SALISBURY NHS FOUNDATION TRUST

TRUST BOARD

MONDAY 3 OCTOBER 2016, 1.30 PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
1.30pm	**1**	**APOLOGIES FOR ABSENCE - Jane Reid**			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES** Public Board Meeting held on 8 August 2016			1
	4	**MATTERS ARISING**			
1.35pm	**5**	**CHIEF EXECUTIVE**			
		1. Chief Executive's Report	PH	SFT 3809	9
1.45pm	**6**	**STAFF**			
		1. Workforce Performance Report to include Nurse Staffing	AK/LW	SFT 3810	11
2.00pm	**7**	**PATIENT CARE**			
		1. Quality Indicator Report to 31 August (month 5)	CB/LW	SFT 3811	43
		2. Customer Care Report – Quarter 1	LW	SFT 3812	51
		3. Clinical Governance Annual Report	CB	SFT 3813	65
2.30pm	**8**	**PERFORMANCE AND PLANNING**			
		1. Finance & Performance Committee Minutes 25 July and 22 August 2016	NM	SFT 3814	77
		2. Financial Performance to 31 August (month 5)	MC	SFT 3815	83
		3. Progress against Targets and Performance Indicators to 31 August (month 5)	AH	SFT 3816	93
		4 Major Projects Report	LA	SFT 3817	97
		5. Capital Development Report	LA	SFT3818	107

3.00pm **9** **PAPERS FOR NOTING OR APPROVAL**

1. JBD Minutes evidencing presentation of Assurance Framework and Risk Register	PH	SFT 3819	117
2. Minutes from Public Section of Council of Governors 18 July 2016	NM	SFT 3820	119
3 Risk Management Strategy 2016/17	LW	SFT 3821	123
4. Risk Management Annual Report 2015/16	LW	SFT 3822	149
5. Maternity and Neonatal Risk Management Annual report	LW	SFT 3823	161
6. Clinical Governance Committee minutes – 21 July 2016	LB	SFT 3824	175
7. Management Letter for 2015/16 – for information	PH	SFT 3825	183

3.45pm **10** **ANY OTHER URGENT BUSINESS**

11 **QUESTIONS FROM THE PUBLIC**

12 **NEXT MEETING**

The next public meeting will be held on Monday 5 December 2016, in the Board Room at Salisbury District Hospital starting at 1.30pm

13 **CONFIDENTIAL ISSUES**

To consider a resolution to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

SALISBURY NHS FOUNDATION TRUST

Minutes of the meeting of Salisbury NHS Foundation Trust Board Held on Monday 8 August 2016

Board Members Present:	Dr N Marsden	Chairman
	Mr P Hill	Chief Executive
	Ms T Baker	Non-Executive Director
	Dr C Blanshard	Medical Director
	Mr I Downie	Non-Executive Director
	Mr A Hyett	Chief Operating Officer
	Mr P Kemp	Non-Executive Director
	Mrs A Kingscott	Director of Human Resources and Organisational Development
	Mr S Long	Non-Executive Director
	Mrs K Matthews	Non-Executive Director
	Ms L Wilkinson	Director of Nursing
Corporate Directors Present:	Mr L Arnold	Director of Corporate Development
In Attendance:	Mr P Butler	Head of Communications
	Mr M Collis	Deputy Director of Finance
	Mr D Seabrooke	Secretary to the Board
	Mr P Lefever	Wiltshire Healthwatch
	Mrs C Martindale	Staff Governor
	Mr M Mounde	Public Governor
	Sir R Jack	Public Governor
	Dr J Lisle	Public Governor
	Mr R Polkinghorne	Appointed Governor
	Mrs J Sanders	Public Governor
	Mr M Wareham	Staff Side
	Pamela Permalloo-Bass	For item 2196/02
Apologies:	Mr M Cassells	Director of Finance and Procurement
	Dr L Brown	Non-Executive Director

ACTION

2192/00 DECLARATIONS OF INTEREST AND FIT AND PROPER/GOOD CHARACTER

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

2193/00 MINUTES – 6 JUNE 2016

The minutes of the meeting of the Board held on 6 June 2016 were agreed as a correct record subject to the deletion of Sir R Jack as in attendance.

2194/00 MATTERS ARISING

There were no matters arising.

2195/00 CHIEF EXECUTIVE'S REPORT - SFT 3789 – PRESENTED BY PH

The Board received the Chief Executive's report.

PH highlighted the high pressure on the hospital's services over the past few weeks and again thanked staff for their efforts in managing this.

He highlighted the Sustainability and Transformation Plans in which the Trust was working with providers in Bath and North East Somerset, Wiltshire and Swindon as one of 44 Sustainability and Transformation Footprints that had been formed nationally. The partners had been working together to identify common challenges and opportunities to improve the local population's health and well-being, service quality and deliver financial stability. There would be engagement with the Governor's Strategy Committee later in the year and PH would feature the plans in a forthcoming round of staff presentations.

The Board noted positive results from National Surveys conducted with cancer patients and inpatients generally.

The Trust's Engage team had received a Queen's award for voluntary service presented by the Lord Lieutenant for Wiltshire.

The report also highlighted the recent Long Service Awards given by the Chief Executive and Chairman, the Transformation Day held as part of the Trust's Save 7 campaign and the celebration of the 25th anniversary of the Art Care Service.

The Board noted the report.

2196/00 STAFF

2196/01 Workforce Performance Report including Nurse Staffing - SFT 3790 - Presented by AK & LW

The Board received the Workforce Performance Report including the National Quality Board Report for month 3. It was noted that the format of the report had been updated. 64 junior doctors had rotated into the Trust and a number of consultant appointments had been made. 21 newly qualified nurses were expected to join in the autumn.

AK highlighted the excellent performance of the Facilities Department in managing appraisals and statutory and mandatory training.

The Trust continued to see staffing levels over the establishment level which was due to the escalation patient accommodation that had been open in recent weeks.

Overall appraisal rates were running at 77% for non-medical and 85% for medical.

A new medical agency contract had just been implemented and it was anticipated that this would reduce the numbers of medical agency breaches against national standards. It was noted that administrative and clerical project managers employed through agencies were in breach of the agency caps.

There was concern that bank usage was down although it was noted that this was not unusual as the holiday season had started. A bank incentive during February and March had improved levels of usage at that time.

In the nurse staffing report, it was noted that the Trust was slightly over on

nursing assistants which was due to the deployment of 'specials' to provide individual care. Midwifery assistants were deployed throughout Maternity Unit and there was flexible usage on Radnor Intensive Care in relation to nursing assistants.

The Board noted the report.

2196/02 Equality and Diversity Annual Report 2016 – SFT 3791 – Presented by AK

The Chairman welcomed Pamela Permalloo-Bass the Trust's Equality and Diversity lead to the meeting. PP-B reminded the Board of its duty to comply with the public sector equality duty and to continue to work through the equality delivery system.

It was noted that the Trust was performing well against the EDS 2 Standards.

The work with the Audiology Department on a Hearing Champion to improve communication between staff and patients was highlighted. The EDS service had also hosted a meeting between the CQC Inspectors in December 2015 and black minority ethnic staff to hear about their experience of working at the Trust. The Trust had also taken part in LGBT history month in February.

The report included the Trust's equality objectives linked to the Trust's corporate goals for 2016.

The Board noted the report

2197/00 PATIENT CARE

2197/01 Quality Indicator Report to 30 June 2016 (Month 3) and Quarter 1 2016/17 – SFT 3792 - Presented by CB and LW

The Board received the Quality Indicator Report. It was noted that this report had been formatted in accordance with the information submitted to Commissioners for contract reporting purposes.

It was noted that the crude rate of mortality was down. There was one CUSUM alert received in March in relation to other connective tissue disease.

The Trust had improved its performance in relation to fractured neck of femur cases being operated on within 36 hours. This local stretch target was in line with evidence of better outcomes for patients were this standard was met.

The number of escalation bed days was high but reducing from a peak in March. This trend was represented in the numbers of multiple patient moves and moves at night. It was however noted that the figures were still being cleansed to ensure that only the appropriate patient move data was captured.

It was noted that five MSSA cases were under investigation but at this stage there was no evidence of the cases being related. There was good control of MRSA and C-Diff.

The Board noted the Quality Report.

2197/02 Customer Care Report – Quarter 4 – SFT 3793 – Presented by LW

The Board received the Quarter 4 report which reflected pressures in the Ophthalmology, Orthopaedics and Plastics Department. Complaints continued to relate principally to communications, attitude, appointments and clinical treatment. There was a focus on ensuring that compliments were all centrally recorded as numbers appeared to be variable. Directorates continued to work to improve their responsiveness for example CSFS were telephoning every complainant. Complaints about cold food from inpatient areas continued and this was reliant on the way that the meal time was organised by the ward and help deployed for those patients requiring it. It was confirmed that the Trust replied to posts on NHS Choices as a matter of routine. Finally the Board reflected on the pressures on the Trust's staff during this time of high demand.

The Board noted the report.

2197/03 Six Monthly Skill Mix Review - SFT 3794 – Presented by LW

The Board received the Six Monthly Skill Mix Report. The report reflected the twice yearly Skill Mix Review in line with national Quality Board guidance. The review covered the Emergency Department and Maternity as well as the range of inpatient areas. A range of information sources had been triangulated including NICE standards, quality outcome data, care hours per patient day, HR indicators and financial information as well as Care Quality Commission findings. Professional judgement in each instance had been exercised by the Directorate Senior Nurses and this had been overseen by the Director of Nursing or the Deputy Director.

The report set out the background including the outcomes of previous Skill Mix Reviews, including the 2014/15 investment of £917,000 into ward based nurse staffing and the move to supervisory status for ward leaders. In 2015/16 there was investment totalling £529,000 in ten registered midwives following the Birth Rate Plus Review, additional cover on Redlynch and Pitton Wards as a pilot and increased cover in the Emergency Department.

The CQC Report issued in April 2016 had made a number of recommendations for review in relation to patient to nurse – patient ratios in place at the time of the inspection and national guidance. The Board was reminded that the nurse to patient ratios were supplemented by nursing assistant roles. It was noted that work was continuing to review staffing levels in the Spinal Unit in relation to the Model of Care and also for the range of services provided to children.

In addressing the issues raised by the CQC Report it was noted that Amesbury Ward now had an RN to patient ratio of 1:11 on the night shift, previously 1:16. Downton and Chilmark Wards were 1:12 and Laverstock 1:13 at weekends only. Following consideration of the range of triangulated factors described above no specific action had been taken in relation to Downton and Chilmark. For Redlynch and Pitton a weekend day shift had been agreed as a six month trial and there was improved feedback which led to the recommendation to make this substantive. In Redlynch Ward in particular the costs would be offset by reduced use of Specials. In Whiteparish Ward the recommendations reflected the increased medical take. In ED another minor's nurse was required. In Critical Care the increase to ten beds had been addressed by the recruiting of twelve new registered nurses and there were no recommendations for this area. The Midwifery Unit continued to fill vacancies for qualified midwives.

The Board approved the investment described in the report and subject to the savings and cost avoidance in relation to reduced specialing in Redlynch and Pitton the following:

Band 2 night shift Redlynch
Band 5 long day Pitton
Substantive funding of weekend funding for Redlynch and Pitton
ED minors nurse 1000 – 2200
Avon Ward Band 3 establishment increase
Whiteparish registered nurse at weekends

Total investment cost £286,919 funded by savings and cost avoidance of £303,000.

2197/04 National In-Patient Survey 2015 – SFT 3795 – Presented by LW

The Board received the report on the survey. It was noted that the report presented an overall positive picture with the Trust retaining scores that were above the national average and maintaining its own year on year position. The findings of the report were being overseen as actions by an internal group and the survey report was accompanied by action plans for the relevant areas.

The Board noted the report.

2197/05 Annual Revalidation Report – SFT 3796 – Presented by CB

The Board received the Annual Revalidation Report as the designated body for the revalidation process. As responsible officer CB described the range of duties undertaken to ensure the skills of the medical workforce were maintained and to take action on any concerns about medical practitioners. There was support from an appraisal lead with a number of appraisers in place. The system was operated through an e-portfolio system. The Responsible Officer looked after just over 200 practitioners. The compliance rate was 96% and she described actions taken in support of the above mentioned objectives. It was requested that a Non-Executive Director be appointed to oversee the Quality Assurance Board. NM

The Board noted the report and that it would be shared with the Second Level Responsible Officer and it approved the Statement of Compliance in relation to the Re-Validation Regulations.

2198/00 PERFORMANCE AND PLANNING

2198/01 Finance & Performance Committee Minutes - 31 May and 27 June 2016 – SFT 3797 – Presented by NM

The Board received for information the confirmed minutes of the meetings of the Committee held on 31 May and 27 June 2016.

2198/02 Financial Performance to 30 June 2016 – SFT 3798 – Presented by MCo

The Board received the Month 3 Finance Report. It was noted that the year to date position was a deficit of £83,000 and there was an in month surplus of £212,000 which was due to continuing over performance on non-elective activity, outpatient attendances and critical care days. This was above the 2016/17 plan. Cost improvement schemes were on target but MCo reminded the Board that the targets were back-loaded to the end of the

financial year. Capital expenditure was broadly on track.

In response to a question from Paul Kemp MCo confirmed that the assumptions of the Trust's cash reporting was that the Sustainability and Transformation Funding was received in full and excluded any amount loaned to the Trust by the Independent Trust Financing Facility.

The Board noted the report.

2198/03 Progress Against Targets and Performance Indicators to 30 June – SFT 3799 – presented by AH

The Board received the Operational Performance Report. It was noted that the Trust did not deliver the Emergency Department Standard in Month 3 – 92.8% of patients had been admitted or discharged within four hours. There was high attendance in the Emergency Department including an increase in patients attending through the major's pathway. Actions to increase ED capacity and decrease demand as described at the previous Board meeting are being followed through.

The Trust had not delivered the RTT Incomplete Standard, delivering 90.1% against the 92% standard. The significant increase in non-elective admissions had resulted in the cancellation of a high number of elective procedures.

The Trust had delivered its cancer waiting times in Quarter 1.

Only a handful of trusts were delivering the ED target nationally at present. It was noted that actions for winter planning were under way and the Trust continued to look at discharge and bed capacity. The Emergency Department could still improve its triage and prioritisation of patients. Other actions being pursued included working with the local authority and Better Care Fund to improve arrangements for discharge, streamlining the pathway out of the hospital. There had been meetings with nursing home organisations although it was noted that these also had staffing difficulties. Local GPs were very well engaged in addressing these issues.

The Board noted the report.

2198/04 Update on Strategic Planning and Programme Management – SFT 3800 - Presented by LA

The Board received the major projects report and it was noted that NHS Improvement's assessment of the Trust's Annual Plan had recently been received. It was understood that there would be a requirement for a two year operational plan with details to be published in September and required to be submitted in December. The Major Project Report highlighted progress with the Electronic Patient Record implementation, GS1, Wiltshire Health and Care, the joint venture to provide a Sterilisation and Disinfection Unit and organisational development impact.

It was noted that the Wiltshire Health and Care LLP was now live and would be reporting to Finance and Performance Committee and Clinical Governance Committee as appropriate. Good progress was being made on the Scan4Safety (GS1) initiative. Work continued on finalising the contract for the SDU with a view to this arrangement starting from 1 September 2016. The go-live date for the Electronic Patient Record was 28 October. It was noted that the Data Warehouse issue was now rated amber (from red).

The Board noted the report.

2199/00 PAPERS FOR NOTING OR APPROVAL

2199/01 Annual Report of the Remuneration Committee 2015/16 – SFT 3801 – Presented by NM

The Board received for information the Annual Report of the Remuneration Committee setting out how the committee had discharged its responsibilities in relation to Executive Directors' pay in the past year.

2199/02 Audit Committee Minutes – 20 May 2016 – SFT 3802 – Presented by PK

The Board received for information the minutes of the Audit Committee which had focused on the approval of the Trust's Annual Report and accounts. PK highlighted an internal audit report which had been considered by the Committee looking at controlled drug and fridge management. It was noted that work continued by the Directorate Senior Nurses to continue to check and audit this at ward level.

The Board noted the minutes of the Audit Committee.

2199/03 Minutes of Clinical Governance Committee – 19 May and 23 June 2016 – SFT 3803 – Presented by NM

The Board received for information the confirmed minutes of the Clinical Governance Committee for 19 May and 23 June.

2200/00 ANY OTHER URGENT BUSINESS

2201/00 QUESTIONS FROM THE PUBLIC

In relation to a question from Raymond Jack it was noted that the Finance and Performance Committee continued to monitor the appointment of agency spend in detail.

An update was given in relation to the turnover and recruitment of nurses through general recruitment, newly qualified nurses and overseas nurses.

2202/00 DATE OF NEXT MEETING

The next ordinary meeting of the Board would be held on Monday 3 October 2016 at 1.30 pm in the Board Room.

CHIEF EXECUTIVE REPORT

MAIN ISSUES:

SUSTAINABILITY AND TRANSFORMATION PLANS

At the end of September I started my autumn staff presentations which give me an opportunity to brief our staff on the latest local and national developments, our performance and key strategic objectives. These presentations also include information about the Sustainability and Transformation Plans (STPs) for our area and the latest position which will increase their understanding of the plans and what they will mean for staff here in Salisbury, prior to the submission of the STP to NHS England in late October. As part of the five year forward view all NHS organisations and local authorities are working in partnership within geographical areas to develop STPs, which aim to transform health and care services within available resources over the next five years.

ELECTRONIC PATIENT RECORD

We are now entering the critical phase in our run up to the introduction of the electronic patient record (EPR) and plans are on track with a full “dress rehearsal” taking place in early October prior to the current planned actual go live at the end of the month. This will start with the replacement of our patient administration system (iPM) and the introduction of the new system in our Accident and Emergency Department, followed by inpatient and outpatient areas. The team have been working closely with staff across the Trust to move information, test systems and carry out training on the new system which will hold health records electronically in one secure place and ensure that staff have faster and easier access to the right level of information to look after their patients. Records are currently kept securely, but on paper and computer in separate places.

SEASONAL FLU CAMPAIGN 2016

In early October we start our staff seasonal flu campaign. Comprehensive staff vaccination can help reduce the risk of flu spreading across patient areas and affecting vulnerable patient groups and can also impact on staff sickness within the Trust. As in previous years the vaccine will be available for all Trust staff in on-site walk in clinics throughout the autumn and winter and staff will also be able to book vaccination appointments in the Occupational Health Department.

SUCCESSFUL PLACE ASSESSMENT

Cleanliness, food quality and patient’s overall experience of facilities and support have been rated highly in the latest national report on the Patient Led Assessment of the Care Environment (PLACE). PLACE inspections assess how an organisation is performing against a range of non-clinical activities that impact on the patient experience of care and covers cleanliness; food; privacy, dignity and wellbeing; condition, maintenance and appearance of the hospital environment. This year it also covered several new topics around ward food quality and support at mealtimes and whether hospitals provide an environment that is supportive for people with disabilities. The results are a credit to our staff and show an improvement on our good scores last year. They also highlight the fact that we are better than the national average in all areas and lead the way in nearly all areas when compared with hospitals in our surrounding area.

MATERNITY UNIT SIGNS UP TO TWO NATIONAL CAMPAIGNS

The Maternity Unit has recently signed up to two new campaigns highlighting our commitment to the promotion of a healthy workplace for our midwives and the wellbeing of pregnant women and their babies. The Royal College of Midwives' *Caring for you Campaign*, focuses on initiatives that support the health, safety and wellbeing of midwives. We are pursuing initiatives such as in house study days, the provision of a variety of holistic therapies and consulting with our staff to identify areas that would benefit from improvement. The unit has also signed up to the Foetal Alcohol Spectrum Disorder (FASD) Trust's campaign to highlight the importance of women having an alcohol free pregnancy, as exposure to alcohol in the womb can increase the risks to the baby.

NEW SHAPE UP@SALISBURY PROGRAMME LAUNCH

We are committed to ensuring that our staff have the right support that they need to do their jobs effectively and we recognise the value of good health and wellbeing at home and work. We already have a wide range of support available from mental health advice to a number of physical activities and we have now launched a new programme of activities. This forms a key part of our health and wellbeing strategy and supports our aim to attract and retain the best staff here in Salisbury.

NURSING ASSISTANT WINS PRIDE IN PRACTICE AWARD

It is important that we recognise the enormous contribution our staff make to local health services and celebrate their achievements whenever we can. I want to congratulate senior nursing assistant Emma Ward who has won our Pride in Practice Award for her enthusiasm and passion for nursing and her compassion and care for her patients. The Pride in Practice Awards were established in 2012 to celebrate the contribution nurses, midwives, therapists and their teams make to the hospital, patients and carers and the extra steps they take to ensure that patients receive high quality care. They reflect the Chief Nursing Officer for England's vision for staff and centres on the six key values of care, compassion, courage, communication, commitment and competence.

SUCCESSFUL AGM

It was pleasing see a good audience again at the Salisbury Arts Centre for the Trust's AGM, highlighting the tremendous support that we enjoy from the community and the real interest people have in the NHS and our local health services. This year we had special presentations by Dr Christine Blanshard (Medical Director) and Lorna Wilkinson (Director of Nursing) on the Trust's progress on our Care Quality Commission (CQC) action plans. Radiologist Dr Lucy Bushby and Services Manager Alison Montgomery gave an overview of the department's achievements and the progress that they had made on their individual CQC action plan. Outpatient and Diagnostics Services were rated as *Good* by the inspectors.

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

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

AUTHOR: Peter Hill

TITLE: Chief Executive

SFT 3810

Workforce Report
M5
2016-17

Alison Kingscott Director of HR&OD

Summary

Salisbury NHS Foundation Trust

- Appraisal compliance for non-medical staff is on target this month at 85%, compared to 84% last month. Medical staff appraisal compliance was 91%.
- The Turnover rate decreased slightly in month 5 from 9.46% to 9.44%. Reasons for turnover are being monitored and actions taken at Trust and Directorate level. The overall turnover trend for the last 2 years is downwards, with the Trust's turnover rate of 9.5% in line with other Hospitals across the patch.
- Staff sickness for the last year is 0.29% above target at 3.29%. This compares favourably with the NHS sickness rate of 4.24% for 2015. The Trust has number of Health and Wellbeing initiatives to support the aim to help staff lead healthy lives.
- Mandatory training compliance remained at 82%, which is slightly below target (85%).
- The total number of overall vacancies has decreased since last month due to the impact of recent recruitment initiatives combined with slightly lower turnover. Nursing and Midwifery recruitment continues apace, with a further EU cohort arriving in August. Further UK and international recruitment is planned over the coming months.

Achievements in Month

Salisbury NHS
NHS Foundation Trust

- The latest cohort of nine EU nurses arrived in August and are going through their induction programme.
- Employee Staff Record Employee Self Service was rolled out to enable staff to view personal details on-line including pay-slip, total reward (pension) statement and to change personal details where applicable.
- The Trust attended the British Forces Resettlement Service job fair at Tidworth to promote the Trust as an employer of choice, and supported the Reserves Day.
- We have reached agreement to implement a ShapeUp@Salisbury Facebook page which will connect like minded staff and enable the Trust to use social media as a tool to promote health and wellbeing.
- Our Equality, Diversity and Inclusion team have started to collate & circulate pen portraits of BME role models.
- The RainbowSHED attended the Wiltshire and Swindon Pride event. This offered the opportunity to share information on SFT as an inclusive employee.
- 41 new Junior Doctors joined the Trust in August and had a full day mandatory induction followed by departmental inductions.
- The Demand for Clinical Simulation Training continues to grow, and has become fully embedded in Paediatrics, with regular dates planned to facilitate 'insitu' scenarios. This will involve all disciplines participating in caring for the deteriorating child or infant within their clinical areas.

Patient-Centred & Safe | Professional | Responsive | Friendly

Directorate headlines

Salisbury NHS
NHS Foundation Trust

Surgery

Surgery are above target for Medical appraisals at 90%, with non –medical appraisals increasing to 79% from 77%. Compliance on MAST levels has increased slightly to 82%, and sickness at 3.56% is higher (worse) than the directorate target (3.40%).

Facilities

Have the highest achievement of appraisals at 95%; and continue to exceed the 85% target in MAST. Sickness is 0.84% above (worse than) the directorate target at 4.34%.

MSK

MSK Appraisal rates are on target for Non-Medical staff and above target for Medical Staff. MAST compliance levels remained the same, and are below target. Sickness is 0.44% worse than the directorate target at 3.19%.

Medicine

Sickness at 3.88% is above (worse than) Directorate target of 3.40%. Medical appraisals are above target. Non-medical appraisals and MAST continue to require improvements to reach target.

CSFS

Very good levels of medical and non-medical appraisal compliance. Evidence of improvements in MAST through close performance management. Sickness is above (worse than) target at 2.60%.

Corporate & Quality

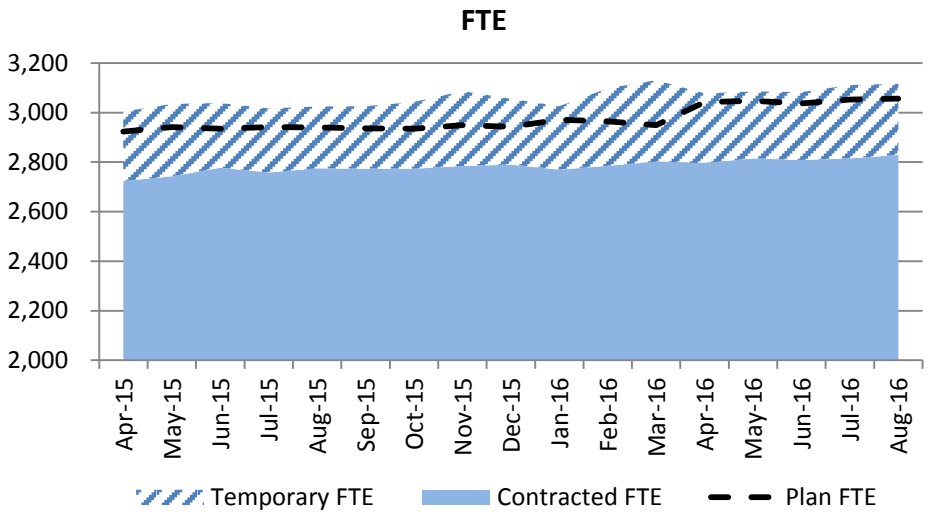
Both Corporate and Quality are exceeding MAST targets. For appraisals, Corporate and Quality are above the Trust Target (85%), at 89% and 88%.

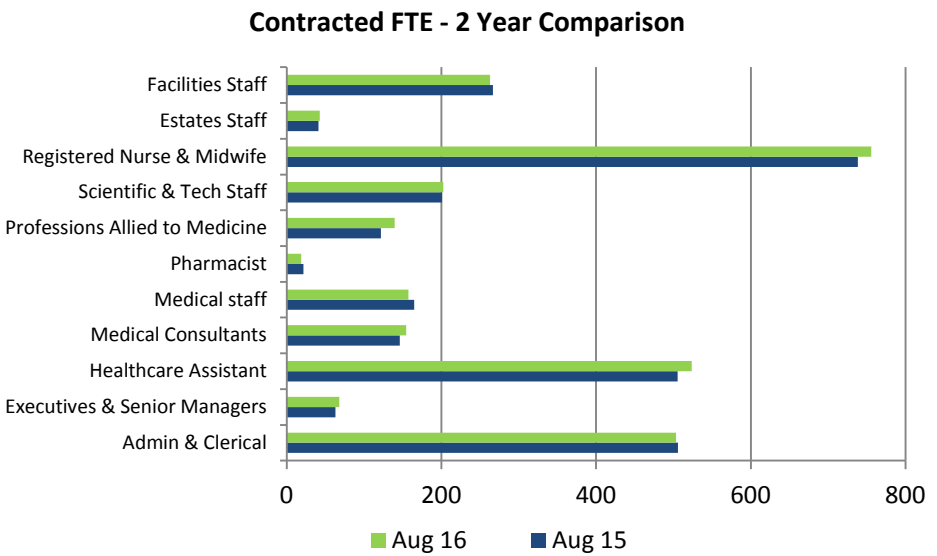
Workforce M5

Salisbury NHS Foundation Trust

August 16

Contracted Total FTE
2,829
(August 15 - 2,775)





Additional Notes

1. Overall staffing numbers remain over plan, reflecting special projects such as Electronic Staff Record, and operational issues relating to escalation beds. The use of temporary staff is seen mainly in registered nursing and nursing assistant.

2. There have been increases in the number of contracted staff (FTE) up by 54 FTE compared with August 2015, due to additional recruitment to replace temporary staff. Key areas of increase are :

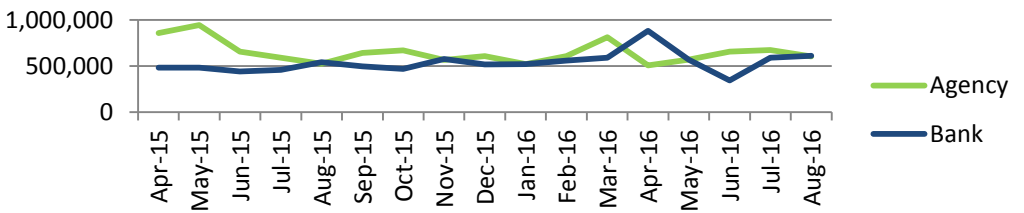
- **Registered Nursing and Midwifery: 17 FTE**
- **Healthcare Assistant: 18 FTE**

Temporary Workforce
M5

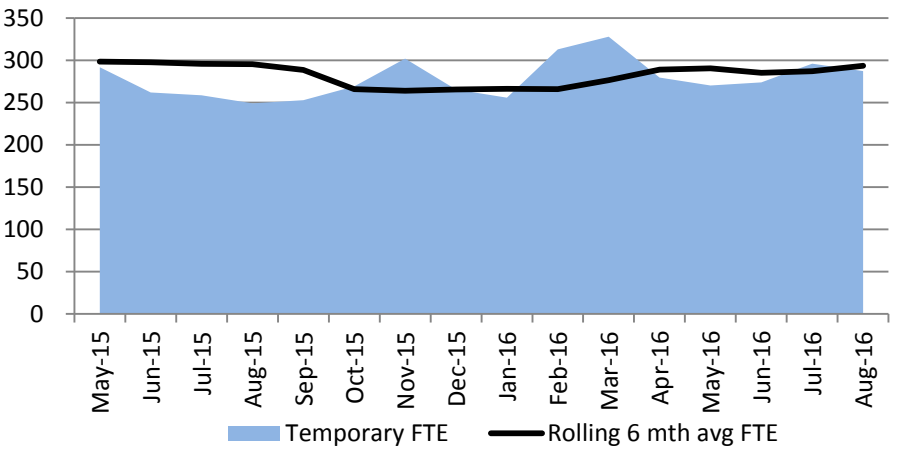
Salisbury NHS Foundation Trust

Temporary FTE 287
(August 15 - 249)

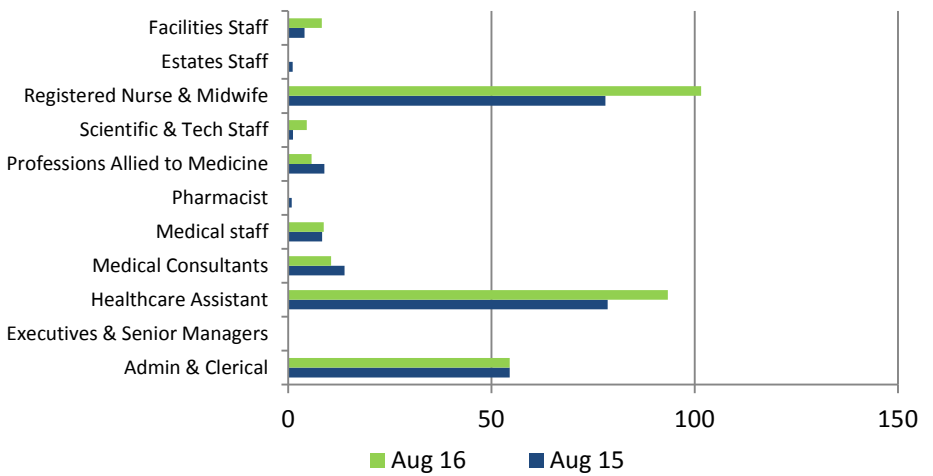
Agency and Bank Spend



Temporary FTE



Temporary FTE - 2 Year Comparison



Additional Notes

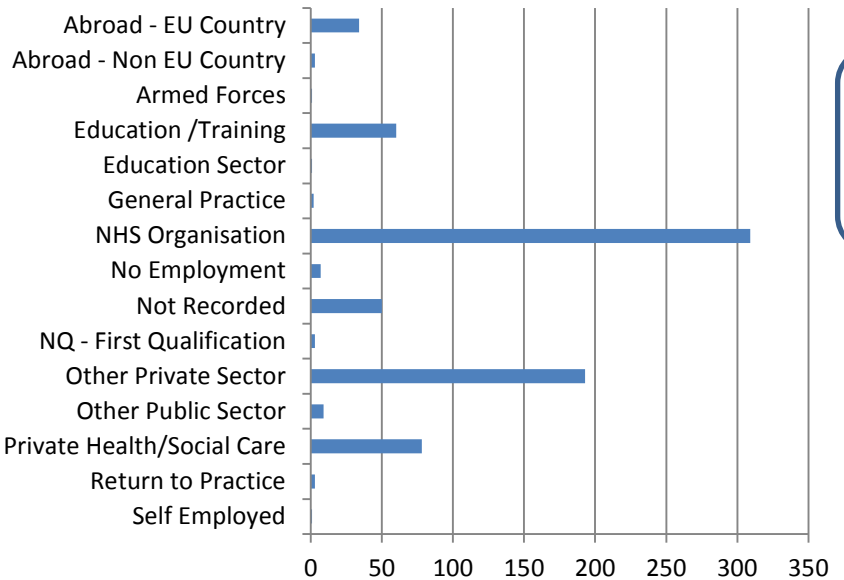
1. **Agency costs for the year to date stood at £3.0m, compared to £3.5m for the same period in 2015/16. Agency costs for August showed a decrease of £69k compared to the previous month.**
2. **Bank costs also stood at £3.0m for the year to date, compared to £2.4m for the same period in 2015/16. Bank costs for August showed an increase of £18k compared to the previous month. This is part of an ongoing effort to replace expensive agency staff with our own "bank" staff.**

Note: Temporary FTE includes bank and agency staff.

Starters – Source of Recruitment M5

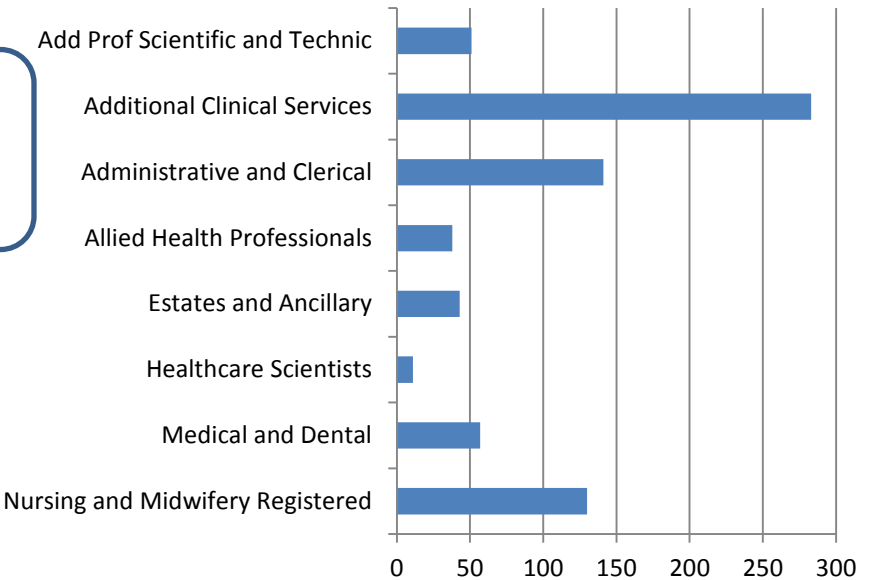
Salisbury NHS Foundation Trust

Number of Starters by Source of Recruitment



Number of M5 Starters 74

Number of Starters by Skills Group



Additional Notes

1. **There were 74 starters in month 5 compared to 45 in month 4.**
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 Southampton University NHS Trust, followed by Great Western Hospital, Swindon, Basingstoke and Dorset Healthcare NHS 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.

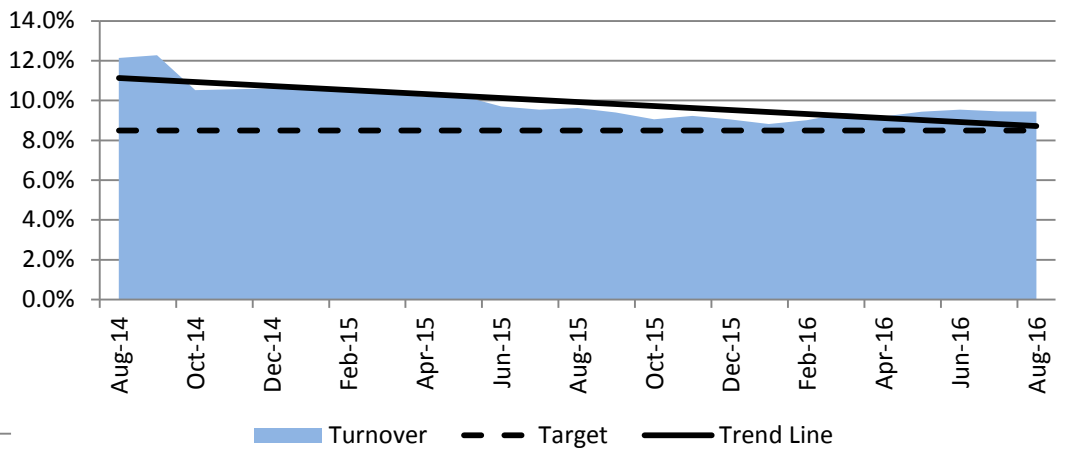
Labour Turnover
M5

Salisbury NHS
NHS Foundation Trust

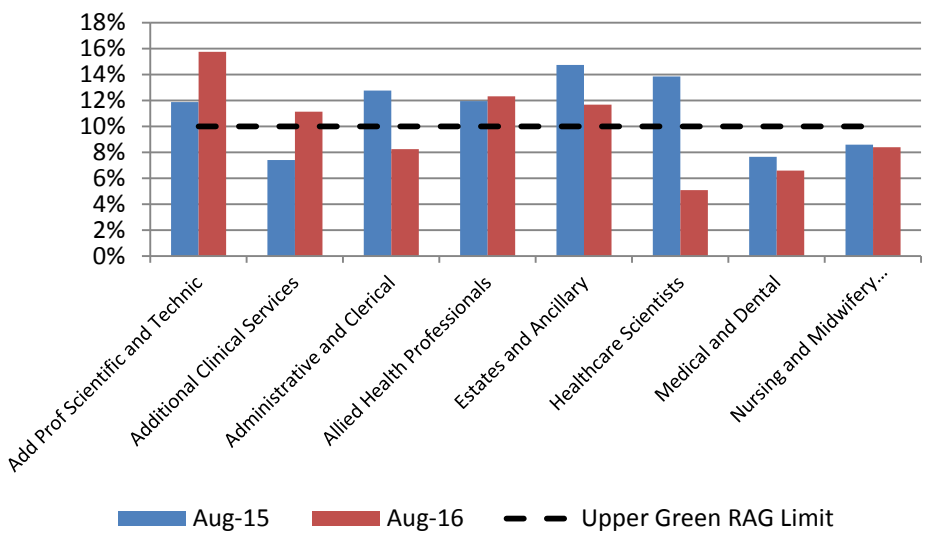
August 16

9.5%
(August 15 – 9.6%)

Labour Turnover



Labour Turnover by Skills Group



Additional Notes

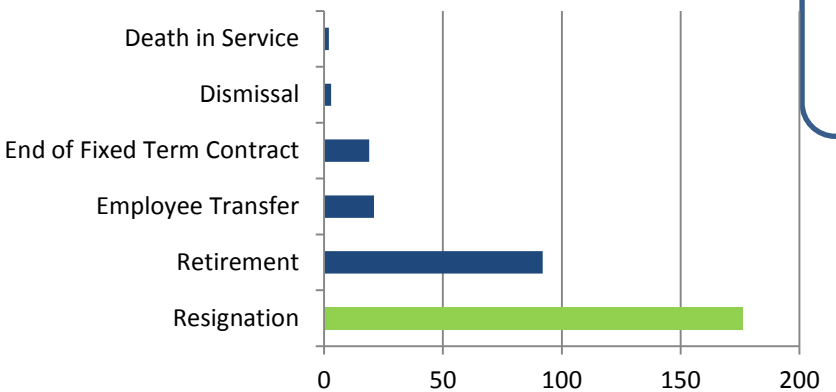
Note: Turnover figures are based on previous 12 months, and exclude bank staff and foundation and training doctors.

1. **Turnover in the year to August 2016 stood at 9.5% compared to 9.6% in the year to August 2015.**
2. **Groups with turnover higher than the Trust's 7-10% green RAG rating are being monitored closely at Directorate level and actions taken as appropriate.**
3. **Although the overall turnover trend is down there has been a slight increase since January 2016. This trend is being closely monitored at Trust and Directorate performance meetings.**
4. **In the year to 31 August 2016, 2,651 employees were in post at the start of the period, with 2,378 remaining at the end meaning 89.5% of employees were retained. A detailed analysis of stability is being discussed at the Executive Workforce Committee.**

Leavers
M5

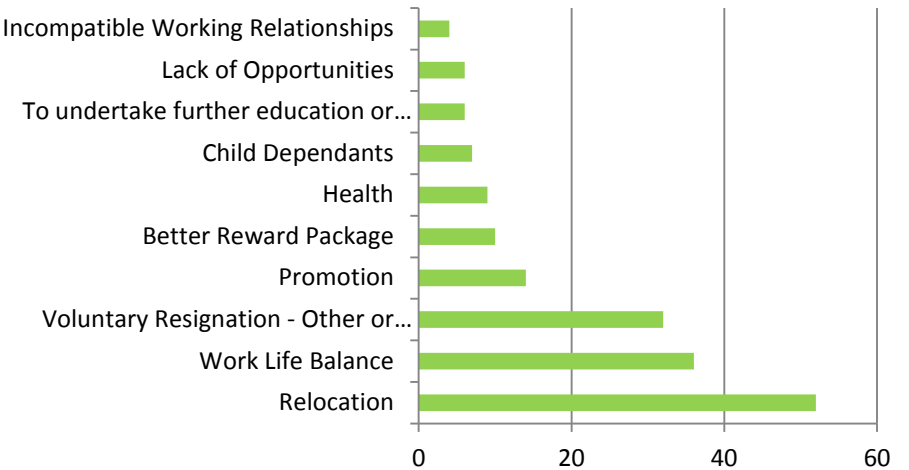
Salisbury NHS
NHS Foundation Trust

Number of Leavers by Reason

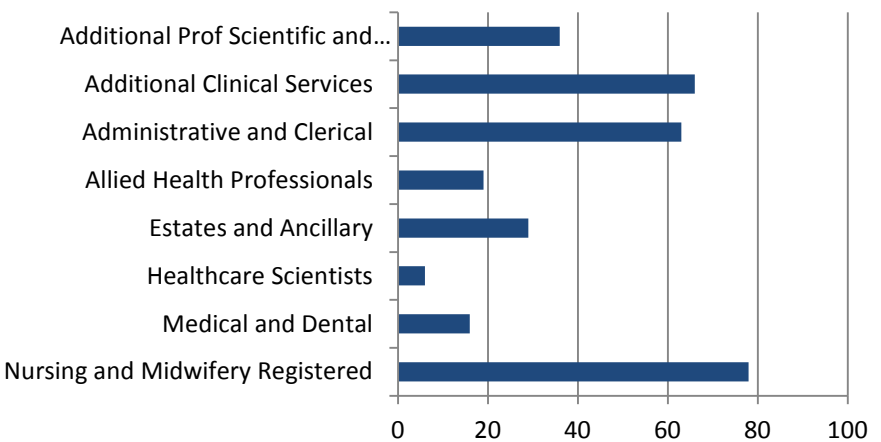


Number of M5 Leavers 28 (August 2015 - 27)

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. 31 leavers completed a leavers questionnaire in the year to date. Themes included pressure of work, opportunities for promotion, a desire for travel, and local departmental issues. These themes are fed back to managers for action.

Note: Figures based on previous 12 months data.

Patient-Centred & Safe | Professional | Responsive | Friendly

Vacancies by Skills Group
M5

Salisbury NHS
NHS Foundation Trust

Vacancies	Budget FTE	Contracted FTE	Vacancy FTE	%
Skills Group				
Admin & Clerical	539.15	503.49	36	7%
Executives & Senior Managers	69.84	67.88	2	3%
Healthcare Assistant	553.59	513.68	40	7%
Medical Consultants	160.74	157.42	3	2%
Medical staff	178.07	160.55	18	10%
Pharmacist	21.31	18.77	3	12%
Professions Allied to Medicine	140.95	139.43	2	1%
Scientific & Technical Staff	204.35	202.57	2	1%
Registered Nurse & Midwife	889.45	796.42	93	10%
Estates Staff	46.42	42.73	4	8%
Facilities Staff	251.96	262.84	-11	-4%
Total	**3055.83**	**2,865.78**	**190**	**6%**

Additional Notes

1. The overall vacancy rate remained the same as last month, with some small changes within the workforce. Professions Allied to Medicine vacancies have decreased since last month by 5 FTE.

