628	-3.0%
Expenditure	52,434	52,039	395	0.8%
EBITDA	**1,522**	**289**	**-1,233**	
Finance and Depreciation Costs	3,549	3,648	99	2.8%
I+E position excl donated income	**-2,027**	**-3,359**	**-1,332**	**-65.7%**
Donated Asset Income Adjustment	150	92	**-58**	
I+E position	**-1,877**	**-3,267**	**-1,390**	**-74.1%**
Variance: Favourable (+ve) / Adverse (-ve)				

2. Sales

NHS clinical revenue was £44,987k which was £1,623k behind the plan. Of this sum excluded pass-through drugs & devices under-performance was £430k which was matched by expenditure, and as such has no impact on the bottom line.

At the time of preparing this report, we continue to experience issues with the reporting of NHS activity and income due to the on-going data warehouse development. Therefore we have estimated the income by reviewing the available coded activity data and analysing the average monthly activity and income trends. At present we manually correcting information from the new data warehouse in conjunction with the updated old data warehouse to analyse the position.

The finance team continues to work closely with IT staff to resolve the data warehouse reporting and it is anticipated that a functioning warehouse will be available from a finance and contracting perspective by the end of July.

Overall NHS clinical income (excluding high cost drugs) appears to be on plan for the month of June. However, there was an adjustment between headings of £235k which was income previously shown against 'non-NHS clinical income'. Also we have accrued income of £400k for the aseptic unit and cancer Multi-Disciplinary Team (MDT) although discussions with commissioners are on-going.

The table below presents the summary activity position. The increase in outpatient procedures relates to ophthalmology and respiratory activity, which was previously shown within the first or follow up categories. The elective underperformance year on year can be partly explained by the fact that there have been two fewer working days this year. Using a simple productivity measure (elective activity/total working days) we can determine that the under-performance (reduced productivity) for inpatient activity is 22 cases and for planned same day 138 cases. This ignores any case mix issues and acuity. However, this has to be viewed in the context that we have out-sourced more activity to private providers when compared to the same period last year and this does not help with the bottom line as they are paid at full tariff. Planned same activity at the weekend is 325 for the year to date, the majority of which is attributable to the work undertaken by a private endoscopy contractor. When this is added back the level of reduced productivity would be 463 cases. Inpatient activity outsourced

during the period was 12 surgical and orthopaedic cases and when this is added back the in-patient productivity reduction becomes 34 cases.

We have undertaken a simple analytical review of activity by comparing the change in actual activity year on year pre and post the implementation of the new patient information system. Taking the actual performance for the first seven months of last year (pre-implementation), we have projected this forward on straight-line basis and then compared this to the actual performance for the year. The difference between predicted and actual activity indicates a decline in performance and productivity. Urgent actions are being taken to review activity in key specialities and there have been discussions with Clinical Directors to ensure that all outpatients and theatre lists are being fully utilised.

There is a lot of work necessary to understand the productivity issue and whilst Lorenzo may be driving some out-patient underperformance it is difficult to link Lorenzo with the decline in elective in-patient work and planned same day work, especially as the decline has been occurring for over more than twelve months.

The plan for 2017/18 was based on the forecast outturn for 2016/17 based on the first seven months with the last 5 months adjusted for seasonality based on 2015/16. In addition we included the national activity growth assumptions in the plan to be consistent with our 5 year STP plan. With the decline in activity in the final five months of 2016/17 the plan is almost certainly overstated. Accordingly the plan needs to be reassessed based on current performance with one scenario being no growth. This will clearly impact on the bottom line and savings needed.

Contract Activity Performance (cumulative YTD)	Last Year Actual 2016-17	This Year Actual 2017-18	Plan 2017-18	Year on Year Variance	Plan Variance
Elective inpatients	1,300	1,235	1,310	-65	-75
Elective PSDs/day attenders	5,705	5,388	5,702	-317	-314
Regular Day Attenders	2,346	2,595	2,612	249	-17
Non Elective Inpatient	6,865	6,856	6,923	-9	-67
Outpatient initial attendances	16,833	16,455	15,942	-378	513
Outpatient follow-up attendances	27,437	24,033	25,396	-3,404	-1,363
Outpatient procedures	9,214	11,471	9,497	2,257	1,974
A&E attendances	11,890	11,824	11,914	-66	-90
Variance: Favourable (+ve) / Adverse (-ve)					

Other non-clinical income was ahead of plan by £317k and this includes an insurance claim payment of £167k which has been confirmed by the brokers.

3. Cost of Sales including indirect costs

The total expenditure for all Directorates in Month 3 was £44,535k, resulting in an adverse variance of £775k. The position can be summarised as follows:

Directorates	In Month			Year to Date (YTD)		
	Plan	Actual	Var	Plan	Actual	Var
	£000s	£000s	£000s	£000s	£000s	£000s
Medicine	3,503	3,864	-361	10,594	11,324	-730
Musculo Skeletal	2,488	2,491	-3	7,392	7,380	12
Surgery	3,109	3,206	-97	9,217	9,379	-162
CSFS	3,440	3,437	3	10,151	10,138	13
Facilities	270	266	4	837	833	4
Corporate	1,858	1,911	-53	5,569	5,481	88
TOTAL	**14,668**	**15,175**	**-507**	**43,760**	**44,535**	**-775**
Variance: Favourable (+ve) / Adverse (-ve)						

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

The main driver of the overall Directorates' adverse variance was the underachievement of CIPs of £381k mainly due to not being able to confirm the delivery of income generation schemes relating to NHS activity. Also there was significant increase in medical staff agency costs predominately in the Medicine Directorate and this is subject to further investigation. Clearly the Medicine Directorate is the main cause of the budget problems and is being carefully reviewed. Nursing overall is achieving their budget which is commendable.

4. Cost Improvement Plan

The total internal cost improvement savings target for the year is £8.5m and Directorates & Corporate Services have been allocated a target of £6.5m with the balance of £2m earmarked for strategic initiatives for which there as yet no clear plans. One area relates to the use of agency and the Director of HR has this as a top priority and is confident of being able to make a significant impact over the next few months.

The Trust has achieved YTD cost savings and income generation schemes of £923k against a phased plan target of £1,304k an adverse variance of £381k (29.2%). This excludes any planned monthly phasing of the additional strategic savings. At this stage due to activity reporting issues we are not able to confirm whether any of the NHS income generation schemes have delivered. We are expecting to next month to provide an indicative Directorate income and activity performance report for June.

Medicine, and CSFS directorates have submitted CIP recovery plans.

The CIP programme is back loaded and therefore on a straight line basis the Trust would be £1,202k (43.4%) below where it should be at this stage of the year.

5. Capital Expenditure (Appendix A)

Expenditure was £846k which was behind plan by £1,904k; this is partly due to slippage on the Modular Ward scheme.

6. Cash & working capital

The group cash balance at the end of the month was £7,018k, which was £2,144k better than plan. This was mainly due to the balance at the year-end being higher than the opening plan position together with lower than planned capital spend. The cash and working capital position will continue to be monitored on daily basis. A working capital loan facility of £1,400k was obtained from the DH in June to cover a forecast shortfall in July 2017, prior to receipt of monthly payments from Commissioners. Further working capital support will be applied for when required, the position is being reviewed throughout each month.

7. NHS Commissioner Contracts

Wiltshire and Dorset CCG have raised concerns in relation to the quality and timeliness of the information due to issues relating to the on-going development of the data warehouse and Lorenzo system. Wiltshire has stated that they expect the Trust to meet the national flex and freeze dates for activity and income reporting.

The information team from NHS England has visited the Trust to review the way we are running the new identification rules in conjunction with the new HRG4+ algorithm. NHSE has confirmed that the Trust is correctly using the right algorithms. The Trust has nearly completed the re-run of the identification rules which should allow for a final transfer of funding between the CCGs and specialist commissioners.

The Trust has met with West Hampshire CCG in relation to the contract performance notice (CPN) that they tried to serve. The Trust has not accepted the CPN and despite ongoing discussions the

CCG has not withdrawn the CPN. After the last performance notice meeting it was agreed by both parties that they would undertake a Joint Investigation in accordance with the contract and this is on-going.

Wiltshire CCG has written to all Trusts in the STP regarding the process the commissioner will follow to challenge maternity pathway activity as they have concerns that they are being charged twice. The suggested proposal is for each Trust to apply the maternity pathway based on the GP practices covered by their community midwifery service as supported by the current guidance. This should not have material impact but we will closely monitor the situation.

A positive meeting was held with Wiltshire CCG at which the reinvestment of MRET monies and readmission monies were discussed. These are sums which are deducted by commissioners and which the guidance indicates should be reinvested to support the Trust. The CCG helpfully shared how they apply the MRET money across Wiltshire and will give further details on the schemes by provider. We will be seeking something similar for readmission monies. For SFT the deductions being made by Wiltshire CCG total roughly £1.7m. Further discussions are necessary with Dorset and WHants CCGs regarding the same issues.

As the Trust has not signed up to the STF fund the Trust is required to meet its constitutional targets and failure to do so may well result in penalties being applied which could be sizable given the current issues with RTT at specialty level and diagnostic pathways. At this stage we have not included a provision for any likely penalties in the financial position. However, based on last year's performance this could be a significant risk and the application of any penalties will need to be discussed further with CCGs, NHSE and NHSI.

8. Risks & Forecast

The Trust's key financial risks for 2017/18 can be summarised as follows:

- Deliver the CIP target of £8.5m, this is the greatest financial challenge;
- Securing of loan to support revenue & capital expenditure;
- Inability to provide robust activity & income performance information;
- Escalating cost and inflationary pressures;
- Meet contractual obligations and avoid penalties;
- Delivery of CQUIN schemes;
- Unplanned growth of non-elective activity impacting on elective work;
- Productivity
- Management capacity to drive forward strategic change whilst dealing with a lot of operational issues.

Next month we will present a number of forecast outturn scenarios using a similar process as last year. Initially the forecast will be calculated using the actual YTD position and then shaping the forecast using the income and expenditure monthly planning profiles. A best and worst case scenario will be developed based on the risks identified above. We will also a produce a simplistic straight-line outturn position and the Directorates will be providing a forecast outturn variance against budget.

This will provide information to facilitate a discussion on the likely outturn, the impact of the known financial risks and mitigation actions, and the effect on cash.

9. Other Financial Issues

The Trust is exploring the possibility with NHSI of our participation in the Financial Improvement Recovery (FIP) wave 2 programme. A meeting has been held with potential advisors against a list provided by NHSI. Trust selection for the programme will be based on the perceived financial benefits from the programme (assumed as return of investment (ROI) of 6 times the cost of advisor) and whether NHSI believes it would be helpful to participate. Phase I of FIP2 would involve an initial rapid diagnostic phase over two weeks to identify saving opportunities and 'quick wins' resulting in a short page report. Phase 2 consists of a further two weeks covering; CIPs and financial governance, the 2017/18 plan, operational leadership and trust-wide culture; and developing a plan for sustainability together with arrangements to transfer skills and experience. Phase 3 (the more expensive stage) is up to 6 months and involves working with the Trust to implement actions and plan to improve operational grip and control and delivery of savings. Clearly Phase 3 depends on the

findings in the first two stages. The Trust and NHSI will have the ability to halt or abort the project if there are any concerns over the ROI or any other issues. It is not yet clear whether this is the best option for SFT but it would enable us to have an external view on the performance of the Trust and its potential to make savings in a way which is supported by NHSI. Alternatively a more tailored approach may be appropriate and this is being discussed with NHSI.

The NHSI's critical financial friend visit is to take place on 2nd August. We have already provided comprehensive responses to their control assurance checklists. The focus of the visit will be to review grip and control, CIPs and workforce controls.

10. Conclusions

The consolidated position for June was a deficit of £3,267k giving adverse variance of £1,390k against plan.

The Trust's overall risk rating score was 3 under the new single oversight framework, 1 being the highest score with maximum autonomy. A score of 3 may result providers receiving mandated support for significant concerns but the Trust is not in breach of its licence.

11. Recommendations

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

Malcolm Cassells
Director of Finance and Procurement / Deputy CE
28 July 2017

APPENDIX A

SUMMARY STATEMENT OF COMPREHENSIVE INCOME

	In month			YTD (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Operating Income						
NHS Clinical Income	14,138	14,052	(86)	42,224	41,031	(1,193)
High cost drugs income	1,566	1,593	27	4,386	3,956	(430)
Other Clinical Income	672	344	(328)	1,933	1,611	(322)
Research & Development & Education	557	570	13	1,670	1,699	29
Other (Excluding Donated Asset income)	1,248	1,351	103	3,743	4,031	288
TOTAL INCOME	**18,181**	**17,910**	**(271)**	**53,956**	**52,328**	**(1,628)**
Operating Expenditure						
Pay - In post (incl apprenticeship levy)	10,359	10,296	63	31,077	30,541	536
Pay - Bank & Locum	624	529	95	1,875	1,840	35
Pay- Agency	511	821	(310)	1,538	2,138	(600)
Drugs	1,839	1,980	(141)	5,072	4,935	137
Clinical Supplies & purchase of healthcare	2,148	2,147	1	6,244	5,934	310
Non-Clinical Supplies	2,246	2,246	0	6,628	6,651	(23)
TOTAL EXPENDITURE	**17,727**	**18,019**	**(292)**	**52,434**	**52,039**	**395**
EBITDA (Earnings Before Interest, Tax, Depreciation & Amortisation)	**454**	**-109**	**(563)**	**1,522**	**289**	**(1,233)**
Financing Costs (including Depreciation, PDC & Interest)	1,183	1,213	(30)	3,549	3,648	(99)
SURPLUS / (DEFICIT) excluding donated income & STF	**-729**	**-1,322**	**(593)**	**-2,027**	**-3,359**	**(1,332)**
Donated Asset Income	150	72	(78)	150	92	(58)
SURPLUS / (DEFICIT)	**-579**	**-1,250**	**(671)**	**-1,877**	**-3,267**	**(1,390)**

APPENDIX B

CAPITAL EXPENDITURE

Project Name / Category	Approved Annual Plan 2017/18 £000s	Agreed Changes 2017/18 £000s	Brought Forward from 2018/19 £000s	Slippage to 2018/19 £000s	Revised Annual Plan 2017/18 £000s	YTD spend (June 2017) £000s	Anticipated Under/(Over) spent on Projects £000s
Donated Assets							
Breast Unit Development - Charitable Funded	2,990	83,180	0	0	86,170	83,180	
Clinical Radiology 2 x Ultrasound	5,900	0	0	0	5,900	0	
Orthodontics & Oral Surgery Cone Beam CT Scanner	4,623	0	0	0	4,623	0	
Small Donated Additions	0	8,400	0	0	8,400	8,400	
Donated Assets - Totals	**13,513**	**91,580**	**0**	**0**	**105,093**	**91,580**	**0**
Phase 3 Building Schemes							
Breast Unit enabling	674	0	0	0	674	669	
Capacity increase including ophthalmology move (balanc	1,200,000	0	0	0	1,200,000	0	
Car Park PV	734	0	0	0	734	2,625	(1,891)
Laverstock Ward (Decant Ward Project)	1,152	0	0	0	1,152	230	
Modular Ward	0	251,141	0	0	251,141	55,393	
SAU Refurb (Decant Ward Project)	15,638	0	0	0	15,638	11,381	
Maternity development	294,660	0	0	0	294,660	0	
Patient Flow - Relocation of AMU (first phase) est	600,000	0	0	0	600,000	11,910	
SDU Development	0	0	0	0	0	67,798	(67,798)
Building Schemes - Totals	**2,112,858**	**251,141**	**0**	**0**	**2,363,999**	**150,006**	**(69,689)**
Building and Works							
Accommodation H&S Work	34,240	0	0	0	34,240	17,712	
Accommodation Boilers (Wylye House & Victoria Drive)	43,495	3,339	0	0	46,834	0	
Accommodation replacement of kitchens and bathrooms	9,271	0	0	0	9,271	3,655	
Accommodation Roof Repairs (Compton & Langley)	60,000	0	0	0	60,000	0	
AHU replacement yr 4 (2016/17) of 7	251,141	-251,141	0	0	0	0	
Air tube	47,000	0	0	0	47,000	0	
Asbestos management	16,161	0	0	0	16,161	1,140	
Avon and Bourne Boiler Replacement	3,339	-3,339	0	0	0	0	
Block 24 Cavity Wall Insulation	15,000	0	0	0	15,000	0	
BMS upgrade	10,323	0	0	0	10,323	0	
Car park machinery replacement	5,243	0	0	0	5,243	450	
Catering Changing Area	8,210			0	8,210	6,175	
Central Booking Relocation	0			0	0	4,325	(4,325)
DSU AHU Modification	4,840	0	0	0	4,840	0	
DSU Roof Repairs	5,050	0	0	0	5,050	0	
DSU - Ventilation Theatre 5	0	0	0	0	0	0	
Electricity at Work Regulations Compliance	70,024	0	0	0	70,024	10,137	
Estates health and safety	174	0	0	0	174	0	
Estates - Oracle software interface	24,000	0	0	0	24,000	0	
Fire alarm upgrade	9,000	0	0	0	9,000	0	
Fire Door Compliance	99,288	0	0	0	99,288	0	
Flooring Replacement	5,838	0	0	0	5,838	0	
General laboratory replacement autoclave and Motuary Disinfector	6,681	0	0	0	6,681	0	
Genetics Cooling	36,000	0	0	0	36,000	0	
Hospice Fire Alarms (was Hospice and Finance)	8,075	0	0	0	8,075	8,810	(735)
Level 4 Bedspace Power Sockets	33,610	0	0	0	33,610	0	
LIfts overhaul - year 3 (2014/15) of 3	13,669	0	0	0	13,669	5,490	
Main Entrance L3 Upgrade	5,570	0	0	0	5,570	0	
Maternity Obstetric Theatre Refurbishment	1,030	0	0	0	1,030	0	
Maternity Post Natal Upgrade	6,137	0	0	0	6,137	0	
Medical Gas Hoses 2nd year of 2 (2015/16)	139,500	0	0	0	139,500	0	
Medical Records Storage (racking)	0	13,000	0	0	13,000	0	
MSK Notes Preparation	6,500	0	0	0	6,500	0	
Nurse Call System Upgrade - SDH North & Maternity - 2nd year of 2	9,666	0	0	0	9,666	0	
OHSS replacement windows	3,215	0	0	0	3,215	0	3,215
Old GUM Clinic Demolition	10,449	0	0	0	10,449	0	
Pathology - conversion of computer room to office	12,000	0	0	0	12,000	0	
Pathology Reception	15,769	0	0	0	15,769	690	
Pharmacy Cold Room	4,277	0	0	0	4,277	200	4,077
Productive Operating Theatres	18,542	0	0	0	18,542	0	
Public & Staff WCs L5,L4,L3	53,260	0	0	0	53,260	0	
Public Spaces Fund	8,506	0	0	0	8,506	0	
Roads and paving repairs	214,259	0	0	0	214,259	0	
Sarum Ward Pipework	0	60,000	0	0	60,000	0	
Server Rooms - Air Conditioning	16,890	0	0	0	16,890	326	
Shower Cubicle Drainage Improvements	11,937	0	0	0	11,937	0	
Site Signage	4,741	0	0	0	4,741	179	
Springs servery upgrade - floor and freezers only	75,000	0	0	0	75,000	87,408	(12,408)
Taps & IPS panels - sitewide	25,354	0	0	0	25,354	71	
Water Safety	35,701			0	35,701	3,381	
Building Projects/Building and Works Totals	**1,497,975**	**-178,141**	**0**	**0**	**1,319,834**	**150,150**	**(10,176)**

Project Name / Category	Approved Annual Plan 2017/18 £000s	Agreed Changes 2017/18 £000s	Brought Forward from 2018/19 £000s	Slippage to 2018/19 £000s	Revised Annual Plan 2017/18 £000s	YTD spend (June 2017) £000s	Anticipated Under/(Over) spent on Projects £000s
Information Technology							
Alternative to Microsoft products - review	15,000	0	0	0	15,000	0	
Bighand	1,250	0	0	0	1,250	0	
Blades	143,500	0	0	0	143,500	0	
Blood Tracking Phases 1 - 3	90,925	0	0	0	90,925	0	
CALS	1,093	0	0	0	1,093	0	
Citrix Support	73,866	0	0	-36,933	36,933	58,104	(21,171)
Community Midwifery system trial	8,867	0	0	0	8,867	5,072	
Connectivity Upgrade for Warminster & Shaftesbury	5,709	0	0	0	5,709	0	
Data Warehouse (16/17 bid)	175,000	0	0	0	175,000	0	
EPR Contigency	32,241	0	0	0	32,241	0	
EPR Data Warehouse	0	2,500	0	0	2,500	0	
EPR Hardware	10,433	0	0	0	10,433	48	
EPR Implementation 17/18	1,171,000	-1,002,500	0	0	168,500	0	
EPR Implementation Costs	0	1,000,000	0	0	1,000,000	254,096	
EPR Network Resilience	100,393	0	0	0	100,393	0	
EPR Supplier Costs	0	0	0	0	0	0	
EPR Scanning	905,051	0	0	0	905,051	19,901	
Genetics High Spec Analysis Equipment & Software	25,677	0	0	0	25,677	23,930	
Genetics MDT Video Conferencing	0	30,000	0	0	30,000	0	
Genomics bioinformatics software	50,000	0	0	0	50,000	0	
Gynaecology System - colposcopy	78,000	0	0	0	78,000	0	
Histopathology Hardware	6,662	0	0	0	6,662	0	
IBD register	671	0	0	0	671	0	671
Inhouse development team	109,000	0	0	0	109,000	26,478	
Infrastructure refresh (£2.5m requested)	0	0	0	0	0	0	
Integration of Vasclab to CRIS and PACS	17,000	0	0	0	17,000	0	
Liteview client rollout	25,000	0	0	0	25,000	0	
Maintenance renewal - estimate	2,229	0	0	0	2,229	0	
Mobile Computing	3,818	0	0	0	3,818	19	
Mortuary module	32,975	0	0	0	32,975	2,924	
Network cabinets (£100k requested - need to phase)	30,000	0	0	0	30,000	0	
Network maintenance - (phase)	50,000	0	0	0	50,000	0	
Network security	139,000	0	0	0	139,000	0	
Network Unsupportable	23,787	0	0	0	23,787	0	
Network Upgrade Consultancy	40,330	0	0	0	40,330	280	
Ophthalmology System	76	0	0	0	76	0	76
Order Comms (includes System Admin Bid & Sexual Health Bid)	15,265	0	0	0	15,265	0	
PACS	57,205	0	0	0	57,205	18,376	
PACS ongoing Development	42,000	0	0	0	42,000	0	
Palliative Care EPR	39,437	0	0	0	39,437	0	
Partial off-line back-up of data to protect against malwar	50,000	0	0	0	50,000	0	
Patient Observations Monitoring and Decision Support/Early Warning System/POET	6,946	0	0	0	6,946	0	
Radiology - OrderComms	31,655	0	0	0	31,655	0	
Replace 6509x3 network hubs	42,249	0	0	0	42,249	0	
Results System in GP Practices 'Review' System	10,079	0	0	0	10,079	0	
SAN Storage	8,070	0	0	0	8,070	0	
SBAR Cardiology DICOM Migration	11,834	0	0	0	11,834	2,008	
StarLIMS Upgrade	30,000	0	0	0	30,000	0	
Telecomms Voice Over IP - invest to save (non clinical areas - subject to a telephony strategy)	18,514	0	0	0	18,514	852	
Telepath to CSCLims (Phase 3 / Year 4 of 4 2016/17)	150,000	0	0	0	150,000	0	
UPS Replacement Programme	19,700	0	0	0	19,700	0	
Whiteboards	95,052	0	0	0	95,052	1,462	
XML for Pathology COSD Submission	11,900	0	0	0	11,900	0	
Information Technology Totals	**4,008,460**	**30,000**	**0**	**-36,933**	**4,001,527**	**413,548**	**(20,424)**
Medical Devices							
AAA screening ultrasound (2 of 4 requested)	53,000	0	0	0	53,000	0	
Bed Buffers	7,657	0	0	0	7,657	0	
Bed replacement programme	10,183	0	0	0	10,183	0	
Cone Beam CT Scanner Enabling Works	6,556	0	0	0	6,556	0	
DSU Ophthalmic Microscope	287	0	0	0	287	242	
DSU Powered patient trolleys (6 of 10 requested)	50,000	0	0	0	50,000	0	
General x-ray machine - Westbury - radiology	632	0	0	0	632	0	
Grouped Items 2016/17	18,884	0	0	0	18,884	0	
Medical Equipment <£50k 17/18	285,673	0	0	0	285,673	0	
MRI patient monitor	74,000	0	0	0	74,000	0	
Operating Tables (3 of 5 requested)	150,000	0	0	0	150,000	0	
Radiology - Cross-Trust imaging support ultrasound	80,000	0	0	0	80,000	0	
Radiology In-patient ultrasound	80,000	0	0	0	80,000	0	
Radiology Room 14	318,000	0	0	0	318,000	0	
Radiology Room 2 Replacement	9,109	0	0	0	9,109	0	
Radiopharmacy Upgrade	23,560	0	0	0	23,560	0	
Scopes	759	0	0	0	759	0	
Static and Pressure Relieving Mattresses	12,283	0	0	0	12,283	0	
Theatre Instrumentation Replacement Programme	122,868	0	0	0	122,868	9,131	
Theatres Patient monitoring systems	50,000	0	0	0	50,000	0	
Medical Equipment Totals	**1,353,451**	**0**	**0**	**0**	**1,353,451**	**9,373**	**0**

Project Name / Category	Approved Annual Plan 2017/18 £000s	Agreed Changes 2017/18 £000s	Brought Forward from 2018/19 £000s	Slippage to 2018/19 £000s	Revised Annual Plan 2017/18 £000s	YTD spend (June 2017) £000s	Anticipated Under/(Over) spent on Projects £000s
Other							
Bed Stacking	23,606	0	0	0	23,606	9,335	
Bed Stacking - Commercial Related	5,822	0	0	0	5,822	0	
Catering boiling pan	18,000	0	0	0	18,000	0	
Efficiency schemes	200,000	0	0	0	200,000	0	
Finance systems	90,000	0	0	0	90,000	5,500	
Hedgerows Dishwasher Replacement	9,388	0	0	0	9,388	0	
HPV - Glossair system	36,000	0	0	0	36,000	0	
Hydro pool	15,000	0	0	0	15,000	0	
LED Lighting	2,523	0	0	0	2,523	0	
Outpatient Kiosks	24,143	0	0	0	24,143	0	
Phhotovoltaic's / Solarthermal PV	17,683	0	0	0	17,683	0	
Procurement Tug 2015/16	2,050	0	0	0	2,050	0	
Project costs	33,546	0	0	0	33,546	3,619	
Scan4Safety (GS1)	45,982	0	0	0	45,982	6,210	
Security	30,373	0	0	0	30,373	6,743	
Telecoms Trunk Lines	6,630	0	0	0	6,630	0	
Theatres Storage and Trolleys	180	0	0	0	180	0	
Ward Waste Bins	1	0	0	0	0	0	
Other Totals	**560,926**	**0**	**0**	**0**	**560,925**	**31,407**	**0**
Trust Totals	**9,547,183**	**194,580**	**0**	**-36,933**	**9,704,830**	**846,065**	**(100,289)**

MONTH 3 OPERATIONAL PERFORMANCE REPORT

Date: 30th July 2017

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

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

Executive Summary:

For Month 3 the trust successfully delivered the ED 4 hour standard, all Cancer standards, RTT 52 week, 12 hour trolley wait and Urgent operation cancelation standard. Whilst the diagnostic standard was not delivered – performance was ahead of the recovery plan.

Emergency Pathway

4 hour performance for Month 3 was delivered at 95.7% which was an excellent achievement. Bed pressure issues in June were less significant with the number of patients with a delayed transfer of care and on a Green to Go pathway reducing.

Both Time to Triage and Time to Treatment metrics have significantly improved and are now being sustained at or close to the national target.

Time to Triage - June		
	All	Ambulance
Longest (minutes)	221	67
Median (minutes)	**10**	**8**

Time to Treat		
	June	July
Longest (minutes)	289	244
Median (minutes)	64	64

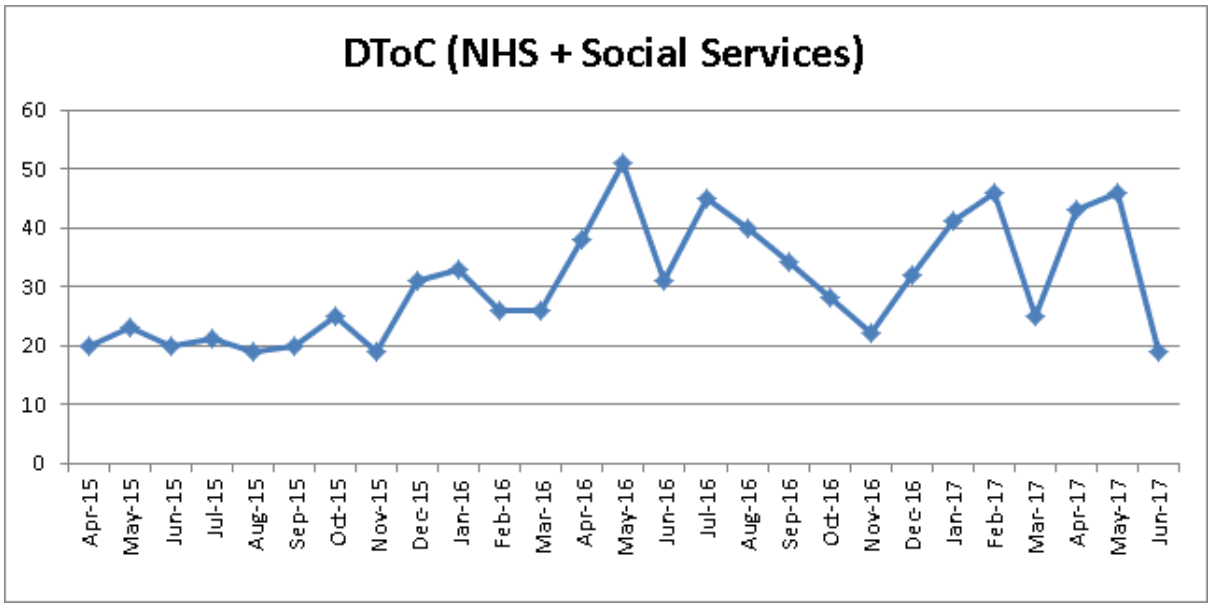
National targets: 15 mins Time to Triage and 60 mins Time to Treatment

There were no ambulance handover breaches over 60 mins in June and 6 breaches less than 60 mins. Of the 1045 patients arriving by ambulance, 94.4% of ambulance handover times were within target.

There were no 12 hour trolley waits in June.

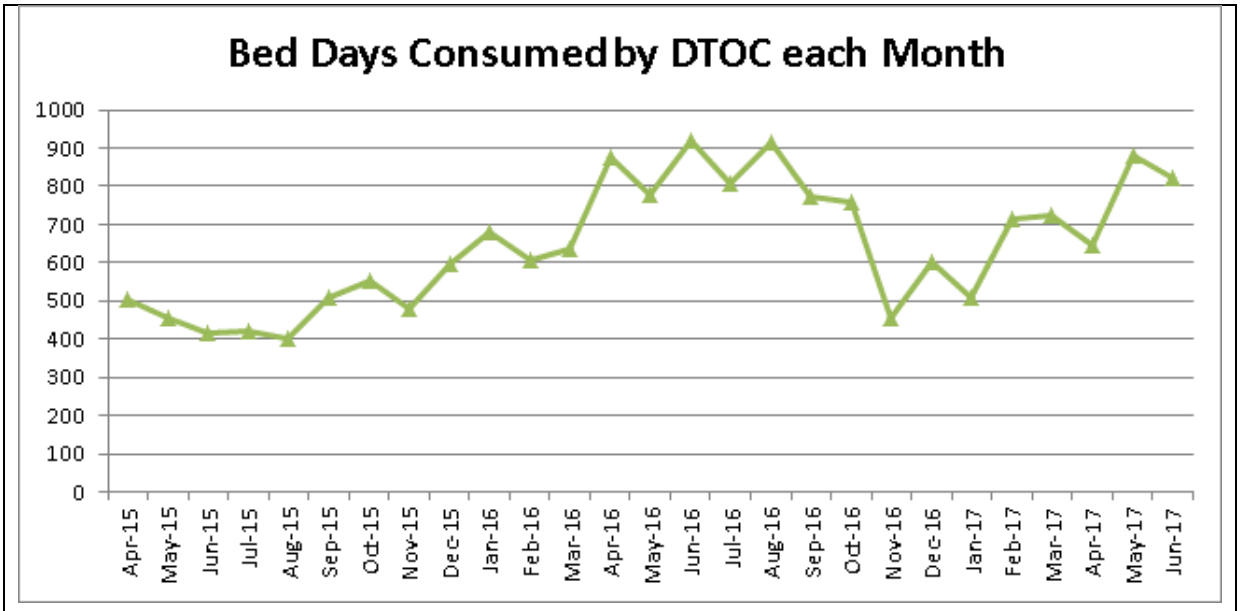
Number of DToCs

DToCs have shown a dip in June after considerable operational effort to reduce prior to the ward reconfiguration programme commencing. The monthly snapshot position was 19 (10 SS and 9 NHS), and it is critical that the total number of DTocs remains below 20.



Number of lost bed days

The number of number of bed-days lost due to delayed transfers of care was 821 in June . This is lower than the May figure but is still unacceptably high.



Longstayer Patients

There has been a significant reduction in the number of long-staying patients in the Trust in June and it would appear that we are on a downward trajectory.

Patients with LOS >10 days has dropped well below 200/ day (187 was the last recorded number in June). Patients with LOS> 30 days has dropped well below 100/day (84 was the last recorded number in June). Both of these metrics are significantly reduced over previous months.

RTT

In June the trusts reported RTT performance of 90%. This was the first time that the trust has reported on time since October last years and reflects the massive amount of work that has taken place to improve data quality.

Diagnostic

The June position was 66 breaches a little better than what was predicted (80).This gave an achievement of 98.4% against the Diagnostic wait time target.

1. Endoscopy

Endoscopy wait times continued to be sustained during June and are now around 4 weeks. The weekly, weekend sessions provided by a private provider, together with the ongoing use of a locum consultants have ensured this position. There were 18 breaches in April,9 breaches at the end of May and 7 in June.

2. Radiology

The main modality where we have seen breaches is MRI. Currently we have a backlog of less than 20 patients predicted at the end of July in line with the trajectory identified . Therefore we are expecting to be fully compliant with the Diagnostic target by the end of July.

Cancer

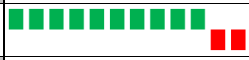
All Cancer standards were delivered for June.

Links to Assurance Framework/ Strategic Plan:

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

Appendices: Appendix 1. Trust Board Performance Report – June 2017

Salisbury Hospital NHS Foundation Trust Board Report June 2017

			Reporting Month		Rolling 12 months
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Jun-17**	**Patients Affected in Jun-17**	**Trend Against National Standard**
Referral to Treatment Incomplete Performance	92%	STF = 92.0%	**90.0%**	1,869	
Referral to Treatment Incomplete Specialty Compliance	16 out of 16		8 out of 16		
Zero tolerance RTT waits > 52 weeks	0	0	0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Jun-17**	**Patients Affected in Jun-17**	**Trend Against National Standard**
A&E - Time in A&E department	95%	STF = 94.4%	95.7%	184	
12 Hour Trolley Waits	0		0		
Diagnostics - Patients waiting less than 6 weeks	99%	97.0%	98.4%	4127	
Diagnostic Test Compliance***	10 out of 10		9 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: 1	0	
Infection control - MRSA*	0		0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Jun-17**	**Patients Affected in Jun-17**	**Trend Against National Standard**
All Cancer two week waits	93%		93.8%	43	
Symptomatic Breast Cancer - two week waits	93%		98.1%	2	
31 day wait standard	96%		99.1%	1	
31 day subsequent treatment : Surgery	94%		100.0%	0	
31 day subsequent treatment : Drug	98%		100.0%	0	
62 day wait standard	85%		89.3%	7	
62 day screening patients	90%		100.0%	0	

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

NHS
Salisbury
NHS Foundation Trust

SFT 3910

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 18th May 2017, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – TANIA BAKER

Present:

Tania Baker – (Chair) Non-Executive Director
Dr Christine Blanshard - Medical Director
Claire Gorzanski – Head of Clinical Effectiveness
Fiona Hyett - Deputy Director of Nursing
Steve Bleakley – Chief Pharmacist
Michael Von Bertele – Non Executive Director
Dr Samuel Williams – F1
Maria Poelvoorde – Staff Nurse

In attendance:

Kate Williams	Minute taker
Jan Sanders	Governor
Carmen Carroll – Consultant in Elderly Medicine	CGC051710
Fenella Hill – Head of Risk Management	CGC051714, CGC051715 & CGC051716

CGC051701 Apologies:

Cara Charles-Barks – Chief Executive Officer
Professor Jane Reid – (Chair) Non-Executive Director
Dr Michael Marsh – Non-Executive Director
Lorna Wilkinson - Director of Nursing
Hazel Hardyman – Head of Customer Care
Andy Hyett – Chief Operating Officer
Mark Stabb – Head of TIAA

CGC051702 – Any Urgent Business

TB noted that this meeting was not quorate, and that therefore no decisions would be taken. Items to be escalated to Trust Board if necessary.

GC051703 – Minutes of the meeting held on 23rd March 2017

Page 1: FHy confirmed that work is ongoing with the 90 day falls challenge. Staff are finding feedback useful and this is going well.

Page 5: Quality Indicator report – clarification of ward moves. LW to review how information is captured. To be discussed at the June CGC. Add to Action Tracker. **KW (completed)**

Page 7: Wiltshire Health and Care assurance. CB noted that Wiltshire Health and Care would be asked to report on their quality metrics every 6 months to the Clinical Governance Committee meeting. Dates to be added to the Action Tracker. **KW**

The minutes were approved by the committee.

CGC051704 – Action Tracker

All items were agreed.

CGC051705 – Matters Arising – Internal Audit Programme – review and update – Christine Blanshard

- Audit of the indicators in the Quality Report 14/15. There is 1 outstanding action related to validation of RTT which is being actively managed and monitored through the Delivery Group and the EPR Stabilisation Project Group.

- Audit of the management of falls and pressure ulcers 1 outstanding action – champions identified in 70% of ward areas who contribute to the falls group.

- Audit of the review of safeguarding children recruitment practices. 3 recommendations are partially outstanding and work is planned to complete them within the next 4 months.

- An assurance review of data quality – 1 item is outstanding - the Data Quality Assurance Framework will be considered as a longer term piece of work once the RTT extract process in the new warehouse has been rebuilt. Not due until October 2017.

- Assurance review of the Medical Device Management Service. 6 recommendations are partially completed and most have started to make progress by the newly appointed Medical Devices trainer.

TB asked if the falls champions are having a significant effect on reducing numbers to which FHy responded that the correlation between having a falls champion and actual falls would be calculated.

TB queried the implications of the safeguarding recruitment practices. CB confirmed that these need to be robust at the time of recruitment but they do not provide continued assurance – therefore FHy has picked this up through the Safeguarding Committee which meets every 3 months.

CGC051706 – Matters Arising – Learning Disabilities end of year report 16/17 (deferred from March 17) – Fiona Hyett

Key achievements:

- Continue to provide good care, with reasonable adjustments being made
- Safeguarding Champions completed LD training
- Honorary Contract process for paid carers drafted but now just needs testing
- Pre- Admission Checklist established but needs testing

FHy reported that there was good external engagement for the Learning Disabilities group and efforts are being made to improve internal engagement. The group will be completing work with the End of Life Care team. The Learning Disabilities work is audited annually and will be reported back to the Clinical Governance Committee.

STRATEGY

CGC051707 – Core Service presentation – Stroke medicine – Toby Black

This item did not take place due to a clinically urgent matter that took precedence.

CGC051708 – Spinal Unit Leadership – verbal update – Christine Blanshard

CB reported that the CQC enforcement notice had been met in full as the backlog relating to follow-up appointments had been cleared.

There are continuing clinical leadership concerns. A member of staff is on long term sick leave, and locums and agency junior doctors are working on the ward. The workforce committee is expecting to receive a paper on clinical therapy leadership with a view to recruiting a senior therapist as lead. AH, CB and LW continue to meet regularly with the team to encourage an improvement in the model of care for all. The urinary tract pathway and bed rest approach pathway have been altered and improved.

MvB asked if an external review would be helpful, and volunteered to give special interest to this which was welcomed by CB. TB asked for timescales regarding a therapy lead to which CB responded that the next workforce committee will take place in June and the paper will be submitted if completed at that time.

MP reported that her experience as a junior nurse on the spinal unit was that there was a significant staff turnover. Support for staff is varied, which has an impact on the care the patients receive. There were not many opportunities to interact with senior members of staff. The clinical educator would be more effective if more time could be allocated to assisting learners on the wards.

FHy commented that there are continual vacancies in the department but the recruitment trip to India has proved successful and it is hoped that the new members of staff will be able to fill the vacancies.

CGC051709 Hot Topic : Medicine Storage – Steve Bleakley

In November 2016 Internal Audit carried out a safe and secure handling of medicines audit across the Trust which identified some systemic issues.

A subsequent improvement plan has been in place, led by the Director of Nursing and Chief Pharmacist. This has included the following actions:

- Discussions at Nursing and Midwifery Forum regarding practice issues and NMC requirements
- Daily audits undertaken by DSNs
- Use of safety crosses on the medicines cupboards to highlight compliance in a real time, ward level way for front line staff
- Regular follow up audits led by the Chief Pharmacist and Director of Nursing

SB reported that a series of audits has shown a good trend of improvement. There will be a further audit in June 17. Teams are working together to make improvements.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC051710 – Dementia annual report (deferred from March 17) – Carmen Carroll

The focus for SFT in the last year has been to:-

1. Improve services available to carers throughout the Trust.

2. Complete the National Dementia Audit and identify gaps in local service provision by completing and working on the Department of Health Self-Assessment Framework.

3. Undertake a Trust-wide delirium audit, which will shape development of a care bundle to address outstanding care needs.

4. Partnership working with end of life and local care homes and other local communities.

CC reported that the audit format has been changed significantly this year. There has been a Trust wide audit which has illustrated that there is recognition of delirium but recording this is proving difficult. The current care bundles are good but files are lacking evidence that this is being translated into practice. There is a robust working group who are looking at Scottish models and are in the process of putting together a fresh care bundle – the next challenge will be implementation. Sandy Woodbridge works to support carers and to implement John's Campaign. Representatives from a new dementia group in Salisbury attended a recent steering group meeting and they are keen for the Trust to sign up as a Dementia Friendly organisation. Falls are a major issue for people with dementia and efforts need to be concentrated on pre-empting these incidents. This work should form part of the ongoing falls action plan

SB asked if more work needs to be undertaken with medicines for dementia patients to which CC responded that the departments need to be more robust with monitoring administration and withdrawal of drug treatments. SB stated that he would like to be involved in the drug treatments and choices. SW noted that it was difficult for junior doctors in ED to become involved in drug choices and that this would generally be passed on to more senior doctors on the wards.

CB noted that an elderly person should always be seen by a geriatrician and if not, a pharmacist

should pick up any medication issues. CC is developing a 'prompt' for non-geriatricians and is currently able to target patients who may have dementia on ward rounds. Patients seen on the delirium round were easier to track and received better care. Communications with GP's can be challenging.

ASSURING CLINICAL EFFECTIVENESS

CGC051711 – Quality Indicator including DSSA – discussion – Dr Christine Blanshard

- 1 case of hospital apportioned C Difficile.
- 1 new serious incident inquiry commissioned in April.
- A new chart – the number of in-hospital cardiac arrests and futile CPR attempts – no cardiac arrests in March 17.
- A decrease in the crude mortality rate in April 17. SHMI is 104 and 102.5 adjusted for palliative care to September 2016. HSMR decreased to 116.4 in January 17 and is higher than expected. Weekend HSMR is 121.0 to January 17 and is higher than expected. The board received a mortality presentation at the May meeting.
- A significant improvement in Q4 of hip fracture patients being operated on within 36 – 48 hours. Those that waited beyond 48 hours were waiting for medical review/further investigations (3) and waiting for theatre (2). Best Practice Tariff compliance improved to 90% in Q4.
- An increase in grade 2 pressure ulcers and one grade 3 pressure ulcer which is under investigation. A new measure included of grade 2 pressure ulcers per 1000 bed days.
- In April 17 there were no falls resulting in moderate or major harm. A new falls reduction strategy was presented to the Clinical Risk Group in May 17.
- 95% delivery of CT scan within 12 hours for stroke patients. A reduction in stroke patients spending 90% of their stay on the stroke unit due to delayed admission to the stroke unit (9) and 1 patient not admitted to the unit at all. Patients arriving on the stroke unit within 4 hours improved but remains below the national benchmark – transferred at 3 hrs 51 minutes to 3 hrs 59 minutes from ED (4), & waiting to see first doctor (2), admitted to AMU (2) and SSEU (1) delay in ED waiting for bed (1).
- A slight reduction in high risk TIA patients seen within 24 hours. Those not seen within 24 hours related to no available morning clinic and consultant availability. Latest Sentinel Stroke National Audit Programme (SSNAP) grade B.
- Escalation bed capacity reduced in April. Ward moves between 22.00 and 06.00 reported by month only. A plan is in place to reconfigure the bed base over the next 6 months in preparation for next winter.
- For the second month running there were no non-clinical mixed sex accommodation breaches.
- Real time feedback improved in April for patients rating the quality of their care – negative comments related to food, communication and noise. The Friends and Family test of patients who would recommend ED, wards, the maternity service and care as a day case and outpatients was sustained.

TB queried the high HSMR rate to which CB responded that it was due to the figures being reported differently – this figure is retrospective. TB asked about data warehouse issues and the accuracy of the figures in this report. CB responded that the figures are accurate but there are three areas which cannot be currently reported due to data issues. CB noted that once all building works have been completed there should be no need for escalation beds.

CGC051712 – Final Quality Account 16/17 – Claire Gorzanski

- Overall, the Trust has made progress in improving the quality of care in 2016/17 but there is still work to do. The report describes progress with this year's improvement priorities: keeping patients safe from avoidable harm; ensuring patients have an outstanding experience of care; working with our partners and patients to prevent ill health; providing patients with high quality care seven days a week and co-ordinated care across the whole health community.

- Five quality priorities have been selected for 2017/18 following a consultation. To sustain and embed good practice the five priorities are the same as last year but the work streams with each are different:

  Priority 1 Continue to keep patients safe from avoidable harm.
  Priority 2 Ensure patients have an outstanding experience of care.
  Priority 3 Actively work with our community partners, patients and carers to prevent ill health and manage long term conditions.
  Priority 4 Provide patients with high quality care seven days a week.
  Priority 5 Provide co-ordinated care across the whole health and care community

.

- KPMG audit of 2 mandated indicators and 1 local indicator. 1) Referral to treatment (RTT) incomplete pathways – start date not always recorded in the notes (5 cases), patients included in the incomplete data when receiving ongoing treatment (4 cases) 2). The Emergency Department 4 hour wait standard – no issues identified. 3) Local indicator – high risk TIA patients seen within 24 hours of referral - the time the patient (6 cases) was first seen was not always recorded accurately on the referral form. Improvement actions identified for immediate action. KPMG limited assurance review awaited.

- Outstanding data items which are not available prior to Board approval will be added to the final published document. These are 1) Data quality score to March 17. 2) Trust re-admission rate at 28 & 30 days, national highest and lowest average. 3) Confirmation of responsiveness to personal needs of patients and patient experience indicators from the national in-patient survey.

CGz reported that there has been good success under Priority 1 with stillbirths and neonatal deaths being reduced from 17 last year to 4 this year. There were also low infection rates and a 10% reduction in antibiotic consumption. Further work is being undertaken regarding safety and falls; and also with regard to mortality to reduce the HMSR. From September there will be more robust reporting to the Board. Priority 2 achievements include those of the OPAL team, particularly with regard to dementia patients. The Hospice @ Home team are working well. More work is being completed to improve discharge procedures. There has been a lot of work with various groups to reduce smoking and alcohol and to improve food choices under priority 3. Priority 4 work has resulted in a better than national average 7 day services. There are continuing challenges under priority 5 and work is being undertaken in order to achieve good outcomes. The Quality Account has also been audited by KPMG and improvement actions identified. Responses from the Governors, Healthwatch and the local authority to this report have all been good. CCG comments remain outstanding. 3 items of data remain outstanding due to the data warehouse issues.

