Salisbury NHS Foundation Trust

Trust Board Meeting in Public

Monday 2 October 2017

1.30pm – 4.00 pm

Board Room, Salisbury Foundation Trust

Timings	Agenda		SFT ref	Presenter	Page
1:30 pm	**1.**	Apologies and Declarations of Interest:/ Fit & Proper/ Good Character			
	2.	Chairman's Business		NM	verbal
	3.	Minutes of the Trust Board meeting held on 7 August 2017		NM/Enc	1
	4.	Action Log and Matters Arising		NM/Enc	13
	5.	Chief Executive's Report	SFT3929	CC-B/Enc	15
1:45 pm	**Assurance and Reports of Committees**				
	6.	Audit Committee Report – 18 September 2017	SFT3930	PK/Enc	21
	7.	Workforce Committee Report – 25 September 2017	SFT3931	KM/Enc	25
	8.	Clinical Governance Committee Report – 28 September 2017	SFT3932	JR/MM/Enc	27
	9.	Finance & Performance Committee Report- 29 August & 25 September 2017	SFT3933	NM/Enc	31
	10.	Integrated Performance Report (Month 5)	SFT3934	LA/Enc	35
		• Operational Performance			41
		• Quality Indicator Report			45
		• Workforce Report			53
		• Finance Report			79
2.45 pm	**Quality and Risk**				
	11.	Customer Care Report – Quarter 1	SFT3935	LW/Enc	89
	12.	JBD Minutes evidencing presentation of Assurance Framework and Risk Register	SFT3936	CC-B/Enc	103
	13.	Risk Management Strategy 2017/18	SFT3937	LW/Enc	105

	14.	Risk Management Annual Report 2016/17	SFT3938	LW/Enc	123
	15.	Clinical Governance Annual Report	SFT3939	CB/LW/Enc	135
3.15 pm	**Strategy and Development**				
	16.	Major Projects Report	SFT3940	LA/Enc	143
	17.	Capital Development Report	SFT3941	LA/Enc	153
	18.	Update on Trust Strategy	-	LA	-
3.30 pm	**Performance and Finance**				
	19.	Auditor Management Letter	SFT3942	CC-B/Enc	163
3.45 pm	**Minutes – for information**				
	20.	Clinical Governance Committee – 27 July 2017	SFT3943	JR/MM/Enc	171
	21.	Finance and Performance Committee – 26 June, 24 July and 29 August 2017	SFT3944	NM/Enc	179
3:50 pm	**Closing Business**				
	22.	Any Other Business			
	23.	**Date of Next Meeting** 4 December 2017 at 1.30 pm			

Minutes of the Trust Board Part I meeting held on
7 August in the Boardroom at Salisbury District Hospital

Board Members Present:

Dr N Marsden	Chairman
Mr M von Bertele	Non-Executive Director
Mr M Cassells	Director of Finance and Procurement
Mrs C Charles-Barks	Chief Executive
Mr P Hargreaves	Director of People and Organisational Development
Mr A Hyett	Chief Operating Officer
Mr P Kemp	Non-Executive Director
Dr M Marsh	Non-Executive Director
Mrs K Matthews	Non-Executive Director
Prof J Reid	Non-Executive Director
Ms L Wilkinson	Director of Nursing

Corporate Directors Present:

Mr L Arnold	Director of Corporate Development
Mrs L Thomas	Director of Finance (Designate)

In Attendance:

Sir R Jack	Lead Governor
Dr A Lack	Public Governor
Mr P Butler	Head of Communications
Miss S Hayland	Anaesthetics STS
Mrs P Permalloo-Bass	Head of Equality and Diversity (for item SFT3916)
Miss S Davies	Clinical Director (for item SFT3917)
Mr D Seabrooke	Secretary to the Board

Apologies:

Ms T Baker	Non-Executive Director
Dr C Blanshard	Medical Director

ACTION

2303/00 DECLARATIONS OF INTEREST AND FIT AND PROPER/GOOD CHARACTER

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

2304/00 WELCOME

The Chairman welcomed the newly appointed Director of People and Organisational Development, Paul Hargreaves to his first Public Board meeting. He welcomed Lisa Thomas currently Director of Finance (Designate) to the meeting – she would be assuming the role of Director of Finance from 1 September.

ACTION

2305/00 MINUTES - 5 JUNE 2017

The minutes of the meeting of the Public Board held on 5 June 2017 were agreed as a correct record.

2306/00 MATTERS ARISING

2283/01 – Workforce Performance Report – LW informed the Board that there continued to be developments on the nurse training agenda.

The action in relation to the Chief Executive's report to the June Board had been completed.