2. 70 offers have been made to Nurses in the Philippines. Bank Nursing budgets are not included in budgeted FTE . Within the nursing FTE, are included Nurses waiting for PIN numbers, and maternity leave circa 4%.

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

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

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

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

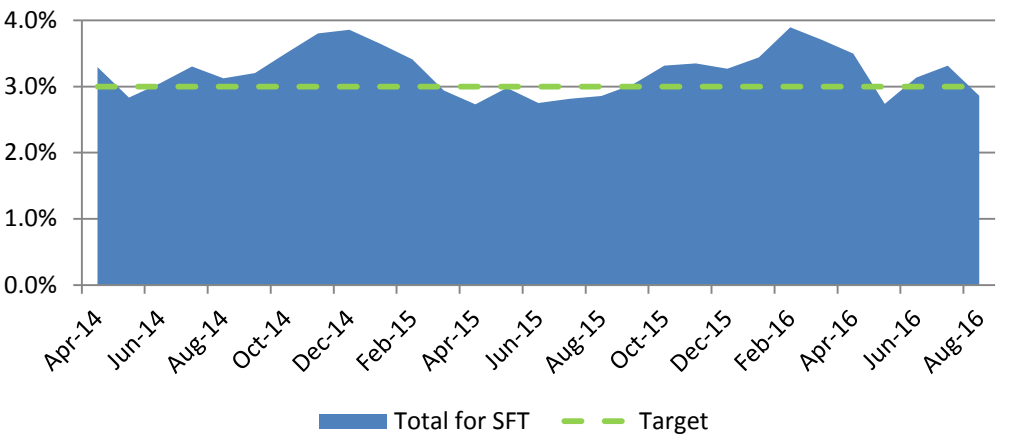
Sickness
M5

Salisbury NHS
NHS Foundation Trust

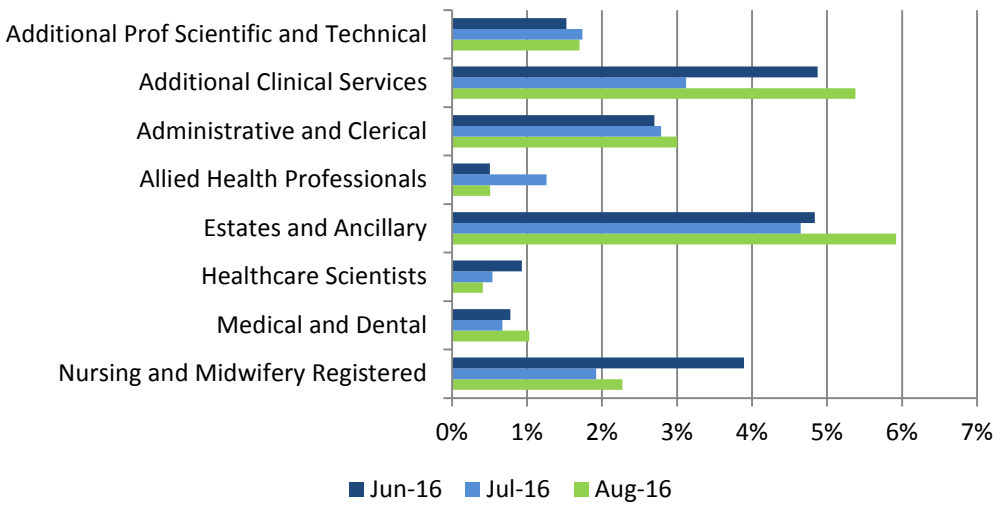
August 16

Percentage
3.29%
(August 15 – 3.21%)

Sickness Absence vs Target



Sickness Absence by Skills Group



Additional Notes

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

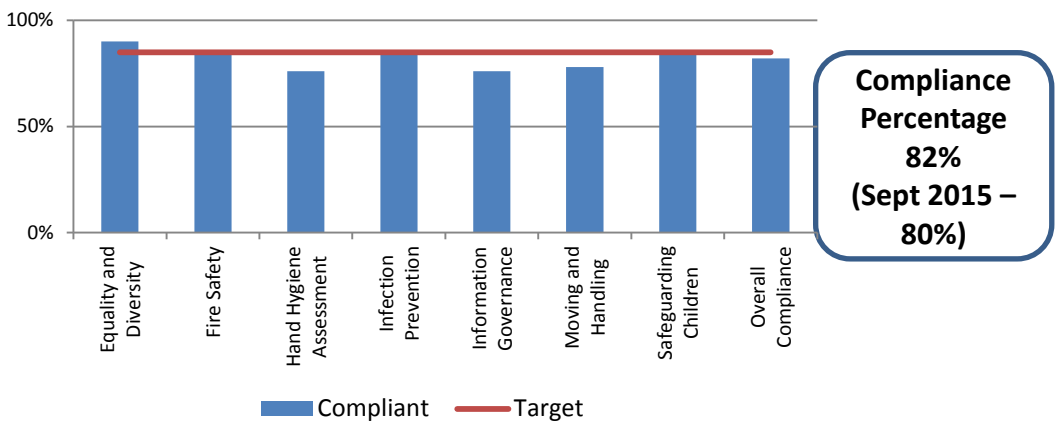
2. The most common reasons for sickness this month were 'Anxiety/stress/depression/other psychiatric illnesses' and 'Other musculoskeletal problems'. Occupational Health are providing support in these areas, and they form regular discussions at Operational Management Board.

3. The skills group with the highest sickness rate was "Estates and Ancillary" with 6%, followed by "Additional Clinical Services" with 5%, both of which are below the national NHS average sickness rates for these groups of 6.4% and 6.2% respectively.

Mandatory Training
M5

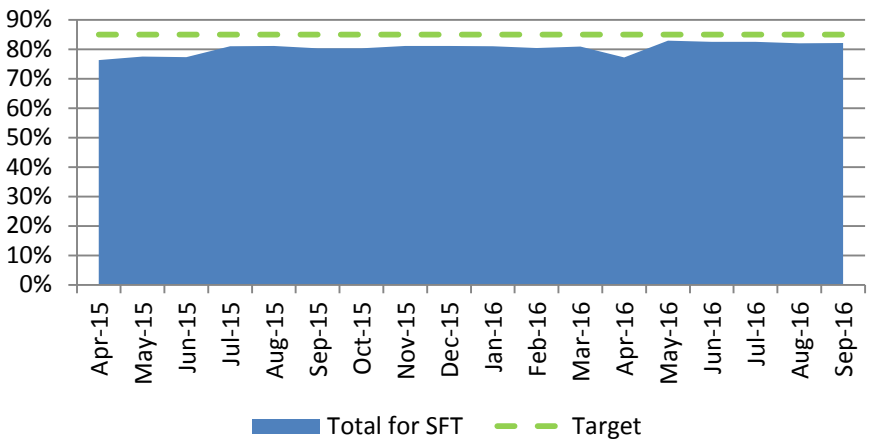
Salisbury NHS
NHS Foundation Trust

MLE Compliance by Category

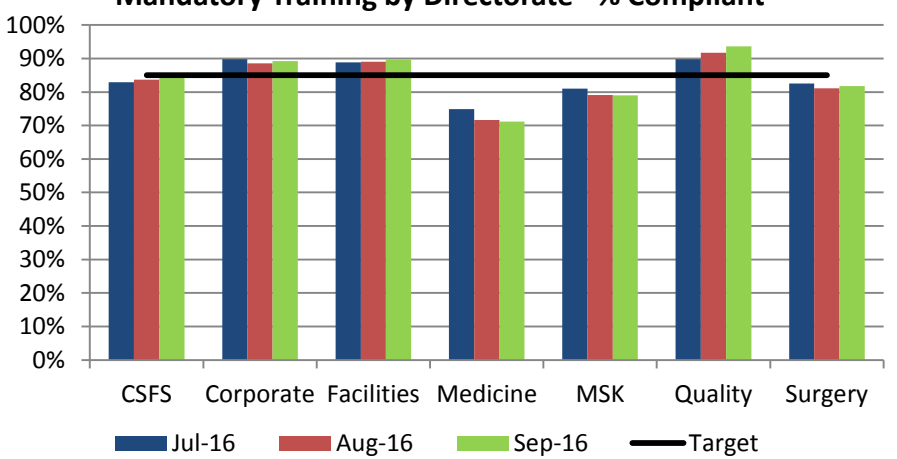


Compliance Percentage 82% (Sept 2015 – 80%)

Mandatory Training Compliance vs Target



Mandatory Training by Directorate - % Compliant



Additional Notes

1. The percentage of staff up to date with their mandatory training has remained at 82% this month against a target of 85%.
2. The directorate with the highest compliance rate was Quality at 94%, and the directorate with the lowest compliance rate was Medicine with 71%.
3. Information Governance training has the lowest levels of compliance, and there is a review of where training compliance is not currently recorded on the MLE system.
4. Highest compliance is in Equality and Diversity, which is viewed as a result of the proactive work of the Head of E&D.
5. Also, Hand Hygiene training is being recorded in live time to give an up to date picture, currently at 76%.

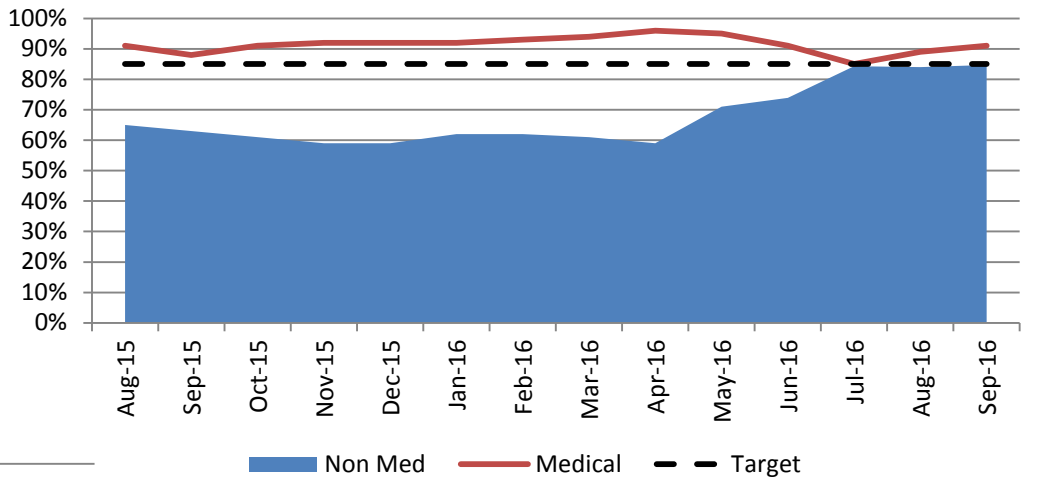
Appraisals
M5

Salisbury NHS
NHS Foundation Trust

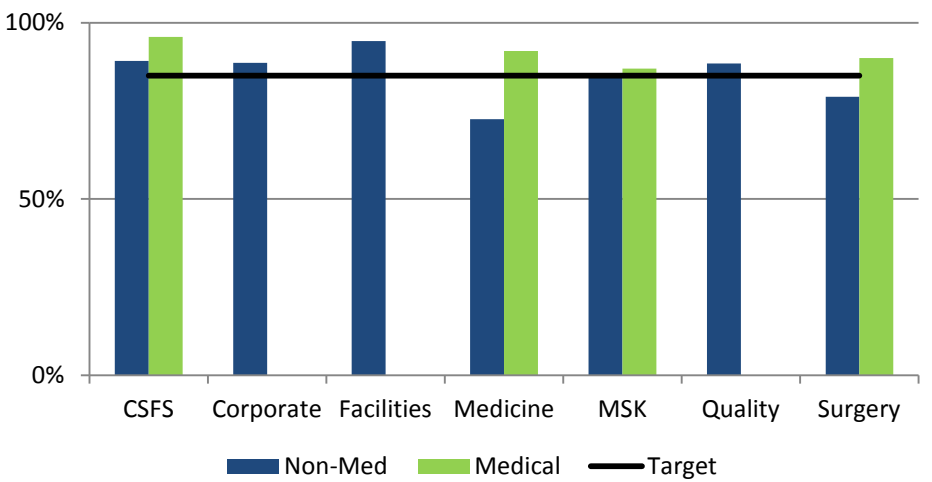
September 16

Compliance percentage - 85% non medical, 91% medical.

Appraisal Compliance vs Target



Annual Appraisal by Directorate - % Compliant



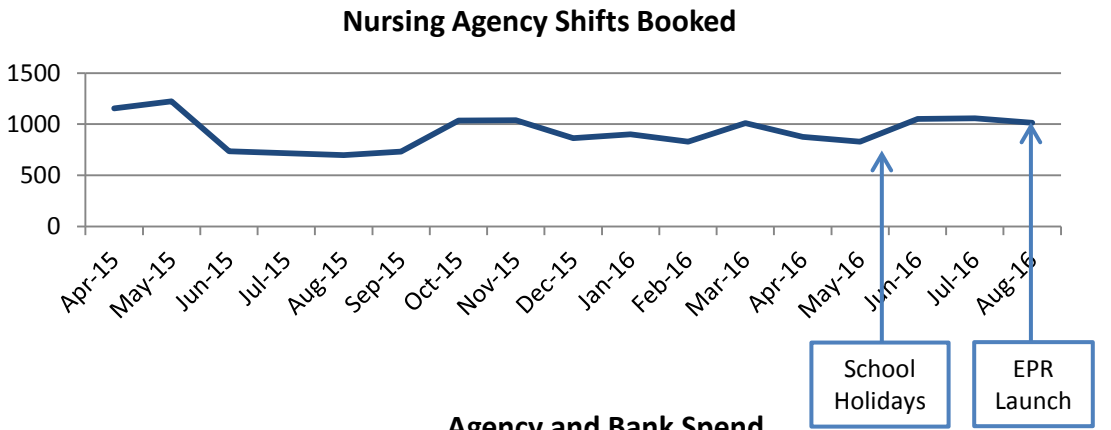
Additional Notes

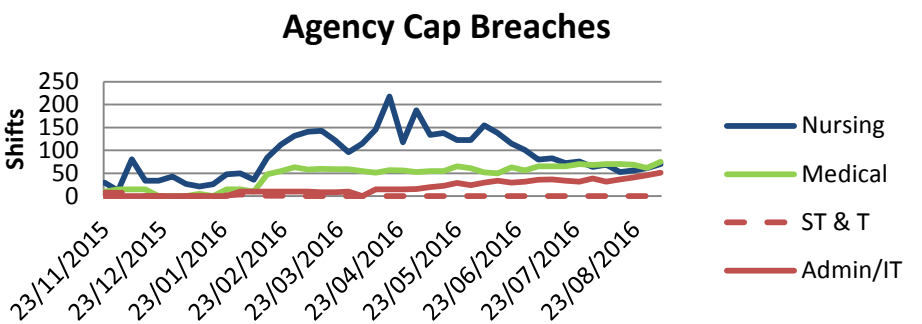
1. **Appraisal compliance for non-medical staff is up this month to 85% from 84%. Data is taken from a 13 month window to more accurately reflect activity.**
2. **Detailed non-compliance reports are now live and available to managers (providing the names of non-compliant individuals) for further action.**
3. **The percentage of medical staff with an annual appraisal in the last 12 months has increased this month from 89% to 91%.**

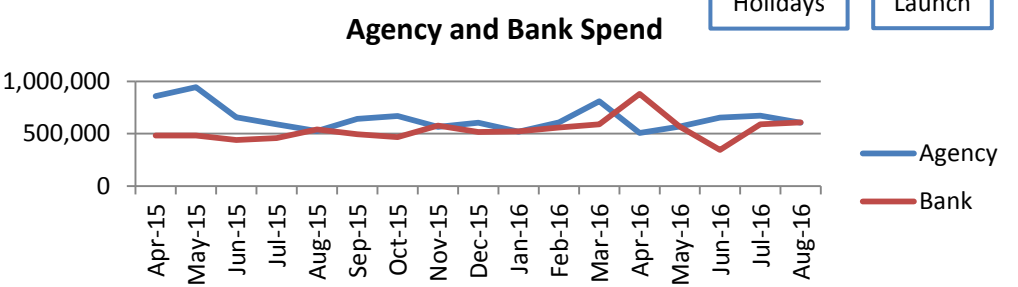
Agency Cap Breaches
M5

Salisbury NHS
NHS Foundation Trust

Agency Nursing Shifts 1015
Agency Nursing Cap Breaches 242 (24%)
Agency Medical Shifts 277
Agency Medical Cap Breaches 277 (100%)







Additional Notes

1. **The data shows a reducing spend on agency since April 2015 . The breaches of the Monitor caps reveals that the cost of agency is not reducing across all shifts and that the cost for agency, when it is used last minute, can be considerably high. The number of shifts booked for nursing (agency) has remained fairly static.**
2. **Escalation means that the use of bank and agency is likely to continue at similar rates in the immediate months. Bank spend began to increase again in July and August which is an encouraging trend.**

WRES (Workforce Race Equality Standard)

Salisbury NHS Foundation Trust

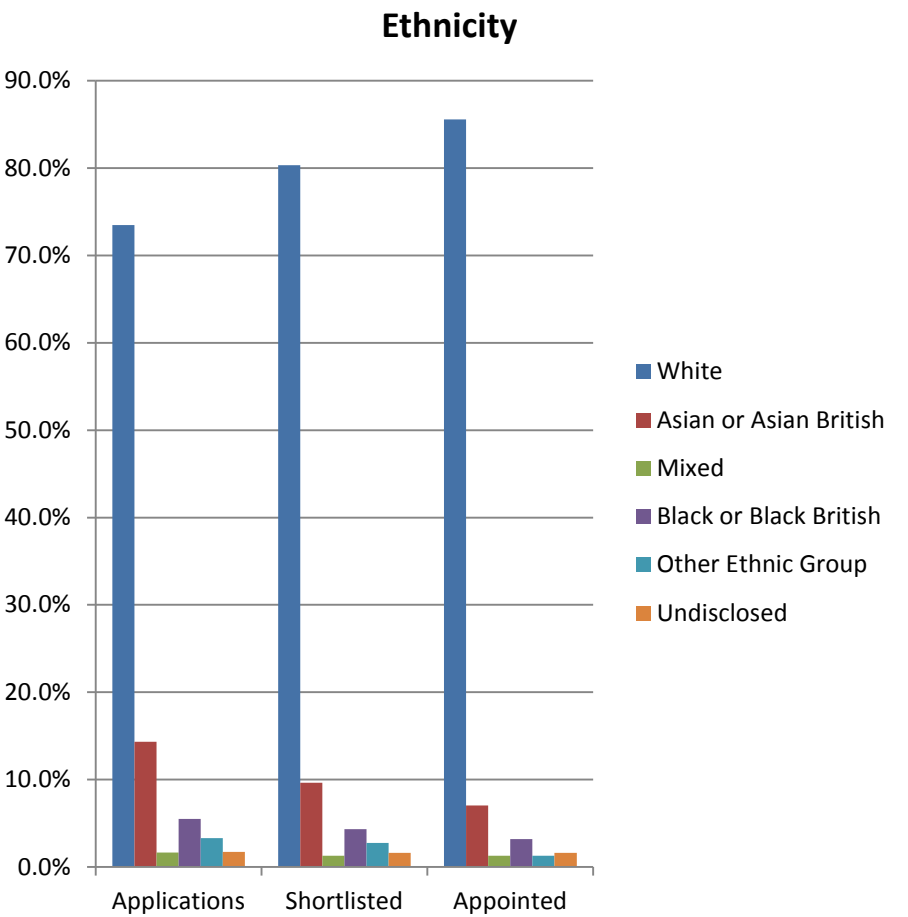
1. The WRES offers SFT the opportunity to understand their workforce race equality performance, including its BME representation at senior management and board level.

2. The evidence of the link between the treatment of staff and patient care is well evidenced for BME staff in the NHS, to this end the NHS is now in its second year of the WRES.

3. We have collated data from April 2015 to March 2016 and refreshed our annual WRES action Plan. The full version of the WRES is attached and includes 9 indicators, which compares data referring to white and BME staff using ESR.

4. Indicator 2 reports on the likelihood of staff being appointed from shortlisting across all posts. Currently if you are a 'white' applicant at SFT you are 1.50 more likely to be appointed to a post than if you are BME.

5. As a result of the data we have identified 4 key Trust wide priorities in our WRES Action Plan (V-2) 2016 onwards, please refer to ***the attachment,*** which also includes the full WRES data template 2016.



Key Risks/Assurances

Salisbury NHS Foundation Trust

- Appraisal rates continue to improve with information accessible to managers allowing for transparency and better targeted action. There is an Appraisal and MAST Steering Group to oversee improvements, and share ideas.

- Health and Well-being is a key retention feature and the “Shape up at Salisbury” initiative has been refreshed and is being promoted in September with a new plan of actions. Salisbury is actively engaged with the NHS Employers Workforce Retention Programme.

- Monitor cap breaches for the supply of Nursing agency shifts have continued to reduce, 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.

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation

Salisbury NHS Foundaton Trust

Date of report: month/year

July 2016

Name and title of Board lead for the Workforce Race Equality Standard

Alison Kingscott - HR & OD Director

Name and contact details of lead manager compiling this report

Pamela Permalloo-Bass - Head of EDI

Names of commissioners this report has been sent to (complete as applicable)

McAlpine Dina (NHS WILTSHIRE CCG) dina.mcalpine@nhs.net Lucy Baker (NHS WILTSHIRE CCG) lucy.baker8@nhs.net

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

Ashley Matthews (NHS Wilshire) ashleymatthews@nhs.net

Unique URL link on which this Report and associated Action Plan will be found

This report has been signed off by on behalf of the Board on (insert name and date)

Steve Long - EDI Champion and NED

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

N/A

b. Any matters relating to reliability of comparisons with previous years

N/A

2. Total numbers of staff

a. Employed within this organisation at the date of the report

4129

b. Proportion of BME staff employed within this organisation at the date of the report

9.30%

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

98%

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

We refreshed the staff E&D census data in 2013

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

We currently do not have a plan to refresh this data. We ask staff to complete at the start of their employment with us.

4. Workforce data

a. What period does the organisation's workforce data refer to?

April 2015 to March 2016

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Band BME White Not Stated Grand Total 1 0.00% 100.00% 0.00% 100.00% 2 11.88% 86.23% 1.88% 100.00% 3 4.27% 93.90%	1% BME 8-9 compares to 9% of the workforce	2015 data - We have not included staff on the AfC ie: consultants, dentists and doctors, as per WRES guidance (2015) 2016, Included AfC and clinical staff (as per WRES guidance 2016)	Please refer to WRES Action plan 2016 onwards
2	Relative likelihood of staff being appointed from shortlisting across all posts.	1.50 greater chance of being appointed if 'White'	1.86 greater chance of being appointed if 'White'	This shows a positive improvement in data, albeit a small improvement.	Please refer to WRES Action plan 2016 onwards
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	Likelihood of BME staff entering formal disciplinary process is 1.37 greater than white staff.	Lower likelihood of BME staff entering formal disciplinary than white staff.	Between 01 April 2014 and 31 March 2016, of 35 staff who entered the formal disciplinary process, 5 were BME. This data shows that BME staff experience is 0.80% worse than White staff experience. Likelihood of BME staff entering formal disciplinary process = 5/383 = 1.31%	Please refer to WRES Action plan 2016 onwards
4	Relative likelihood of staff accessing non-mandatory training and CPD.	78% of BME staff who completed Staff Survey answered Yes to completing ' non mandatory training' in comparison to	Incomplete in 2015/14	78% of BME staff who completed Staff Survey answered Yes to completing ' non mandatory training' in comparison to 75% White.	Please refer to WRES Action plan 2016 onwards

Report on the WRES indicators, continued

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White 22% BME 17%	White 31% BME 23%	This data has been extracted from the staff survey results and shows the experience of harassment, bullying or abuse from patients is higher for white staff.	Please refer to WRES Action plan 2016 onwards
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White 22% BME 29%	White 27% BME 23%	This data has been extracted from the staff survey results and shows the experience of harassment, bullying or abuse from staff is higher for BME staff, which is an increase from last years results.	Please refer to WRES Action plan 2016 onwards
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White 91% BME 71%	White 93% BME 62%	We know from our data that In 2015/16 90% of promoted staff were white,7% were BME. This compares to 89% ration white and 9% BME ratio.	Please refer to WRES Action plan 2016 onwards
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 4% BME 19%	White 7% BME 19%	This data has been extracted from the staff survey results 2015. 889 (94%) White and 55 (6%) BME staff in 2015 completed the Staff Survey. 10 people (19% BME)	Please refer to WRES Action plan 2016 onwards
	Board representation indicator For this indicator, compare the difference for White and BME staff.				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	100% White voting Board in comparison to 9% BME workforce	100% White voting Board in comparison to 9% BME workforce	The Trust had several NED vacancies in 2015/16 which have now been filled. There were no BME shortlisted despite active headhunting from our recruiting agency.	Ongoing awareness raising of BME representation on Executive Team & Trust Board. Equality Analysis (EA) discussed at prior to advertising. E&D competency to added to CEO interviews.

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

6. Are there any other factors or data which should be taken into consideration in assessing progress?

We have set up a WRES working group which includes BME staff members. Part of this group is to discuss and formulate ideas going forward. So far the WRES Network plan to work on pilot project as BME observers during interview/selections stages for selected jobs and profile BME role models within the Trust.

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

www.salisbury.nhs.uk/AboutUs/EqualityAndDiversity/Documents/WRESActionPlan2016onwards.pdf

Click to lock all form fields and prevent future editing

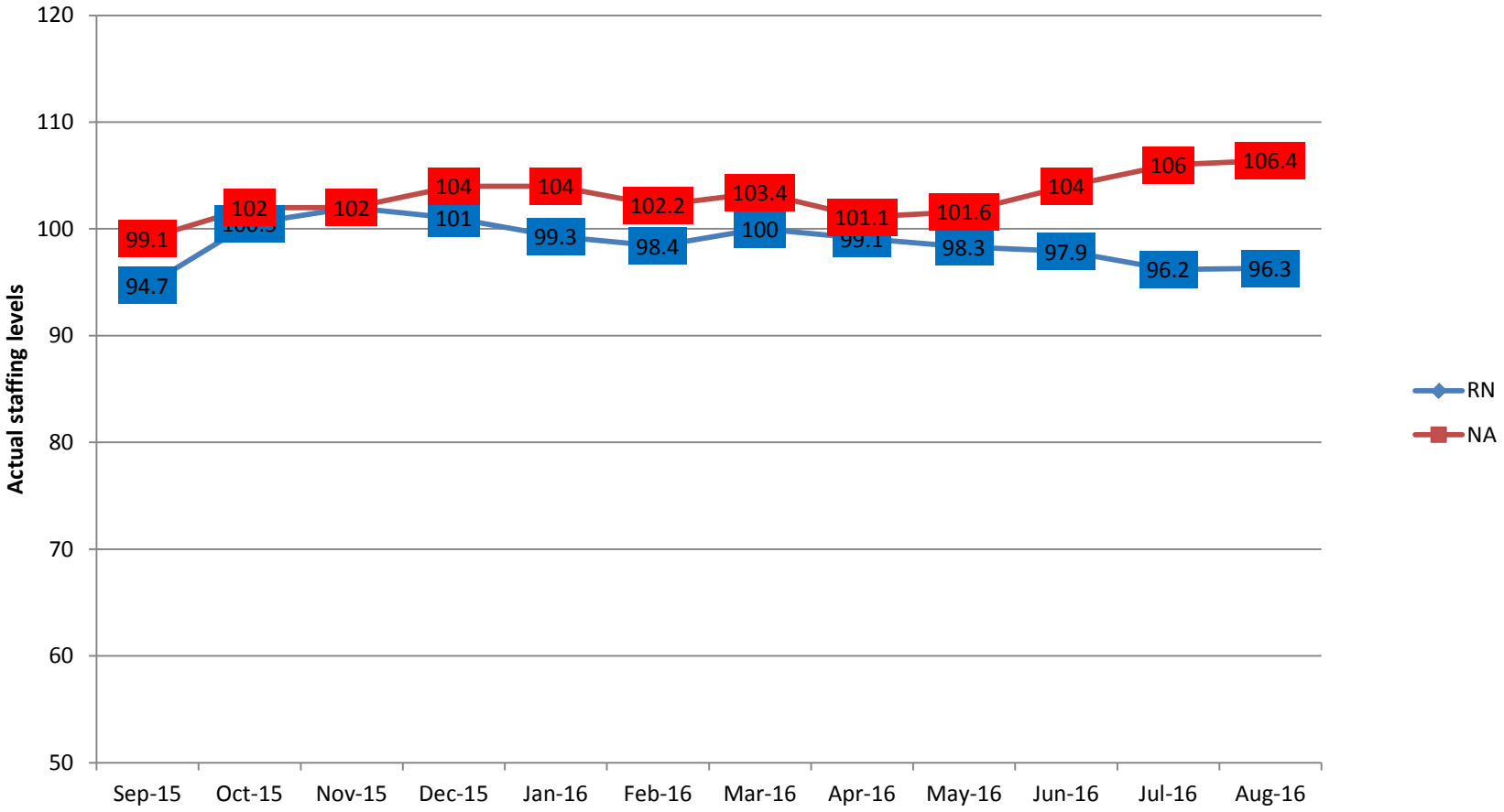
Equality, Diversity & Inclusion – WRES (Workforce Race Equality Standard) – 2016 Onwards (Version–2)

WRES – Priorities 2016/17	Current Position	Plans for 2016/17	Future Developments/ Plans for 2017/18
We will share our WRES audit with our entire workforce with a narrative to explain data.	We have published the WRES on the hospital website.	Request PR guidance and support for a communication strategy relating to our WRES headlines for internal & external use.	Using the WRES, drill down data, we will work with 'Hot Spot' areas with tools to support directorates.
We will set up a WRES network group to assist with issues that have arisen from the WRES audit and help with tangible results to close the gap between White and BME staff treatment, experience and opportunities in the workplace.	We have set up a WRES network of BME staff who are contributing to the debate and outcomes of the current WRES data.	We are reviewing NHS jobs data quarterly by directorates and plan to share data with respective directorate managers/ leaders.	Develop the WRES network further, including its increasing membership.
We will nominate a Board member responsible for the WRES implementation in our organisation.	We have a NED Equalities Champion and Executive Equalities Lead.	The NED and Executive Lead will champion the WRES at Trust Board on a regular basis.	Through continued engagement with our managers/leaders SFT will identify tangible data outcomes.
We will identify senior BME role models within our organisations and support recruiting managers, increasing their awareness of unconscious bias.	We have identified BME staffs who have agreed to become BME role models for the organisation.	Ensure that the 'Role Model' profile is promoted through various communication channels. Using existing leadership programmes promote the programme directly to aspiring BME leaders. Executive Equality Lead will engage with the Trust Board on E&D competencies during CEO selection & recruitment process.	Develop BME Observers at interview stage – pilot this programme and review and any changes.

Safe Staffing NQB Report – August 2016

Monthly Comparisons – Actual Staffing Levels

Registered Nurses			Nursing Assistants			Combined			Actual Skill Mix	
P	A	%	P	A	%	P	A	%		
56255.8	54192.9	96.3%	32168.2	34231.9	106.4%	88424	88424.8	100%	61%	39%



Overview of Nurse Staffing Hours – August 2016

	RN	NA
Total Planned hours (day shift)	33137.8	21322.2
Total Actual hours (day shift)	31328.8	22020.6
Percentage	**94.5%**	**103. %**
Total Planned hours (night shift)	23118	10846
Total Actual hours (night shift)	22864.1	12211.3
Percentage	**98.9%**	**112.6%**

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

Nursing Hours by Day Shifts

Row Labels	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**13277.48**	**12776.07**	**96.2%**	**9398.50**	**10688.17**	**113.7%**
Breamore Ward	1051.00	1047.75	99.7%	846.50	1020.50	120.6%
Durrington Ward	1010.00	975.17	96.6%	821.50	1240.92	151.1%
Farley Ward	1799.50	1728.83	96.1%	1464.00	1630.33	111.4%
Hospice	901.00	923.25	102.5%	662.50	669.50	101.1%
Pembroke Ward	771.00	762.00	98.8%	361.00	369.50	102.4%
Pitton Ward	1486.00	1482.50	99.8%	1185.00	1173.25	99.0%
Redlynch Ward	1437.23	1411.90	98.2%	1178.00	1143.17	97.0%
Tisbury Ward	2014.75	1752.50	87.0%	708.00	794.50	112.2%
Whiteparish Ward	1638.50	1740.17	106.2%	995.50	1172.00	117.7%
Winterslow Suite	1168.50	952.00	81.5%	1176.50	1474.50	125.3%
Surgery	**5940.00**	**5821.92**	**98.0%**	**2365.50**	**2201.60**	**93.1%**
Britford Ward	1831.00	1683.42	91.9%	860.00	876.00	101.9%
Downton Ward	1360.50	1338.00	98.3%	1050.00	964.60	91.9%
Radnor	2748.50	2800.50	101.9%	455.50	361.00	79.3%
Clinical Support	**5072.00**	**4508.83**	**90%**	**1901.00**	**1713.75**	**90.1%**
Maternity	2679.00	2405.92	90%	1248.25	1122.75	90%
Sarum Ward	1008.25	978.17	97.0%	325.50	436.25	134.0%
Musculo-Skeletal	**8848.32**	**8222.00**	**92.9%**	**7657.17**	**7417.08**	**96.9%**
Amesbury Suite	1518.98	1412.38	93.0%	1396.00	1583.00	113.4%
Avon Ward	1512.67	1193.83	78.9%	1951.33	1623.83	83.2%
Burns Unit	1384.50	1425.70	103.0%	573.00	567.92	99.1%
Chilmark Suite	1590.00	1593.75	100.2%	1140.75	1127.50	98.8%
Laverstock Ward	1495.50	1453.00	97.2%	1060.25	967.75	91.3%
Tamar Ward	1346.67	1143.33	84.9%	1535.83	1547.08	100.7%
Grand Total	**33137.80**	**31328.82**	**94.5%**	**21322.17**	**22020.60**	**103.3%**

Nursing Hours by Night Shifts

Row Labels	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**9494.00**	**9561.83**	**100.7%**	**5030.00**	**6036.25**	**120.0%**
Breamore Ward	713.00	767.50	107.6%	713.00	632.50	88.7%
Durrington Ward	713.00	685.17	96.1%	713.00	1114.00	156.2%
Farley Ward	1069.50	1046.50	97.8%	713.00	860.75	120.7%
Hospice	589.00	589.00	100.0%	406.50	384.00	94.5%
Pembroke Ward	713.00	713.00	100.0%	0.00	12.50	0
Pitton Ward	1069.50	1364.67	127.6%	713.00	734.50	103.0%
Redlynch Ward	1069.50	1046.50	97.8%	356.50	517.50	145.2%
Tisbury Ward	1426.00	1287.00	90.3%	356.50	481.50	135.1%
Whiteparish Ward	1418.50	1349.50	95.1%	356.50	414.00	116.1%
Winterslow Suite	713.00	713.00	100.0%	702.00	885.00	126.1%
Surgery	**4218.00**	**4298.25**	**101.9%**	**1161.50**	**1296.00**	**111.6%**
Britford Ward	930.00	940.00	101.1%	620.00	731.50	118.0%
Downton Ward	620.00	611.00	98.5%	541.50	553.00	102.1%
Radnor	2668.00	2747.25	103.0%	0.00	11.50	0
Clinical Support	**4607.00**	**4303.50**	**93.4%**	**1472.00**	**1249.00**	**103.7%**
Maternity	2479.00	2249.50	90.7%	1069.50	1053.50	98.5%
Sarum Ward	1069.50	1023.50	95.7%	46.00	103.50	225.0%
Musculo-Skeletal	**4799.00**	**4700.50**	**97.9%**	**3182.50**	**3630.08**	**114.1%**
Amesbury Suite	1069.00	1042.00	97.5%	713.00	988.50	138.6%
Avon Ward	930.00	876.25	94.2%	620.00	640.00	103.2%
Burns Unit	671.00	762.25	113.6%	335.50	325.50	97.0%
Chilmark Suite	589.00	579.50	98.4%	589.00	750.08	127.3%
Laverstock Ward	920.00	820.00	89.1%	310.00	311.00	100.3%
Tamar Ward	620.00	620.50	100.1%	615.00	615.00	100.0%
Grand Total	**23118.00**	**22864.08**	**98.9%**	**10846.00**	**12211.33**	**112.6%**

Overview of Areas with Red/Amber

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	**Radnor**	79%		√	Day	Template alterations align for reporting from November rosters which should reflect the accuracy of shifts versus budget. The ability to cancel unrequired shift demand is beginning to reflect greater accuracy in reporting with 34% improvement in compliance compared to July
Red	**Avon**	79%	√		Day	RN shifts were unfilled on various days throughout August and establishment run at a lower level due to there being no ventilated patients on Avon which meant there was a lower level of acuity across the ward. Where needed RN staff were re-deployed from other areas and Supervisory Ward Leaders were moved into core staffing numbers.
Amber	**Avon**	83%		√	Day	
Amber	**Tamar**	85%	√		Day	
Amber	**Breamore**	89%		√	Night	Shifts were covered by a Band 4 who is currently supernumerary to numbers but with appropriate skills (Overseas nurse)
Amber	**Tisbury**	87%	√		Day	Unfilled shifts are covered by skilled Band 4 staff acting up subject to rigorous risk assessments . Data entry processes and reporting translates this into an overstaffing of NA numbers and reduced RN cover.
Amber	**Laverstock**	89%	√		Night	Due to relocation the temporary reduced bed stock of 3 means that some RN shifts can be safely left unfilled . This is subject to shift by shift review
Amber	**Winterslow**	81%	√		Day	Highly skilled Band 4 staff supported unfilled RN shifts during the day supported by risk assessments and flexible rostering

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

Red:- Two wards flagged Red for August (Radnor & Avon) and 6 others are evidenced at Amber

Senior staff on Radnor now have the ability to "cancel" shift demand where too many NA shifts exist on the roster template. The impact of this is approach is being demonstrated by 79% of NA shifts now being accurately reported – a 34% improvement on July

The roster template has now been adjusted within the set timeframe with agreement from Finance. Allowing for advanced roster planning, this will align for November reporting .

- Avon –No ventilated patients in the ward during August which meant they could flex down

Amber.

- Winterslow :- The ward has been safely staffed by risk assessing the need for the staffing levels on a shift by shift basis and either re-deploying RN staff from other areas or utilising highly skilled Band 4 staff subject to risk assessment to ensure safe staffing levels across the directorate.
- Tisbury:- If patient acuity levels permit, a highly skilled Band 4 may be deployed to support RN shifts subject to the appropriate risk assessments. This translates into "unfilled" RN shifts.
- Laverstock:-The reduction in bed -stock by 3 means the template demonstrates the appearance of under-staffing and flexible rostering is employed.
- Tamar& Avon:-

  See above for Avon. RN staff were re-deployed from other areas where needed and Supervisory Ward Leaders were moved into core staffing numbers. Shifts assessed by DSN each day

NICU is not reported due to continued inaccuracies within the roster templates . These have been reviewed but still require more finite work between finance and the department prior to implementation. The "cancel demand" process has also been introduced to help provide a more accurate reflection of the staffing levels. Shifts are reviewed several times a day and ratios are met.

Overview of Overstaffed Areas >115%

Ward	%	RN	NA	Shift	Comments
Sarum	133%		√	Day	Supernumery day shifts for local induction of a new NA accounts for this. On one day shift a highly skilled Band 2 acted up to support an unfilled RN shift following risk assessment.
Sarum	225%		√	Night	An experienced NA with paediatric competency was rostered to support RN staff over three nights of the month and a fourth night was allocated as a supernumery induction shift for a new NA.
Britford	118%		√	Night	A 13% decrease in over-staffing from July but required a Band 2 special to provide 1:1 care for a patient at risk of harm or falls due to confusion/dementia
Breamore	121%		√	Day	Bed stock was escalated from 20 ↑ 24 increasing the need for additional cover above budgeted levels
Winterslow	126%		√	Night	Extra Band 2 staff required on both to provide enhanced care (one to one) to ensure patient safety for those who had either Mental Health issues, confusion or a risk of falls . Also reflective of using high level Band 4 skills to support unfilled RN shifts subject to risk assessments on a shift by shift basis
Winterslow	125%		√	Day	
Amesbury	139%		√	Night	An 8% decrease since July . 4 patients required 1:1 care and all were cohorted to help reduce the demand for extra staff but ensure high levels of patient safety
Chilmark	127%		√	Night	An increase of 32% from July due to patient acuity needs & 2 patients requiring 5 person turns.
Farley	121%		√	Night	New NA staff x2 on 4 nights undergoing local induction therefore supernumery & additional to budgeted staffing levels. Enhanced care (1:1) for a patient on 1 night shift was provided by a Band 2
Redlynch	145%		√	Night	A 36% reduction from July .Extra care levels required to provide enhanced care (one to one) to ensure patient safety for who had either Mental Health issues, confusion or a risk of falls .
Tisbury	135%		√	Night	A 28% increase on July. Band 4 staff redeployed from days & used rather than a 4th RN subject to careful risk assessments
Durrington	151%		√	Day	An increase of 11% on days and 5% on nights since July. For 24 hour 1:1 care required for patients at risk. Band 2 staff used for 1:1 rather than qualified staff subject to rigorous risk assessments
Durrington	156%		√	Night	
Whiteparish	116%		√	Night	A higher than usual demand for enhanced care for patients at risk of falls or suffering confusion/Mental Health issues
Whiteparish	118%		√	Day	An NA returned to work on phased return/restricted duties and covered vacant ward admin shifts. (Band 2 staff are trained and skilled to cover ward administration roles) This account s for some of the over-staffing on day shifts plus the need for enhanced 1:1 care for a patient at risk.
Pitton	128%	√		Night	Band 5 nurse required for 1:1 special of Level 2 patient with a tracheostomy

Actions taken to mitigate risk

The skill mix is 61/39 for August (RN/NA) and actions remain the same as for July:-

Staffing levels are flexed according to patient acuity and dependency levels. These are assessed by the nurse-in-charge of individual wards.

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

Trust Board meeting **SFT 3811**

Quality indicator report – August 2016

Date: 20 September 2016

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

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

Executive Summary:

- No MSSA or MRSA bacteraemias. No cases of C Difficile.
- 8 new serious incident inquiries commissioned in August.
- A decrease in the crude mortality rate. SHMI is 107 to March 16 and is as expected. HSMR is 115 to May 16 and is higher than expected. 2 new CUSUM alerts – cancer of pancreas (May 16) and thyroid disorders (Dec 15) – both to be investigated.
- A reduction in grade 2 pressure ulcers. There has been a reduction in grade 2 pressure ulcers per 1000 beds days from 1.13 to 1.04 when April to August 2015 is compared to the same period in 2016. Share and learn meetings continue to drive improvements.
- There were 6 falls, 1 resulting in catastrophic harm (head injury), 3 resulting in major harm (all fractured hips requiring surgery) and 2 resulting in moderate harm (1 fractured wrist, and one patient with both a dislocated/lacerated finger and a head injury) both managed conservatively. Ongoing improvement work via the Falls Working Group.
- CT scan within 12 hours and patients spending 90% of their time on the stroke unit achieved for all patients. Patients arriving on the unit within 4 hours remained at 80% due to bed capacity (3), arriving 5 minutes after 4 hours (1) and admitted to AMU (1). Improvement work continues between the stroke unit and ED.
- Only 38% of high risk TIA patients were seen within 24 hours. 7 patients were not seen within the timeframe due to investigations & treatment completed just outside 24 hrs (5), 1 referral not sent to the single point of access and 1 delay in referral of over 24 hours. Discussion held with GP practices concerned.
- A decrease in the number of complaints and concerns in August. Re-opened cases remain at a low level. Early contact with patients & relatives in the initial phase of a complaint is in place.
- Escalation bed capacity decreased in August with an increase in the percentage of patients moved more than once. Multiple ward moves remain at a low level and work continues with our partners to transform patient flow.
- In August there were 2 non-clinical mixed sex accommodation breaches affecting 18 patients all on AMU, all resolved within 4 days and due to bed capacity issues.
- The time of patient moves is reported for ongoing monitoring purposes. The majority of overnight moves are from Whiteparish, SSEU and Britford SAU to maintain patient flow. However, there were a number of moves from one ward to another to create bed capacity and maintain flow. The majority of discharges between 10 pm and 7 am are from ED/SSEU, Whiteparish and Britford SAU.
- The mean score of patients rating the quality of their care dipped (note small sample) although the percentage of staff who would recommend the Trust as a place to work or receive care was sustained in Q1. Responses to the Friends and Family test consistently show that patients would recommend wards, ED, the maternity service, outpatients or care as a day case.