TB observed that under priority 5, it was important to recognise that building relationships takes time and that this should be acknowledged.

The committee thanked CGz for her work in completing this report.

CGC051713 – Raising Concerns Policy Annual Report – Dr Christine Blanshard

Concerns

- No new concerns have been reported for the central log during the reporting period.
- The outstanding concern from the last report regarding midwifery staffing levels has been resolved.
- In the Trust's Freedom to Speak Up Guardian's Board report some issues were raised around staffing, communication and organisational change. These have been addressed with the relevant departments and the Guardian monitors any follow up. There have been no major concerns raised.

Freedom to Speak Up Guardian

- Trust Governor, Isabel McLellan, who undertook this role on a voluntary basis from its inauguration, stepped down at the end of March 2017.

- With effect from 1 April 2017, three members of staff will voluntarily share this role - Hazel Hardyman, Head of Customer Care; Lizzie Spicer, Administration Services Manager; Pamela Permalloo-Bass, Head of Equality and Diversity.

Training and Resources

- NHS Employers have published a suite of resources including an updated self-assessment tool and updated Manager's Guide for Raising Concerns. These are available on their website at: http://www.nhsemployers.org/your-workforce/retain-and-improve/raising-concerns-at-work-and-whistleblowing/draw-the-line

Policy Review

- The Trust's revised Policy, which has been renamed 'Freedom to Speak Up: Raising Concerns', was approved by the OMB in September 2016 and ratified by the JBD the following month. The Policy is next due for review in July 2019.

Staff Survey

- The national staff survey 2016 showed Salisbury to be in the top 20% of all Trusts for staff feeling confident and secure in reporting concerns about unsafe clinical practice.

Next Steps

- A self-assessment against the NHE Employers standards will be undertaken by the end of July 2017.
- The Freedom to Speak Up Guardians will continue to report concerns directly to the Chief Executive

CB confirmed that there are no new concerns. The outstanding concern from the last report has been resolved. The committee had previously queried as to whether the Freedom to Speak Up Guardians need to be external / independent – this has been investigated and the Trust are able to choose internal or external representatives but they must be monitored. There are various avenues for staff to report concerns.

ASSURING SAFETY

CGC05174 – Risk Report Card Q4 – Fenella Hill

- 1982 incidents reported over the quarter
- 0 incident categorised as catastrophic*
- 9 incident categorised as major*
- 6 major incident due to fractures within the quarter
- 1 new Never Event reported within the quarter*
- 8 new Serious Incident Inquiries commissioned within the quarter
- No new Clinical Review commissioned within the quarter
- No new Non-clinical Reviews commissioned within the quarter
- No new Local Reviews commissioned within the quarter

*Initial grading and subject to change following review.

TB queried the increased number of near-misses to which FHi responded that it was due to a change in reporting. Equally there has been a slight increase in major incidents but there has also been a reporting change. The Trust reports incidents well.

CGC051715 – SII/CR report Q4 – Fenella Hill

Updates to outstanding recommendations:

- SII 204, SII 207, SII 208, SII 212, SII 217, SII 220, SII 218, SII 222, SII 224, SII 225, SII 227, SII 228, SII 229, SII 230, SII 231, SII 232, SII 233, SII 236

Reviews with outstanding recommendations:

- SII 204, SII 206, SII 212, SII 217, SII 220, SII 218, SII 222, SII 227, SII 229, SII 230, SII 232, SII 233, SII 236

New Recommendations since January 2017 CGC

- SII 218, SII 222, SII 224, SII 225, SII 227, SII 228, SII 229, SII 230, SII 231, SII 232, SII 233, SII 236

Serious Incident Inquiry/Clinical Review for Closure

- SII 207, SII 208, SII 224, SII 225, SII 228, SII 231

FHi confirmed that this report has been to the Clinical Management Board. Updates are being received and the process is working. TB asked how it is evidenced that the Sepsis prescribing therapy guidelines are being followed to which FHi responded that this is a CQUIN and is regularly audited.

CGC051716 – NPSA NRLS Organisation Patient Safety Incident Report – Fenella Hill

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

Key items to note are:

- Reporting rate per 1000 bed days shows the Trust to be in the highest 25% of reporters for Acute (non-specialist organisations). This demonstrates a further rise in our position to the next cluster group up since the last report (previously middle of middle 50% reporters). We are now reporting a rate of 47.68 incidents per 1000 bed days compared to 39.34 for the previous 6 month reporting period (median reporting rate for cluster 40.02). This increase is seen as a positive safety culture indicator.

- Patient accidents continue to be the top reported incident at SFT (17.5% against the cluster reporting 17.3%).

- Nationally 73% of reported incidents result in no harm. We reported 89.4% of incidents as resulting in no harm, compared to 76% for the remainder of the Acute (non-specialist) organisations.

- Incidents reported in 6 of the 6 months 1 April – 30 September 2016.

FHi noted that the Trust encourages reporting and this works well.

CGC051717 – Medication Safety annual report 16/17 including missed doses update – Steve Bleakley

- Pharmacy workforce plan:

The proposal to increase the pharmacy workforce by two members of staff to improve the ward based clinical service has been supported. Currently out to recruitment. Once in post will bring a number of safety benefits to wards with a limited pharmacy service.

Recruitment of mid-grade pharmacists has proved challenging, so a decision to train in house was taken. Four have been recruited internally and one externally this year. An educational contract is to be put in place to help retain the trained pharmacists.

- Antimicrobial stewardship

The availability and price of antibiotics is a national problem. Prices are being investigated nationally. Regional procurement teams have highlighted a significant global shortage of Tazocin over the next few months (Tazobactam/Piperacillin). Tazocin is a key antibiotic for the trust used in sepsis / resistant cases. Stock is being monitored weekly and regular discussions are taking place with microbiology regarding alternatives. Information has gone out to Junior Doctors. The microbiologists are actively chasing to check usage.

- A monthly medicine safety bulletin is being produced, and there is a need to ensure this is reaching junior doctors

CGC051717B Items for escalation to Trust Board

The statutory Supervision of Midwives stopped in April.
Existing arrangements are continuing locally, as this supports midwives and mother and baby safety. Maternity are developing resource ideas, and these will come back to CGC.

CMB
- **Clinical Leads**:
- There are challenges in recruitment of clinical leads in critical areas:
    - Appraisal lead
    - Clinical information officer
    - Sepsis lead
    - Smoking cessation lead
- Broadcasts and asking people directly is not working.
- This puts quality improvement programmes at risk, i.e. Sepsis and the Antibiotic CQUIN.
- Everyone is under time pressure already.

TB asked if we could have a nurse lead, e.g. for Sepsis, rather than a clinical lead. CGz replied that engagement is better with a clinical lead, and the current Sepsis lead is very involved. CB said the smoking cessation lead could be a nurse, but the rest need to be a doctor. CB will continue to work on this

Challenges delivering CQUINS:
- Antibiotic reduction CQUIN challenges include:
    - Sepsis
    - Tazocin use based on 2013/14 baseline
    - Total dose target
- We are unlikely to achieve 100% of the CQUINs monies this year, which would mean a loss of £300-£500k at worse.
- Each scheme has an Executive Lead, Senior responsible officer and has to report quarterly to a working group.

CQC inspection
- CMB discussed the preparation for the next CQC inspection, which will probably be in Q4.
- The pathways in ED are feeling better with the navigators in post.
- Reconfiguring wards should help with patients moving downstream.
- A Task & Finish group has been set up for Nursing Documentation.
- The service action plan is mostly completed.
- We are focussing on preparing services:
    - Developing a clinical strategy with the whole team engaged
    - Looking at where they aim to be in 5 years' time.
    - They have monthly meetings in departments

Ethics Committee
- This year's meetings have now been set up, and they will be starting again on 9/6/17.

REPORTS FROM BOARDS OR COMMITTEES BY EXCEPTION

CGC051718	Clinical Management Board meeting minutes (February, March, April 2017)	Noted
CGC051719	Clinical Risk Group meeting minutes (February 2017)	Noted
CGC051720	Information Governance Group meeting minutes (March 2017)	Noted
CGC051721	Integrated Safeguarding Committee meeting minutes (January 2017)	Noted
CGC051722	Infection Prevention and Control Committee meeting minutes (January 2017)	Noted
CGC051723	Supervision of Midwives Assurance meeting minutes (March 2017)	Noted

NEXT MEETING

2017 dates will be Thursdays, 10am-12pm in the Boardroom – 22nd June, 27th July, 28th September, 26th October, 23rd November. No meetings in April, August or December.

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 22nd June 2017, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – DR MICHAEL MARSH

Present:

Dr Michael Marsh – (Chair) – Non-Executive Director
Cara Charles-Barks – Chief Executive Officer
Dr Christine Blanshard - Medical Director
Mark Stabb – Head of TIAA
Tania Baker – Non-Executive Director
Maria Poelvoorde – Staff Nurse

In attendance:

Kate Williams	Minute taker
Jan Sanders	Governor
Denise Major – Deputy Director of Nursing	CGC061705, CGC061711, CGC061712, CGC061721 & CGC061722
Stephen Veitch – Orthopaedic Consultant	CGC061708
Katie Ransby – Senior Nurse, Chilmark Ward	CGC061708
Gill Hibberd – Head of Orthopaedic Therapy Team	CGC061708
Sarah Bartram – Rheumatology Consultant	CGC061708
Mark Geraghty – Human Resources Manager	CGC061719
Katrina Glaister – Clinical Effectiveness Facilitator	CGC061720

CGC061701 Apologies:

Professor Jane Reid – (Chair) Non-Executive Director
Lorna Wilkinson - Director of Nursing
Fiona Hyett - Deputy Director of Nursing
Claire Gorzanski – Head of Clinical Effectiveness
Hazel Hardyman – Head of Customer Care
Andy Hyett – Chief Operating Officer
Steve Bleakley – Chief Pharmacist
Michael Von Bertele – Non Executive Director
Dr Samuel Williams – F1

CGC061702 – Any Urgent Business

MM noted that this meeting was not quorate, and that therefore no decisions would be taken. Items to be escalated to Trust Board if necessary.

GC061703 – Minutes of the meeting held on 18th May 2017

The following actions were noted:

MS to complete internal audits as requested. **MS**

Stroke Core Service Presentation to be reinstated onto Clinical Governance Committee Schedule. **KW (completed)**

Medicines Storage June audit to be added to the action tracker to come back to the committee in July. **KW (completed)**

Wiltshire Health and Care are producing a dashboard and this will be brought to the committee in September. **KW (completed)**

The minutes were approved by the committee.

CGC061704 – Action Tracker

All items were agreed.

CGC061705 – Matters Arising – National Inpatient Survey 2016 – CQC Benchmark report and local Action Plans – Denise Major

Salisbury NHS Foundation Trust (SFT) participated in the 14th national inpatient survey between September 2016 and January 2017. The sample size was 1,250 patients and 719 patients (60%) responded. The survey contained 65 questions which could be analysed, grouped into 11 sections.

Comparisons with other Trusts

Comparisons with its own 2015 benchmark results

- SFT's results had significantly decreased in seven areas. These are being addressed through the Trust-wide action plan.

Care Quality Commission website

- The results have been published on the Care Quality Commission's website at: http://www.cqc.org.uk/provider/RNZ/survey/3

They show that 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.

Local Results Analysis

- 429 comments were received on things that were good.
- 329 comments were received on things that could be improved.
- The main area where more negative than positive comments were received related to discharge.

The Next Steps

- Each ward has identified its themes from the national in-patient survey, real-time feedback, Friends and Family Test, concerns and complaints.
- A Trust-wide action plan has been produced
- Ward action plans have been produced. These will be reviewed in six months' time when completed actions will be removed and new actions added based on themes arising from more current feedback. This exercise forms a six-monthly rolling programme.

Comparisons with Neighbouring Trusts

- Salisbury had the highest or joint highest mean score in 5 of the 11 overall sections and 13 of the 65 individual questions.
- It had the lowest or joint lowest score in 1 of the overall sections and 4 of the individual questions.

DM reported that overall, SFT was similar to other Trusts. Wards collect information from Real-Time Feedback and Friends and Family results to create actions. There is a variation in how each ward is completing this. There needs to be an improvement in the writing of action plans.

MM noted that there are 5 clear themes relating to the following – noise, food, facilities, flow, communications.

CC-B suggested that there be Trust-wide action regarding escalation and to pinpoint any theme that comes up across the wards. There needs to be consistency across the Trust and within the

values of the organisation. CB added that it was important to be aware that patients' experiences before they attend hospital are included in the surveys, ie appointment waiting times.

TB stated that it should be a challenge to the wards to consider their discharge procedures and DM responded that efforts are being made to link the discharge procedures with the information received.

CGC061706 – Matters Arising – Clarification of ward moves and review of capture of information – Christine Blanshard

1. From April 2017 in line with contract requirements the number and percentage of patient ward moves that occur more than once, twice or three times is reported in the quality indicator report. The timing of ward moves between 22.00 and 06.00 hours by month rather than cumulatively is also reported.

➢ Definitions used to report patients moving multiple times during their in-patient stay
- Includes all non-elective and elective admissions.
- Only includes countable ward moves (but not moves within the same area such as between Britford-SAU to Britford, Tisbury to Tisbury-CCU) and escalation capacity when it is open.
- Excludes moves to and from the Cardiac Suite, from main theatre to DSU (except as escalation capacity), moves from wards to endoscopy unit and back (except as escalation capacity), from wards to Nunton Unit (Discharge Lounge), from wards to Radiology and back, from the Surgical Assessment Lounge, from ED to the Short Stay Emergency Unit, from the Pembroke Suite (except if used for escalation capacity), moves to and from theatre, moves from Whiteparish AMU and the Surgical Assessment Unit. Also excludes NICU, Beatrice (mums) and Beatrice (cots).

➢ Ward moves between 22.00 – 06.00
- Includes all non-elective and elective admissions.
- Only includes countable ward moves (not moves within the same area such as between Britford-SAU to Britford, Tisbury to Tisbury-CCU) and escalation capacity when it is open.
- Excludes Radiology, Theatres & Endoscopy as above.
- Excludes NICU, Beatrice (Mums), Beatrice Cots, Cardiac Suite, SAL, Nunton.

2. The majority of moves that occur between 22.00 – 06.00 are from Whiteparish AMU to downstream wards, ED to wards, and the Surgical Assessment Unit to surgical wards.

CB stated that it would be preferable to see fewer moves from Whiteparish AMU downstream during the night. CC-B noted that moves should be tracked in order to stop this occurring. MS can pick this up on data quality work.

The committee await notification of improvements.

CGC061707 – Matters Arising – Internal Audit plan – short report – Mark Stabb

The 2017/18 Internal Audit Plan was agreed by the Audit Committee at their meeting on 13th March 2017; all completed audits are reported to the Audit Committee for assurance purposes. The following audits of relevance to the CGC are to be undertaken in 17/18:

- Data Quality
- Complaints Management
- Medical Device Management – Follow Up
- Safe and Secure Management of Medicines
- Theatre Safety
- Decontamination
- Serious Incident Management – Action Plan Implementation
- CQC Standards

CB requested that she be given sight of the relevant audit reports before they go to the audit committee. TB noted the challenges relating to EPR and data warehouse and asked if this has been given enough emphasis. MS confirmed that CC-B has requested this information.

MM asked MS to try to avoid duplication of reports across committees.

STRATEGY

CGC061708 – Core Service presentation – Orthopaedics – Stephen Veitch, Katie Ransby and Gill Hibberd

SV, KR and GH gave an overview of the CQC outcome for Orthopaedics as a core service, and the achievements and challenges within the department. There have been improvements in staffing ratios, a more robust therapy service is in place, a change of culture to 'share and learn', increased support to geriatricians, improved nursing documentation and increased communication with procurement resulting in improved departmental efficiency. There have been positive changes in clinical practice, with ring-fenced beds remaining the only outstanding issue.

CC-B asked if the results of the monthly team discussions were reported to the management team and this was confirmed. SV noted that it would be beneficial to make faster decisions / complete actions more quickly than is currently possible, and that this issue would be considered further. DM noted that the appraisal rate and training of staff in the department is very good.

The committee noted the significant changes and improvement to the department and thanked the team for their presentation.

CGC061708 – Core Service Presentation – Rheumatology - Sarah Bartram

SB gave an overview of the CQC outcome for Rheumatology as a core service, and the achievements and challenges within the department.

There is a good rate of appraisal in the department, the HQIP national audit for recognition and management of RA shows that the department are performing well in the South Central region, there is safer monitoring of patients and significant financial savings through the Biologics Review Clinics, there is consistently good feedback from Friends and Family. The biologics drugs give patients personalised treatment and this has proved very successful. Mortality and Morbidity reviews are taking place. There are some delays relating to follow up appointments which need to be resolved. There continue to be periodic issues with a leak into the patient waiting area which the committee asked to be resolved as a priority.

CB commented that it was encouraging to note that there was ownership of issues and that learning from the issues was creating improvements in the department.

MM asked what improvements could be made to the follow-ups to which SB responded that fundamental changes will be necessary. CB suggested that there be access to health coaching for patients to manage their own disease – more training for nurses on this may be necessary.

The committee thanked SB for her presentation and for the efforts of the department.

CGC061709 Hot Topic for July 2017 CGC - NEDs

It was agreed that the following items would be Hot Topics for the Clinical Governance Committee meeting in July 2017 –

- Nurse documentation
- Medicines storage

ASSURING A QUALITY PATIENT EXPERIENCE

CGC061710 – CQC inspection action plan update – verbal – Christine Blanshard

CB reported that there has been good progress on most items on the Action Plan. 2 items remain outstanding –

- nursing documentation for which LW is chairing a Task and Finish group
- the discharge of patients from Day Case Surgery Patient Recovery for which a pilot scheme is in place and which should continue thereafter.

The implementation of a navigator role took some time to set up but is in place now.

In preparation for the next CQC inspection there will be Core Service workshops, drop in sessions for staff, guidance reviews, workshops and mock inspections, and reciprocal arrangements are in place with Royal United Hospital, Bath; Royal Berkshire Hospital and University Hospital, Southampton. 'Green' items will be checked to ensure that they remain green. Team relationships have been developed with the CQC and feedback is that the Trust are open and engaging. SFT is one of four Trusts in the South to be working with NHSI.

CGC071711 – Annual Food and Nutrition Report 16/17 – Denise Major

In March (2017) the Trust completed the Patient Led Assessment of the Care Environment (PLACE) audit, provisional scores identify improvements since 2016. Improvements were also identified in the National Inpatient Survey. During the year 'Food or Nutrition' were not identified as principle concerns in any formal complaint and the Trust continues to receive positive real time feedback regarding food and food services, with improving results regarding food temperatures.

DM noted that the catering team are very responsive.

The committee noted the report.

CGC071712 – Q4 Customer Care Report – Denise Major

65 complaints were received in Q4 compared to 62 complaints in Q3 and 84 complaints for the same period in the previous year. The activity from comments, concerns and enquiries has increased from 434 in Q4 last year to 474 in Q4 this year.

The main issues from complaints are:

- Clinical treatment (23), 5 less than Q3 (28) - sub-themes were 15 unsatisfactory treatment across 11 different areas, 4 further complications, 2 delay in receiving treatment, 1 correct diagnosis not made and 1 treatment unavailable. Orthopaedics received 5 complaints about clinical treatment with 3 related to further complications, and 1 each for delay in treatment and unsatisfactory treatment.
- Appointments (12), 3 more than Q3 (9) – sub-themes were 6 appointment system delays, 4 appointments cancelled, 1 appointment date required and 1unsatisfactory outcome, across 7 different specialties.
- Staff attitude (10), 1 less than Q3 (11) – 5 related to medical staff, 4 nursing staff and 1 administrative staff across 9 different areas.

The main issues from concerns were appointments (36), clinical treatment (24) and attitude of staff (15). The main specialties across concerns and complaints for appointments were Orthopaedics (9), Ophthalmology (8) and Central Booking (6).

There was a theme around use of escalation within complaints and concerns which can be seen in Clinical Support and Family Services and Medicine. This underlines the importance of the ward reconfiguration work planned for Q2 in 2017-18 in order to prepare for growing demand.

There were no new requests for independent review by the Parliamentary and Health Service Ombudsman.

A total of 295 inpatients were surveyed in the quarter. They made 180 positive and 186 negative comments. The main areas of concern were food and nutrition on the ward, communication, call bells and noise.

The responses to the Friends and Family Test remain overwhelmingly positive and the numbers are too low to identify any main area of concern.
There have been 6 new project requests in Q4, 5 completed projects and 1 new National Patient Survey. NHS Choices received 16 comments in Q4 with 13 positive and 3 negative comments relating to 11 different areas.

MM noted that the level of MSK complaints are higher than expected to which DM responded that a DMT member is now always contactable to try to address any issues immediately.

CC-B commented that this should be triangulated back to the Inpatient Survey regarding the attitudes of staff. This should be 'outstanding every time'. CC-B suggested a re-launch of the values Trust wide. MM noted that this is an important issue for CQC, and TB suggested encouraging staff engagement.

ASSURING CLINICAL EFFECTIVENESS

CGC061713 – Quality Indicator including DSSA – tabled only – Dr Christine Blanshard

- 4 new serious incident inquiries commissioned in May.
- 4 in-hospital cardiac arrests in April 17, two of which had a futile CPR attempt.
- An increase in the crude mortality rate in May 17 with an increase in admissions. SHMI decreased to 102 to December 16 and is 102.5 adjusted for palliative care to September 2016. HSMR increased to 119 in February 17 and is higher than expected. Weekend HSMR is 121.0 to January 17 and is higher than expected. The board received a mortality presentation at the May meeting as did the commissioners in June 17.
- An increase in grade 2 pressure ulcers. Share and learning meetings continue to drive improvements.
- In May 17 there were 3 falls resulting in major harm (all fractured hips/femur requiring surgical repair). A new falls reduction strategy was presented to the Clinical Risk Group in May 17 and to the commissioners in June 17.
- 100% delivery of CT scan within 12 hours for patients with possible stroke and a significant improvement in patients with a stroke spending 90% of their stay on the stroke unit. Patients arriving on the stroke unit within 4 hours improved but remains below the national benchmark – transferred at 3 hrs 58 minutes from ED (2), waiting for specialist doctor (1), admitted to AMU (1), ED waiting for bed (1), no reason given (1).
- A slight reduction in high risk TIA patients seen within 24 hours. Those not seen within 24 hours related to no available morning clinic, consultant availability and one GP referral not received.
- Escalation bed capacity increased in May. Ward moves between 22.00 and 06.00 reported by month only. A plan is in place to reconfigure the bed base over the next 6 months in preparation for next winter.
- For the third month running there were no non-clinical mixed sex accommodation breaches.
- Real time feedback improved significantly in May for patients rating the quality of their care. The Friends and Family test of patients who would recommend ED, wards, the maternity service and care as a day case and outpatients was sustained.

MM noted an improvement in performance of Stroke indicators and questioned whether there needed to be focus on the admission to stroke ward within 4 hours to prompt further improvement. CB commented that it was likely that the SNAAP audit rating will drop due to issues with getting stroke patients onto a ward within 4 hours due to a lack of awareness in ED, and locum acute physicians not sending the patients straight to Farley ward. TB noted that it was disappointing that the HSMR was worsening. CC-B reported that there was a consistent success with same sex breaches over the last 3 months due to the efforts of staff.

CGC061714 – Annual Clinical Governance Report – Christine Blanshard

- The report is structured around the Quality Governance Framework and the work needed to ensure compliance with the NHS Outcomes Framework 2016/17. It takes into account the new Integrated Governance Framework and Accountability Framework to ensure the Board has a clear line of sight on the issues and attention is given to the most significant areas of risk.
- The Quality Account is the key driver for improvement and overall the Trust has made good progress in improving the quality of care in 2016/17. Nevertheless, there are still improvements to be made which are reflected in the quality priorities and work streams for 2017/18.
- Good progress has been made in the ‘must do’ and ‘should do’ elements of the Care Quality Commission Trust wide action plan. It continues to be robustly monitored to ensure progress is sustained in practice. Preparation of the organisation for a CQC inspection in 2017/18 is underway.

MM noted that there is a need to ensure that Clinical Governance is used and embedded in all departments. CB reported that all 26 service lines are audited and it is encouraging to see that Clinical Governance work has been taken on board.

CGC061715 – Annual Clinical Audit Report and CGC061715A Clinical Audit Plan – Christine Blanshard

- Clinical audit is a requirement of the Care Quality Commission effective domain. The clinical audit plan is a prioritised list of audits that the Trust takes part in each year. Many of the audits are required to be published in the Quality Account.

- This end of year report provides assurance that the Trust has delivered the clinical audit plan almost in full. Interventions are in place for audits not on target.

- Examples are given to show how clinical audit has improved patient outcomes.

- Priorities for improvement in 2017 - 2018 are set out in the report.

The Clinical Audit Plan is a prioritised list of 'must do' audits that need to be undertaken during the forthcoming financial year. Audits with actions that are due for completion in 2017/18 are also included to ensure improvements are made to patient care.

CB reported that there is a lot of activity and participation in audits and trials. Recently an audit was declined for the first time due to time pressure in relation to data collection. This has been escalated to Nigel Acheson, regional medical director, NHS England for South Region..

MM noted that the NICE guidance compliance report was excellent but sought assurance and clarification on how assessments / judgements are made against NICE guidance. CB responded that a clinical / management lead is assigned for each NICE guidance at CMB, it is then their responsibility and provides a robust process. All audits are presented to CMB and action plans are required and improvements are identified.

MM noted there is 97.6% progress against the clinical audit plan which is excellent.

CGC061716 – Annual NICE Report 16/17 – Dr Christine Blanshard

The report sets out the current status of NICE guidance published between 1 April 2016 and 31 March 2017 and includes information on all outstanding NICE guidance within the Trust.

NICE guidance published between 1 April 2016 and 31 March 2017

A total of 141 sets of guidance have been published. The current status is as follows:-

Compliant	48
Working towards compliance	20
Awaiting feedback	4
Non-applicable to SFT	69

Progress towards compliance with guidance outstanding more than 12 months

A total of 22 sets of guidance have had areas of non-compliance for more than 12 months. None of these present a significant risk to quality of care.

CGC061717 – Annual Research and Development report (information only) – Stef Scott

This item was deferred to July 2017.

CGC061718 – Mortality Review Report – Christine Blanshard

- SHMI is 102 (as expected) to December 16 and when adjusted for palliative care is 102 (as expected) to September 16. HSMR is 119.4 to February 17 (higher than expected). Deaths in low risk diagnosis groups are within the expected range with a relative risk of 61. Our co-

morbidity upper quartile rate has declined from 26.1% in 15/16 to 23.7% in 16/17 and our palliative care coding rate declined from 4.46% in 14/15 to 3.91% in 16/17 compared to a national rate of 3.57% in 16/17. Both may impact negatively on the mortality rate.

- Care Quality Tracker - our overall risk is 5, lower than the national median of 10. There are two elevated risks and one risk.

- CUSUM alerts – 5 new diagnosis groups review findings and learning points.

- The review of the spinal cord injury deaths has been completed. None were due to delayed follow up.

- National Quality Board – National guidance on learning from deaths implementation plan. 43.5% of April 17 deaths reviewed, none were avoidable. Learning points noted.

CB reported that patient admissions on Fridays and Sundays are to be reviewed. The pathway for patients with cancer of the pancreas is quite complicated and relatives of patients have been engaged to streamline this.

CC-B asked if lessons learned are being shared with the teams to which CB responded that there are good processes for dissemination to the teams and in addition a newsletter is now being circulated. Some issues are proving more difficult to resolve, others have been completed. MM asked if reports are sent to the directorates to which CB responded that the newsletter is very useful and a mortality dashboard will be produced at directorate / specialty level. The CQC dashboard is very good.

ASSURING SAFETY

CGC061719 – Annual Report for Profession Registration – Mark Geraghty

All registered staff are checked at appropriate intervals to ensure their registration is maintained and current. If registration should lapse they are not able to work in a registered capacity and may be dismissed. All medical and dental staff registrations are also checked to ensure they are registered and licenced and the Trust is working to implement all the requirements of revalidation. All new recruits who require professional registration have their registration status checked via the regulators web site, GMC, HPC and NMC by the HR administrative team.

The committee agreed that there is a need to publicise the importance of maintaining professional registration.

CGC061720 – Q4 Sign up to Safety Programme Report – Katrina Glaister

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

Workstream One – Reducing Harm in Frailty
1a) Reducing falls resulting in injury
1b) Reducing harm from pressure ulcers
1c) Reducing harm from catheter associated urinary tract infections (CAUTIs)

Workstream Two – Deteriorating Patient
1a) Reducing harm from sepsis
1b) Reducing harm from acute kidney injury
1c) WAHSN deteriorating patient workstream

Workstream Three – Perioperative Safety
1a) Reducing perioperative harm through use of safety checks and briefings
1b) Reducing surgical site infections through implementation of the surgical site infection bundle

Workstream Four – Maternity Safety
1a) Reducing still births and intrauterine deaths through improved recognition of growth issues in the unborn.

KG reported that there have been real improvements in saving babies lives. CC-B noted that the

team have highlighted an increase in elective caesarean sections. The catheter work is looking very promising.

MM questioned the clarity of the graphs and KG confirmed that this will improve as time goes on. The wards are moving onto an app and there will be a more uniform look to the graphs in the future.

CGC061721 – Safeguarding Children Q4 Report – Denise Major

The purpose of the report is to inform Salisbury NHS Foundation Trust (SFT) Clinical Governance Committee about activity and performance in relation to children's safeguarding arrangements for Quarter 4, 2016/17.

MM questioned the level of involvement relating to Table 2 and this will be a challenge for Angela Conway.

CGC061722 – Safeguarding Adults Q4 Report – Denise Major

Included in the Q4 report is information around referrals, activity & themes in relation to the Adult Safeguarding/ MCA/ DoLS agenda.

The Local Authorities continue to be unable to meet the demand to complete the Best Interest & Mental Health Assessments within the 7 day Urgent Authorization period; at the end of March 2017 Wiltshire DoLS Helpdesk had a backlog of 1700 authorisations to process.

Safeguarding Adults Level 2 training compliance has dropped to 53% following the end of the 'grace' period that was set by the Education department following the introduction of Level 2 training last year. Surgery and Clinical Support have compliance less than 60%, and Medicine less than 50%.

Attendance at face to face Domestic Abuse training has dropped again in the last quarter, with some sessions being cancelled because of poor attendance. MCA & DoLS ½ day workshops have commenced, with good attendance at the first session. It is thought that the operational challenges the Trust has been under have impacted on staff being released for training.

CB confirmed that the management pathway is agreed that when presented with a self-harming adolescent the child will be placed in paediatric care unless there is a risk to other children, in which case the patient will be seen by a paediatrician on an adult ward. All checks and balances remain in place.

MM questioned whether domestic abuse in pregnancy is being asked about with sufficient frequency to which DM responded that this will be picked up with Angela Conway. DM confirmed that Gill Cobham is working hard to improve training levels.

CGC061722 - Items for escalation to Trust Board

- Leak into patient waiting area in Rheumatology
- Focus of CQC preparation
- Opportunities to better triangulate staff / management complaints

REPORTS FROM BOARDS OR COMMITTEES BY EXCEPTION

CGC061724	Clinical Management Board meeting minutes (May 2017)	Noted
CGC061725	Clinical Risk Group meeting minutes (April 2017)	Noted
CGC061726	Information Governance Group meeting minutes (April 2017) – this meeting did not take place	Noted

NEXT MEETING

2017 dates will be Thursdays, 10am-12pm in the Boardroom – 27th July, 28th September, 26th October, 23rd November. No meetings in April, August or December.

SALISBURY NHS FOUNDATION TRUST

SFT 3911

Minutes of the Finance & Performance Committee
Held on 30 May 2017

Present:	Dr N Marsden	Chairman
	Mr M Cassells	Director of Finance and Procurement
	Mrs C Charles-Barks	Chief Executive
	Mr A Hyett	Chief Operating Officer
	Mr P Kemp	Non-Executive Director
	Prof J Reid	Non-Executive Director
	Mr L Arnold	Director of Corporate Development (for item 9)
In Attendance:	Mr R Burrows	Salisbury Trading Limited (for item 3)
	Mr K Newton	Salisbury Trading Limited (for item 3)
	Mr P Casson	Odstock Medical Limited (for item 4)
	Mr R Webb	Associate Director of Procurement (for item 5)
	Mrs K Willoughby	Head of Procurement (for item 5)
	Mr D Seabrooke	Head of Corporate Governance
Apologies:	Ms T Baker	Non-Executive Director
	Mrs K Matthews	Non-Executive Director

1. FINANCE AND PERFORMANCE COMMITTEE MINUTES – 24 APRIL 2017

The minutes of the meeting of the Committee held on 24 April 2017, were agreed as a correct record.

2. MATTERS ARISING

There were no matters arising.

3. SALISBURY TRADING LIMITED

The Chairman welcomed Ron Burrows and Kevin Newton to the meeting. The Committee was reminded of the improvements to productivity and financial benefits to the Trust brought by Salisbury Trading since the launch in 2013. A number of tendering opportunities in southern Britain were coming up and were being monitored by the company. Discussions continued with other NHS laundries in the area with a view to extending capacity and resilience.

It was noted that the company followed EN14065 in relation to quality control. The company had employed a Commercial Director to take forward further tendering activity and also a Quality Control Manager. Succession plans were being developed in relation to the planned expansions.

The Committee noted the report and thanked the company representatives for their attendance.

4. ODSTOCK MEDICAL HALF YEARLY REVIEW

The Committee received the update from OML and the Chairman welcomed Phil Casson to the meeting. The company was turning over £2m and had made a £100,000 profit. Principal revenue streams were from CCG funded treatment and from product sales. A range of treatment and education services continued to be provided.

In order to comply with new regulatory and testing requirements, the company was forecasting much higher costs of goods and operating expenses which meant it was not forecasting a profit for 2017/18.

The Committee requested the company return to a future meeting to discuss the three year outlook. **DS**

5. HEAD OF PROCUREMENT

The Chairman welcomed Rob Webb and Kelly Willoughby.

The following principal points were highlighted:

- The service had delivered £1.3m of savings, meeting its stretch target.
- Single tender actions continued to reduce.
- A master vend arrangement was in place for medical locums but this continued to be a challenging contract because of supply issues.
- The contract with the orthopaedics supplier had been successfully renegotiated.
- Good progress including clinical engagement was being made via the Scan4Safety project.
- There were some moves at the centre to strengthen the central agency's offer on procurement of standard items.
- The Trust was reviewing the capital bid process to involve procurement at an earlier stage.

MC gave a brief update on the proposals being taken forward at another trust in relation to site and facilities management. It was agreed that this would be discussed further at the 3 July Board Seminar Day. **DS**

6. FINANCE REPORT

The Committee received the month 1 Finance Report and Contracting Report.

It was noted that the income and expenditure position for April was a deficit of £112k which was an adverse variance against the plan of £387k. On a straight line basis this would be a deficit of £583k in relation to a £7m deficit.

Issues continued to be experienced with the reporting of activity and income through the data warehouse. Estimating of activity and income trends was continuing. Out coming of outpatient work was continuing.

There was some concern that the Lorenzo project team was reporting a more positive position with the progress of the stabilisation progress than had appeared to be the experience in ascertaining the income position. It was noted that a revision to the business case would be coming to the June Finance and Performance Committee to update the benefits realisation position. **LA**

It was noted that the CIP target for 2017/18 had been moved up to £8.5m. This would be held centrally as it was not considered realistic to pass on to directorates.

MC updated the Committee on discussions he was having with Wiltshire CCG about areas of income.

7. CIP REPORT

The Committee received the CIP Report. It was noted that at this stage the report did not attribute finances to income schemes.

8. OPERATIONAL PERFORMANCE REPORT

The Committee received the Operational Performance Report for month 1.

It was noted that there had been one attributed C-diff case. RTT performance for April was 88.8% against the trajectory and national target of 92%. Performance for A&E had been 95%. Recovery of diagnostics performance was on trajectory.

There were 49 delayed transfers of care. There continued to be good engagement with the local authority in addressing this concern.

9. CAPITAL DEVELOPMENT REPORT

The Committee received the Capital Development Report. It was noted that progress was being made with the planned ward configuration and that plans were in place in relation to the temporary reduction in the number of beds during the summer. A planning approval had been received for the new Ophthalmology build.

10. ANNUAL GOVERNANCE DECLARATIONS

The Committee received completed declarations which were required to be made by NHS Improvement. It was understood that the templates were not required to be submitted to NHSI but that NHSI may audit a selection of Trusts for compliance.

Declarations were received in relation to the Corporate Governance Statement, taking steps to ensure training for governors and systems for compliance with licence conditions.

11. ANY OTHER BUSINESS

Laundry Task and Finish Group

It was noted that a Task and Finish Group had reviewed the content of the Trust's contract with the on-site laundry.

12. DATE OF NEXT MEETING

The next meeting will be on Monday 26 June 2017 at 9.30 am.

Action	Who	Comments
OML review – 3 year outlook	DS /PC	Coming to 24 July F&PC meeting
Site and Facilities options	MC	On agenda for 3 July seminar day
EPR benefits realisation	LA	On agenda for 26 June F&PC

SALISBURY NHS FOUNDATION TRUST
Minutes of the Audit Committee
Held on: Friday 19 May 2017

Present: Mr P Kemp (Chairman and Non-Executive Director)
Mrs K Matthews (Non-Executive Director)
Mr M von Bertele (Non-Executive Director)

In Attendance: Mr R Batley (KPMG)
Miss A Nash (KPMG)
Mr M Stabb (TIAA)
Mr M Cassells (Director of Finance & Procurement)
Mrs C Charles-Barks (Chief Executive)
Mr D Seabrooke (Head of Corporate Governance)
Mrs F Hill (Head of Risk Management, for item 7)
Mrs L Wilkinson (Director of Nursing, for item 8)
Mrs N House (Head of Medical Device Management Services, for item 8)
Mr A Stagg (Directorate Manager CS&FS, for item 8)

Apologies: Dr M Marsh (Non-Executive Director)

ACTION

1. MINUTES – 13 MARCH 2017

The minutes of the meeting of the Committee held on 13 March 2017, were agreed as a correct record subject to a minor correction at the foot of page 1.

2. MATTERS ARISING

IR 35 – it was noted that the requirements of IR 35 were being applied to existing contract workers and would be applied to new engagements.

Assurance Framework – it was noted that the Trust Board would be reviewing the Assurance Framework at a forthcoming meeting.

Audit recommendations – a process for closing out outdated audit recommendations had been discussed with TIAA.

Audit Programme 2017/18 it was noted that executives had discussed and agreed sponsorship of internal audit reviews. Other items signalled in the 13 March minutes as matters arising were scheduled for discussion at this meeting.

3. SUMMARY INTERNAL AUDIT PROGRESS REPORT

The Committee received the report and it was noted that the following audits and outcomes had been reported since the last meeting of the Committee.

Policy Management	Reasonable Assurance
Board Assurance Framework and Risk Management	Reasonable Assurance
Laundry	Reasonable Assurance
Deprivation of Liberty Safeguards	Reasonable Assurance
Safe Guarding Children and Adults training	Reasonable Assurance
Estates Procurement	Reasonable Assurance

Arising from the Audit on policy management was a concern that out of date clinical policies were being removed from the ICID system. An improved means of managing policies nearing their expiry date within clinical directorates was being investigated to address this.

The presentation of the board assurance framework would be streamlined. A task and finish group was considering streamlining the nursing documentation to improve the consistency.

On past audits there continued to be concerns regarding progress with the replacement of the firewall. A broader update of the Estates Strategy was underway.

It was noted that the Trust had accepted the requirements of the Competition and Markets Authority in relation to private patient income and was registering with PHIN as required. It had requested that the CMA underwrite any liabilities arising from the transfer of patient information to PHIN.

4. ANNUAL REPORT AND HEAD OF INTERNAL AUDIT OPINION FOR 2016/17

The Committee received the narrative section of the draft annual report and the internal audit opinion. The Head of Internal Audit's annual opinion was that the Trust had adequate and effective management control and governance processes to manage the achievement of its objectives. The overall opinion was that reasonable assurance can be given. This conclusion was supported by substantial assurance being received in relation to six internal audits, 15 were reasonable and there was one limited assurance review.

Advance drafts of the narrative had been circulated to all Board members for comment. The Chairman of the committee felt that the repetition of material, particularly that regarding specific achievements through the year. It was suggested that the references to the maximum amount required to support the cash position from the Department of Health should be amended.

5. KPMG AUDIT HIGHLIGHTS MEMORANDUM (ISA260) 2016/17

There was concern that the external audit report had not been circulated to the Committee in sufficient time to form the basis of assurance to the Trust Board. It was noted that the appointed auditor intended to issue an unqualified audit opinion on the accounts.

There were two unadjusted accounting differences – the first was in relation to the treatment of partially completed spells and the second in relation to the inventory adjustment which reflected stocks which may have been in part purchased in previous years but this was not considered to be material. A clean opinion was proposed for value for money and for the content of the Quality Account.

In relation to the 'limited assurance' opinion on the performance indicators in the Quality Account the finding were that the four hour emergency department indicator was the subject of a clean opinion; no opinion was required for the locally selected indicator in relation to TIA referrals and that the limited assurance opinion could not be given for the 18 weeks RTT data.

The auditor was satisfied with the Trust's land and buildings re-evaluation and there were no matters to report on the recognition of income or fraud risk.

The auditor was satisfied with the Trust's statement on going concern.

The Audit fees 2016/17 were clarified and were comprised of £53,000 for the audit, £6,500 on the external assurance on the quality report and £3,500 on the financial statement of the Trust's charity.

With regard to the RTT/18 weeks key performance indicator it was reported that in five cases of the sample of 20 the pathway start dates had not been evidenced and that in four cases patients were receiving treatment so should not have been included. It was noted that the Trust's patient tracker list held 26,500 patients and this figure should be verified to 14,000 – 15,000 patients and this was part of the Trust's stabilisation plan for Lorenzo. There was concern that this issue had been raised in the previous two annual audits. It was noted that the program of staff training and auditing of these records would continue.

On the TIA referrals it was noted that this was a shared pathway with primary care. The time the patient was first seen was not consistently recorded and at present it was the Trust's practice to estimate this. The recommendations signalled in the report were agreed by management and the wording would be finalised.

As regards the letter of representation, KPMG had provided drafts to the Trust and it was agreed that the one in relation to the Quality Account would be amended to take account of the findings of the limited assurance reviews.

6. DRAFT CONSOLIDATED FINANCIAL STATEMENTS FOR THE YEAR TO 31 MARCH 2017

The Committee received the Financial statements circulated with the Trust Board agenda and the Draft Annual Governance Statement.

It was noted that there was a specific requirement for any information governance incidents to be disclosed in the Annual Governance Statement.

It was noted that the Chairman of the Committee had provided detailed comments to the Finance Department on the draft accounts and there were no matters requiring discussion.

7. EXTERNAL ASSURANCE ON THE TRUST'S QUALITY REPORT 2016/17

The Committee received the final draft Quality Account which had been discussed by the Clinical Governance Committee and the Council of Governors. Comments from the Council of Governors and from Wiltshire CCG were provided at the meeting.

The report set out progress on the 2016/17 priorities for improvement which were -

1. To continue to keep patients safe from avoidable harm.
2. To ensure that patient have an outstanding experience of care.
3. Actively work with community partners, patients and carers to prevent ill health and manage long term conditions.
4. Provide patients with high quality care seven days a week.
5. Provide coordinated care across the whole of the health and care community.

8. PROGRESS UPDATES

The Committee reviewed a progress update on earlier findings regarding medicines management. It was noted that physical security arrangements in the PFI building had been improved as part of a range of actions summarised in the report. Procedures would be developed to improve the management of drugs in transit or those required for immediate emergency use.

It was noted that this issue would be managed through the Nursing and Midwifery Forum going forward.

A report on progress with earlier recommendations on the management of Medical Devices was received. It was noted that the Trust had tightened up processes around tracking of medical device assets. A medical devices trainer had been recruited and had started in February and more medical devices training was being made available through the Managed Learning Environment. Work continued to ensure that devices were kept under regular review within manufacturer's guidelines. The Medical Devices Services were working as a library following a notice to a clinician about a change in progress so that responsibility for use of a medical device checked out to a user including training, past to that user. The service required clinician owned devices to be declared for example apps via IT or devices to the Medical Devices Service.

9. DATES OF MEETINGS 2017

Monday 18 September 2017 at 10 am.
Monday 11 December at 10 am

Title: Customer Care Report Q4

Report from: Hazel Hardyman, Head of Customer Care

Executive Summary:

65 complaints were received in Q4 compared to 62 complaints in Q3 and 84 complaints for the same period in the previous year. The activity from comments, concerns and enquiries has increased from 434 in Q4 last year to 474 in Q4 this year.

The main issues from complaints are:

- Clinical treatment (23), 5 less than Q3 (28) - sub-themes were 15 unsatisfactory treatment across 11 different areas, 4 further complications, 2 delay in receiving treatment, 1 correct diagnosis not made and 1 treatment unavailable. Orthopaedics received 5 complaints about clinical treatment with 3 related to further complications, and 1 each for delay in treatment and unsatisfactory treatment.
- Appointments (12), 3 more than Q3 (9) – sub-themes were 6 appointment system delays, 4 appointments cancelled, 1 appointment date required and 1unsatisfactory outcome, across 7 different specialties.
- Staff attitude (10), 1 less than Q3 (11) – 5 related to medical staff, 4 nursing staff and 1 administrative staff across 9 different areas.

The main issues from concerns were appointments (36), clinical treatment (24) and attitude of staff (15). The main specialties across concerns and complaints for appointments were Orthopaedics (9), Ophthalmology (8) and Central Booking (6).

There was a theme around use of escalation within complaints and concerns which can be seen in Clinical Support and Family Services and Medicine. This underlines the importance of the ward reconfiguration work planned for Q2 in 2017-18 in order to prepare for growing demand.

There were no new requests for independent review by the Parliamentary and Health Service Ombudsman.

A total of 295 inpatients were surveyed in the quarter. They made 180 positive and 186 negative comments. The main areas of concern were food and nutrition on the ward, communication, call bells and noise.

The responses to the Friends and Family Test remain overwhelmingly positive and the numbers are too low to identify any main area of concern.

There have been 6 new project requests in Q4, 5 completed projects and 1 new National Patient Survey.

NHS Choices received 16 comments in Q4 with 13 positive and 3 negative comments relating to 11 different areas.

Proposed Action:

To note the report.

Customer Care Report - Quarter 4
1st January – 31st March 2017

PURPOSE OF PAPER

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

1. COMPLAINTS

The main issues from complaints are:

- Clinical treatment (23), 5 less than Q3 (28) - sub-themes were 15 unsatisfactory treatment across 11 different areas, 4 further complications, 2 delay in receiving treatment, 1 correct diagnosis not made and 1 treatment unavailable. Orthopaedics received 5 complaints about clinical treatment with 3 related to further complications, and 1 each for delay in treatment and unsatisfactory treatment.
- Appointments (12), 3 more than Q3 (9) – sub-themes were 6 appointment system delays, 4 appointments cancelled, 1 appointment date required and 1unsatisfactory outcome, across 7 different specialties.
- Staff attitude (10), 1 less than Q3 (11) – 5 related to medical staff, 4 nursing staff and 1 administrative staff across 9 different areas.

The main issues from concerns were appointments (36), clinical treatment (24) and attitude of staff (15). The main specialties across concerns and complaints for appointments were Orthopaedics (9), Ophthalmology (8) and Central Booking (6).

There was a theme around use of escalation within complaints and concerns which can be seen in Clinical Support and Family Services and Medicine. This underlines the importance of the ward reconfiguration work planned for Q2 in 2017-18 in order to prepare for growing demand.