2307/00 REPORT OF THE CHIEF EXECUTIVE – SFT 3908 – PRESENTED BY CC-B

The Board received the Chief Executive's report.

It was noted that the Bath and North East Somerset, Swindon and Wiltshire Sustainability and Transformation Partnership had received a rating from NHS England of Advanced.

Cara Charles-Barks highlighted the joint venture co-owned with Great Western hospitals and Royal United Hospital Bath in relation to Wiltshire Health and Care which had recently undergone a CQC inspection. The Trust continued to learn from other providers and the developments in the CQC's inspection process were highlighted including a return to unannounced inspections for the core clinical areas.

On performance Cara Charles-Barks highlighted an improvement in the number of systems and processes that had seen a steady improvement in waiting times and in the four hour wait in Accident and Emergency. She thanked the staff for all their hard work and commitment in this area.

She highlighted the financial challenge for 2017/18 which was a further £8.5m savings requirement to lead to a year end deficit of £7m for the Trust. This included £6.5m of planned savings made by the Trust's directorates and a further £2m of strategic savings. A financial recovery plan was being developed.

There continued to be national workforce challenges and Salisbury experienced these in a number of areas. The Trust was responding with a refreshed recruitment strategy and was reviewing its health and wellbeing support to existing staff.

Good progress was being made with implementation of the Trust planned site changes with ward moves taking place over recent months and the planned new build due in the autumn. Information and briefing for staff was continuing.

The Elevate Programme had received funding from Arts Council England to commission a theatre company to develop a show especially for children on Sarum Ward.

The Trust had been recertified for the information standard following an assessment by NHS England. This standard assures anyone who used information provided by the Trust of the quality of this.

Finally she reminded everyone of the staff BBQ taking place in the afternoon following the Board meeting as a further way to thank staff and acknowledging their efforts.

The Board received the Chief Executive's Report.

2308/00 INTEGRATED PERFORMANCE REPOT – SFT 3909 – PRESENTED BY LA

The Board received the Integrated Performance Report containing chapters devoted to workforce, quality, operational performance and finance for month 3, with an overview from the executive containing the very latest information available. This was the first time the report had been published and work to develop it was continuing.

Local Services

It was noted that there had been an improvement to patient flow with a decrease in green to go and delayed transfers of care. This supported the Trust's position in maintaining ED performance and linked to 18 weeks. There was concern about the reduced interventional radiology service which was provided by Southampton Hospital and this continued to be discussed. The service may increase in September but at present capacity and demand was not aligned.

Work on the Medical Assessment Unit at the Trust was starting and as noted in the Chief Executive's Report the modular build for Ophthalmology was expected to arrive later in August.

Some of the Trust's surgical activity had been outsourced to the private sector – in response to questions it was noted that this represented an opportunity cost rather than a financial loss. It was noted that Theatre efficiency and activity levels were being reviewed to ensure that there

was not unused capacity – filling theatre lists and outpatient clinic sessions was a priority.

Specialist Services

It was noted that waiting times had been improved for Diagnostic procedures and there had been a positive deanery visit for the Plastics service. There had been improvements made on the Spinal Unit. A national tender for Genomics Services was expected in November and it was understood that this was set to reduce the number of laboratories nationally. The Trust was discussing the positioning of bid with potential partners.

The Trust was developing a business case in support of the Spinal Unit to recognise the shortage of capacity in the South of England. The bid described what inputs were required to operate the service including changes to workforce, pathways and follow-up requirements.

Innovation

It was noted that the Salisbury Trading Limited were taking over other laundry sites based at hospitals. This was giving rise to some cash flow issues for the new business coming on stream. The Trust's payroll insourcing service had started to provide services for Southampton Hospital and additional HR services had been requested.

Good progress was being made with the arrangement with the SSL and the build was due to start in the autumn. The My Trusty product range was now being stocked by Lloyds Pharmacies and was going into more Tesco's stores. Grants had been applied for in support of the photo-voltaic cells proposed for the site. The Trust was working with its partner on the bed stacker initiative and the Trust would be making appointments to a new company board.

Care

It was noted that there was good performance on infection control and there had been no DSSA breaches (single sex accommodation) in four months. Although stroke performance had improved in quarter 1 the SSNAP assessment had been changed to a D.

Complaints were up somewhat in quarter 4 as a result of the extensive use of escalation accommodation. Falls were decreasing from a peak in 2016.

Work on Care Quality Commission inspection preparations was

continuing to engender a business as usual approach as a normal state of the hospital. The Trust Board's Safety Walkrounds had recently been redesigned.

The report mentioned that the mortality rate was above expected but in response to a question from Michael Marsh this was confined only to the HSMR (Hospital Standardised Mortality Rate). The Trust continued to promote a learning organisation and there was good engagement on mortality matters. These continued to be discussed in clinical governance half days and performance reviews.