Proposed Action:

1. **To note the report**

Links to Assurance Framework/ Strategic Plan:
CQC registration

Appendices:
Trust quality indicator report – August 2016
Supporting Information

Salisbury NHS
NHS Foundation Trust

Trust Quality Indicators - August 2016

Quality Measures

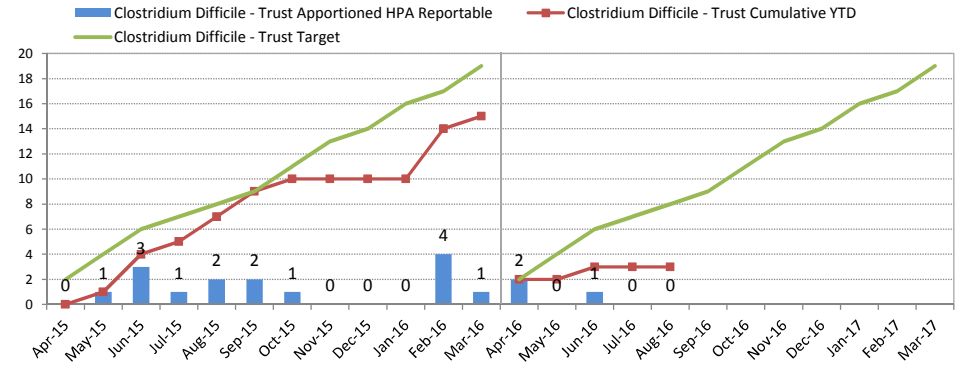
Infection Control	*2015-16 YTD*	*2016-17 YTD*
MRSA (Trust Apportioned)	**0**	**0**

Trust Incidents	*2015-16 YTD*	*2016-17 YTD*
Never Events	**2****	**0**
Serious Incidents Requiring Investigation	**28*****	**25**

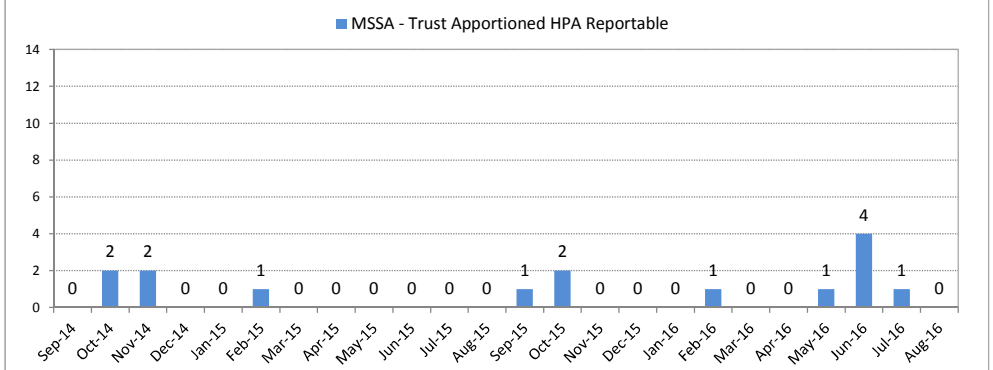
** A formal agreement was reached with the CCG to downgrade a third never event as it did not meet the definition.

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

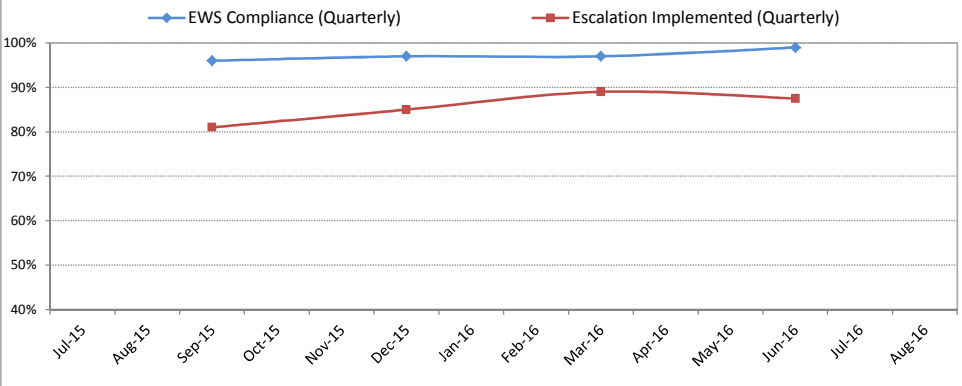
Clostridium Difficile - Trust Apportioned



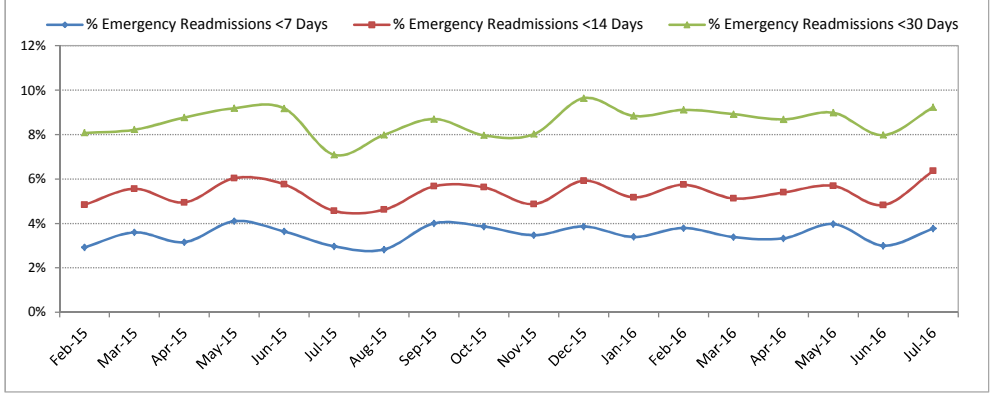
MSSA - Trust Apportioned



EWS (Early Warning Score) & Escalation



Emergency Readmissions within 7, 14 & 30 days of Discharge

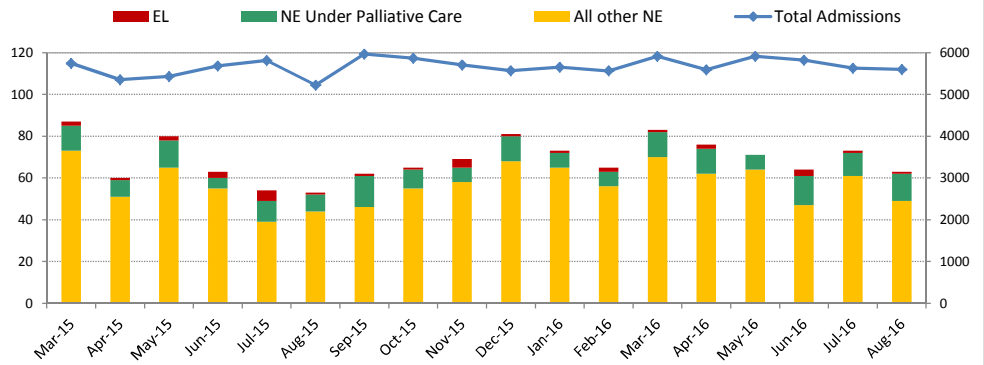


Salisbury NHS
NHS Foundation Trust

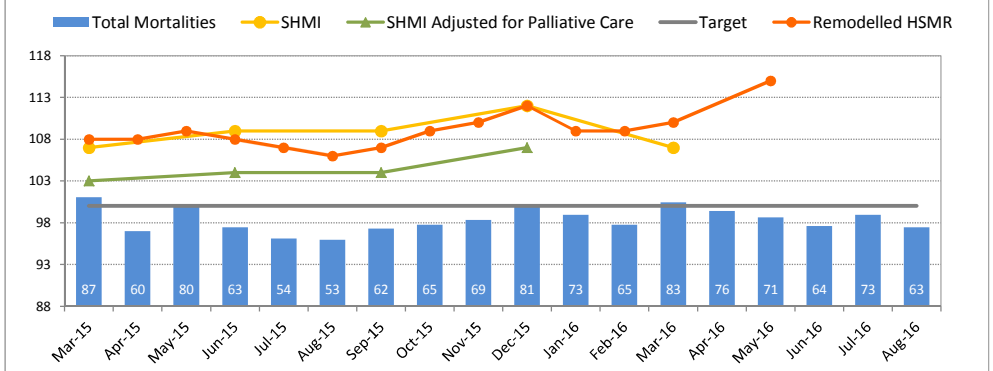
Trust Quality Indicators - August 2016

Quality Measures

Hospital Mortalities

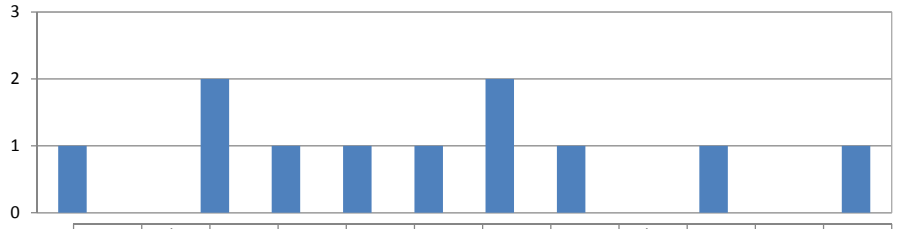


HSMR and SHMI



CUSUM Alerts

Cumulative sum of mortality outcomes (Observed > Expected)

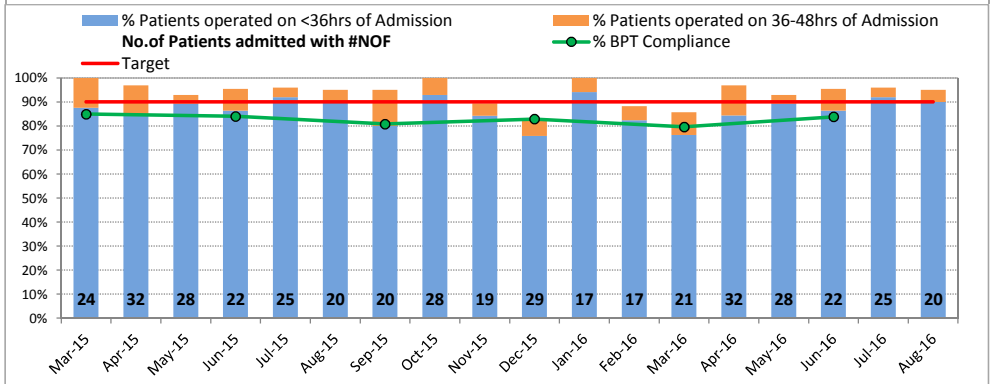


	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
CUSUM	1	0	2	1	1	1	2	1	0	1	0	1

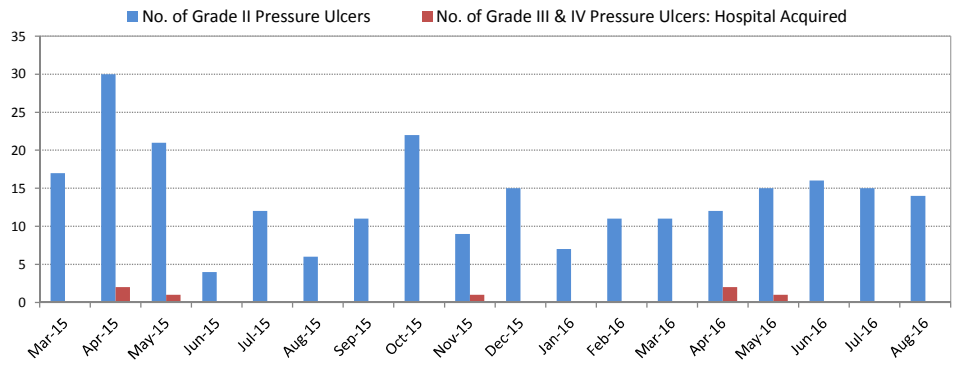
Alert:

Dec-15	Thyroid disorders
May-16	Cancer of pancreas

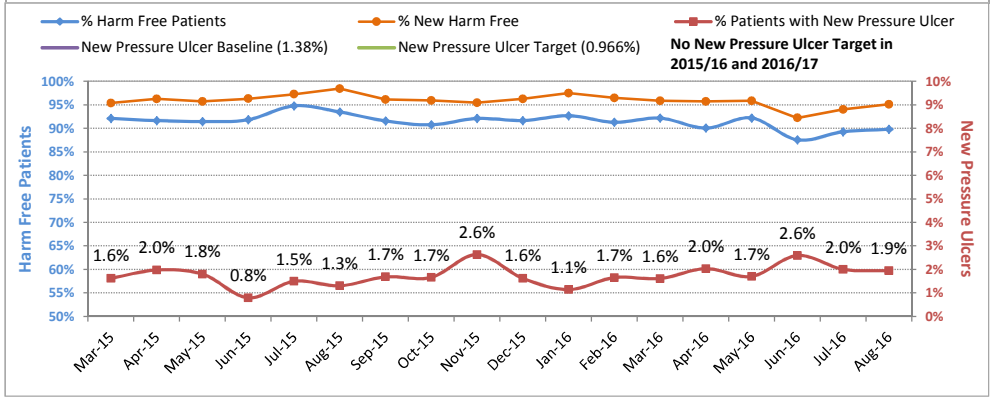
Fracture Neck of Femur operated on within 36 hours (Revised following TIAA Audit)



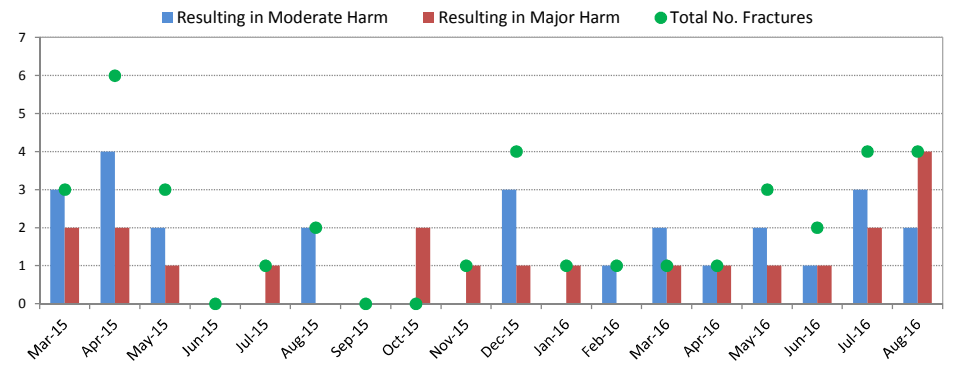
Pressure Ulcers



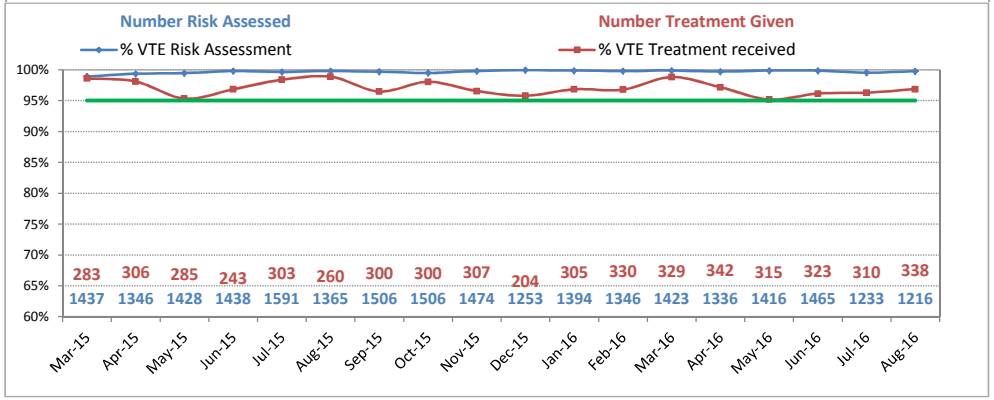
Safety Thermometer - One Day Snapshot per Month



Patient Falls in Hospital

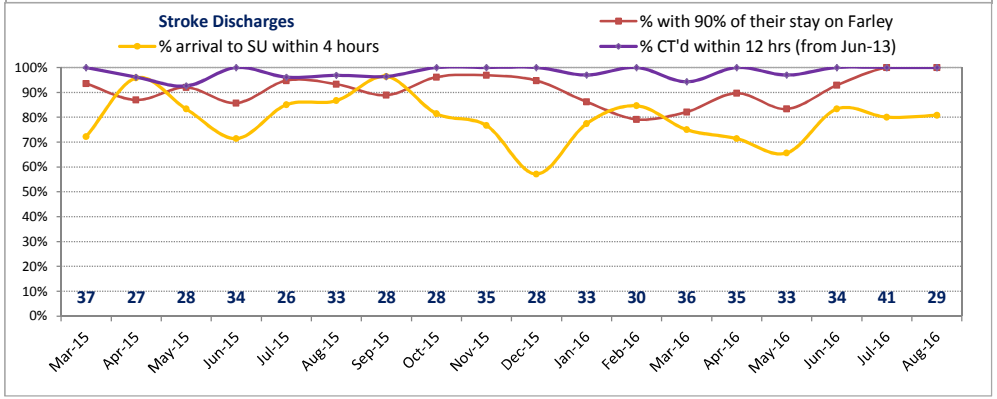


Venous Thrombous Embolism: Risk Assessment & Prophylaxis

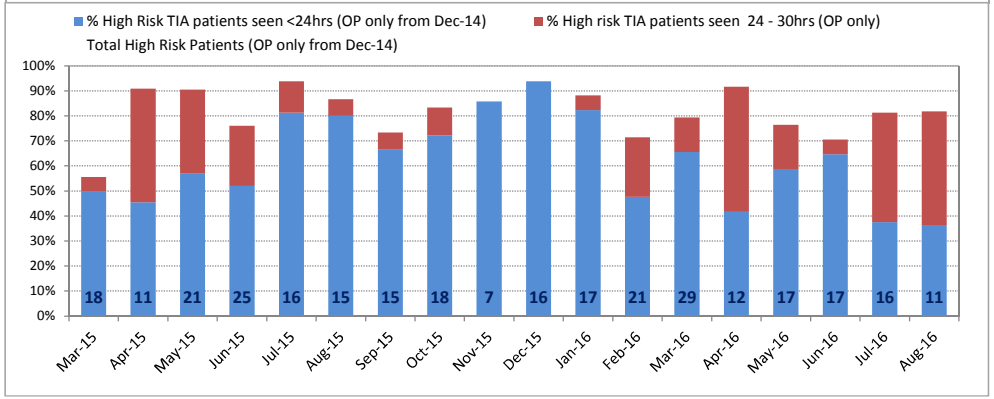


Please note, due to the time it takes to complete Clinical Coding, the current months Fracture Neck of Femur data will be subject to change over the following months.

Stroke Care



TIA Referrals



SSNAP Case Ascertainment Audit

Highest level = Grade A

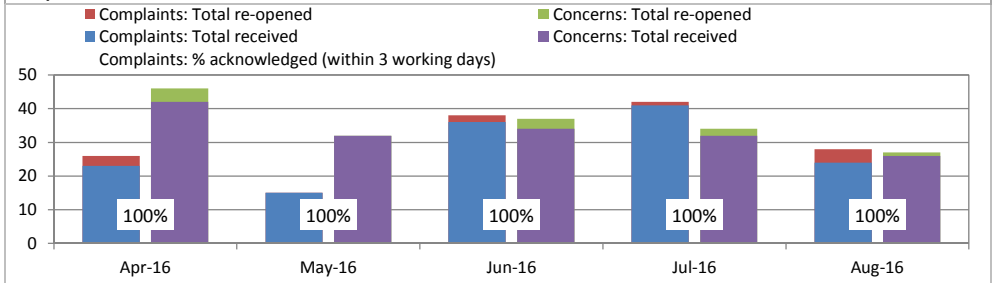
Lowest level = Grade E

(These Grades are measured quarterly)

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

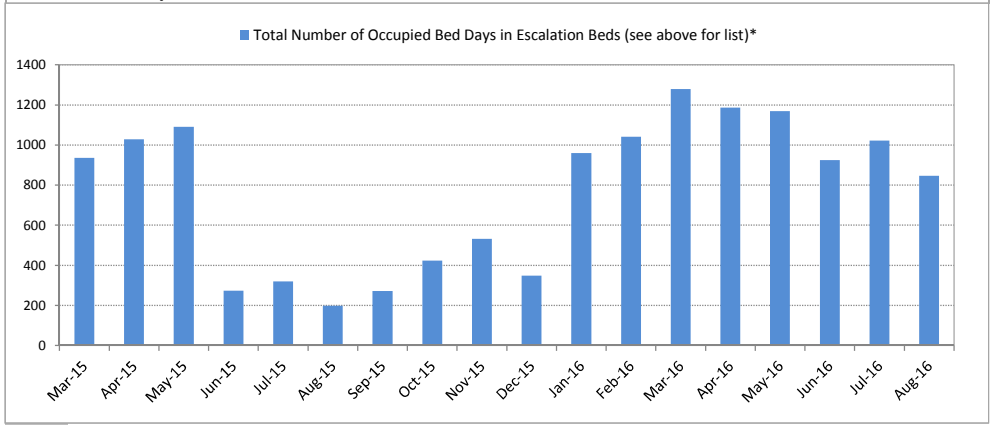
*From April 2016 escalation capacity includes beds on Breamore, DSU, Clarendon, Endoscopy, Avon, Burns cots, Britford SAU overnight stays, Whiteparish AMU overnight stays, Clarendon NHS, Pembroke Suite and Burns assessment room.

Complaints and Concerns

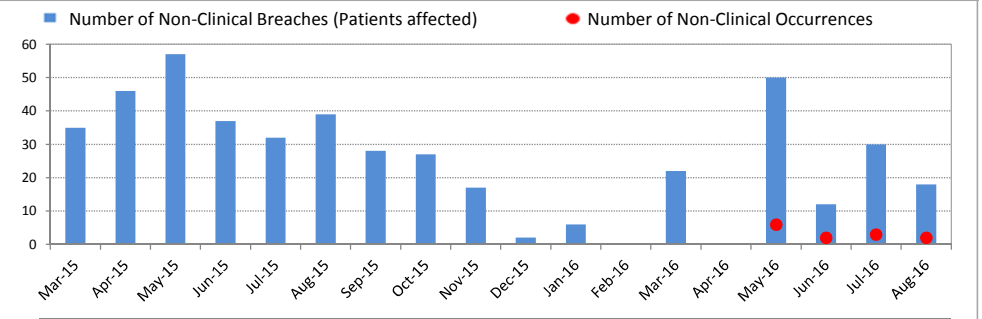


	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Complaints: Total received	23	15	36	41	24
Complaints: Total re-opened	3	0	2	1	4
Concerns: Total received	42	32	34	32	26
Concerns: Total re-opened	4	0	3	2	1

Escalation Bed Days

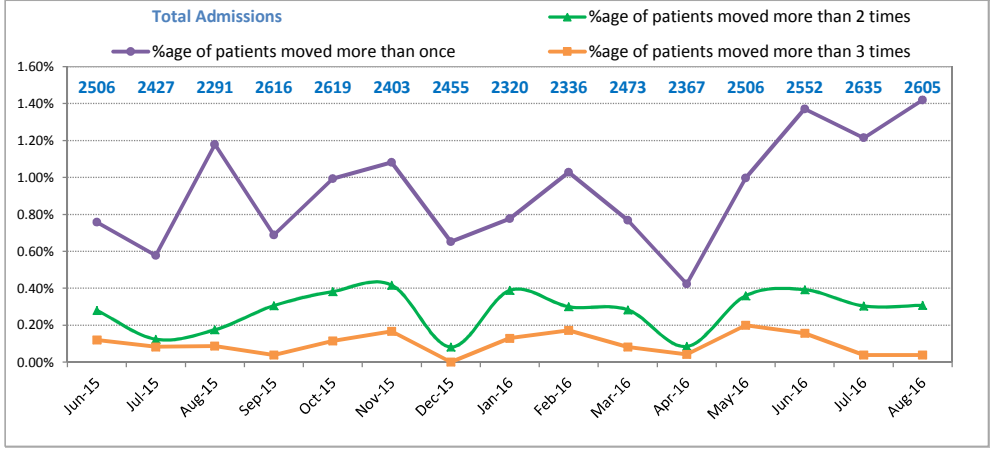


Delivering Same Sex Accommodation



	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
■	35	46	57	37	32	39	28	27	17	2	6	0	22	0	50	12	30	18
●															6	2	3	2

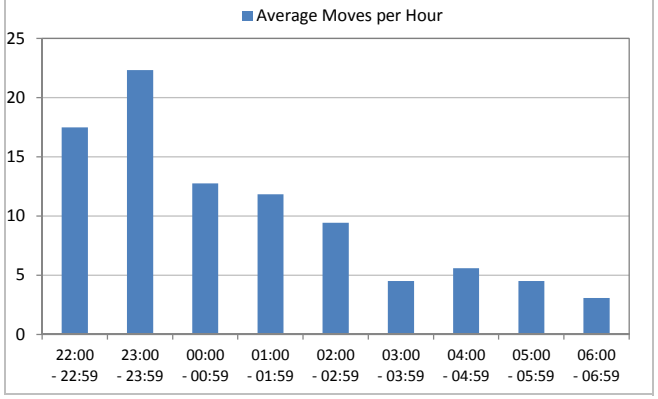
Patients moving multiple times during their Inpatient Stay



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

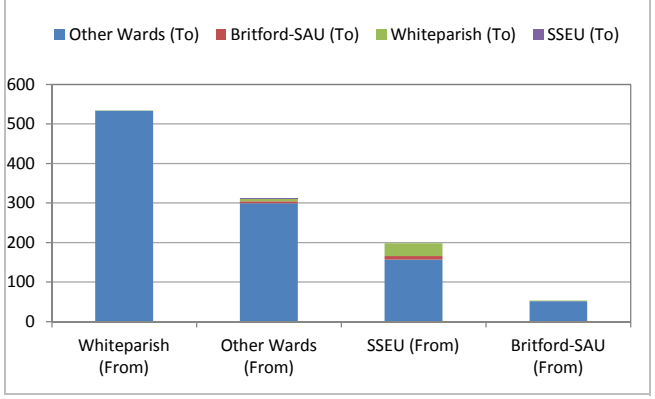
Ward moves between 22:00 and 07:00

01 April 2016 to 31 March 2017



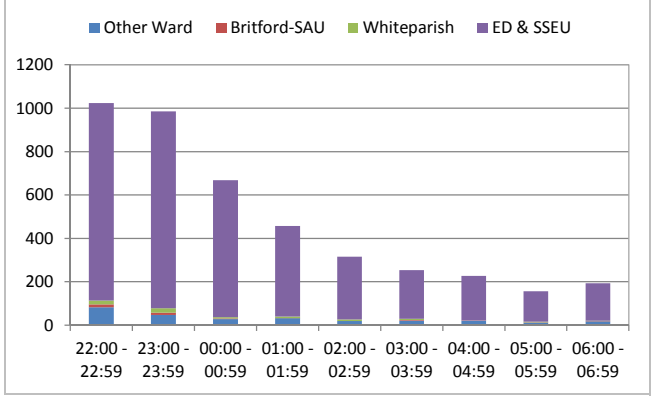
Ward to Ward moves between 22:00 and 07:00

01 April 2016 to 31 March 2017

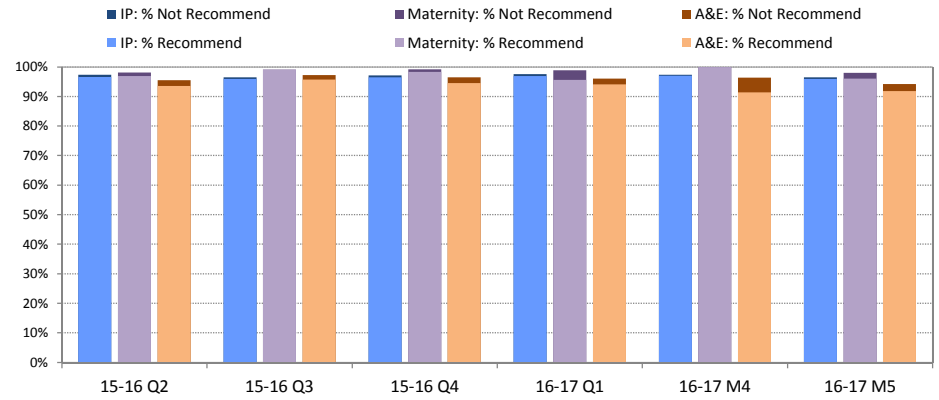


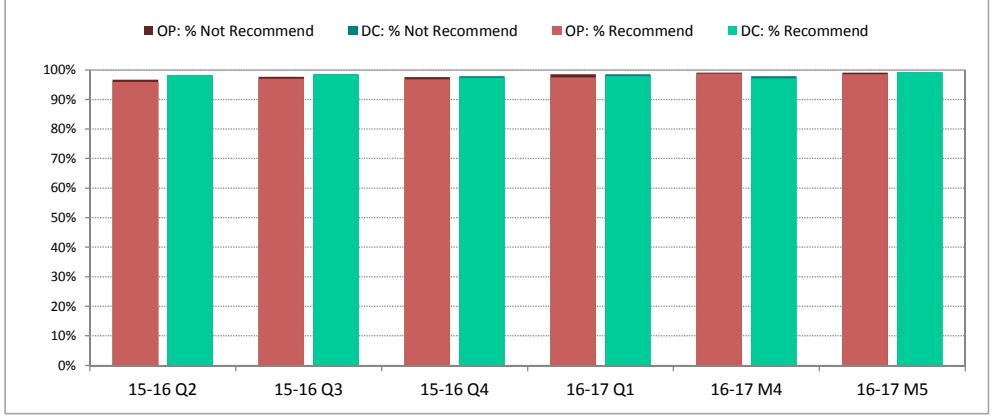
Discharges by Hour

01 April 2016 to 31 March 2017

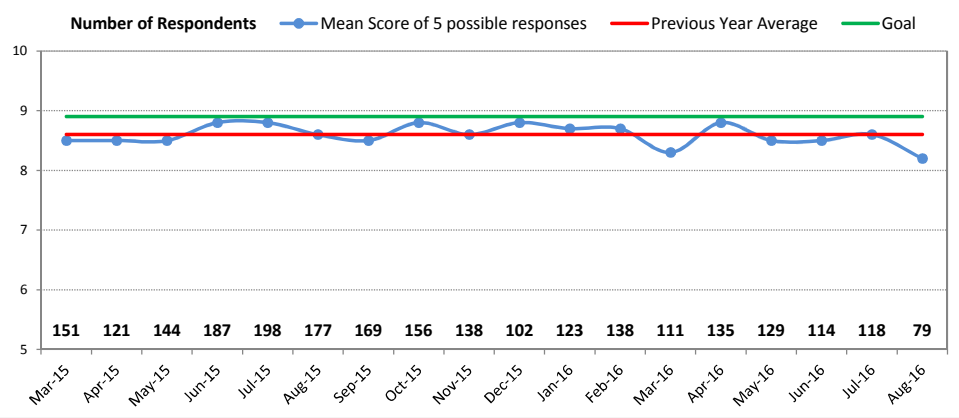


Friends & Family Test: Responses by Area

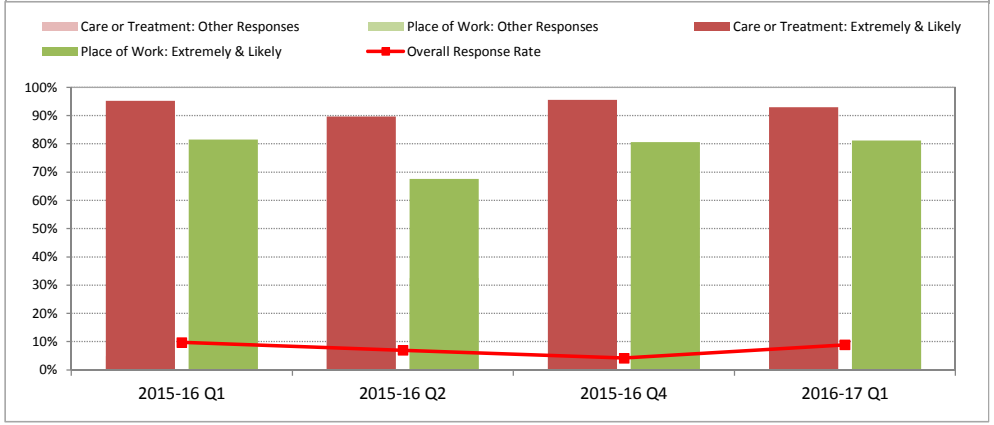




Real Time Feedback: Overall how would you rate the quality of care you received?



Friends & Family Test: Staff (% Responses)



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

CUSTOMER CARE REPORT - Quarter 1 (1st April – 30th June 2016)

Date: Monday 3rd October 2016

Report from: Hazel Hardyman, Head of Customer Care
Presented by: Lorna Wilkinson, Director of Nursing

Executive Summary:

79 complaints were received in Q1 compared to 84 complaints in Q4 and 87 complaints for the same period in the previous year. The activity from comments, concerns and enquiries has decreased from 470 in Q1 last year to 450 in Q1 this year.

The main issues from complaints are:

- Clinical treatment (33), 2 more than Q4 (31) - sub-themes were 15 unsatisfactory treatment across14 different areas, 8 delay in receiving treatment, 2 each for pain management, further complications and inappropriate treatment, and 1 each for correct diagnosis not made, funding problems, surgery unsuccessful and treatment unavailable. Orthopaedics received 5 complaints about clinical treatment with 2 related to unsatisfactory treatment, 2 delays in receiving treatment and 1 further complications. Adult Medicine and the Spinal Treatment Centre both received 4 complaints relating to clinical treatment with no themes.
- Staff attitude (13), 1 more than Q4 (12) – 9 related to medical staff and 4 nursing staff across 13 different areas.
- Communication (9), 7 less than Q4 (16) - sub-themes were 3 lack of communication, 3 wrong information and 1 each for letter sent incorrectly, information not given and delay in sending information.
- Appointments (7), 7 less than Q4 (14) – sub-themes were 2 each for cancelled appointments, appointment date required, appointment delays and 1 for appointment system procedures across 5 different specialties.

The main issues from concerns are appointments (30), clinical treatment (28) and staff attitude (18). The main specialties for appointments across concerns and complaints were Orthopaedics (6), Oral Surgery (4) and Plastic Surgery (4).

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

A total of 378 inpatients were surveyed for real time feedback in the quarter. They made 230 positive and 224 negative comments. The three main areas of concern were food and nutrition on the ward, noise and communication.

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

There were 5 new requests to undertake Patient and Public Involvement projects, four projects were completed and one put on hold.

NHS Choices received 18 comments in Q1 with 9 positive and 9 negative relating to 11 different areas.

Proposed Action:

To note the report.

Links to Assurance Framework/ Strategic Plan:

Improving Patient Experience
Patient Feedback – acting on complaints and compliments

Appendices:

None

Supporting Information

None

Customer Care Report - Quarter 1
1st April – 30th June 2016

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 (33), 2 more than Q4 (31) - sub-themes were 15 unsatisfactory treatment across14 different areas, 8 delay in receiving treatment, 2 each for pain management, further complications and inappropriate treatment, and 1 each for correct diagnosis not made, funding problems, surgery unsuccessful and treatment unavailable. Orthopaedics received 5 complaints about clinical treatment with 2 related to unsatisfactory treatment, 2 delays in receiving treatment and 1 further complications. Adult Medicine and the Spinal Treatment Centre both received 4 complaints relating to clinical treatment with no themes.
- Staff attitude (13), 1 more than Q4 (12) – 9 related to medical staff and 4 nursing staff across 13 different areas.
- Communication (9), 7 less than Q4 (16) - sub-themes were 3 lack of communication, 3 wrong information and 1 each for letter sent incorrectly, information not given and delay in sending information.
- Appointments (7), 7 less than Q4 (14) – sub-themes were 2 each for cancelled appointments, appointment date required, appointment delays and 1 for appointment system procedures across 5 different specialties.

The main issues from concerns are appointments (30), clinical treatment (28) and staff attitude (18). The main specialties for appointments across concerns and complaints were the Orthopaedics (6), Oral Surgery (4) and Plastic Surgery (4).

79 complaints were received in Q1 compared to 84 complaints in Q4 and 87 complaints for the same period in the previous year. The activity from comments, concerns and enquiries has decreased from 470 in Q1 last year to 450 in Q1 this year. A breakdown of numbers and themes from complaints according to Datix is below:

	CS&FS	Corporate	Facilities	Medicine	MSK	Operations	Surgery	Q1 total 2016 -17	Q1 total 2015 -16
Admission	0	0	0	0	1	0	0	1	1
Appointments	0	0	0	0	5	0	2	7	18
Attitude of staff	3	0	0	3	5	0	2	13	15
Car parking	0	0	1	0	0	0	0	1	0
Clinical treatment	7	0	0	9	14	0	3	33	29
Communication	3	0	0	3	0	0	3	9	7
Confidentiality	1	1	0	0	0	0	0	2	1
Delay	2	0	0	0	2	0	0	4	0
Dementia	0	0	0	0	0	0	0	0	1
Discharge	1	0	0	0	0	0	0	1	6
End of life care	0	0	0	2	0	0	0	2	0
Equipment	0	0	0	0	0	0	0	0	2
Falls	0	0	0	1	0	0	0	1	0
Hospital procedures	1	0	0	0	0	0	0	1	0
Nursing care	0	0	0	0	1	0	0	1	2
Operation	0	0	0	0	1	0	1	2	1
Privacy & dignity	0	0	0	0	0	0	0	0	1

Property	0	0	0	0	0	0	0	0	1
Safeguarding	0	0	0	0	0	0	0	0	1
Transfer arrangements	0	0	0	0	0	1	0	1	0
Waiting time	0	0	0	0	0	0	0	0	1
Totals:	18	1	1	18	29	1	11	**79**	**87**
Patient Activity	10,096	0	0	28,810	18,327	0	17,723		

In Q1 the Trust treated 17,316 people as inpatients, day cases and regular day attendees. Another 11,895 were seen in the Emergency Department and 45,745 as outpatients. 79 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. 446 compliments were received across the Trust in Q1, 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.

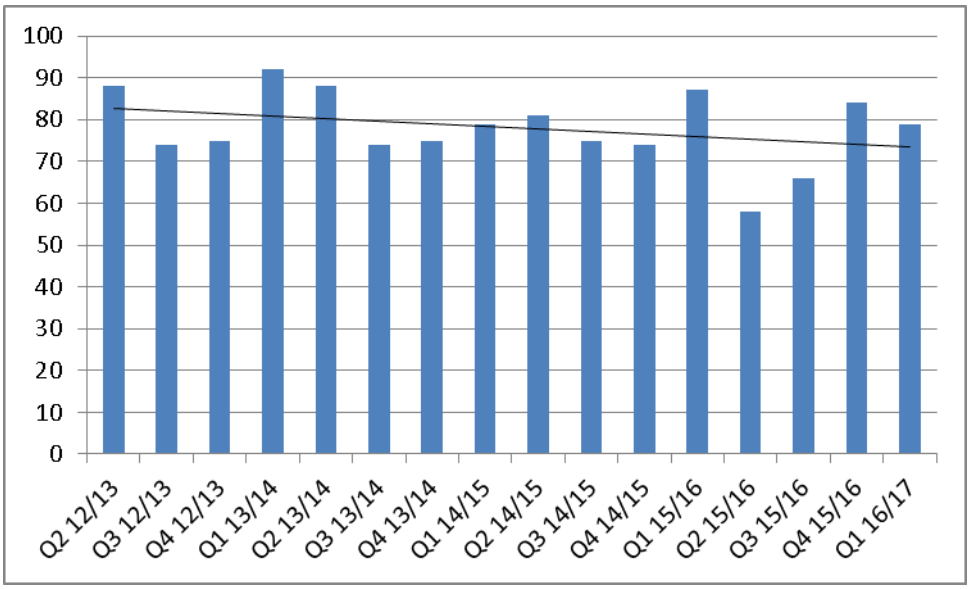
100% of complaints were acknowledged within three working days. Five complaints were re-opened in Q1 compared to 12 in Q4 (see below in the directorate section). The overall number of enquiries, comments, concerns and complaints response times was:

0-10 working days		**11-24 working days**		**25+ working days**	
408	77%	46	9%	75	14%

Reasons for some complaints taking more than 25 working days to respond to is: arranging meetings; operational pressures in the Musculo Skeletal Directorate; and key members of staff on leave. The overall response timescale for 25+ working days has decreased in compliance in Q1 (14%) compared to Q4 (10%).

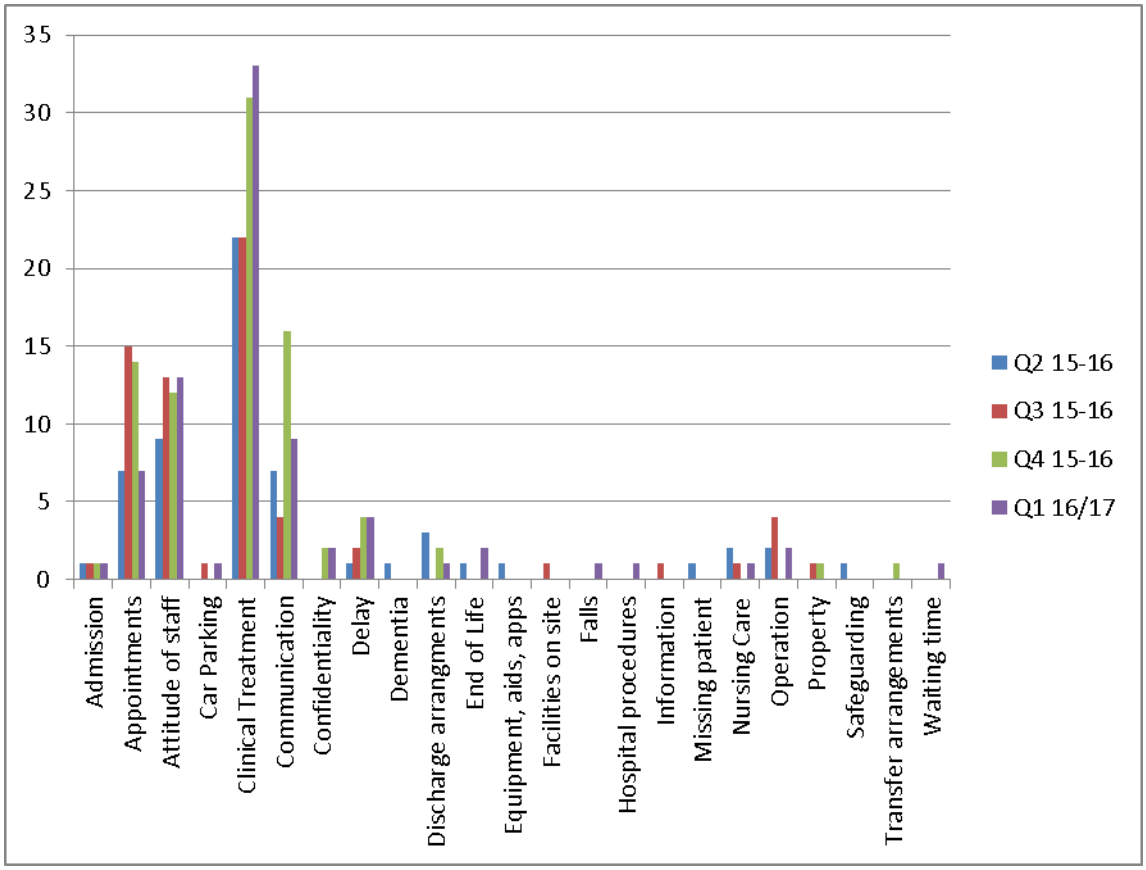
COMPLAINTS BY QUARTER

The following graph shows the trend in complaints received by quarter. There has been a decrease in complaints in Q1 compared to Q4 2015-16. The specialty areas with the most complaints are Orthopaedics (12), Plastic Surgery (7) and Adult Medicine (6) 12 related to clinical treatment.



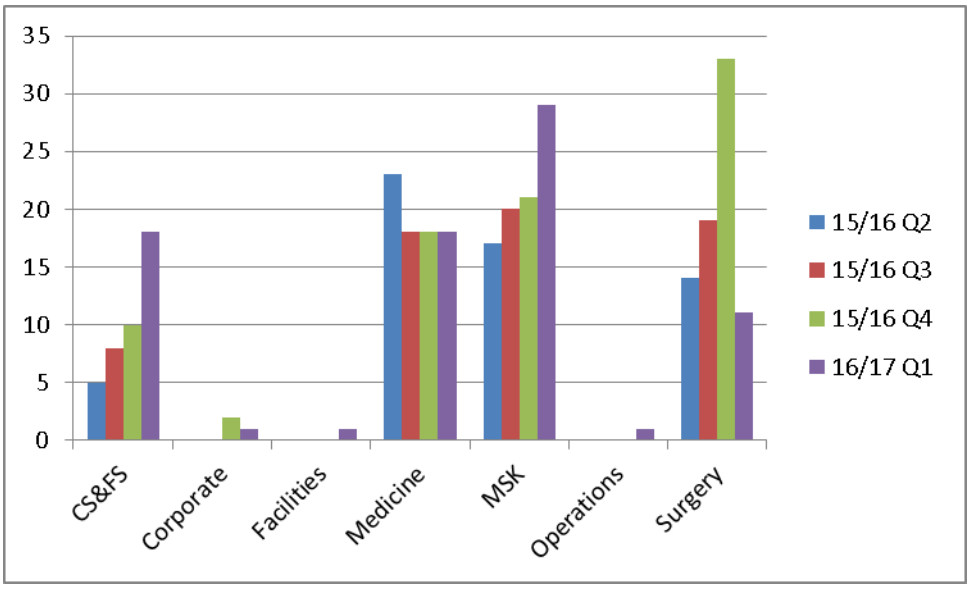
COMPLAINTS BY SUBJECT

The following graph shows the trend in complaints by subject over the last four quarters. Complaints about Communication (9) has decreased from Q4 (16) by 7. The sub-themes are 3 lack of communication, 3 wrong information and 1 each for letter sent incorrectly, information not given and delay in sending information. Appointments (7) also decreased from Q4 (14) by 7 with the sub-themes 2 each for cancelled appointments, appointment date required, appointment delays and 1 for appointment system procedures.