65 complaints were received in Q4 compared to 62 complaints in Q3 and 84 complaints for the same period in the previous year. The activity from comments, concerns and enquiries has increased from 434 in Q4 last year to 474 in Q4 this year. A breakdown of numbers and themes from complaints according to Datix is below:

	CS&FS	Finance	Medicine	MSK	Surgery	Q4 total 2016-17	Q4 total 2015-16
Admission	2	0	0	1	0	3	4
Appointments	3	0	0	4	5	12	10
Attitude of staff	2	1	1	6	0	10	12
Call bells	0	0	0	0	0	0	1
Capacity	0	0	0	0	0	0	1
Clinical treatment	4	0	10	8	1	23	31
Communication	2	0	1	1	1	5	6
Confidentiality	0	0	0	1	0	1	3
Delay	0	0	1	0	2	3	1
Discharge	0	0	0	1	1	2	1
Equipment, aids, apps	0	0	1	0	1	2	0
Medical Records	0	0	0	1	0	1	0
Nursing care	0	0	0	0	0	0	2
Operation	0	0	0	1	1	2	1
Privacy & dignity	0	0	0	0	0	0	1
Property	0	0	1	0	0	1	0
Totals:	**13**	**1**	**15**	**24**	**12**	**65**	**74**
Patient Activity	**9,649**		**25,933**	**13,672**	**13,731**		

In Q4 the Trust treated 15,688 people as inpatients, day cases and regular day attendees. Another 11,512 were seen in the Emergency Department and 35,785 as outpatients. 65 complaints were received overall which is 0.1% of the number of patients treated, this percentage has remained unchanged. There were no complaints about mental health issues this quarter. 354 compliments were received across the Trust in Q4, which represents 0.6% of the number of patients treated. Those sent directly to the Chief Executive or Customer Care Department were acknowledged and shared with the staff/teams named.

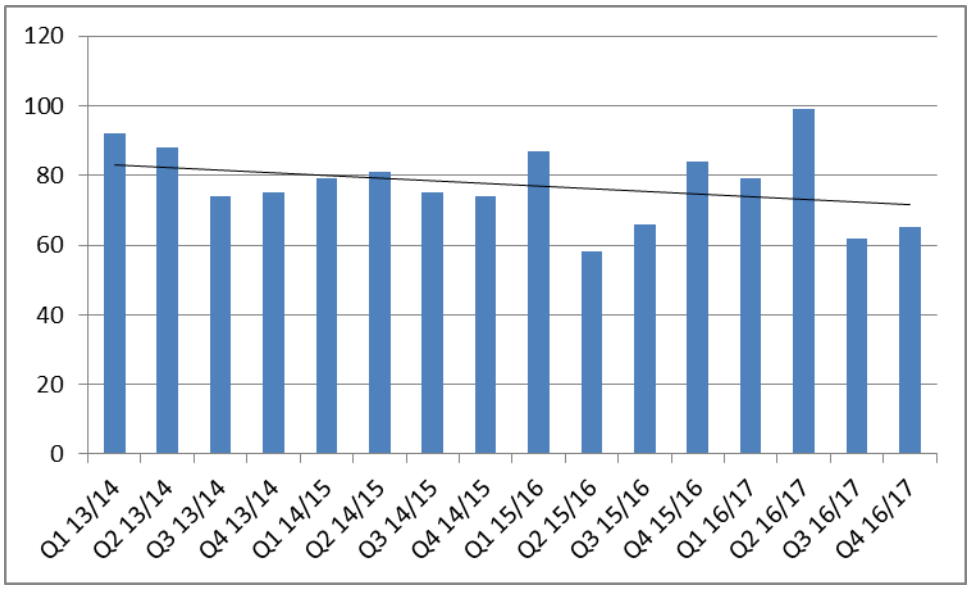
100% of complaints were acknowledged within three working days. 21 complaints were re-opened in Q4 compared to 14 in Q3 (see below in the directorate section). The overall number of enquiries, comments, concerns and complaints response times was:

0-10 working days		11-24 working days		25+ working days	
419	78%	45	8%	75	14%

Reasons for some complaints taking more than 25 working days to respond to is: arranging meetings; operational pressures; and key members of staff on leave. The proportion of contacts falling into the 25+ working days has increased from 10% in Q3 to 14% in Q4.

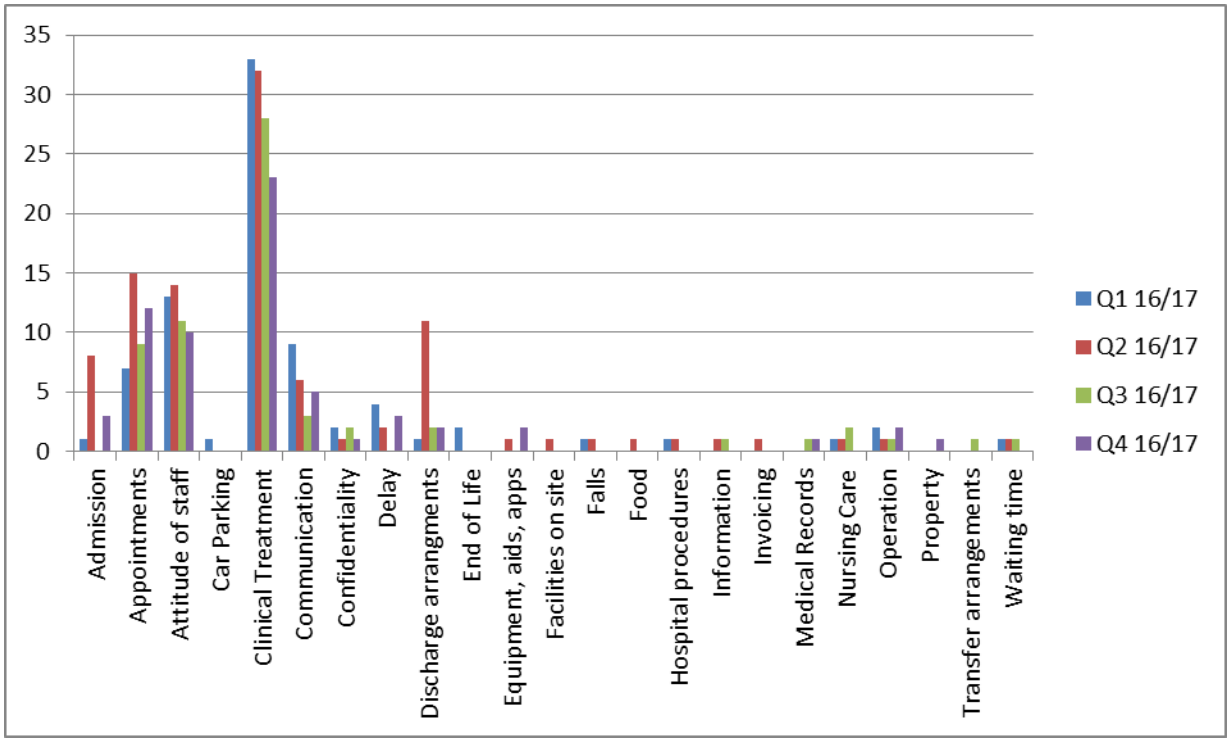
COMPLAINTS BY QUARTER

The following graph shows the trend in complaints received by quarter. There has been a slight increase in complaints in Q4 compared to Q3. The specialty areas with the most complaints are Orthopaedics (14), Adult Medicine (5) and the Spinal Treatment Centre (5) with 11 related to clinical treatment.



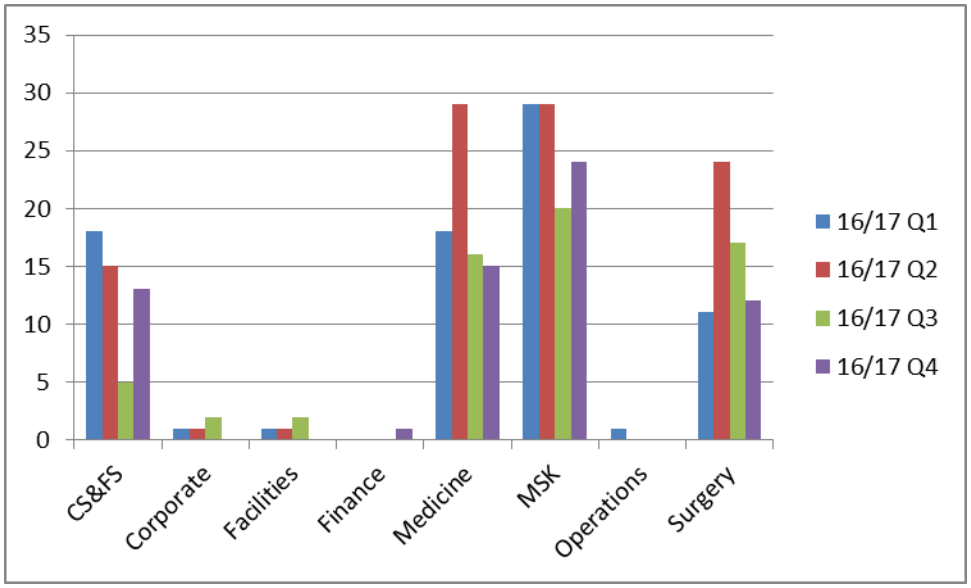
COMPLAINTS BY SUBJECT

The following graph shows the trend in complaints by subject over the last four quarters. Complaints have increased slightly from the previous quarter with most subject areas remaining static. Complaints about clinical treatment have decreased for the fourth consecutive quarter.



COMPLAINTS BY DIRECTORATE

The following graph shows the number of complaints by directorate over the last four quarters. CS&FS and MSK have both seen an increase in complaints in Q4 compared to Q3, whereas Medicine and Surgery have both had a decrease in complaints.



CLINICAL SUPPORT AND FAMILY SERVICES

	Quarter 4 2015-16	Quarter 3 2016-17	Quarter 4 2016-17
Complaints	10	5	13
Concerns	15	19	21
Compliments	86	61	94
Re-opened complaints	1	0	1
% complaints responded to within 25 working days	60%	20%	31%

- Complaints have increased by 8 this quarter compared to Q3, and the number has also increased by 3 compared with Q4 2015-16.

- The Endoscopy Unit received the most complaints with 4, this was due to the department being used for Escalation and appointments had to be cancelled.
- 1 complaint was re-opened in this quarter; this was due to the complainant having further questions.
- Total activity within the directorate was 9,649 and of this number 0.13% raised a complaint.
- No meetings took place this quarter.
- There has been a slight increase in the number of concerns raised in comparison to Q3 with no particular theme.
- The number of compliments received this quarter has increased by a significant amount.
- Low response compliance was due to consultants annual leave commitments.

Themes and actions

Department/Ward	Topic	Actions
Endoscopy Unit	Cancelled Admissions/Appointments due to bed shortage and escalation	• Use of Endoscopy as inpatient escalation area ceased on 01/02/2017. Plan underway to recover waiting, RTT times, by weekend working via 18/52 support and additional GA lists mid-week.
Sarum Ward and Gynaecology	Unsatisfactory treatment – lack of communication and lack of appropriate care given.	• Staff involved in complaint made aware of concerns and issues. Wider learning shared with rest of team via team meetings, briefings and governance reports. • Where possible specific action has been undertaken (replacement bottle brush) and staff reminded of their responsibility to use white boards and photo boards. DSN following up to ensure adoption.

Compliments

In total 94 compliments have been received across the directorate with the breakdown as: Sarum ward = 38, Bowel screening = 24, Postnatal = 7, 4 each for Beatrice Ward and Maternity Admin, 3 each for Gynaecology, Endoscopy and Labour Ward, 2 each for Radiology and Antenatal, and 1 each for Neonatal Unit, Pathology, Retinal Screening and Spinal X-ray.

MEDICINE DIRECTORATE

	Quarter 4 2015-16	Quarter 32 2016-17	Quarter 3 2016-17
Complaints	18	16	15
Concerns	27	24	28
Compliments	151	122	112
Re-opened complaints	1	3	7
% complaints responded to within 25 working days	77%	56%	40%

- The number of complaints has decreased by 1 from Q3.
- Pitton Ward received the most complaints with 4 and the Emergency Department received 3. The theme for Pitton Ward was unsatisfactory treatment and for the Emergency Department it was delayed diagnosis and unsatisfactory treatment. .
- 7 complaints were re-opened this quarter due to complainants requesting a follow-up meeting; they felt that their concerns had not been addressed fully and still had outstanding questions; and one case the complainant was not happy with the financial offer for lost property.
- Total activity within the Directorate was 25,933 and of this number 0.06% raised a complaint.
- Two meetings were held this quarter.
- The number of concerns has increased by 4 from Q3. The highest theme was attitude of staff (6) across 6 different areas.

- The Pembroke Unit received 9 concerns due to the unsatisfactory surroundings and facilities as the ward was being used for escalation purposes.
- Reduction in response compliance was due to arrangements of meetings and annual leave commitments.

Themes and actions

Department/Ward	Topic	Actions
Pitton Ward Tisbury Ward	Unsatisfactory treatment – communication and lack of appropriate care.	• Tisbury to review the clinical management of neutropenic sepsis patients. They are also going to ensure adequate communication between relatives and consultants. • Pitton ward are reviewing nutritional assessments and nutritional intake and making sure that snacks and fruit are available at all times. They are also recognising the need to escalate when bariatric equipment is needed for patients.
Pembroke Unit	Unsatisfactory facilities/surroundings – patients being put in waiting room for chemotherapy treatment.	• Clarification of the use of Pembroke Unit for escalation beds with the limit now set at only using 5 beds for escalation.

Compliments

In total 112 compliments have been received across the Directorate with the breakdown as: Emergency Department = 44, Whiteparish Ward = 13, Pembroke Ward = 12, Farley Ward = 10, Redlynch Ward = 8, 6 each for Durrington Ward and Radiology, 2 each for Breamore Ward, Cardiology, Respiratory, Tisbury Ward and Winterslow Ward, and 1 each for Short Stay Unit, Pitton Ward and Gastroenterology.

MUSCULO-SKELETAL DIRECTORATE

	Quarter 4 2015-16	Quarter 3 2016-2017	Quarter 4 2016-17
Complaints	21	20	24
Concerns	21	34	27
Compliments	74	60	60
Re-opened complaints	6	2	7
% Complaints responded to within 25 working days	52%	35%	50%

- The amount of complaints received this quarter has increased although the amount of concerns received has decreased.
- The amount of compliments received was the same as Q3 but decreased from Q4 last year.
- Total activity within the Directorate was 13,672 and of this number 0.17% raised a complaint.
- There have been seven re-opened complaints and four meetings held to resolve further issues. The main issues that were raised was that the final response letter was not accurate and the issues had not been addressed in full and questions not answered. These re-opened complaints are complex and multifactorial and following discussion at the Directorate Management Team meeting, all lead clinicians will have sight of the complaint and time to comment on the response to hopefully ensure complex questions are answered fully and clearly.
- The departments with the greatest number of complaints are orthopaedic outpatients (8) and orthopaedics (4). Attitude of medical and nursing staff, further complications and unsatisfactory treatment were the most common themes, all with 3 complaints each.
- Orthopaedics also received 6 concerns and orthopaedic outpatients received 5 with appointments being the highest theme.

- There have been 5 complaints raised for various areas on the Spinal Unit with no particular theme.
- The most common theme for concerns for the directorate was requests for appointment dates (4), and 3 each for unsatisfactory treatment and appointment systems.

General actions

- The Complaints Co-ordinator attends monthly DMT meetings. There has now been a system set up between the Directorate and Customer Care for daily telephone contact with a member of the Directorate Management Team to try to resolve potential complaints either by going to the wards or telephoning the patient/carer, which has been working very well.

Themes and actions

Department/Ward	Topic	Actions
Orthopaedics	Delays in receiving appointments and treatment, due to long waiting times and multiple cancellations	• Orthopaedic cancellations on the day require Chief Operating Officer authorisation. • Implementation of orthopaedic expansion business case to separate the management of elective and non-elective workload. • Outsourcing non complex joints. • Outsourcing spines.
Plastics Department	Delays in receiving appointments and treatment, due to long waiting times and multiple cancellations	• Increased capacity for trauma and electives with two substantive and one locum Plastic surgeon. • Theatre efficiency project to maximise the use of theatre resources (ongoing) – draft new capacity model with lead clinician. • Progress use of theatre 9 for blocks and local anaesthetics for minor trauma to free up theatre and DSU capacity

Compliments

In total 60 compliments have been received across the Directorate with the breakdown as:
Chilmark Suite = 23, Wessex Rehab = 19, 4 each for Laverstock Ward and Orthopaedic Outpatients, 2 each for Amesbury Suite, Orthopaedics and Rheumatology, and 1 each for Maxillofacial Surgery, Oral Surgery, Spinal Unit (non ward area) and Tamar Ward.

SURGICAL DIRECTORATE

	Quarter 4 2015-16	Quarter 3 2016-2017	Quarter 4 2016-17
Complaints	33	17	12
Concerns	23	22	35
Compliments	104	104	77
Re-opened complaints	2	3	4
% complaints responded to within 25 working days	90.9%	65%	66%

- There has been a decrease in complaints received in Q4 compared to Q3 and a significant decrease from Q4 2015-16 for the Directorate.
- Total activity within the Directorate was 13,731 and of this number 0.09% raised a complaint.
- Four complaints were re-opened this quarter with meetings for two of these complaints and resolution was agreed. The reasons were that in three of the complaint responses the Directorate had not addressed all the questions the complainant had raised originally. The other complaint was re-opened because the complainant had further questions after receiving copies of the medical records.
- The highest number of complaints was in Central Booking and the most common theme was the appointment system and delays in receiving appointments.
- The highest number of concerns was in Ophthalmology with 14 concerns logged and the most common theme was for appointment procedures and delays in receiving appointments.

Themes and actions

Department/Ward	Topic	Actions
Central Booking	Appointment booking issues	• Staffing levels have been increased and recruited to in Central Booking. • Fortnightly EPR stabilisation project group continues. • Work continues on improving the PTL to be more detailed.

Compliments

In total 77 compliments have been received across the Directorate with the breakdown as: Britford Ward = 26, Downton Ward = 15, 8 each for Clarendon Suite and Urology, Radnor Ward = 7, Day Surgery Unit = 4, 2 each for Audiology, ENT and Ophthalmology, and 1 each for the Breast Service, Central Booking and Urology.

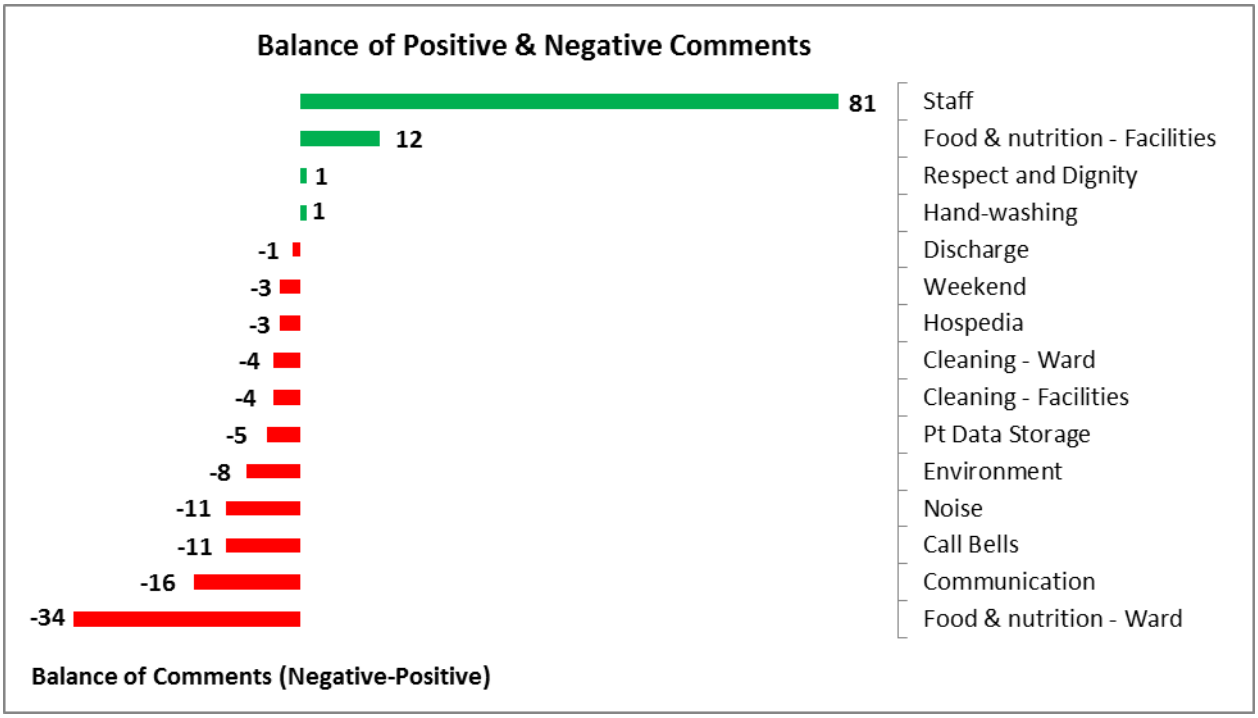
2. TRUSTWIDE FEEDBACK – INCLUDING REAL TIME FEEDBACK AND THE FRIENDS AND FAMILY TEST

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

Feedback area	Theme	Actions
Complaints	Clinical Treatment Appointments Staff Attitude	• Wider learning shared with team via team meetings, briefings and governance reports. • Staffing levels have been increased and recruited to in Central Booking. • Staff involved in complaint made aware of concerns and issues.
Inpatient RTF	Food and nutrition on the ward Communication Call bells Noise	• Wards are currently reviewing progress on their action plans.
FFT	Numbers too low	• Wards are currently reviewing progress on their action plans.

3. INPATIENT REAL TIME FEEDBACK

A total of 295 inpatients were surveyed in the quarter. They made 180 positive and 186 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below.



The main areas of concern were food and nutrition on the ward, communication, call bells and noise.

Food and Nutrition on the Ward

A total of 39 negative and 5 positive comments were received regarding food and nutrition on the ward. The negative comments have been categorised as set out in the table below.

REASON	WARD
Temperature (21)	Chilmark (4)
	Amesbury (2)
	Avon (2)
	Durrington (2)
	Pitton (2)
	Winterslow (2)
	Breamore (1)
	Burns (1)
	Downton (1)
	Pembroke (1)
	Redlynch (1)
	Tamar (1)
	Tisbury (1)

REASON	WARD
Help with food (6)	Laverstock (2)
	Amesbury (1)
	Britford (1)
	Burns (1)
	Durrington (1)
Unprotected mealtime (4)	Breamore (2)
	Chilmark (2)
Portion size (3)	Breamore (1)
	Downton (1)
	Redlynch (1)
Uncomfortable position to eat (3)	Britford (1)
	Chilmark (1)
	Winterslow (1)

REASON	WARD
Availability of beverages (1)	Britford (1)
Requirements not met (1)	Laverstock (1)

Communication

A total of 23 negative and 7 positive comments were received regarding communication. The areas of negative comments are as follows:

REASON	WARD
Requires more information (12)	Britford (2)
	Pitton (2)
	Tamar (2)
	Tisbury (2)
	Amesbury (1)
	Burns (1)
	Downton (1)
	Farley (1)

REASON	WARD
Attitude of staff (4)	Britford (3)
	Amesbury (1)
Language difficulties (2)	Pembroke (1)
	Tisbury (1)
Disagreement (1)	Avon (1)
Medical Records (1)	Pitton (1)
Inter-departmental (1)	Whiteparish (1)
Request not met (1)	Laverstock (1)

REASON	WARD
Conflicting information (1)	Avon (1)

Call Bells

A total of 13 negative and 2 positive comments were received regarding response to call bells. The negative comments were made in the following areas:

WARD	WARD	WARD	WARD
Farley (3)	Burns (2)	Amesbury (1)	Pembroke (1)
Avon (2)	Chilmark (2)	Laverstock (1)	Tamar (1)

Noise

A total of 12 negative and 1 positive comment was made regarding noise. The negative comments have been categorised as follows:

REASON	WARD
General (5)	Redlynch (2)
	Chilmark (1)
	Pembroke (1)
	Tamar (1)

REASON	WARD
Equipment (3)	Downton (1)
	Tisbury (1)
	Winterslow (1)

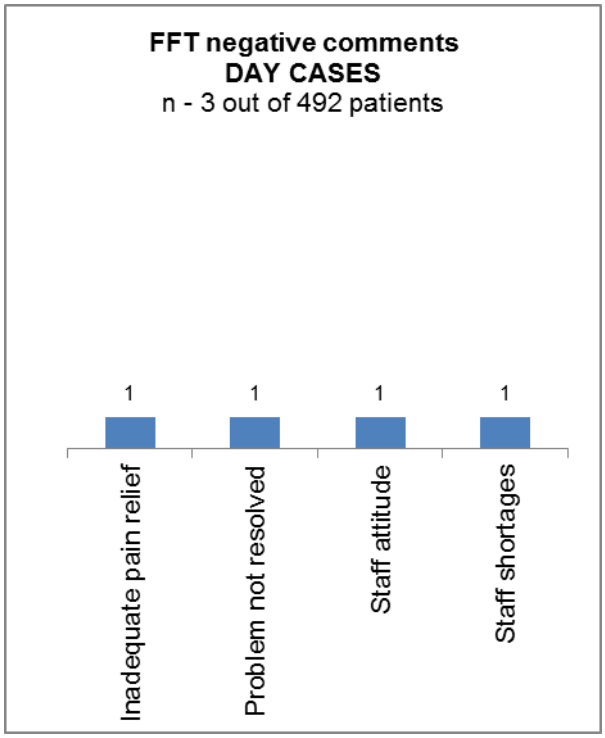
REASON	WARD
Handover (2)	Tamar (2)
Night staff (2)	Redlynch (1)
	Tamar (1)

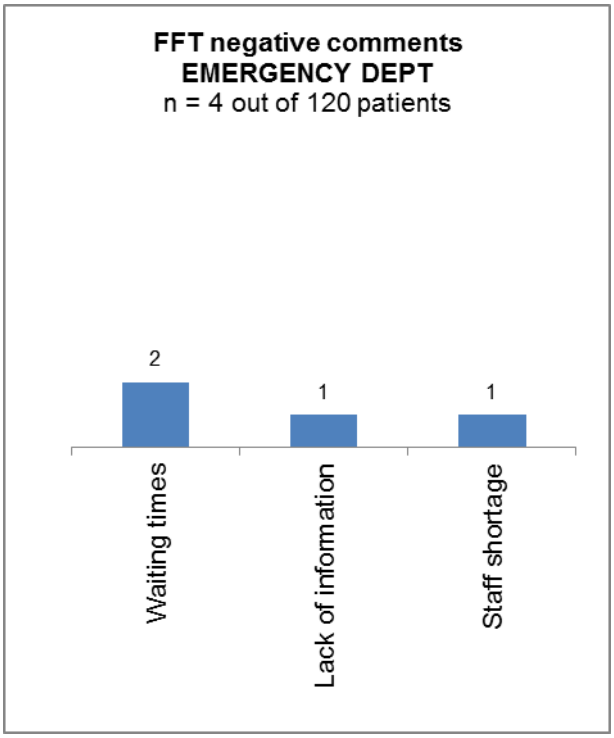
4. FRIENDS AND FAMILY TEST

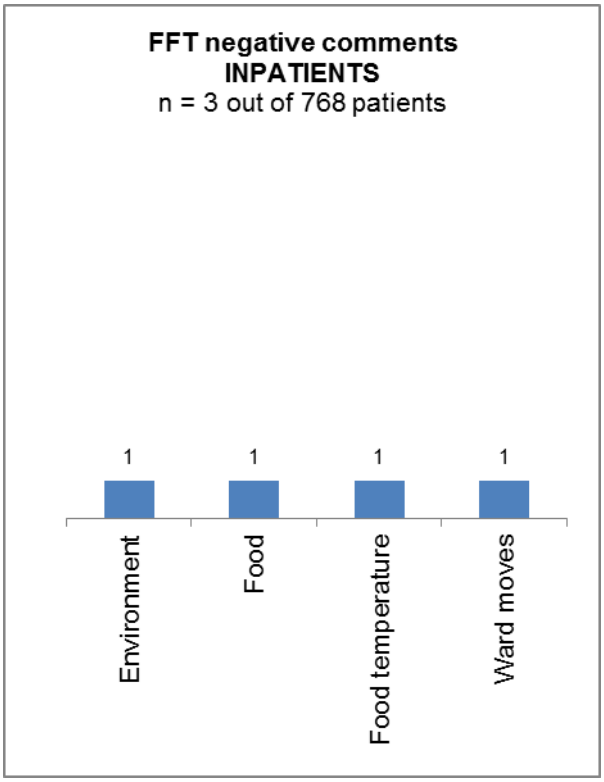
Responses for the period were as follows:

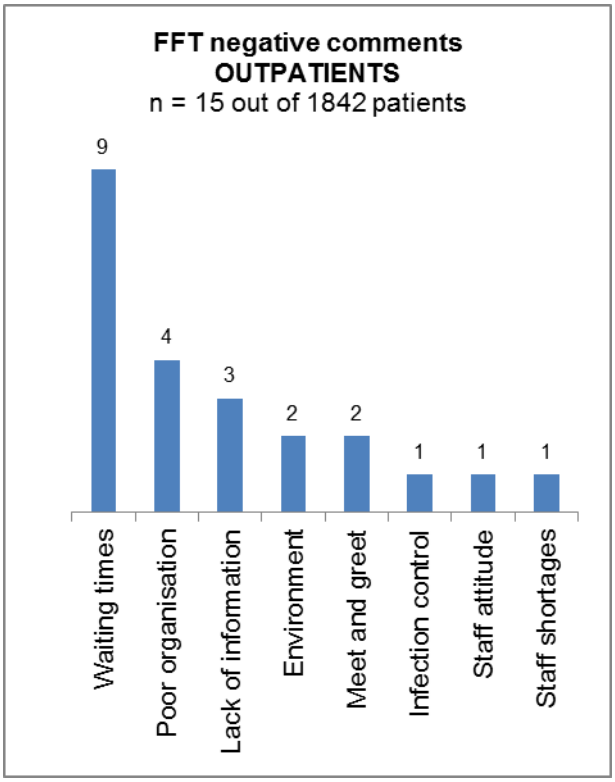
		Rating		
	Total Responses Received	Extremely Likely	Unlikely	Extremely Unlikely
Day Case	492	440	1	2
Emergency Department	120	103	2	2
Inpatients	768	690	2	2
Maternity	49	42	0	0
Outpatients	1842	1558	8	8

Comments made by those patients who stated they would be unlikely or extremely unlikely to recommend the hospital have been categorised as set out in the graphs below (no negative comments were received for Maternity).









The numbers are too low to identify any main areas of concern.

Action taken on areas of concern
Wards are currently reviewing progress on their action plans and identifying areas of work for the next six months. Details will be available for the Quarter 1 report of 2017/18.

5. PATIENT AND PUBLIC INVOLVEMENT (PPI)

There have been six new project requests in Quarter 4, five completed projects and one new National Patient Survey.

Clinical Support and Family Services Directorate
One project was approved for Cooke's catheter balloons for induction for labour. The aims of this project are to keep in line with current national best practice; to improve patient flow through the service and to increase patient satisfaction.

Two projects were completed, the first was a questionnaire sent to patients attending the Diabetic Eye Screening Service. The final report clarified that the service was doing well and there were no anomalies.

The Cardiac CT service, patient satisfaction survey was also completed. Overall the results were excellent and show a high level of patient satisfaction which was fed back to the Cardiac Team to reinforce current good practice.

MusculoSkeletal Directorate
Two new projects commenced this quarter:

Early supported discharge (ESD) for hip fractures/enhancing discharge planning by therapists. The main aims for undertaking this project are to:

a) Review the ESD hip fracture service that has been running since the start of October 2016 to understand which aspects patients feel are successful and what can be improved;
b) Look at discharge planning at SDH in a more general sense and try to understand the barriers to discharge from a patient and family perspective. The overall aim is to be able to put together a training package for therapists to improve discharge planning and reduce length of stay by focussing on what patients and families feel would help with the discharge process.

The Fracture Clinic has produced a questionnaire to gain feedback to enable the therapy team to understand the level of patient satisfaction following assessment as a new patient within the clinic.

Medicine Directorate
No new projects commenced.

Surgery Directorate
The Audiology patient survey has been approved, to gain department specific feedback from patients to ensure they are meeting the IQIPS accreditation criteria.

The NHS England project regarding the Wiltshire and Dorset Vascular Network is now complete and all questionnaire responses have been sent to NHS England to collate.

Quality Directorate
The National Children and Young People's survey 2016 commenced in Quarter 4.

The Project Management Office undertook two projects as part of the Perfect Week Initiative; the first was the implementation of placemats and the second was the implementation of a patient leaflet. On both occasions the Customer Care Advisor for PPI went to the ward areas to gain feedback from the patients. Both projects were completed within this quarter

PPI Projects are shared on the following web page on the Intranet:
http://intranet/website/staff/quality/customercare/patientandpublicinvolvement/ppiprojects/index.asp

5. PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

In Q4 there were no new requests for independent review.

The PHSO has obtained clinical advice on the urology case that it is investigating and has begun to draft the provisional findings which it will share with the Trust soon.

In the respiratory case, the PHSO has agreed the action plan and an update will be given in July 2017. The PHSO publishes complaints data on a quarterly basis that includes numerical information on the complaints received, assessed, and investigated and is available at:
http://www.ombudsman.org.uk/reports-and-consultations/reports/health/quarterly-reports-on-complaints-about-acute-trusts

6. NHS CHOICES WEBSITE

In Q4 there were 16 comments posted on the NHS Choices website relating to 11 different areas. Of the 13 positive comments, one person said "This was the second visit for my Dad in under 2 weeks. Sadly he passed away this time. The staff in A & E were caring, compassionate, sensitive and helpful through what was a very difficult time for the whole family. I doubt that better care could have been provided anywhere in the country." Of the 3 negative comments, one person said "The (Urology) department used to be very good but over the past twelve months has deteriorated markedly. The patient is no longer listened to and is treated as an anonymous number. Despite promises (in writing) of follow up consultations within 3 months it is now 12 months since I was last seen. My situation has deteriorated meanwhile". All the feedback was shared with the departments.

AUTHOR: Hazel Hardyman
TITLE: Head of Customer Care
DATE: June 2017

Salisbury NHS Foundation Trust Board - 7 August 2017

SFT 3914

Title : Six Monthly Nursing Skill Mix Review

Report from: Lorna Wilkinson, Director of Nursing
Fiona Hyett, Deputy Director of Nursing

Executive Summary:

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

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

This update covers the in-patient wards and maternity, excluded are Paediatric Services and Spinal as these are all subject to separate reviews as agreed at previous skill mix review. This review covers an update on progress against the actions from the last review in December 2016; an overview of performance against the key metrics provided by INSIGHTs data ; analysis of current headroom requirements; a focus on enhanced care/specials particularly the requirements for Registered Mental Health Nurses (RMNs); proposal for amending the approach to the required skill mix reviews; focus on maternity and neonates.

The paper also updates the Board with the policy context, particularly the most recent updated NQB guidance for Safe Staffing.

Proposed Action:

The Board are asked to:

- Note the analysis completed which will be further updated in next full skill mix review
- Agree the recommendations for the change in process for future reports
- Agree the continued focus on recruitment and retention initiatives
- Note that nurse staffing is subject to change due to the ward reconfigurations and that the impact of this will be reported on in the full skill mix review in December

Supporting Information

Trust Board August 2017

1.0 Background

This is the 5th year of skill mx reviews and is part of the reporting requirements that every Trust are expected to have in place. The last full review took place in the summer of 2016, with an update at the December 2016 Trust Board and a full review is currently taking place which will be reported to Board later this year. This paper is to provide an update on key areas and recommend a change in approach for the skill mix reviews. It is to be noted that nurse staffing is in a process of change in some areas due to the ward reconfiguration work taking place over the summer. The report to Board in December will consider the impact of this on the wards affected. The Ward reconfiguration Programme Management Board has a workforce subgroup overseeing all changes.

The Trust was inspected by the Care Quality Commission (CQC) in December 2015 with their report published in April 2016. These recommendations were reviewed in the April 2016 skill mix review and from this there was a decision for the Emergency Department, Spinal Services and Children's services to be subject to their own individual reviews. This review therefore covers all other acute wards and maternity services.

The annual review provides an assessment of the current nurse staffing position at Salisbury NHS Foundation Trust (SFT) as assessed locally, against national guidance and validated tools and the CQC feedback. All in-patient wards as identified are currently subject to a detailed skill mix review taking place during July/August 2017. The reviews are undertaken using a defined approach to ensure consistency for comparison which includes a range of information; triangulating the ward staffing levels against nurse sensitive indicators, quality indicator / outcome data, Care Hours per Patient Day data (SafeCare), HR indicators and financial information. Professional judgement is encapsulated through the presence at each review of the Ward Leader, Directorate Senior Nurse and the Deputy Director of Nursing.

It is important to note that nursing requirements do change overtime due to the acuity/dependency and overall case mix changes which leads to the requirement to undertake an annual strategic staffing review followed by a comprehensive staffing report to Board after six months to ensure plans still appropriate.

This review is intended to provide an update and will focus on the following areas:

- Review of previous recommendations
- Overview of Insights Data
- Headroom
- Enhanced Care/Specials including Registered Mental Health Nurses (RMN)
- Proposal for changing approach to skill mix reviews
- Maternity/Neonates

2.0 Policy Context

In February 2013, Sir Robert Francis QC published his final report of the inquiry into failings at Mid Staffordshire NHS Foundation Trust. Compassion in practice, the strategy for nurses, midwives and care staff (2012), the Francis report and the government response, Hard truths: the journey to putting patients first, led to fundamental changes in how NHS provider boards are expected to assure they are making safe staffing decisions. In November 2013 the National Quality Board set out these expectations in relation to getting nursing, midwifery and care staffing right. It provided a clear governance and oversight framework alongside recommended evidence-based tools, resources and examples of good practice, to support NHS providers in delivering safe patient care and the best possible outcomes for their patients. The National Institute for Health and Care Excellence (NICE) undertook work to produce guidelines on safe staffing for specific care settings, which led to the publication of Safe Staffing for Nursing in Adult In-patient Wards in Acute Hospitals and Safe Midwifery Staffing for Maternity Settings.

The Carter report and the NHS Five Year Forward View planning guidance make it clear that workforce and financial plans must be consistent to optimise clinical quality and the use of resources. The Carter report highlighted variation in how acute trusts currently manage staff, from annual leave, shift patterns and flexible working through to using technology and e-rostering. It underlined that, in addition to good governance and oversight, NHS providers need a framework to evaluate information and data, measure impact, and enable them to improve the productive use of staff resources, care quality, and financial control. Lord Carter's report recommended a new metric, care hours per patient day (CHPPD), as the first step in developing a single consistent way of recording and reporting staff deployments.

Nursing and midwifery leaders have built on Compassion in practice to create a national nursing, midwifery and care staff framework, Leading change, adding value. This framework is aligned to the Five Year Forward View, with a central focus on reducing unwarranted variation and meeting the 'Triple Aim' measure of better health outcomes, better patient experience of care and better use of resources.

The 2015 Shape of Caring report recommended changes to education, training and career structures for registered nurses and care staff and is aimed at maximising the capabilities and contribution of healthcare assistants/ support workers/nursing associates to meet patient needs and provide fulfilling job roles and career pathways in nursing.

As an integral part of developing their Sustainability and Transformation Plans, local health and care systems need to develop local plans for how they will develop, support and retain a workforce with the rights skills, values and behaviours in sufficient numbers and in the right locations.

In July 2016 the NQB published an updated set of expectations for nursing and midwifery staffing which are aimed at helping NHS providers make local decisions that deliver high quality care for patients within their available staffing resource.
The first two sections of this guidance brings together the work of the Carter team and sets out key principles and tools which Boards can use to measure and improve their use of staffing resources to ensure safe, sustainable and productive services.
The third section updates 3 of the expectations that form a triangulated approach (Right time, right staff, right place) to making staffing decisions. This triangulated approach moves from having judgements made based solely on numbers or ratios to one which decides staffing levels based on patients' needs, acuity and risk.

The box below show measures that can be used alongside CHPPD to demonstrate and understand the impact of staffing decisions on the quality of care that patients are receiving in acute inpatient wards.

<table>
<tr><th colspan="3">Safe, Effective, Caring, Responsive and Well-Led Care</th></tr>
<tr><td colspan="3">Measure and Improve
-patient outcomes, people productivity and financial sustainability -- report investigate and act on incidents (including red flags) -
- patient, carer and staff feedback -</td></tr>
<tr><td colspan="3">- Implementation Care Hours per Patient Day (CHPPD) -
- develop local quality dashboard for safe sustainable staffing -</td></tr>
<tr><th>Expectation 1</th><th>Expectation 2</th><th>Expectation 3</th></tr>
<tr><td>Right Staff
1.1 evidence-based workforce planning
1.2 professional judgement
1.3 compare staffing with peers</td><td>Right Skills
2.1 mandatory training, development and education
2.2 working as a multi-professional team
2.3 recruitment and retention</td><td>Right Place and Time
3.1 productive working and eliminating waste
3.2 efficient deployment and flexibility
3.3 efficient employment and minimising agency</td></tr>
</table>

NHS Improvement is also coordinating work to develop safe staffing improvement resources for a range of care settings including: mental health, learning disability, acute adult inpatients, urgent and emergency care, children's services, maternity services, and community services. Of these maternity is currently out for consultation and engagement.

3.0 Review of Previous Recommendations

The last skill mix review did not seek any additional investment into nursing. The review prior to that saw an investment of nearly £300k, which was offset by savings from the reduction across all wards of B7 supervisory time.

Set out below are the recommendations from the 2016 review and an update on current progress:

Recommendation	Update
All ward areas to undertake comparative audits of Shelford tool scores with aim of improving reliability and validity of data to be able to use to inform future skill mix reviews	Partially completed and will be reviewed as part of the full skill mix review.
To continue the work on developing the Band 4 role	Trust secured place as part of national pilot for Nursing Associates and has 8 candidates on the programme which finishes in March 2019. Work continues to further develop the role of the Band 4 and progress has been made with Assistant Practitioners completing a medication administration module.
Surgical Directorate to undertake a review of the impact of the introduction of the ward managers assistant on enabling the ward lead to focus on providing clinical leadership and the impact on providing quality care	Still to be completed

To continue with the focus on recruitment and ensure this is focused on Nursing Assistants (NAs) as well as Registered Nurses (RNs)	This work is ongoing and a recruitment strategy is in place which is refreshed annually. This needs to be seen in the context of reduction of EU nurses registering with NMC, increase numbers of nurses leaving the profession and increase to Trust footprint through site reconfiguration. A ban on the use of agency for NAs will be implemented in November.
Have further discussion on the level of headroom provided within ward establishment and what level this should be set	This has been an ongoing theme in skill mix reviews. On-going and further analysis included in this report
Revisit the opportunities to provide the requirements for the provision of enhanced care	A focus on use of additional staff to support enhanced care requirements is within this report
Further analysis to be undertaken of the impact of the previous investment on the areas that were given monies from previous skill mix review and reported in next review.	Full analysis of the impact of this investment will be completed during the current review however the impact of these posts is being affected by challenges in recruiting to RN vacancies and a junior skill mix.

4.0 Assessment/Findings

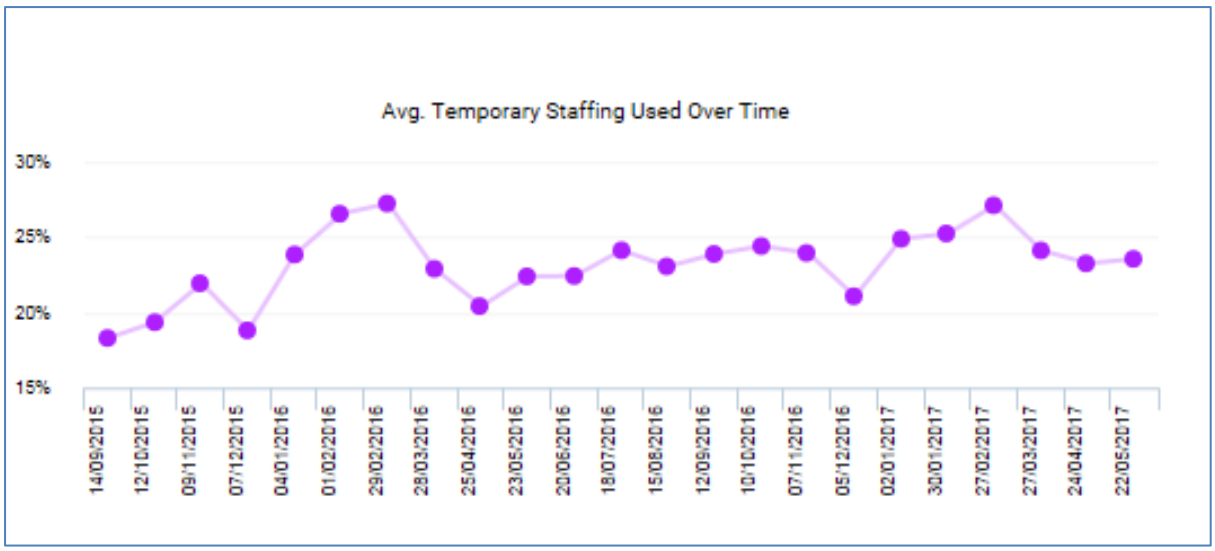
4.1 INSIGHTS

The Trust as part of its work with Lord Carter and as an Allocate Exemplar site had the opportunity to be involved in Allocate-Insights – a managed service that combines monthly reporting,, metrics and benchmarks designed to measure performance in rostering productivity and efficiency against 6 key metrics:

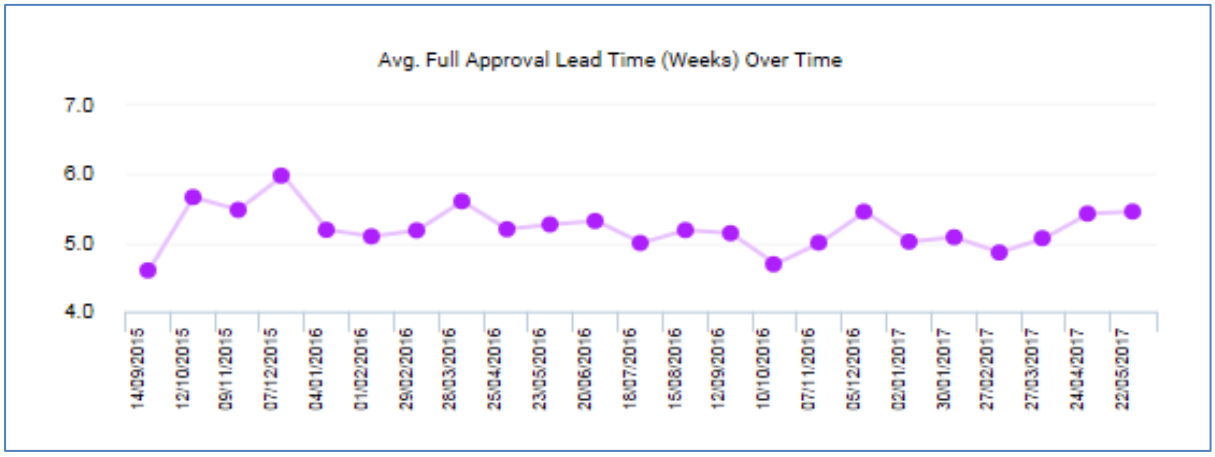
- Temporary staffing
- Roster approval lead time
- Unavailability (Headroom)
- Additional Duties
- Unfilled Duties
- Hours Balance

These metrics are viewable via a portal and enables a view of our performance both as a Trust with comparisons at ward level and also against all other Trusts using the portal, including those of similar size, Foundation Trusts and all acute Trusts. A monthly call is held with the Insight team and progress against goals evaluated. Analysis below provides detail of each key metric and our current performance. An overview graph has been provided for each metric and Appendix 1 provides further detail.

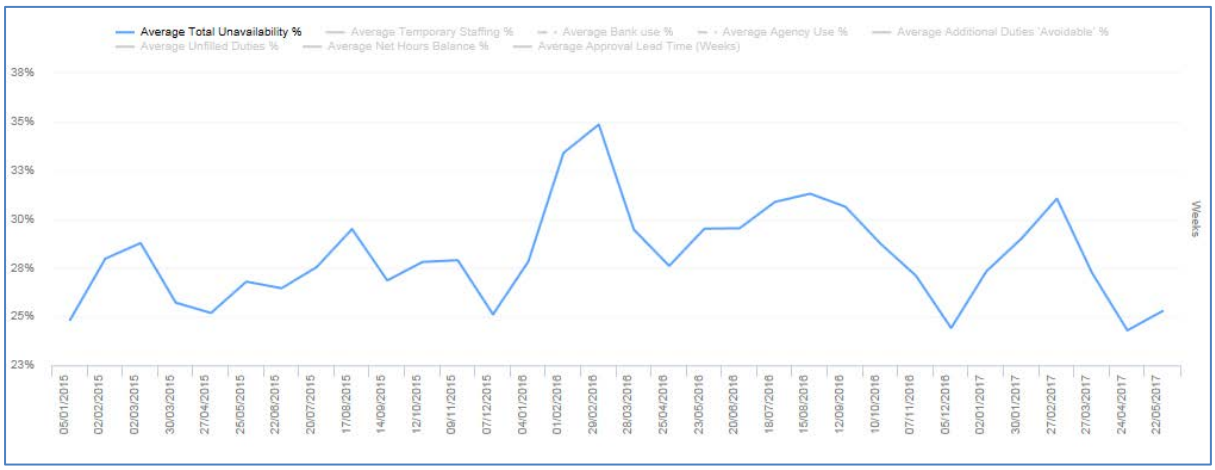
Temporary Staffing – this measure looks at the percentage of the roster that is made up of temporary staff both bank and agency, and also the percentage of temporary staffing that is agency. When analysing trends over time there has been an overall upward trend in the use of temporary staffing since September 2015 as shown in graph below. This is consistent with the escalation pressures that have been in place across the year and also with the challenges of RN vacancies.