COMPLAINTS BY DIRECTORATE

The following graph shows the number of complaints by directorate over the last four quarters with Musculo-Skeletal seeing an increase from 21 in Q4 to 29 in Q1. The two main areas of increase were delay in receiving treatment (from 0 in Q4 to 5 in Q1) and attitude of medical staff (from 1 in Q4 to 4 in Q1) across 4 different areas. Clinical Support also had an increase from 10 in Q4 to 18 in Q1 with the main increase in unsatisfactory treatment (from 2 in Q4 to 5 in Q1) with 4 complaints in Maternity and NICU.



CLINICAL SUPPORT AND FAMILY SERVICES

	Quarter 1 2015-16	Quarter 4 2015-16	Quarter 1 2016-17
Complaints	15	10	18
Concerns	13	15	26
Compliments	103	86	100
Re-opened complaints	4	1	0

% complaints responded to within 25 working days	40%	60%	50%

- 8 more complaints were received in this quarter in comparison to quarter 4, and the number has increased compared with quarter 1 2015-16. The areas of increase were clinical treatment, communication, staff attitude, confidentiality and hospital procedures across a number of specialities.
- 2 concerns were re-opened and no complaints were re-opened in Q1.
- Total activity within the directorate was 10,096 and of this number 0.17% raised a complaint.
- 1 meeting was undertaken for this quarter.
- There has been an increase in the number of concerns raised, with the Bowel Screening Department having the highest number which was 9 in total, all of which were resolved by the Bowel Screening team. The sub-themes were unsatisfactory treatment 4, pain management 3 and 1 each for wrong information and information not given. This service also received the highest number of compliments.
- The number of compliments received this quarter has increased.
- The Directorate Senior Nurse telephones all complainants on receipt of a complaint.

Themes and actions

Department/Ward	Topic	Actions
Labour Ward	Unsatisfactory treatment and attitude of nursing staff	Staff cited in the letters of complaint have reflected on their practice. Themes of complaints are discussed at the mandatory study days and more recently, at the clinical leads meeting. Complaints/concerns have been added to the 'Maternity Risk Meeting' agenda.
Radiology Department	Lack of communication	Communication – individuals have been spoken to and asked to reflect on their practice. The way information is given to patients is being reviewed.

Compliments

In total 100 compliments have been received across the directorate with the breakdown as: Bowel Screening = 37, Sarum Ward = 31, Labour Ward = 12, Postnatal Ward = 5, Endoscopy = 5, Speech and Language Therapy = 4, Sexual Health = 2 and 1 each for NICU, Radiology, Anticoagulation and Spinal X-ray.

MEDICINE DIRECTORATE

	Quarter 1 2015-16	Quarter 4 2015-16	Quarter 1 2016-17
Complaints	29	18	18
Concerns	27	27	27
Compliments	121	151	153
Re-opened complaints	6	1	1
% complaints responded to within 25 working days	48%	77%	50%

- The number of complaints was the same as Q4, although the number has reduced compared with Q1 2015-16.
- 1 complaint was re-opened in this quarter.
- The Emergency Department's complaints reduced from 6 in Q4 to 3 this quarter.
- The delay in responding to complaints was due to delays in obtaining statements mainly from medical staff (annual/sick leave).

- Total activity within the Directorate was 16,915 and of this number 0.1% raised a complaint.
- 1 meeting was undertaken this quarter.
- The number of concerns was also the same as Q4 with Durrington and Winterslow wards having the most at 4 each.
- The number of compliments received this quarter has increased slightly since Q4.

Themes and actions

Department/Ward	Topic	Actions
Pitton ward	Unsatisfactory treatment and poor communication and information given to patients and relatives.	The interim sister for Pitton Ward is working hard with all nursing staff to raise their awareness of themes from complaints and how these can be addressed and prevented.
Emergency Department	Unsatisfactory treatment and missed diagnosis	An alert is populated on Symphony for any returning patient to ED stating that the patient needs to be seen by or case discussed with ED consultant. Increased communication with regards to bank/agency nurses and new doctors to the department that all referrals to outpatient clinics, such as TIA, chest pain have to be taken to ED reception and faxed. Tick boxes re fax sent added to the discharge section on the front of the ED CAS card. In place before Q1, but all patients discharged overnight by junior doctors – notes are reviewed by ED consultant next day and action taken accordingly. Good safety net and also increased education to doctors.

Compliments

153 compliments were received in total = Emergency Department = 31, Farley Ward = 26, Hospice = 22, Winterslow Ward = 19, Whiteparish AMU = 9, Redlynch Ward = 9, Pitton Ward = 8, Tisbury Ward = 7, Durrington Ward = 7, Pembroke Suite = 6, Cardiology Unit = 4, Respiratory = 2, and 1 each for Breamore Ward, Cardiac Suite and Gastroenterology.

MUSCULO-SKELETAL DIRECTORATE

	Quarter 1 2015-16	Quarter 4 2015-16	Quarter 1 2016-17
Complaints	21	21	29
Concerns	37	21	25
Compliments	81	73	107
Re-opened complaints	2	6	1
% Complaints responded to within 25 working days	48%	52%	21%

- Response timescales have fallen in complaints received compared to Q4 in 2015-16 and this is due to operational pressures within the Directorate Management Team and an increase in the amount of complaints received.
- Increased operational bed pressure, theatre staffing gaps and SDU issues have been a factor in the cancellation of surgery and subsequent concerns/complaints raised.
- There has been an increase in compliments this quarter compared to Quarter 4.
- Total activity within the Directorate was 18,327 and of this number 0.15% raised a complaint.

- Unsatisfactory treatment, delay in receiving treatment and attitude of staff were the most common themes across the directorate.
- The department with the greatest number of complaints is orthopaedics especially outpatients with regards to appointments, delay being the most common theme (10 complaints). Plastic surgery has also had the same themes being raised (6 complaints).
- There has been one re-opened complaint and three re-opened concerns.
- There has been one complaint meeting held. There was one complaint and three concerns which have been resolved by the Directorate Senior Nurse by going to see the patient on the ward.

Themes and actions

Department/Ward	Topic	Actions
Orthopaedics	Delays in receiving appointments and treatment, due to long waiting times and multiple cancelations	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.
Plastics Department	Delays in receiving appointments and treatment, due to long waiting times and multiple cancellations	Increased capacity for trauma and electives with two additional locum plastic surgeons (July 2016). Theatre efficiency project – to maximise use of theatre resources (ongoing). Progress use of Theatre 9 for blocks and local anaesthetics for minor trauma to free up theatre and Day Surgery Unit capacity.

Compliments
In total 107 compliments have been received across the Directorate with the breakdown as: Laverstock Ward = 29, Chilmark Ward = 19, Amesbury Ward = 15, Burns Unit = 13, Avon Ward = 8, Orthopaedics = 7, Tamar Ward = 4, Oral Surgery = 4, Plastics Department = 4, Fracture Clinic = 2, and one each for the Spinal Unit and Cleft Lip and Palate Service.

SURGICAL DIRECTORATE

	Quarter 1 2015-16	Quarter 4 2015-16	Quarter 1 2016-17
Complaints	22	33	11
Concerns	34	23	32
Compliments	53	104	76
Re-opened complaints	1	2	3
% complaints responded to within 25 working days	72%	90.9%	54.5%

- A significant decrease in complaints received this quarter for the Directorate.
- Due to the complexity of the complaints received and multiple clinician involvement, the response time has fallen with a decrease in complaints being responded to within 25 working days, which is escalated to the directorate management team as required.
- Total inpatient and outpatient activity within the Directorate was 17,723 and of this number 0.06 % raised a complaint.
- Three complaints were re-opened in this quarter. Although one of these was actually regarding the response letter not being franked and the patient having to collect it from the post office, therefore not requesting further information about the complaint itself.
- The highest number of complaints were in relation to Urology, with 4 cases.

- There were no common sub themes within the Directorate.
- The highest number of concerns was in General Surgery, with 9 cases. Out of the 9 issues, 3 were the appointment system and appointment dates, 2 were for attitude of staff (medical and nursing), 1 delayed operation, 1 for information not given, 1 lack of information, 1 further complications.
- There is one concern open for which there is a meeting arranged for September.

Themes and actions

Department/Ward	Topic	Actions
Urology	2 concerns and 1 complaint about different clinicians attitude, which were not related to a specific theme	No specific action, monitor themes for next quarter for recurring clinician names and issues. All data forwarded to the Medical Director as linked to medical revalidation process.
Ophthalmology	Due to the range of subjects for the 6 concerns raised, there was no theme.	Monitor next quarter to see if recurring themes from Q1

Compliments

In total 76 compliments have been received across the Directorate with the breakdown as: Downton Ward = 20, Radnor Ward = 27, Britford Ward =12, Day Surgery Unit = 4, Clarendon Suite=3, ENT = 2, Audiology = 2 and 1 each for Surgical Admissions Unit, Urology, Vascular, Ophthalmology, Medical/Surgical Outpatients and Breast Service.

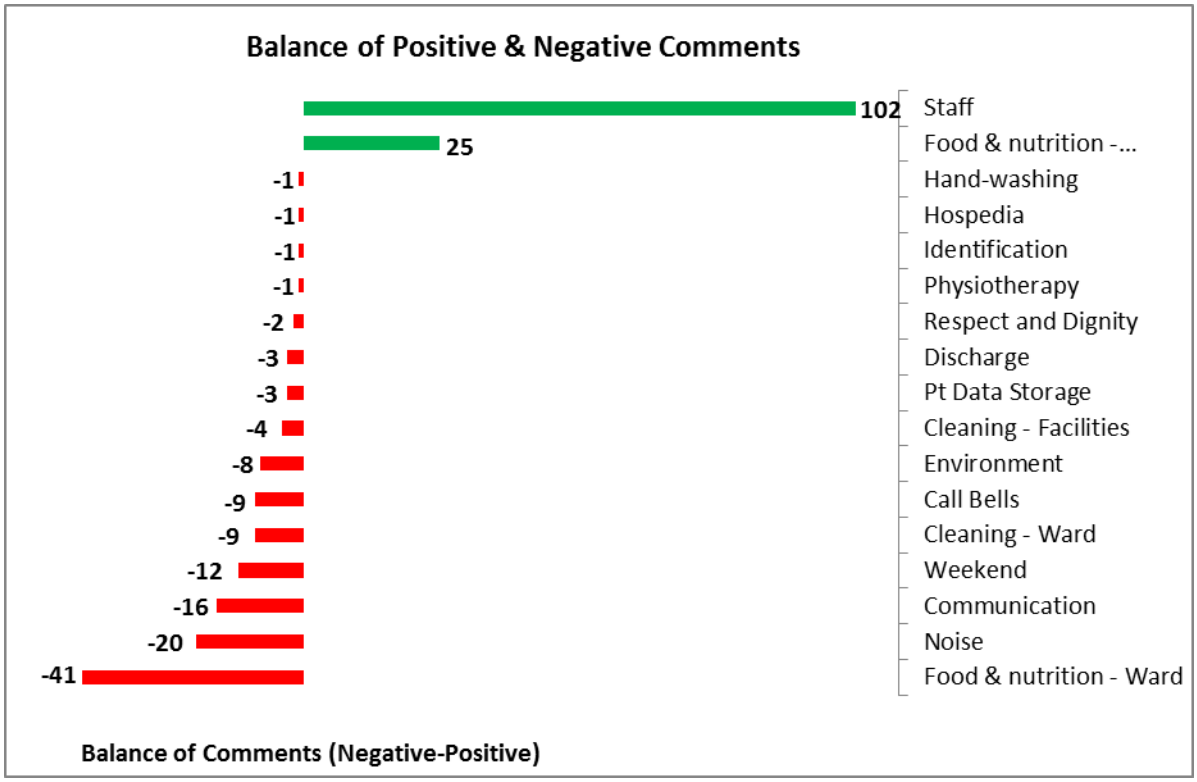
2. TRUSTWIDE FEEDBACK – INCLUDING REAL TIME FEEDBACK AND THE FRIENDS AND FAMILY TEST

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

Feedback area	Theme	Actions
Complaints	Staff Attitude Communication Appointments	• Monitoring themes for next quarter for recurring staff names and issues. • Individuals have been spoken to and asked to reflect on their practice. The way information is given to patients is being reviewed within specialities. • Orthopaedic cancellations on the day require chief operating officer authorisation. • Maximising the use of theatre and DSU capacity.
Inpatient RTF	Food and nutrition on the ward Noise Communication	• All wards are trying to keep the food temperature right until it reaches the patient and it is being monitored. • Wards are trying to reduce the volume of call bells at night. Using the safety brief to remind staff to keep noise to a minimum and to offer patients ear plugs. Silencers to be fitted to doors that tend to slam. • Safety briefs are being used to promote communication with patients. Information sheets have been developed and updated. Staff have been reminded to introduce themselves to patients. Patients to know what their plan of care is. A nurse is present on the doctor's ward round on some wards to aid communication.
FFT Emergency Department, Eye Clinic, Paediatric Outpatients and Pre-Operative Assessment	Waiting Times	• Waiting times continue to be displayed on screens and staff always address enquiries regarding delays, doing their best to alleviate any anxieties which arise.

3. INPATIENT REAL TIME FEEDBACK

A total of 378 inpatients were surveyed in the quarter. They made 230 positive and 224 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below.



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

A total of 43 negative and 2 positive comments were received regarding food and nutrition on the ward. The negative comments have been categorised in the table below.

REASON	WARD
Temperature (33)	Tisbury (5)
	Amesbury (4)
	Durrington (4)
	Avon (3)
	Burns (2)
	Chilmark (2)
	Pembroke (2)
	Redlynch (2)
	Winterslow (2)
	Britford (1)
	Downton (1)
	Farley (1)
	Laverstock (1)
	Pitton (1)
	Tamar (1)
	Whiteparish (1)

REASON	WARD
Lack of beverages (3)	Chilmark (1)
	Redlynch (1)
	Whiteparish (1)
Staff attention to food (2)	Amesbury (1)
	Laverstock (1)
Portions too small (2)	Redlynch (1)
	Tamar (1)
Help with food (1)	Burns (1)
Portions too large (1)	Tisbury (1)
Texture of porridge (1)	Tamar (1)

A total of 24 negative and 4 positive comments were received regarding noise. The areas of negative comments are as follows:

REASON	WARD
Staff at night (9)	Britford (2)
	Amesbury (1)
	Avon (1)
	Burns (1)
	Downton (1)
	Durrington (1)
	Tisbury (1)

REASON	WARD
Laundry (2)	Britford (2)
Staff (2)	Amesbury (1)
	Britford (1)
Vehicles outside (2)	Britford (1)
	Pitton (1)
Other patients (1)	Amesbury (1)

	Whiteparish (1)
Call bells (3)	Chilmark (2)
	Tisbury (1)
Unspecified noise at night (3)	Burns (1)
	Durrington (1)
	Farley (1)

Ward noise (1)	Whiteparish (1)
Unspecified (1)	Britford (1)

A total of 35 negative and 19 positive comments were received regarding communication. The negative comments are categorised as follows:

REASON	WARD
Involvement in care (17)	Amesbury (3)
	Chilmark (3)
	Whiteparish (3)
	Britford (2)
	Burns (10
	Downton (1)
	Laverstock (1)
	Pitton (1)
	Tisbury (1)
	Winterslow (1)
Staff access to information (2)	Britford (2)

REASON	WARD
Staff attitude (11)	Amesbury (2)
	Winterslow (2)
	Britford (1)
	Chilmark (1)
	Downton (1)
	Eye Clinic (1)
	Farley (1)
	Laverstock (1)
	Whiteparish (1)
Inter-department (5)	Whiteparish (2)
	Amesbury (1)
	Tamar (1)
	Winterslow (1)

Action taken on areas of concern

Food Temperature

All wards have been working on ways to keep food at the right temperature until it reaches the patient. This will be monitored over the coming months to see if the actions identified have proved successful.

Noise

The Spinal Unit have undertaken to answer call bells quickly and reduce the volume at night. Nurses have been reminded to speak quietly. They are also sourcing different apron rolls with a quieter way of dispensing and moving these away from the patient's head. Sensory waste bins are also being sought which close more quietly.

Britford Ward has used their safety briefing folder to remind staff on night shifts to keep noise to the minimum and to offer ear plugs to patients. They are also trying to manage patients' expectations by informing them that some noise is unavoidable due to the requirement to provide 24 hour care to patients. In the longer term they will be carrying out spot checks of the ward at night and will review patient feedback for signs of improvement.

Farley Ward has a 'noise at night' champion and a ward poster is being produced highlighting the need for patients to have a restful night.

Pembroke Ward has asked for silencers to be fitted to all doors that slam shut. The message about noise levels is being reinforced at team meetings and the possibility of moving the ward telephone into an office at night is being considered.

Tisbury Ward has removed a radio and reminded staff on the need to try to reduce the level of noise at night whilst bearing in mind that it is an acute ward and the nights are very busy with patient care.

Communication

Farley Ward have been discussing ways to improve the multi-disciplinary team approach to communication and have asked all staff to contribute ideas as to how more effective communication can be achieved.

Pitton Ward has used their safety brief to encourage the nursing team to promote communication with patients. Discussions are being held with the medical team during the morning multi-disciplinary meetings to encourage explanations of all interventions to each individual patient. In the longer term, the ward will attempt to implement a routine whereby the nurse-in-charge follows the doctors on the ward round so that they can communicate all information to both the staff and the patients. It is recognised, however, that due to time limitations this may not always be possible.

Whiteparish AMU used their recent study day to discuss the issue of communication and an information sheet is being developed for the waiting room for staff to hand out to patients.

Winterslow Ward has reminded staff of the need to always introduce themselves. Ward sisters will use weekly audits to check that patients and next-of-kin understand the plan of care.

The spinal wards are ensuring that each patient knows the current plans for their care. They are also looking to improve documentation within care plans and notes, and to document the outcome of ward rounds in the patient's care plan at the end of ward rounds.

Staff on Chilmark Suite is ensuring that they introduce themselves to the patients on every shift so that patients are aware of which nurse and nursing assistant is looking after them. They are also trying to ensure that other members of the multi-disciplinary team introduce themselves to the patients. They are also updating the patient information leaflets on injuries and ensuring that these are offered to patients.

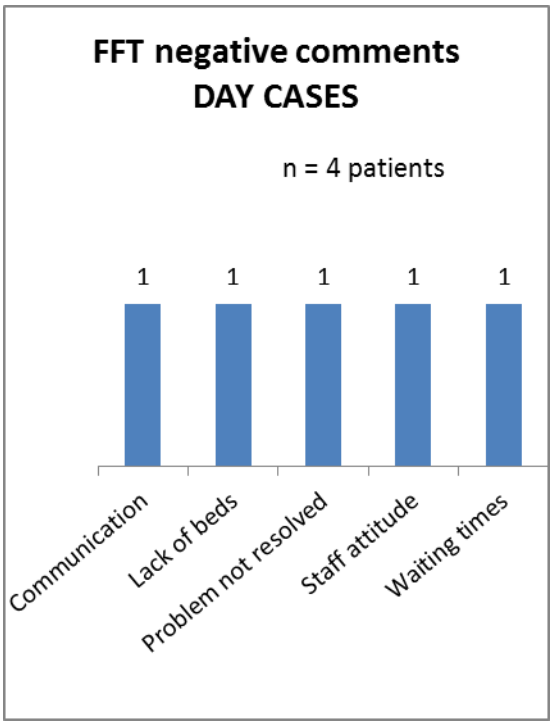
Britford Ward is trying to ensure that wherever possible a nurse is present on doctors' ward rounds.

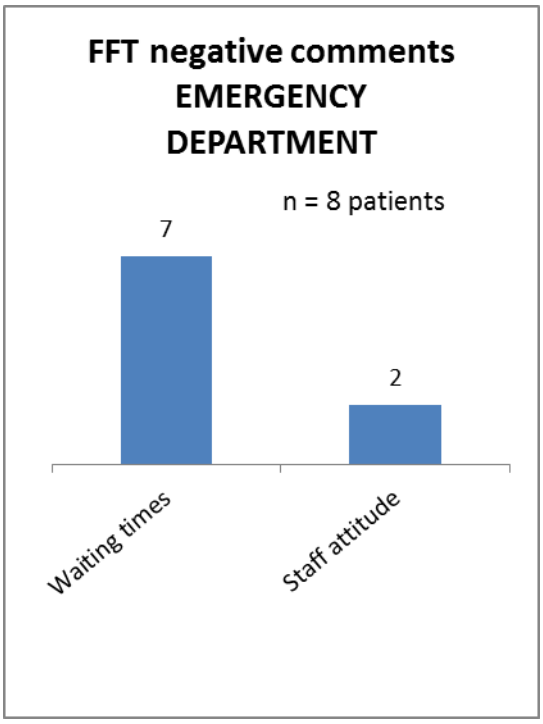
4. FRIENDS AND FAMILY TEST

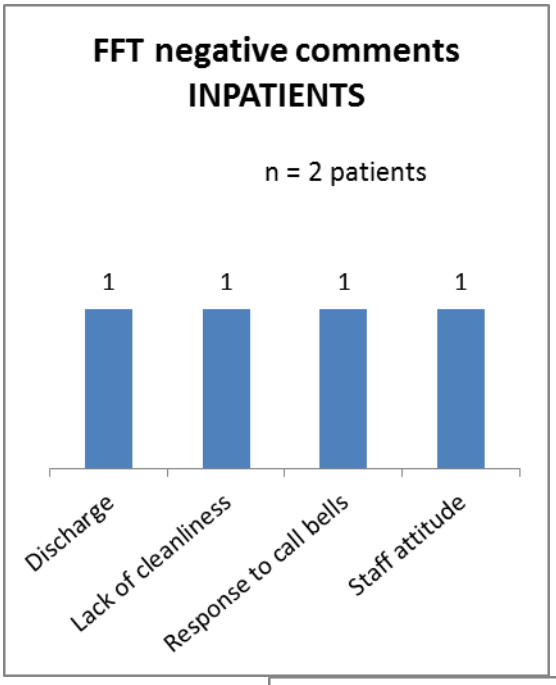
Responses for the period were as follows:

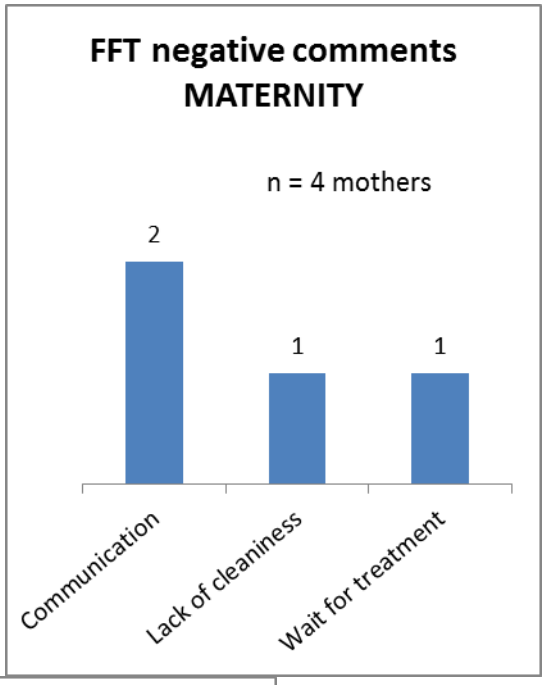
		Rating		
	Total Responses Received	Extremely Likely	Unlikely	Extremely Unlikely
Day Case	780	694	3	2
Emergency Department	524	400	5	5
Inpatients	1104	895	6	3
Maternity	199	164	2	4
Outpatients	3147	2618	21	13

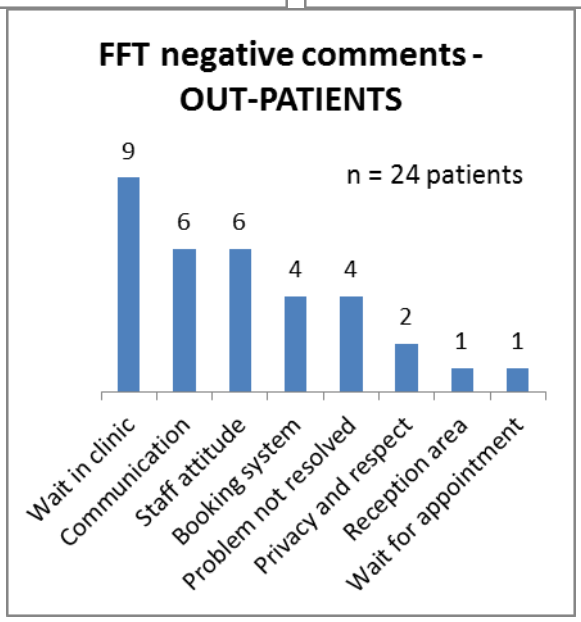
Comments made by those patients who stated they would be unlikely or extremely unlikely to recommend the hospital have been categorised as set out in the graphs below.











The main area of concern is waiting times (7 in the Emergency Department; 6 in the Eye Clinic; 2 in Paediatric outpatients and 1 in pre-op assessment).

Waiting times and explanations for all areas in the Emergency Department is now displayed on the plasma screen in the waiting room together with other patient information, and the names of the consultants, nurse practitioner and receptionists on duty. Details of any breaches in waiting times are published on the staff notice board.

Waiting times continue to be displayed on screens in other areas and staff always address enquiries regarding delays, doing their best to alleviate any anxieties which arise.

5. PATIENT AND PUBLIC INVOLVEMENT (PPI)

In Q1 there were five new project requests to the Patient and Public Involvement Group. Four earlier projects were completed and one was put on hold for the time being.

Clinical Support and Family Services

There was one new project to assess patient satisfaction with both the Antenatal and Postnatal Screening service offered by SFT. The feedback will be reviewed and used to inform and improve the screening service provided.

Medicine

The National Dementia Audit, which consists of a carer questionnaire, is underway. The purpose is to assess carer's perceptions of care received by the person they care for, in addition to their satisfaction with their involvement during the patient's admission.

The patient evaluation of the weekend TIA clinics was completed.
The weekend TIA clinic service at Salisbury District Hospital, in conjunction with Bournemouth and Poole hospitals, has now been in operation since March 2013. This 6 month audit allows us to monitor patient's experiences and use the gathered information to further develop and expand the services that we provide and forms part of the PPI work undertaken by the Stroke service. Overall respondents were mainly very satisfied and said they found the clinic very beneficial.

Musculo-Skeletal
There were two projects with the first for the Spinal Unit. This was commenced following the recent Care Quality Commission report, which highlighted concerns that patients in the Spinal Unit were not always provided with enough options for activities that met their needs and preferences. The project wanted to identify activities in which patients would like to participate and develop action plans to facilitate them where feasible.

The project was completed, however the response rate to the questionnaire was disappointing, but this may reflect the health and priorities of the patients in the Spinal Unit at the time. There was support for all of the existing activities and encouragement that some patients were able to make constructive suggestions. Some of the activities were already available in the Spinal Unit, therefore the frequency of these and how well they are publicised will be reviewed.

The second project aims to understand why the patient reported outcome health gain measures for patients having a primary total knee replacement are slightly below the national average but is not statistically significantly so.

There were 2 completed projects for MSK.

The Alveolar Bone Graft (ABG) surgery for children with a cleft palate project, evaluating patient and family satisfaction with the support provided pre and post ABG has been completed, however the final report is not ready yet.

The Peristeen Transanal Irrigation versus conservative bowel management techniques for spinal patients' project was put on hold due to staffing and will be re-submitted at a later date.

Surgery
There was 1 PPI project commenced in Q1 for the Surgery Directorate.

This project is within the Audiology department with an aim to assess the efficacy of using a modified form of Tinnitus Retraining Therapy. Patients with significant tinnitus will be asked to complete a national survey in regards to their treatment.

1 project was completed during Q1. This was a survey focusing on patients sleep within the ICU. A report is still awaited for this project.

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

6. PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

In Q1there was one new request for independent review from the PHSO for a Respiratory complaint.

The Plastic Surgery case previously reported was not upheld. The PHSO found evidence of failings in record keeping, consent and communication but did not believe that the failings had a significant impact on the patient's physical health and cannot be certain the patient consented to the further operation. The PHSO found no evidence of issues with the operation itself or complaint handling. As the Trust

acknowledged and apologised for all the failings identified in the report, the PHSO did not consider that there was any unresolved injustice to the patient for which the PHSO would need to raise recommendations.

The PHSO quarter 4 report on complaints about acute Trusts is available at:
http://www.ombudsman.org.uk/reports-and-consultations/reports/health/quarterly-reports-on-complaints-about-acute-trusts/q4-2015-complaints-about-acute-trusts

7. NHS CHOICES WEBSITE

In Q1 there were 18 comments posted on the NHS Choices website relating to 11 different areas. Of the 9 positive comments, one person said of Cardiology “My experiences throughout my eventful as yet unfinished journey to all the folk I have met I wish to thank you for your skill, kindness and professionalism you really are a credit to the NHS”. Of the 9 negative comments, one person said of the Surgical Admissions Unit, “In quite a lot of pain but no one giving me any information about what's going on or likely timescales. It was more like being treated as cattle rather than a human being. I accept that they can only get through patients at a certain rate but does that also stop the staff giving information and treating us as people. Very poor”. All the feedback was shared with the departments.

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

Trust Board meeting **SFT 3813**

Annual quality governance report 2015 - 2016

Date: 21 September 2016

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

Executive Summary:

- The report is structured around the Quality Governance Framework and the work needed to ensure compliance with the NHS Outcomes Framework 2016/17.
- The Quality Account is the key driver for improvement and overall the Trust has made good progress in improving the quality of care in 15/16. Nevertheless, there are still improvements to be made which are reflected in the quality priorities and work streams for 16/17.
- The CQC Trust wide action plan is also a key driver for improvement and is robustly monitored to ensure progress is made and sustained in practice.

Proposed Action:

1. **To note the report**

Links to Assurance Framework/ Strategic Plan:
CQC registration

Appendices:

Annual quality governance report 2015 - 2016

Supporting Information

SALISBURY NHS FOUNDATION TRUST

CLINICAL GOVERNANCE COMMITTEE

TITLE: *CGC061611* - Annual quality governance report 2015 - 2016

PURPOSE OF PAPER:

To inform the Committee of progress made in assuring and improving the quality, safety and patient experience of care in 2015 – 2016.

EXECUTIVE SUMMARY:

- The report is structured around the Quality Governance Framework and the work needed to ensure compliance with the NHS Outcomes Framework 2016/17.

- The Quality Account is the key driver for improvement and overall the Trust has made good progress in improving the quality of care in 15/16. Nevertheless, there are still improvements to be made which are reflected in the quality priorities and work streams for 16/17.

- The CQC Trust wide action plan is also a key driver for improvement and is robustly monitored to ensure progress is made and sustained in practice.

CARE QUALITY COMMISSION OUTCOME:

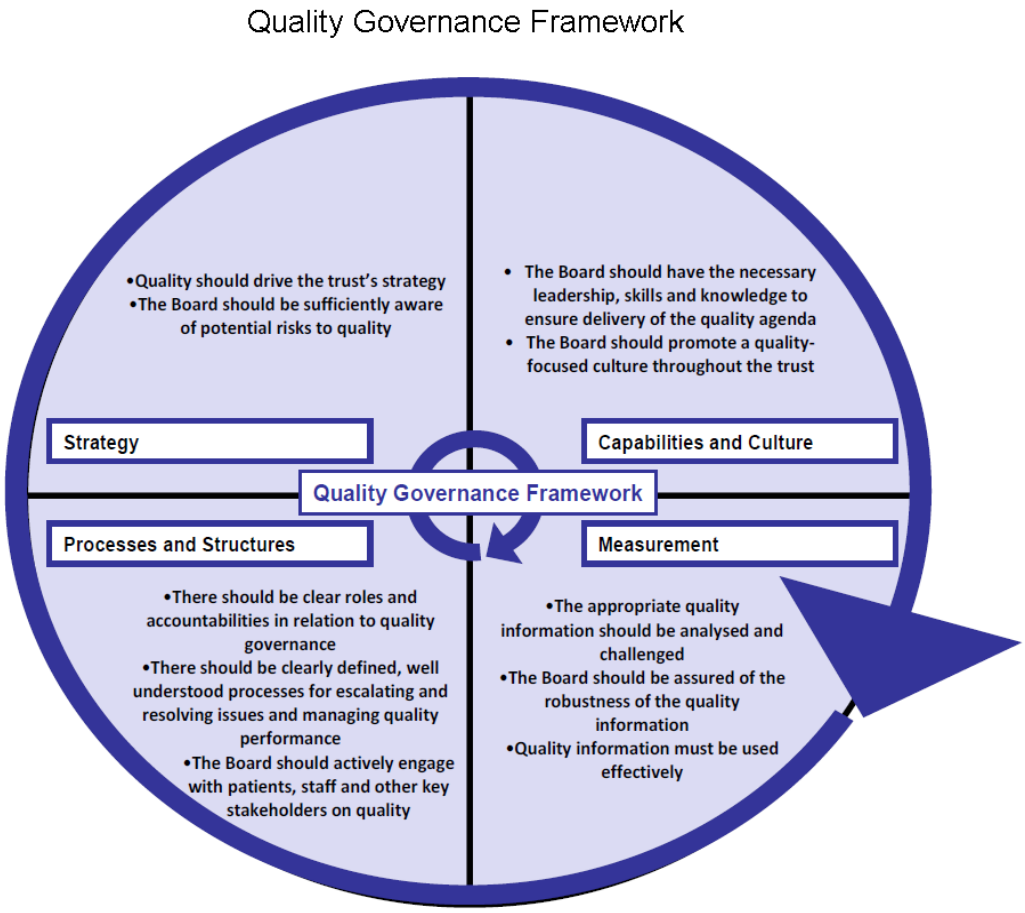
Safe, caring, responsive, effective and well-led.

ACTION REQUIRED BY THE COMMITTEE.

1. To note the report.

Author: **Dr Christine Blanshard & Lorna Wilkinson**
Title: **Medical Director & Director of Nursing**
Date: **June 2016**

Salisbury NHS Foundation Trust



ANNUAL QUALITY GOVERNANCE REPORT 2015 – 2016

1.0 Introduction

This annual report sets out the progress made between April 2015 and March 2016 to improve the quality of care for patients within the Trust and to provide assurance to the Clinical Governance Committee about the quality and safety of care within the organisation. Our quality priorities for 2016 to 2017 are set out in the report.

2.0 Quality governance

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

- Clinical effectiveness
- Patient safety and management of risk
- Patient experience

Quality governance is achieved through a robust quality governance framework which delegates responsibility from the Board down to the operating levels in the organisation. There is an open and transparent culture within the organisation that enables clinicians and clinical teams to work at their best, measure and monitor quality, and learn and improve. The quality governance framework sets out a definition of quality governance and its component parts can be seen in the diagram on the front cover of this report. Its purpose is to:

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

This is described within the Trust's Quality Strategy.

3.0 Quality strategy

The Trust's Quality Strategy 2016 - 2019 sets out the 3 year vision and framework for delivery of quality throughout the Trust. The Strategy aims to:

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

Delivery of the Quality Strategy is underpinned by the publication of the annual Quality Account which sets out the progress made in our five quality priorities in 2015/16 and the five quality priorities selected for 2016/17. Progress of the priorities will be monitored via the quality indicator report, patient real time feedback, national audits and survey results, the Friends and Family test, complaint themes, patient stories and clinical effectiveness reports presented to the Clinical Governance Committee.

The NHS Outcomes Framework 2016/2017 focuses on health outcomes which matter to patients and the public. Measuring and publishing information on health outcomes drive improvements in quality. The framework sets out 5 domains where health improvement can be achieved over a number of years.

These domains are:

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

4.0 Quality account

The Trust is required by NHS Improvement (Monitor) to provide a Quality Account for the public each year. The purpose is to inform people about progress made in improving the quality of care in 2015/2016 and is the key driver for improvement through the quality priorities in 2016/2017.

Overall, the Trust has made good progress in improving the quality of care in 2015/2016 but evidence and patient feedback tells us there are still further improvements to be made. In setting the quality priorities for 2016/2017 we have listened to a broad range of stakeholders in helping us to decide the priorities along with the work streams to support that underpin them.

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

5.0 Highlights for the year 2015/2016

5.1 Patient safety

- The Trust was in the first cohort of 22 hospitals working with Lord Carter to review the nursing workforce. Work focused on efficient rostering practices and testing of the metrics - care hours per patient day.
- A 35% reduction in grade 2 pressure ulcers.
- A 37% reduction in the number of patients with a new catheter-associated urine infection.
- No patient had an MRSA blood stream infection
- A 60% reduction in hospital acquired MSSA blood stream infection.
- Reduced the number (15 cases) of hospital acquired C difficile cases to below the upper limit of 19 cases which was the lowest in the region.
- Improved the prevention, recognition and treatment of patients with acute kidney injury.
- Improved the treatment of patients with severe sepsis on admission, ensuring they received antibiotics within an hour of arrival.
- A 20% reduction in the number of patients who had a fall resulting in moderate or severe harm.
- Consistent screening and diagnostic assessment of patients with dementia.
- The Trust remained in the lowest possible (band 6) CQC rating.

5.2 Clinical effectiveness

- The CQC rated the Trust as Good in the effective domain.
- Increased the number of patients recruited into clinical trials (1724 patients into 70 studies compared to 886 patients into 55 studies in 14/15) and increased the number of specialties taking part in research.
- High participation in national audits - 41 (95%) with broadly good patient outcomes and NCEPOD audits – 5 (100%)
- A high percentage of national audits published in 2014 presented to CMB by clinicians – 18 (75%)
- Outcomes of joint replacement surgery are published in the National Joint registry
- Published outcomes of breast, thyroid, vascular and colorectal surgery are consistently good with low mortality and complication rates.
- Sustained a high level of patients having a VTE risk assessment (98 – 100%) and prophylaxis (95 – 100%)
- Made progress in the implementation of the10 clinical standards of the NHS 7 Day Services review.

5.3 Patient experience

- The CQC rated the Trust as Good in the caring domain.
- Parents, children and young people rated their experience of care highly in the national children's inpatient and day case survey.
- New mothers recognised the outstanding care and support they received during labour and birth and after the baby was born in the national maternity survey.
- Implementation of a new Personalised Care Framework for end of life care.
- Embedding of Allocate and the introduction of the Safer Care module to link nursing staffing levels to the acuity and dependency of patients. Introduction of Insight and Value Added modules to improve the productivity and efficient use of the workforce.
- The national staff survey 2015 put the Trust in the top 20% of Trusts. 85% of staff recommended the Trust to their friends and family needing care and treatment compared to a national average of 70%.

5.4 Risk management

- We have implemented the Statutory of Duty of Candour. The CQC said our staff had a good understanding of their responsibilities. TIAA gave the Trust substantial assurance in a recent audit on Duty of Candour.
- We have implemented on line reporting of incidents via Datix web and increased the number of clinical staff reporting incidents.
- Sustained turnaround times of serious incident inquiries and clinical reviews and an improvement in the completion of recommendations.

5.5 Other achievements

- Almost full delivery of CQUINs worth £3.67M.
- Retained the Patient Information Standard accreditation.
- Introduction of a Freedom to Speak Up Guardian and Dignity at Work Ambassadors to enable staff to raise concerns in confidence, be provided with advice, guidance and signposting.
- Implementation of nurse/midwifery revalidation.

6.0 Areas for improvement/development

These are described in the Quality Account priority work streams for 2016/17 and our CQC Trust wide improvement plan. A summary of some of the work streams is set out below:

6.1 Patient safety

- The CQC rated the Trust as requires improvement for patient safety. Areas in need of improvement specifically related to nurse staffing levels in emergency and urgent care, surgical wards, the paediatric ward, NICU, critical care, maternity and the spinal unit. We will continue to review nursing staffing levels and skill mix to ensure there are sufficient numbers of suitably qualified and experienced nurses to deliver safe, effective and responsive care.
- Reduce the number of spinal cord injured patients waiting for a VUD investigation and OPD follow up and manage the risk effectively.
- Redesign the triage model in the Emergency Department so that patients are assessed within 15 minutes of arrival.
- Improve the number of staff receiving mandatory training.
- Undertake a review of mortality and morbidity activity at service level and make improvements.
- Continue to support staff to understand the risks relevant to their area of work and are able to manage the risks effectively.
- Continue to reduce the number of catheter-associated UTIs
- Achieve a reduction in the number of patients who have preventable falls and suffer harm.
- Maintain low levels of infection and responsible antibiotic prescribing.
- Improve peri-operative care.
- Implement the Saving Babies' Lives care bundle.

6.2 Clinical Effectiveness

- Achieve Sepsis Six roll out in acute inpatient wards.
- Deliver the 4 priority clinical standards for NHS 7 day services.
- Introduce frailty screening, a comprehensive geriatric assessment and personalised care plan for those patients who have moderate, severe or very severe frailty.
- Continue to increase the number of patients recruited to clinical trials and build on the relationship with the AHSN.
- Reduce the number of NICE guidance with areas of non compliance.
- Reduce the number of people dying from preventable conditions by better health promotion.
- Work to eliminate avoidable in-hospital mortality and report our avoidable mortality rate in line with national guidance

6.3 Patient experience

- Eliminate mixed sex accommodation.
- Ensure patients are moved a minimal number of times during their stay.
- Work with Wiltshire Health and Care and our other partners to integrate care and support improvements in patient flow.
- Introduce the Accessible Information Standard.
- Sustain and expand our staff health and wellbeing programme.
- Maintain the improvements in the care of patients with long term conditions, dementia and carer support.
- Work with Healthwatch and other external stakeholders to gain the views of a range of people and hard to reach groups to improve care.

7.0 Capabilities and culture

7.1 Leadership

Whilst the Trust Board has overall responsibility for quality, safety and patient experience, leadership for these areas is delegated to the Medical Director and the Director of Nursing. The Medical Director is the Trust's Responsible Officer with statutory responsibility for quality governance in the Trust. In respect of the 5 domains in the NHS Outcomes Framework the Medical Director drives quality improvement through clinical leadership to achieve the improved outcomes for patients in Domains 1 to 3.

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

7.2 Culture

There is a strong culture of reporting and learning from mistakes supported by robust policies of being open and honest and raising concerns. The Trust was rated as o*utstanding* and in the top five Trusts in the country for openness and transparency in 15/16 Learning from Mistakes League table published by NHS Improvement. The Duty of Candour was well understood. The CQC noted there was an extremely positive culture in the Trust and staff felt respected and valued. The CQC also noted that working in this positive environment had developed a culture of candour, openness and honesty.

The development of the workforce is key to delivering high quality care. The Trust has embedded the values and behaviours it expects of all staff through the appraisal system and development plans. A number of staff have attended leadership development opportunities via the NHS Leadership Academy and used the skills learnt to lead improvement projects. Staff involvement in improvement projects is crucial to sustain improvements as seen in the HIMP projects and the PMO transformation programme.

7.3 Sharing the learning

7.3.1 Clinical Governance half days

There are six clinical governance half days a year which support the quality governance framework. Four of the core sessions are held in the lecture theatre (topics in the table below). Unfortunately, this year two sessions were cancelled due to operational pressures and the junior doctor's strike; Patient Flow in June 15 and R&D in January 16. The protected time allows teams to meet together to discuss and improve aspects of quality as well as attend core sessions which cover patient safety, effectiveness and patient experience. Core sessions are well evaluated by attendees, with on average 85% of participants rating them as good or excellent.

Date	Topic
June 2015	Cancelled
July 2015	Patient safety
November 2015	HIMP group presentations
January 2016	Cancelled due to junior doctor's strike R&D was the topic and was presented in April 16.

7.3.2 Quality Governance newsletter

A Quality Governance newsletter is published which enables the Trust to publicise good practice and highlight areas for improvement. The newsletter is published to coincide with the clinical governance half days and content is based on the presentations given. This allows colleagues who were unable to attend the oral presentations to catch up later. The newsletter is distributed in hard-copy to all clinical leads and a broadcast with the link is sent out to all staff on the day of publication. It is also available on the intranet. Stakeholder feedback suggests the newsletter supports best practice and are well received. One was published in 15/16.

7.3.3 Striving for excellence awards

The Trust held its 9th annual awards day in December 2015 to recognise the achievements of staff and the way they have improved services for patients across the hospital. There were 9 categories which included service improvement projects, equality and diversity, customer care, as well as the Chairman's outstanding contribution award, the Chief Executive's leadership award, a Governor's volunteer of the year award, and an unsung hero award.

8.0 Structure and processes

8.1 Quality structure

The Trust Board is responsible for overseeing the quality of care delivered across all services within the hospital and being assured that quality, safety, patient experience and the management of risk are achieved across the organisation. Some of this responsibility is delegated to the Clinical Governance Committee (CGC). A report on the effectiveness of the Committee was presented to the Trust Board in year. The CGC monitors quality through a robust reporting schedule and has received a range of quality assurance reports and presentations from clinical services during the year. Patient experiences are heard through patient stories presented by patients or relatives at the beginning of some meetings. Quality is also assured and enhanced by Quality and Safety Executive Walk Rounds where staff are able to raise quality and safety concerns with an Executive and Non-Executive Director.

The CQC inspection report noted areas of weakness in governance, risk management and quality measurement in that the CGC minutes did not detail the roles of the people attending and not all actions were captured in the minutes. The minutes detailed little challenge from the non-executive directors. The CQC report also noted that a self-assessment against Monitor's quality governance framework did not identify weaknesses or areas for improvement. These issues are being addressed as part of our Trust-wide CQC action plan

The Clinical Management Board (CMB) has reviewed its terms of reference and reporting schedule. The reports of 18 (75%) published national clinical audits and 5 (100%) NCEPOD studies were reviewed by the CMB by the clinical lead responsible for implementing the changes. The majority of working groups, boards or committees that report to the CMB presented progress against their work programmes during the year.

8.2 Quality processes

Each individual service undertakes a six monthly self assessment using the Salisbury Organisational Risk Tool which alerts the DMT to risks relating to the quality of care and enables plans to be put in place for improvement. 3 to 3 quality performance meetings are held three times a year where quality information is reviewed to provide assurance of effectiveness, safety and patient experience. Quality improvement plans are agreed where needed. Information reviewed includes Directorate key quality indicators, risk reports, patient feedback and audit summaries.

The CQC inspection report identified that risk registers held at corporate, Directorate and local level did not consistently identify all risks, contain mitigating actions or where it did, the actions had not always been taken. This is being addressed as part of the Trust wide CQC action plan

9.0 Quality measurement

Measurement is a key component of assessing whether quality care is being provided and quality improvement is making a difference. It underpins all quality processes. The introduction of an electronic patient record in mid-2016 will give the opportunity for real time measurement.

The Trust Board receives quality reports to enable members to analyse trends and make challenges and be acted upon where appropriate. Key risks to quality are identified and remedial actions taken to mitigate the risk.

10. Quality priorities for 2016 – 2017

There are a number of areas where further improvements are needed and the following priorities have been agreed in consultation with key stakeholders.

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 economy.

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

The delivery of the CQC action plan will be monitored and managed via the following routes:

- At the monthly Directorate performance meetings – where each Directorate Management Team will be held to account on delivery of their core service actions.
- Oversight of the action plan as a whole and delivery of the Trust wide actions through a dedicated CQC Steering Group, chaired by the Director of Nursing.
- Board oversight of progress is through the CGC.
- Both the CGC and the Joint Board of Directors have a programme of core area presentations to enable them to hear direct from the services on progress with their improvement plans.

- The Action Learning Group to assess levels of compliance to assure improvements in practice.

11.0 Summary

Overall, the Trust's Quality Governance Framework is effective in providing assurance about the quality of care that is being delivered across the Trust and identifying areas for improvement. Challenges and areas for improvement in the coming year are set out in the Quality Account priorities and Trust wide CQC improvement plan.

Claire Gorzanski
Head of Clinical Effectiveness
June 2016

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
Held on 25 July 2016

Present	Dr N Marsden	Chairman
	Dr L Brown	Non-Executive Director
	Mr I Downie	Non-Executive Director
	Mr P Hill	Chief Executive
	Mr A Hyett	Chief Operating Officer
	Mr M Collis	Deputy Director of Finance
In Attendance:	Mr P Kemp	Non-Executive Director
	Mr D Seabrooke	Head of Corporate Governance
	Ms L Wilkinson	Director of Nursing (for item 3)
	Mrs C Gorzanski	Head of Clinical Effectiveness (for item 3)
	Ms F Hill	Head of Risk Management (for item 4)
	Mrs K Stovin-Bradford	Business Relations Manager (for item 10)
	Mr L Arnold	Director of Corporate Development (for item 10)
Apologies	Mr M Cassells	Director of Finance and Procurement

1. FINANCE AND PERFORMANCE COMMITTEE MINUTES – 27 JUNE 2016

The minutes of the meeting of the Committee held on 27 June 2016 were accepted as a true record subject to a clarification of the favourable variance described in minute 5 representing a small in-month operating surplus.

With that amendment, the minutes of the 27 June meeting of the committee were accepted as a correct record.

2. MATTERS ARISING

Minute 5 – following the discussion at the June meeting, Mark Collis described three costing scenarios for the treatment of a non-elective patient where this had differing degrees of effect on elective activity.

It was also noted that Breamore Ward was being added as a permanent ward providing up to 24 additional beds to the Trust's bed base. The Day Surgery Unit would move to a 23 hour facility and an additional patient area was being created through the re-location of the Central Booking Team. The refurbishment of Laverstock Ward was continuing and this would become available again in time for winter pressures.

It was agreed that these developments would be discussed in more detail at the Board Seminar Session in September.

3. CQUIN 2016/17

The Committee received the Quarter 1 CQUIN report setting out the position for Wiltshire, Dorset and associate CCGs, SHIP (West Hampshire CCG) and NHS England Specialised Commissioning CQUINs 2016/2017.

It was noted that the Wiltshire CQUIN was worth £2.6m of which £470,000 had been achieved in Quarter 1. Other CQUINs where on track apart from Sepsis in Emergency Departments where £19,000 was at risk.

The West Hants CCG CQUIN was worth £353,000 of which £69,000 had been achieved in quarter 1. A local CQUIN in relation to frailty care planning and delivery remained under negotiation – this was worth £177,000. The Specialised Commissioning which included military, dental, offender and screening contract was worth a total of £542,500 of which £105,000 had been achieved in Quarter 1.

A challenging target for staff flu vaccinations had been set at 75% and this target had been discussed by the Council of Governors.

It was agreed that the CQUIN report would be presented again at the October meeting. **DS**

4. ASSURANCE FRAMEWORK AND RISK REGISTER

The Committee received the quarterly update report on the Assurance Framework and Risk Register.

It was noted that a new gap in control under Risk 4.2 (failure to secure income) had been identified, being the provision of accurate and timely data for contract monitoring from the new EPR system – solutions to this were being reviewed.

Under Risk 4.3 (failure to contain cash and expenditure) a gap in control had been identified in relation to the full savings requirement of £9.5 m had not been fully identified with a remedial action of refreshing planning and budget setting guidance for 2016/17.

It was noted that the Cost Improvement Programme of £6.5 m was fully identified. NHS Improvement had recently published the criteria to access the Sustainability and Transformation Fund and this had been reflected as a gap in control i.e. to ability to achieve performance trajectories to secure Sustainability and Transformation Fund payments after Quarter 1. No specific additional remedial actions had been identified.

FHi undertook to ensure that an executive lead was allocated to each risk action plan in the Risk Register. FHi

5. FINANCE AND CONTRACTING REPORT TO 30 JUNE 2016

The Committee received the report and it was noted that an in-month surplus of £212,000 had been generated in June. After three months, against a planned £1,403,000 deficit the actual deficit stood at £83,000. Clinical income continued to run ahead of the plan in day attenders and outpatients. Agency spend was ahead of the control total but had reduced compared with the previous year.

The Trust's cash position had improved and it was noted that the consolidated cash position at the end of Quarter 1 was ahead of plan by £2m.

The cash flow forecast detailed in the report assumed NHS income based on contract values, full payment of Sustainability and Transformation Funding and no assumption had been made in relation to the proposed ITFF £6m loan towards the EPR project.

The Trust had submitted an Activity Query Notice to Wiltshire CCG. There was general acceptance that there was increased activity that would continue for the foreseeable future. Discussions had resulted in an action plan, the majority of which would be led on by the CCG.

It was noted that the first quarter payment under the Sustainability and Transformation fund had been received.

Reference Costs Collection Exercise 2015/16

The Committee approved a report giving details of the costing processes and systems to be used to support the 2015/16 reference cost collection.

The Committee was satisfied that the Trust would be able to produce the information to the required standards of accuracy and timescale.

6. TRANSFORMATION AND COST IMPROVEMENT

The Committee received the PMO report for month 3. It was noted that red, amber and green schemes totalled to 105% of the £6.5 m CIP saving requirement. Good progress had been made on quality impact assessments for the schemes and there were 63 completed. 61% of the identified schemes were considered to be recurring and the 39% deemed as non-recurring at this stage were being reviewed as one-fifth of these were considered to be recurring at this stage.

7. OPERATIONAL PERFORMANCE REPORT – JUNE 2016

The Committee received the Operational Performance Report. It was noted that the Trust had delivered 92.8% in June in relation to the A & E – Time in the Department measure, which was close to the year to date figure of 92.7%. The 18 Weeks Incomplete figure was affected by cancellations for ENT and Orthopaedics Surgery and the month 3 figure was 90.1% against the requirement of 92%. Cancer figures were still subject to variation – the indications were that the Trust had met the Cancer Standards with the exception of the Two Week Wait for Symptomatic Breast Cancer.

8. REPLICA 3D UPDATE

It was noted that eight out of the ten shareholders the Trust was in contact with had returned their forms and discussions continued with OML.

9. QUARTER ONE GOVERNANCE RETURN TO NHS IMPROVEMENT

The Committee received the targets and indicators tab for Quarter 1 2016/17 for approval.

The draft return indicated that the Trust was declaring it had not met the A & E and 18 Weeks Targets for Quarter 1. Performance on the Cancer Two Week/ (Breast Symptoms) Standard was showing at 89.5% against

the standard of 93%. The return would be made with the latest verified position on this indicator. The return also reflected the Spinal Injuries Unit Warning Notice and it was noted that the Trust continued to work through the action plan to clear the Video Uro-Dynamic Diagnostic Test and Outpatients backlogs in this area.

The return was approved for submission to NHS Improvement.

10. GP REFERRALS/MARKET INTELLIGENCE

The Committee received a report looking at activity arising from the Trust's principal referring GP practices. It was noted that Abbey View at Shaftesbury and Sturminster Newton GP Surgeries had merged and that Wilton Healthcare was now part of the Salisbury Medical Practice.

GP education events were being planned along with a more regular gathering of hospital consultants and GPs.

The report gave details of market share over the past twelve months in respect of Cardiology, General Surgery, Urology, Ophthalmology, Arthroscopy, new hip replacement, Trauma and Orthopaedics.

11. DATE OF NEXT MEETING

Monday 22 August at 9.30 am.

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
Held on 22 August 2016

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

1. FINANCE AND PERFORMANCE COMMITTEE MINUTES – 25 JULY 2016

The minutes of the meeting of the Committee held on 25 July 2016 were agreed as a correct record.

2. FINANCE AND CONTRACTING REPORT TO 31 JULY 2016

The Committee received the month 4 report and it was noted that the Trust had made an in-month surplus of £42,000 and was registering a year to date deficit of £41,000 which was a favourable variance against plan of £1529k. Income was above plan and there had been extensive agency use in July. Broadly the Cost Improvement Programme was ahead of plan in relation to the £6.5m savings target and was making some head way in relation to the remaining £3m requirement.

It was noted that the first quarter of the Sustainability and Transformation Funding had been received from NHS Improvement. Quarter 4's payment would be made in year on the basis of forecasts.

The Trust had served activity notices on Wiltshire and West Hampshire CCG. CQUINs were agreed and discussions continued with NHS England on the future of the Hub and Spoke arrangements for Vascular Surgery.

The contract with Synergy Health had been signed in recent days and this meant that the arrangement with Sterile Supplies Limited and the Trust would commence on 1 September 2016. The Committee was reminded that Malcolm Cassells and David Taylor would be the Trust's representatives on the company board.

Subject to planning permission the Trust was proceeding with the photo-voltaic array on car parks and the first step was a framework agreement to cover the initiative. The panels would help to offset charges under the Carbon Reduction Regulations. The installation of the arrays could be phased to minimise disruption to the car parks and the loss of car parking spaces was minimal.

The Committee noted the Finance and Contracting Report.

3. PROGRAMME MANAGEMENT OFFICE REPORT – MONTH 4

The Committee received the PMO report. It was noted that schemes were 102% identified. Some were income based. At present the PMO were not crediting income schemes for Clinical Support and Family Services as there had been a reduction in maternity activity and income.

It was agreed that the issue of cashable savings from the Electronic Patient Record in 2016/17 would be discussed at the Board Seminar day in September.

4. OPERATIONAL PERFORMANCE – MONTH 4

It was noted that the Trust had met its standards for diagnostic tests and had delivered for cancer standards in quarter 1. The Breast 2 Week Cancer Target continued to be affected by patient availability. All of the cancer performance figures were close to the target. Validation for 18 Weeks performance was continuing. The Trust had delivered 90% for the A&E 4 Hour Target in July.

In relation to this it was noted that July had been the busiest month on record. The new medical trainees had rotated into the department. Electronic whiteboards were being implemented and the Electronic Patient Record would further help with the management of patient flow. Alternatives with nursing home providers had been investigated, but staffing continued to be an issue. There had been a positive meeting with Wiltshire CCG towards actions they could take in support of providers. There was growing concern about Delayed Transfers of Care for Dorset and Hampshire.

It was suggested that the Executive Workforce Committee should consider the measures being taken to promote staff welfare during these busy times.

5. REPLICA 3D UPDATE

It was noted that OML had now taken over operations. The acquisition of the shares remained ongoing.

6. DATE OF NEXT MEETING

Monday 26 September at 9.30 am.

TRUST BOARD

FINANCE & CONTRACTING REPORT TO 31st August 2016

1. Introduction

This paper outlines the main drivers behind the SFT Group consolidated financial position for the period ending 31st August 2016.

The Income & Expenditure (I&E) position was a Year-to-Date (YTD) surplus of £242k (after adjusting for donated income & assuming sustainability & transformation funding), a favourable variance against the plan of £2,132k, and an in-month surplus of £284k.

Summary of Key Financial Information	Year to Date (YTD)			
	Plan £000s	Actual £000s	Var £000s	Var %
Income	85,734	87,609	1,875	2.2%
Expenditure	84,243	84,226	17	0.0%
EBITDA	**1,491**	**3,383**	**1,892**	**126.9%**
Finance and Depreciation Costs	6,006	5,894	112	1.9%
I+E Surplus /(Deficit) excl donated income & STF	**-4,515**	**-2,511**	**2,004**	**44.4%**
Donated Asset Income Adjustment	0	128	**128**	
Sustainability & Transformation Fund	2,625	2,625	**0**	
I+E Surplus /(Deficit)	**-1,890**	**242**	**2,132**	**112.8%**
Favourable Variances are shown as +ve				

The main reasons for the YTD favourable variance were:-

- Over-performance on NHS commissioner contract income particularly for non-elective activity and critical care days;
- Donated assets of £128k; and,
- A non-recurring rebate of PFI insurance of £289k which has been applied to the £3m strategic CIPs requirement, resulting in savings being ahead of the YTD plan by £507k.

It is important to note that on a straight line basis to achieve the control total we should have a surplus of £750k after five months but the plan is phased to reflect more savings in the latter part of the year.

2. Sales

NHS activity revenue was £75,027k (excluding sustainability & transformation funding) which was £852k above the plan. Of this sum 'excluded pass-through drugs & devices' over-performance was £241k and this was offset by a similar overspend on expenditure, and as such adds no benefit to the bottom line.

Contract Activity Performance 2016/17	Actual 2015-16	Actual 2016-17	Plan 2016-17	Year on Year Variance	Plan Variance
Elective inpatients	2,262	2,137	2,227	-125	-90
Elective PSDs/day attenders	9,496	9,383	9,535	-113	-152
Regular Day Attenders	3,250	3,907	3,142	657	765
Non Elective Inpatient	10,782	11,358	10,888	576	470
Outpatient initial attendances	27,780	27,659	27,033	-121	626
Outpatient follow-up attendances	45,439	44,470	45,492	-969	-1,022
Outpatient procedures	14,925	15,151	14,955	226	196
A&E attendances	19,092	20,241	19,164	1,149	1,077
Favourable Variances are shown as +ve					

- Elective spells were down by 90 against plan and down on the year on year comparison by 180, with notable reductions in ENT, Plastic Surgery and Gynaecology, however this has been partly offset by over-performance in Urology, Breast Surgery and T&O. The under-performance was due to a lack of capacity with procedures being cancelled due to non-elective pressure on beds.
- Day Cases were down by 152 against plan and down on the year on year comparison by 113. There were notable adverse variances in Plastic Surgery, Gastroenterology, and Dermatology. This has been offset by over-performance in Urology, Colorectal Surgery, T&O and Ophthalmology. The adverse performance can be mainly attributed to use of the Day Surgery Unit for escalation purposes resulting in cancellations.
- Non-Elective activity has over-performed by 470 spells against plan with activity up in: General Medicine, Trauma & Orthopaedics and Gynaecology.
- Overall Outpatient attendances were down by 200 against when compared to last year.
- A&E activity was up against plan by 1,077 attendances (6.0%). There was an unprecedentedly high level of activity during the month.

Other income was ahead of plan by £1,023k due partly to the reclassification of some clinical income and the insurance rebate.

3. Cost of Sales including indirect costs

The total YTD net expenditure for all Directorates was £72,974k, resulting in an adverse variance of £938k. The position is summarised below:

Directorates	In Month			Year to Date		
	Plan	Actual	Var	Plan	Actual	Var
	£000s	£000s	£000s	£000s	£000s	£000s
Medicine	3,493	3,790	(297)	17,778	18,401	(623)
Musculo Skeletal	2,431	2,409	22	12,233	12,010	223
Surgery	2,942	3,200	(258)	15,112	15,564	(452)
CSFS	3,268	3,339	(71)	16,161	16,369	(208)
Facilities	389	397	(8)	1,889	1,811	78
Corporate	1,354	1,427	(73)	8,863	8,819	44
TOTAL	**13,877**	**14,562**	**(685)**	**72,036**	**72,974**	**(938)**

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

The main drivers of the overall Directorates' adverse variance were:-

- Continuation of the nursing overspends due to vacancies and the resultant premium paid to agency staff;
- An increase in the number of Nurse 'Specials' used in the month; and,
- A reduction in month of over-performance for NHS activities to offset expenditure.

4. Cost Improvement Plan

The Trust achieved YTD savings and Income Generation schemes of £2,656k against a plan target of £2,149k a favourable variance of £507k. The favourable movement in the variance this month was mainly due to the insurance rebate of £289k and this has been included as a strategic scheme. It is recognised the CIP programme is back loaded and therefore on a straight line basis the Trust would be £1,302k (67%) below where it should be. At the time of preparing this report, unidentified schemes relating to the £6.5m distributed target amount to £298k (4.6%).

5. Statement of Financial Position

Overall the working capital position (current assets less liabilities) was better than plan by £3,596k mainly due to Debtors being higher than plan and the Trust currently retaining £2,000k cash, which is due to be loaned to the new SDU joint venture company (the Trust's plan includes this sum as a long term investment). NHS debtors include two months of accrued income in respect of the Sustainability and Transformation Fund (£1,050k) and a sum of £2,300k for over-activity to date.

6. Cash

The consolidated cash position at the end of August was ahead of plan by £548k. The plan includes a sum of £500k, being the anticipated first drawdown of the £6m ITFF loan the Trust has applied for (see below). The first quarter's Sustainability and Transformation Fund payment of £1,575k was received in the month.

The cash flow reflects the actual position for the first five months of the year and a forecast for the remaining seven months. It is based on a number of assumptions; some of the key ones are as follows:-

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

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

7. Capital Expenditure

Expenditure was £3,387k which was ahead of plan by £400k although expected to be on plan by the end of the year. The Trust is still waiting to hear whether its loan application to the Independent Trust Financing Facility has been successful.

8. NHS Commissioner Contracts

The Activity Query Notices (AQN) issued to Wiltshire and West Hampshire CCGs remains in place and the Trust has met with both CCGs. Wiltshire CCG has been working with the Trust to develop an action plan that will help manage the increased emergency care activities. West Hampshire CCG initially requested their AQN be closed despite recognising the substantial increase in activity from their locality. The Trust has met again with the CCG to develop action plan broadly similar to the one agreed with Wiltshire.

The Trust has received and responded to the first quarter's challenges from the commissioners. It has become clear that the CCGs are using the challenge process to enforce their interventions not normally funded policies. The SHIP (Southampton, Hampshire, Isle of Wight and Portsmouth CCGs) consortia who use an on-line application process have now stated that retrospective applications will no longer be accepted. The clinical teams and central booking will need to ensure that they only book a patient for a procedure once prior approval has been confirmed. It is acknowledged that this may slow the treatment process but it will ensure that funding is secured.

The Trust will be shortly meeting with NHS England Specialist Services to discuss the challenge process and sign off on the month 12 2015-16 position and the first quarter of 2016-17. A revised rebasing exercise based on specialist commissioning logic is expected to be required shortly.

The Trust has responded to the tariff consultation and whilst broadly supporting the proposals. The Trust has not accepted the proposal for block contract for outpatient attendance and is seeking further clarification on a number of the proposals prior to the statutory consultation process.

NHSE and NHSI have confirmed that they expect all contracts for 2017-18 & 2018-19 to be agreed and signed off by the end of December 2016.

9. Risks & Forecast Outturn

The Trust's key financial risks can be summarised as follows:

- The level of DTOCs and 'green to go' patients in the hospital affecting flow;
- Delivery of the CIP target of £9.5m; this is the greatest financial challenge;
- Developing CIPs for future years;
- Contractual challenges from CCGs and to meet contractual obligations to avoid penalties;
- Securing the Sustainability and Transformation Funding (STF);
- Delivery of CQUIN targets;
- Unplanned growth of non-elective activity which has a detrimental impact on elective work;
- Impact of junior doctor's industrial action

We have calculated a number of forecast out-turn scenarios to incorporate the impact of the risks identified above, as follows:-

- Scenario 1 (Upside) has been calculated using the actual YTD position and shaping the forecast using the income and expenditure monthly planning profiles. The forecast outturn would be a surplus of £1.8m which is in accordance with our approved plan. This does assume that the STF payment is received in full; the allocated savings target of £6.5m is achieved and the balance of £3m savings is achieved.

- Scenario 2 (Breakeven) has been calculated using the same methodology as Scenario 1. However, this assumes that we fail to deliver the financial plan for quarter 4 mainly due to a shortfall in the savings target by circa £1m. This will also result in a potential reduction of STF payment by roughly £1m.

- Scenario 3 (Downside) has been calculated using the same methodology as Scenario 1, but we have assumed a shortfall on savings of £2m (£0.5m against allocated target £6.5m and £1.5m against the £3m strategic schemes); failure to achieve our STF performance trajectories for A&E for 2 quarters resulting in a loss of £0.5m; and failure to achieve our finance plan in the last quarter £1m. The forecast outturn deficit would be £2.1m which is above plan by £3.8m.

- Scenario 4 has been calculated using a simplistic straight-line methodology excluding the STF. This would give a deficit £5.8m and if we assume 75% of the STF this would give an outturn deficit of roughly £1m. If the Trust received the STF in full it would be a surplus of £0.5m.

In terms of the forecast outturn for all the scenarios, the following assumptions have been used:-

- CQUIN is delivered in full.
- There is no escalation of challenges, contractual fines and penalties.
- Resilience funding has been allocated to the Directorates and assumes costs will be managed accordingly.
- All Electronic Patient Record (EPR) project costs are capitalised.
- Inflation pressures are zero to allow the inflationary contingency reserve to offset the shortfall in strategic savings.
- No adjustment has been made for the impact of junior doctor's industrial action.

10. Other Financial Issues

SDU – The new joint venture company Sterile Supplies Ltd (SSL) took over the service from 1 September 2016 and there has already been good progress in addressing processes which had previously led to theatre cancelations. Staff have been TUPE'd to the new organisation and this has gone well. New technology is being introduced over the coming weeks to greatly improve flow. Work on the design of the new building is progressing to plan.

The Trust has responded to a NHS consultation on a major revision to the Risk Assessment Framework. This aims to create a **Single Oversight Framework** which brings together the operational and financial governance and risk assessment. The principles are broadly acceptable and the initial changes will be implemented from 1 October, however there will be further proposals around quality measures and some additional financial metrics which will need careful consideration when they are issued.

11. Conclusions

The Group reported position for August was a surplus of £242k giving a favourable variance of £2,132k against plan.

The Trust's overall risk rating score was 4 and whilst this is the maximum score the Trust can achieve it is not a true reflection of the financial situation.

12. Recommendation

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

Malcolm Cassells
Director of Finance and Procurement

Appendix 1 - ACTIVITY & INCOME

	PLANNED SAME DAY			ELECTIVE IN-PATIENT			NON-ELECTIVE IN-PATIENT		
	Plan Spells	Actual Spells	Variance Spells	Plan Spells	Actual Spells	Variance Spells	Plan Spells	Actual Spells	Variance Spells
Clinical Commissioning Groups (CCGs)									
Wiltshire	6,328	6,264	(64)	1,229	1,165	(64)	7,119	7,563	444
Dorset	1,261	1,269	8	336	308	(28)	1,270	1,260	(10)
West Hampshire	881	828	(53)	249	243	(6)	1,142	1,138	(4)
Other CCGs	129	108	(21)	97	101	4	221	255	34
TOTAL CCGs	**8,599**	**8,469**	**(130)**	**1,911**	**1,817**	**(94)**	**9,752**	**10,216**	**464**
NHS England (NHSE)									
Specialist Commissioning	218	212	(6)	138	142	4	219	195	(24)
Dental	344	316	(28)	61	49	(12)	69	61	(8)
Military	286	272	(14)	69	71	2	594	550	(44)
Offender Health	13	23	10	0	5	5	19	45	26
TOTAL NHS England	**861**	**823**	**(38)**	**268**	**267**	**(1)**	**901**	**851**	**(50)**
Non Contracted Activity	75	91	16	47	53	6	234	291	57
Balance to Trust Annual Plan	0	0	0	0	0	0	0	0	0
Total Activity	**9,535**	**9,383**	**(152)**	**2,227**	**2,137**	**(90)**	**10,888**	**11,358**	**470**

INCOME	Year to Date (Income)		
	Plan £000s	Actual £000s	Variance £000s
Elective inpatients	7,576	6,439	(1,137)
Day Cases	7,722	7,751	29
Non Elective	23,371	25,153	1,782
Outpatients	10,711	10,498	(213)
A&E	2,389	2,500	110
Critical Care	2,255	2,339	84
Excluded Drugs & Devices	6,340	6,581	241
Other (Incl Maternity, Direct Access & Day Attenders)*	15,386	16,392	1,006
TOTAL NHS CLINICAL INCOME	**75,750**	**77,652**	**1,902**

* Includes Sustainability & Transformation Funding of £2,625k. (Payment in full)

Appendix 2 - CAPITAL EXPENDITURE

Project Name / Category	Approved Annual Plan 16/17 £000s	Agreed Changes 2016/17 £000s	Slippage to 2017/18 £000s	Revised Annual Plan 2016/17 £000s	YTD spend (August 2016) £000s	Anticipated Under/(Over) spent on Projects £000s
Donated Assets						
Bariatric Bed	11,140	0	0	11,140	0	
Clinical Radiology 2 x Ultrasound	17,700	0	0	17,700	0	
Orthodontics & Oral Surgery Cone Beam CT Scanner	110,000	0	0	110,000	0	
Small Donated Additions	0	127,772	0	127,772	127,772	
Donated Assets - Totals	**138,840**	**127,772**	**0**	**266,612**	**127,772**	**0**
Phase 3 Building Schemes						
Breast Unit enabling	10,194	42,317	0	52,511	292,141	-239,630
Car Park PV	0	0	0	0	0	
CT Scanner Building and Enabling	9,013	0	0	9,013	0	
Laverstock Ward (Decant Ward Project)	354,720	0	0	354,720	152,238	
SAU Refurb (Decant Ward Project)	88,147	0	0	88,147	75,295	
Maternity development	354,712	0	0	354,712	5,242	
Radnor Ward Development	12,594	0	0	12,594	0	
SDU Development	30,338	0	0	30,338	7,245	
Springs entrance development	1,228,718	-1,228,718	0	0	0	
Ward changes - Dementia Patient Care	1,457	0	0	1,457	445	
Building Schemes - Totals	**2,089,894**	**-1,186,401**	**0**	**903,493**	**532,606**	**-239,630**
Building and Works						
Accommodation H&S Work	40,000	0	0	40,000	0	
Accommodation Boilers (Wylye House & Victoria Drive)	80,000	0	0	80,000	0	
Accommodation replacement of kitchens and bathrooms	46,850	0	0	46,850	26,999	
Accommodation Roof Repairs (Compton & Langley)	60,000	0	0	60,000	0	
AHU replacement yr 4 (2016/17) of 7	170,596	30,000	0	200,596	581	
Asbestos management	17,776	0	0	17,776	0	
Avon and Bourne Boiler Replacement	52,000	11,532	0	63,532	56,649	
BMS upgrade	44,023	-30,000	0	14,023	0	
Car park machinery replacement	10,071	37,000	0	47,071	1,768	
Catering Changing Area	19,000			19,000	0	
Catering Dishwasher	49,066	0	0	49,066	461	
Catheter Suite - Rebalance of Heating System	6,048	0	0	6,048	0	
Central booking relocation - block 79 (Wilton ward)	101,439	0	0	101,439	50,903	
DSU Roof Repairs	5,822	0	0	5,822	0	
DSU Salto	13,668	0	0	13,668	1,544	
Ductwork & Fire Damper Cleaning Whole Site	129,483	0	0	129,483	7,564	
Electricity at Work Regulations Compliance	84,239	0	0	84,239	5,923	
Estates health and safety	4,725	0	0	4,725	1,910	
Estates - Oracle software interface	24,000	0	0	24,000	0	
Fertility Centre Upgrade	15,000	0	0	15,000	4,602	
Fire compartmentation SDH north - remedial works	18,271	0	0	18,271	0	
Fire Door Compliance	40,000	0	0	40,000	712	
Flooring Replacement	40,534	0	0	40,534	20,699	
General laboratory replacement autoclave and Motuary Disinfector	54,075	0	0	54,075	44,225	
Genetics Coolong	36,000	0	0	36,000	0	
Genetics Modular cold room	0	0	0	0	0	
Helipad Temporary Parking	0	17,870	0	17,870	1,294	
Hillcote Sale Costs	0	0	0	0	0	
Hospice Fire Alarms (was Hospice and Finance)	45,295	2,000	0	47,295	350	
Lab Medicine Cold Room	0	0	0	0	2,049	-2,049
Level 4 Bedspace Power Sockets	41,610	0	0	41,610	0	
Lifts overhaul - year 3 (2014/15) of 3	40,488	25,000	0	65,488	3,392	
Main boiler burners	5,549	-5,549	0	0	0	
Main Entrance L3 Upgrade	5,807	0	0	5,807	0	
Maternity Obstetric Theatre Refurbishment	1,030	0	0	1,030	0	
Maternity Post Natal Upgrade	6,437	0	0	6,437	0	
Mattress Laundering	2,521	0	0	2,521	0	
Medical Gas Hoses 2nd year of 2 (2015/16)	147,000	0	0	147,000	0	
MSK Notes Preparation	6,500	0	0	6,500	0	
Nurse Call System Upgrade - SDH North & Maternity - 2nd year of 2	123,167	0	0	123,167	0	
OHSS replacement windows	5,270	0	0	5,270	2,055	
Old GUM Clinic Demolition	10,449	0	0	10,449	0	
Pathology - air tube upgrade	4,119	0	0	4,119	0	
Pathology - conversion of computer room to office	12,000	0	0	12,000	0	
Pathology Reception	6,370	32,800	0	39,170	44	
Pharmacy Cold Room	10,000	0	0	10,000	0	
Powered Door Curtains Level 2	30,000	-15,000	0	15,000	18	
Productive Operating Theatres	18,542	0	0	18,542	0	
Public & Staff WCs L5,L4,L3	53,357	0	0	53,357	97	
Public Spaces Fund	12,441	0	0	12,441	0	
Roads and paving repairs	214,259	0	0	214,259	0	
Sarum Ward Playdeck	0	7,000	0	7,000	0	
SDH North Drain Survey	4,999	0	0	4,999	0	
Server Rooms - Air Conditioning	16,890	0	0	16,890	0	
Shower Cubicle Drainage Improvements	17,693	0	0	17,693	5,756	
Site Signage	7,517	0	0	7,517	287	
Spinal Boiler Replacement & Associated Pipework	5,983	-5,983	0	0	0	
Spinal treatment centre refurbishment	16,306	0	0	16,306	3,865	
Spinal Unit Doors and Locks	4,282	0	0	4,282	59	
Springs servery upgrade - floor and freezers only	75,000	0	0	75,000	0	
Taps & IPS panels - sitewide	48,056	0	0	48,056	3,314	
Water Safety	42,000			42,000	0	
Water tanks access - main tanks only	30,000	0	0	30,000	0	
Building Projects/Building and Works Totals	**2,233,620**	**106,670**	**0**	**2,340,291**	**247,117**	**-2,049**
Information Technology						
Alternative to Microsoft products - review	75,000	0	0	75,000	0	
Blades	193,000			193,000	0	
Blood Tracking Phases 1 - 3	185,945	0	0	185,945	50,315	
BMS Network Upgrade	987	0	0	987	1,771	-784
Brocade Switch Replacement	5,004	0	0	5,004	3,089	
CALS	200,000			200,000	0	
Catering Cash Register Replacement	4,400	0	0	4,400	2,060	
Citrix Support	102,276	0	-68,184	34,092	0	
Community Midwifery system trial	29,244	0	0	29,244	0	
Connectivity Upgrade for Warminster & Shaftesbury	19,023	0	0	19,023	13,647	
Data Warehouse (16/17 bid)	175,000	0	0	175,000	0	
EEG Neurophysiology Review Software	5,000	0	0	5,000	4,194	
Electronic Letters	14,617	0	0	14,617	0	

Project Name / Category	Approved Annual Plan 16/17 £000s	Agreed Changes 2016/17 £000s	Slippage to 2017/18 £000s	Revised Annual Plan 2016/17 £000s	YTD spend (August 2016) £000s	Anticipated Under/(Over) spent on Projects £000s
EPMA	405	0	0	405	0	405
EPR Contigency	0	0	0	0	287,973	-287,973
EPR Lines	11,000	0	0	11,000	0	
EPR Network Resilience	0	87,000	0	87,000	18,989	
EPR Implementation Costs	-170,248	1,891,500	0	1,721,252	582,945	
EPR Hardware	-188,526	650,000	0	461,474	284,415	
EPR Data Warehouse	0	224,200	0	224,200	66,756	
EPR Supplier Costs	0	1,570,200	0	1,570,200	0	
EPR Scanning	0	932,000	0	932,000	0	
Genetics - software upgrade	7,836	0	0	7,836	0	
Genetics High Spec Analysis Equipment & Software	29,405	0	0	29,405	0	
Histopathology Hardware	10,773	0	0	10,773	0	
IBD register	8,951	0	0	8,951	4,140	
Inhouse development team - applications, databases and Dashboards (subject to bus case)	101,465	0	0	101,465	42,043	
Maintenance renewal - estimate	38,034	0	0	38,034	28,410	
Mobile Computing	8,772	0	0	8,772	3,325	
Mortuary module	52,000	0	0	52,000	0	
Network Unsupportable	24,000	0	0	24,000	213	
Network Upgrade Consultancy	129,774	0	0	129,774	28,365	
Ophthalmology System	140,926	0	0	140,926	99,550	
Order Comms (includes System Admin Bid & Sexual Health Bid)	15,265	0	0	15,265	0	
PACS	116,873	-54,000	0	62,873	0	
PACS ED Machines	0	54,000	0	54,000	29,490	
Palliative Care EPR	39,437	0	0	39,437	0	
PAS 2016 Replacement - Consultancy Costs	780	0	0	780	0	780
Patient Observations Monitoring and Decision Support/Early Warning System/POET	0	0	0	0	1,515	-1,515
Radiology - OrderComms	36,117	0	0	36,117	0	
Replace 6509x3 network hubs	67,479	0	0	67,479	28,232	
Reporting System	3,570	0	0	3,570	0	
Results System in GP Practices 'Review' System	10,079	0	0	10,079	0	
SAN Storage	210,000	0		210,000	128,163	
SBAR Cardiology DICOM Migration	45,100	0		45,100	0	
SBAR for PAS	2,476	0	0	2,476	0	2,476
SBAR re NACS Update to ED Symphony	7,500	0	0	7,500	0	7,500
SBAR re UPS Replacement (formerly UPS Replacement - Room based for Computer Rooms)	21,150	0	0	21,150	0	
Telecomms Voice Over IP - invest to save (non clinical areas - subject to a telephony strategy)	189,543	0	0	189,543	44,266	
Telepath enhancements	3,505	0	0	3,505	0	
Telepath to CSCLims (Phase 3 / Year 4 of 4 2016/17)	150,000	0	0	150,000	0	
TMG-UAG	15,000			15,000	0	
UPS Replacement Programme	34,132	0	0	34,132	4,209	
Whiteboards	208,320	0	0	208,320	37,864	
XML for Pathology COSD Submission	11,900	0	0	11,900	0	
Information Technology Totals	**2,402,290**	**5,354,900**	**-68,184**	**7,689,006**	**1,795,937**	**-279,111**
Medical Devices						
ANC Ultrasound (GROW Programme)	80,000	0	0	80,000	0	
Bariatric Bed (2016/17 bfwd)	346	-346	0	0	0	
BED replacement programme - 4th (2016/17) yr of 4	58,996	0	0	58,996	31,071	
Cone Beam CT Scanner Enabling Works	0	43,402	0	43,402	1,060	
DSU Camera Stack	98,000	0	0	98,000	0	
DSU Ophthalmic Microscope	120,000	0	0	120,000	0	
General x-ray machine - Westbury - radiology	99,000	0	0	99,000	0	
Genetics DNA Extractor	77,000	0	0	77,000	0	
Genetics Cytology Ozone Free Hood	0	23,500	0	23,500	20,939	
Grouped Items 2015/16	1	0	0	1	6,477	-6,476
Grouped Items 2016/17	100,000	0	0	100,000	60,317	
Maternity Theatre Equipment	26,014	0	0	26,014	0	
Medical Equipment <£50k 14/15	26,400	-26,400	0	0	0	
Medical Equipment <£50k 15/16	11,635	0	0	11,635	0	
Medical Equipment <£50k 16/17	231,780	26,400	0	258,180	103,770	
Powered Patient Trolleys	0	0	0	0	0	
Radiology Lead Aprons	30,000	0	-20,000	10,000	0	
Radiology Room 2 Replacement	228,000	0	0	228,000	0	
Radiology Room 11 Ultrasouind Replacement	80,000	0	0	80,000	79,824	
Refrigerated Centrifuge	444	-444	0	0	0	
Rigid hysteroscopes x 4 plus stack	3,561	0	0	3,561	0	
Ringwood Ophthalmology Equipment	50,000	0	0	50,000	0	
Scopes	32,153	0	0	32,153	0	
Spinal Hoists	37,574	0	0	37,574	40,918	-3,345
Static and Pressure Relieving Mattresses	22,209	0	0	22,209	0	
Theatre Instrumentation Replacement Programme	773,355	0	0	773,355	275,854	
Thermometery Data Loggers	12,958	0	0	12,958	12,924	
VAC Terapy Machines	3,600	0	0	3,600	3,600	
Videoscopes x2 - main theatres	50,000	0	0	50,000	0	
Medical Equipment Totals	**2,253,026**	66,112	-20,000	2,299,138	636,755	-9,821
Other						
Bed Stacking	36,494	0	0	36,494	25,122	
Car Park Machinery	37,000	-37,000	0	0	0	
Catering Boiling Pan	15,000	0	0	15,000	0	
Cold Servery Counters	70,000	0	0	70,000	0	
Demand Response Generator Conversion	178,920	0	0	178,920	0	
Efficiency schemes	222,170	-141,800	0	80,370	0	
Finance systems	90,000	0	0	90,000	0	
LED Lighting	30,737	0	0	30,737	2,900	
Lightning Repairs	0	0	0	0	0	
Outpatient Kiosks	65,953	0	0	65,953	0	
Phhotovoltaic's / Solarthermal PV	17,683	0	0	17,683	0	
Portering Bed Movers	0	0	0	0	0	
Procurement Tug 2015/16	2,050	0	0	2,050	0	
Project costs	25,529	0	0	25,529	933	
Scan4Safety (GS1)	0	109,000	0	109,000	4,536	
Security	40,000	0	0	40,000	4,190	
Telecoms Trunk Lines	8,280	0	0	8,280	0	
Theatres Storage and Trolleys	2,580	0	0	2,580	0	
Ward Waste Bins	60,643	0	0	60,643	8,788	
Other Totals	**903,040**	**-69,800**	**0**	**833,240**	**46,469**	**0**
Trust Totals	**10,020,711**	**4,399,253**	**-88,184**	**14,331,780**	**3,386,655**	**-530,611**

Trust Board meeting

SFT3816

MONTH 5 OPERATIONAL PERFORMANCE REPORT

Date: 29th September 2016

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

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

Executive Summary:

Operational pressures resulted in the trust failing to deliver the referral to treatment standard and ED standard for Month 5. Cancer, Infection control and diagnostic standards were all met in August and all Cancer standards were met in Q1.

Emergency Pathway

The trust failed to deliver the Emergency pathway standard in Month 5, with 93.57% of all patients being admitted or discharged within 4 hours.

During this period escalation capacity was opened to manage emergency flow and clinical teams in ED and AMU reported an increase in the acuity of patients presenting in addition to high numbers of attendances. This is reflected in the attendance numbers with ED attendances up 11% compared to August last year. ED Majors attendances up 36% compared to August last year

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

RTT

In order to manage the significant increase in non elective admissions a high number of elective procedures have been cancelled. This has directly resulted in the failure of the RTT incomplete standard delivering 91% against a standard of 92%.

Diagnostic

The trust is continuing to work to decrease diagnostic waiting times further. The trust has seen a significant increase in request for diagnostic tests and particularly imaging. A business case for increased MRI capacity is currently being finalised. Despite this the trust has maintained delivery of the diagnostic standard.

Cancer

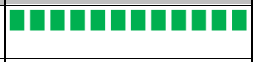
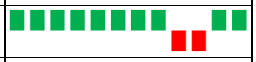
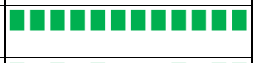
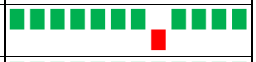
The trust delivered all cancer standards for Q1 and delivered all standards except the 31 day wait standard in August. The most significant cause of breaching continues to be patient choice and we are working with local GPs to ensure patients are available at the point of referral.

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 – August 2016

Salisbury Hospital NHS Foundation Trust Board Report August 2016

			Reporting Month		Rolling 12 months
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Aug-16**	**Patients Affected in Aug-16**	**Trend Against National Standard**
Referral to Treatment Incomplete Performance	92%	92.01%	**91.0%**	1,272	
Referral to Treatment Incomplete Specialty Compliance	16 out of 16		**9 out of 16**		
Zero tolerance RTT waits > 52 weeks	0	0	0	0	
A&E - Time in A&E department	95%	95.94%	**93.6%**	278	
12 Hour Trolley Waits	0		0		
Diagnostics - Patients waiting longer than 6 weeks	99%	99.5%	99.1%	35	
Diagnostic Test Compliance***	11 out of 11		**7 out of 11**		
Urgent Ops Cancelled for 2nd time (Number)	0		TBC		
Mixed Sex Accommodation Breaches	0		**18**		
Infection control – Clostridium difficile (YTD)	8		Total for Fiscal Year = 3	0	
Infection control - MRSA*	0		0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Aug-16**	**Patients Affected in Aug-16**	**Trend Against National Standard**
All Cancer two week waits	93%		94.4%	37	
Symptomatic Breast Cancer - two week waits	93%		97.7%	3	
31 day wait standard	96%		94.4%	6	
31 day subsequent treatment : Surgery	94%		96.6%	1	
31 day subsequent treatment : Drug	98%		100.0%	0	
62 day wait standard	85%	90.6%	92.9%	5	
62 day screening patients	90%		100.0%	0	
62 day patients waiting first definitive treatment after Consultant upgrade	85%		100.0% (Mar-16)	0 (Mar-16)	
Cancer 104 Day Waits**	0		0	0 (Apr-16)	

Cells with black dotted outlines indicate provisional data

*Please note: MRSA is no longer monitored by Monitor

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

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

Major Projects Report

Date: September 2016

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

Executive Summary:

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

- **IT/technology (EPR and GS1) and the adaptive impact on the organisation**
- **a joint venture to improve the responsiveness and efficiency of sterilisation services which began on 1st September, and**
- **Wiltshire Health & Care went live on 1st July and is now fully operational**

Proposed Action:
To note the report.