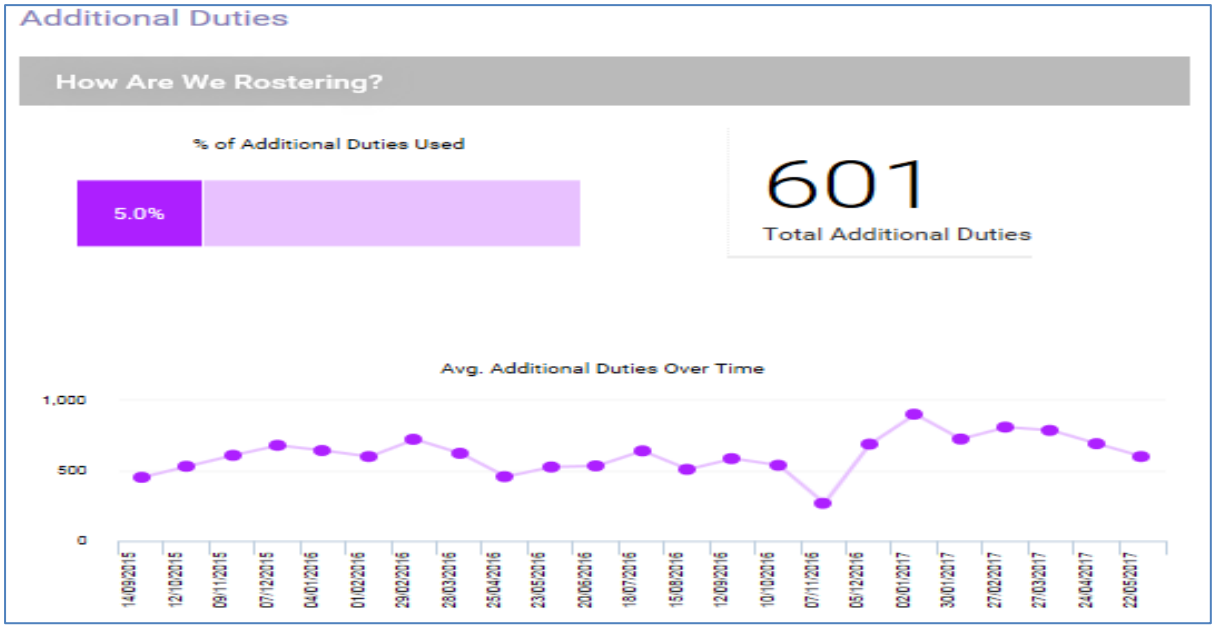
Roster Approval Lead time – expectation that rosters should be published 6weeks in advance to maximise opportunity for any unfilled shifts to be filled by bank staff, this measure has subsequently been added to the Effective Rostering Guide produced as output of Lord Carter programme. For this measure the Trust has moved from average of 4.5weeks in September 2015 to average of 5.5weeks in May 2017 and nationally we are one of the best performers. All rosters are reviewed and have second sign off by the DSN and if they reject rosters this can impact on achieving 6 weeks.



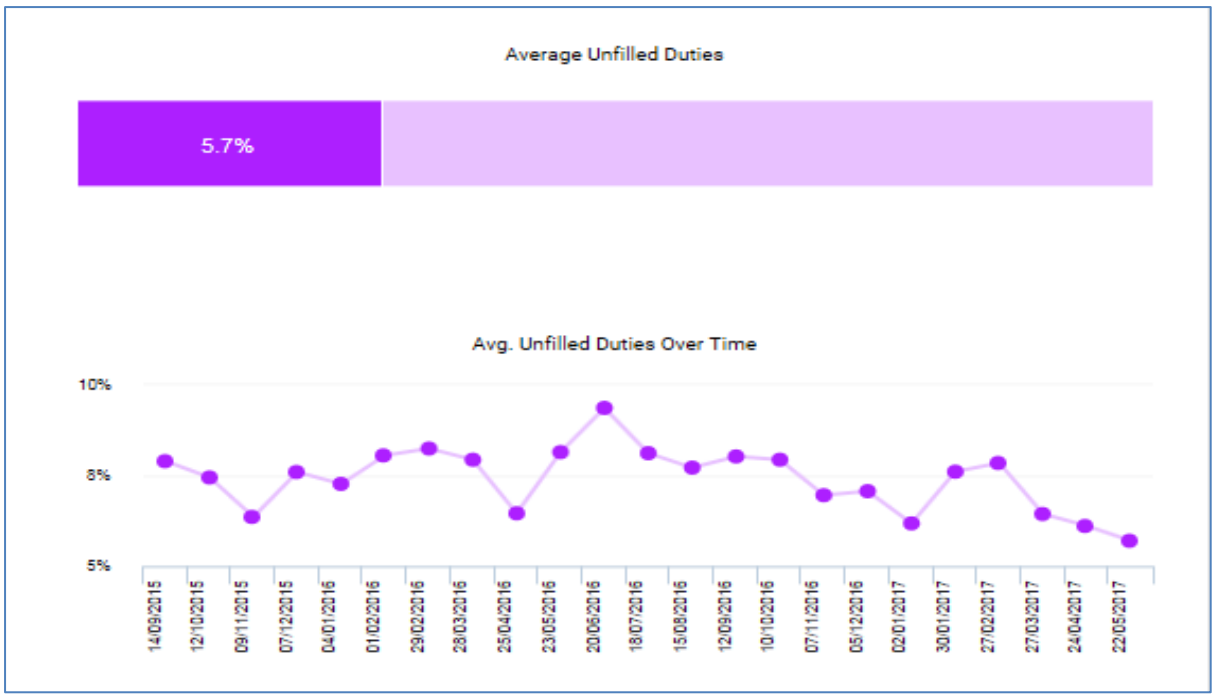
Unavailability (Headroom) – this metric measures the amount of staff rostered but who are not providing direct patient care; includes annual leave, study leave, parenting, sickness, working day and other. Within this measure the Trust has seen the 2017 trend line be consistently below 2016 but with the same seasonal spikes. The main reason for this reduction is the work done on challenging the use of working day. There was a lack of clarity in the roster policy around unavailability reasons which could result in staff defaulting to using it as a “grey area” reason. To review the impact of Working Day the definitions for unavailability reasons were tightened up by adding clarity around the Working Day reason. The impact of this was significant and we saw a reduction in the use of Working Day by 46% over six months. When comparing 29th Feb 16 and 15th Aug 16 it reveals a reduction in the reliance on the Working Day reason has softened the increase in the Total Unavailability %, despite similar levels of Annual Leave. There has also been a correlating reduction in the use of Study Day as a reason for time off due to the clarification of Working Day as separate from Study Day features. This has also resulted in reducing the gap between our Total Unavailability % and the Peer Average from 4% to 2%. Further analysis of headroom is included in section 4.2.



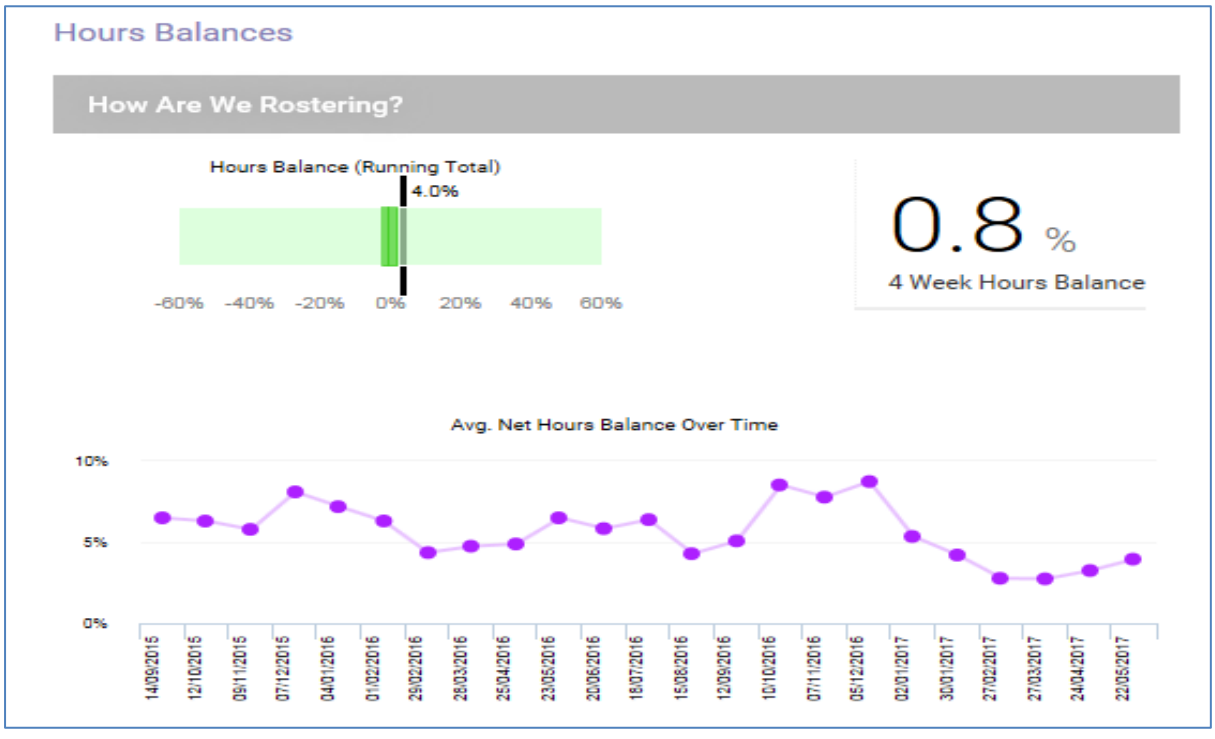
Additional Duties – this metric measures the number of additional shifts that are added to the roster template where extra staff are required and this is broken down into legitimate reasons such as patients requiring enhanced care, high acuity, additional beds, induction/supervision and avoidable reasons such as using up staff ours or staff patterns where extra shifts are added to meet staff requests. In terms of benchmarks against other Trusts we are in the mid-range. There has been significant focus on ensuring that additional duties added are legitimate and the main reason for use is for specialling patients with enhanced care needs/high acuity and induction/supervision of new staff which has been high due to numbers of overseas nurses.



Unfilled Duties – this metric measures the number of shifts that go unfilled on a roster, and is measured in 2 ways – unfilled duty hours excluding additional shifts and unfilled roster which includes additional duties. There has been a reduction over time in this metric which is due to good housekeeping measures being maintained around rosters including cancelling shifts not filled but not required. An example of this would be in Radnor who are established for 10patients but may only have 5 patients – they re-allocate staff and cancel any unrequired shifts. Nationally we are one of the top performers for this metric with a current average of 5.7% against 24.6% for similar size Trusts.



Hours Balance – this metric measures the hours balances on and between rosters ie ensuring staff hours are fully utilised. Again it can be seen over time that we have made a significant improvement through good housekeeping and ensuring rosters are productive. Again nationally we are one of the top performers with our average currently 4% against benchmark of 23.5% for similar sized Trusts.



SafeCare

SafeCare is an additional product offered by Allocate that assesses the acuity and dependency levels of the patients on a shift against both the budgeted roster template and the actual staff on shift – Care Hours Per Patient Day (CHPPD). Since the previous skill mix reviews this has now been fully embedded across the Trust.

The use of SafeCare has now been operationalised in the twice daily staffing meetings and is used to support decisions to review any gaps in shifts and review where staff can be moved or whether escalated to agency .

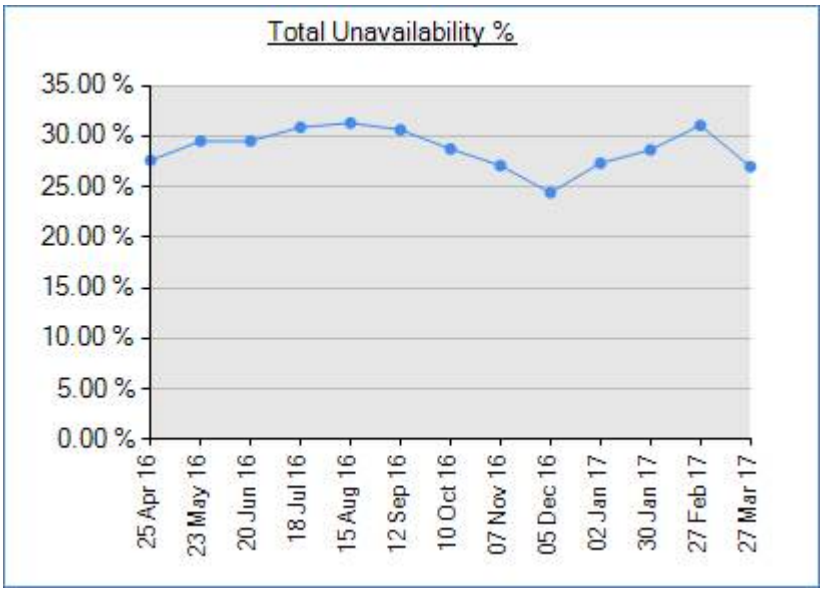
The SafeCare data for each ward is reviewed as part of the skill mix discussions and is triangulated with establishment and quality indicator data and alongside professional judgement. Appendix 2 gives an overview of the current data for each ward and this will be reviewed as part of the full ward skill mix reviews over the summer.

In addition to the above the Trust is participating in joint work with Allocate and NHSi with other selected Trusts across the country over the summer and early Autumn. The work is focused on an in-depth analysis of the rosters of 10 wards and focused on 4 key areas – foundation, clinical utilisation, temporary staffing and delivered CHPPD. The focus in on gaining a baseline in these areas, carrying out interventions in any key areas of challenge and reviewing what improvements can be made.

4.2 Headroom

With the implementation of Allocate E-rostering system it was agreed that once embedded the headroom included within the ward establishment would be reviewed and this has been a theme in previous skill mix reviews. The e-rostering system is now sufficiently embedded to enable headroom to start to be analysed. This review has included the actual headroom required across the wards from April 2016-April 2017 (Appendix 3) with the data being taken directly from the electronic rostering system. Currently headroom provision within the ward establishments is set at 19%, which does not include maternity leave (the funding for which is now held at directorate level).

The graph below gives on overview of actual headroom across all wards, which has varied across the year from 25% to 31%:



The data for headroom over the last year shows an average total headroom of 28.7% with parenting leave at 3.5%. The range across wards varies from 13.8% to 30% (should be noted this is as a percentage of contracted hours ie staff in post not establishment).
The table below gives a summary of the range across each of the headroom domains:

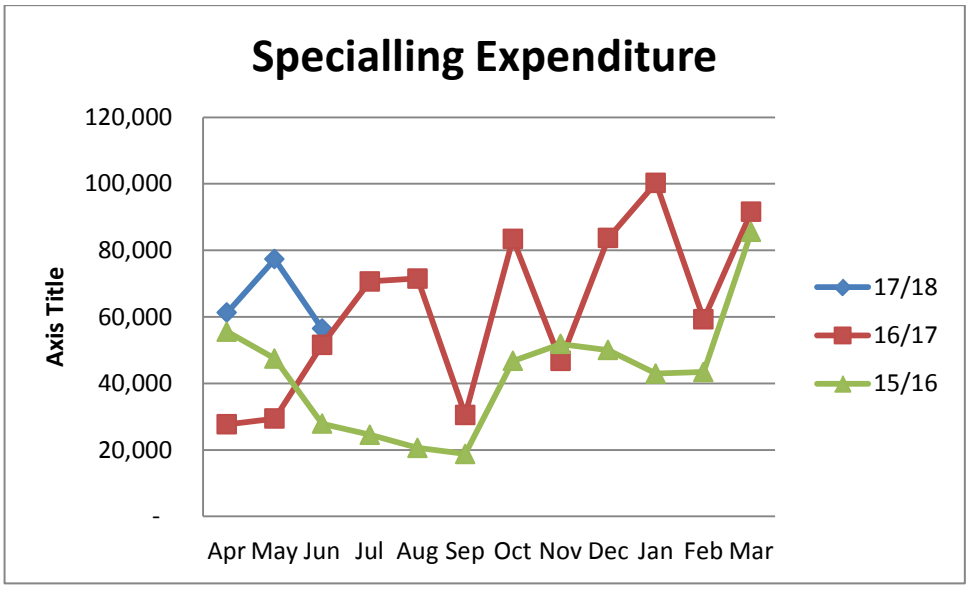
	Headroom allowance	Lowest	Highest	Average
Total	19%	13.8	30	28.7
Annual leave	11-16%	8.6	13.5	13.8
Parenting	0	0	9.3	3.5
Sickness	3%	1.6	7.7	5
Study	1%	1.4	3.6	2.9
Working Day	0	0.2	3.7	2.6

In the last skill mix review it was identified that we were an outlier for working day (this was being used for a variety of reasons where staff appear on a roster but do not contribute to the numbers of staff on shift for example staff on supernumerary as new to ward). There has been focused work on this and it is now at 2.6% which is in line with other organisations.

4.3 Specials/Enhanced Care

The use of additional staff to support patients with enhanced care needs continues to be challenging across the wards.

The graph below shows expenditure year to date and alongside a comparison with previous years:

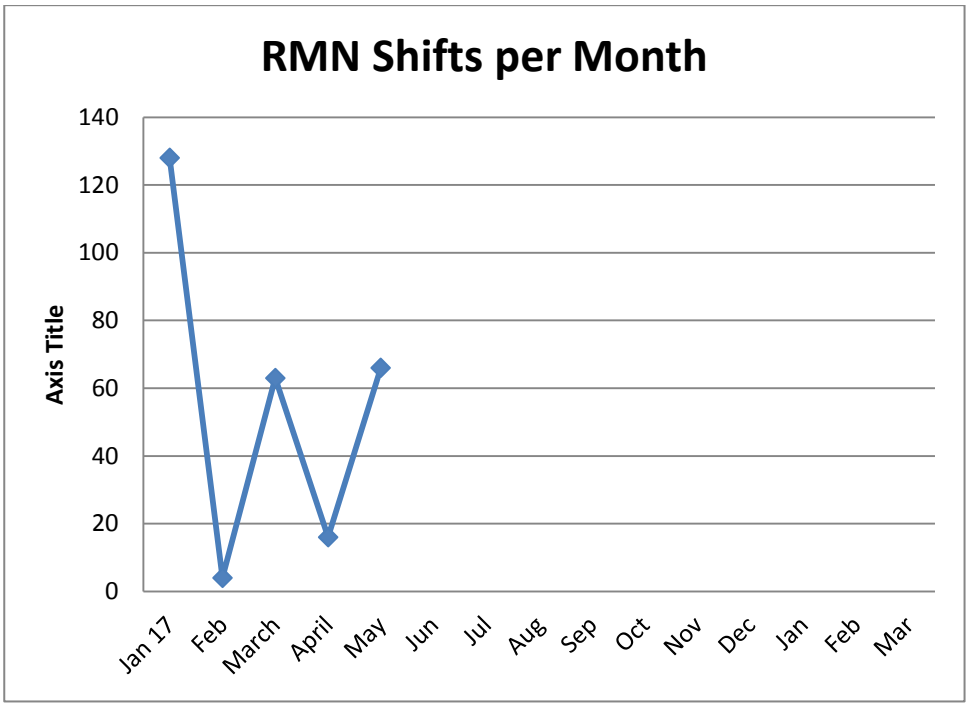


The Trust has requested to be part of future NHSi collaborative events focused on use of specials but in the absence of any detail a small working group has been identified to start looking at additional inputs and learning from early implementer sites.

Registered Mental Health Nurses (RMNs)

One aspect of enhanced care is patients who require the nursing expertise of an RMN and over time there has been an increase in the requirement for an RMN to support patient's health needs. Since January of this year we have started to record the actual number of RMN shifts requested per month via the bank reports. When a patient requires an RMN it is usually required for the full 24 hour period and these patients can be in the Trust for several weeks and occasionally months. Recent examples include a patient awaiting a specialist eating disorders bed and patients within the Burns unit with underlying complex mental health conditions. If one patient requires an RMN for 24hrs per day this equates to a 4.5wte staffing requirement.

All patients requiring an RMN are continuously reviewed by the Mental Health Liaison Team. The numbers of patients requiring this input has increased since the MHLT started within the organisation but this is a reflection of patients now getting the correct level of support.
The graph below shows the number of RMN shifts by month:



From May RMN has been added as a specific definition within the e-rostering system which will enable future reviews to identify the specific cost associated to use of RMNs.

4.4 Vacancies

The most significant challenge in managing the ward establishment is the number of vacancies, particularly for RNs, which at Month 3 is approaching 15%. This is an issue nationally for the nursing workforce and has been compounded by challenges as a result of Brexit and the requirement for all overseas nurses (European and International) to achieve IELTS (International English Language Test) at level 7. As a result we have experienced a significant reduction in the market for European nurses and slow progress in non EU international nurses arriving.
In addition more recently the Nursing and Midwifery Council (NMC), nurse registration body, for the first time has seen more nurses leaving than entering the profession. Bursaries have also been removed for student nurses and the impact of this has yet to be known – early indications show Bournemouth University to be potentially oversubscribed for September.
As identified in the previous skill mix reviews work continues in looking at innovative ways to recruit as set out in the recruitment strategy.

Focused work has commenced on retention to ensure we make every effort to develop and retain staff.

Work continues in identifying opportunities to grow our own registered workforce through career development opportunities, the Trust forms part of the pilot work for the introduction of the Nurse Associate role.

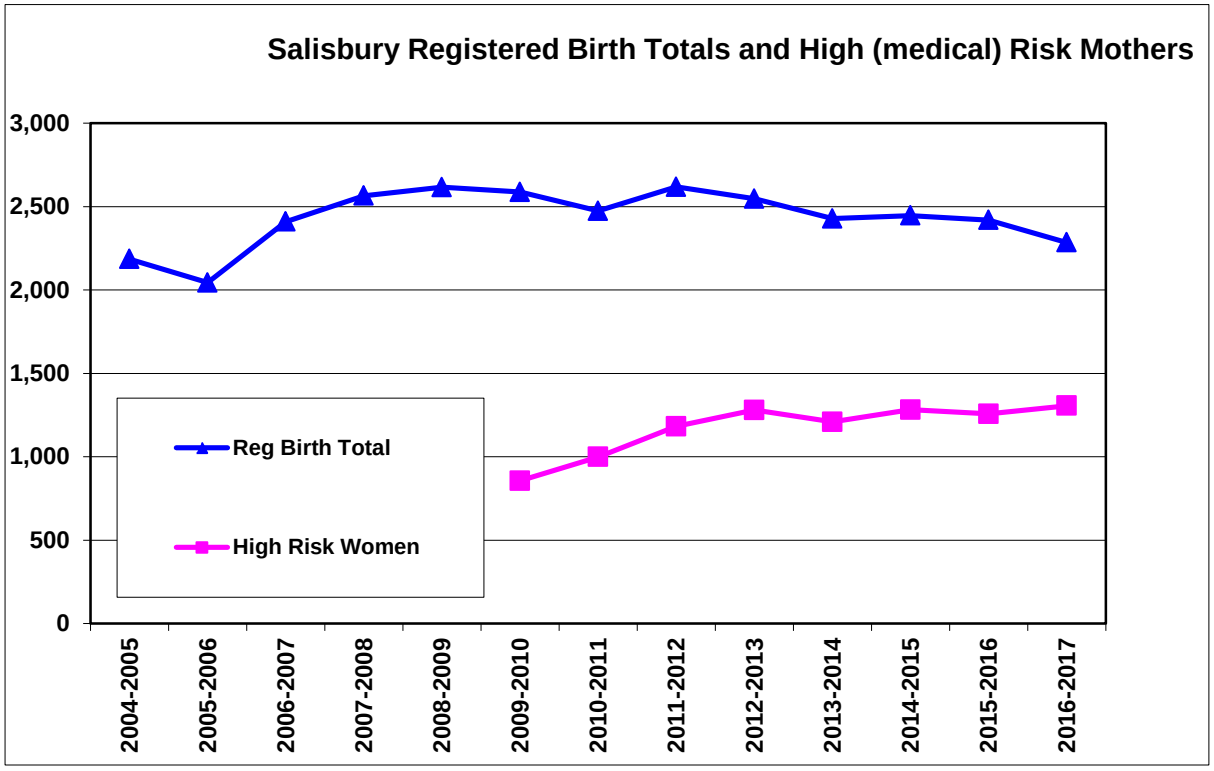
Appendix 4 shows the current nurse to patient ratios based on ward establishment, the challenge with the high numbers of vacancies is in ensuring these ratios are maintained balanced with avoiding the use of high cost agency staff.

5.0 Maternity and Neonatal

Maternity

The Midwifery workforce is reviewed on a monthly basis alongside acuity and activity. Although there has been a slight decline in birth numbers, there has been a corresponding increase in antenatal surveillance and an in the acuity of women (see graph below).

The Maternity services have been successful in reducing the midwife to birth ratio to 1:31 from an unacceptably high level which was seen pre investment in 2016. (Appendix 5 Midwife to Birth ratio).



Key challenges include

- High sickness rate and maternity leave. Maternity leave looks to remain constantly at 3-4% and so fixed term contracts have been utilised to cover this. Sickness has been a combination of both long and short term sickness and there has been increased support from HR to actively manage and a reduction is now starting to be seen.
- Challenges to recruiting into community posts (requires experienced midwives).
- A shift to a more junior workforce in the skill mix requiring preceptorship time as well as support and guidance.

With all of the work on recruitment, retention and sickness management it is positive to note that the department has not required the use of agency midwives since January 2017 but retains the use of bank staff.

The department are conducting a table top Birth rate plus exercise in July to fully appreciate the impact that the increased acuity against a drop in births is having and this will be reported at the strategic nursing and midwifery staffing group in August.

Statutory supervision of Midwives became obsolete on 31st March 2017 but to maintain a quality service it was agreed with the senior nursing and quality team that the supportive element of supervision would prevail for the first 6 months. This provides a senior on call service out of hours.

Neonatal
A workforce review was undertaken in 2016 which resulted in the reduction of cots based on activity data. This was implemented in November 2016. The department has subsequently been in escalation on 76 occasions. There has been a rise in the number of high dependency babies which is thought to be related to the higher acuity of women accessing the maternity service. The Neonatal network has developed an acuity tool which enables staff to consider the staffing, capacity and activity in real time and activate escalation when necessary. A gap analysis is currently being undertaken against British Association of Perinatal Medicine (BAPM) guidelines alongside more recent activity data to consider whether changes need to be made to the number of cots. This analysis will come back with the full skill mix review.

Key challenges within the neonatal unit have been short term sickness which has been over 3% on average in the first 6 months of the year. In addition the service continues to struggle to recruit experienced nursing staff that are qualified in speciality and therefore focusses on a 'grow your own' ethos which is robustly pursued. Within the staffing establishment 70% of RNs should ideally be Qualified in speciality (QIS) and the unit is currently at 50%. There are always at least 2 QIS nurses on per shift to maintain safety and appropriate supervision - places are assured on the new-born intensive care course but this of course does have a lead in time for training to be completed.

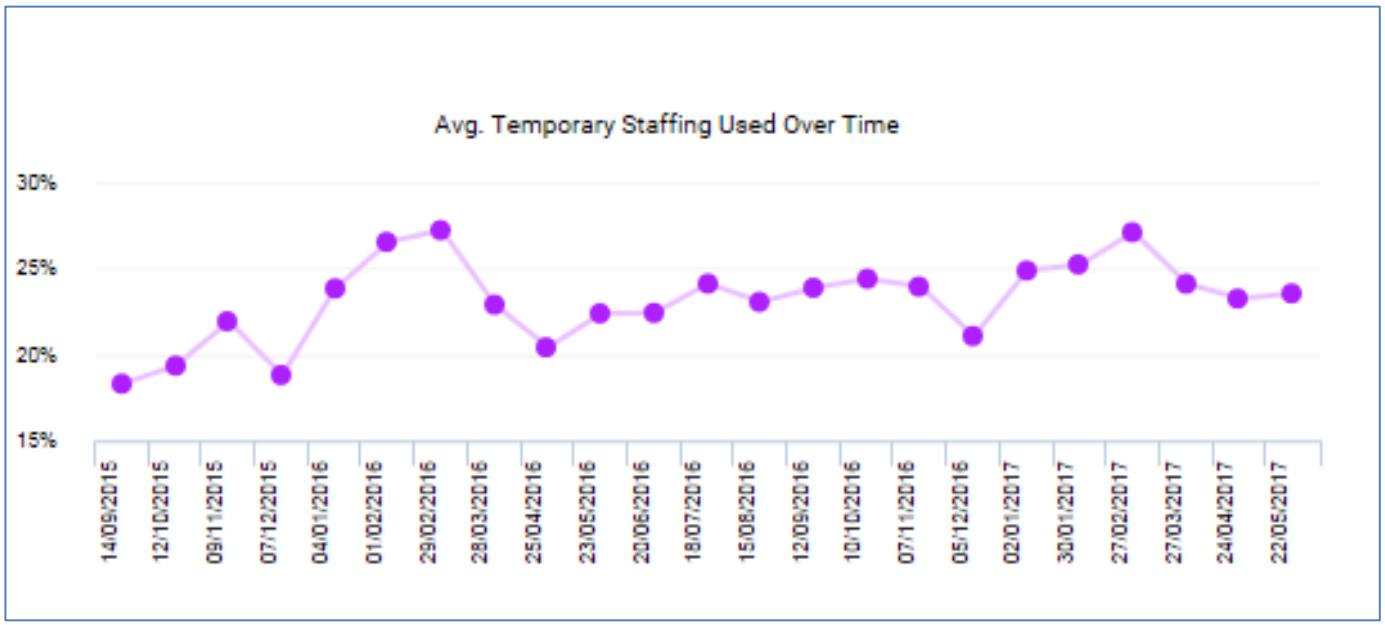
7.0 Changes to future skill mix reviews
The July 2016 NQB Safe Staffing Guidance, Expectation 1 directed that there should be an annual strategic staffing review based on a triangulated approach and that this should be followed up six months later by a comprehensive staffing report to the board to ensure workforce plans are still appropriate.
Therefore it is suggested that the following approach is used:

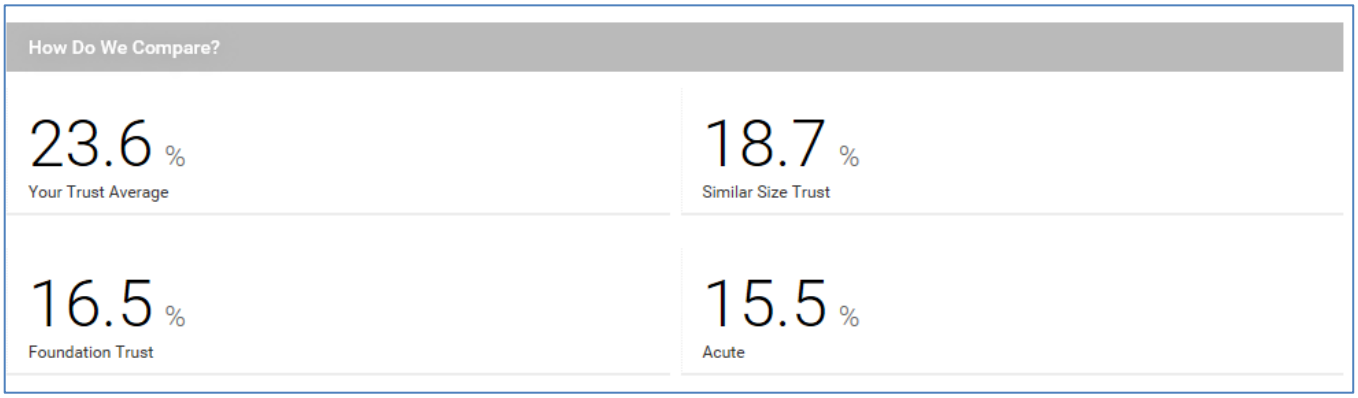
Q2	Skill mix reviews are completed by Deputy Director of Nursing
Q3	6-month follow up review from previous skill mix reviews Submit full skill mix review to JBD for financial planning
Q4	Full skill mix review to Public Board for discussion and ratification
Q1	Implement recommendations from review

6.0 Recommendations
The Board is asked to:

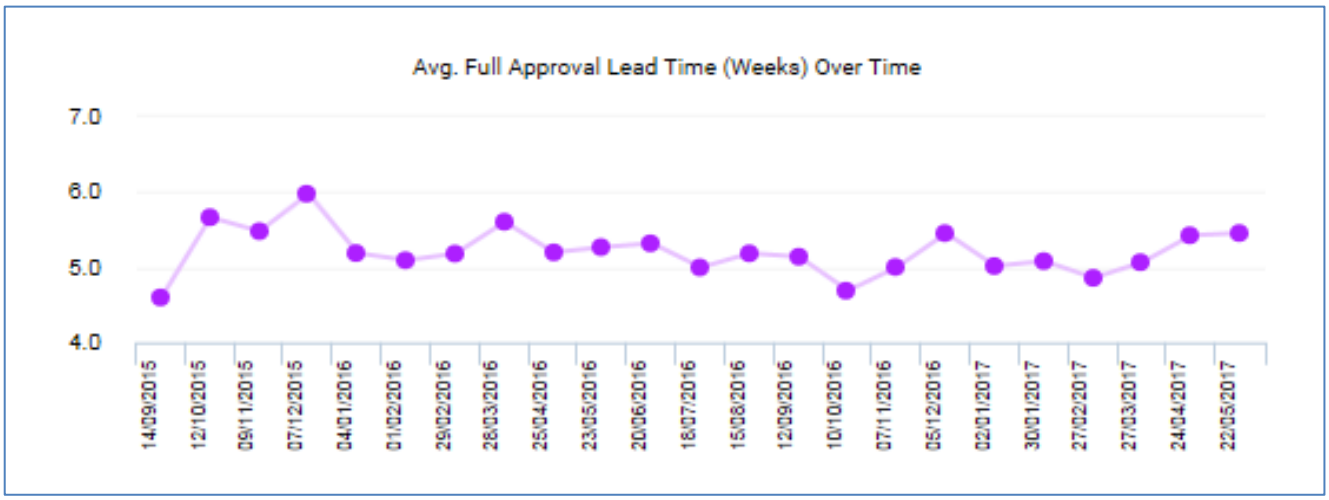
- Note the analysis completed which will be further updated in next full skill mix review
- Agree the recommendations for the change in process for future reports
- Agree the continued focus on recruitment and retention initiatives
- Note that nurse staffing is subject to change due to the ward reconfigurations and that the impact of this will be reported on in the full skill mix review in December

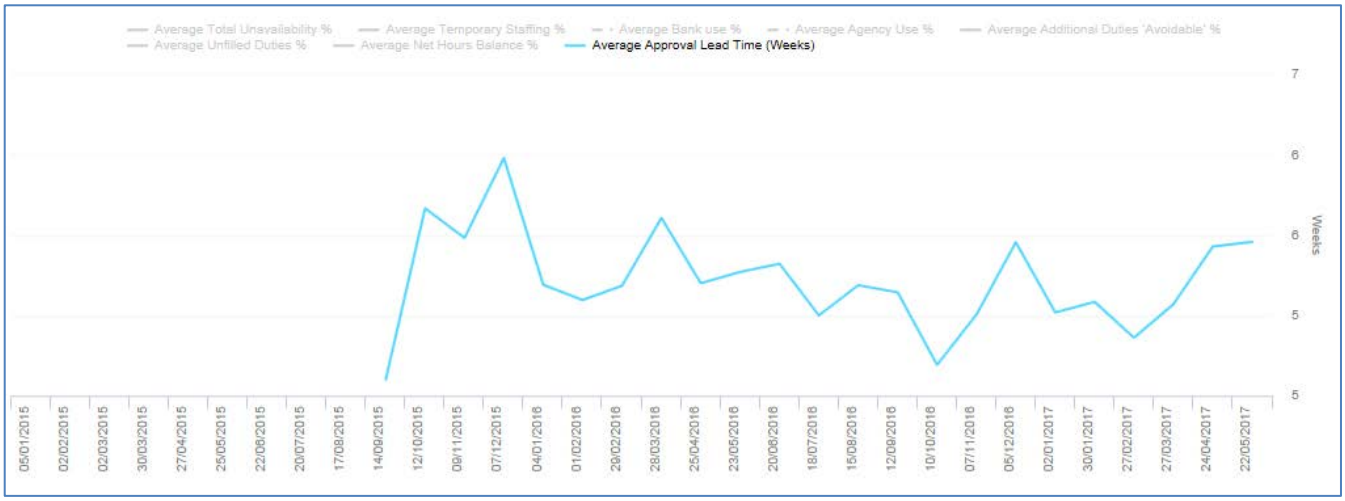
KPI 1. Temporary Staff Use

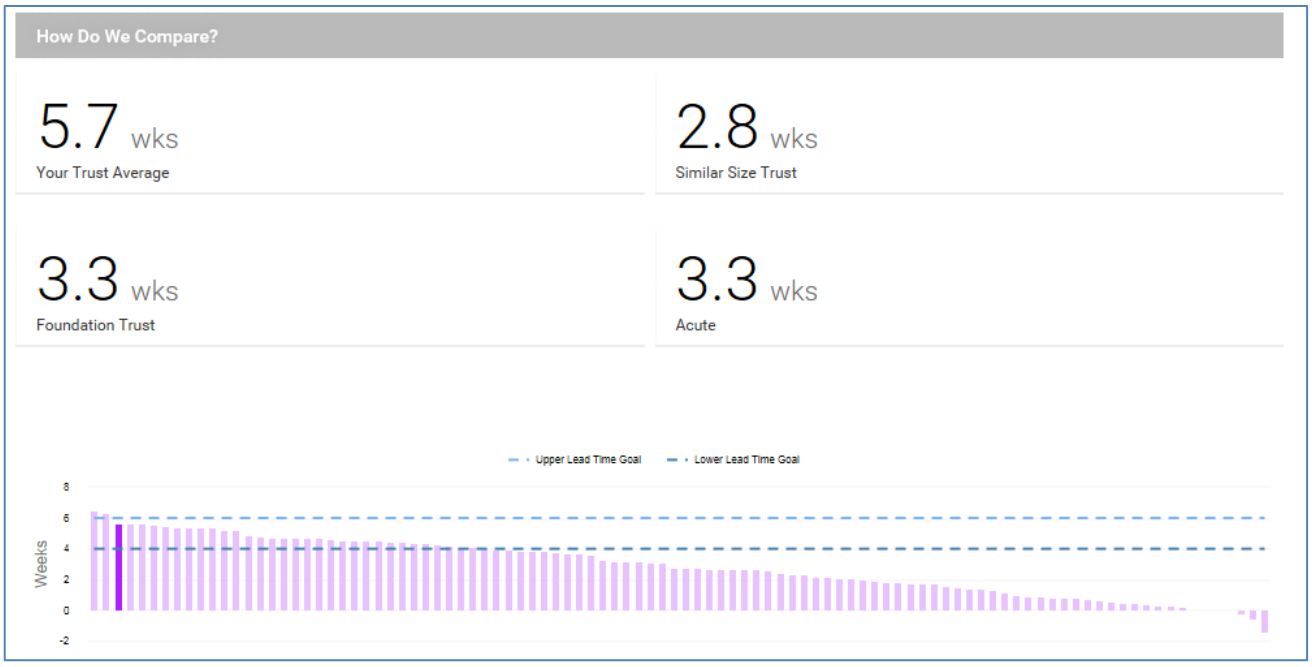




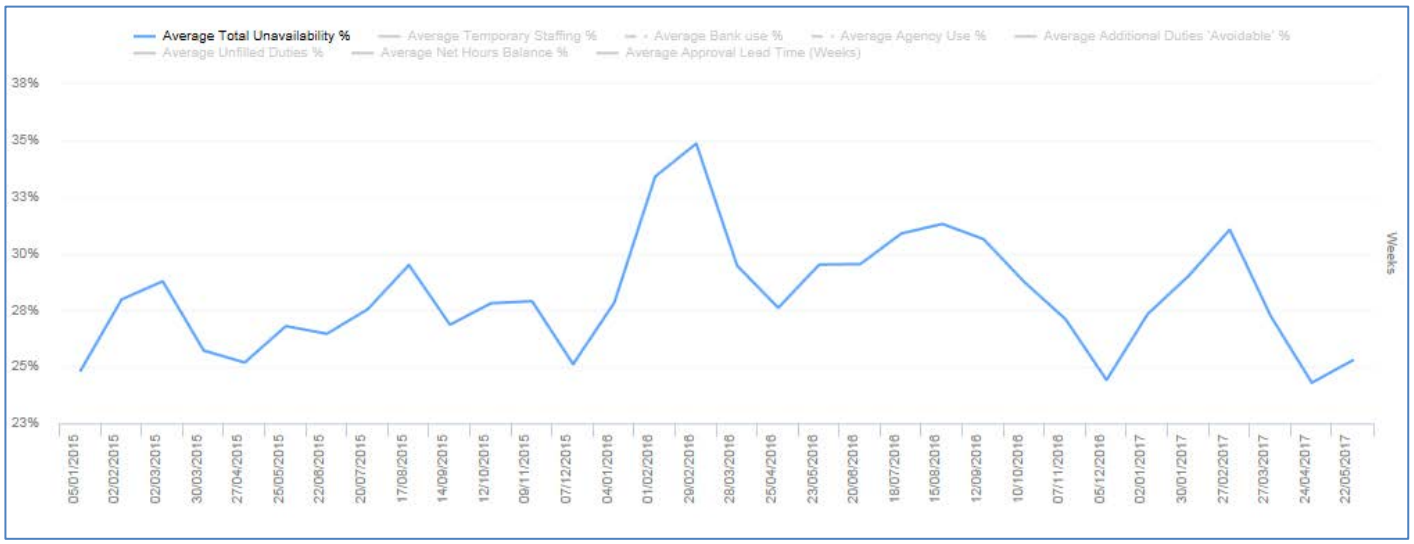
KPI 2. Approval Lead Time

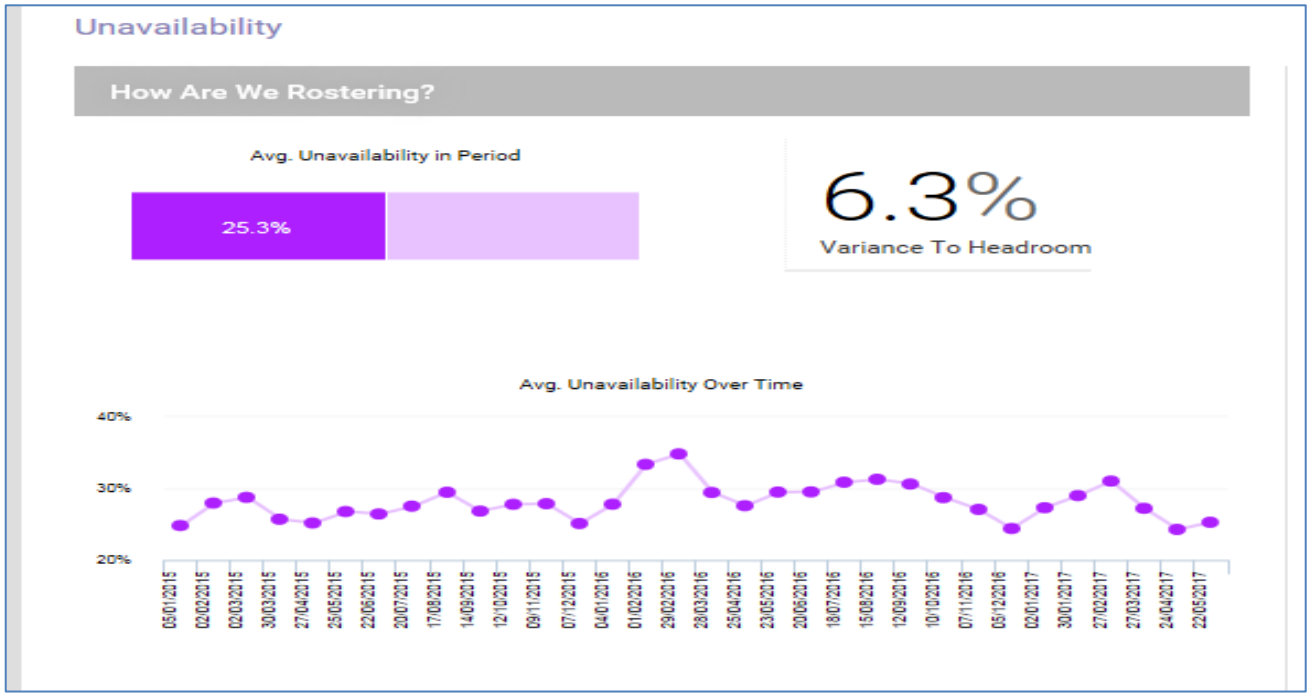


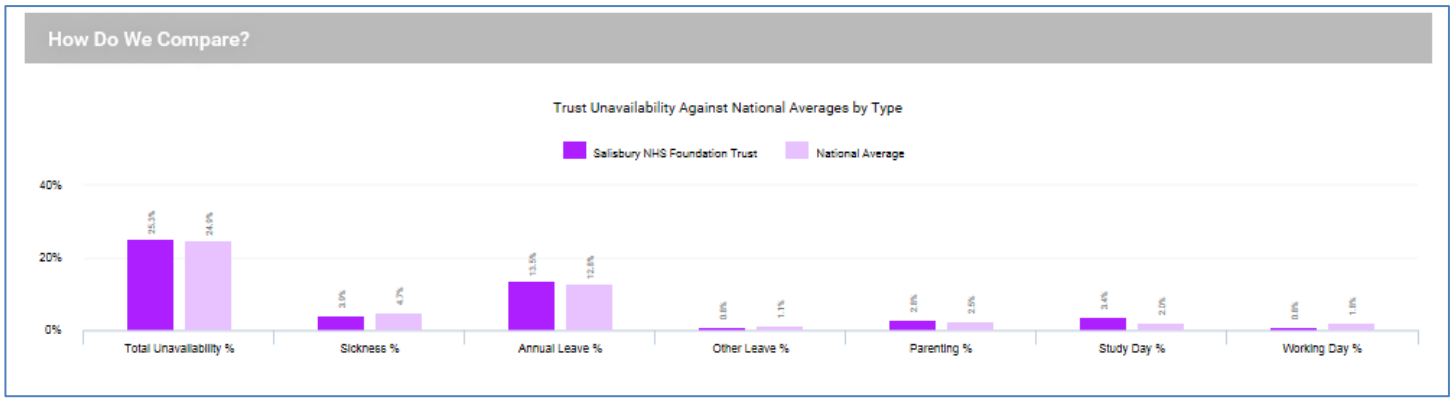




KPI 3. Unavailability



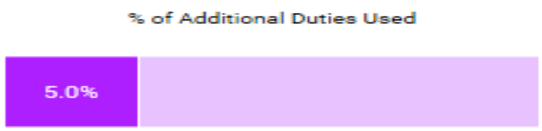




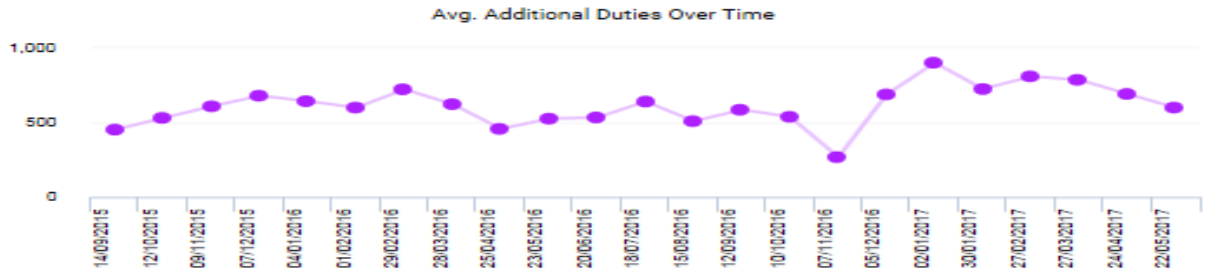
KPI. 4 Additional Duties

Additional Duties

How Are We Rostering?



601
Total Additional Duties



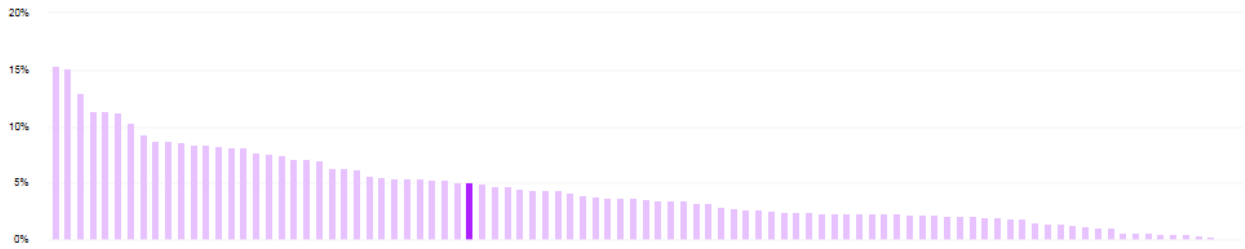
How Do We Compare?

5.0 %
Your Trust Average

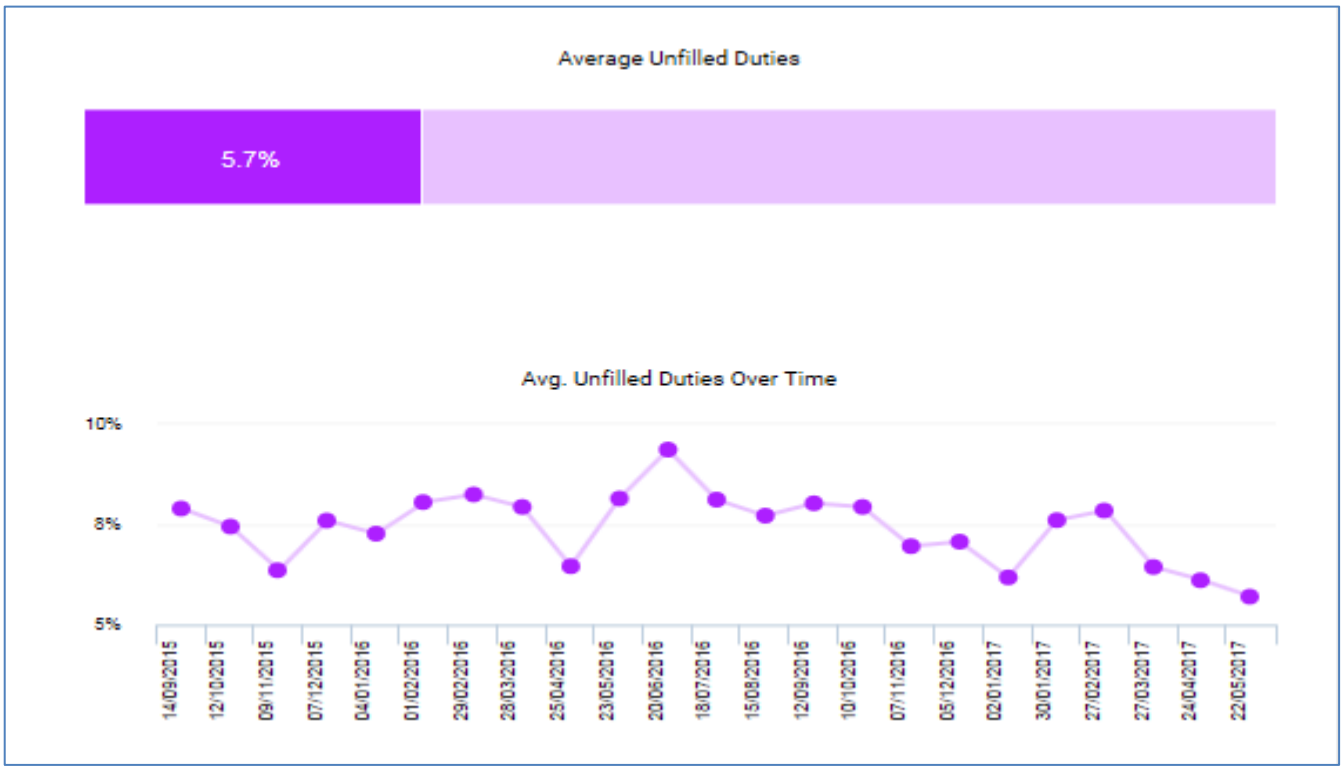
5.0 %
Similar Size Trust

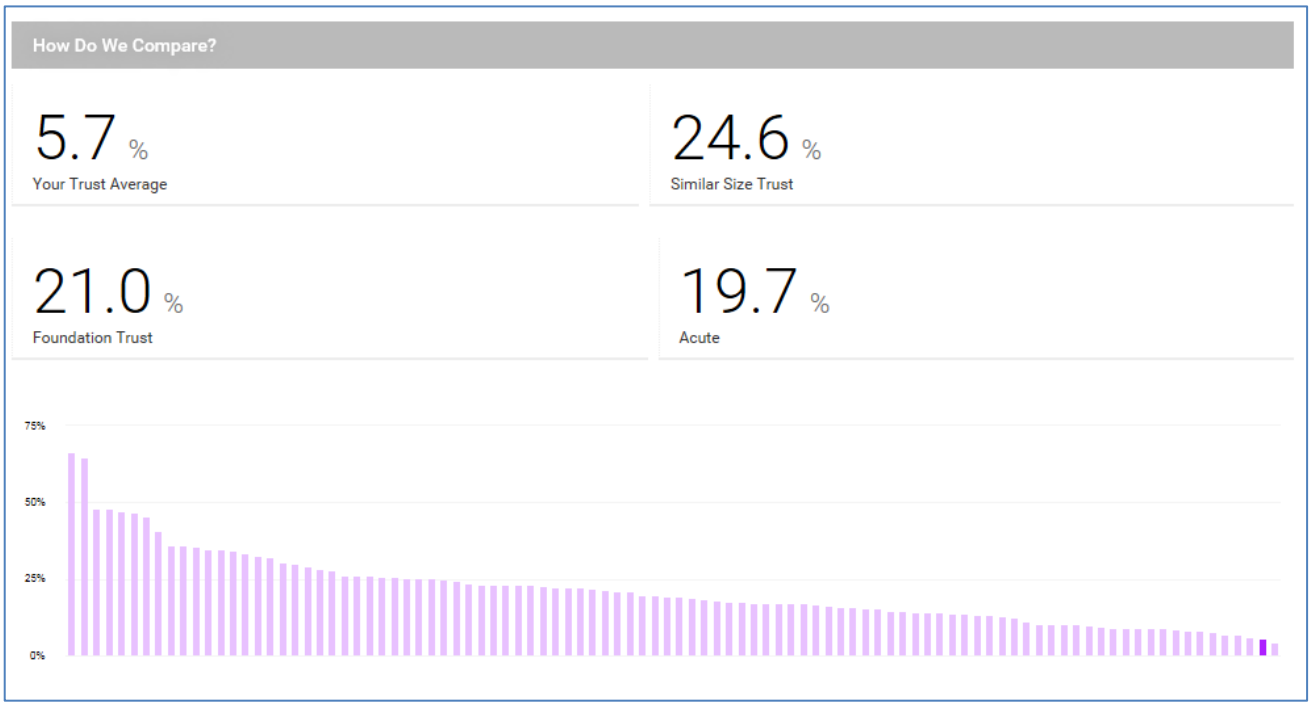
4.4 %
Foundation Trust

3.5 %
Acute

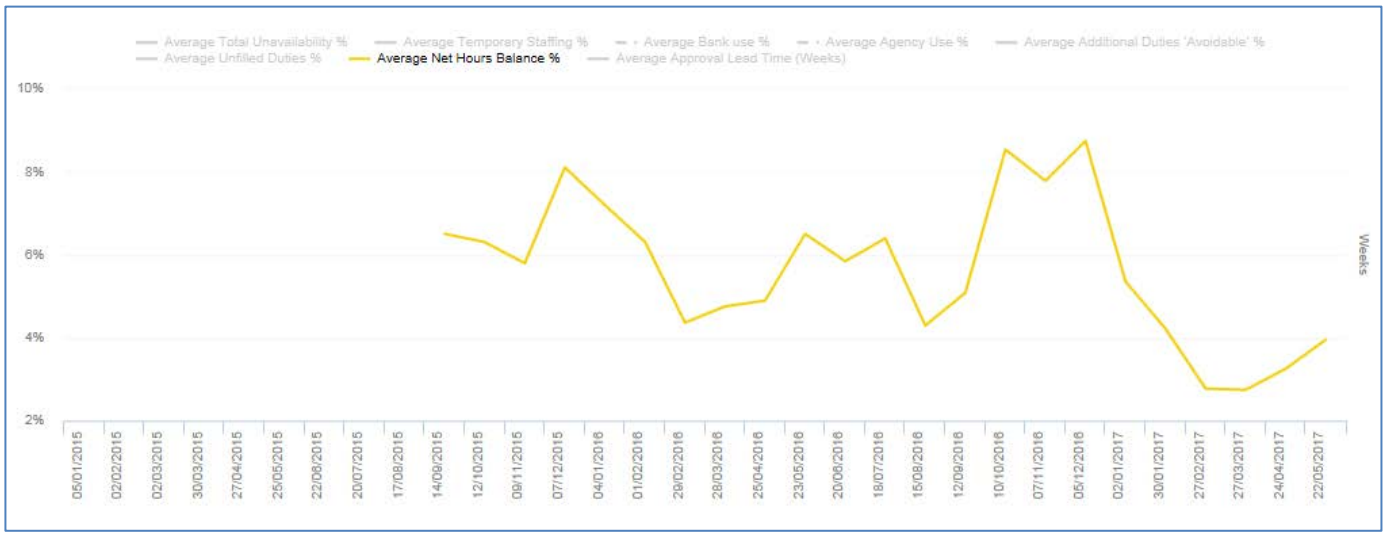


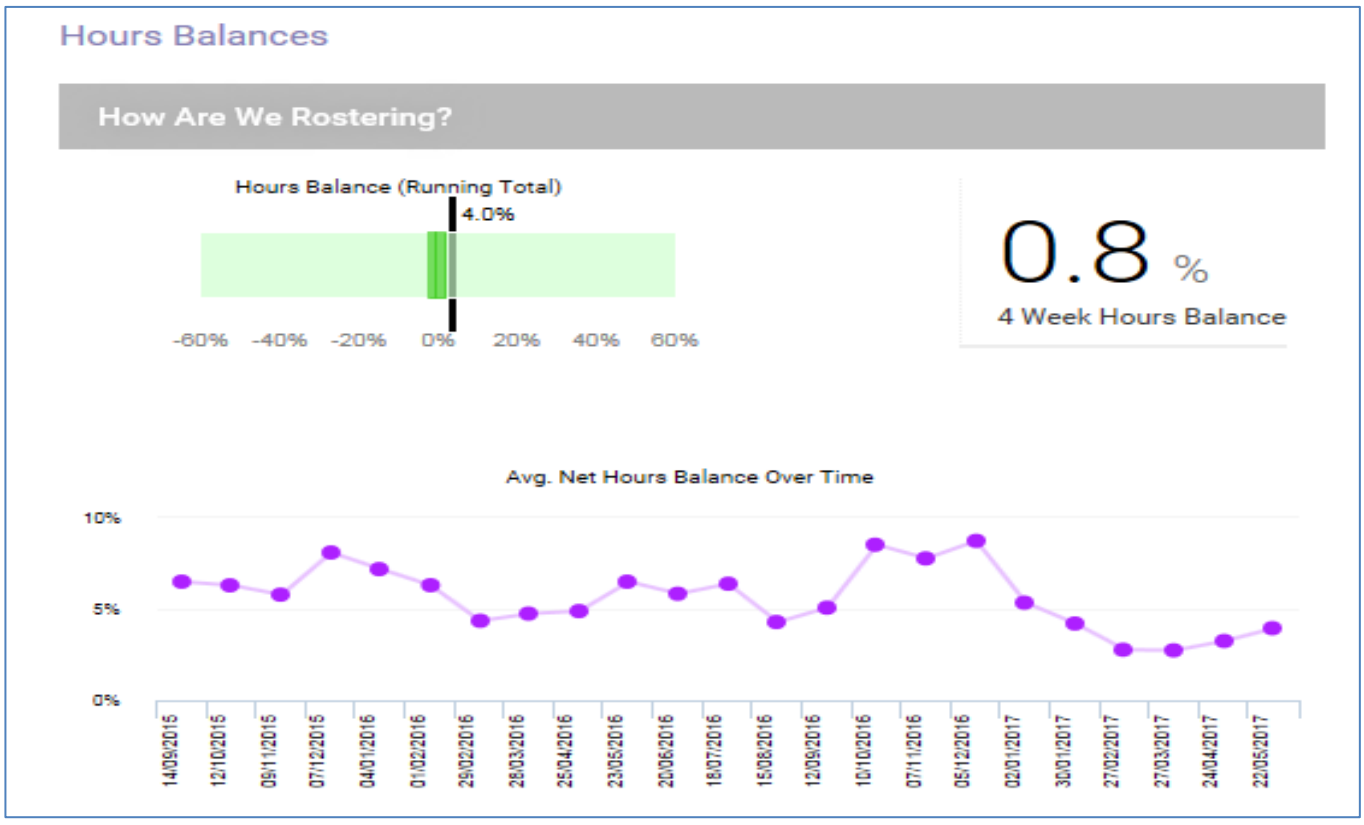
KPI 5. Unfilled hours

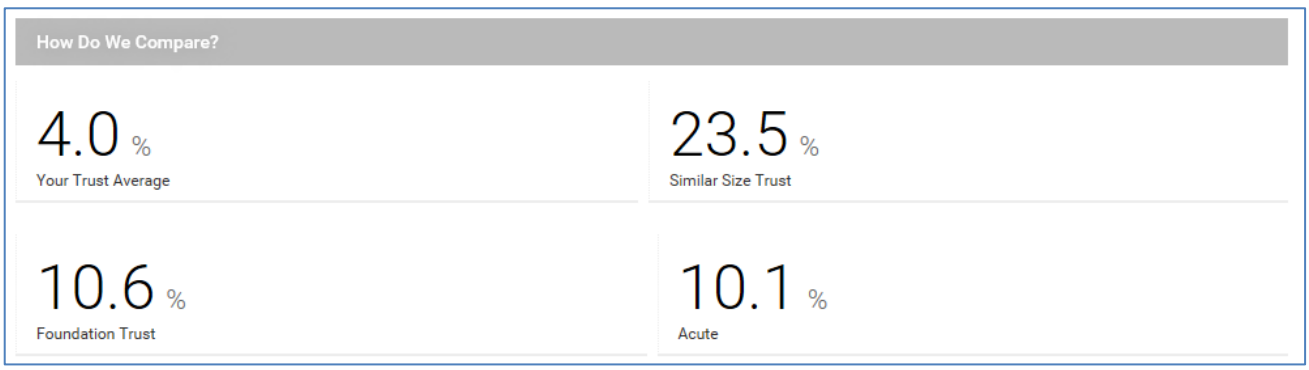




KPI 6. Hours Balance

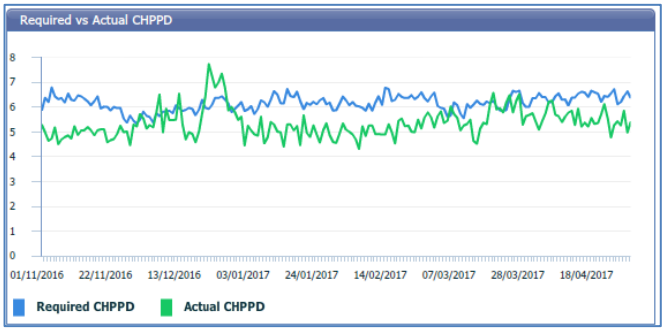




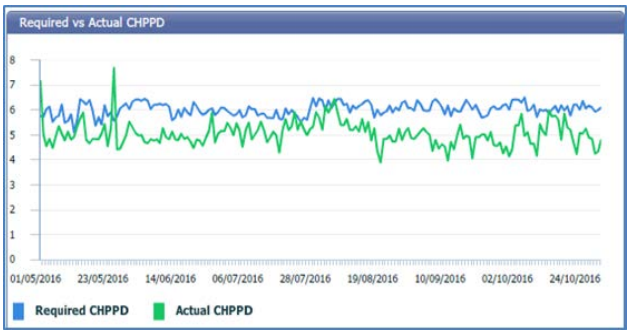


AMESBURY

01/05/2016 -31/10/2016

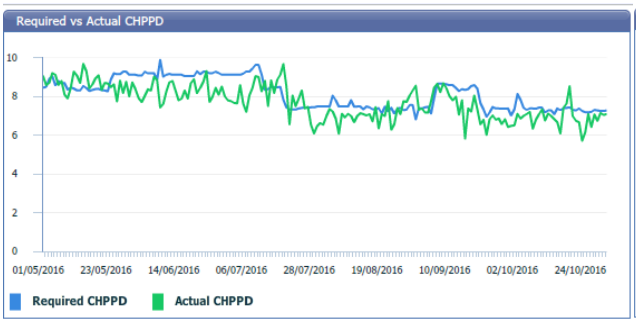


01/11/2016 -30/04/2017

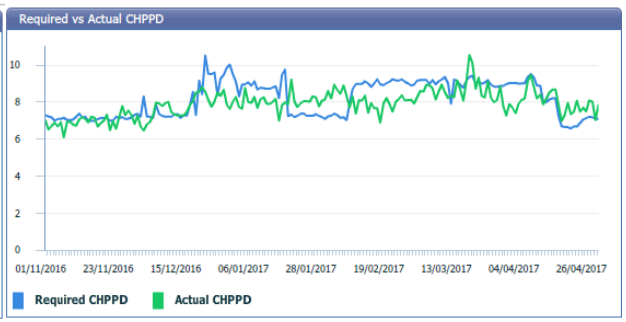


AVON

01/05/2016 -31/10/2016



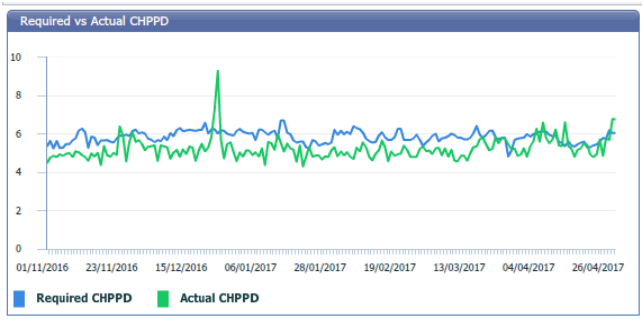
01/11/2016 -30/04/2017



BREAMORE

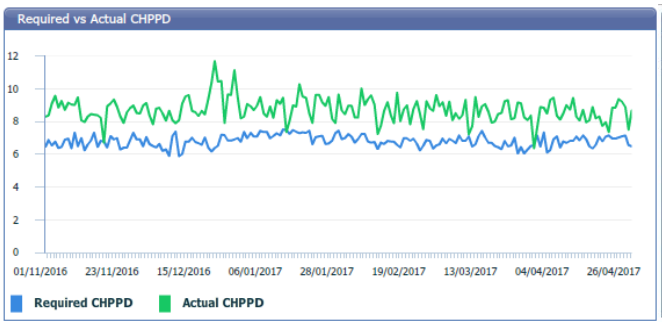
01/05/2016 -31/10/2016

01/11/2016 -30/04/2017

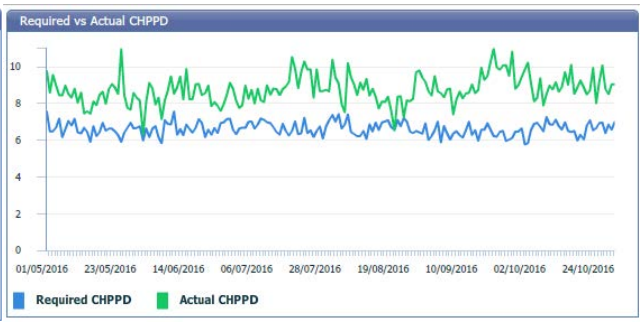


BRITFORD

01/05/2016 -31/10/2016

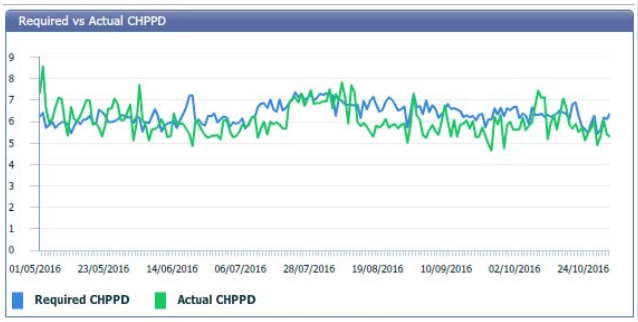


01/11/2016 -30/04/2017



BURNS

01/05/2016 -31/10/2016

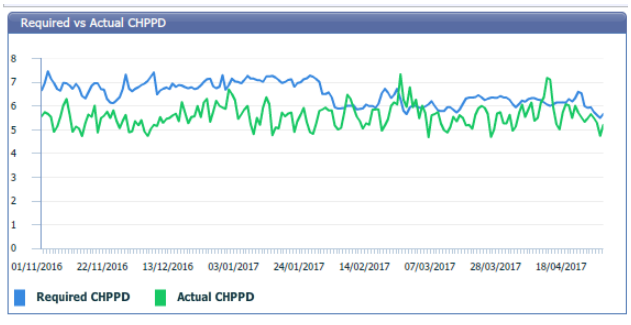


01/11/2016 -30/04/2017

CHILMARK

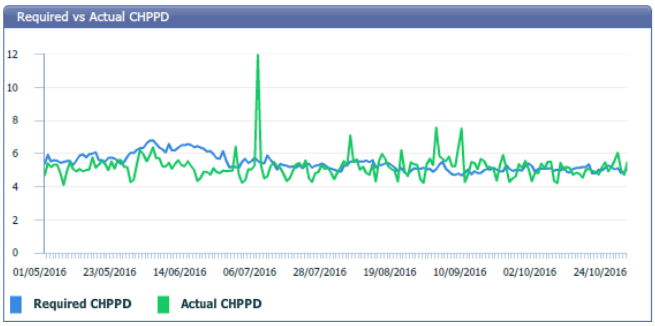
01/05/2016 - 31/10/2016

01/11/2016 -30/04/2017



DOWNTON

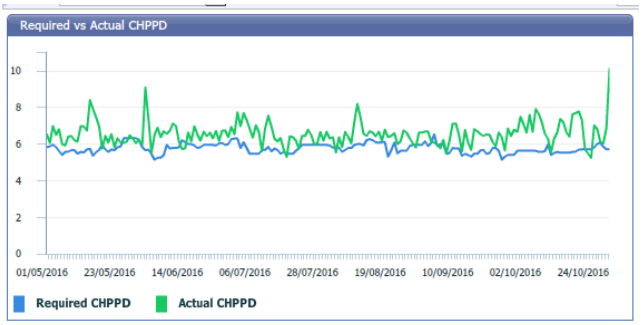
01/05/2016 - 31/10/2016



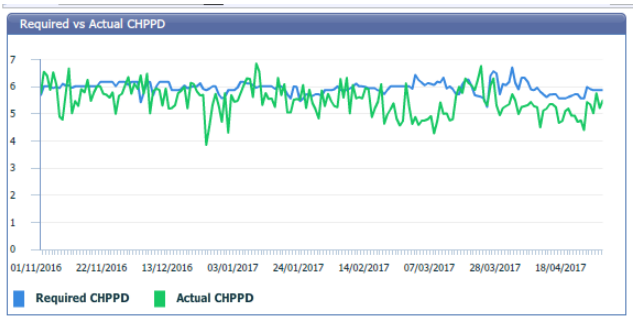
01/11/2016 -30/04/2017

DURRINGTON

01/05/2016-31/10/2016

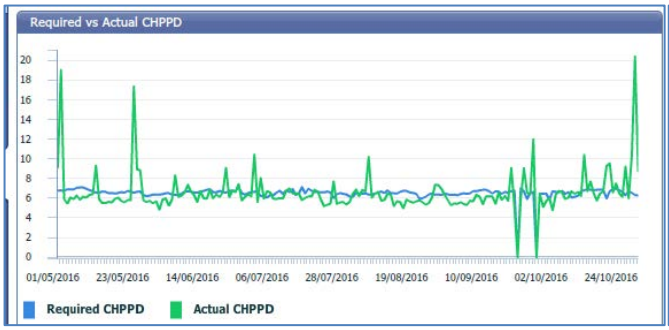


01/11/2016 -30/04/2017

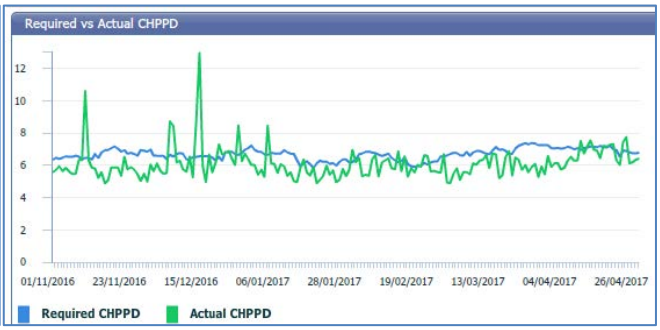


FARLEY

01/05/2016 -31/10/2016

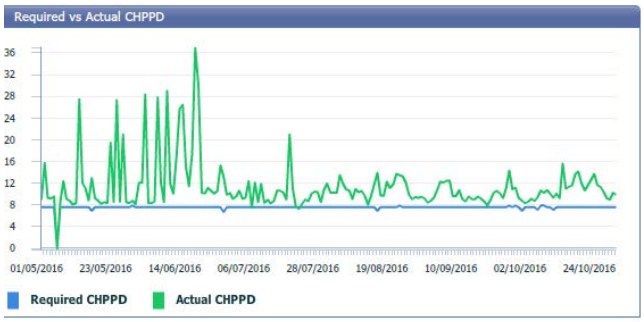


01/11/2016 -30/04/2017

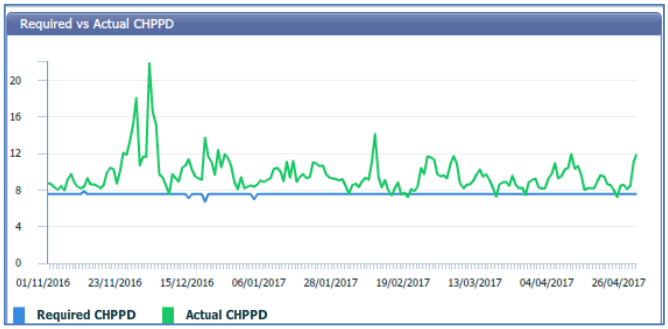


HOSPICE

01/05/2016 -31/10/2016

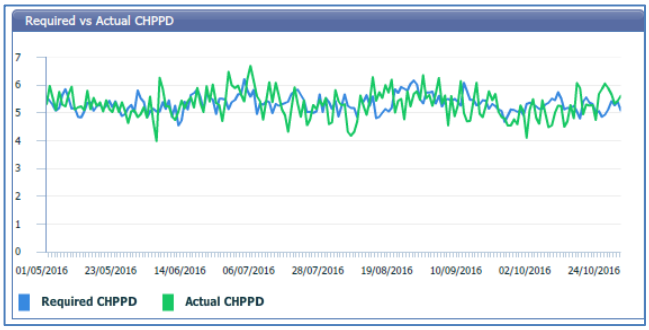


01/11/2016 -30/04/2017

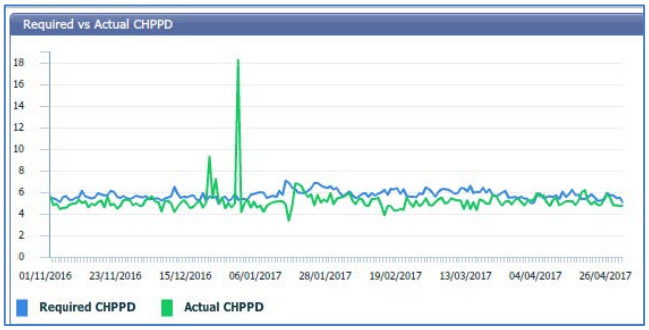


LAVERSTOCK

01/05/2016 -31/10/2016

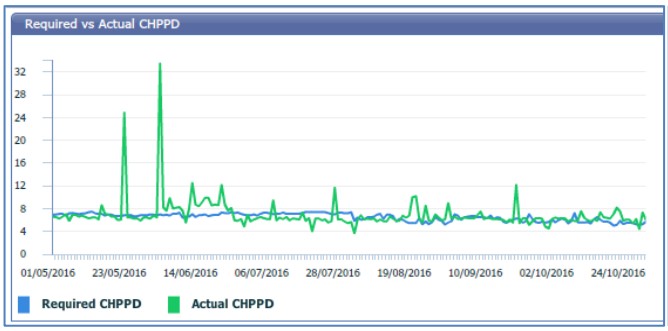


01/11/2016 -30/04/2017



PEMBROKE UNIT

01/05/2016 -31/10/2016



01/11/2016 -30/04/2017

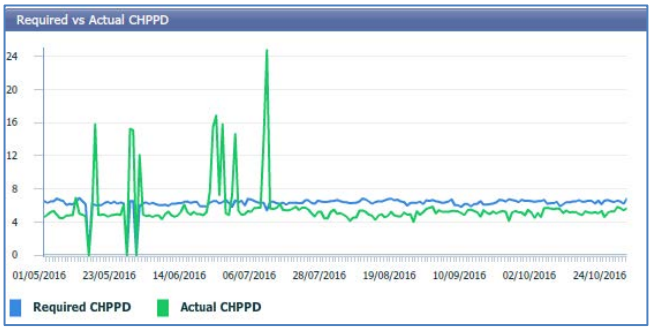
PITTON

01/05/2016 -31/10/2016

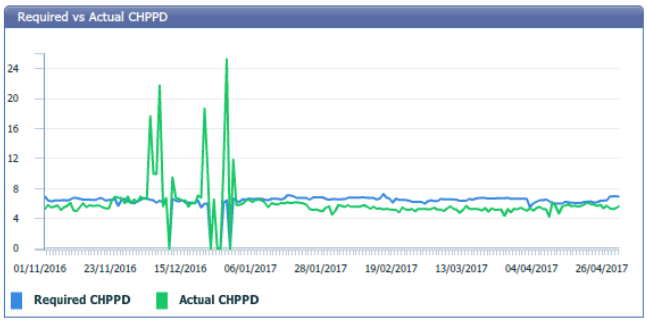
01/11/2016 -30/04/2017

REDLYNCH

01/05/2016 -31/10/2016

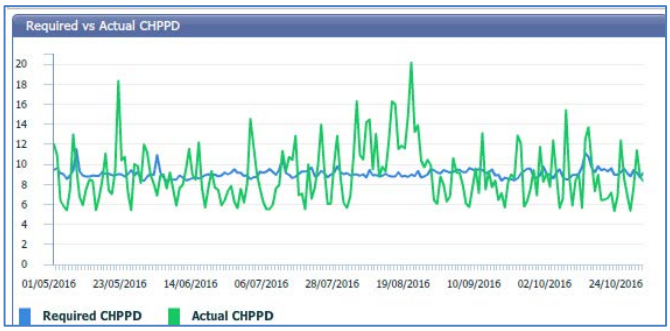


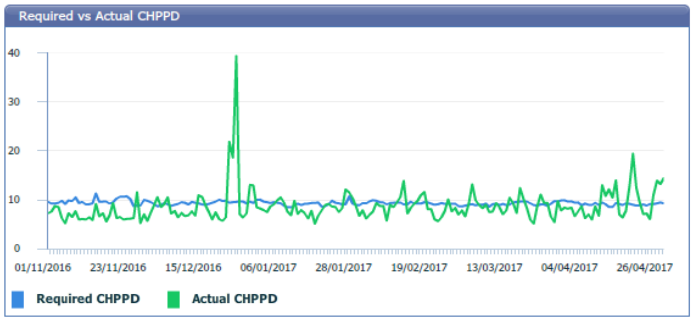
01/11/2016 -30/04/2017



SARUM

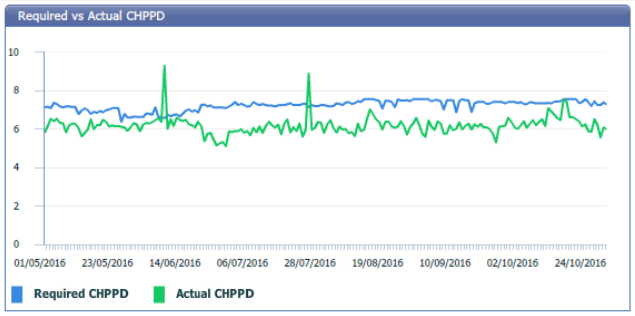
01/05/2016 -31/10/2016



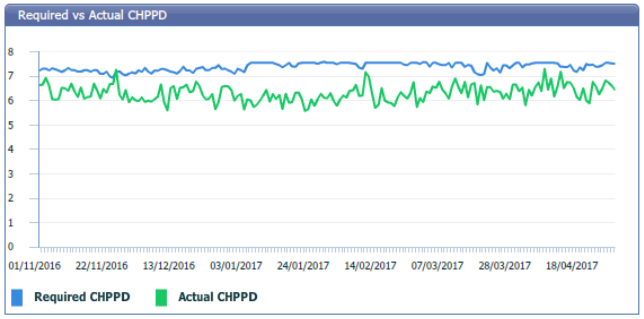


TAMAR

01/05/2016 -31/10/2016

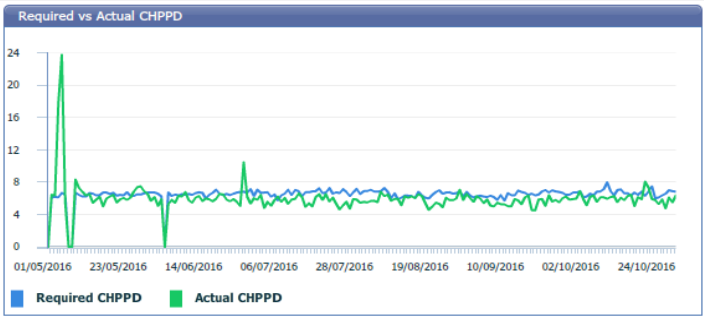


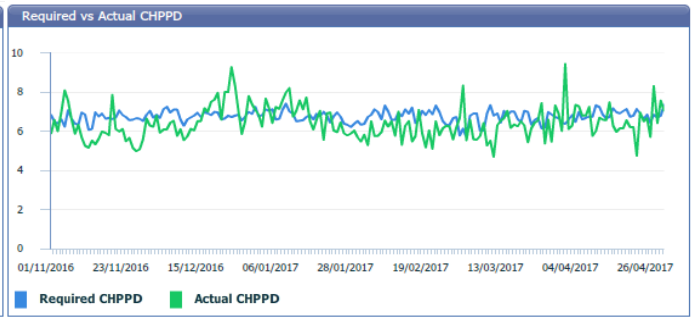
01/11/2016 -30/04/2017



TISBURY

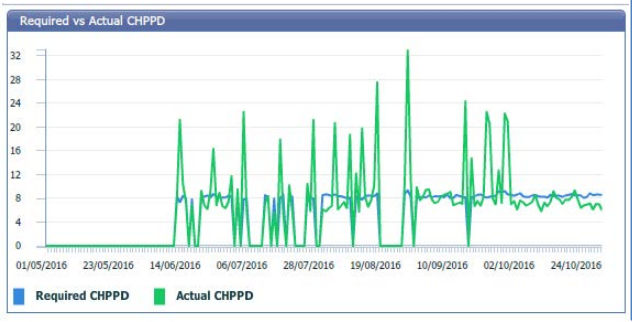
01/05/2016 -31/10/2016



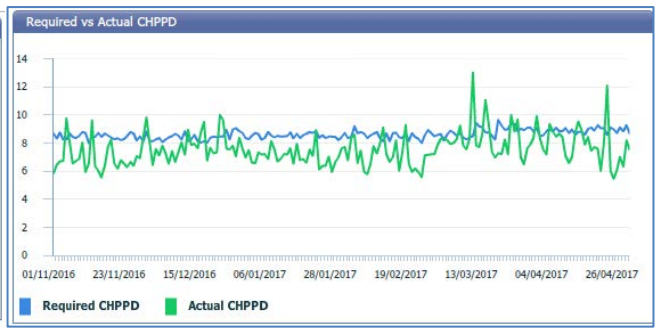


WHITEPARISH

01/05/2016 -31/10/2016

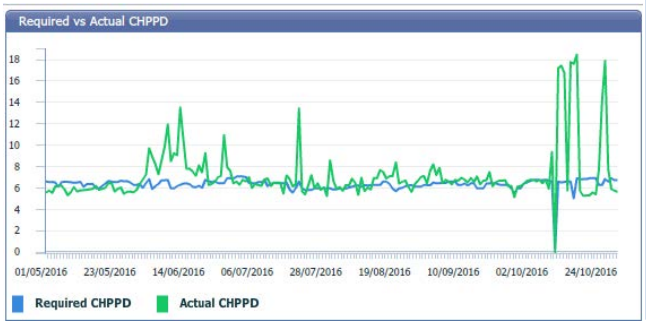


01/11/2016 -30/04/2017

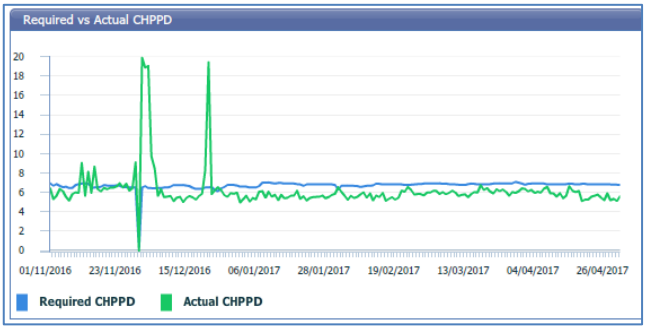


WINTERSLOW

01/05/2016 -31/10/2016



01/11/2016 -30/04/2017



TRUST TOTAL HEADROOM

(PERCENTAGE OF CONTRACTED HOURS)

	Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Salisbury NHS Foundation Trust	13.8%	0.7%	3.5%	5.0%	2.9%	2.6%	28.7%

AMESBURY

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Orthopaedics Amesbury	Amesbury Ward - 101310	Registered	10.0%	0.3%	3.3%	4.8%	2.6%	1.2%	22.3 %
		Unregistered	11.3%	0.6%	0.1%	4.3%	3.2%	3.2%	22.7 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Orthopaedics Amesbury	Amesbury Ward - 101310	10.6%	0.4%	1.8%	4.6%	2.9%	2.1%	22.5 %

AVON

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Unknown	Working Day	Total
Spinal - Avon	Avon Ward - 101530	Registered	9.3%	0.2%	4.1%	2.1%	2.5%	0.2%	5.4%	23.8 %
		Unregistered	10.7%	0.7%	3.5%	4.1%	3.5%		1.1%	23.6 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Unknown	Working Day	Total
Spinal - Avon	Avon Ward - 101530	10.1%	0.5%	3.8%	3.1%	3.0%	0.1%	3.1%	23.7 %

BREAMORE

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Sickness	Study Leave	Working Day	Total
-	Breamore Ward - 100500	Registered	8.5%		1.4%	1.3%	0.7%	11.9 %
		Unregistered	10.3%	1.2%	1.9%	2.5%	0.5%	16.3 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Sickness	Study Leave	Working Day	Total
-	Breamore Ward - 100500	9.3%	0.5%	1.6%	1.8%	0.6%	13.8 %

BRITFORD

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Unknown	Working Day	Total
-	Britford Ward - 100100	Registered	10.4%	0.4%	3.4%	1.4%	1.5%	0.0%	0.8%	17.9 %
		Unregistered	11.5%			3.7%	1.3%		0.2%	16.7 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Unknown	Working Day	Total
-	Britford Ward - 100100	10.8%	0.2%	2.2%	2.2%	1.4%	0.0%	0.6%	17.5 %

BURNS

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Burns Unit	Burns Unit - 101010	Registered	13.4%	0.2%	11.1%	2.0%	2.8%	1.4%	30.8 %
		Unregistered	13.5%	0.5%	3.5%	7.4%	0.8%	1.5%	27.2 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Burns Unit	Burns Unit - 101010	13.5%	0.3%	9.3%	3.2%	2.3%	1.4%	30.0 %

CHILMARK

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Sickness	Study Leave	Unknown	Working Day	Total
Orthopaedics Chilmark	Chilmark Ward - 101320	Registered	8.7%	0.0%	0.8%	1.5%	0.0%	0.2%	11.4 %
		Unregistered	11.4%	0.4%	3.8%	4.1%	0.1%	0.4%	20.1 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Sickness	Study Leave	Unknown	Working Day	Total
Orthopaedics Chilmark	Chilmark Ward - 101320	9.6%	0.2%	1.8%	2.4%	0.0%	0.3%	14.2 %

DOWNTON

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
-	Downton Ward - 100280	Registered	9.1%	0.1%	0.4%	1.2%	1.6%	1.1%	13.6 %
		Unregistered	7.6%	0.4%		8.8%	1.7%		18.5 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
-	Downton Ward - 100280	8.6%	0.2%	0.2%	4.0%	1.6%	0.7%	15.4 %

DURRINGTON

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Sickness	Study Leave	Working Day	Total
Inpatient Elderly Care	Durrington Ward - 100050	Registered	9.8%	0.2%	1.7%	3.1%	4.6%	19.6 %
		Unregistered	9.4%	1.0%	3.7%	2.5%	1.4%	18.1 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Sickness	Study Leave	Working Day	Total
Inpatient Elderly Care	Durrington Ward - 100050	9.6%	0.6%	2.7%	2.9%	3.1%	18.9 %

Clarendon

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
-	Clarendon Suite - 100300	Registered	13.7%	1.1%	0.2%	1.4%	2.7%	1.0%	20.1 %
		Unregistered	8.5%	0.4%	0.1%	2.7%	2.6%	0.8%	15.1 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
-	Clarendon Suite - 100300	11.2%	0.8%	0.2%	2.0%	2.7%	0.9%	17.7 %

EMERGENCY DEPT.

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
-	Emergency Dept - Nursing - 104020	Registered	10.0%	0.9%	3.1%	6.8%	1.3%	4.3%	26.4 %
		Unregistered	11.8%	0.5%		4.8%	5.0%	1.6%	23.8 %
		Ward Management	11.3%					40.7%	52.0 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
-	Emergency Dept - Nursing - 104020	10.3%	0.8%	2.5%	6.3%	2.0%	4.2%	26.2 %

RADNOR

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
-	I.C.U. - 100400	Registered	11.6%	0.4%	1.5%	4.6%	2.5%	3.8%	24.4 %
		Unregistered	11.1%	0.5%		1.9%	2.6%	2.0%	18.1 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
-	I.C.U. - 100400	11.6%	0.4%	1.4%	4.4%	2.5%	3.7%	23.9 %

FARLEY

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Inpatient Elderly Care	Farley Ward - 101090	Registered	8.1%	0.4%	0.1%	4.5%	1.2%	0.8%	15.1 %
		Unregistered	11.0%	0.6%	0.1%	4.9%	2.4%	2.8%	21.7 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Inpatient Elderly Care	Farley Ward - 101090	9.2%	0.5%	0.1%	4.7%	1.7%	1.6%	17.8 %

HOSPICE

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Unknown	Working Day	Total
-	Palliative Care/Hospice - 101130	Registered	13.9%	0.3%		2.7%	2.3%	0.0%	0.5%	19.8 %
		Unregistered	11.7%	0.4%	2.6%	15.8%	1.2%		2.9%	34.6 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Unknown	Working Day	Total
-	Palliative Care/Hospice - 101130	13.1%	0.3%	1.0%	7.7%	1.9%	0.0%	1.4%	25.4 %

LAVERSTOCK

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Laverstock	Laverstock Ward - 100150	Registered	12.5%	1.1%	4.7%	3.3%	1.9%	0.3%	23.8 %
		Unregistered	13.9%	1.2%	0.1%	11.4%	3.7%	1.2%	31.5 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Laverstock	Laverstock Ward - 100150	13.0%	1.2%	3.2%	5.8%	2.5%	0.6%	26.2 %

PEMBROKE UNIT

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
-	Pembroke Unit - 103500	Registered	10.5%	0.6%	1.3%	2.3%	1.3%	0.6%	16.6 %
		Unregistered	10.6%	0.2%	0.0%	4.8%	5.0%	3.4%	24.0 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
-	Pembroke Unit - 103500	10.6%	0.5%	1.1%	2.7%	1.9%	1.1%	17.8 %

PITTON

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Pitton	Pitton Ward - 100200	Registered	9.7%	0.7%	8.7%	2.1%	2.4%	2.1%	25.8 %
		Unregistered	10.8%	1.5%	0.7%	6.4%	2.7%	2.9%	25.0 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Pitton	Pitton Ward - 100200	10.1%	1.0%	5.9%	3.6%	2.5%	2.4%	25.5 %

REDLYNCH

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
-	Redlynch Ward - 100020	Registered	10.2%	0.6%	1.9%	1.2%	3.0%	1.8%	18.7 %
		Unregistered	10.6%	1.0%	0.1%	3.7%	4.2%	5.4%	24.9 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
-	Redlynch Ward - 100020	10.4%	0.8%	1.1%	2.3%	3.6%	3.3%	21.4 %

SARUM

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Sarum	Sarum Ward - 101360	Registered	12.5%	0.3%	5.3%	1.6%	2.5%	0.8%	23.0 %
		Unregistered	10.4%	1.7%		2.1%	1.2%	0.5%	15.9 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Sarum	Sarum Ward - 101360	12.2%	0.5%	4.5%	1.7%	2.3%	0.7%	21.9 %

TAMAR

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Unknown	Working Day	Total
Spinal - Tamar	Tamar Ward - 101550	Registered	8.8%	0.6%		3.1%	2.3%	0.2%	2.4%	17.4 %
		Unregistered	11.4%	0.4%	1.6%	3.9%	4.9%	1.3%	2.3%	25.7 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Unknown	Working Day	Total
Spinal - Tamar	Tamar Ward - 101550	10.0%	0.5%	0.7%	3.5%	3.5%	0.7%	2.3%	21.3 %

TISBURY

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Tisbury	Tisbury Ward - 100010	Registered	9.1%	0.4%	4.7%	2.1%	1.3%	1.7%	19.4 %
		Unregistered	8.0%	0.2%		3.7%	8.8%	3.1%	23.8 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Tisbury	Tisbury Ward - 100010	8.8%	0.3%	3.5%	2.5%	3.2%	2.1%	20.5 %

WHITEPARISH

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Whiteparish	Whiteparish Ward - 100210	Registered	8.9%	0.2%	9.0%	2.4%	1.1%	0.7%	22.3 %
		Unregistered	10.8%	1.6%		8.1%	8.4%	0.4%	29.4 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Whiteparish	Whiteparish Ward - 100210	9.4%	0.5%	7.0%	3.7%	2.7%	0.6%	23.9 %

WINTERSLOW

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Sickness	Study Leave	Working Day	Total
Inpatient Elderly Care	Winterslow Ward - 100030	Registered	9.3%	0.2%	2.9%	2.4%	0.2%	15.0 %
		Unregistered	8.5%	0.6%	4.6%	2.2%	0.3%	16.2 %

Total Unit Unavailability (Percentage of Contracted Hours)

		Annual Leave	Other Leave	Sickness	Study Leave	Working Day	Total
Inpatient Elderly Care	Winterslow Ward - 100030	8.8%	0.4%	3.9%	2.3%	0.2%	15.7 %

Ward	RN: Patient Ratio (Early)	RN: Patient Ratio (Late)	RN: Patient Ratio (Night)	Comments
Medicine				
Breamorw	1:6.6(8)	1:6.6(8)	1:10(12)	
Durrington	1:7	1:7	1:10.5	
Farley	1:6	1:6	1:10	
Hospice	1:5	1:5	1:5	
Pembroke	1:5	1:5	1:5	
Pitton	1:5.4(6.75)	1:5.4 (6.75)	1:9	
Redlynch	1:6.75	1:6.75	1:9	
Tisbury	1:4.5/2.5	1:4.5/2.75	1:5.75	
Winterslow	1:8 *1:6.5	1:8 *1:6.5	1:13.3 *1:8.6	*As part of ward reconfiguration Winterslow relocate to 26 bedded ward for summer and ratios change
Whiteparish	1:5	1:5	1:7(5.25)	
MSK				
Amesbury	1:8	1:10.6	1:10.6	Band 4 role included on every early shift As part of ward reconfiguration template will staffing model will change
Avon	1:4.25	1:5.6	1:8.5	
Chilmark	1:6	1:8	1:12	As part of ward reconfiguration template and staffing model will change
Plastics & Burns	1:4.25	1:4.25	1:5.6	
Tamar	1:7	1:7	1:10.5	
Surgery				
Britford	1:5	1:5	1:7	
Downton	1:8	1:8	1:12	
Radnor	ICS Levels of Care 1;1 or 1:2			10 beds commissioned from April 2016
CSFS				
Sarum	1:4	1:4	1:4	Based on 12 commissioned beds

Midwives to Births Ratio
(excluding HOM & Management time)

Month	Midwives Establishment	Reg Births (E3)	Non Reg Births (E3)	Total Births	Midwife to Birth ratio		12 Month average
Jan-14	65.4	186	1	187	1:34	34	
Feb-14	65.4	171	1	172	1:32	32	
Mar-14	65.4	192	1	193	1:35	35	
Apr-14	65.4	197	0	197	1:36	36	
May-14	65.4	198	4	202	1:37	37	
Jun-14	65.4	206	1	207	1:38	38	
Jul-14	65.4	206	2	208	1:38	38	
Aug-14	65.4	209	4	213	1:39	39	
Sep-14	65.4	235	3	238	1:44	44	
Oct-14	65.4	238	2	240	1:44	44	
Nov-14	65.4	198	3	201	1:37	37	
Dec-14	65.4	198	1	199	1:37	37	
Jan-15	65.4	229	3	232	1:43	43	38.3
Feb-15	65.4	146	1	147	1:27	27	37.9
Mar-15	65.4	190	2	192	1:35	35	37.9
Apr-15	65.4	184	2	186	1:34	34	37.8
May-15	65.4	205	4	209	1:38	38	37.8
Jun-15	71.21	191	3	194	1:33	33	37.4
Jul-15	71.21	204	1	205	1:35	35	37.2
Aug-15	71.21	178	1	179	1:30	30	36.4
Sep-15	71.21	221	3	224	1:38	38	35.9
Oct-15	71.21	223	4	227	1:38	38	35.4
Nov-15	71.21	225	4	229	1:39	39	35.6
Dec-15	71.21	188	3	191	1:32	32	35.2
Jan-16	71.21	220	4	224	1:38	38	34.8
Feb-16	71.21	176	1	177	1:30	30	35.0
Mar-16	71.21	204	2	206	1:35	35	35.0
Apr-16	71.21	209	5	214	1:36	36	35.2
May-16	71.21	203	1	204	1:34	34	34.8
Jun-16	71.21	185	0	185	1:31	31	34.7
Jul-16	71.21	206	1	207	1:35	35	34.7
Aug-16	71.21	199	4	203	1:34	34	35.0
Sep-16	71.21	235	1	236	1:40	40	35.2
Oct-16	71.21	174	2	176	1:30	30	34.5
Nov-16	71.21	180	4	184	1:31	31	33.8
Dec-16	71.21	161	2	163	1:27	27	33.4
Jan-17	76.21	179	2	181	1:29	29	32.7
Feb-17	76.21	157	4	161	1:25	25	32.3
Mar-17	76.21	197	7	204	1:32	32	32.0
Apr-17	76.21	190	3	193	1:30	30	31.5
May-17	76.21	190	0	190	1:30	30	31.2
Jun-17	76.21	198	2	200	1:31	31	31.2

Totals		8281	99	8380	

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

Notes: This calculation is based on estalishment from June 15 of 83 WTE minus 6.79 WTE management time
Total Births sourced from E3 reports
Ratios are rounded to nearest integer

Major Projects Report

Date: May 2017

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

Executive Summary:

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

- **IT/technology (EPR and GS1) and the adaptive impact on the organisation**
- **a joint venture to improve the responsiveness and efficiency of sterilisation services which began on 1st September**
- **the delivery of more integrated adult community services in Wiltshire, and**
- **ward reconfiguration to improve the management of emergency and planned patients**

Proposed Action:
To note the report.