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

Appendices:

Supporting Information

Introduction

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

- Electronic Patient Record
- The GS1 initiative
- Wiltshire Health and Care management of community services – now operational
- Joint venture to provide a sterilisation and disinfectant unit (SDU)
- Organisational development impact – a draft strategy and action plan has been discussed at Executive Workforce Committee in June and the Board in July. The action plan is being developed further with executives and senior managers. Monitoring of this action plan will be through the Executive Workforce Committee

Summary

Salisbury NHS Foundation Trust

Project	Lead	Status	Workstreams	Summary
EPR	LA	Stable at Amber	7 x green 4 x amber 1 x red	**Go live due weekend of 28/10 – currently on track but challenges remain.** Detailed planning underway –business process testing went well. Increasing communication and readiness around the organisation. Progress with data warehouse continues to fluctuate.
Scan for Safety	MC (LW)	Stable at Green	3 x green 1 x amber	Phase 2 in Progress – Implementation of Inventory Management major areas of work. Required changes to systems to allow positive patient id agree with IT to improve timescale to delivery
Wiltshire Health & Care	LA	Stable at Green		New service operational from 1st July. Establishing southern locality group to promote integrated working locally.
SDU	MC	Improving at Green	3 x green	Contract now signed. SSL mobilisation underway – Synergy Track goes live 19/9 and meetings with key customers held. Demolition work for new facility begins 10/10

Organisational Development

- Strategy developed
- Action Plan created and monitored through Executive Workforce Committee
- Current OD projects ongoing
  - EPR implementation
  - Emergency Department future workforce review
  - Theatres workforce review
  - Spinal Unit Medical Workforce Review
  - Save 7 champions and Quality Improvement skills
  - Impact of Apprenticeship levy on workforce models
  - Lead for STP digital project
  - Lead on STP Workforce stream for Values and Culture
  - Exploration of opportunities working across Wiltshire Health and Care

Salisbury NHS Foundation Trust

Electronic Patient Record (EPR)

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

Workstream	Status	Trend	Actions
Infrastructure	Green	Improving	Continuing roll out of hardware.
Configuration	Amber	Reducing	Significant work underway on letter templates and configuration changes arising from testing. Additional resource brought in.
Integration	Amber	Reducing	A number of systems still need confirmed integration approaches, most notably Somerset and e-whiteboards
Data migration	Green	Stable	Preparing for dress rehearsal
Data warehouse	Red	Improving	Additional resources have been employed and together with a revised approach with CACI are yielding benefits

Electronic Patient Record (EPR)

Salisbury NHS Foundation Trust

Workstream	Status	Trend	Actions
Business change	Amber	Stable	Largely positive, but issues remain in relation to ED. Working through these
Benefits	Green	Stable	Business case review will come to the part 2 of the Board in October
Role based access	Green	Stable	Cards issued to just over 80% of total of staff
Training	Green	Stable	Training now underway – largely good feedback, and good attendance. Plans for refresher courses for early attendees
Requests & Results	Amber	Reducing	Challenges to achieving the expected timescales
Validation	Green	Stable	Integration and exception testing started. Business process validation running at 97% pass rate
Cutover planning	Green	Declining	High level plans in place. Communicating plans. Resource requirements identified.

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	In Micad 50% of the CAD floorplans have been uploaded and 35% of all rooms have been validated, requiring no updates. Hardware to print barcodes now in place, team identified within Estates to print and locate which will commence in late September
Catalogue management	Green	Stable	Planned to capture Orthopaedic product data within next month Master Data – continuing to engage manjor suppliers and collaborate with other sites. Salisbury leading on catalogue elements working with other sites to produce national guidance
Patient identification	Amber	Improving	IT development resource needed to make changes to POET resource limited to enable changes. Agreed reprioritise within IT to enable scanning development in Oct. Working with bloodhound project to ensure roll out can support.
Purchase to pay/Inventory	Green	Stable	Main set up for Cardiology completed , with a planned go live date of September/October wards and Theatres (Material managed) to follow in October

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

- New clinical director starts 4th October and adverts out for two non-executive directors one with a primary care focus and the other a patient representation interest
- WH&C have identified 6 priorities for 16/17:
  - ❶ Higher intensity care managed in the community
  - ❷ Early supported discharge for stroke patients
  - ❸ Health coaching
  - ❹ Musculo-skeletal physiotherapy provision in the community
  - ❺ Development of urgent care centres
  - ❻ Mobile working
- Detailed planning underway for ❶ and ❷with good engagement from SFT clinical staff – intent is for EDS to begin in November. Training on ❸is starting
- ❻Mobile working being trialled in the Amesbury locality
- Developing clinical and operational links within the southern locality. Terms of reference written, first meeting to be in October
- Reporting links into Board to be via the Finance Committee with reports to other Board sub-committees as appropriate

Salisbury NHS
NHS Foundation Trust

SDU Joint Venture

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

Workstream	Status	Trend	Actions
Commercial	Green	Improving	JV agreement , leases and service contract signed mid August
Operational	Green	Stable	SSL mobilisation team in place – Synergy Track goes live 19/9. SDU Operational Management Board met 9/9.
Facility design	Green	Stable	Space being freed up ready for demolition work to begin on 10th October. Preliminary design meetings proceeding well.

Capital Development Report

Date: October2016

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

Executive Summary:

The Capital Development Report describes the improvements that have been made in the last four months to the Estate, across buildings, information technology, medical equipment and infrastructure.

Ongoing improvements to the estate infrastructure - building work is well underway on the new breast unit which will complete in November and the second phase of the Laverstock upgrade is close to completion.

The EPR project is a major focus for 2016 and work is underway (see major projects report). This is involving substantial amount of staff time to review, amend or refine those processes.

Further upgrades to two home-grown digital systems managing patient observations and discharge summaries is extending the range of clinical data recorded and transmitted electronically and the electronic whiteboards system has gone live over the summer.

Proposed Action:
To note the report.

Links to Assurance Framework/ Strategic Plan:
Choice – "Delivering an estates strategy which ensures patient care is provided from the highest possible quality accommodation and which makes optimal use of the Trust's estate"

Appendices:

Supporting Information

PAPER: SFT 3818

CAPITAL DEVELOPMENT REPORT

PURPOSE:

The purpose of this paper is to update the Board on developments with some of the more significant capital schemes on the Salisbury District Hospital site since the date of the last report (April 2016).

BUILDING SCHEMES:

Breast Care Unit
The building work is well underway and the Breast Care Team and their supporters have had their first site visit and are pleased with the building so far. The contractor is currently reporting a slight delay to the programme with the building now expected to be completed and fully operational mid November 2016.

Further Improvements to Phase 1 Wards
Building work for the second phase of the refurbishment of Laverstock Ward is well advanced and whilst there has been a slight delay the contractor will complete the building works 30th September. Programme for the subsequent ward moves is being confirmed and it is expected to have these moves completed by the 14th October.

Maternity Unit
Planning application 16/02951/FUL has now been approved. Tender documents have now been finalized and, subject to Board approval, will go out to tender in 2017.

IT SCHEMES:

Single Sign On (SSO)
All main inpatient wards, Theatres and DSU have had their PC's/laptops replaced with a Lorenzo ready build giving them SSO 'bridges' (which retain username and password, where possible) to clinical applications and quick links to other applications. "HAS" is being decommissioned. Maternity and Radiology SSO builds are now undergoing departmental testing

Electronic Whiteboards
The system successfully went live on the 5th of July, and is actively being used by 19 wards to manage patient flow. Live data from the boards are being used by the teams on the wards during ward rounds and to support bed meeting using both current bed state information and predicted discharges. Future phases of work will include the creation of a single point of referral for health and social care support post discharge, bidirectional information with Lorenzo and the implementation of upgrades to improve functionality.

Patient Observation and Escalation Tool (POET)
Implementation continues. The system is currently live in Laverstock, Britford, Britford SAU, Downton, Farley, Winterslow, Avon and Tamar, and training is taking place on Chilmark, Amesbury and Durrington. Development work is ongoing in order to fix issues and expand functionality in response to different ward requirements as the system is rolled out. Larger pieces of development work have also been scheduled in, which include a link from POET to Review, the creation of a fluid balance chart and the development of scanning functionality in support of the Scan for Safety Programme.

Electronic Discharge Summaries
The EDS is being well utilised across the Trust with about 80% of discharge summaries produced and communicated electronically.

Blood Tracking – Phase 2
The Bloodhound production issue kiosk and the validation kiosk have been replaced with new models that support Windows 7.

The Bloodhound application has been upgraded to the latest version and is being validated by Laboratory Medicine.

A pilot of the Bloodhound Bedside application was conducted on Nunton. The pilot highlighted a gap in functionality when dealing with the administration of emergency blood when using a handheld device which the supplier is developing functionality for.

ACTION REQUIRED BY THE BOARD:

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

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

Other significant schemes in the Approved Capital Programme for 2016/2017 (Appendix A to C inclusive)

Laurence Arnold
Director of Corporate Development

APPENDIX A

Other significant schemes in the Approved Capital Programme for 2016/76

Building and Works schemes	Completion date	Budget cost incl VAT
Efficiency schemes (7703C0) Funding available to support efficiency projects with rapid payback revenue savings. Funding ring-fenced for in-year bids.	2016	£80k
Demand Response Generator Conversion (7717C0) This scheme will allow the Trust to generate electricity at peak times during the winter months to reduce high demand charges *Project shelved until full details of the proposed Photo-Voltaic project are clarified.*	2016/17	£180K
Spinal Treatment Centre refurbishment (7049C0) Replacement of single glazed windows with double glazed units along with range of smaller refurbishment items prioritised in the 2014/15 programme. **Project complete**	June 2016	£190k
Road repairs and Pedestrian crossings (7020C0) Repairs to the roads on site and upgrading the pedestrian crossings to current standards – scope of project to be reviewed in line with site developments.	TBC	£120K
Accommodation upgrade (7011C0) Work completed in Avon, Bourne & Wylye House Work on-going in Langley House (Block 94)	December 2016	£150K

Rolling work programmes (multi year projects)

Building and Works schemes	Completion date	Budget cost incl VAT
Air Handling Units (7041C0) This is the fourth year of a 7 year (£2m) programme to replace the 50 specialist ventilation systems supporting SDU, Pharmacy, ED/SSEU, Pathology, Spinal X ray and all the Theatres.	March 2020	£170k this year
Ductwork and fire damper cleaning (7093C0) Across whole SDH site, ventilation ductwork and fire dampers will be cleaned out to comply with fire and health and safety legislation. 3rd year of 3. **Project complete**	June 2016	£130k
Nurse Call System upgrade (7202C0) Project to replace ageing nurse call systems throughout wards in the main SDH north building and maternity wards. 2nd year of 2. Work undertaken during ward refurbishments (Laverstock) and replacement of Nurse Call system in the Spinal Unit to be completed this financial year.	2016/17	£123k (this year)
Lift Refurbishment Programme (7056C0) A programme to upgrade all the lifts in Phase 1 building. Year 3 of 3. Lifts 3 & 4 completed work in progress on lifts 1 & 2. Work on lift #2 tocomplete by March 2017.	March '17	£66k

APPENDIX B

Information Technology schemes	Completion date	Budget cost incl VAT
PACS/RIS (7943C0) Further operational PACS issues were discovered in the second week of July - this has significant clinical impact as clinicians were unable to see the full patient history on PACS. This problem was resolved by the replay of 988,896 messages which completed on 6th September. Successful upgrade to latest version of CRIS 9th August. XDS has had to be delayed whilst the replay of messages occurred. Formal testing to take place on Tuesday 18th October.	October 2016 (XDS)	
Order Comms and Results Reporting (7942C0) **GP Tquest** Final fix for "copy to" applied on Tuesday 13th September, no further RFC's have been requested by the GP community or the service. All GP practices that have requested to use the functionality have now got access. GP review has had a very successful pilot in Amesbury but due to resource issues this has now been put on hold until next year.		
SAN Storage (7907CO) Additional storage installed; follow up work on-going.	March 2017	£210K
Ophthalmology EPR (7934C0) The implementation of the system is on schedule with the final milestone in October 2016. It is intended to also use the system at outreach clinics in Shaftesbury and Warminster as well as enabling virtual clinics which will increase the number of patients that can be scheduled for a consultation.	October 2016	£141K
Telecoms Voice Over IP (7948CO) After initial pilot has proved the configuration removal of the old Mital system is being planned. External connections are being migrated which once in place will result in cheaper external calls. Now working on switchboard consoles and infrastructure.	Pilot complete July 2016	£189,000
SpIda SpIda 2 has been in use now for over 6 months and several patches have been applied to resolve issues that have been found. All compliancy reports are now working correctly in the LIVE environment and the new administration page is complete. The analysis work for SpIda 3 is underway and the next PMB in November will discuss what is to be included in the changes expected early 2017.	Early 2017 (phase 3)	N/A

Information Technology schemes	Completion date	Budget cost incl VAT
CALS (7905C0) Option Appraisal document under development – currently with ten possible options for client side licensing.	March 2017	£200,000

APPENDIX C

Medical Devices schemes	Completion date	Budget cost
Capital schemes		
Bed Replacement programme (7131C0) The bed replacement programme is progressing. 423 of the replacement beds have now been ordered. The remaining beds are due to be ordered this year, however owing to limited availability of capital funding, the scheme will extend to a 5th year. A capital bid has been submitted for 2017/18 to complete this scheme.	Year 4 of a 5 year programme	£150k (2014/15) £204k (2015/16) £120k (2016/17)
Review of Theatre Instruments (7122C0) The Trust commissioned an external review of instrumentation. A capital bid has been submitted for 2017/18 to continue this programme. The newly formed SSL will influence the future needs of the Trust and a stakeholder group has therefore been established to monitor and audit the ongoing requirements.	Rolling programme	£300k (2014/15) £500k (2015/16) £500k (2016/17)
Ophthalmic microscope for DSU (7166C0) The existing microscope is 15 years old. It is used mainly for cataract surgery and treats between 1300-1500 patients each year. £4.5k was spent on parts in the last 2 years to maintain the service. The new microscope will be future proofed to enable intraoperative OCT, robotics and laser cataract surgery to be undertaken. It will also be wifi enabled. Evaluations are currently being undertaken.	October 2016	£120k
Camera stack for DSU (7165C0) This stack will replace a broken 8-year old stack from DSU Theatre F. It will be wifi enabled and connect to PACS. A stack is currently being moved between Main Theatres and DSU.	September 2016	£98k
General x-ray machine – Westbury (7115C0) The machine currently installed at the White Horse Medical Centre in Westbury is coming to the end of its life. Owing to the increased activity and newly implemented walk-in service, a new machine will be purchased to accommodate the patients using this facility.	December 2016	£181k Including enabling works

Medical Devices schemes	Completion date	Budget cost
Site visits have been undertaken and a specification drafted to consider the future needs. Clinical evaluations have been undertaken and preferences tabled. Enabling costs are currently being finalised.		
Radiology Room 2 (7157C0) A stakeholder group was formed to determine the needs of this room moving forwards. The current machine has been condemned as the result of a flood. Increased functionality (stitching) is required to enable orthopaedic work to be undertaken. Machines have been evaluated and negotiations are ongoing.	December 2016	£246k Including enabling works
<u>Donated Assets</u>		
Orthodontics and Oral Surgery Cone Beam CT Scanner (7127C0) The scanner produces images which are used to aid diagnosis and treatment planning of orthodontic and orthognathic cases. The enabling costs have been finalised (c£44k) and an installation date scheduled for November 2016.	November 2016	£110k
New born hearing programme A paper was submitted to the Charitable Trustees requesting the purchase of otoport hearing screener machines in order to update the existing equipment and train the newborn hearing screeners in time for the programme launch in September 2016. The request for funding was approved.	August 2016	£34k
Bilirubin meters for community midwives A paper was submitted to the Charitable Trustees requesting the purchase of 11 monitors to test babies in the community who are jaundiced. The request for funding was approved.	August 2016	£69k
Genetics Fluorescence Microscope A paper was submitted to the Charitable Trustees for the purchase of a Fluorescence microscope for Genetics. The main focus is genetic testing for cancer patients, predominantly haematological conditions but it is also used to study specific paediatric and adult solid tumours. The request for funding was approved.	August 2016	£26k

PAPER - SFT 3819

JOINT BOARD OF DIRECTORS (JBD) MINUTES FROM 27 JULY 2016 RE: QUARTERLY REVIEW OF ASSURANCE FRAMEWORK AND RISK REGISTER

PURPOSE

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

MAIN ISSUES

During the year delegated responsibility for reviewing the Assurance Framework and Risk Register falls to a combination of the Finance Committee, Clinical Governance Committee and the Joint Board of Directors (JBD).

Extract of JBD minutes – 27 July 2016

ASSURANCE FRAMEWORK REVIEW
The Board received the quarterly update to the Assurance Framework and Risk Register. Fenella Hill attended for this item. As previously noted there were two new Risks being raised in relation to non-elective admissions. Risk 3885 would be re-worded to make it generic across the Trust. The wording of Risk 1.2 had been agreed by the Trust Board would be reviewed again.

ATTACHMENTS AVAILABLE TO VIEW ON WEBSITE

none

ACTION REQUIRED BY THE BOARD

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

Nick Marsden
Chairman

SALISBURY NHS FOUNDATION TRUST

Minutes of the Council of Governors Meeting – Part 1
At Salisbury District Hospital
Held on Monday 18 July 2016

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

In Attendance:
Kirsty Matthews (Non-Executive Director)
Paul Kemp (Non-Executive Director)
Lydia Brown (Non-Executive Director)
John Brown (KPMG)
John Oldroyd (KPMG)
Peter Hill (Chief Executive)
Lorna Wilkinson (Director of Nursing) for item 5
Malcolm Cassells (Director of Finance and Procurement) for item 4
Laurence Arnold (Director of Corporate Development) for item 6
David Seabrooke (Head of Corporate Governance)
Isabel Cardoso (Membership Manager)

ACTION

1. CHAIRMAN'S UPDATE

The Chairman welcomed Jill Crook who had been appointed to represent Wiltshire CCG on the Council of Governors. He also welcomed Kirsty Matthews who had been appointed a Non-Executive Director.

He reminded the Council of the opportunities for Governors to take part in the work of the Trust and to deliver wider role through constituency meetings, conducting real time feedback in the hospital and attending Medicine For Member's events.

2. MINUTES – 16 MAY 2016

The minutes of the meeting of the Council of Governors held 16 May 2016 were accepted as a correct record subject to :

- Minute 7 reference should be to MRSA Bacteraemia cases.
- Minute 11 the Terms of Reference for the Strategy Committee would make either the Deputy of the Lead Governor Chair of the Committee.

3. TRUST PERFORMANCE TO 31 MAY (MONTH 2)

The Council received the month 2 Performance Report.

The Trust had not delivered the A & E Four Hour Performance but it was noted that only a handful of trusts nationally were now delivering this target. The 18 Week RTT Target had been affected in month 2 by the junior doctor's strike and the Trust had delivered 90.9% against the target of 92%. The percentage of patients who would recommend the Trust in the Friends and Family Test was above 97%. There had been no MRSA bacteraemia cases and for C-diff there were two attributed hospital acquired cases.

A brief update was given on the progress with the Dorset Clinical Services review which was looking at both planned and emergency care pathways.

4. FINANCE REPORT – MONTH 2

Malcolm Cassells attended for this item.

The Council received the month 2 Finance Report and it was noted that both income and expenditure were up against the plan. Outpatient cases were up and the hospital was experiencing operational pressure and the challenge of Delayed Transfers of Care remained. There was good progress in planning and delivering against the £6.5m CIP target and some ideas were emerging around the £3m remaining target. The Trust had served an Activity Query Notice on Wiltshire CCG in the light of the activity levels that continued to be experienced.

The contract with Dorset CCG had been signed. The Trust was continuing to work on the design of CQUINs with West Hampshire and with NHS England particularly with regard to the future funding of the Spinal Injuries Unit. NHS Improvement had visited the Trust and gained a good understanding of the financial control measures in place. Payment under the Sustainability and Transformation Plan was worth up to £6.3m in 2016/17 and this was reliant on the generation and delivery of a credible Sustainability and Transformation Plan and the Trust continued to work with its partners in this regard.

On Sterile Services it was noted that negotiations were continuing with the partner company towards the start-up of this new arrangement.

The Council noted the Finance and Contracting Report.

5. CUSTOMER CARE REPORT – QUARTER 4

Lorna Wilkinson attended for this item.

The Council received the Customer Care Report for Quarter 4 20115/16. It was noted that around 0.1% of activity resulted in a complaint. The Trust was responding to complaints within the prescribed timescales in 90% of cases. Executives continued to work with Directorates to improve communication with patients where complaints were showing this to be continuing issue. There continued to be operational pressures particularly on the Orthopaedics Department which was being addressed and Ophthalmology where there were recruitment difficulties. There was one case referred to the Ombudsman in the Quarter.

The Council noted the Quarter 4 Customer Care Report.

6. ELECTRONIC PATIENT RECORD

The Chairman welcomed Laurence Arnold who gave the Council an update on the Electronic Patient Record development. The project was due to go live in October 2016 and this would be followed in March 2017 by diagnostics requests and results reporting. There was widespread engagement in what was presented to the organisation as a business change process.

7. REPORT OF THE APPOINTED AUDITOR

The Council received the report which was addressed by John Brown and John Oldroyd.

The report described a smooth and timely year's end process with clean audit opinions on value for money, the financial statements and management judgements, the quality report being a fair and balanced presentation. The Annual Governance Statement was balanced.

The Referral to Treatment indicator was the subject of a Qualified Limited Assurance Opinion. It was noted that that following significant issues highlighted in 2014/15 that the Trust was making progress in redesigning the process to improve the accuracy of the data with effect from July 2015. It was expected that over half of Foundation Trusts would be subject to a qualification on this issue. The Trust considered that to expend the manual resources necessary to meet this requirement in full was not proportionate.

The Chairman thanked the KMPG representatives for the presentation.

8. RE-APPOINTMENT OF EXTERNAL AUDITOR

The Council received a report from the Head of Corporate Governance setting out the timescale to appoint external auditors from April 2017. It was noted that under the Code of Governance responsibility for this appointment fell to the Council of Governors, advised by the Audit Committee. KMPG had been appointed for a five year contract from April 2012 to 31 March 2017.

The appointment of an external auditor would be overseen by a panel comprising the Chairman of the Audit Committee, Director of Finance and Procurement and two members of the Council of Governors.

It was agreed that the Council would be represented by Michael Mounde, and Sharan White in this regard.

9. GOVERNOR QUERIES

Hospital Vending Machines – Healthier Snacks

It was noted that all new vending was managed by Revive and there were now no drinks that were sugar sweetened. Remaining vending machines would be changed following a new contract with Revive in September. It was noted that the Spinal Unit managed their own vending.

Flu Immunisation 2016

Governors felt that the level of immunisation by staff should be raised. The Chairman undertook to discuss this with the Chief Executive. NM

10. COMMITTEE/WORKING GROUP REPORTS

The Council received for information the report of the Membership and Communications Committee held on 1 June 2016 and Patient Experience Group Reports on Clinical Ethics, organ donation/strategy and Patient Food Forum.

11. DATES OF COUNCIL OF GOVERNORS MEETINGS IN 2016

The next meeting of the Council of Governors will be on 21 November at 4 pm.

The next informal meeting with the Chairman and Non-Executive Directors was on 15 August at 4 pm.

The Annual General Meeting was on 26th September from 5 pm.

SFT 3821

Trust Board meeting
Risk Management Strategy 2016

Date: 3rd October 2016

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

Executive Summary:

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

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

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

The Strategic Objectives and Key Performance Indicators (KPIs) have been updated for 2016/17 and include:

- Theming of incidents to highlight trends and areas requiring further investigation/action
- Embedding risk management at all levels of the organisation – creating a safety culture
- Ensuring there is appropriate provision of training
- Ensuring compliance with 'Duty of Candour' requirements
- Move to a single Risk Management Strategy for the Trust as recommended by TIAA during their review of Risk Management and Risk Registers

The following KPI's are also in place:

- Achieve compliance with regulations and requirements as determined by NHSI following the 'Single Oversight Framework' consultation;
- Maintain full registration with the Care Quality Commission;
- To be above average reporters of incidents when benchmarked against Trusts of a similar size (NRLS Report);
- Participation in the 'Sign up to Safety' campaign and patient safety collaborative;

- 100% completion of a full root cause analysis for all fractures or head injuries, resulting in moderate or greater harm, following a fall, ensuring themes and actions fed into the Trust action plan for falls;
- Evidence of a decreasing trend in hospital acquired pressure damage;
- Maintain a culture where staff feel risk management processes are fair and responsive, evidenced through the annual Staff Survey;
- Ongoing participation in the Safety Thermometer to allow monitoring of our work in reducing patient harm;
- Compliance with contractual requirements associated with the reporting and management of SI's;
- Cascade and Timely response to NHS England Patient Safety Alerts.

Proposed Action:

The Trust Board is asked to consider and approve the revised Risk Management Strategy 2016/17.

Links to Assurance Framework/ Strategic Plan:

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

Appendices: Risk Management Strategy 2016/17

Salisbury NHS
NHS Foundation Trust

Risk Management Strategy

Directorate Responsible for Strategy:	Quality Directorate
Name of responsible board/committee:	Trust Board
Post Holder Responsible for Strategy:	Head of Risk Management
Contact Details:	Risk Management 01722 336262 x2496
Date Written:	September 2006
Approved and Ratified by:	Trust Board
Date ratified:	October 2016
Date Strategy Becomes Live:	October 2016
Next Due for Review:	October 2017

VERSION INFORMATION

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

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

Table of Contents

Salisbury NHS Foundation Trust

Risk Management Strategy

1) Introduction

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

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

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

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

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

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

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

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

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

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

2) Purpose of the Risk Management Strategy

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

3) Responsibility for Risk Management

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

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

4) Promoting a Fair and Open Culture

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

5) Strategic Goals

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

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

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

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

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

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

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

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

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

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

6) Compliance and Assurance

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

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

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

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

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

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

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

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

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

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

7) The Trust Risk Register

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

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

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

7.4 The Assurance Committees shall receive their extract of the Risk Register quarterly along with the Assurance framework.

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

8) Risk Management Policy

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

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

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

9) Strategic Objectives 2016/17

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

- Theming of incidents to highlight trends and areas requiring further investigation/action
    - Monthly theming of incidents at Clinical Risk Group.
    - Provision of data to Directorates to support departments and specialty's in identifying themes and trends and to support change as evidence of learning and action.
    - Linking with complaints and Litigation team to look at broader themes and learning.

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

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

- Ensuring there is appropriate provision of training
    - Review existing in-house training provision in relation to risk management to identify gaps in training provision.
    - Review current availability of training opportunities both internal and external
    - Implementation of monthly case study based RCA training with Customer Care for staff at all levels of the organisation.
    - Evaluation of Board risk management session to include risk appetite.

- Delivery of Department/Directorate specific training to enhance the user experience of Datix and showcase functionality.

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

- Move to a single Risk Management Strategy for the Trust as recommended by TIAA during their review of Risk Management and Risk Registers
  - Development of a Standard Operating Procedure within Maternity Services recognising the high risk nature of maternity and detailing how safety and risk issues are operationalised within the department.

The following KPI's are also in place:

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

10) Accountability and Responsibility Arrangements

10.1 The Chief Executive

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

10.2 Executive and Non Executive Directors

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

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

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

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

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

10.3 Head of Risk Management

The Head of Risk Management is responsible for:

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

10.4 Specialist Areas

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

10.5 Directorate Management Teams

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

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

10.6 Departmental Managers/ Clinical Leads

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

- Ensuring that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility as per this Strategy and related Risk Management Policies.
- Adverse Events are reported, reviewed and investigated thoroughly and in a timely way.
- Ensuring that the grading of incidents are appropriate and regulated actions taken where Duty of Candour is triggered

- Disseminating learning and implementing recommendations made as a result of incident investigations, clinical reviews, and serious incident inquiries within their area of responsibility.
- Monitor and report on the implementation and progress of any recommendations made which fall directly within their area of responsibility i.e. within the Department.
- Maintaining a dynamic departmental risk register
- Ensuring that where high or extreme risks are identified these are brought to the attention of the Directorate Management Team for inclusion onto the Directorate Risk Register.
- Ensuring that all staff are made aware of these risks within their work environment and are aware of their individual responsibilities for raising concerns.
- Ensuring that all staff have appropriate information, instruction, and training to enable them to work safely.
- Ensuring that all new staff attend Trust Induction, receive a departmental induction and are released for mandatory training.

10.7 All Staff

All Staff are required to:

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

11) Organisational Arrangements and Risk Management Structure

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

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

12) Ensuring Compliance with National Standards

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

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

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

13) Monitoring and Review

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

APPENDIX A

The Trust's Assurance Committees

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

The Audit Committee

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

q) Review accounting policies.

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

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

The Finance and Performance Committee

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

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

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

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

The Clinical Governance Committee

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

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

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

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

Patient Safety:

- Agree the annual safety plan and monitor progress

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

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

Clinical Effectiveness / Clinical Outcomes:

- Agree the annual quality plan and monitor progress

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

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

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

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

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

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

Patient Experience:

- Agree the annual patient experience plan and monitor progress

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

Learning From Others:

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

The Joint Board of Directors

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

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

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

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

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

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

e) To agree policy and procedural change as required.

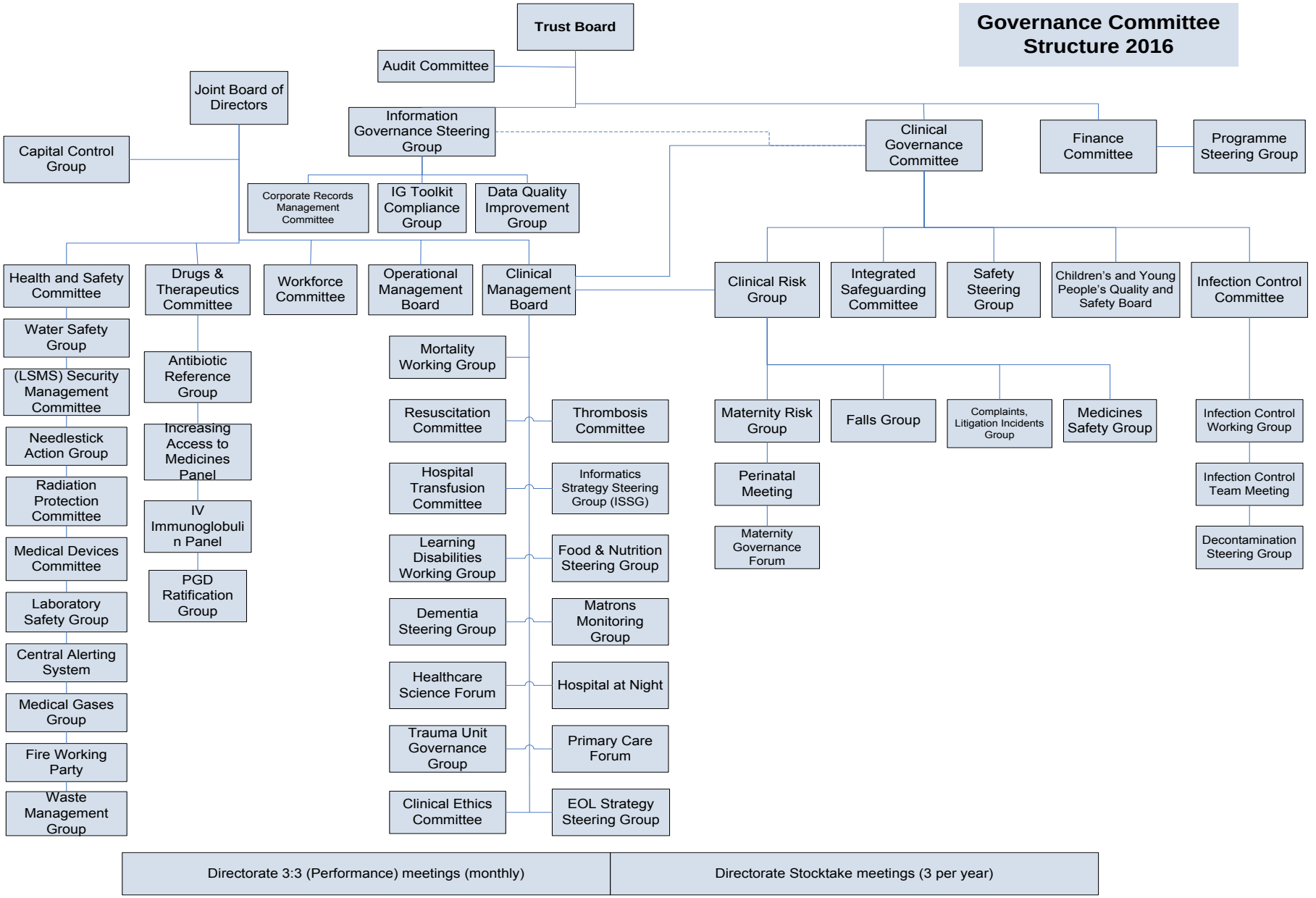
f) To review financial, clinical or operational performance as required.

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

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

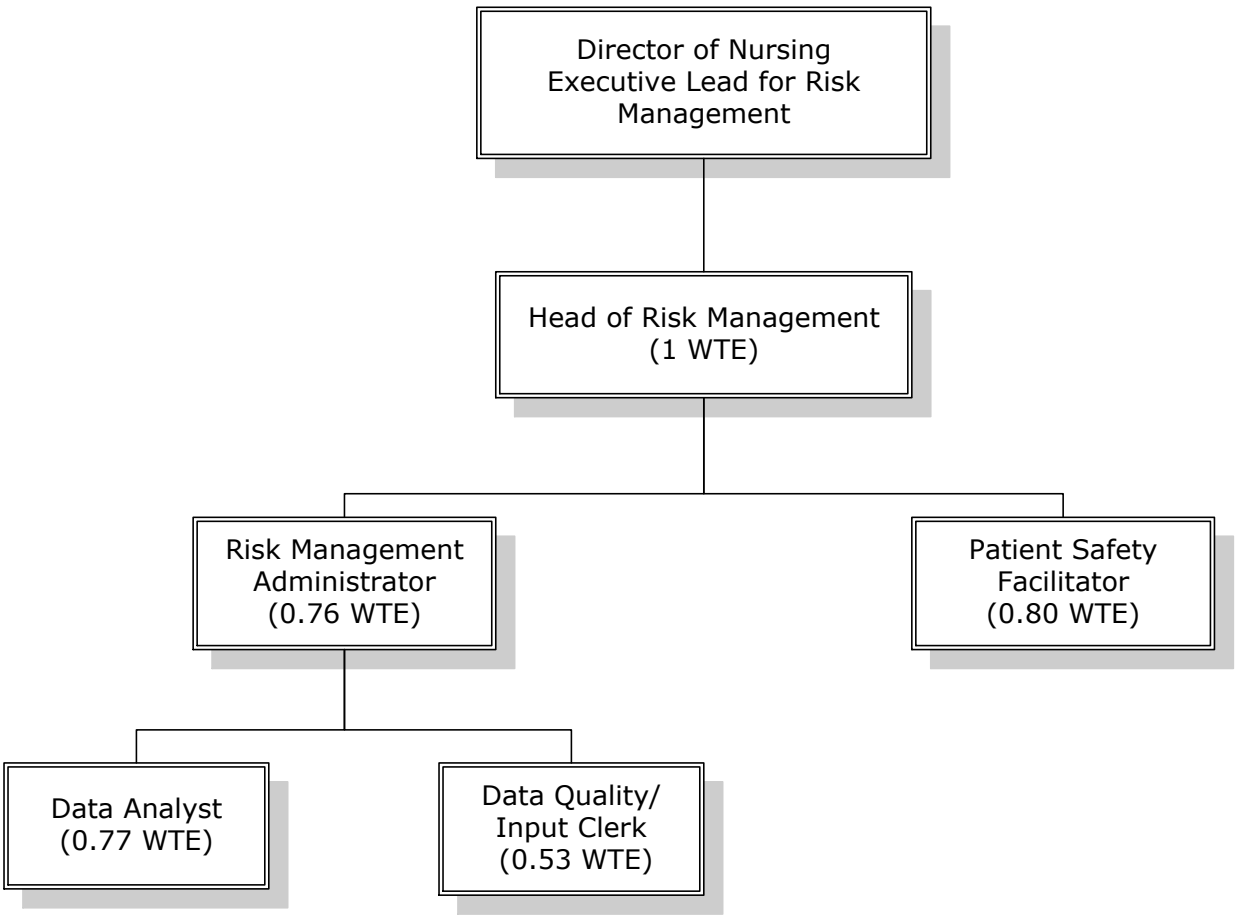
APPENDIX B

Governance Committee Structure 2016



APPENDIX C

Organisation Chart for Risk Management Team



APPENDIX D

Assurance Framework Report to Trust Board

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

3. New Risks Identified for Inclusion onto Assurance Framework

Risk: Executive Lead:

4. Newly Identified Gaps in Control/Assurance

Details of gap: Remedial Actions agreed:

5. Newly Identified Positive Assurances

Please detail the assurance and the linked risk:

6. Risk Register – Newly Identified Extreme Risks

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

APPENDIX E

RISK MANAGEMENT STRATEGY

THE IMPLEMENTATION PLAN

INTRODUCTION

Fundamentals:

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

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

Frequency of Review

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

IMPLEMENTATION PLAN

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

APPENDIX F

Equality Analysis (EA's) Template

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

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

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

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

SFT 3822

Trust Board meeting
Risk Management Annual Report

Date: 3rd October 2016

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

Executive Summary:

The Risk Management Annual Report focuses on the progress that has been made against the strategic goals as set out in the Risk Management Strategy (2015), the lessons that have been learnt as a result of incident reviews undertaken, changes within the risk (particularly incident reporting) processes over the 2015/16 year and ongoing progress against agreed key performance indicators.

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

The report concludes with the future developments that will be driven forward in 2016/17 to ensure the implementation of the Risk Management Strategy.

Proposed Action:

The Board are asked to note the achievements within the Annual Report and Strategy.

Links to Assurance Framework/ Strategic Plan:

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

Appendices: None

SALISBURY NHS FOUNDATION TRUST

Risk Management Annual Report 2015/16

1. Introduction

1.1. The Trust recognises that Risk Management must be fully embedded in order for the organisation to function safely and effectively. Robust Risk Management processes must be in place for the Board to be assured on performance and standards. To achieve this aim the Trust Board needs to be confident that the systems, policies and staff it has put in place are operating in a way that is effective, focused on key risks, and driving the delivery of the corporate objectives. To demonstrate this there is a Risk Management Strategy in place, which was agreed by the Trust Board in October 2015. The Risk Management Annual Report is the mechanism for measuring the progress that has been made towards achieving the strategic goals and objectives within the Risk Management Strategy.

Good risk management has the potential to impact on performance improvement, leading to:

- Improvement in service delivery
- More efficient and effective use of resources
- Improved safety of patients, visitors and staff
- Promotion of innovation within a risk management framework
- Proactive management of incidents and a reduction in time spent 'firefighting'
- Assurance that information is accurate and that controls and systems are robust and defensible.

This report presents the achievements as measured against the strategic goals within the Risk Management Strategy (2015) over the last financial year (1st April 2015 – 31st March 2016).

2. Risk Management Strategy Objectives

2.1 The Risk Management Strategy (2015) sets out the strategic goals towards which Salisbury NHS Foundation Trust has been working with regards to Risk Management, and provides a framework which sets out clear expectations of the roles and responsibilities of all Trust staff.

2.2.1 Strategic Goals

The strategic goals within the Risk Management Strategy (2015) are as follows:

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

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

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

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

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

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

- To develop an Annual Risk Management Plan.

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

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

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

3 Progress against Strategic Goals 2015/16

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

3.1.1 Monitor (which became NHS Improvement on the 1st April 2016) has a very clear compliance framework which ensures that all NHS Foundation Trusts are able to demonstrate that they are remaining within their agreed licensing authorisation. It is imperative that the Trust is aware of any risks which may impact on its ability to adhere to this framework. The Assurance Framework, Trust risk register, and risk processes enable the Trust to identify risks which may affect the Trust's financial and Governance ratings throughout the year and respond to these.

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

3.2.1 The Trust Board carried out an annual review of the Assurance Framework in September 2015 (ratified at the December 2015 Board Meeting). Trust Board members agreed the principal risks for inclusion in the 2015/16 framework.

3.2.2 The Assurance framework template identifies the principal risks facing the Trust and identifies the assurances in place to ensure risk containment is being carried out effectively. The Head of Risk Management attends the Assurance Committees on a quarterly basis to co-ordinate this process, ensuring the monitoring and management of principal risks is in place, as well as updating and co-ordinating the continued development of the document. Regular meetings are held with the Executive Leads, or nominated deputies, for the identified risks and additional information accessed through subject experts. Where additional risks have been identified within the year

risks have added or amended, with agreement of the Board, to ensure that the Assurance Framework remains a 'live' document.

3.2.3 The Audit Committee monitors the overall Assurance Framework process bi annually. The Assurance Framework process was presented to the Audit Committee in October 2015 and February 2016. The Audit Committee members were satisfied that the current process produces a compliant assurance framework where key information and risks travel upward within the organisation and subsequent actions taken are very clear.

3.2.4 Internal audit carried out a full review of the Assurance Framework and Risk Register processes during 2015/16. This included a full documentary evidence review. The subsequent report gave an overall opinion of 'reasonable assurance'. The conclusion of the auditors was:

- The 2015/16 Board Assurance Framework (BAF) is embedded within the governance structure of the Trust. BAF processes ensure that it is continually updated (for controls, assurances, risks and gaps) and therefore operates as a 'live' document.

However, three 'important' and one 'routine' action were identified as a result of the audit as follows:

- Timescales to be identified for the risks 'awaiting approval';
- Risk owners be reminded to provide written actions of how they are addressing the management of the risk/s recorded;
- The Board to identify and agree their 'risk appetite' as a formal statement;
- The amalgamation of the Trust and Maternity Services strategy to form one combined document.

3.2.5 The Trust produced an Annual Governance Statement for 2015/16, which was fully compliant and evidenced through the Assurance Framework and supporting documentation.

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

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

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

This suite of supporting policies provide the 'how to' practicalities for staff and have been updated as a result of the introduction of Datix web.

3.3.2 All Directorates have risk registers and high risks (12+) are monitored via quarterly quality performance meetings. During 2015/16 work has continued to ensure that monitoring within the performance meetings is adequately documented within the minutes and the Trust Risk Register is updated accordingly.

3.3.3 The Adverse Events Reporting Policy was significantly updated in 2015/16 to reflect the changes made since the introduction and implementation of web reporting of incidents to the electronic database (Datix). Reporting across the Trust decreased during 2015/16 as was expected with the changes to incident reporting. This was

only a small decrease (3.35%), was during a period of significant change for the reporting of incidents, and in line with trends reported from other Trusts during implementation and stabilisation. This continues to reflect an environment in which staff feel able to report, and identify the process as worthwhile. There has also been an increase in the number of Nursing/Midwifery/Medical and Ancillary staff reporting incidents and the biggest staff groups that have decreased reporting are Allied Health Professionals and Clinical Assistants. AHP reduction partly relates to the changes that have been made to pharmacy intervention reporting.

- The 2015 Staff Survey indicated that one of the five Key Findings for which Salisbury NHS Foundation Trust which compared most favourably with other acute trusts in England was the staff confidence and security reporting unsafe clinical practice (3.86 vs national average of 3.62) The Trust also were within the 20% (best) trusts for staff witnessing potential harmful errors, near misses and incidents in the last month, reporting errors, near misses or incidents witnessed in the last month and fairness and effectiveness of procedures for reporting errors, near misses and incidents. This continues to evidence that staff have trust and confidence in the incident reporting and investigation processes within the Trust.

- The National Reporting and Learning System report for April 2015 - September 2015 identified the Trust to be in the upper part of the middle 50% of reporters of incidents with 41.44 incidents per 1000 bed days reported. The median for Acute (non specialist) organisations is 38.25 incidents per 1000 bed days. 89.7% of reported incidents resulted in no harm to patients against a national average of 72%.

  It is important to note that a high reporting rate of near misses as well as actual incidents indicates a strong reporting and learning culture and therefore is a positive measure.

3.3.4 The process for commissioning and carrying out reviews (Clinical Reviews and Serious Incident Inquiries) is set out in the Adverse Events Reporting Policy. During 2015/16 there were 28 Serious Incident Inquiries commissioned (2 were subsequently downgraded, in collaboration with the CCG, following completion of the investigation) and 2 Clinical Reviews. These figures compare with 32 Serious Incident Inquiries and 6 Clinical Reviews in 2014/15.

Of the 28 Serious Incident Inquiries, 3 were grade III hospital acquired pressure ulcers and there were no grade IV hospital acquired pressure ulcers. This compares to 5 grade III hospital acquired pressure ulcers in the previous year and again demonstrates a small decrease and the continued success of shared learning and the Trust Wide Action plan. Monthly ‘share and learn’ reviews are also undertaken to identify areas where ‘clusters’ of hospital acquired grade 2 pressure ulcers are identified to promote a proactive approach to learning.

3 ‘Never Events’ were reported during the year, 1 was downgraded on review of the case and the remaining 2 both related to wrong site surgery. This has identified a clear need for procedural review within both theatre and outpatient environments and is being progressed through the ‘Sign up to Safety’ programme and implementation of the National Patient safety Alert in relation to invasive procedures.

2 maternity cases were reported as serious incidents - a neonatal death and a stillbirth. This is a reduction of the number of maternity cases on the previous review (5).

4 cases were reported relating to safeguarding concerns. Safeguarding concerns are reported as soon as there suspicion or an allegation is made - 1 was subsequently downgraded on review of the case. Review of these cases has provided considerable learning for staff in relation to communication between teams about patient comments, behaviours and vulnerabilities that help build a picture of the best way to manage and support these patients.

All Clinical Reviews/Serious Incident Inquiries are reported to the Trust Board, detailing the nature of the incident, the key findings and subsequent recommendations. The Head of Risk Management also provides the Clinical Governance Committee with a quarterly report on compliance with the recommendations from these reviews. The themes arising from such reviews during 2015/16 have led to some key pieces of work being undertaken including:

- Trial and purchase of sensor mats for patients at high risk of falling;
- Review of Naso-gastric tube guidance;
- Inclusion of VTE risk assessments within the Emergency Department;
- Review of failsafe policies within the retinal screening service;
- Pre-operative assessment provision for spinal patients;
- Standardisation of equipment and training within specialities to reduce variation;
- Introduction of WHO checklists to areas that undertake operative procedures outside of the main theatre environment;
- Pop-up banners to enhance infection control signage during outbreaks;
- Changes to emergency department documentation to ensure that tests/investigations requested are easily seen and staff are aware that they need review and documenting prior to discharge of the patient.