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

Appendices:

Supporting Information

Introduction

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

- Electronic Patient Record
- Ward reconfiguration programme
- The GS1 Scan for Safety initiative
- Wiltshire Health and Care management of community services through a joint venture involving RUH Bath, GWH Swindon and SFT
- Joint venture to provide a sterilisation and disinfectant unit (SDU)

Summary

Salisbury NHS Foundation Trust

Project	Lead	Status	Workstreams	Summary
EPR	LA	Improving at Amber	4 x green 5x amber	Good progress on system stabilisation. Data warehouse issues remain a risk, but progressing towards plan. Working through priorities for next few months.
Ward changes	AH	Green	4 x green 1x amber	Work in MAU starts 7th August. Major impact for the organisation over the summer with reductions in bed numbers.
Wiltshire Health & Care	LA	Reducing at Amber	1 x green 2 x amber 1 x red	Established southern locality group to promote integrated working locally. Major focus on working with primary care on managing the frail elderly. Recruitment issues hampering progress on some key projects. CEO to be SFT representative on the Board.
Scan for Safety	MC (LW)	Stable at Green	4 x green	Phase 2 completed – wristbands now compliant. Moving to Phase 3 further with wards and in Theatres/Ortho
SDU	MC	Improving at Green	3 x green	New service well established – good feedback from clinical departments. Site demolition complete with planning permission received. Tenders for building work to be evaluated in early August.

Electronic Patient Record (EPR)

Salisbury NHS Foundation Trust

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

Workstream	Status	Trend	Actions
Stabilisation Plan	Amber	Improving	• Themed, more in depth support and training post go live, continues based on process reviews and feedback • Optimisation support in diabetes, to be followed in paediatrics and gynaecology • Reducing trend of issues being raised • Introducing BigHand to improve workflow for clinical and admin staff for clinical correspondence
Data migration	Amber	Improving	Issues with migrated data in the system now reducing through a combination of validation and system fixes
Data warehouse	Amber	Improving	Improved progress with data warehouse, Project plan in place, marginally behind schedule. Current focus on parallel running and validation. Increased operational reporting now in place

Electronic Patient Record (EPR)

Salisbury NHS Foundation Trust

Workstream	Status	Trend	Actions
Configuration	Green	Stable	Knowledge transfer and training to new starters underway, focus on the resolution of issues identified though process reviews and surveys
Benefits	Amber	Declining	Further analysis / review will be undertaken as part of the stabilisation activity.
Role based access	Green	Stable	Activity embedding into BAU.
Integration	Green	Stable	Integration to Somerset Cancer record now live – first successful referral 27/7. Work ongoing for bi-directional messaging with whiteboards
Phase 2 planning	Amber	Stable	Phase 2 re-planning being reviewed in light of stabilisation requirements
RTT Reporting	Green	Improving	• PTL & RTT validation exercise underway, improving trend, now below 19k. RTT return submitted on time in July. • Training, process & outcome forms changes also being implemented – still work in progress

Ward Reconfiguration Programme

Salisbury NHS Foundation Trust

To reconfigure the wards over the summer/autumn to manage patient flow through the hospital more effectively

Work stream	Status	Trend	Actions
Create an expanded acute medical unit	Green	Stable	Tenders returned and allowed for full scheme to be undertaken Begin building work in early August for November completion and commissioned early/mid December
Consolidate MSK beds into burns / orthopaedic template	Green	Stable	Change complete
Open new ophthalmology facility	Green	Stable	Unit layout complete and signed off. Planning permission approved. Units to arrive on site in mid August. ££
Convert current eyes department to medical ward area	Amber	Declining	Planning of new cancer facility completing, clinical sign off of plans achieved. Next step is to develop full specification for tender purposes.
Short stay surgical ward in current Braemore ward	Green	Stable	Planning underway of types of patients who will be eligible for management through short stay ward. Due to open in late mid December

A joint venture has been established to enable SFT, together with RUH Bath and GWH Swindon Trusts, to manage adult community services to aid the integration of services across acute and community settings. WH&C underwent their CQC inspection in June – the outcome is due in September / October

Workstream	Status	Trend	Actions
Early Supported Discharge – Stroke	Red	Stable	Issues with recruitment remain – OT and rehabilitation support workers in place, failed to recruit to physio. SFT PMO supporting the project. Meeting in mid August to take forward staff rotation
Higher Intensity Support	Amber	Stable	• standardisation of admission avoidance processes • review of benefits to inform further development
Home First	Amber	Reducing	Additional rehabilitation support workers employed facilitating discharge. 85% recruited now and looking to go live in mid August. A project manager to be appointed to take this forward
Workforce Development	Green	Stable	Project being established to allow for rotational posts across SFT and WH&C to aid with recruitment and retention across both organisations.

Scan for Safety

Salisbury NHS Foundation Trust

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

Work stream	Status	Trend	Actions
Global location numbering	Green	Stable	Physical locations at 70% completed First Use case for onsite deliveries and internal distribution.
Catalogue management	Green	Stable	Focus on Orthopaedic process ensuring increased level of control with regards to new products and loan and consignment sets
Patient identification	Green	Improving	New thermal printers located to enable improved scanning. Wristband signed off as GS1 compliant. Working with POET team to increase scanning
Purchase to pay/Inventory	Green	Stable	Ortho and Cardiology live Planning next areas for point of use scanning Late September go live

SDU Joint Venture

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

Workstream	Status	Trend	Actions
Commercial	Green	Stable	JV agreement , leases and service contract signed mid August '16
Operational	Green	Stable	Performance continues to exceed expectation KPI's - Fast Track volumes should not exceed 9%: March = <2% KPI's – Failed trays (SSF1) target <0.25%, May = 0.24%. Turnaround time not achieved (SSF2) target < 5%, May = **6.32%.** No procedures cancelled
Facility design	Green	Stable	Demolition work now complete. Planning permission received. Detailed design work progressing well and tender submissions to be evaluated in early August

Salisbury NHS Foundation Trust Board – 7 August 2017

SFT 3916

Title: Equality, Diversity & Inclusion Annual Report 2017

Report from:

Executive Sponsor – Paul Hargreaves Director of People and Organisational Development

Head of EDI (Equality Diversity and Inclusion) - Pamela Permalloo-Bass

Executive Summary:

This report provides an annual Equality, Diversity and Inclusion update to the board. The Trust has a statutory obligation under the Equality Act 2010 to publish a range of monitoring information relating to workforce, patients and local community. The data and narrative includes the WRES (Workforce Race Equality Standard), EDS2 (Equality Delivery System v2) and PSED (Public Sector Equality Duties).
The EDI agenda is inspected under the CQC Well Led domain, incorporated within our commissioning contracts and it is a legal requirement under The Equality Act 2010. The Trust can use this report as one of the ways in which we fulfil our legal obligations under the PSED.

WRES
"*Almost 1 in 5 of staff working in the NHS are from BAME (Black, Asian and Minority Ethnic) background, yet we know that the treatment and opportunities that they get in the workplace often do not correspond with the values that the NHS represents."*
The WRES was mandated across the NHS in April 2015 and assists organisations to meet the 5 Year Forward, Developing People & Improving Care, as well as the values set out in the NHS Constitution. The WRES was also part of the Trusts CQC inspections under the Well Led domain in April 2016.

Proposed Discussion & Action:
GENDER PAY – Gender pay difference between all staff including non – AfC.
Female average salary £28k, male average salary 37K.
Proposed Action: Set up committee to recommend and assess glass ceiling inequalities, include women and BAME staff. We will design adverts, T&C's to ensure diverse workforce across the organisation.

WRES – Cara Charles- Barks CEO as the Executive Lead on the WRES.
Proposed Action: We will track as an overall percentage of the staff survey completions, a 5% reduction in BAME harassment & discrimination by 2019.
Our vision is to ensure that we have 10% BAME staff at senior levels of the organisation.

LGBT Agenda – In preparation for the SOM (Sexual Orientation standard) that will be mandated across the NHS in 2019, we will raise awareness, support & promote LGBT allies and RainbowSHED, by LGBT allies wearing RainbowSHED Lanyards, participating with local LGBT Pride events and relaunching the RainbowSHED committee. This will enable LGBT staff & patients to have an outstanding experience at the hospital.

Supporting Information

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:
Appendix 1 – Equality Objectives 2016 onwards
Appendix 2 - Workforce, Gender Pay Gap & Grievances Data 2017/18
Appendix 3– NHS Job Equality Data (applied, shortlisted & appointed) 2017/18
Appendix 4 – Patient Equality Data Jan 2016 – Dec 2016
Appendix 5 – WRES Action Plan 2017 onwards
Appendix 6 – WRES Data 2017 (word format)

Equality, Diversity & Inclusion Annual Report 2017

EDS2 Progress August to July 2017

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

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

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

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

The EDS2 has been integrated into the strategic business of the Trust through both the Quality Account and Annual Strategic Plan and will be refreshed in January 2018 in line with the new version of the EDS2.

WRES (Workforce Race Equality Standard) – Shining a light on the experience of BAME staff (Black, Asian, Minority Ethnic)- Appendix 6

The evidence of the link between the treatment of staff and patient care is well evidenced for BAME staff in the NHS; to this end the NHS has launched the WRES (Workforce Race Equality Standard). 87% of our staff believes that the Trust provides equal opportunities for career progression or promotion. 9% of the staff completing the survey identified they have experienced discrimination at work in the last 12 months; the national average for Acute Trusts is 11%.We have collated data from April 2016 to March 2017, our annual WRES action Plan and WRES data has been published on our hospital website. Nationally we fare well with our data results, however the national picture is not a positive one for BAME staff. http://www.salisbury.nhs.uk/AboutUs/EqualityAndDiversity/Pages/EqualityDeliverySystem.aspx

Our Workforce

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

Occupations by Ethnicity – At the Trust 10% of the workforce describe themselves as from the BAME communities. The Office for the National Statistics estimates that 4.7% of Wiltshire population identify as BAME. Of the 10% BAME staff working in the Trust 39% work in roles from band 4 and below, 38% in band 5 to 6 and 23% in band 7 and above. This data includes clinical and non-clinical staff. Further work is required to reflect BAME diversity at senior management levels, this has been reflected in our WRES action Plan 2017 onwards (appendix 5)

Age Range of Workforce - The chart shows the proportionality of staff ages across the workforce. Of the staff aged over 60 who work at the Trust, 14% work in band 4 and below positions and 57% aged 40-59 work in band 7 and above positions.

Gender Pay Gap all staff including non AfC - The average mean salary for women is £27,910 and the average mean salary for men is £36,784 (appendix 2). The total average salary for both men and women is £30,070. This is not unusual as this depicts a trend that is reflected across most of the NHS whereby a larger proportion of senior consultant roles are held by men.

Gender Pay Gap all staff AfC only – The average mean salary for women is £25394.00 and the average mean salary for men is 26233.00 (appendix 2). Of the band 7 and above 7.9% of women occupy these AfC roles compared to 6.5% occupied by men.

All staff at the Trust have the same opportunities to work flexibly, with on site child care arrangements, home working options, carers leave and flexible hours which contribute to the opportunities for staff with childcare and carers responsibilities.

We will be providing the Trust Board with a detailed report on this data before the end of March 2018 as part of our statutory requirements of the Gender Pay Gap Annual Report.

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

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

In preparation for the SOM (Sexual Orientation standard) that will be mandated across the NHS in 2019, we will raise awareness, support & promote LGBT allies and RainbowSHED; by LGBT allies wearing RainbowSHED Lanyards, participating with local LGBT Pride events and relaunching the RainbowSHED committee. This will enable LGBT staff & patients to have an outstanding experience at the hospital.

NHS Jobs – applications, shortlisted and appointed - The Trust has analysed NHS Jobs data from March 2016 to April 2017 which illustrates applications, shortlisted and appointed under ethnic background, gender, disability, age, region and sexual orientation, (refer to Appendix 3). The report continues to identify disproportionality with White applications to appointments in comparison with BME applications to appointments; this theme also applies to female applications to appointments in comparison to male applications to appointments.

Staff Training on Mandatory Equality, Diversity & Inclusion - To date approximately 90% of our workforce have undertaken mandatory equality, diversity & inclusion training, the national average for acute Trusts being 63% and the best acute trust score at 85%.

Workforce Data - Further workforce data is available under appendix 3, which also includes equality data on grievances, dismissals and complaints about discrimination.

We know from our data that In 2017/18, 92% of promoted staff were white, 6% were BAME. This compares to a ratio of 79% white staff to 10% BAME staff in the workforce as a whole.

Occupations by Gender (Part & Full Time) - Of the Trusts female workforce, 39% are full time and 61% are part time. In total 68% of male staff are full time and 32% are working part time. The gender balance varies considerably by occupational group, for example the Trust has more females than males working in Nursing and Midwifery, more males than females working in Estates and Ancillary and a 50/50 split of males and females in Medical and Dental.

Our Patients (Different Protected Characteristics)

Feedback from the National Inpatient Survey 2016 showed that when patients were asked if they felt they were treated with respect and dignity, 88% said "always" and 10% said "sometimes". Patients were asked to score their overall care on a sliding scale between 0 (I had a very poor experience) and 10 (I had a very good experience). 27% rated their overall care as 10 with a further 24% rating it as 9.

Appendix 4 describes the protected characteristics of patients attending outpatients and inpatients from January 2016 to December 2016. The protected characteristic data includes, age, ethnicity, disability, religion, gender, transgender, pregnancy and maternity attendances. The Trust currently does not collate all sexual orientation data from patients. The Trust does collate data on Transgender, in total 10 people identified under this category.

In total there were 42678 female patients and 41233 male patients. 83% patients described themselves as White. 3% patients described themselves from a BAME (Black, Asian, Minority & Ethnic) community, whilst 13% of patients did not specify or not stated.

The hospital has a varied distribution of age ranges. 22% of our patients are aged 19 or below, 50% of our patients are within the age category of 20 to 60, and 31% of our patients are aged 60 and above.

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

In 2016-17 the Customer Care Team received 1666 compliments for many wards and departments. There were no formal complaints recorded under discrimination.

Key Activities 2016/17

Salisbury NHS Foundation Trust has been chosen to be one of the Diversity and Inclusion Partners for 2017/18 for NHS Employers Programme, extract NHS Employers;" *The level of competition this year was higher than ever before – with our largest ever number of applications for the programme. In addition, the quality of applications was also much higher. You and your team should therefore be very proud to have been successfully chosen for the programme - and we congratulate you on that. We hope that your involvement in this programme will help you meet some of the challenges ahead and look forward to working with you over the next year to support you to embed and integrate diversity and inclusion into the culture and structures of your organisation."*

As a result of this partnership, the Trust will increase its profile at network events, conferences and through the NHS Employers website and communications. We will gain advice, guidance and assistance from NHS Employers in meeting the minimum requirements of the Equality Act 2010. We will be offered access to free access to training, development, coaching and mentoring for the partner lead person on the use of the tools and techniques within the programme. We will have the opportunities to discuss, network and test out new concepts and influence national policy direction.

The Trusts Disability Champion and EDI assistant has been leading on activities to promote emotional wellbeing, called the Colouring Club and Unwind & Wander walks, linking staff wellbeing to positive mental health for our workforce. Both initiatives are supported by ArtCare, Shapeup@salisbury & Chaplaincy.

As part of LGBT History Month, The LGBT flag was raised on the Green at the Trust by our CEO, Cara Charles-Barks. Lisa Brown our LGBT Champion was a finalist for Inclusive Leader for Thames Valley Leadership Awards 2017.

The EDI team were approached by our European workforce to offer a support network in light of Brexit. We have worked closely with the NHS Employers 'LoveEUStaff' campaign and are now mirroring the national approach. We have appointed to 2 EU Equality Champions who co-chair the LoveEUStaffNetwork. Through the network we have shown the diversity in our Europeans staff who work across all directorates in our hospital.

The Head of EDI was on the judging panel for Thames Valley Leadership awards 2017 and on the design committee for the forthcoming Compassionate Leadership Programme by the Leadership Academy.

Equality Analysis (EA)

The Trust continues to use the Equality Analysis methodology for all policies, new and updated. Formal and informal discussions occur to assess equality analysis for protected groups. Further work is required to incorporate EA's into organisational and service changes.

Equality Compliments and Complaints from Patients

In 2016-17 the Customer Care Team received 1666 compliments for many wards and departments. There were no formal complaints recorded under discrimination.

Authors:

Executive Sponsor – Paul Hargreaves Director of People and Organisational Development

Head of Equality, Diversity & Inclusion – Pamela Permalloo-Bass

Trust vision: An outstanding experience for every patient

Salisbury NHS Foundation Trust

Equality Objectives 2016 onwards:

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

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

Salisbury NHS Foundation Trust

"Better health outcomes for all"

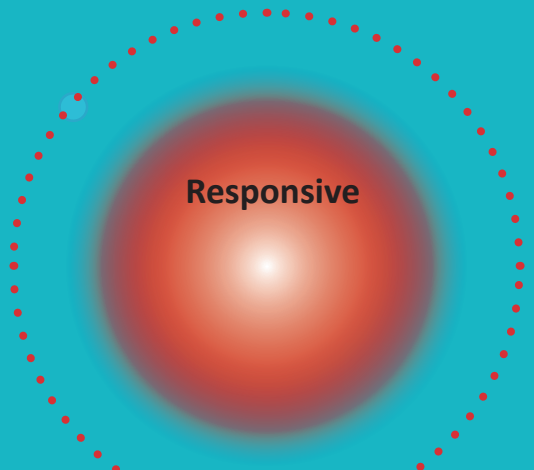
As a result of the alcohol misuse review we will understand the needs of our community. This will help us deliver a targeted approach to specific equality groups

Care

Choice

"Improved patient access and experience"

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



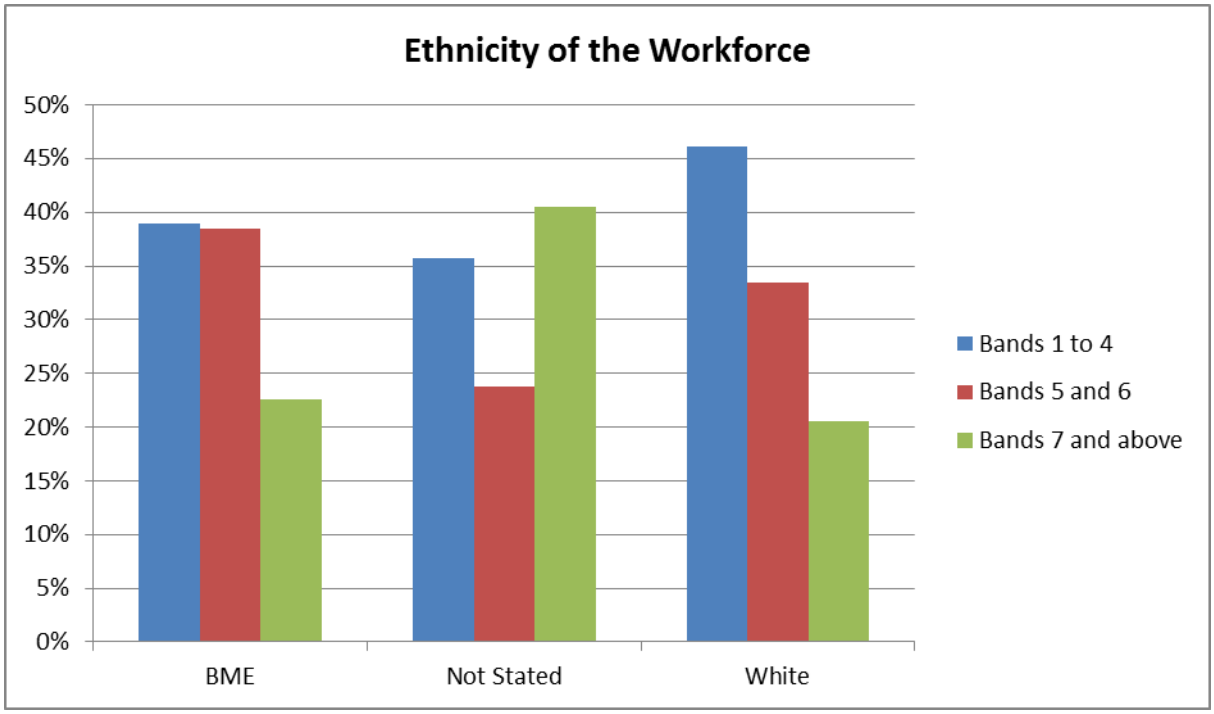
"Empowered, engaged and well supported staff"

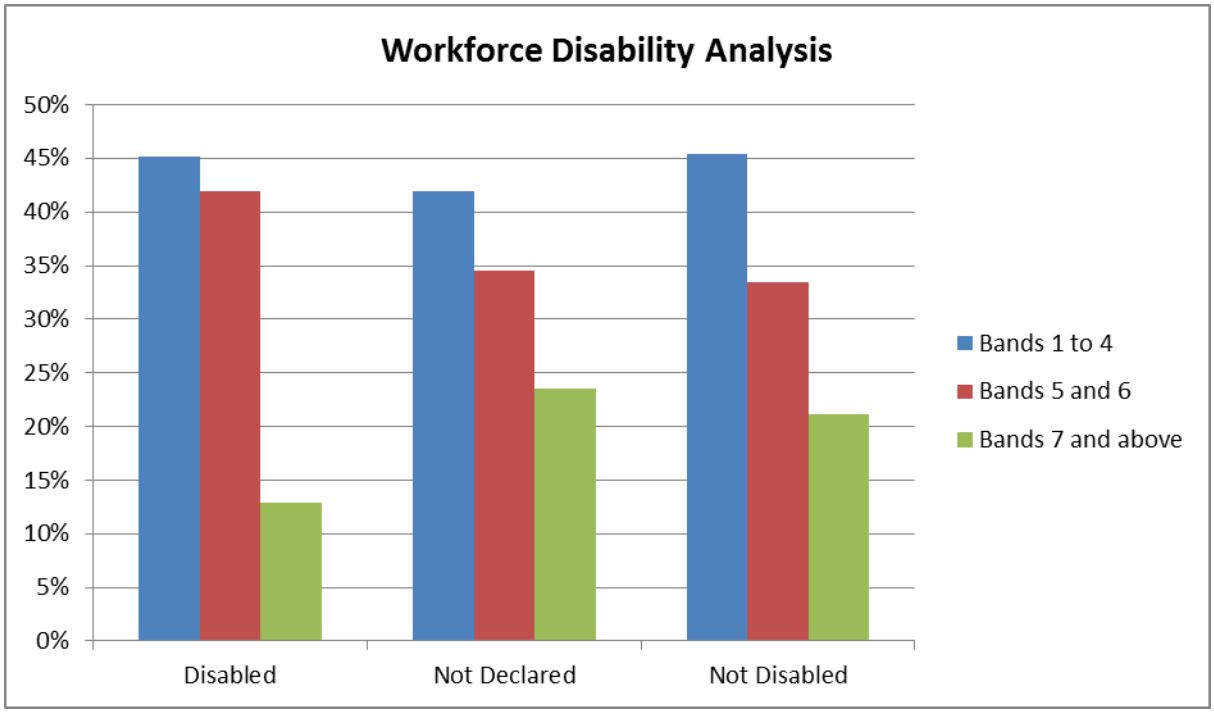
We will assess data at the end of each quarter to determine whether different equality groups have varying experiences

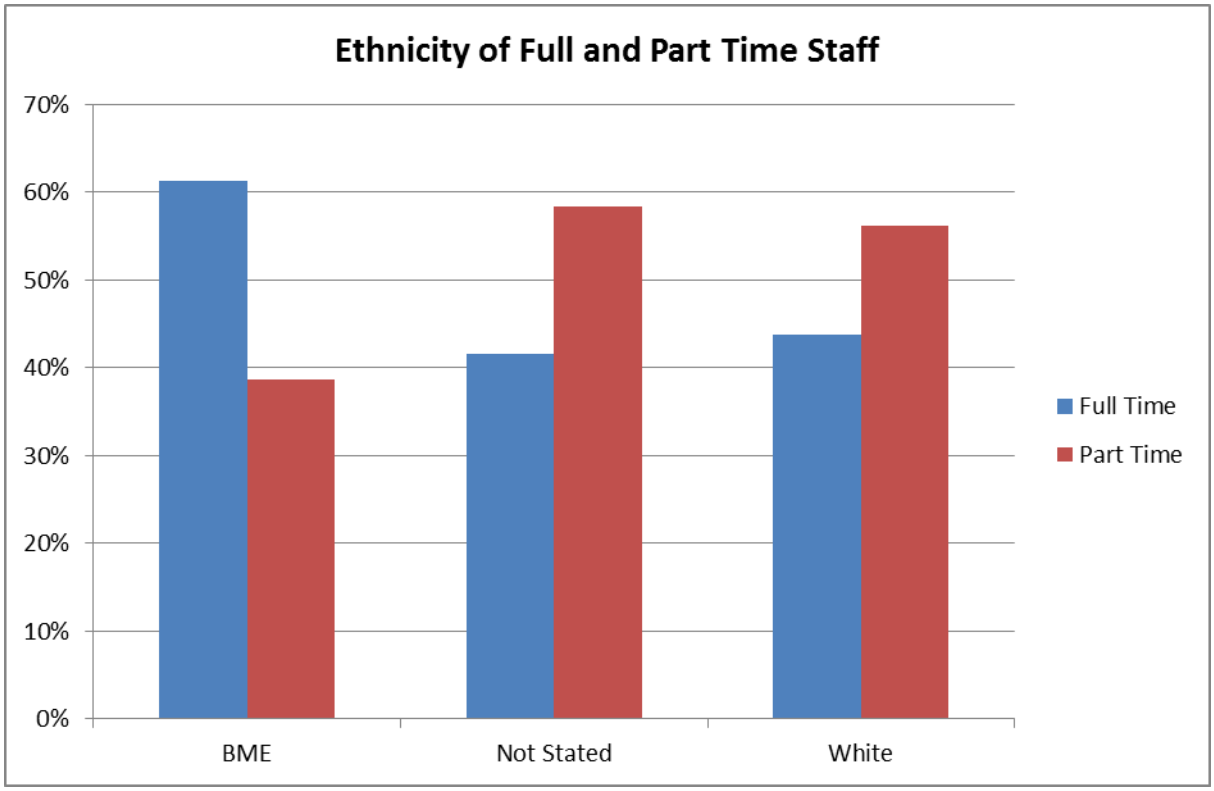
Staff

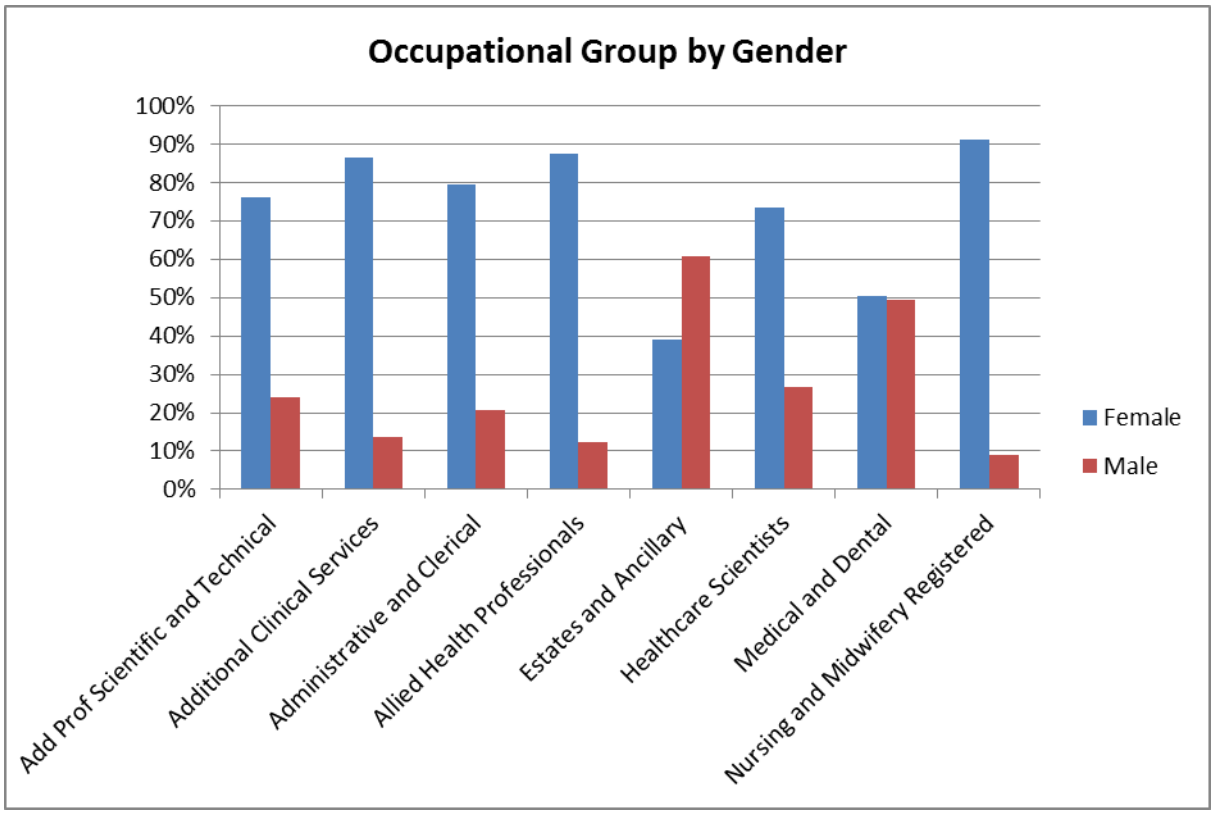
"Inclusive leadership at all levels"

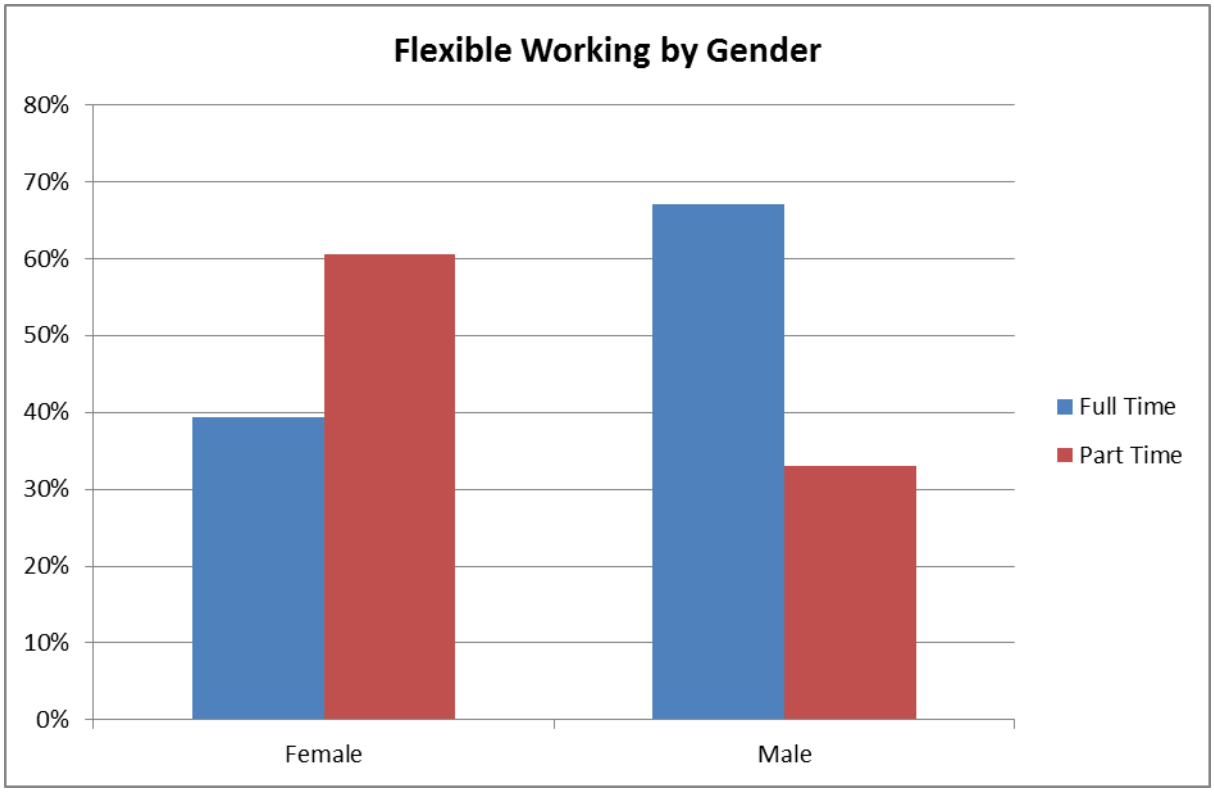
As part of our commitment to ensure that we are representative at all levels of our organisation we support women, BME, disabled and LGBT staff to support them to develop leadership skills, equipping them to apply for leadership roles

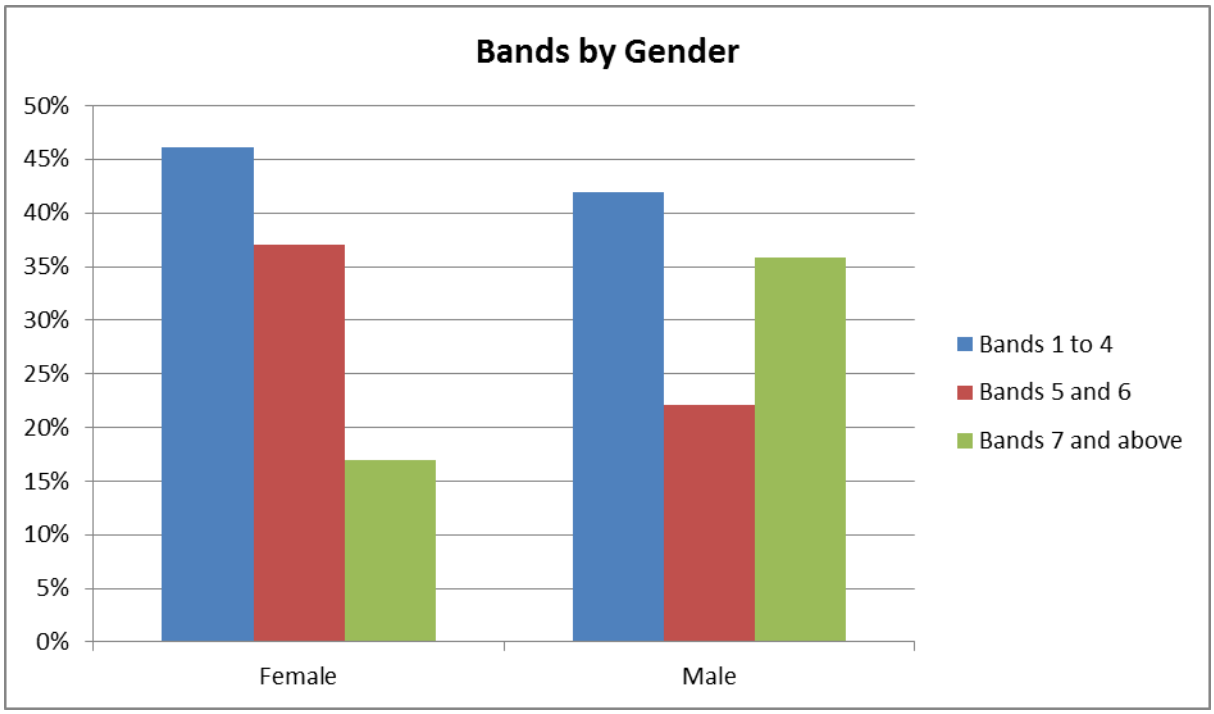

Ethnicity of the Workforce
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
BME
Not Stated
White
Bands 1 to 4
Bands 5 and 6
Bands 7 and above

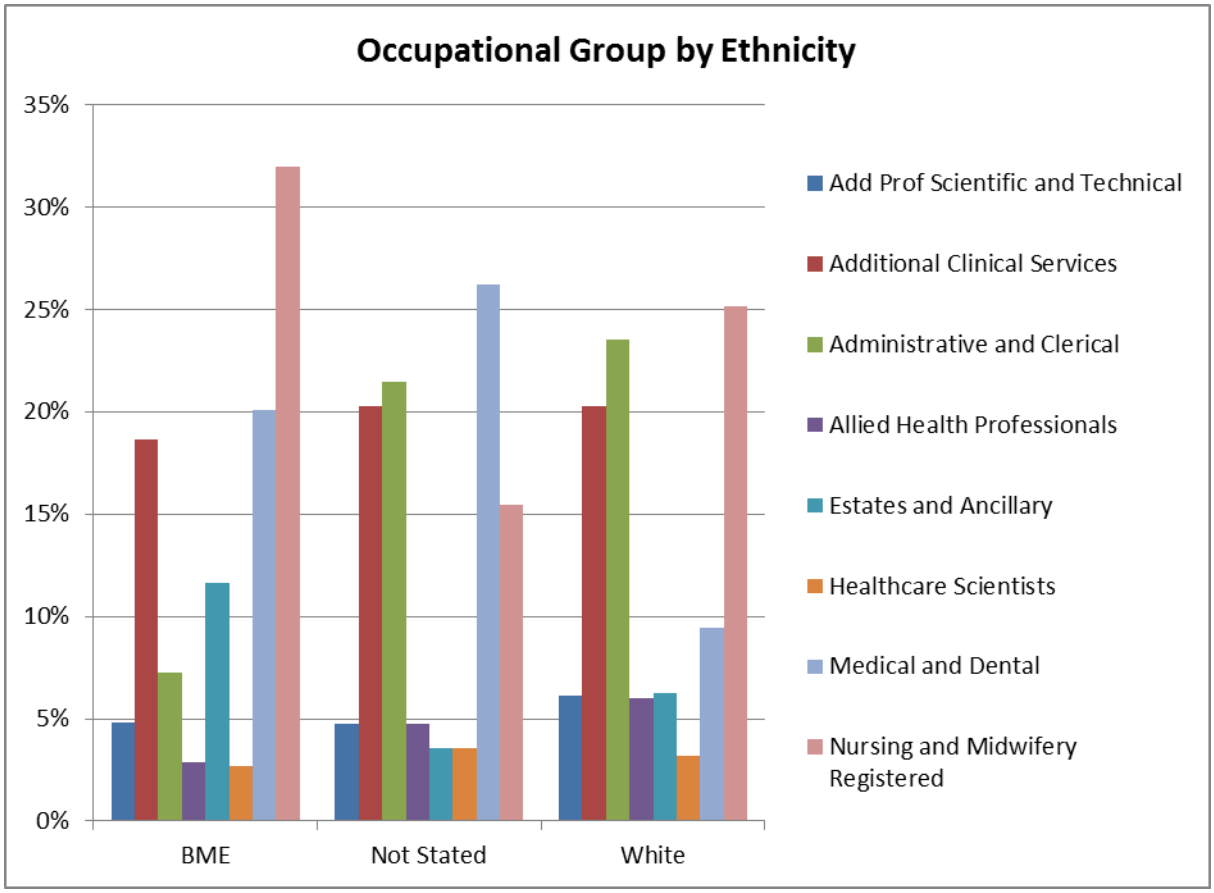

Workforce Disability Analysis
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Disabled
Not Declared
Not Disabled
Bands 1 to 4
Bands 5 and 6
Bands 7 and above

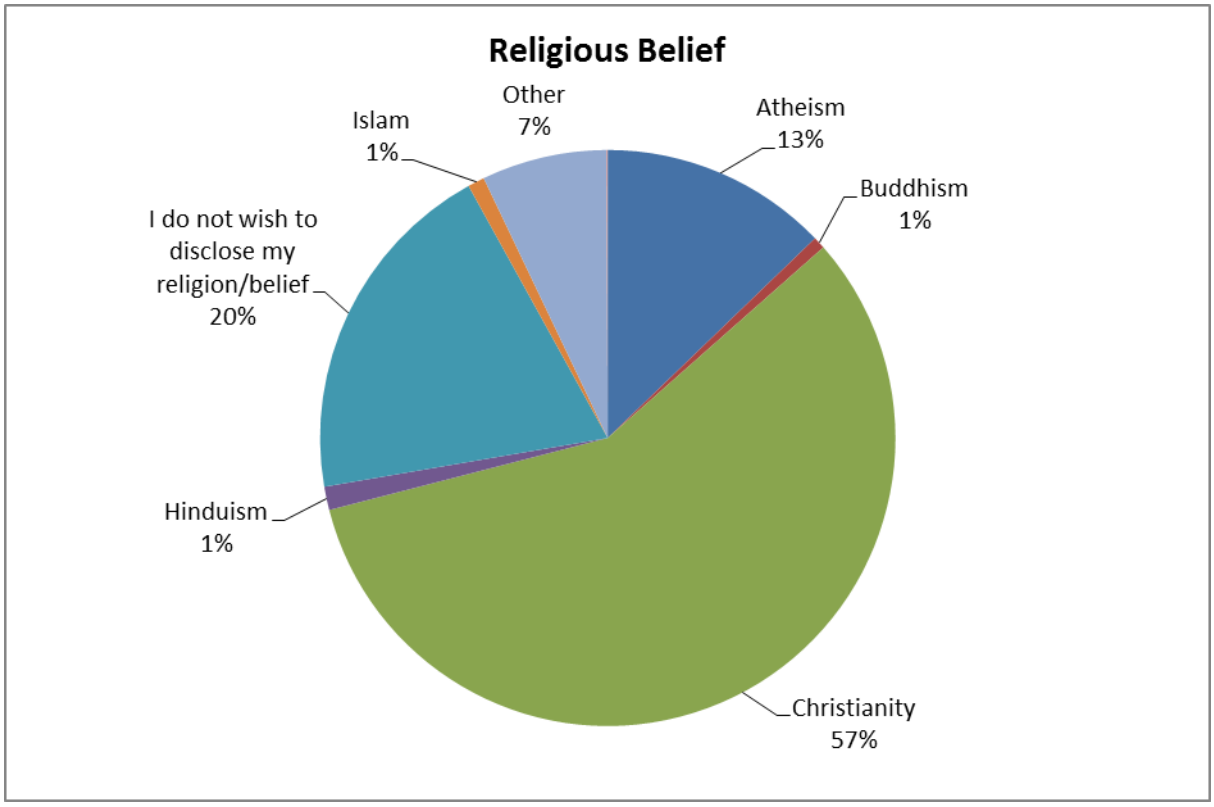

Ethnicity of Full and Part Time Staff
70%
60%
50%
40%
30%
20%
10%
0%
BME
Not Stated
White
Full Time
Part Time

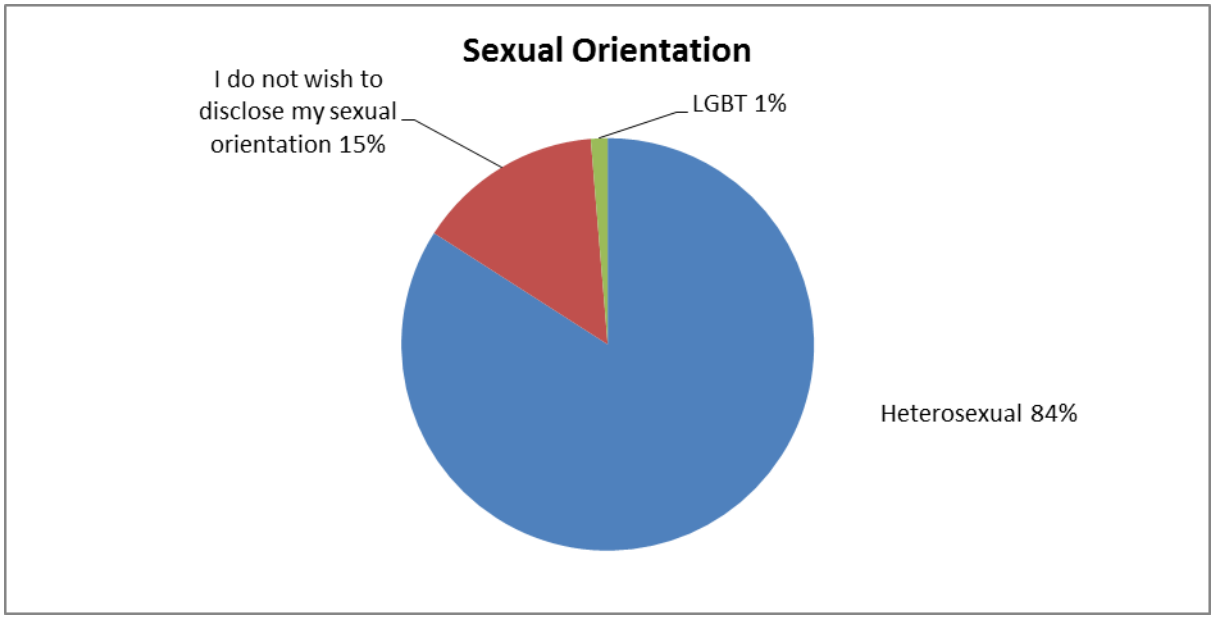

Occupational Group by Gender
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Add Prof Scientific and Technical
Additional Clinical Services
Administrative and Clerical
Allied Health Professionals
Estates and Ancillary
Healthcare Scientists
Medical and Dental
Nursing and Midwifery Registered
Female
Male