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

Whilst communication with families within the Serious Incident Inquiry and Clinical Review process has always been good, this has not always been reliable within departmental and local review processes. This area has therefore been a focus this year in implementing the statutory ‘Duty of Candour’. The Duty of Candour places a requirement on providers of health and adult social care to be open with patients when things go wrong. This requirement is built into the new web incident reporting form so that compliance can be monitored at all stages of the incident process. Duty of Candour compliance for Serious Incidents is reported regularly to the Clinical Risk Group, Clinical Governance Committee and Trust Board. Work is ongoing to ensure that compliance is achieved for events that meet the Duty of candour threshold but not that of a serious incident.

Internal audit carried out a full review of Duty of Candour processes during 2015/16. The subsequent report gave an overall opinion of ‘substantial assurance’. The conclusion of the auditors was:

- Duty of Candour requirements have been well-publicised across the Trust.
- Testing showed Duty of Candour requirements are being complied with, subject to a couple of minor observations
- TIAA benchmarking showed the Trust to have adopted the best practice identified in a survey undertaken on this topic.

Two 'routine' recommendations were made as a result of the audit findings:

- Ensuring written evidence of duty of candour conversations are available within 10 days of occurrence;
- Supporting report sharing with patients/families within 10 days of 'sign off'.

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

During 2015/16 a workshop was undertaken with the Directorate Management Teams to ensure that data they receive on a quarterly basis promotes learning from incidents. As a result of that workshop, the way in which information is presented to the DMT's has been changed. Rather than a directorate report card of figures for the previous quarter, the information is broken down by speciality. The aim of this is to support teams in identifying key areas where reporting is high within their speciality and put changes in place that may support a positive change. These changes and outcomes can then be reviewed with subsequent quarter's data to track progress and identify whether the changes made were the correct ones or require further amendment. This information is then discussed at their performance meetings with the Executive Directors and also disseminated via the DMT's to their teams as it identifies key themes for inclusion into service plans and objectives.

Any clinical or non-clinical working group are able to utilise the incident report cards to review and analyse incident data in more detail. The reports can be structured depending on the requirements of the group. This is exemplified by sharps and needlestick incidents for the Needlestick Action Group, medication errors for the Medicines Safety Group and security incidents for the Security Management Committee. Reports are also compiled for clinical areas with active risk groups so that they may review themes within incidents and use this to inform their risk registers. The introduction of the web reporting system has further enhanced this as the system has the functionality for teams and individuals to set up bespoke reports. Regular training sessions on reporting are available for staff to book on through the Datix Administrator.

An annual Complaint, Litigation and Incident Partnership (CLIP) Trustwide report is produced. Whilst there are links between incidents and complaints within the timeframe reviewed, there is often disparity with claims data as there is frequently a time lag between the incident and a claim being brought. The introduction of web reporting will support directorates and teams being able to review data independently and aggregate their own themes over differing time periods.

Ongoing developments have taken place in 2015/16 to meet the requirements of quality in line with commissioner contracts and the Quality Account. This work will continue in 2016/17 as part of the Quality Meetings.

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

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

3.4.2 Reporting across the Trust remains fairly consistent with the numbers of incidents graded major and catastrophic remaining low (0.2%) which is positive. There is also an increase on last years figure in the number of incidents identifying no harm, which is an encouraging indicator of reporting within the Trust. All departments and staff groups in the Trust report incidents although some more frequently than others. There is continued work to identify low reporting areas and understand the reason for this, putting in support and education measures where required. The following staff groups increased reporting rates in 2015/16: Nursing/Midwifery, Medical and Ancillary. Reports by Allied Health Professionals, Clinical Assistants, Managers and Administrative/Clerical/Secretarial staff have reduced.

3.4.3 A KPI was introduced to ensure that all department risk registers are robust and in line with the Trust Risk Management Policy and Procedure, and to support staff in understanding this process. This has been a challenge over the last year and was picked up by the CQC during their inspection in December 2015. It was identified that some departmental risk registers did not consistently identify all risks, mitigating actions or where it did the actions had not always been taken or where they had the risk had not been updated.

This will be a focus of the 2016/17 work plan. All risks have now been transferred to the risk module of Datix, regardless of score, resulting in all risks being visible via a central database. This allows the Trust to build a picture of organisational risks at all levels and support the allocation of resources to mitigate Trust wide risks however requires careful management to ensure appropriate and timely escalation where required.

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

During 2015/16, there have been 35 reported needlestick injuries and 18 reported sharps injuries which compares to 46 reported needlestick injuries and 36 reported sharps injuries during 2014/15. There has been a slight decrease in the number of reported near miss incidents resulting in no harm from 28 during 2014/15 to 25 during 2015/16. Needlestick incidents are followed up by the Safety Advisor to ensure they have been seen by OHSS as per policy, and any learning points identified with the staff members involved. Themes and trends from the reported incident are discussed at the Needlestick Action Group.

The Trust has a Needlestick Action Group, chaired by the Trust's Safety Advisor. A Key workstream in 2015/16 related to the completion of the programme to introduce needle safe devices throughout the Trust and monitoring of their use. Any departments who do not have suitable devices available (based on clinical suitability not personal choice) have been asked to complete a risk assessment to justify the use of a non-safety device and work continues to explore the market as new equipment is developed. Any injuries which are sustained where a safe sharp option is available are followed up by the Safety Advisor and/ or Medical Devices Sister to identify cause and offer preventative strategies (further training, alternative device etc.).

Going forward, the Needlestick Action Group purpose and terms of reference has recently been reviewed and agreed at the Health and Safety Committee. It is to transfer into the Safe Sharps Steering Group, meeting quarterly with a more strategic approach, and acting as a task and finish group to address key areas or issues.

3.4.5 The reduction of hospital acquired grade III and IV pressure sores has continued to decrease with 3 grade III pressure sores being reported in 2015/16. No patients experienced grade IV hospital acquired pressure damage. The Trust wide action plan is ongoing to ensure that work in this area continues to see a reduction in pressure area development and the focus continues in supporting root cause analysis in ward areas that see clusters, 2 or more in a month, of grade II pressure areas to identify learning.

3.4.6 An ongoing KPI to evidence 100% completion of a full root cause analysis (RCA) for all fractures following a fall. This is successfully embedded in practice and used across the Trust.

A total of 20 fractures were reported in 2015/16 compared to 29 fractures in 2014/15, a reduction of almost a third. Of the 20, 7 were categorised as major harm (patient required surgical repair) and all of these were subject to external reporting as an SII. The remaining 13 were graded as moderate harm (requiring conservative management such as immobilisation in plaster cast).
A new theme which emerged last year were falls where patients sustained head injuries causing serious harm (3 reported as SI's), of which two were fatal and the subject of coroners inquests where the verdict of accidental death was recorded.

A quarterly report of all falls root cause analysis undertaken continues to be discussed at the Falls Group, Clinical Risk Group, and Clinical Management Board and fed back through the Contract Quality Review Meeting. This report has been revised recently in order to provide a more comprehensive overview of all the falls related work across the Trust and now also includes full numerical trends (including no harm falls), sign up to safety falls workstream, falls trustwide action plan.

Internal Audit undertook a compliance review of the fall processes within the Trust for 2015/16. The overall judgement was 'reasonable compliance' and noted some actions:

- Introduction of link nurse roles for Falls
- Disparity in timeframes for completion of nursing assessments stated in falls policy and nursing assessments
- Not all patients had their assessments/re-assessments completed as per policy
- Lack of consistent training in falls prevention and management
- Falls policy needs review (was in draft at time of audit)
- Availability of patient information leaflets

These actions were embedded within the Falls Action Plan.

The Trust participated in the Royal College of Physicians National Audit of Inpatient falls. Our results were presented to CMB by the Lead Clinician for Falls. Key actions from this national piece of work have been embedded in the Falls Action Plan and include the review of nursing assessments and raising awareness about lying and standing blood pressure measurements as the main areas of focus.

Trustwide work led by the Patient Falls Group for last year focused on updating both the patient falls policy and patient information leaflets as well as rolling out the new falls and bedrails assessment tools. All of which has now been completed.

In addition to the work by the Falls Group, the Trust is participating in the national 'Sign up to Safety' campaign and falls is one of the workstreams aimed at reducing harm caused by falls. The measurement agreed is to reduce the numbers of falls resulting in fracture or severe harm by 10% which was achieved during 2015-16.

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

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

The 2015/16 Annual Risk Management Plan was developed by the Risk Management Team and agreed by the Clinical Risk Group and Clinical Governance Committee. It was presented to the Trust Board in October 2015 as part of the Annual Report. All objectives have been completed or are ongoing. Notable successes are:

- 'Reasonable Assurance' from internal audit (TIAA) review of Risk Management Processes and the Assurance Framework 2015/16
- 'Substantial Assurance' from internal audit (TIAA) review of the Statutory Duty of Candour.
- Development of processes to ensure that patients and families are involved within reviews and have the opportunity to raise questions and concerns.
- Ongoing support of the Quality and Safety Walks to ensure that staffs views and concerns are heard and actioned, including raising health and safety concerns;
- Maintaining the tracking of recommendations from internal reviews and follow up where progress lacking;
- The use of reported incidents to support the security agenda including 24 hour security guard provision and training for high risk areas
- Small investment in PSF hours to support falls work with evidence of positive changes.

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

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

3.6.2 Incidents reported within the Directorates are reviewed quarterly at the performance meetings via the Risk Management Incident data.

3.6.3 Patient Safety and Risk Management continues to be integral to the educational programme for junior doctors.

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

3.7.1 There has been a reduction of staff within the Risk Team during 2015/16 which will be monitored to ensure that there is sufficient resource to support the risk agenda

3.8 Ensuring Compliance with National Standards - To *ensure compliance with the Care Quality Commission, Monitor and Health and Safety standards*

3.8.1 The Risk Team continues to work with the Chief Executive's Office and Directorate management Teams in order to demonstrate compliance with the Care Quality Commission's regulations and provide additional information where requested from the CQC.

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

3.8.3 The Risk Team continues to collaborate with NHS England. This includes the Trust's participation in the National Reporting and Learning System as well as co-ordinating a Trust response to the NHS England Patient Safety Alerts. This activity is co-ordinated by the Clinical Risk Group and monitored by the Clinical Governance Committee.

The Trust currently has no open NHS England Patient Safety Alerts, which are beyond their due date.

4 Future Developments

4.1 2016/17 will see the further development of Datixweb to support the Trust in its risk management processes and provide accurate and timely information to staff, managers and the Trust Board.

4.2 2016/17 will see ongoing development of the Assurance Framework to ensure that it is providing the Trust Board with intelligent information during increasingly challenging times.

4.3 The Risk Team shall actively support ongoing work regarding the Care Quality Commission regulations.

4.4 The Risk Team shall continue to ensure that risk information is provided to the commissioners as per the 2016/17 contract requirements.

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

4.6 The Risk Team will work with Trust departments and Directorate Management Teams to support the development of robust local risk registers, with appropriate risks escalated for Directorate/Board awareness.

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

4.8 A review of review staff requirements and training available will be undertaken to ensure that the needs of staff at all levels of the organisation are being met.

4.9 Investigator training workshops will be held on a monthly basis. The session is set out to engage participants in the contribution that Root Cause Analysis (RCA) has to make in investigations and to help develop the skills needed to conduct RCA systems-based investigations. Training is built around a case study.

4.10 In February 2016 the Interim Deputy Director of Nursing met with the DSNs to develop ways for the directorates to report on the actions taken and demonstrate how the wards/departments have used the learning from incidents, complaints and RTF to improve services. The Risk Team will continue to provide data to support the Directorates in demonstrating identification of themes and trends within specialty's and evidence of learning/improvement.

Trust Board

SFT 3823

TITLE OF REPORT

Maternity and Neonatal Risk Management Annual Report 2015/16

Date: September 2016

Report from: Louise Jones **Presented by: Lorna Wilkinson**

Executive Summary:

This paper covers the period 1st April 2015 to 31st March 2016 with the aim of assuring the board members that the Maternity and Neonatal Services are committed to minimising risk, and improving patient safety. This is achieved through a comprehensive, pro-active, multidisciplinary approach to risk management.

Summary of 2015/16 achievements

Positive progress in all of the Risk Management Strategy measurable objectives

- The Maternity department achieved a GOOD following the CQC assessment in December 2015. In the report the CQC stated that "*The maternity services strived to learn from investigations in order improve the care, treatment and safety of patients. This was evident with the robust, rigorous and deep level of analysis and investigation applied when serious incidents occurred. Further evidence of this was available in meeting minute records. In addition, a wide range of staff demonstrated that learning from incidents was a goal widely shared and understood*". Likewise the CQC reported "*the Benson bereavement suite facilities, and sensitive care provided to patients experiencing loss were outstanding. These services had been developed with the full involvement of previous patients and their partners. The facilities were comfortable and extensive, enabling patients and their families' privacy and sensitive personalised care and support*"
- The continued training to implement Datix web reporting of incidents within maternity and neonatal unit. This can be evidenced by an 28% increase in the reporting of incidents.
- The ongoing development of a rag rated clinical dashboard enabling benchmarking against other trusts in the South West.
- The full implementation of the obstetric theatre provision 24 hours 7 days a week . .
- The implementation of the GROW (Gestation Related Optimal Weight) project
- Maintaining the quarterly 'quality of midwifery supervision' meeting occurs with the Director of Nursing, Head of Midwifery, Head of Governance and the Contact Supervisor of Midwives to feedback outcome of supervisory investigation and completion of any recommendations to provide additional assurance to the Trust.
- The restructure of the departments PROMPT training. To incorporate CTG training and sepsis into the PROMPT day so that all doctors and midwives receive the same training.
- Maternity is participating with the RCOG national audit 'Each baby counts'.

- On going development with Duty of Candour to maintain open and transparent culture within the department
- Completion of the stillbirth review.
- Completion of OASIS review (3rd and 4th Degree tears).
- The Local Supervising Authority (LSA) carried out their annual audit of supervision of midwives.

Future Plans

- Continue to promote an open and supportive approach towards risk which continues to reflect an environment in which staff feel able to report so that reporting rates increase.
- To continue participation into the National audit Each Baby Counts the lead by RCOG's.
- To implement a hospital based screening model for New born hearing screening.
- To further increase the antenatal clinic capacity when the new Consultants are in post.
- Full implementation of the GROW Programme
- Salisbury has signed up to be an early implementer for the NHS England 'Reducing stillbirths care bundle'
- Continue midwifery recruitment
- Ongoing focus and work on medical staffing model

Proposed Action:

The Board members are asked to note the achievements within the Annual Report

Links to Assurance Framework/ Strategic Plan:

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

Choice - To be the hospital of choice, we will provide a comprehensive range of high quality local services enhanced by our specialist centres

BAF – 1.3 and 2.2

Appendices:

SALISBURY NHS FOUNDATION TRUST

Maternity and Neonatal Risk Management Annual Report 2015/16

1. INTRODUCTION

This paper covers the period 1st April 2015 to 31st March 2016 with the aim of assuring the board members that the Maternity and Neonatal Services are committed to minimising risk, and improving patient safety. This is achieved through a comprehensive, pro-active, multidisciplinary approach to risk management.

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

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

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

2. MEASURABLE OBJECTIVES FOR MANAGING RISK VIA THE MATERNITY AND NEONATAL SERVICES RISK MANAGEMENT STRATETY

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

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

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

Year	Total number of incidents reported for year
2012/13	**446**
2013/14	**477**
2014/15	**530**
2015/16	**679**

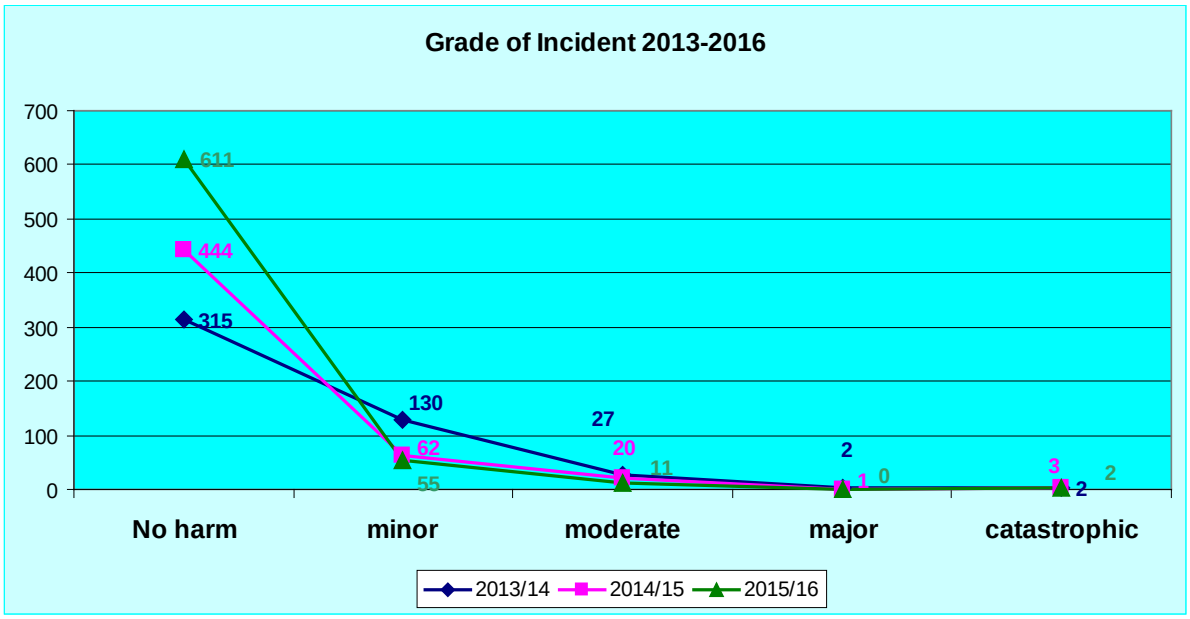
The total number of incidents reported has increased by **149 (28.1%)** on the previous year. An open and supportive approach towards risk continues, which reflects an environment in which staff should feel able to report. The monthly incident report summary continues to be cascaded to all staff outlining all incidents reported, with outcomes, thus creating an opportunity for discussion, but fundamentally for learning to be enhanced. This ensures that there is transparency surrounding activity, that there is a robust process for reviewing and investigating incidents, and that the outcomes and any learning achieved can be fed back to the workplace.

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

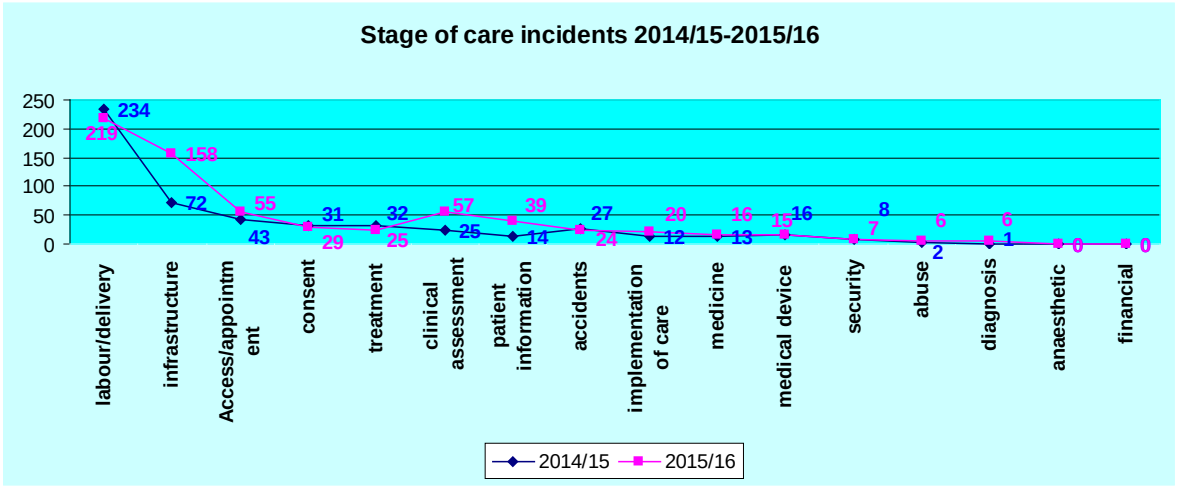
The Maternity Risk and Governance Manager and the Obstetric Consultant lead for risk work collaboratively to ensure all risks and incidents are considered, and that the Duty of Candour is extended and upheld for incidents graded moderate and above, as a minimum.

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

The table below shows the breakdown of incidents by severity. There has been a decrease in the number of catastrophic incidents reported from 3 to 2 since previous year. The number of majors have reduced from 2 to 0 incidents over the year with a reduction in moderate and minor events and a continued significant increase in the number of no harm events reported. This is reflective of a positive reporting culture and enables the team to proactively review themes coming through which could be posing a risk to patients before harm has resulted.

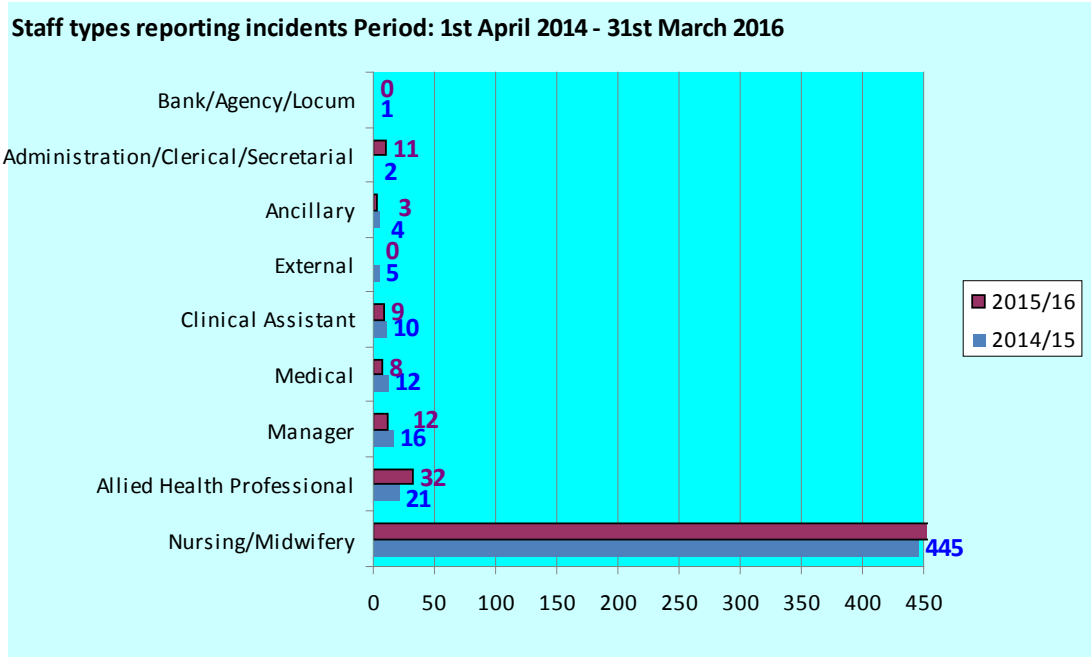


The largest number of reported incidents 234, (43.3%), were clinical incidents within the labour and delivery stage of care (Intrapartum), this is unchanged from the previous year. The majority of these are trigger events which are known potential complications of labour that all maternity units should be reporting against. This allows us to monitor whether complication rates are rising and therefore where further investigation should be focussed.



2.3 All staff groups across Maternity and Neonatal Services must report incidents as per the Adverse Events Reporting Policy and in compliance with the Maternity and Neonatal Services Trigger List.

The graph below demonstrates the reporting rates amongst non midwife groups. The number of midwives reporting incidents has increased however the other groups have either stayed the same or reduced. This is likely to be due to the implementation of Datix web and staff in these groups are being encouraged to sign up to the training.



Where necessary incidents will be reported to other agencies, for example: , MBRACE, UKOSS, NHS Litigation Authority and Local Supervising Authority, RCOG (each baby counts).

In September 2014, the web reporting of incidents to the electronic database (Datix) was implemented in Maternity. All adverse incidents and near misses continue to be inputted onto the Trust's electronic database (DatixWeb).

Once inputted Datix web automatically notifies the Maternity Risk and Governance Manager, the Labour Ward Manager and the Contact Supervisor of Midwife of the incident. The Maternity risk and Governance manager considers whether there are any fitness to practice issues. This would necessitate escalation to the Head of Maternity and Neonatal Services in the first instance. This may lead to a Supervisory review conducted by a Supervisor of Midwives (SOM) and inputted onto the LSA database.

Via Datix web clinical ward leads are notified of the incidents through email and are then able to investigate the incident within their area of expert knowledge and can complete the investigation. Once completed the grading is confirmed by the Maternity Risk and Governance manager who will then review and close the incident. Datix reporting system is used for the logging of all incidents which are reported and these are then monitored at the monthly Maternity Risk Management forum and the Trust's Clinical Risk Group. The Risk and Governance Manager reports all serious incident inquiries (SII's) to the head of Risk Management and they are then reported through STEISS as per national framework and contractual requirements.

Maternity services ensure that any external reporting requirements are met in collaboration with the Head of Risk.

Each Baby Counts is the RCOG's national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of

incidents occurring during term labour. The maternity and neonatal services signed up to this initiative when it launched in January 2015 and we continue to report .

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

Feedback and learning from reviews are discussed at the department's Clinical Governance sessions. This is a multidisciplinary forum where lessons learnt can be cascaded . All Clinical Reviews/Serious Incident Inquiries are reported to Clinical Risk Group, and Trust Board, detailing the nature of the incident, the key findings and subsequent recommendations. The Head of Risk Management also provides the Clinical Governance Committee with a quarterly report on compliance with the recommendations from the reviews.
Some of the recommendations, changes to practice, and learning arising from incidents in 2015/16.

2.5.1 Fetal surveillance and the correct plotting of fundal height on the growth chart: Continual training and reviews of fetal surveillance is ongoing to ensure the profile is constantly high.
The GROW programme (Perinatal Institute's Growth Assessment Protocol ,GAP) was implemented in February 2016. 3 Midwives have now completed their sonography training and a GROW scanning clinic is running. Progress with the GROW Programme will be reported quarterly via the Safety Steering Group to Clinical Governance Committee through 2016/17.

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

2.5.3 Neonatal Observations:- enhanced guidance and expectations on identification of a deteriorating neonate and required escalation.

2.5.4 Importance of placental histology on PM results:- clear responsibilities and awareness raising around the process of placenta labelling and identification..

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

There have been no reported 4th degree tears during this period.

2.6 Maternity and Neonatal Risk Group is to meet at least 10 times annually with an attendance list and documented minutes of actions being taken

The Maternity and Neonatal Risk Management group has met on 10 occasions throughout this period. The forum is jointly chaired by the Maternity Risk and Governance Manager and the Lead Obstetric Consultant for risk. Attendance from the Head of Maternity, the Lead Anaesthetic Consultant for Obstetrics and the Paediatric Consultant for risk is mandatory. This forum is supported by the Trust Lead for Risk.

The attendance at maternity risk forum is encouraged for all staff, to promote openness and for learning. All meetings are minuted, actions identified and a copy disseminated to all staff through the communication folders. The minutes provide an audit trail which provides a link to the other forums when issues need to be discussed with a wider group of staff. (see appendix 1 for Terms of reference). Staff are keen to learn about outcomes of incidents that they have reported, and this continues to be acknowledged as a positive change.

2.7 The Maternity and Neonatal Risk Group must report to the Trust Clinical Risk Group as a standing agenda item.

The Maternity Risk and Governance Manager and/or the Obstetric Consultant lead for Risk and Governance have attended the Trust's Clinical Risk Group monthly where Maternity and Neonatal risk items are a standing agenda item, and the maternity dashboard is presented for scrutiny. The development of a regional dashboard is now in place and the department now uses this tool to benchmark against.

A robust review into stillbirths was undertaken and shared with the clinical risk group and with the commissioners. (see point 3).

2.8 There must be attendance at the Directorate Governance 3:3 by the Head of Midwifery (or nominated deputy) to ensure that maternity and neonatal incidents and risks are discussed as part of the Directorate Risk Register and Incident Report Card with the executives present and the Head of Risk Management.

The Head of Midwifery attends the Directorate 3:3s to ensure a seamless and open reporting structure of relevant information relating to risk and governance.

2.9 Annual review of staffing of clinical areas and review skill mix to ensure leadership and safe clinical practice is maintained, for all disciplines of staff.

Additional funding was agreed to increase staffing establishment from 73 WTE to 83 WTE following a comprehensive Birthrate+ review. Staffing remains a challenge due to ongoing vacancies, maternity leave, and sickness. Agency staff have been utilised to backfill these posts, with a robust process of CV review and booking for lines of shifts only in order to mitigate risk.
The service continues with its recruitment initiatives and this work is reported into the Nursing, Midwifery, and Therapies Workforce Steering Group chaired by the Director of Nursing. During 2016/17 the service has signed up to the RCM *'caring for you'* campaign ensuring workforce sustainability and wellbeing will remain a priority

***2.10 There should be evidence that National Guidance i.e. NSF / NICE / National Confidential Enquiries have been reviewed and recommendations implemented where appropriate*.**

All Trust clinical guidelines are based on relevant national guidance and are formally approved through the Trust process. Within maternity and the neonatal service new guidance that is released nationally is reviewed within the Governance forums. The findings are then presented and discussed at the Maternity/Neonatal Clinical Governance Forum. A baseline audit assessment is then undertaken by a nominated clinician to ensure that recommended quality standards are included within the local guidance as applicable. The audit results are returned to the clinical governance session for review, and adjustments to practice are made following discussion.
An example of this is the Induction of labour audit which is going to lead to the introduction of balloon catheters into practice.

2.11 Risk and patient safety awareness is everyone's business and is included in all staff's job description. *Achieved*

2.12 The Maternity and Neonatal Service must have a dynamic risk register which shows depth and breadth of risks identified. Risks should be reviewed as a standing agenda item (as a minimum quarterly) at the Maternity and Neonatal Risk Group meeting. As a result all risks should be in date.

The Risk Register is maintained and discussed as a set agenda at the monthly Maternity and Neonatal Risk Management meeting within a multidisciplinary forum. All risks due for review are assessed and the risk escalated or reduced as the risk changes.
Departmental risks are identified through adverse events/near misses, complaints, claims, clinical risk assessments, health and safety inspections and audit and incorporate all risks associated with delivery of care.

The current highest risk on the departmental risk register is:

Maternity staffing which is reviewed monthly. The complexity of this involves balancing a static number of staff with the challenge of predicting when women will labour. National guidance is available to support midwifery staffing numbers which the department considers alongside the local skill mix review process. As previously stated in 2.9 a work force review has been undertaken which initiated the commissioning of Birth Rate Plus to review the departments staffing and acuity. This work is ongoing as part of the Maternity Services Review

A robust escalation plan is utilised daily to ensure 1:1 care in labour and the safety of women. This is led by the supervisors of midwives out of hours and a duty manager during office hours. There is a National Maternity review underway and this is expected to have an impact on traditional working patterns. The service is conducting a gap analysis against the proposals and will await the outcomes of the national pilot sites. The Midwife to Birth ratio is a metric reported on the Maternity dashboard, 1:1 care in labour as a metric on this document is being developed in 2016/17

During the year a high risk was mitigated with the opening of the ***dedicated obstetric theatre.*** Historically this had been open between 8am to 5pm on weekdays for the last 15 years. Out of hours in emergency situations women were transferred to main theatres by the midwifery staff. Since November 2015 the Obstetric theatre operates 24 hours 7 days a week.

Going into 2016/17 an emerging risk has been medical staffing, which is currently a focus of work.

3. SERIOUS INCIDENT INQUIRIES(SII)/CLINICAL REVIEWS.

The department has commissioned and undertaken 3 reviews during the 2015/16 period compared to 7 in 2014/15. An SII commissioned at the end of 2014/15 was completed in this reporting year following a maternal death, we are still awaiting the conclusion of the inquest.

1 review was completed using the local review format (monitoring of jaundice), and 2 were reported as SII's. (This compared to 6 SII's that were reported during 2014/15.

The 2 SII's were in relation to a stillbirth and a neonatal death. All SI reviews had engagement from staff involved in all aspects of care, and involvement with each of the families was sought. As a result of these reviews a number of recommendations were made and implemented. The recommendations are reviewed prior to implementation and are then monitored by the Clinical Governance Committee.

An aggregated review into still births was carried out as it was noted that the number of stillbirths in the year 2014/15 was 10 (0.4%) and that number increased to 14 (0.6%) in 2015/16. Currently every stillbirth is reviewed in either a multidisciplary meeting such as Perinatal or a formal SII review where omission or commission of care is identified. All cases are inputted to the SDH database and as appropriate they are inputted into the RCOG 'Each Baby Counts' audit and MBRRACE.

Of these 14 stillbirths, 5 were identified as being small for gestational age, and this was the main theme arising from the review. . The care for these women was considered appropriate at the time - as it was before the individualised growth charts were implemented (GROW). During 2015 the case for reducing stillbirths through the GROW programme gained national attention. This combined with our own 'deep dive' into this issue has resulted in a change in antenatal management and local implementation of the GROW programme as part of our Sign up to Safety Campaign.

All women booked for maternity care at SDH are now on the GROW programme (Gestation Related Optimal Weight), which was implemented in February 2016.The GROW software provides the generation of an individual or 'customised' growth chart by adjusting physiological factors such as maternal height, weight, parity and ethnic group which are known to affect fetal growth. Additional scanning capacity is facilitated by 3 x weekly midwife led growth scanning clinics. As women who have been on the programme are starting to deliver their babies, audit into the impact on our antenatal detection rate of small for gestational age babies has begun

4. USER FEEDBACK

4.1 Complaints

We continue to see only a low level of complaints - 9 for the reported year

1) Complaint via NHS England regarding ultrasonography service.
2) Complaint regarding perceived lack of care.

3) Management of care and interpretation of the CTG during induction
4) Treatment on the postnatal ward.
5) Complaint regarding how a concern was escalated to social care without parental knowledge.
6) Failure of antenatal screening processes
7) Community midwife communication during a home visit.
8) Lack of midwifery support offered during a night duty.
9) Clinical treatment. – joint investigation with RUH Bath

Complaints are fed back at the monthly risk meeting and Clinical Governance sessions. Themes are cascaded out to all clinicians. One example of change to practice resulting from a complaint is that there are now robust processes in place, overseen by the antenatal screening coordinator, to ensure that all antenatal screening is completed and followed up if results are abnormal or a sample is insufficient.

5. SUMMARY OF 2015/16 ACHIEVEMENTS

- Positive progress in all of the Risk Management Strategy measurable objectives

- The Maternity department achieved a rating of GOOD following the CQC assessment in December 2015. In the report the CQC stated that "*The maternity services strived to learn from investigations in order improve the care, treatment and safety of patients. This was evident with the robust, rigorous and deep level of analysis and investigation applied when serious incidents occurred. Further evidence of this was available in meeting minute records. In addition, a wide range of staff demonstrated that learning from incidents was a goal widely shared and understood*". Likewise the CQC reported "*the Benson Bereavement Suite facilities, and sensitive care provided to patients experiencing loss were outstanding. These services had been developed with the full involvement of previous patients and their partners. The facilities were comfortable and extensive, enabling patients and their families' privacy and sensitive personalised care and support*"
- The ongoing development of a rag rated clinical dashboard enabling benchmarking against other trusts in the South West.
- Maintaining the quarterly 'quality of midwifery supervision' meeting occurs with the Director of Nursing, Head of Midwifery, Head of Governance and the Contact Supervisor of Midwives to feedback the outcome of supervisory investigation and completion of any recommendations to provide additional assurance to the Trust.
- The restructure of the departments PROMPT training. To incorporate CTG training and sepsis into the PROMPT day so that all doctors and midwives receive the same training.
- The continued training to implement Datix web reporting of incidents within maternity and neonatal unit. This can be evidenced by an 28% increase in the reporting of incidents.
- The full implementation of the obstetric theatre provision 24 hours 7 days a week
- The implementation of the GROW project
- Scanning capacity had been stretched to over capacity which had hampered the delay in implementing GROW. 3 midwife sonographers are now qualified which has enabled this implementation to go ahead.
- The implementation of Allocate for electronic off duty rosters.
- Baby steps was implemented within the public health agenda. This work continues. It is an intensive programme of education delivered to vulnerable

families and has a strong evidence base suggesting that the programme directly impacts upon health and social outcomes for babies and children.

- PIMS (Positive image motivation service) continues and is supported by the Wiltshire public health team. This is a concentrated care package for women with raised BMIs to support them to manage weight gain in pregnancy and to make life changing choices that enable them to be healthier in the long term.
- Maternity is participating with the RCOG national audit 'Each baby counts'.
- On going development with Duty of Candour to maintain open and transparent culture within the department
- The successful recruitment and appointment of a local manager and an administrator for NHSP.
- The refurbishment of the postnatal ward.
- Completion of the stillbirth review.
- Completion of OASIS review.
- The Local Supervising Authority (LSA) carried out their annual audit of supervision of midwives. The LSA examined health care records, patient information, specific care plans written for women with complex care needs

6. FUTURE PLANS

- Continue to promote an open and supportive approach towards risk which continues to reflect an environment in which staff feel able to report so that reporting rates increase.
- New Midwifery- led unit is to be built to increase birth choices for women.
- To include bank staff into the Allocate rostering system.
- To continue participation into the national audit Each Baby Counts the lead by RCOG's.
- To implement a hospital based screening model for newborn hearing screening.
- To further increase the antenatal clinic capacity when the new Consultants are in post.
- To extend the the Consultant cover on labour ward to a full day.
- Full implementation of the GROW Programme
- Salisbury has signed up to be an early implementer for the NHS England 'Reducing stillbirths care bundle'

MEETINGS AND FORUMS

TERMS OF REFERENCE
Maternity and Neonatal Risk Management Form

- ***AIMS.***

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

The main functions of the group are:

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

MEETINGS AND AGENDAS

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

Membership

Consultant Obstetrician lead for risk (Chair)
Maternity Risk and Governance Manager
Head of Maternity and Neonatal Services
Consultant Anaesthetist
Postnatal and Neonatal Services Manager
Labour ward lead
Community Manager and Named Midwife for Safeguarding children.
Consultant Paediatrician

Antenatal lead
Supervisor of Midwives
Minimum attendance being 50%
(This forum is open to all clinical staff within the Maternity and Neonatal department).

Salisbury NHS
NHS Foundation Trust

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 21st July 2016, 10am-12pm
Boardroom, Salisbury District Hospital

SFT 3824

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair) - Non-Executive Director
Peter Hill - Chief Executive Officer
Lorna Wilkinson - Director of Nursing
Fiona Hyett - Deputy Director of Nursing
Steve Long - Non-executive Director
Hazel Hardyman – Head of Customer Care
Ian Downie - Non-executive Director

In attendance:

Kate Williams	Minute taker
Jan Sanders	Governor
Alison Montgomery – Specialty Manager, Radiology	CGC071605
Alison Hemming – Nursing Manager, Outpatients	CGC071605
Maria Ford – Nurse Consultant in Critical Care	CGC071606
Fenella Hill – Head of Risk Management	CGC071612, CGC071613 & CGC071614
Henry Wilding	

Observing:

Kirsty Matthews – Non-executive director

CGC071601 Apologies:

Dr Christine Blanshard - Medical Director
Claire Gorzanski – Head of Clinical Effectiveness
Steve Bleakley – Chief Pharmacist
Mark Stabb – Head of TIAA
Andy Hyett – Chief Operating Officer
Dr Samuel Williams – F1

It was agreed by the committee that the Chief Pharmacist would be required to attend the Clinical Governance Committee meetings 4 times a year only and that the agenda would be managed so that there would be a stronger focus on medicines at those meetings. **LW / CGz / KW**

A newly qualified nurse will be joining the committee once started in post September 2016.

CGC071602 – Minutes of the meeting held on 23rd June 2016

The minutes were approved by the committee.

CGC071603 – Matters Arising / Action Tracker

All items were agreed.

CGC071604 – CQC Inspection Report December 2015 – report on key issues – Lorna Wilkinson

- The CQC Steering Group meets monthly to review the action plan by core service area
- There is ongoing action across all areas

- An update shows where achievements have been made as well as flagging areas where focussed action is still required

The committee discussed the format of the report and it was agreed that going forward the three most challenging items would be presented at the top of the report.

ID challenged LW for assurance that the hospital is ensuring that all necessary audits are being undertaken as assurance on the actions taken and that this, and evidence of this, is being embedded in practice. LW confirmed that as action plans go green they will be tested in practice.

STRATEGY

CGC071605 – Core Service presentation – Outpatients and Diagnostic Imaging – Alison Montgomery, Alison Hemming

AM and AH gave a presentation giving an overview of the CQC outcome. The department received a rating of 'Good' for Safety, Caring, Responsiveness and for being Well-Led.

The action plan was then presented and discussed, with AM and AH highlighting achievements and challenges.

PH noted the good results achieved by the team, and thanked them for their work.

LB thanked AM and AH for their helpful presentation.

CGC071606 – Hot Topic – Nursing Documentation Audit – Maria Ford

MF gave a presentation regarding the aims of the Nursing Documentation Audit :

- To evaluate the level and quality of nursing assessment on admission to hospital
- To evaluate the level and quality of nursing reassessment during admission and/or transfer
- To evaluate the level and standard of nursing management/care plans
- To evaluate the standard of record keeping in the nursing records

The committee considered the new version of the Assessment booklet which is completed for each patient within 6 hours of admission and from which a care or management plan is created.

MF reported on actions taken following the CQC inspection and noted that there had been positive feedback regarding the Assessment booklet.

LB thanked MF for her presentation.

CGC061707 – Spinal Unit Leadership – verbal update – Lorna Wilkinson

LW reported that there has been a lot of work in this area. There are challenges around the spinal leadership, and there has been an increase in referrals for VUD's. A workshop has been organised which will also be attended by an external expert for review of the pathway in video urodynamics.

Directors continue to meet with the DMT weekly to track progress on all actions.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC071608 – Annual Patient Experience Report – Hazel Hardyman

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

HH reported that there has been a decrease in complaints and an increase in Real-Time feedback.

There have been 2 national surveys after which negative feedback was pulled together and themed, then fed into action plans. Of 6 Trusts involved in the After Francis project, this Trust is one of the highest recruiters. The response timescale has improved regarding phone calls to complainants.

There was excellent feedback from staff following work with NHS Elect.

SL challenged the low figures regarding food and nutrition. FH responded that the Spinal Unit was always difficult due to the long stays of the patients, and there are always challenges in Paediatrics.

ID suggested that the app regarding patient experience needs to be promoted as this currently is not used significantly.

CGC071609 – Accessible Information Standard – Hazel Hardyman

The new Accessible Information Standard was agreed on 24th June 2015 and all NHS and adult social care organisations must follow the Standard by law by 31st July 2016.

The Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

The Standard specifically aims to improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in autonomous decision-making about their health, care and wellbeing. The Standard tells organisations how to support people's communication needs, e.g.- Large print; Easy Read, Braille, via email, British Sign Language (BSL) / Deafblind manual interpreter); Advocate.

We must do five things:-

Ask people if they have any information or communication needs, and find out how to meet their needs; record those needs in a set way; highlight a person's file stating those needs and how they should be met; share information about a person's needs with other NHS and adult social care providers with the person's consent or permission to do so; make sure that people get information in an accessible way and the communication support if they need it.

HH reported that the communication guidance on the Action Plant went to CMB and will become green.

LW noted that from a clinician's point of view this work will be very helpful.

ASSURING CLINICAL EFFECTIVENESS

CGC071610 – Quality Indicator including DSSA – discussion – Lorna Wilkinson

- No MRSA bacteraemias in Q1.
- 4 MSSA bacteraemias in June, none were device related. Q1 total – 5 MSSA bacteraemias.
- 1 Trust apportioned C Difficile case in June. Q1 total – 3 cases below upper limit at the end of Q1.
- 4 new serious incident inquiries commissioned in June. Q1 total – 15. No never events in Q1.
- A new chart showing compliance with early warning scores to recognise deteriorating patients and escalation implementation.
- A decrease in the crude mortality rate in Q1 with an increase in admissions. SHMI is 112 to December 2015 and remains as expected. HSMR is 110 to March 16 and is higher than expected. New item - CUSUM alerts triggered when a diagnosis or procedure group has a higher number of deaths observed than expected. Each alert is investigated by the appropriate clinician and reported to the Mortality Surveillance Group to ascertain if the death was avoidable and any learning points to improve the patient pathway. One new alert in March 16.
- Time to theatre for patients with a fractured neck of femur improved in Q1, as did BPT compliance at 83%.
- 42 grade 2 pressure ulcers in Q1 compared to 54 in Q1 15/16. 3 grade 3 pressure ulcers in Q1

compared to the same number in Q1 15/16. Share and learn meetings continue to drive improvements.

- Safety Thermometer – a decrease in 'new harm free care' in June 16 and of patients admitted to hospital with a harm.

- In June there were 2 falls, 1 resulting in major harm (fractured hip requiring surgery) and 1 resulting in moderate harm (fractured fibula managed with a cast). In Q1 there were 7 falls, 3 resulting in major harm (2 fractured hips requiring surgery & 1 fractured elbow requiring internal fixation) and 4 resulting in moderate harm (fractured fibula, 2 fractured wrists all managed with casts and a head injury).

- In Q1 CT scan within 12 hours was achieved for all except one stroke patient. In June, an increase in patients spending 90% of their time on the stroke unit. Patients arriving on the unit within 4 hours significantly improved in June following improvement work between ED and the stroke unit. In Q4, SNNAP was a grade C.