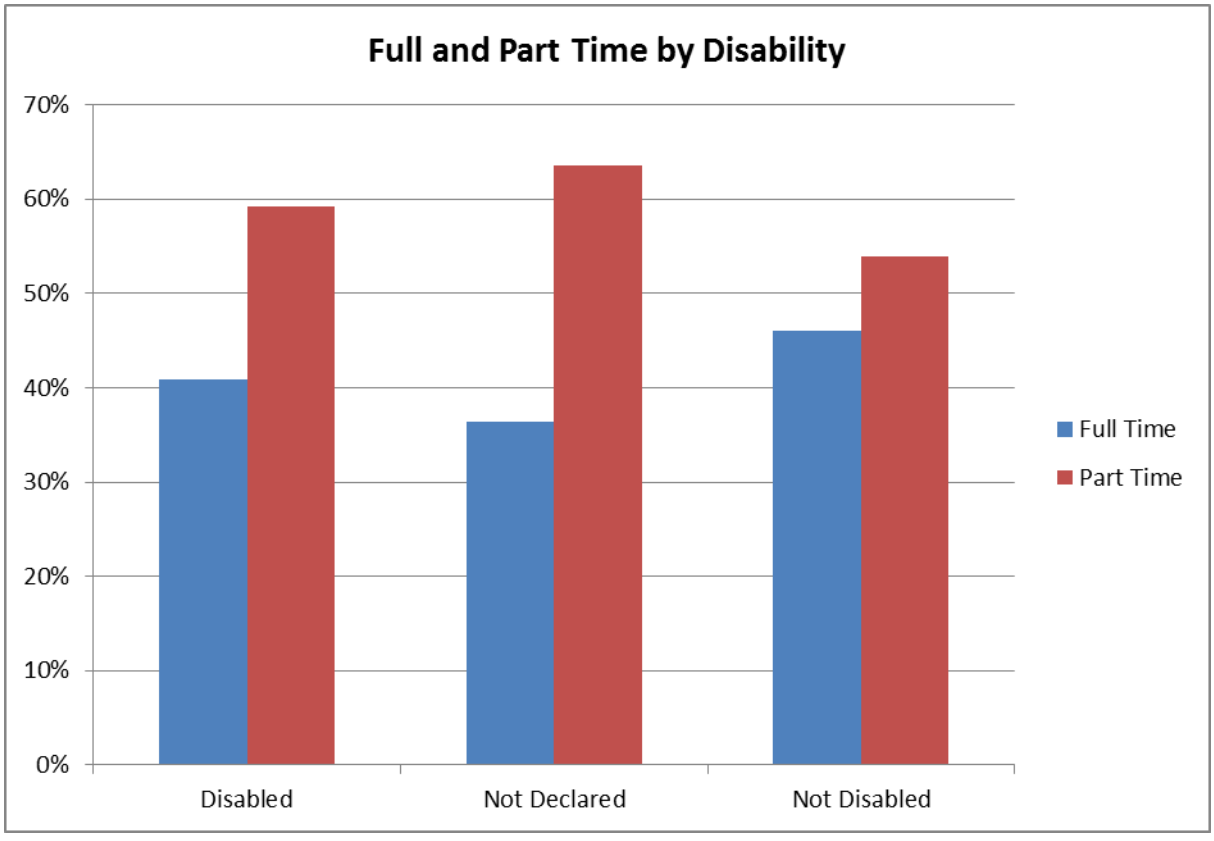

Flexible Working by Gender
80%
70%
60%
50%
40%
30%
20%
10%
0%
Female
Male
Full Time
Part Time

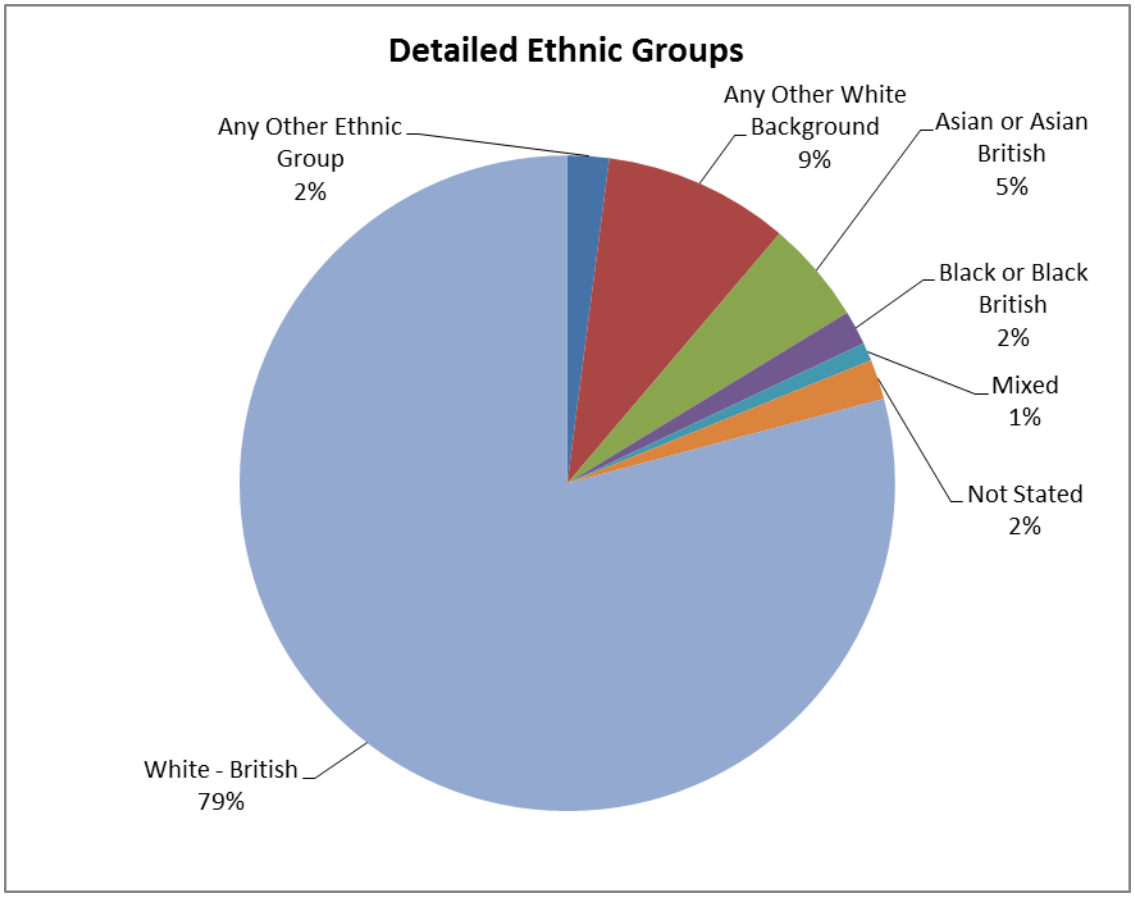

Bands by Gender
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Female
Male
Bands 1 to 4
Bands 5 and 6
Bands 7 and above

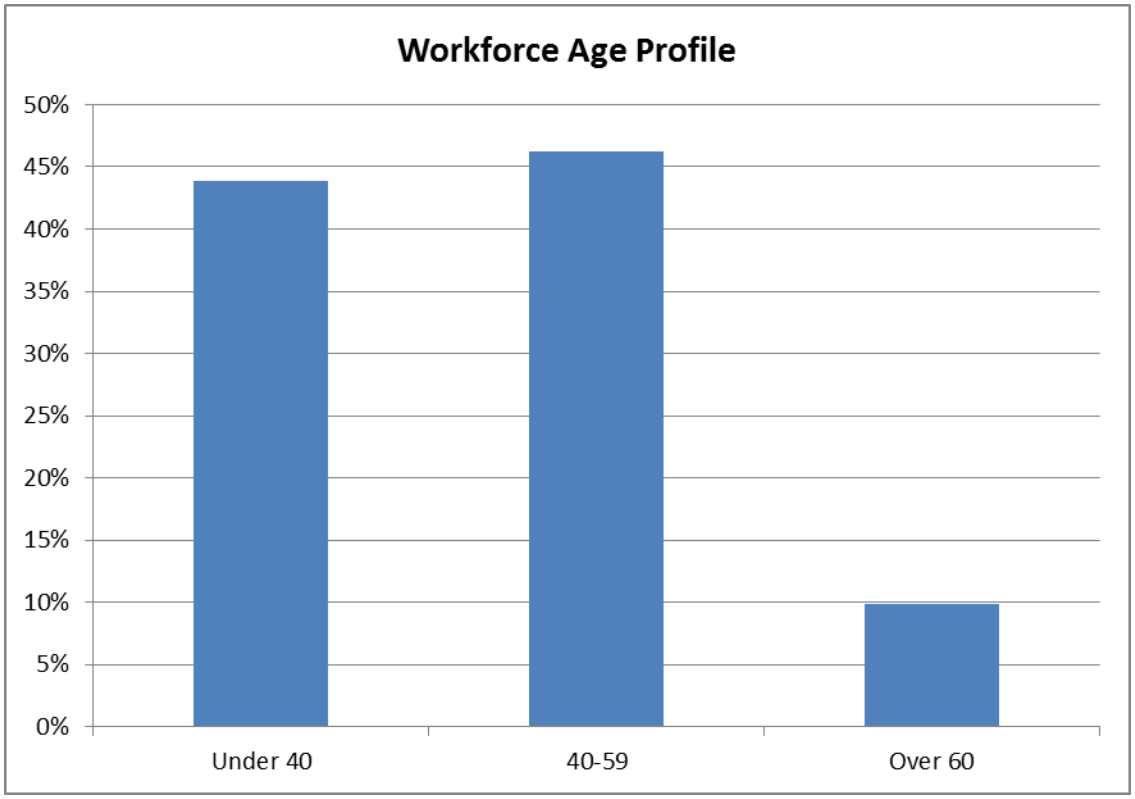

Occupational Group by Ethnicity
35%
30%
25%
20%
15%
10%
5%
0%
BME
Not Stated
White
Add Prof Scientific and Technical
Additional Clinical Services
Administrative and Clerical
Allied Health Professionals
Estates and Ancillary
Healthcare Scientists
Medical and Dental
Nursing and Midwifery Registered

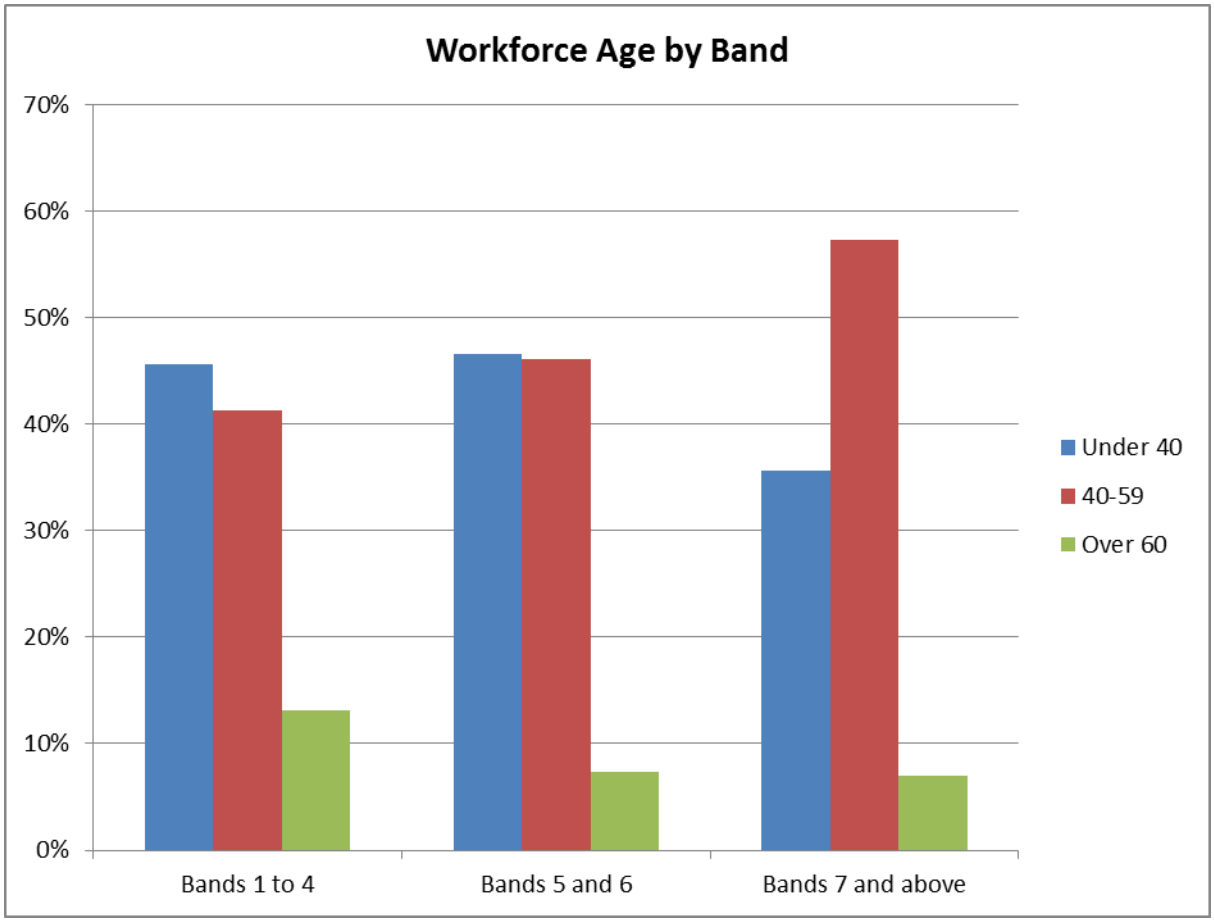

Religious Belief
Other 7%
Islam 1%
Atheism 13%
Buddhism 1%
I do not wish to disclose my religion/belief 20%
Hinduism 1%
Christianity 57%

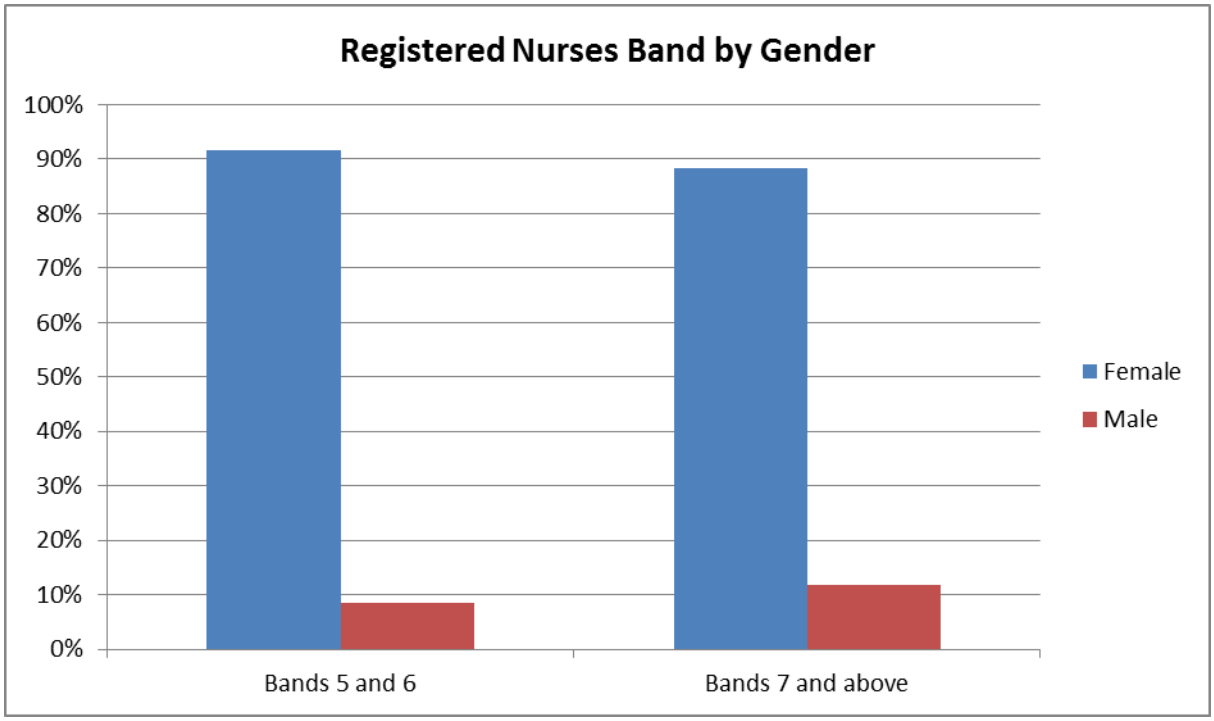

Sexual Orientation
I do not wish to disclose my sexual orientation 15%
LGBT 1%
Heterosexual 84%

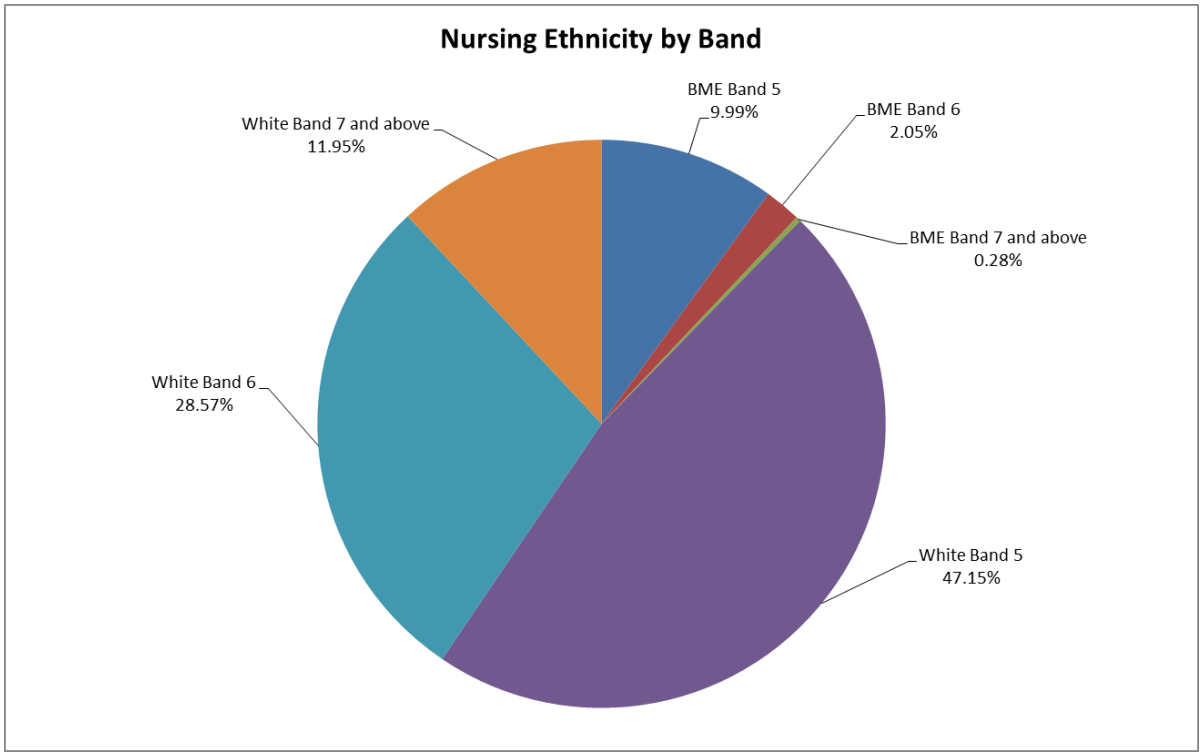

Full and Part Time by Disability
70%
60%
50%
40%
30%
20%
10%
0%
Disabled
Not Declared
Not Disabled
Full Time
Part Time


Detailed Ethnic Groups
Any Other Ethnic Group 2%
Any Other White Background 9%
Asian or Asian British 5%
Black or Black British 2%
Mixed 1%
Not Stated 2%
White - British 79%


Workforce Age Profile
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Under 40
40-59
Over 60


Workforce Age by Band
70%
60%
50%
40%
30%
20%
10%
0%
Bands 1 to 4
Bands 5 and 6
Bands 7 and above
Under 40
40-59
Over 60


Registered Nurses Band by Gender
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Bands 5 and 6
Bands 7 and above
Female
Male



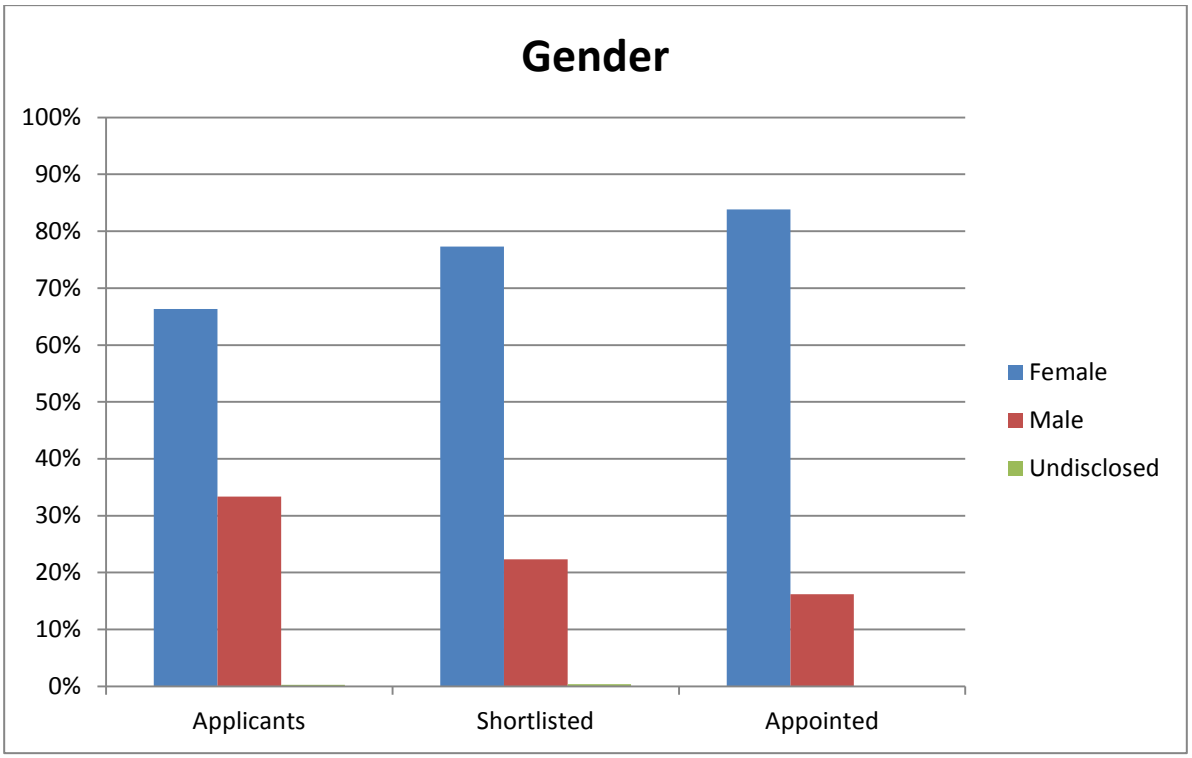
Grievance and Dismissal Information
In 2016/17 there were a total of 21 grievance, disciplinary and capability cases. 10 of the staff involved were male, 11 were female.
As per EHRC guidance, analysis by any other protected characteristic is not possible due to the small number of staff involved.
2 staff were dismissed for misconduct or capability reasons. It is not possible to provide further analysis due to the small numbers involved.

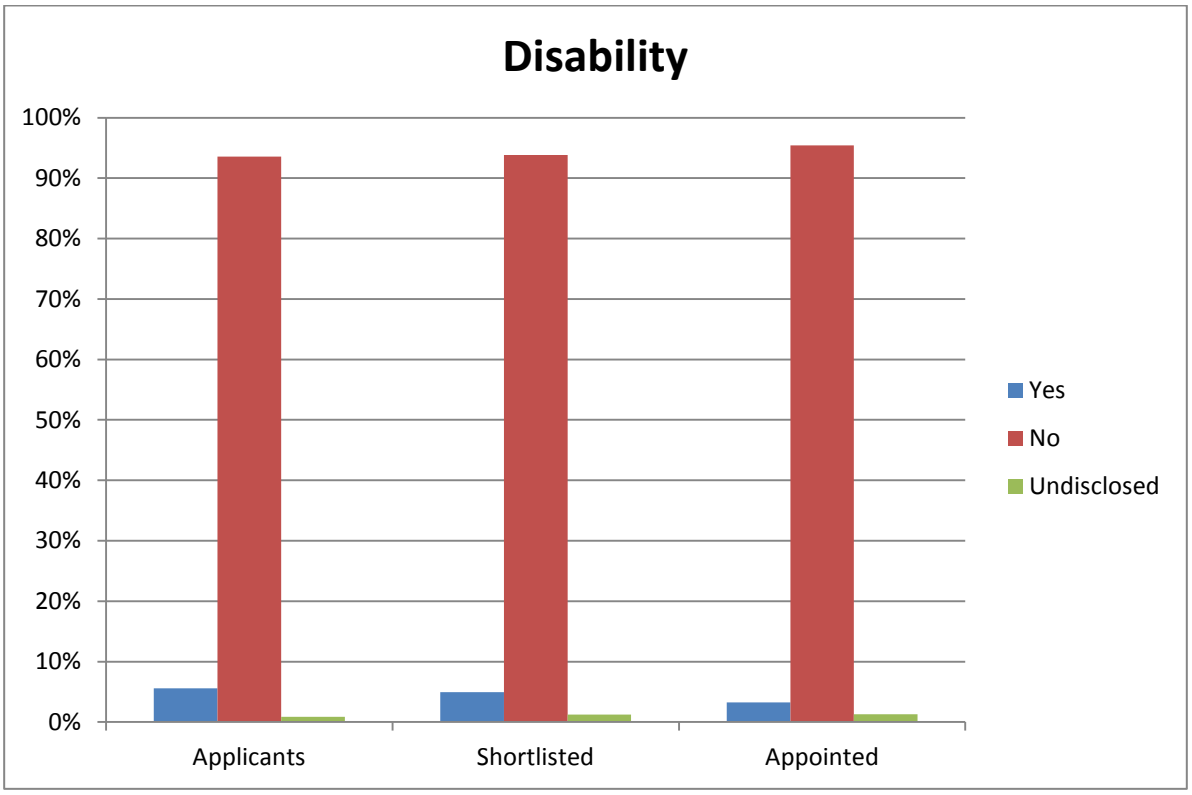
Complaints About Discrimination and Other Prohibited Conduct
In 2016/17 there was 1 formal allegation against the Trust of discrimination on the grounds of race, disability, age and religion or belief.

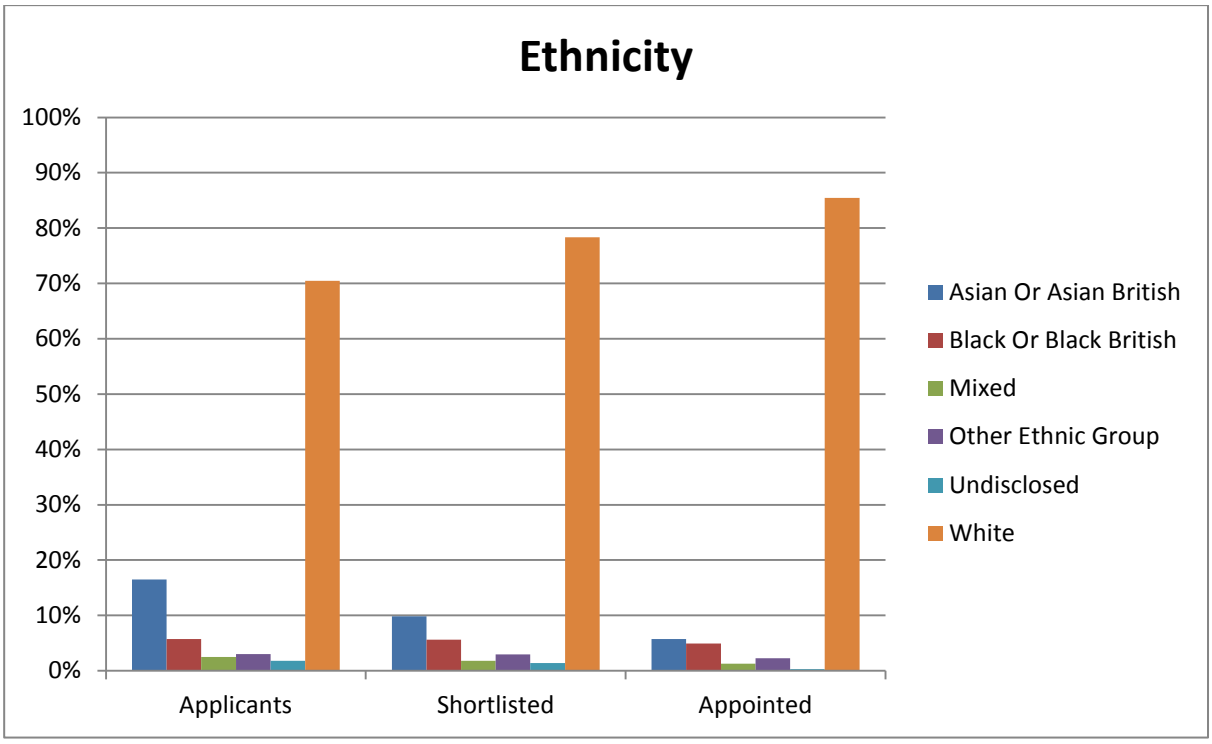
Gender Pay Gap

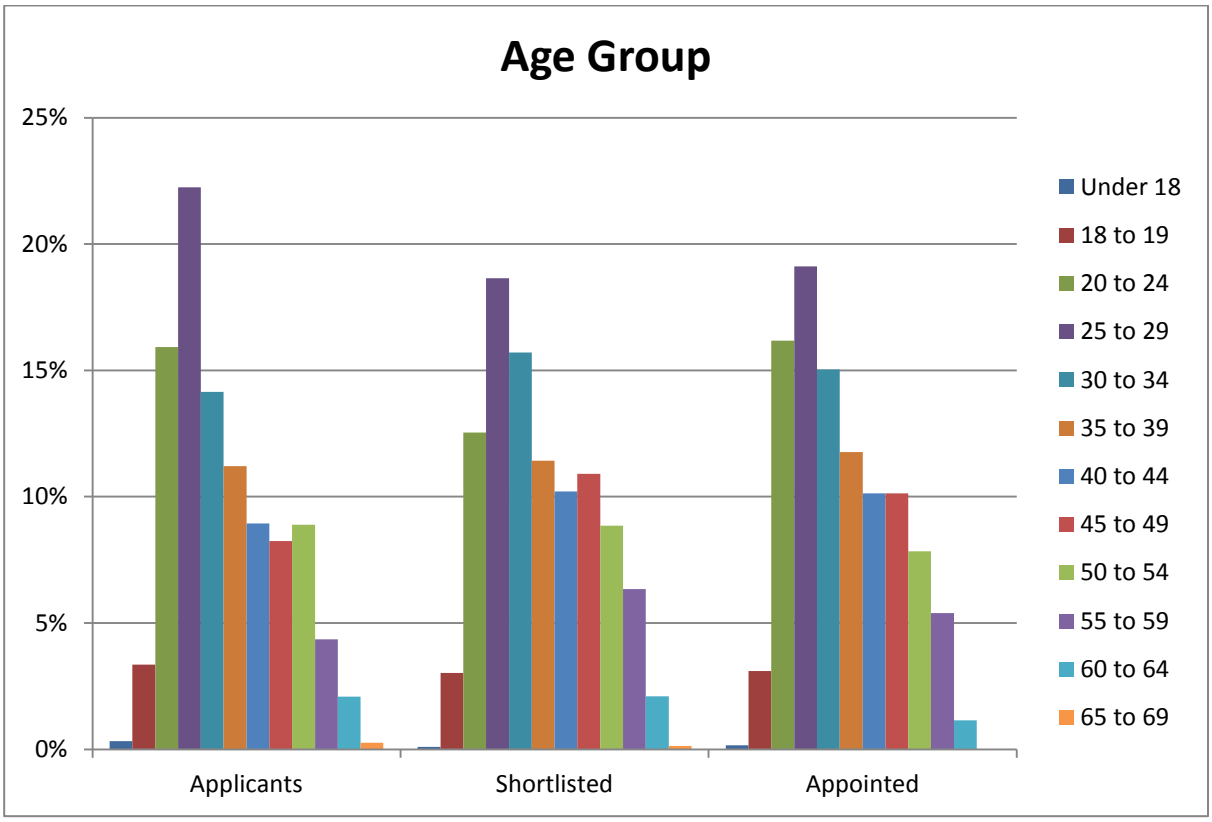
	Total Salary	FTE	Average Pay
Female	£60,952,258	2183.90	£27,909.81
Male	£25,854,647	702.89	£36,783.58
Total	**£86,806,905**	**2886.79**	**£30,070.42**

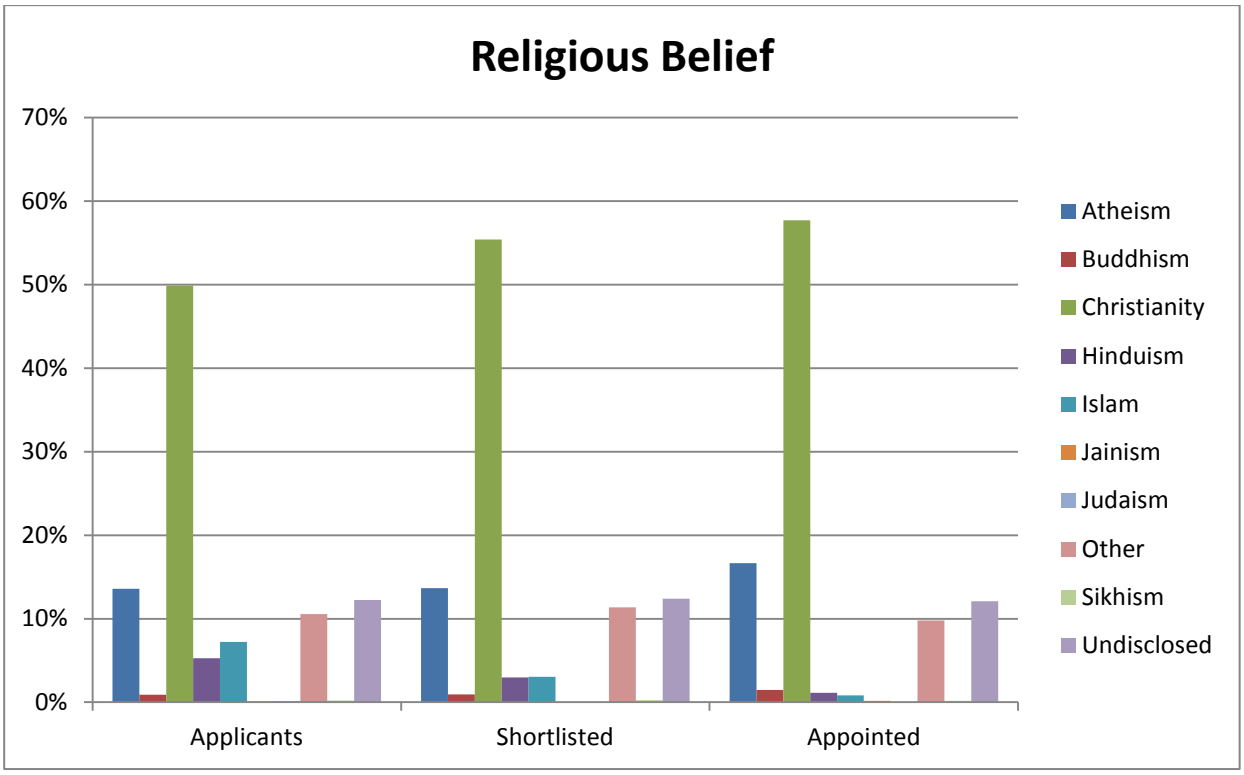
AfC Band	Female	Male
Band 1	3.2%	12.2%
Band 2	27.5%	27.1%
Band 3	12.9%	10.1%
Band 4	6.1%	7.5%
Band 5	23.8%	17.4%
Band 6	16.1%	12.6%
Band 7	7.3%	6.5%
Band 8	3.0%	6.5%
	100.0%	100.0%

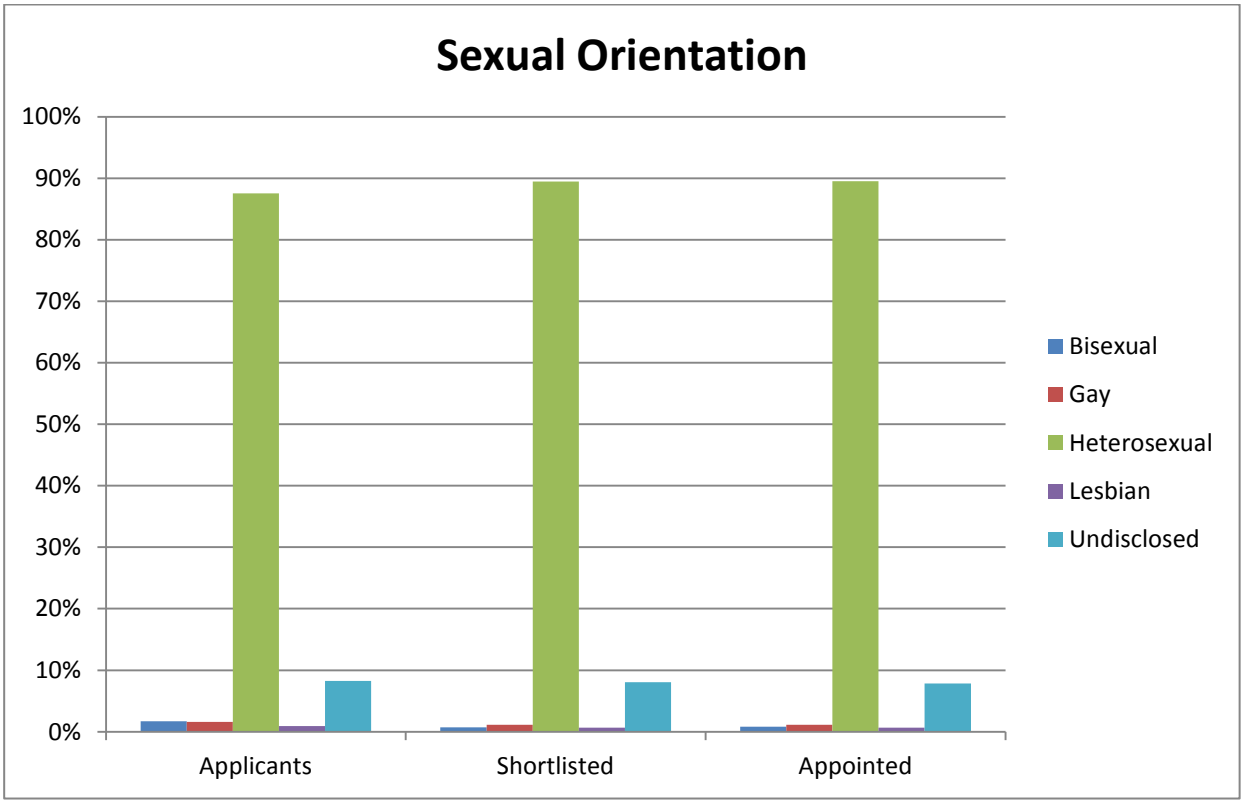

Gender
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Applicants
Shortlisted
Appointed
Female
Male
Undisclosed


Disability
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Applicants
Shortlisted
Appointed
Yes
No
Undisclosed


Ethnicity
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Applicants
Shortlisted
Appointed
Asian Or Asian British
Black Or Black British
Mixed
Other Ethnic Group
Undisclosed
White


Age Group
25%
20%
15%
10%
5%
0%
Applicants
Shortlisted
Appointed
Under 18
18 to 19
20 to 24
25 to 29
30 to 34
35 to 39
40 to 44
45 to 49
50 to 54
55 to 59
60 to 64
65 to 69

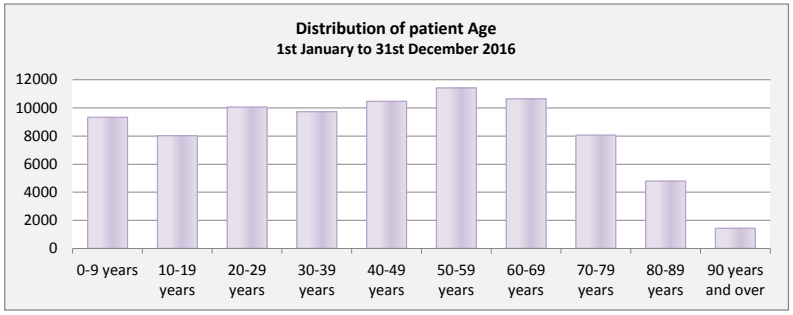

Religious Belief
70%
60%
50%
40%
30%
20%
10%
0%
Applicants
Shortlisted
Appointed
Atheism
Buddhism
Christianity
Hinduism
Islam
Jainism
Judaism
Other
Sikhism
Undisclosed


Sexual Orientation
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Applicants
Shortlisted
Appointed
Bisexual
Gay
Heterosexual
Lesbian
Undisclosed

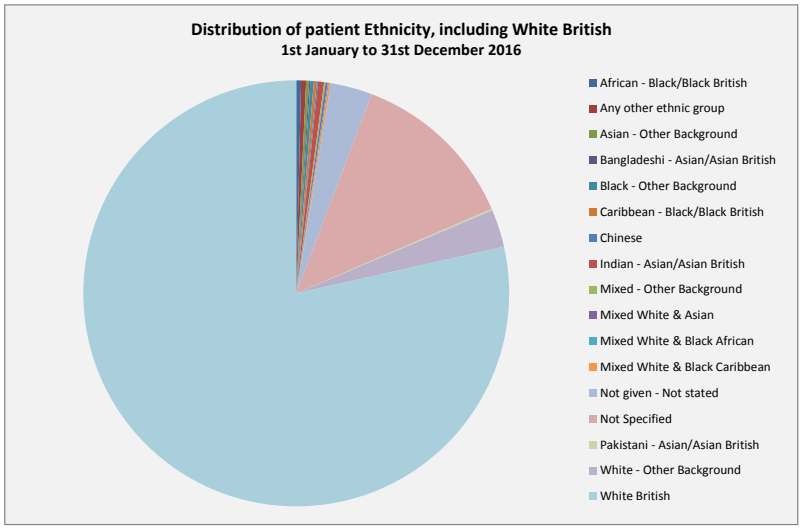
Equality & Diversity Data

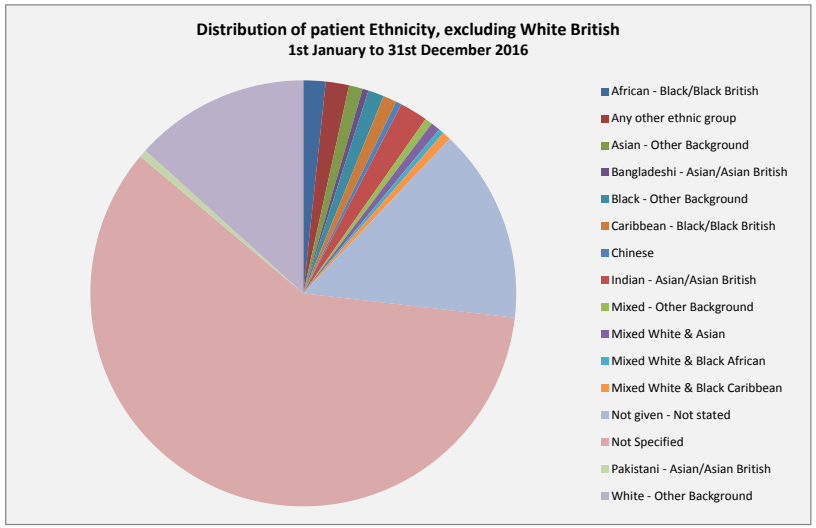
1st January to 31st December 2016

Age Group	Total
0-9 years	9325
10-19 years	8017
20-29 years	10055
30-39 years	9723
40-49 years	10463
50-59 years	11411
60-69 years	10638
70-79 years	8058
80-89 years	4793
90 years and over	1433
Grand Total	**83916**



Ethnicity	Total
African - Black/Black British	304
Any other ethnic group	317
Asian - Other Background	188
Bangladeshi - Asian/Asian British	82
Black - Other Background	216
Caribbean - Black/Black British	186
Chinese	78
Indian - Asian/Asian British	381
Mixed - Other Background	103
Mixed White & Asian	126
Mixed White & Black African	74
Mixed White & Black Caribbean	117
Not given - Not stated	2651
Not Specified	10662
Pakistani - Asian/Asian British	105
White - Other Background	2390
White British	65707
White Irish	229
Grand Total	**83916**





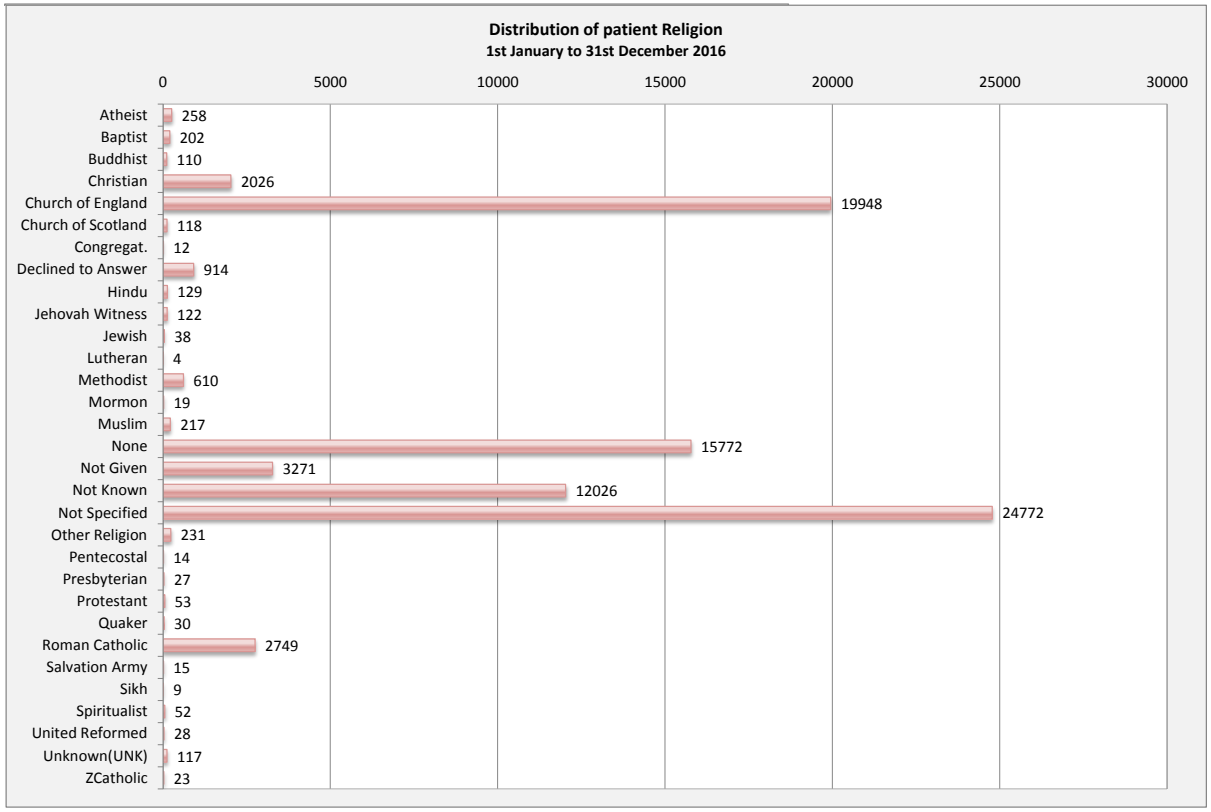
Disability	Total
N	76248
Y	1
Grand Total	**76249**

This data is no longer available

Equality & Diversity Data

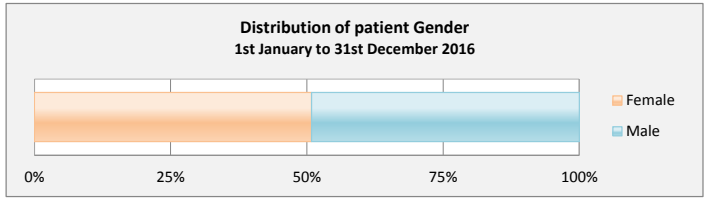
1st January to 31st December 2016

Religion	Total
Atheist	258
Baptist	202
Buddhist	110
Christian	2026
Church of England	19948
Church of Scotland	118
Congregat.	12
Declined to Answer	914
Hindu	129
Jehovah Witness	122
Jewish	38
Lutheran	4
Methodist	610
Mormon	19
Muslim	217
None	15772
Not Given	3271
Not Known	12026
Not Specified	24772
Other Religion	231
Pentecostal	14
Presbyterian	27
Protestant	53
Quaker	30
Roman Catholic	2749
Salvation Army	15
Sikh	9
Spiritualist	52
United Reformed	28
Unknown(UNK)	117
ZCatholic	23
Grand Total	**83916**



Gender	Total
Female	42678
Male	41233
Grand Total	**83911**

5 additional patients who are gender 'not spec'



Gender Reassignment

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

F649: Gender identity disorder, unspecified
F640: Transsexualism

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

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

Pregnancy

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

Equality, Diversity & Inclusion – WRES (Workforce Race Equality Standard) – 2017 Onwards (Version–3)

WRES – Priorities 2017/18	Current Position	Plans for 2017/18	Future Developments/ Plans for 2018/19
1. We will reduce the percentage of BAME staff experiencing discrimination at work by a manager/ team leader or other colleague.	In the staff survey results, currently 19% of BAME staff versus 6% white staff describe that they experience discrimination by their managers/team leader or other colleague.	Director of People and OD to deep dive into the data. HR Directorate Managers to work with their Directorates and Head of EDI to assess, review and action any further support needed for staff, white & BAME staff. WRES update report to CEO (WRES Executive Lead) Feb 2018 and August 2018.	Inclusive workforce improvements should lead to a decrease in discrimination for all staff, including BAME staff.
2. We will reduce the percentage of BAME staff experiencing harassment, bullying or abuse from staff.	In the staff survey results, currently 29% of BAME staff versus 22% white staff experience harassment, bullying or abuse from staff.	Director of People and OD to deep dive into the data. HR Directorate Managers to work with their Directorates and Head of EDI to assess review and action any further support needed for staff, white & BAME staff. WRES update report to CEO (WRES Executive Lead) Feb 2018 and August 2018.	Inclusive workforce improvements should lead to a decrease in discrimination for all staff, including BAME staff.
3. We will increase our confidence with BAME staff to enable all staff have equal opportunity for career progression at the Trust.	In the staff survey results, currently 89% White staff believe that the Trust provides equal opportunities to career progression to 71% of BAME staff.	Current data suggest low disproportionality with BAME internal promotions versus White internal promotions. Assess glass ceiling for BAME staff within this promotion data. Further work required to highlight the ethnic diversity within the Trust, through BAME role models, increasing confidence and sharing BAME promotions stories. Head of EDI will lead on this work.	Practical solutions to engage with BAME staff to access professional and personal development, through line management interventions. We will know we have achieved this target as ethnic diversity will be visible in senior non clinical roles and senior nursing roles.