- In Q1 a decrease in high risk TIA patients being seen within 24 hours. In June 5 patients were not seen within the timeframe due to lack of same day clinic availability (3), investigations not completed within 24 hrs (1) and a patient seen in a general medical clinic rather than a TIA clinic (1).

- A new chart showing the number of complaints and concerns received and re-opened with 100% acknowledged within 3 working days. Work is progressing towards a more proactive approach in the initial phase of a complaint and learning from themes.

- Escalation bed capacity reduced in June but still remains at a high level with significant demand continuing in the non-elective pathway including admissions and the number of delayed transfer of care and 'green to go' patients.

- In June 16 there were 2 non-clinical mixed sex accommodation breaches affecting 12 patients all on AMU, all for a short periods of time to enable timely access to medical care, and all due to bed capacity issues and patient acuity. In Q1 a total of 8 non-clinical mixed sex accommodation breaches occurred affecting 62 patients all on AMU.

- New items - of patients experiencing ward moves more than once, twice and three times with a significant increase in moves more than once in June reflecting the pressures on bed capacity and patient acuity. Also included is the time of patient moves for ongoing monitoring purposes. The majority of overnight moves are from Whiteparish, SSEU and Britford SAU to maintain patient flow. However, there were a number of moves from one ward to another to maintain patient flow. The majority of discharges between 10 pm and 7 am are from ED/SSEU, Whiteparish and Britford SAU.

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

LW will check to see if new mothers leaving hospital after giving birth are included in the 'discharges after 10.00pm' figures.

PH reported that the Trust is currently running at 55 escalation beds and this will lead to some complaints.

CGC071611 – New Procedures Report – Fiona Hyett

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

<u>New Procedures Approved</u>
Two new procedures have been approved within the reporting period:-

- Implantation and Follow-Up of Subcutaneous Implantable Cardioverter Defibrillators (S-ICDs)

- FISH urine testing in bladder cancer diagnosis and follow-up subject to patient follow up and regular audits.

Procedures under Development
One new procedure is currently under development:-
- Prostatic Urethral Lift (Urolift®)

Completed Audits within the Current Reporting Period
One audit was completed and is compliant:
- Holmium Laser Resection of the Prostate (HoLEP)

Completed Audits from Previous Reporting Periods
One audit was completed and is compliant:
- Balloon sinoplasty

Audits Outstanding from previous Reporting Periods
One audit is on hold until sufficient patients have been seen:-
- Hycosy Procedure as part of a new One-stop Fertility Assessment Clinic

Four audits are progressing:-
Use of conscious sedation for adult patients only for oral and maxillofacial treatment/surgery in the Oral Outpatient Department
- MRI Arthrography
- Blue light cystoscopy with Hexvix
- Insertion of anal fistula plug

Other New Procedures
Three procedures were approved in previous reporting periods but have not yet commenced due to operational issues:-
- Sentinel Node Biopsy in Anal Cancer
- Sacral Nerve Stimulation
- Wireless capsule endoscopy of the small bowel

The committee noted the report.

CGC071611A – NHSE Quality surveillance of specialised services – Fiona Hyett

- Overall, a change of approach is envisaged and will be more arm's length than previously, risk based, reports by exception and better use of nationally available data. The aim is to focus on patient outcomes and patient experience with less focus on structure and process.
- Annual self-declaration – each specialised commissioned service and all cancer services however they are commissioned will be required to make an annual declaration against agreed quality indicators or key quality requirements.
- Annual assessment will be made by NHSE by reviewing all the information available including the self-declaration and the quality indicators each service has submitted to the Specialised Services Quality Dashboard (SSQD).
- A Quality profile will be developed at both Trust and service level and be RAG rated based on the information held in the portal.
- QST peer review visits – 3 types comprehensive, targeted or rapid reviews.

Action required:

- All cancer services to complete registration on QSIS by 30 June 16 – Cancer Services Manager has this in hand.
- Self-declaration by cancer services to be completed by 31 August 16 – Cancer Services Manager has this in hand.
- All other specialised services to complete registration on QSIS by 31 July 16.
- Self-declaration to be completed by 30 September 16.
- Nominate an executive lead or senior manager to ratify/validate the self-declaration for each service.

FH reported that cancer services are on track and CGz has diarised this with other services.

The committee approved this course of action.

CGC071611B – Mortality and Morbidity Review proposal – Fiona Hyett

- The review is being undertaken to provide assurance that mortality and morbidity meetings are undertaken in a standardised way and lead to improvement in the quality and safety of care. Similarly, Clinical Governance meetings are being undertaken and lead to improvement in patient safety, clinical effectiveness and patient experience. As there is often overlap between the mortality and morbidity meetings and clinical governance meetings it was felt sensible to review both functions at the same time.

- During our CQC inspection in December 2015 it was noted there were some weaknesses in the mortality and morbidity function in some departments. As part of the action plan it was decided to undertake a Trust wide review of mortality and morbidity function.

- Standards and guidance on mortality and morbidity review meetings have been set and a meeting report template developed and they need to be made available on the Trust's intranet.

The review will be undertaken by a combination of :

- Department/speciality self- assessment questionnaires.
- Interview with the clinical governance department/speciality lead.
- Observation at a selection of mortality and morbidity meetings and clinical governance meetings to provide background and context to the self-assessment and interview with the lead. **CGz/WG/KG /CB/FH**

- An evaluation report will be presented to the Clinical Governance Committee in January 2017.

ASSURING SAFETY

CGC071612 – Assurance Framework – Fenella Hill

FHi reported on newly identified gaps in control/assurance, newly identified positive assurances and summarised risks that are on the Risk Registers.

LB noted that HSMR is above the expected rate and asked if this needed to be included in the next report. FHi will consider this as it may be shown as a separate item.

SL suggested that it would be helpful for the report to indicate items which can be cross-referenced with papers during the meeting. LW suggested, based on today's discussions, that it might be useful for the committee to consider ensuring that non-elective capacity, mortality and spinal appear within the BAF.

The committee discussed the need to continue to identify reasons for increased pressure on capacity. LW reported that this had been discussed with CCG and GP's recently – there is a high level of acuity regarding the need to ensure that patients can leave hospital at the appropriate time to aid flow. A 14 point action plan had evolved from this discussion.

CGC071613 – Risk Report Card Q1 – Fenella Hill

- 2111 incidents reported over the quarter
- 1 incident categorised as catastrophic*
- 5 incident categorised as major*
- 3 major incident due to fractures within the quarter
- No new Never Event reported within the quarter*
- No new Clinical Review commissioned within the quarter
- No new Non-clinical Reviews commissioned within the quarter
- 15 new Serious Incident Inquiries commissioned within the quarter
- No new Local Reviews commissioned within the quarter

*Initial grading and subject to change following review

The report was noted by the committee.
POST MEETING NOTE: The three fractures were all orthopaedic patients, two managed on Amesbury Ward and one on Downton Ward.

CGC071614 – SII/CR Report Q1- Fenella Hill

Updates to outstanding recommendations:
SII 181, SII 182, SII 187, SII 188, SII 190, SII 191, SII 192, SII 193, SII 194, SII 195, SII 198, SII 203.

Reviews with outstanding recommendations:
SII 160, SII 176, SII 181, SII 185, SII 191, SII 194, SII 198, SII 203.

New Recommendations since May 2016 CMB:
SII 181, SII 190, SII 191, SII 192, SII 193, SII 194, SII 198, SII 195, SII 203.

Serious Incident Inquiry / Clinical Review for Closure:
SII 182, SII 187, SII 188, SII 190

The report was noted by the committee.

CGC071615 – Risk Annual Report – Fenella Hill

This item will now come before the committee in September 2016.

CGC071616 – Safeguarding Children Q1 – Angela Conway

This item will now come before the committee in September 2016.

CGC071617 – Safeguarding Adults Q1 – Gill Cobham

This item will now come before the committee in September 2016.

Challenges

Item	Challenge	Action
CQC Inspection Report December 2015 – report on key issues	Assurance that the hospital is ensuring that all necessary audits are being undertaken and that evidence of this is being embedded in practice.	As action plans go green they will be tested in practice.

PAPERS FOR NOTING

CGC071618	Clinical Management Board meeting minutes (June 2016)	Noted
CGC071619	Clinical Risk Group meeting minutes (May 2016)	Noted
CGC071620	Infection, Prevention and Control Committee (April 2016)	Noted
CGC071621	Children and Young People's Quality and Safety Board (March 2016)	Noted
CGC071622	Supervision of Midwives Assurance meeting (May 2016)	Noted

CGC071623 - ANY OTHER BUSINESS

PH reported to the committee on the matter of a forthcoming inquest where 3 external experts have given conflicting reasons for death. This is something that will gain media coverage.

ID requested an update regarding the Sepsis toolkit. LW reported that this was used last year for admissions, and this year for inpatients. The results are being audited each month. There are challenges in ED with this and this will be refocussed, resources have been released for this.

CGC071623A – Proposed dates for Clinical Governance Committee meetings 2017 – Lydia Brown

January26th, February 23rd, March 23rd, April - No meeting, May 18th (early due to Final Quality Account), June 22nd, July 27th, August - No meeting, September 28th, October 26th, November 23rd, December - No meeting.

The committee agreed these dates.

NEXT MEETING

2016 dates will be Thursdays, 10am-12pm in the Boardroom – 22nd September, 20th October, 24th November. No meeting in December.

KPMG

External Audit Report

Salisbury NHS Foundation Trust

23 May 2016

I confirm that this is the final version of our ISA 260 Audit Memorandum relating to our audit of the 2015/16 financial statements for Salisbury NHS Foundation Trust. This document was discussed and approved by the Trust's Audit Committee on 20th May 2016.

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Jonathan Brown

Senior Statutory Auditor for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
100 Temple Street
Bristol
BS1 6AG
23 May 2015

Our audit opinions and conclusions:	
Financial Statements: unqualified	Use of resource: clean
Quality Accounts (content): clean	Quality Report (indicators): qualified

Content

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Important Notice

This report is presented under the terms of our audit engagement letter. Circulation of this report is restricted. The content of this report is based solely on the procedures necessary for our audit. This report is addressed to Salisbury NHS Foundation Trust (the Trust) and has been prepared for your use only. We accept no responsibility towards any member of staff acting on their own, or to any third parties. The National Audit Office (NAO) has issued a document entitled Audit Code (the Code). This summarises where the responsibilities of auditors begin and end and what is expected from the Trust. External auditors do not act as a substitute for the Trust's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

Basis of preparation: We have prepared this External Audit Report (Report) in accordance with our engagement letter dated 27 April 2016.

Purpose of this report: This Report is made to the Trust's Audit Committee in order to communicate matters as required by International Audit Standards (ISAs) (UK and Ireland), and other matters coming to our attention during our audit work that we consider might be of interest, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone (beyond that which we may have as auditors) for this Report, or for the opinions we have formed in respect of this Report.

Restrictions on distribution: This Report is subject to disclosure restrictions as set out in our Engagement Letter.

Limitations on work performed: This Report is separate from our long form audit report and does not provide an additional opinion on the Trust's financial statements, nor does it add to or extend or alter our duties and responsibilities as auditors reporting. We have not designed or performed procedures outside those required of us as auditors for the purpose of identifying or communicating any of the matters covered by this Report.

The matters reported are based on the knowledge gained as a result of being your auditors. We have not verified the accuracy or completeness of any such information other than in connection with and to the extent required for the purposes of our audit.

Status of our audit: Our audit is not yet complete and matters communicated in this Report may change pending signature of our audit report. We will provide an oral update on the status of our audit at the Audit Committee meeting but would highlight the following work is still outstanding:

- Annual Report, final comments on draft.

KPMG

Summary

Section One

Summary

Financial Statements Audit

We intend to issue an unqualified audit opinion on the accounts following the Audit Committee adopting them and receipt of the management representations letter.

We have completed our audit of the financial statements in line with our agreed plan. We have also read the content of the Annual Report (including the Remuneration Report) and reviewed the Annual Governance Statement (AGS). Our key findings are:

- There is one unadjusted audit differences, explained in section 2 and appendix 2.
- We have agreed presentational changes to the accounts with Finance, mainly related to compliance with the Annual Reporting Manual (ARM).
- We have reviewed the annual report and have no matters to raise with you.

Quality Accounts

We have completed our audit of the Trust's Quality Accounts:

- You have achieved a clean limited assurance opinion on the content of your Quality Report which could be referenced to supporting information and evidence provided. This represents an unmodified audit opinion on the Quality Report.
- This year we have tested referral to treatment and A&E 4 hour wait as the two mandated indicators. Our detailed testing on the indicators has concluded that we are able to give a clean limited assurance opinion on the presentation and recording of the A&E target but not the referral to treatment target.
- Our work on the local indicator 'falls resulting in serious harm or fracture' as selected by Governors has indicated that would be able to provide a clean opinion, save for the inherent limitations regarding underlying clinical judgement and completeness.

Use of resources

The Trust made a deficit for the year of £6.5m, the first in the Trust's history.

Based on the findings of our work, we have concluded that the Trust has adequate arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required to certify that we have completed the audit of the Trust financial statements in accordance with the requirements of the Code. If there are any circumstances under which we cannot issue a certificate, then we must report this to those charged with governance. No such circumstances exist.

Other Matters

We intend to issue an unqualified Group Audit Assurance Certificate to the NAO regarding the Whole of Government Accounts submission, made through the submission of the summarisation schedules to Monitor.

We have identified two prior year recommendations that require further action by management. We have made two recommendation as a result of our 2015/16 work. These recommendation relate to the completeness and accuracy of quality indicator data. All recommendations are shown in Appendix 1.

In auditing the accounts of an NHS body auditors must consider whether, in the public interest, they should make a report on any matters coming to their notice in the course of the audit, in order for it to be considered by Trust members or bought to the attention of the public; and whether the public interest requires any such matter to be made the subject of an immediate report rather than at completion of the audit. There are no matters that we wish to report.

KPMG

Financial Statements Audit

Financial Statements Audit

We audit your financial statements by undertaking the following tasks:

Work Performed	Accounts production stage		
	Before	During	After
1. Business Understanding: review your operations	✓	✓	–
2. Controls: assess the control framework	✓	–	–
3. Prepared by Client Request (PBC): issue our prepared by client request	✓	–	–
4. Accounting standards: agree the impact of any new accounting standards	✓	✓	–
5. Accounts Production: review the accounts production process	✓	✓	✓
6. Testing: test and confirm material or significant balances and disclosures	–	✓	✓
7. Representations and opinions: seek and provide representations before issuing our opinions	✓	✓	✓

We have completed the first six stages shown above and report our key findings below:

1. Business Understanding	In our 2015/16 audit plan we assessed your operations to identify significant issues that might have a financial statements consequence. We confirmed this risk assessment as part of our audit work. We have provided an update on each of the risks identified later in this section.
2. Assessment of the control environment	We have assessed the effectiveness of your key financial system controls that prevent and detect material fraud and error. We found that the financial controls on which we seek to place reliance are operating effectively. We have reviewed the work undertaken by TIAA, your internal auditors, in accordance with ISA610 and used the findings to inform and planning and audit approach.
3. Prepared by client request	We produced this document to summarise the working papers and evidence we ask you to collate as part of the preparation of the financial statements. We discussed and tailored our request with Andy James (Financial Controller) and this was issued as a final document to the finance team. The documentation was completed to a very high standard and was ready for the first day of our audit which enabled a smooth and efficient audit process.

Financial Statements Audit

4. Accounting standards	We work with you to understand the changes to accounting standard and other technical issues. For 2015/16 these changes have related to: • IFRS 13 (Fair Value Accounting) – no impact on the Trust in 2015/16; • Disclosing the cost of PFI schemes in the summarisation schedules – required the Trust to analyse the unitary payment of PFI schemes in the FTCs; • Disclosing operating expenditure and salaries in excess of the Prime Minister – required the Trust to disclose internal audit fees and the salaries of certain individuals in the Annual Report.
5. Accounts Production	We received complete draft accounts by 22 April 2016 in accordance with Monitor's deadline. The accounting policies, accounting estimates and financial statement disclosures are in line with the requirements of Monitor. As in previous years, we will debrief the Finance team to share views on the final accounts audit. Hopefully this will lead to further efficiencies in the 2016/17 audit process. In particularly we would like to commend the Trust finance staff who were available throughout the audit visit to answer our queries and thank them for their co-operation throughout the visit which allowed the audit to progress and complete within the allocated timeframe.
6. Testing	We have summarised the findings from our testing of significant risks and areas of judgement within the financial statements on the following pages. During the audit we identified one unadjusted audit difference in relation to partially completed spells (see Appendix 2) and minor presentational issues which have been adjusted as they have no material effect on the financial statements.
7. Represent-ations	You are required to provide us with representations on specific matters such as your going concern assertion and whether the transactions in the accounts are legal and unaffected by fraud. We provided a draft of this representation letter to the Director of Finance and Procurement on 18 May 2016. We draw your attention to the requirement in our representation letter for you to confirm to us that you have disclosed all relevant related parties to us.

We are required under ISA 260 to communicate to you any matters specifically required by other auditing standards to be communicated to those charged with governance; and any other audit matters of governance interest. As the Trust is required to comply with elements of the UK Corporate Governance Code through the Foundation Trust Code of Governance, ISA 260 (16-1) also requires us to communicate to you any information that we believe is relevant to understanding our rationale and the supporting evidence for the exercise of our professional judgement. This includes our view of: Business risks relevant to the financial reporting objectives, the application of materiality and the impact of our judgements on these areas for the overall audit strategy and audit plan; significant accounting policies; management's valuations of the Trust's material asset and liabilities and the related disclosures; the quality of management's assessment of the effectiveness of the system of internal control included in the AGS; and any other matters identified during the course of the audit. We have not identified any other matters to specifically report.

To ensure that we have provided a comprehensive summary of our work, we have over the next pages set out:

- The results of the procedures we performed over valuation of land and buildings and recognition of NHS and non-NHS income which were identified as significant risks within our audit plan and which will form a part of our audit opinion;
- The results of our procedures to review the required risks of the fraudulent risk of revenue recognition and management override of control; and
- Our view of the level of prudence you have applied to key balances within your financial statements

Financial Statements Audit

SIGNIFICANT audit risk	Account balances affected	Summary of findings
Valuation of land and buildings	Land and buildings have a carrying value of £107m (2015: £110m).	We have undertaken the following work over the valuation, existence, ownership, completeness and accuracy of material fixed asset balances: • We assessed the qualifications, expertise and objectivity of the external valuer (Cushman and Wakefield) and noted no issues; • We considered the terms of engagement of the valuer and the instructions provided to the valuer. We did not identify any issues; • We agreed the appropriateness of any amendments made by management to the information received from the valuer before incorporation into the financial statements; and • We undertook work to understand the basis upon which any revaluations to land and buildings have been recognised in the financial statements and determined whether they complied with the requirements of the ARM. No issues were identified.
Recognition of NHS and non-NHS income	Total operating income in year was £205m (2015: £204m). This included operating income from patient care activities of £182m (2015: £182m) and other operating income of £23m (2015: £22m).	We have focused on the recognition of NHS income and our testing has considered the completeness, existence and accuracy of the balances recorded within the financial statements: • We agreed commissioner income of £155m (86% of income from patient care activities) to signed contracts with third parties. We selected a sample of four commissioner contracts (income of £166m) for more detailed testing and agreed the breakdown of income to supporting documentation. These four contracts accounted for 91% of income from patient care activities. We reviewed material variations and documented the explanations and supporting evidence. We did not identify any material issues; • We confirmed that the Trust was not in formal dispute or arbitration in relation to any material balances through enquiry with management and review of the Whole of Government Accounts exercise; • We inspected the third party confirmations from other NHS counter parties and compared the values disclosed by both parties in their respective financial statements through the English Agreement of Balances exercise (details of all disputed balances over £250k are outlined in Appendix 2); and • We considered the adequacy of the Trust's income disclosures. In accordance with prior years, the Trust does not account for partially completed spells. We did not identify any issues with the completeness or existence of income.

Financial Statements Audit

Risks that ISAs require us to assess in all cases	Why	Our findings from the audit
Fraud risk from revenue recognition	Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk. We recognise that the incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk. These incentives in the NHS include the requirement to meet regulatory and financial covenants, rather than broader financial reporting or share based management concerns.	Other incentives that should be considered for the Trust are the desire to avoid regulatory attention or to mask financial errors or irregularities which could be seen to apply in a public sector context. We have classified recognition of NHS and non-NHS income as a significant audit risk for 2015/16 and have outlined on page 9 the audit work we have undertaken on this which fulfils our responsibilities for this risk.
Fraud risk from management override of controls	Professional standards require us to communicate the fraud risk from management override of controls as significant because management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We have not identified any specific additional risks of management override relating to this audit.	Our procedures, including testing of journal entries, accounting estimates and significant transaction outside the normal course of business, identified no instances of fraud.

Judgements in your financial statements

We always consider the level of prudence within key judgements in your financial statements. Given the communication of additional expectations to Foundation Trusts this year by NHS Improvement to specifically review the strength of their balance sheet we have summarised our view below using the following range of judgement:

Financial Statements Audit

We set out below our assessment of key subjective areas. These areas were highlighted by Monitor during spring 2016 as key areas for potential year end manipulation.

Assessment of subjective areas				
Asset/liability class	**Current year**	**Prior year**	**Balance (£m)**	**KPMG comment**
Provisions	3	3	£0.5m (PY:£0.9m)	The provisions balance is mostly attributable to injury benefits (£0.3m), legal claims (£0.1m) and pensions (£0.05m). The level of prudence is balanced.
Accruals	3	3	£0.4m (PY:£0.4m)	The Trust only apply genuine accruals as standard practice. The level of prudence is balanced.
Deferred income	2	2	£0m (PY:£0m)	The Trust only recognise deferred income where it is required to finance future expenditure. The level of prudence is balanced.
Injury cost recovery	3	3	£2.9m (PY:£3.0m)	The Trust apply the nationally prescribed percentage of 21.99%. The level of prudence is balanced.
Partially completed spells	2	2	£0m (PY:£0m)	This area was identified as an area for review by NHS Improvement in Spring 2016. The Trust's currently does not account for partially completed spells.
Debtors provisioning	3	3	£1.1m (PY: £0.9m)	The Trust have undertaken a detailed analysis of the historical recoverability of debt over ages and classes to determine a provision percentage for different classes of debt. These more refined percentages are applied to all other debt.
Assets (lives and valuations)	3	3	£107m (PY: £110m)	There was a full revaluation of assets at the Trust in 2015/16. The Trust uses the valuer's assessment to review asset lives annually. The level of prudence is balanced.

Financial Statements Audit

Annual report

We have read the contents of the Annual Report (including the Accountability Report, Performance Report and AGS) and audited the relevant parts of the Remuneration Report. Based on the work performed:

- We have not identified any inconsistencies between the contents of the Accountability, Performance and Director's Reports and the financial statements.
- We have not identified any material inconsistencies between the knowledge acquired during our audit and the director's statements. As Directors you confirm that you consider the that the annual report and accounts taken as a whole are fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.
- The part of the Remuneration Report that is required to be audited were all found to be materially accurate;
- The AGS is consistent with the financial statements and complies with relevant guidance subject to updates as outlined within section three; and
- The report of the Audit Committee included in the Annual Report is currently being reviewed by management to ensure that it appropriately addresses matters communicated by us to the Audit Committee, and meets guidance as set out in the ARM.

Independence and Objectivity

ISA 260 also requires us to make an annual declaration that we are in a position of sufficient independence and objectivity to act as your auditors, which we completed at planning and no further work or matters have arisen since then.

Audit Fees

Our fee for the audit was £53.5k (£53.5k in 2014/15). This fee was in line with that highlighted within our audit plan agreed by the Audit Committee in October 2015. Our fee for the external assurance on the quality report was £6.5k (£6.5k in 2014/15). We have not performed any non-audit work outside of that already disclosed to you as part of our audit planning, at which stage we also confirmed the safeguards put in place to preserve our audit independence.

KPMG

Value for Money

Section Three

Value for Money

From 2015/16 our value for money (VFM) work follows the NAO's new guidance. It is risk based and targets audit effort on the areas of greatest audit risk. Our methodology is summarised below. We did not identify any significant VFM risks and provide a summary below of the routine work required to issue our VFM conclusion, which is that we are satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2016.

AGS review	Regulatory review	Other matters considered in risk assessment
We reviewed the 2015/16 AGS and took into consideration the work of internal audit. We confirm that the AGS reflects our understanding of the Trust's operations and risk management arrangements.	We considered the outcomes of relevant regulatory reviews in reaching our conclusion. We reviewed the outcome of the Care Quality Commission inspection and we believe the Trust is making sufficient responses to the findings to ensure the issues raised will be appropriately addressed. We reviewed the Trust's current NHSI ratings, Financial sustainability risk rating (2, no evident concerns) and Governance rating (Green), and are satisfied that the Trust is responding appropriately to the ratings to make improvements.	As part of our risk assessment we reviewed various matters, including: • Recurrent cost improvement schemes are identified and delivered. • Current operational performance and commissioner relationships / contractual risks. • Management's assessment of the Trust's ability to continue as a going concern. • Partnership arrangements / relationships with key third parties. • Corporate risk registers. • Internal reports from the Trust and internal audit reports. We also considered the impact of the evidence we gathered as part of our Quality Report audit, particularly on the operation of the processes around the referral to treatment target. The issues identified in this area are not considered sufficient to result in any amendment to our value for money conclusion.

KPMG

Quality Accounts

Quality Accounts

Conclusion on content of quality account

Subject to carrying out our final checks to ensure you have reflected our comments in the quality report and reviewing changes made by the Trust after the date of this report, we are satisfied that there is sufficient evidence to provide a limited assurance opinion on the content of the quality report.

Work performed and findings

We consider two criteria:

- Review of content to ensure it addresses the requirements set out in the ARM; and
- Review of content in the quality report for consistency with other information specified by Monitor.

Our findings are set out below:

Issue considered	Findings
Inclusion of all mandated content	The content of the quality report presented for audit was accurately reported in line with the quality report regulations. As with previous years, we have found your quality report to be well written and easy to read.
Are significant matters in the specified information sources reflected in the quality report and significant assertions in the quality report supported by the specified information sources?	We identified that the Trust's quality report reflected its significant matters, relevant to the selected priorities from the specified information sources. • Significant assertions in the quality report are supported by the relevant information sources and • Significant assertions in the draft of the quality report were supported by the specified information sources,

Quality Accounts

Audit of indicators within the quality account

We carried out work on two mandated indicators, which require a public opinion, chosen by the Trust from a list of three available indicators as specified by the Monitor in its guidance:

- Referral to treatment within 18 weeks for patients on incomplete pathway; and
- A&E four-hour wait.

In addition, we carried out work on a locally selected indicator chosen by your Council of Governors. The indicator selected was falls resulting in serious harm or fracture. This indicator is not subject to a limited assurance opinion.

Conclusion

Our work on the two mandated indicators has concluded that there is sufficient evidence to provide a limited assurance opinion in respect of *A&E four-hour wait*. We are not able to provide a limited assurance opinion for *Referral to treatment within 18 weeks for patients on incomplete pathway* because there were a number of variances identified between data record and the underlying source. For the local indicators, falls resulting in serious harm or fracture, we have concluded that if required we would be in a position to provide a limited assurance opinion (save for the inherent limitations regarding underlying clinical judgement and completeness of data) (however as the local indicator this is not required).

Please note that the extent of the procedures performed is reduced for limited assurance. The nature of the procedures may be different and less challenging than those used for reasonable assurance. Therefore, our work was not a reasonable assurance audit of either the performance indicators or the processes used to collate and report them.

Results of our work

We have set out overleaf the key findings from our work as described above in relation to the two mandated indicators and the locally selected indicator. In reaching our conclusions we are required to have assessed the design and operation of the systems of control over the data against the six data quality dimensions defined by the NAO. In reaching our conclusion we have assessed these arrangements to consider whether they can be graded as:

- **Green**: No improvement to achieve compliance with the dimensions of data quality noted.
- **Amber**: Opportunities to achieve greater efficiency or better control in compliance with the dimensions of data quality noted.
- **Red**: Concern that systems will not achieve compliance with one or more aspects of the dimensions of data quality and therefore a limited assurance opinion cannot be provided.

Quality Accounts

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	**Design**	**Operation**	**Commentary on ratings**		
Mandated Indicator: Referral to treatment within 18 weeks for patients on incomplete pathway Performance target: 92% Performance recorded in Quality Account: 94.0% (Q1 – Q4 Arithmetic Average)					
Accuracy	● Amber	● Red	**Is accurate data used and reported?** Validation activities are carried out on an ongoing basis to ensure that reported data reflects actual activity. However, we note that limitations of human error amongst staff can lead to pathways being incorrectly coded as RTT applicable.	A patient level breakdown of incomplete pathways as reported on a monthly basis was obtained from the Trust and from this a sample of 30 patients were selected for testing. The clock start date was agreed to underlying documentation and the patient notes were scanned for contradictory evidence which may suggest that the pathway was closed at the reporting date. The number of weeks waiting was recalculated and reconciled to the patient level data submitted on a monthly basis. It was identified that for May 2015, February 2016 and March 2016 the % submitted could not be agreed to underlying records.	As a result of the procedures performed, it is not possible to provide a clean limited assurance opinion over this indicator as we have not been able to gain assurance over the six dimensions of data quality as required by Monitor.
Completeness	● Amber	● Amber	**How is completeness ensured?** The Trust uses PAS for all sites and clinics from which Trust services are delivered. The clock start takes place on the receipt of the referral letter from the GPs. There are monthly internal validation procedures intended to identify instances where patients have not been correctly coded or included on the RTT pathway.		
Relevance	● Green	● Green	**Is the information relevant for the reported purpose?** The calculation has been performed in accordance with the guidance laid out by the Department of Health and is therefore considered relevant.		
Reliability	● Amber	● Amber	**Is the information reported reliable insofar as it agrees to data source(s)?** The clock start and clock stop applied throughout the year has not been consistent. The main problem is with interpretation of clock start and clock stop dates by staff. Further training is required.		

Quality Accounts

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	Design	Operation	Commentary on ratings		
Timeliness	● Green	● Green	**Is real-time data used and is it reported on a timely basis?** Performance against the target is reported by the Trust on a monthly basis. The performance reported in the quality report is the arithmetic average of the monthly performance for the full financial year.	As part of this review we identified the following issues: 1. For three patients included within our sample, we identified that the patients were in receipt of ongoing treatment and therefore should not have appeared on the incomplete listing. The patients had therefore not been identified by the validation procedures and had been incorrectly included within the reported quality indicator value. 2. For eight patients, we were unable to agree the clock start dates to patient files. 3. For nine patients there were discrepancies between the clock start date and the referral letter or clinic attendance.	See page 18.
Validity	● Green	● Green	**What checks are performed to ensure that the data is valid?** A number of checks are performed over data validity during the course of the month, as well as specific procedures being performed over the monthly submission. These procedures are designed to ensure the pathway is appropriately recorded. The Trust have training in place to ensure individuals across the Trust are using the relevant systems appropriately.		
Overall	● Amber	● Red	**Appropriate arrangements in place to ensure the quality of data for this indicator?** Following significant issues highlighted in 2014/15 the Trust is making progress in redesigning the process to ensure the data are captured accurately and with a high standard. However, some of these new processes were not implemented until July 2015 and this has been reflected in the results of our testing. It is acknowledged that the issues identified from our sample testing were more prominent in the period up to July 2015, albeit errors were still identified in the period after this. As a result of the findings from the testing performed, it is not possible to provide a limited assurance opinion over this indicator as we have not been able to gain assurance over the six dimensions of data quality.		

Quality Accounts

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	**Design**	**Operation**	**Commentary on ratings**		
Mandated Indicator: A&E four-hour wait Performance target: 95% Performance recorded in Quality Account: 94.85% (Q1 – 4 Arithmetic Average)					
Accuracy	● Green	● Green	**Is accurate data used and reported?** The data is extracted from Symphony on a daily basis. Based on the coding set by informatics and they are converted into meaningful statistics. The data is sent to the Trust senior management, who then send updates to the Board and Department of Health on a monthly basis and to Monitor on a quarterly basis. There was one issue identified where the data was not accurate due to the time the patient left the department being subsequently amended, on extension of our sample no further issues were noted.	A patient level breakdown of A&E wait times as reported on a monthly basis was obtained from the Trust and from this a sample of 30 patients were selected for testing. The clock start and clock end time were both agreed to the underlying system which records all the data. The waiting time was recalculated and compared to the scanned records for accuracy.	We have not comes across any indications that data for this indicator is not produced in line with national guidance.
Completeness	● Green	● Green	**How is completeness ensured?** All patients admitted at the Trust are entered on Symphony with their movements and treatment throughout the Trust, including admission and discharge being recorded on this system.		
Relevance	● Green	● Green	**Is the information relevant for the reported purpose?** The Trust applies the nationally mandated A&E 4-hour wait definition. The calculation has been performed in accordance with the guidance.		
Reliability	● Green	● Green	**Is the information reported reliable insofar as it agrees to data source(s)?** Staff recording the clock start and clock stop dates have been trained. Each patient who has entered the A&E 4-hour pathway is closely monitored in Symphony.		

Quality Accounts

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	**Design**	**Operation**	**Commentary on ratings**		
Mandated Indicator: A&E four-hour wait Performance target: 95% Performance recorded in Quality Account: 94.85% (Q1 – 4 Arithmetic Average)					
Timeliness	● Green	● Green	**Is real-time data used and is it reported on a timely basis?** Clock start data is captured at the time of arrival and recorded on the system. Clock stops are recorded at the time of discharge from the Emergency Department, although these can be recorded in retrospect where time does not permit data recording. These are all real time data and being monitored real time.	See page 20	See page 20
Validity	● Green	● Green	**What checks are performed to ensure that the data is valid?** Validations occur on a daily basis throughout the week and on Mondays for the data from the week end. This is because some patients classified as a breach of 4-hour may have been treated under 4 hours according to national guidance, but were recorded differently. These would be manually adjusted and validated before data submission.		
Overall	● Green	● Green	**Appropriate arrangements in place to ensure the quality of data for this indicator?** We have not comes across any indications that data for this indicator is not produced in line with national guidance.		

Quality Accounts

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	Design	Operation	Commentary on ratings		
Local Indicator: Falls resulting in serious harm or fracture Performance recorded in Quality Account: 23					
Accuracy	● Amber	● Amber	**Is accurate data used and reported?** All falls are recorded in datix, for serious falls resulting in harm or fracture these are investigated. There was nothing that came to our attention during our testing that indicated that the data was not accurate.	We tested a sample of 25 falls including some serious and some 'no harm' falls to confirm that there was evidence of the fall recorded in he patient notes and that all falls resulting in serious harm or fracture had been investigated and reported on STEIS in line with national guidelines.	Apart from the inherent limitations over the clinical judgement involved in determining whether a serious fall results in harm or fracture, and over the completeness of the data recorded, we have not come across any indications that data for this indicator is not produced in line with national guidance.
Completeness	n/a	n/a	**How is completeness ensured?** It is not possible to test the completeness over the data.		
Relevance	● Green	● Green	**Is the information relevant for the reported purpose?** The risk management team investigate all serious falls and therefore this confirms that the fall is correctly recorded as a fall resulting in serious harm or fracture.		
Reliability	● Green	● Green	**Is the information reported reliable insofar as it agrees to data source?** The data provided comes directly from Datix and agrees to underlying records.		
Timeliness	● Green	● Green	**Is real-time data used and is it reported on a timely basis**? Falls are reported as and when they occur and falls resulting in serious harm or fracture are investigated on a timely basis.		
Validity	● Green	● Green	**What checks are performed to ensure that the data is valid**? The data is validated by the risk management team and an RCA for all serious incidents is performed to ensure that the injury or harm resulted from the fall itself and therefore that it is correct to be recorded as a serious harm or fracture fall.		
Overall	● Amber	● Amber	**Appropriate arrangements in place to ensure the quality of data for this indicator?** The data quality is monitored by the risk management team.		

KPMG

Appendices

Appendix 1

Recommendations raised and followed up

There are no new recommendations coming out of our work in 2015/16, however we have followed up on the recommendations from the previous years audit, in summary:

Priority rating for recommendations					
1	Priority one: issues that are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.	2	Priority two: issues that have an important effect on internal controls but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system.	3	Priority three: issues that would, if corrected, improve the internal control in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them.

Total number of recommendations	Number of recommendations implemented	Number outstanding (repeated below):
6	2	4

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date	Current Status (May 2016)
Financial Statements				
1	3	**Payroll leavers** In the prior year for two of the sample of 25 leavers we noted that payroll were notified that the member of staff had left and their contract was terminated. However their employee number remained active and they continued to work. Both instances were with bank staff. We recommended that employee numbers were closed by HR when an employee is deemed to have left and their contracts terminated.	Andy James (Financial Controller)	**Implemented** We have not identified any further issues as part of our testing in 2015/16.
2	3	**Bank hours in WTE** During our review on the monthly WTE we noticed an increase from August 2014. This was due to the WTE of the bank hours worked being added in from this point. The Trust noted that this was due to a specific issue, with the difference reported clearly within the workforce analysis report. The result was a WTE figure that was inconsistent throughout the year and with the prior year basis. We recommend that the Trust adapted a consistent basis for measuring headcount across the year and consider updating the current and prior year balance to disclose WTE consistently throughout the both periods.	Andy James (Financial Controller)	**Implemented** We have not identified this as an issue in 2015/16.

Appendix 1

Recommendations raised and followed up

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date	Current Status (May 2016)
Financial statements				
3	3	**Approval of Instructions to the valuer** We have noted that no committee within the Trust reviews and approves the instructions issued to the valuer in relation to the revaluation of PPE. We also noted that details of changes made to Trust assets in the period were not formally communicated to the district valuer in order to be used with the review. As the revaluation can have significant impact on the surplus for the period the Trust needs to ensure that these instructions are robust and appropriate. To ensure the instructions provided are robust, a relevant sub-committee of the board should formally approve the instructions prior to these being issued to the district valuer.	Andy James (Financial Controller)	**Not implemented** In the current year the valuer changed to Cushman and Wakefield. It was noted that the valuation instructions were not formally approved.
4	3	**Segmental Reporting** We noted that the Trust did not report by detailed operating segments in the financial statements in the prior year and preceding year financial statements. The risk is that the Trust is not reporting in line with Monitor guidance issued in the Annual Reporting Manual or the requirements of IFRS8. It is recommended that the Trust discloses results by segment in order to ensure that the Trust is in compliance with the ARM and IFRS8.	Andy James (Financial Controller)	**Not implemented** The Trust continues to report under 'healthcare'.

Appendix 1

Recommendations raised and followed up

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date	Current Status (May 2016)
Financial statements				
5	1	**Completeness and accuracy of quality indicator data** As part of our testing of the percentage of referral to treatment within 18 weeks for patients on incomplete pathways indicator, we identified three instances where the patient was in receipt of ongoing treatment and therefore the patient was incorrectly included on the incompletes list for that period. In all three cases, the waiting time did not exceed 18 weeks and therefore the existing validations did not identify these. The Trust should ensure there is a procedure to sample check a selection of cases with waiting times below the breach mark in addition to the full validation of 18 weeks plus waits to include identifying those patients in receipt of ongoing treatment that are included within the data set. Linked to this recommendation we identified that where validation adjustments are identified as part of the routine monthly data processes, the Trust does not retrospectively adjust the value previously reported. The guidance issues by Monitor, in February 2015, requires the Trust to report an arithmetical average figure for the year in relation to this indicator. Given the live nature of the data systems for capturing RTT data it is not possible to apply the adjustments in all reported months, so assurance cannot be provided over the figure stated in the quality report. Should the indicator continue to be reported in this way for future periods, we will need to develop an audit or documentation retention methodology which allows retrospective review of pathway records throughout the 2015-16 period.	Laurence Arnold (Director of Corporate Development) Given the high bar that is set for this indicator, the huge number of members of staff who interact with every waiting list entry and the large number of data items involved. We believe that the data is not perfect, but the actual material difference that this makes to patient care is relatively small and we have other priorities which will make a material difference. We do not disagree with the recommendations you are making, but remain unconvinced that this would not prevent exactly the same outcome in 12 months time.	**Partially implemented** We noted as part of our testing that there have been improvements in the process since July 2015 with only 4 out of 14 cases with errors identified being after July 2015.
6	1	**Agreement of underlying patient data to support quality indicators** From a sample of 30 patients selected for testing the percentage of referral to treatment within 18 weeks for patients on incomplete pathways indicator, we were unable to agree the clock start dates to patient files in 5 cases.	Laurence Arnold (Director of Corporate Development) See above.	**Not implemented** It was noted as part of our work in the current period that evidence is not retained on file for all RTT referral dates.

Appendix 2

Audit Differences

Unadjusted audit differences

Under UK auditing standards (ISA (UK&I) 260) we are required to provide the Audit Committee with a summary of unadjusted audit differences (including disclosure misstatements) identified during the course of our audit, other than those which are 'clearly trivial', which are not reflected in the financial statements. In line with ISA (UK&I) 450 we request that you correct uncorrected misstatements. However, they will have no effect on the opinion in our auditor's report, individually or in aggregate. As communicated previously with the Audit Committee, details of all adjustments greater than £200K will be disclosed.

There is one unadjusted audit difference as follows;

Unadjusted audit differences				
No.	Detail	SOCI Dr/(cr)	SOFP Dr/(cr)	Comments
1	Dr Income Dr Accrued income Cr Retained Earnings	£332 - -	- £396,867 (£397,199)	This relates to partially completed spells which the Trust does not account for at year end.
Total		£332	£(332)	

Adjusted audit differences

Under UK auditing standards (ISA UK&I 260) we are required to provide the Audit Committee with a summary of adjusted audit differences (including disclosures) identified during the course of our audit.

We are pleased to report that there were no adjusted audit differences, although one minor amendment to the accounting policies has been made.

Appendix 2

Audit Differences

Presentational issues

We identified a number of minor presentational issues during our audit and these have been amended by the Trust.

Agreement of balances

We are required to report any inconsistencies greater than £250,000 between the signed audited accounts and the consolidation data and details of any unadjusted errors or uncertainties in the data provided for intra-group and intra-government balances and transactions regardless of whether a Trust is a sampled or non-sampled component. We have provided details of the inconsistencies that we are reporting to the NAO as follows:

Counter party	Type of balance	Balance as per Trust (£'000)	Balance as per counter party (£'000)	Difference (£'000)	Comments on Difference
Great Western NHS Foundation Trust	Income	£559	£0	£559	SFT have requested confirmation from counter party but the difference has not been resolved as at the date of this report.

Appendix Three

Audit Independence

The purpose of this Appendix is to communicate all significant facts and matters that bear on KPMG LLP's independence and objectivity and to inform you of the requirements of *ISA 260 (UK and Ireland) Communication of Audit Matters to Those Charged with Governance.*

Integrity, objectivity and independence

We are required to communicate to you in writing at least annually all significant facts and matters, including those related to the provision of non-audit services and the safeguards put in place that, in our professional judgement, may reasonably be thought to bear on KPMG LLP's independence and the objectivity of the Engagement Lead and the audit team.

We have considered the fees paid to us by the Trust for professional services provided by us during the reporting period. We are satisfied that our general procedures support our independence and objectivity.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP Audit Partners and staff annually confirm their compliance with our Ethics and Independence Manual including in particular that they have no prohibited shareholdings.

Our Ethics and Independence Manual is fully consistent with the requirements of the Ethical Standards issued by the UK Auditing Practices Board. As a result we have underlying safeguards in place to maintain independence through: Instilling professional values, Communications, Internal accountability, Risk management and Independent reviews.

We would be happy to discuss any of these aspects of our procedures in more detail. There are no other matters that, in our professional judgement, bear on our independence which need to be disclosed to the Board of Governors.

Audit matters

We are required to comply with *ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance* when carrying out the audit of the accounts.

ISA 260 requires that we consider the following audit matters and formally communicate them to those charged with governance:

- Relationships that may bear on the firm's independence and the integrity and objectivity of the audit engagement lead and audit staff.
- The general approach and overall scope of the audit, including any expected limitations thereon, or any additional requirements.
- The selection of, or changes in, significant accounting policies and practices that have, or could have, a material effect on the Trust's financial statements.
- The potential effect on the financial statements of any material risks and exposures, such as pending litigation, that are required to be disclosed in the financial statements.
- Audit adjustments, whether or not recorded by the entity that have, or could have, a material effect on the Trust's financial statements.

Appendix Three

Audit Independence

- Material uncertainties related to event and conditions that may cast significant doubt on the Trust's ability to continue as a going concern.
- Disagreements with management about matters that, individually or in aggregate, could be significant to the Trust's financial statements or the auditor's report. These communications include consideration of whether the matter has, or has not, been resolved and the significance of the matter.
- Expected modifications to the auditor's report.
- Other matters warranting attention by those charged with governance, such as material weaknesses in internal control, questions regarding management integrity, and fraud involving management.
- Any other matters agreed upon in the terms of the audit engagement.

We continue to discharge these responsibilities through our attendance at Audit Committees, commentary and reporting and, in the case of uncorrected misstatements, through our request for management representations.

Auditor Declaration

In relation to the audit of the financial statements of the Trust for the financial year ending 31 March 2016, we confirm that there were no relationships between KPMG LLP and the Trust, its directors and senior management and its affiliates that we consider may reasonably be thought to bear on the objectivity and independence of the audit engagement lead and audit staff. We also confirm that we have complied with Ethical Standards in relation to independence and objectivity.