Percentage of BME staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members)

	31st MARCH 2016			31st MARCH 2017		
1a) Non Clinical workforce	WHITE	BME	ETHNICITY UNKNOWN	WHITE	BME	ETHNICITY UNKNOWN
Under Band 1	0	0	0	0	0	0
Band 1	73%	26%	1%	74%	26%	0%
Band 2	93%	5%	1%	94%	6%	0%
Band 3	95%	3%	2%	96%	4%	0%
Band 4	92%	5%	3%	94%	6%	0%
Band 5	97%	1%	1%	98%	2%	0%
Band 6	88%	5%	7%	96%	4%	0%
Band 7	97%	3%	0%	96%	4%	0%
Band 8A	95%	5%	0%	92%	8%	0%
Band 8B	96%	0%	4%	100%	0%	0%
Band 8C	100%	0%	0%	100%	0%	0%
Band 8D	100%	0%	0%	100%	0%	0%
Band 9	100%	0%	0%	100%	0%	0%
VSM	100%	0%	0%	100%	0%	0%

	31st MARCH 2016			31st MARCH 2017		
1b) Clinical workforce	WHITE	BME	ETHNICITY UNKNOWN	WHITE	BME	ETHNICITY UNKNOWN
Under Band 1	0	0	0	0	0	0
Band 1	0%	0%	0%	100%	0%	0%
Band 2	89%	9%	2%	91%	9%	0%
Band 3	93%	5%	2%	95%	5%	0%
Band 4	93%	5%	2%	98%	2%	0%
Band 5	84%	15%	1%	84%	16%	0%
Band 6	92%	7%	1%	92%	8%	0%
Band 7	96%	2%	2%	97%	3%	0%
Band 8A	91%	2%	7%	98%	2%	0%
Band 8B	95%	0%	5%	100%	0%	0%
Band 8C	100%	0%	0%	100%	0%	0%
Band 8D	100%	0%	0%	100%	0%	0%
Band 9	0%	0%	0%	0%	0%	0%
VSM	100%	0%	0%	100%	0%	0%
Medical Consultants	81%	13%	6%	82%	18%	0%
Non-consultant career grade	70%	23%	7%	79%	21%	0%
Trainee grades	75%	23%	2%	76%	24%	0%
Other Medical	0%	0%	0%	90%	10%	0%

Relative likelihood of staff being appointed from shortlisting across all posts

	31st MARCH 2016			31st MARCH 2017		
	WHITE	BME	ETHNICITY UNKNOWN	WHITE	BME	ETHNICITY UNKNOWN
Number of shortlisted applicants:	2180	490	84	1681	434	0
Number appointed from shortlisting:	267	40	2	523	87	0
Relative likelihood of shortlisting/appointed:	12%	8%	2%	31%	20%	0%
Relative likelihood of White staff being appointed from shortlisting compared to BME staff:	1.5			1.55		

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
Note: This indicator will be based on data from a two year rolling average of the current year and the previous year

	31st MARCH 2016		31st MARCH 2017	
	WHITE	BME	WHITE	BME
Number of staff in workforce:	3029	321	3327	421
Number of staff entering the formal disciplinary process:	30	5	10	2
Likelihood of staff entering the formal disciplinary process:	0.99%	1.56%	0.30%	0.48%
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff:		1.57		1.58

Relative likelihood of staff accessing non-mandatory training and CPD

	31st MARCH 2016		31st MARCH 2017	
	WHITE	BME	WHITE	BME
Number of staff in workforce (White):	3029	321	3327	421
Number of staff accessing non-mandatory training and CPD (White):	0	0	0	0
Likelihood of staff accessing non-mandatory training and CPD:	0	0	0	0
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff:	0	0	0	0

Staff Experience : Harassment, bullying and abuse, discrimination and career progression

	31st MARCH 2016			31st MARCH 2017		
	WHITE	BME	ETHNICITY UNKNOWN	WHITE	BME	ETHNICITY UNKNOWN
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	22.42%	16.67%	0.00%	21.21%	19.74%	0.00%
% of staff experiencing harassment, bullying or abuse from staff in last 12 months	22.46%	29.09%	0.00%	22.51%	29.73%	0.00%
% staff believing that trust provides equal opportunities for career progression or promotion	90.64%	70.97%	0.00%	89.27%	71.93%	0.00%
% staff personally experienced discrimination at work from Manager/team leader or other colleague	4.42%	18.87%	0.00%	5.08%	18.67%	0.00%

BME Representation on Board

	31st MARCH 2016			31st MARCH 2017		
	WHITE	BME	ETHNICITY UNKNOWN	WHITE	BME	ETHNICITY UNKNOWN
Total Board members	13	0	0	13	0	
of which: Voting Board members	13	0	0	13	0	
: Non Voting Board members	0	0	0	0	0	0
Total Board members	13	0	0	13	0	
of which: Exec Board members	6	0	0	6	0	
: Non Executive Board members	7	0	0	7	0	0
Number of staff in overall workforce				3327	421	
Total Board members - % by Ethnicity	100%	0%	0%	100%	0%	0%
Voting Board Member - % by Ethnicity	100%	0%	0%	100%	0%	0%
Non Voting Board Member - % by Ethnicity						
Executive Board Member - % by Ethnicity	100%	0%	0%	100%	0%	0%
Non Executive Board Member - % by Ethnicity	100%	0%	0%	100%	0%	0%

Overall workforce - % by Ethnicity				89%	11%	0%
Difference (Total Board -Overall workforce)				11%	-11%	0%

Salisbury NHS Foundation Trust Board - 7 August 2017

SFT 3917

Title :
Revalidation – Annual Board Report

Report from:
Dr Christine Blanshard – Medical director

Executive Summary:
In April 2014 NHS England published a framework for quality assurance for revalidation which requires Responsible Officers to produce their annual report on revalidation for the Board of their Designated Body in a prescribed format, and the chairman or chief executive to sign a statement of compliance to be submitted to the level 2 Responsible Officer. This report describes the number of doctors with a prescribed connection to the Trust, the number of completed appraisals within the appraisal year 2016-17, the appraisal quality assurance process, any issues with the revalidation process and an action plan.

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

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

Supporting Information

Report and appendices attached

Revalidation - Annual Board Report

1. Executive summary

In April 2014 NHS England published a framework for quality assurance for revalidation which requires Responsible Officers to produce their annual report on revalidation for the Board of their Designated Body in a prescribed format, and the chairman or chief executive to sign a statement of compliance to be submitted to the level 2 Responsible Officer. This report describes the number of doctors with a prescribed connection to the Trust, the number of completed appraisals within the appraisal year 2016-17, the appraisal quality assurance process, any issues with the revalidation process and an action plan.

2. Purpose of the Paper

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

3. Background

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

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

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

4. Governance Arrangements

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

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

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

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

She is also required to:

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

- Where appropriate refer concerns about the medical practitioner to the General Medical Council
- Respond to requests from the GMC for information about a doctors practice
- When requested to do so deal with concerns raised to the GMC at a local level , ensuring only the most serious concerns are investigated by the GMC
- Where a medical practitioner is subject to conditions imposed by, or undertakings agreed with, the General Medical Council, to monitor compliance with those conditions or undertakings
- Make recommendations to the General Medical Council about medical practitioners' fitness to practise

She is line managed in this respect by her "second level responsible officer" who is currently the Medical Director of NHS England South, and appraised with regard not only to her performance as an RO, but on the whole of her practice, by an NHSE appointed appraiser. Her annual appraisal was completed in March 2017.

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

The RO is supported by an appraisal lead. After five years in the role Dr Claire Fuller has stepped down and Dr Clare Hennebry has been appointed. The appraisal lead is responsible for ensuring that:

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

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

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

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

Appraisers are responsible for:

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

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

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

For the 2016/17 NHS England has revised its guidance for ROs to state that an appraisal must be completed on or before the anniversary of the last appraisal rather than allowing up to six weeks tolerance as was the case before.

a. Policy and Guidance

Our appraisal policy for medical staff, remediation policy and handling concerns policy have all been updated within the last year. Our remediation policy has been used as an example of best practice by NHSE, and we have been commended for the section on non-engagement in the appraisal policy. The handling concerns policy will require further updating in line with national guidance which is currently out to consultation.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

For the appraisal year 2016-2017:

201 doctors had a prescribed connection to the Trust (similar to the previous year) comprising 164 consultants, 18 SAS doctors and 19 temporary or short-term contract holders (trust locums and junior doctors not in a training post).

Appraisal compliance rates are tabulated below with last years and national figures for comparison. It can be seen that appraisal compliance rates have fallen across the board and this is thought to be for the following reasons:

1. The vast majority of doctors underwent revalidation between 2012 and 2015. Revalidation was a powerful incentive for doctors to complete their appraisal and doctors at this stage in the five year revalidation cycle are harder to engage.
2. A change in the NSE definition of a timely completed appraisal so that appraisals must be completed on or before the anniversary of the previous appraisal – previously a delay of up to six weeks was acceptable.

3. We have been working to improve alignment of appraisal dates with revalidation dates to ensure all doctors can get five appraisals completed in a five year cycle. This has caused some confusion.
4. Difficulty keeping track of all doctors with a prescribed connection particularly bank doctors, retire-and-returnees and short term contract holders
5. Processes for ensuring that doctors who have a valid reason for missing an appraisal (eg maternity leave or sickness absence) have this recorded require improvement
6. Maternity leave of the revalidation administrator

National figures have also shown a fall in doctor's appraisal rates in this year but the fall at SFT has been greater.

	Number 2016/17	Number 2015/16	Appraisal rate	Appraisal rate 2015/16	Similar Trusts
consultants	164	168	81%	94%	91%
SAS	18	12	78%	82%	84%
Other	19	24	95%	100%	81%
Total	201	204	82% (165)	94%	87%

Two doctors were excused due to maternity leave or long-term sickness absence. Thirty-four doctors had a missed or incomplete appraisal at the time of submission of the national audit. The majority of these have now been completed but at the time of writing eleven remain outstanding, one of whom has been given a deferral due to sickness absence.

At the time of writing the most overdue appraisals are for two retired consultants whose last appraisal was in October 2014 and December 2014 respectively. Their previous appraisals have been satisfactory and I have no concerns about their fitness to practice; both have been warned that their non-engagement in the appraisal process means they will not be revalidated. Both provide valuable additional capacity in services with significant recruitment challenges.

Efforts are underway to recover appraisal performance. Maternity cover has been sourced for the revalidation administrator and our data has been cleansed and validated. At M3 medical staff appraisal was reported to the workforce committee as 93%

Sixty-five doctors were due for revalidation during the course of the year and a positive revalidation recommendation was made by the due date in all cases. This year no doctor had their revalidation deferred, due to maternity leave, sick leave or insufficient evidence.

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

One doctor has been dismissed for misconduct, and referred by the RO to the GMC.

Two doctors have been subject GMC investigation for concerns raised about their practice prior to appointment and appropriately notified to the RO.

Two doctors are undertaking a formal remediation process, one as a result of a period away from clinical practice and one in response to a clinical incident.
Two doctors have been formally investigated for misconduct under the handling concerns policy: one case has concluded with an informal warning and the other is ongoing.

This year we have had a small number of locum doctors behave unprofessionally by cancelling assignments at short notice or failing to attend. Their Responsible Officers have been notified.

The RO meets quarterly with her GMC employer liaison officer to discuss ongoing and potential fitness to practice concerns and regularly consults her National Clinical Assessment Service local adviser for advice.

b. Appraisers

The trust has 56 trained appraisers of whom all attended at least one appraiser support group meeting or training session and completed at least two appraisals over the course of the year. All directorates are represented and the pool of appraisers includes SAS doctors.

We held a number appraiser support group meetings and drop in training sessions, as well as a half day workshop for appraisers, facilitated by the appraisal lead. Topics for discussion were selected by the RO, the appraisal lead and appraisers to ensure they met their needs and included:

- Trust values and behaviours and their link to GMP
- Dealing with health concerns
- Challenging conversations
- Confidentiality
- Raising concerns
- The reluctant appraisee
- Managing the link between appraisal and job planning
- Appraisal for SAS doctors

The appraisal lead has been invited to attend NHS England (South) appraisal leads network meetings.

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

c. Quality Assurance

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

We have an appraisal quality assurance board chaired by a non-executive director which last met in March 2017. The board reviews the number, training and engagement of appraisers, the feedback given by appraisees to appraisers and independently reviews a random selection of 10% of completed appraisals using a validated quality assurance numerical scoring tool called PROGESS. The findings can be summarised as follows:

- Most output forms were consistent professional & objective, but tended to be more supportive than challenging. Some forms captured the appraisal discussion better than others
- Some input forms evidenced a process of deep reflection
- Scores ranged from 7-20 (max score 20)
- There was good evidence that the appraisers had prepared well for the appraisal meeting by reviewing the evidence presented and reflecting on it. However gaps in presented evidence were not always identified and there was usually no mention of where the Dr is in the revalidation cycle.
  .

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

In January we had a peer review visit led by NHS England (South) to review the appraisal and revalidation system. This reported positively with several areas of good practice and substantial assurance on the quality and robustness of our processes. The report is included in appendix 1 and our action plan in response to the visit at appendix 2. Progress against the action plan will be monitored at the executive workforce committee.

d. Access, security and confidentiality

Access to data in appraisal portfolios is limited to the appraiser, responsible officer and appraisal quality assurance board. Doctors are reminded that no patient-identifiable data should be included in the portfolio.

The data is “owned” by the doctor and can be downloaded to a suitable storage device if the doctor leaves the Trust; the doctor’s record on the e-portfolio system is then archived.

e. Clinical Governance

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

6. Recruitment and engagement background checks

Prior to recruitment the medical personnel department carries out relevant background checks including confirmation of the doctor’s identity, qualifications and professional registration. Out of hours this is the responsibility of the senior clinician on site. On appointment the revalidation administrator asks the doctors previous Responsible Officer to complete a Medical Practice Information Transfer Form disclosing any relevant information to the Trust RO.

7. Risk and Issues

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

There is a lack of senior expertise in medical personnel at present, risking failure of recruitment checks, limiting the support available for remediation or disciplinary

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

The trust has only one doctor trained as a Case Investigators and the RO is the only trained and experienced Case Manager. This is mitigated by using non-medical case investigators when the issue is clearly one of misconduct and external case investigators where necessary.
A small number of doctors are struggling to engage with the revalidation process and there is a risk that they will lose their licence to practice; however this is unlikely as compliance increases markedly as the revalidation date draws close. The difficulty will be keeping these doctors engaged in appraisal once they have been revalidated, and this is beginning to be apparent as all doctors have now been revalidated once.

8. Next Steps

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

9. Recommendations

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

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

Higher Level Responsible Officer Quality Review Summary

Date: Thursday 5 January 2017 **Designated Body: Salisbury District Hospital NHS Foundation Trust**

Designated Body:	**Salisbury District Hospital NHSFT**	**Review Team:**
Type/sector of Designated Body	Acute Trust	Ros Crowder, Deputy Director Revalidation, NHS England (South), Regional Representative Claire Brown, Revalidation Manager, NHS England (South), Regional Representative Debbi Turner, Project Support Officer, NHS England (South), Regional Representative Henrik Steinbrecher, Lead Appraiser, University Hospital Southampton NHS Foundation Trust, Designated Body Representative Liz Thomas, Deputy Medical Director, NHS England South (South West), Local Office Representative Rod Walker, Lay Representative
Responsible Officer	Dr Christine Blanshard	
Appraisal Lead	Dr Clare Fuller	
Revalidation Manager	Ms Jacqueline Cooper	
HR Lead	Ms Lahra Fox	
Clinical Governance Lead	Ms Claire Gorzanski	
Patient Safety Lead	Ms Fenella Hill	
Patient Experience Lead	Ms Hazel Hardyman	
Revalidation Administrator	Jacqueline Cooper and Saloua Ragbi	

Summary - *Size, location, number of doctors, revalidation key facts, appraisal rates, CQC or other regulator position, any patient safety, financial or organisational issues*. ***Documentation provided by the DB*****.**

Salisbury NHS Foundation Trust is an acute Trust with a track record of high performance. It provides acute services primarily to the populations served by Wiltshire CCG, Dorset CCG and West Hampshire CCG. It also supplies regional services for plastics, burns, cleft lip and palate and genetics and a supra-regional service for spinal injuries. Trust staff provide outpatient clinics in other locations in Dorset and Hampshire and specialist staff hold outreach clinics in hospitals within the Wessex area.

The Trust has an open and honest culture of involvement and engagement and effective feedback mechanisms for staff. We take pride in having had consistently good staff survey results compared with other acute Trusts in the South and South West.

The Trust's clinical services are managed within four Clinical Directorates by a Clinical Director, a Directorate Manager and a Directorate Senior Nurse: clinical support and family services; medicine; surgery and musculoskeletal services. The hospital has around 470 beds, 174 WTE consultant posts, 149 trainees

and a relatively small number of SAS doctors (21)

The Trust has an Education Centre close to the clinical areas and a library. Educational activities include weekly hospital rounds and regular meetings of the Salisbury Medical Society. Rooms are available for clinical departmental meetings. The Trust is committed to multi-professional education and to continuing professional development for all staff. All new consultants are allocated a mentor who is an established consultant within the Trust, usually from another clinical specialty.

A full range of additional training and development courses and opportunities are available both within the Trust and externally.

The Clinical Governance framework in the Trust is focused around quality of care, including patient safety, clinical effectiveness and patient experience. This is designed to help individuals and teams to continually monitor and improve standards of care. It forms a central part of appraisal and revalidation of doctors.

The framework includes the provision of six clinical governance half days, which aim to promote multi-professional working, and enable shared learning. There is no scheduled elective activity undertaken during these sessions and all doctors are expected to take part in the arranged activities.

After a long period of financial stability the Trust posted a deficit for the first time last year and is likely to be in deficit again this year. It is in risk band 2 of the single oversight framework (routine monitoring by the regulators) and was rated by the CQC last year as good for care and effectiveness but requires improvement overall.

Documentation received: Annual Trust Board Report, Medical Appraisal Policy, Guidance on complying with information governance, confidentiality and data protection, Responding to Concerns Policy, Remediation Policy, Raising Concerns (whistleblowing policy), ToR for Revalidation Advisory Quality Assurance Board, and six anonymised appraisal summaries.

On the day of the review, meetings were held with:

Responsible Officer/Medical Director
Clinical Appraisal Lead
Revalidation Manager
HR Medical Staffing manager
HR Advisor (Medical & General)
Clinical Governance Lead
Head of Risk
Head of Customer Care (PPI Lead)
X 2 Appraisees
X6 Appraisers

The Review Team's Summary: • **Examples of good practice identified during discussions on the day** • **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**		
Examples of good practice	**Areas for development**	**Resources that may be helpful**
The Designated Body and Responsible Officer		
A comprehensive annual report is provided for the board. A positive level of recognition from the Board of the high appraisal rates for doctors. The Revalidation Manager meets regularly with her counterparts in neighbouring Trusts to share practices and exchange ideas. User group meetings are held with external suppliers for systems of appraisal and 360 feedback.	Review the resources available to support the RO to deliver the statutory functions. In particular, to make sure there is a robust and sufficient level of HR support available to work with the RO in managing concerns about doctors and the recruitment and English language checking of new doctors, including locums. Consider offering colleagues supporting the RO to deliver their statutory functions, the opportunity to attend the RO training (including completing the e-learning package) and Regional Network meetings.	Suggested challenging questions for the Board:  Challenging Questions for Boards If responses to requests for information are not forthcoming from other ROs the regional team are available to help. The GMC publishes Revalidation Operational Data reports about the revalidation decisions it makes for each designated body. The reports included data for the late recommendations made by each designated body. Online booking for Responsible Officer training Regional Network Meetings  161115 RO network dates 2017 v.3.pdf GMC REV6 – request to send a non-engagement concern letter Where local processes are ongoing to secure a doctor's engagement, an RO can use the REV6 form where a doctor (whether under notice or not) is not engaging in appraisal or other activities or, the level of their engagement is not sufficient, to support a recommendation.

The Review Team's Summary: • **Examples of good practice identified during discussions on the day** • **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**		
Examples of good practice	**Areas for development**	**Resources that may be helpful**
Appraisal		
The use of two appraisal systems in tandem appears to work well and offers an advantage of a potentially more portable output for doctors on short term contracts. (Premier IT is used for permanent doctors and the MAG for doctors on temporary contracts) This is a model that could be helpful to share with other organisations employing doctors on short term contracts. Medical appraisal in the Trust started before revalidation was introduced and has helped to embed the process, securing a good level of engagement and the current high appraisal rates. The appraisal policy has an appendix which defines non engagement which is very helpful in making it clear to doctors what they are required to do. A non-exec director is a member of the Appraisal quality assurance board.	Explore ways to bring more challenge to doctors' appraisals. Consider incorporating the Trust's corporate vision and values into medical appraisal e.g. suggesting doctors include a statement to indicate how they put the Trust values into practice (Frimley Health) Explore ways to provide appropriate linkage between job planning, performance review and medical appraisal, encouraging clinical directors to meet with doctors to discuss job plans and to provide feedback on performance and any concerns to feed in to appraisal. (Gloucester uses Form A, contact Janet Ropner, Portsmouth has a form, contact Mike Homer-Ward) Consider sharing doctors' appraisal dates with the Clinical Governance Lead and explore options for an automated feed of incident information to make sure it's not possible for doctors to avoid asking for this information ahead of their appraisal.	Appraisal Logistics Handbook – link to website: https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2015/11/med-apprs-logstc-hndbk.pdf Quality Assurance of medical appraisal: guidance notes: https://www.england.nhs.uk/revalidation/appraisers/qa-guidance-notes/. Appraisal QA Tools - ASPAT, Progress & Excellence:  150217_MAPS A1 App1_ASPAT form dr  PROGRESS QA template Sept 2012.c  Excellence QA tool Oct 2013 v2.doc Appraisal summary and PDP audit tool (ASPAT) – explanatory notes October 2016:  20160628 Draft NHS England ASPAT guida Link to Appraiser Training and Support: https://www.england.nhs.uk/revalidation/appraisers/app-train-sup/ Examples of good appraisal – Primary care:

The Review Team's Summary: • **Examples of good practice identified during discussions on the day** • **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**		
Examples of good practice	**Areas for development**	**Resources that may be helpful**
	Consider giving advice to appraisees about the requirements for reflecting on evidence in light of the system's mandatory fields which require reflection to be completed for every piece of evidence uploaded.	 Summary of appraisal discussion -  3. Summary of the appraisal discussion - Examples of good appraisal – Secondary care & leadership roles:  Summary of appraisal discussion -  RO appraisal summary example (gc Useful appraisal summary stems:  Appraisal summary stems.pptx Link to appraiser skills videos https://www.fmlm.ac.uk/resources/medical-appraisal-scenarios http://www.england.nhs.uk/revalidation/Clinical appraisal skills video workshops https://www.youtube.com/playlist?list=PL6IQwMACXkj1zbMA27JZs9SgPXOuwgPWm A guidance document on inputs to appraisal: https://www.england.nhs.uk/revalidation/appraisers/improving-the-inputs-to-medical-appraisal/ GMC Case Studies on collecting patient feedback: http://www.gmc-

The Review Team's Summary: • **Examples of good practice identified during discussions on the day** • **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**		
Examples of good practice	**Areas for development**	**Resources that may be helpful**
		uk.org/doctors/revalidation/colleague_patient_feedback.asp
Monitoring Performance and Responding to Concerns		
The Trust has a good Remediation Policy with helpful appendices and this would make a useful template to share with other organisations. The Duty of candour appears to be well embedded and an open and honest culture exists to support this. Concern and comments captured by volunteers who visit wards to ask patients about their experience of care, are routinely fed back to the relevant clinical director. A non-executive director dip samples complaint/concern cases, reviewing these to check the robustness of the investigation and the follow up action plan.		Risk assessment for establishing levels of concerns:  Establishing Levels of concerns.pdf Link to NHS England information flows guidance to support medical governance and responsible officer statutory function. It sets out the common legitimate channels and arrangements for the flow of information flows and gives toolkits and good practice examples. The guidance is relevant to ROs, appraisal leads, HR and clinical governance colleagues. https://www.england.nhs.uk/revalidation/ro/info-flows/
Recruitment and Engagement		
The Trust uses an assessment form for Locums which is completed for every placement and makes sure locum agencies always receive feedback about their doctors.	Explore ways to strengthen the links between the RO and HR roles, to make sure that HR colleagues can support the RO across the full extent of statutory functions. Review processes for checking the	Link to NHS Employment Check Standards: http://www.nhsemployers.org/your-workforce/recruit/employment-checks/nhs-employment-check-standards Link to GMC guidance on employing a doctor http://www.gmc-

The Review Team's Summary: • **Examples of good practice identified during discussions on the day** • **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**		
Examples of good practice	**Areas for development**	**Resources that may be helpful**
	English language of new doctors, including locums, to make sure the requirements are met prior to employment/engagement. For example, consider developing and using a checklist which could help to deliver the necessary assurance to the RO that all the necessary checks have been carried out in a timely fashion and that new doctors have the level of English needed to fulfil the role. Give information about the Trust's appraisal and revalidation arrangements, to new doctors, as part of their corporate induction.	uk.org/doctors/register/employing_a_doctor.asp Letter from Nigel Acheson to Responsible Officers, Medical Directors and Directors of HR (South region) about employing doctors  160106 To ROs,MDs & HRDs re Employmer Information about HPANs: http://www.ncas.nhs.uk/about-ncas/alert-notices/ NHS Employers information and toolkits for helping the NHS recruit staff with values that fit with their organisation: http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/values-based-recruitment Dartford and Gravesham NHS Trust Testing English Language Competency for Medical Staff Policy 2014  PRS074 - Testing English v1 Jan 14.pdf
Other - Public and Patient Involvement etc		
	Consider ways to give patients and lay audiences in general, information about doctors' revalidation. For example, explain why revalidation is important and	Suggested opportunities for involving patients & public:

The Review Team's Summary: • **Examples of good practice identified during discussions on the day** • **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**		
Examples of good practice	**Areas for development**	**Resources that may be helpful**
	the ways in which the Trust makes sure patients and public are involved in the process. Explore ways in which patient and public involvement can be incorporated into the recruitment for medical staff for example, a lay person sitting on an interview panel. Consider potential opportunities for lay involvement in the appraisal and revalidation process. For example, involving a lay person in the quality assurance of appraisals	 Opportunities for Patient and Public Eng Leaflets - information for patients – Hapia & GMC:  Revalidation_Leaflet-AUGUST19-2013-2-M  GMC Patient feedback.pdf

ACTION PLAN TEMPLATE

Higher Level Responsible Officer Quality Review (HLROQR)

This template is provided for documenting actions if desired.

Designated Body:	Salisbury NHSFT	**Date of HLROQR:**	5th January 2017
Responsible Officer:	Dr Christine Blanshard		
Area for development identified at HLROQR	**Action**	**Responsibility**	**Timescale**
1) Review the resources available to support the RO to deliver the statutory functions. In particular, to make sure there is a robust and sufficient level of HR support available to work with the RO in managing concerns about doctors and the recruitment and English language checking of new doctors, including locums. (Pg.3)	- Ensure support for RO included in Trust Induction of new medical Staffing Manager	Dr Christine Blanshard (RO) Ms Hilary Salisbury (Deputy Director of HR)	By 31st October 2017

2) Consider offering colleagues supporting the RO to deliver their statutory functions, the opportunity to attend the RO training (including completing the e-learning package) and Regional Network meetings. (Pg.3)	- Appraisal Lead has completed RO Training & attends some regional network meetings - Revalidation administrator and Deputy director of HR to be given dates of future RO network meetings	Dr Clare Fuller (appraisal lead) Dr Christine Blanshard	Ongoing Complete
3) Explore ways to bring more challenge to doctors' appraisals. (Pg.4)	- Challenge vs support has been the subject of previous appraiser training and further sessions will be offered - Explore improving the link between performance review, service and personal objectives and appraisal	Dr Clare Fuller Dr Clare Fuller, Dr Christine Blanshard, Ms Saloua Ragbi	By 31st March 2018 By 31st October 2017
4) Consider incorporating the Trust's corporate vision and values into medical appraisal e.g. suggesting doctors include a statement to indicate how they put the Trust values into practice (Frimley Health) (pg.4)	- Incorporate into rolling programme of appraisal training workshops.	Dr Clare Fuller	By 31st March 2018

5) Consider sharing doctors' appraisal dates with the Clinical Governance Lead and explore options for an automated feed of incident information to make sure it's not possible for doctors to avoid asking for this information ahead of their appraisal. (Page.4)	- Training and access for revalidation administrator to Incident and Customer Care modules of Datix (Risk Database). This will ensure they are able to supply a report to appraisee and appraiser confirming incident, complaint, concern and compliment information prior to appraisal.	Sam King (Datix Administrator)	Complete
6) Consider giving advice to appraisees about the requirements for reflecting on evidence in light of the system's mandatory fields which require reflection to be completed for every piece of evidence uploaded. (pg.5)	- Consideration will be given to modifying the appraisal policy being explicit about the minimum about of reflection required in the annual input form	Dr Clare Fuller Dr Christine Blanshard	31st March 2017
7) Explore ways to strengthen the links between the RO and HR roles, to make sure that HR colleagues can support the RO across the full extent of statutory functions. (Pg.6)	- Regular 1:1 RO, Medical Staffing Manager & Revalidation Administrator	Dr Christine Blanshard New appointee Saloua Ragbi	CB/SR: complete Three way meetings on appointment of new medical staffing officer

8) Review processes for checking the English language of new doctors, including locums, to make sure the requirements are met prior to employment/engagement. For example, consider developing and using a checklist which could help to deliver the necessary assurance to the RO that all the necessary checks have been carried out in a timely fashion and that new doctors have the level of English needed to fulfil the role. (Pg.7)	- Review current check list to address any stages that we may be lacking. Information from NHS Employers, IELTS guidelines – employment check standards. Evidence provided and checked on the check list and kept on file. - Incorporate the level of English and if understood by the interviewer (panel members) in the interview scores.	Lahra Fox (medical HR)	31st July 2017
9) Give information about the Trust's appraisal and revalidation arrangements, to new doctors, as part of their corporate induction. (Pg.7)	- Include the appraisal policy in the doctors induction pack - Consider designing a leaflet summarising appraisal and revalidation - Meeting with revalidation administrator to be included in induction	Lahra Fox Saloua Ragbi	31st October 2017

10) Consider ways to give patients and lay audiences in general, information about doctors' revalidation. For example, explain why revalidation is important and the ways in which the Trust makes sure patients and public are involved in the process. (Pg.8)	- GMC Leaflets available in clinics. Made available when Drs are requesting Patient Feedback. - Hard & soft copies available in Medical Education for Drs who request, and also to make them aware when they enquire about setting up patient feedback - Consider publishing information about appraisal and appraisal rates on the Trust website	Saloua Ragbi Saloua Ragbi Clare Fuller Saloua Ragbi	31st October 2017 Complete 31st October 2017
11) Explore ways in which patient and public involvement can be incorporated into the recruitment for medical staff for example, a lay person sitting on an interview panel. (Pg.8)	- Identify with the "Patient and public involvement team" – Hazel Hardyman, if there can be members that can be trained to sit on the recruitment panels. Identify if there are currently any members that have the appropriate training in place to sit on recruitment panels	Lahra Fox	31st October 2017
12) Consider potential opportunities for lay involvement in the appraisal and revalidation process. For example, involving a lay person in the quality assurance of appraisals. (Pg.8)	- RO to attend network day themed on role of patient and public involvement - Consider having a Governor, as a lay representative on the Appraisal Quality Assurance Board	Christine Blanshard Christine Blanshard/Clare Fuller	Complete 31st March 2018

I confirm that the action plan above has been discussed and agreed with my Board or equivalent The action plan has been agreed by the appraisal quality assurance board and will be monitored by regular reporting to the Workforce Committee (which is a subcommittee of the Trust Board)	 *Dr Christine Blanshard (Responsible Officer)*

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Version 4, April 2014

NHS England INFORMATION READER BOX		
Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**01142**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, **Annex E - Statement of Compliance**
Author	NHS England, Medical Revalidation Programme
Publication Date	4 April 2014
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees
Description	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	Replaces the Revalidation Support Team (RST) Organisational Readiness Self-Assessment (ORSA) process
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers (ROCR approval applied for).
Timings / Deadline	**From April 2014**
Contact Details for further information	england.revalidation-pmo@nhs.net http:// www.england.nhs.net/revalidation/
Document Status This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet	

Annex E – Statement of Compliance

Designated Body Statement of Compliance

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

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

   Comments:

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

   Comments:

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

   Comments:

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

   Comments:

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

   Comments:

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

   Comments:

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

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

Comments:

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

Comments:

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

Comments:

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

Comments:

Signed on behalf of the designated body

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

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

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

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

Salisbury NHS Foundation Trust Board – 7 August 2017

SFT 3918

Title:	National Inpatient Survey 2016 Analysis of Care Quality Commission Benchmark Report and Local Action Plans

Report from:	Lorna Wilkinson, Director of Nursing

Executive Summary:

Salisbury NHS Foundation Trust (SFT) participated in the 14th national inpatient survey between September 2016 and January 2017. The sample size was 1,250 patients and 719 patients (60%) responded. The survey contained 65 questions which could be analysed, grouped into 11 sections.

Comparisons with other Trusts

- SFT scored 'about the same' as most other Trusts in all 11 sections.
- SFT scored 'better' for two individual questions:-
  - Confidence and trust in doctors
  - Explanations of how operations or procedures had gone.

Comparisons with its own 2015 benchmark results

- SFT's results had significantly decreased in seven areas. These are being addressed through the Trust-wide action plan.

Care Quality Commission website

- The results have been published on the Care Quality Commission's website at: http://www.cqc.org.uk/provider/RNZ/survey/3

  They show that 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.

Local Results Analysis

- 429 comments were received on things that were good.
- 329 comments were received on things that could be improved.
- The main area where more negative than positive comments were received related to discharge.

The Next Steps

- A Trust-wide action plan has been produced (Appendix A).
- Each ward has an individual action plan based on feedback received from this survey together with comments received from real-time feedback, Friends and Family Test, complaints and concerns.

Comparisons with Neighbouring Trusts

- Salisbury had the highest or joint highest mean score in 5 of the 11 overall sections and 13 of the 65 individual questions.
- It had the lowest or joint lowest score in 1 of the overall sections and 4 of the individual questions.

Proposed Action:

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

Supporting Information

1) National Inpatient Survey 2016: Analysis of Care Quality Commission Benchmark Report and Local Action Plans
2) Appendix A: Trust-wide Action Plan

NATIONAL INPATIENT SURVEY 2016
ANALYSIS OF CARE QUALITY COMMISSION BENCHMARK REPORT AND LOCAL ACTION PLANS

1.0 Introduction

Salisbury NHS Foundation Trust participated in the 14th national inpatient survey between September 2016 and January 2017. Questionnaires were sent to 1,250 patients who had stayed at Salisbury District Hospital for at least one night during the month of July 2016. 719 patients (60%) responded.

2.0 The Benchmark Report

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

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

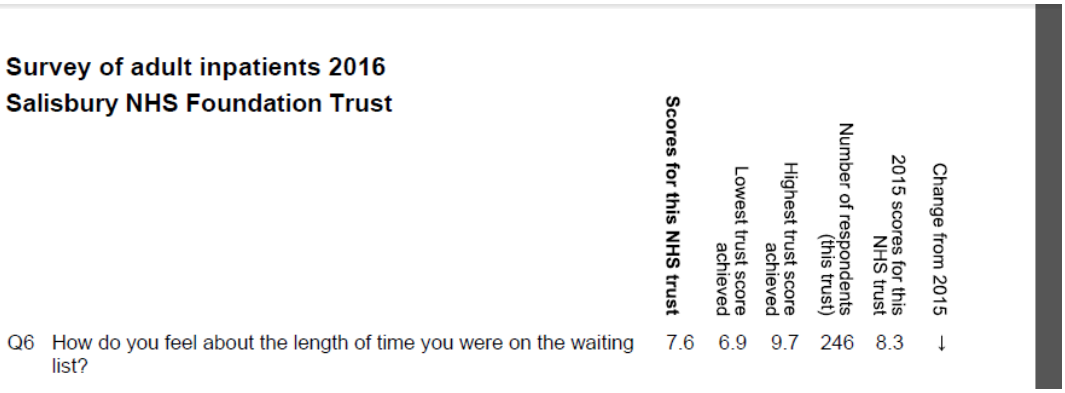
A scoring system is used which marks each question out of a maximum of 10 points.

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

Example 1

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

Example 2



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

The report is available on the NHS Surveys website
at: http://www.nhssurveys.org/Filestore/IP16_BMK_Reports/IP16_RNZ.pdf

3.0 Analysis of the Benchmark Report

The survey contained 65 core questions which could be analysed. Other questions (known as filters) instructed respondents to skip certain questions or sections that did not apply to them.

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

SFT scored 'about the same' as most other Trusts in all 11 sections.

Section	SFT score	National average score
The Emergency/A&E Department	8.9	8.4
Waiting list and planned admissions	8.5	8.9
Waiting to get to a bed on a ward	7.6	7.7
The hospital and ward	8.1	8.2
Doctors	9.0	8.8
Nurses	8.1	8.2
Care and treatment	8.0	8.0
Operations and procedures	8.6	8.5
Leaving hospital	7.4	7.4
Overall views of care and services	5.6	5.9
Overall experience	8.2	8.3

SFT scored 'better' than most other Trusts in 2 of the 65 individual questions:

Question	SFT score	National average score
Did you have confidence and trust in the doctors treating you?	9.4	9.2
Afterwards, did a member of staff explain how the operation or procedure had gone?	8.4	8.1

When compared with its own 2015 benchmark results, SFT showed a statistically significant decrease in 7 areas:-

Question	SFT 2016 score	SFT 2015 score	Difference
How do you feel about the length of time you were on the waiting list?	7.6	8.3	-0.7
Was your admission date changed by the hospital?	8.9	9.3	-0.4
From the time you arrived at the hospital, did you feel you had to wait a long time to get to a bed on a ward?	7.6	8.8	-1.2
Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.4	8.8	-0.4
In your opinion, were there enough nurses on duty to care for you in hospital?	7.6	8.0	-0.4
In your opinion, did the members of staff caring for you work well together?	8.7	9.0	-0.3
Did you find someone on the hospital staff to talk to about your worries and fears?	5.8	6.6	-0.8

4.0 Comparisons with Demographic Characteristics

The split between male and female respondents was 48% male and 52% female, compared with 47% / 53% nationally. Age group, religion and sexual orientation responses were in line with national figures. SFT's ethnicity responses for the White group were slightly higher than nationally (94% compared with 90%); responses from other ethnic groups were 6% compared with 10% nationally.

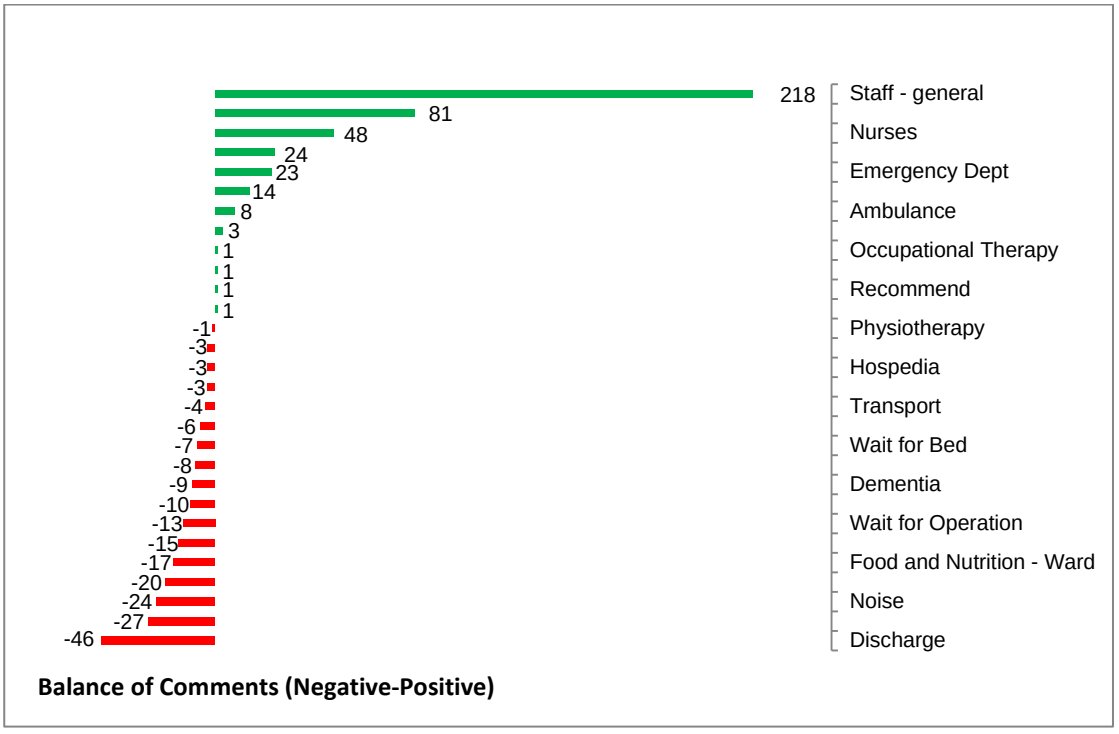
5.0 Care Quality Commission website

The results have been published on the Care Quality Commission's website. They show that Salisbury scored 'about the same' as most other Trusts in England for the 11 sections. For the individual questions, it scored '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.

The results can be viewed on the CQC website at: http://www.cqc.org.uk/provider/RNZ/survey/3

6.0 Local Results Analysis and The Next Steps

In addition to the standard questions, patients were invited to make comments about anything which they felt was particularly good about their care or things that they felt could be improved. A total of 429 comments were received regarding things that were good about the patients' stay and 329 comments on things that could be improved. These have been categorised and analysed to show the areas where further attention is required, as indicated in the graph below:



A Trust-wide action plan is presented in Appendix A. In addition, each ward has an individual action plan based on feedback received from this survey together with comments received from real-time feedback, Friends and Family Test, complaints and concerns. These were presented to the Clinical Governance Committee in June 2017 and are available upon request.

7.0 Comparisons with Neighbouring Trusts

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

Salisbury had the highest or joint highest mean score in 5 of the 11 overall sections and 13 of the 65 individual questions:-

Overall

- The hospital and ward
- Doctors
- Care and treatment
- Operations and procedures
- Leaving hospital

Individual

- Staff quiet at night
- Doctors answering important questions
- Confidence and trust in doctors
- Doctors not ignoring patients
- Patient involvement in decisions about care and treatment
- Confidence in decisions about care and treatment
- Information provided about condition or treatment
- Privacy when being examined or treated
- Pain control
- Explanation of how operation or procedure had gone
- Purpose of medication explained
- Medication side effects explained
- Explanation of how to take medication

Salisbury had the lowest or joint lowest score in 1 of the overall sections and 4 of the individual questions:-

Overall

- Waiting list and planned admissions

Individual

- Length of time on waiting list
- Changes in admission date
- Call bell response
- Explanation of how patient would be put to sleep or pain controlled during an operation or procedure

Full details of the comparisons are available upon request.

Lorna Wilkinson
Director of Nursing
August 2017

ACTION PLANNING 2017 – TRUST-WIDE

OBJECTIVE FOR IMPROVEMENT	ACTIONS THIS WEEK	ACTIONS THIS MONTH	ACTIONS OVER THE NEXT 3 MONTHS	LEAD AND WHOM TO INVOLVE	PROPOSED COMPLETION DATE	PROGRESS TO DATE AND EVIDENCE OF CHANGE
NEW ACTIONS FROM FEBRUARY 2017						
There has been a theme around the use of escalation within complaints and concerns. In addition, SFT's benchmark results for the National Inpatient Survey 2016 show a significantly lower score than in 2015 for:- • length of time on waiting list; • hospital changing admission dates; • waiting to get to a ward; • mixed sex bathroom/ shower area. These issues link to pressure on capacity and the need to prepare for growing demand.	Ward reconfiguration work entitled 'Giving patients the right care in the right place' will be undertaken during the summer of 2017 to provide the Trust with an extra medical ward and a totally redesigned acute medical unit. This work has the aim of optimising both the elective and non-elective pathways			Andy Hyett Chief Operating Officer	January 2018	
Compared with its own results in 2015, SFT showed a significantly lower score for patients being able to talk to a member of staff about worries and fears.	A 'patient centred escalation tool' currently used by UHS will be piloted at SDH during June 2017. Patient responses to four questions will be scored and appropriate action taken dependent upon the outcome (minimum score 4 / maximum 20).		The results of the pilot will be analysed by the DSNs.	Directorate Senior Nurses / Customer Care	August 2017	