Staffing

The Trust had good staff survey results. There was continued work on overseas nursing recruitment. The Trust had been recognised for its work on equality and diversity by NHS Employers. However the Trust continued to be challenged by staff vacancies in a number of areas. The staff survey had highlighted stress levels and additional hours worked. Because of vacancies, temporary staffing spend was up and work was underway with suppliers to address this. As noted in the Chief Executive's report work was underway to improve the Trust's approach to recruitment and retention. The Trust continued to track sickness particularly where there were hot spots where intensive support was being provided.

Effective

There had been some improvement to activity levels but this had been in part facilitated by outsourcing. The in-month deficit was at £1.2m which was due to the progress being made with the delivery of the Cost Improvement Programmes and reliance on income generation. There was a recovery plan being developed. This included grip and control, capacity utilisation, controlling agency use, estates and facilities, the developing of a long term financial model, the capacity and capability of the organisation and work around quality improvement and Save 7 to develop a single way of achieving improvements.

It was noted that the outsourcing activity was due to constraints on bed capacity and also MRI scanning requirements. The Trust continued to make full use of available capacity to fill its lists and clinics.

The report to the July Finance Committee had signalled an increase in activity which it was expected would be reflected in future iterations of this report. LA undertook to ensure that in transitioning the data warehouse that any duplicate data was properly destroyed. LA

ACTION

It was noted that there was not yet sufficient detailed data to look closely at the factors driving the cost of provision of services such as revisions, re-admissions and length of stay. MC explained however the Trust did benchmark well within the reference costs national scheme and the planned deficit of £7m was considered to be in line with the planned deficit for the NHS as a whole.

AH undertook to look in detail at the findings of the report issued recently by Professor Tim Briggs on clinical efficiency. AH

Partnership

The conversations about capacity held by the Trust's site team were being reflected forward to the Emergency Care Delivery Board. The debate on how does the system as a whole respond to delayed transfer of care experienced by the hospital was being developed. There was cultural change and an improvement in the Trust's engagement with the local authority around social care. The Older People's Board continued to review the pathways and there would be feedback on this to the next Board meeting. AH

In the Quality Report it was felt that the Trust needed a greater understanding of the operation of the Burns Service. Quarterly data was all that was available. It was felt that there needed to be greater signposting of issues not flagged in the reports. The Board was reminded however that the executive looked very critically at what was reported and that considerable work went into reporting to the Trust Board.

Finally it was noted that NHS Improvement were proposing changes to their reporting requirements under the SOP.

The Board received the Integrated Performance Report.

2309/00 REPORTS OF BOARD COMMITTEES

The Board received for information and presented by the respective chairs the minutes of the Clinical Governance Committee (approved) for 18 May and 22 June 2017 and the Finance and Performance Committee minutes (approved) for 30 May 2017. The Finance and Performance Committee had continued to discuss mismatches between operational and financial reports. A useful discussion had been held on Odstock Medical Limited around their three year plan.

The Draft minutes of the Audit Committee held on 19 May 2017were received, which had focused on the Annual Report and Accounts.

ACTION

It was noted that at Clinical Governance Committee a report on fire safety following the Grenfell Tower tragedy had been considered at the July meeting.

The Executive Workforce Committee had met on 31 July and the Chair of this had been handed from the Chief Executive to Kirsty Matthews with a view to the Board establishing a Workforce Committee in its place.

Arrangements for the production of a highlight report from Committees to the Board including points for escalation was continuing.

2310/00 PATIENT CARE

2310/01 Customer Care report – Quarter 4 – SFT 3913 – Presented by LW

The Board received the Customer Care Report for quarter 4. It was noted that the number of complaints was static and that there was good performance on acknowledgements of complaints within three days. There was some slippage on substantive responses to the required timescale. Hot spots had included the use of the Endoscopy area for inpatients during the period of escalation associated with quarter 4. There were also complaints around appointments and there were plans to improve this for outpatients. Patients were also involved in the design for the new Ophthalmology Unit.

A Parliamentary and Health Service Ombudsman Complaint had been upheld in respect of Urology.

The Board received the Customer Care Report.

2310/02 Skill Mix Review – SFT 3914 – Presented by LW

The Board received the Nursing and Midwifery Skill Mix Review six monthly update. It was noted that the national Quality Board were bringing out revised standards in this area which would entail an annual and mid-year review in future. Under the current approach the Directorate Senior Nurses, ward leaders and the Deputy Director of Nursing undertook the review process. The update covered inpatient wards, Maternity but not Paediatric and Spinal as these were all subject to separate reviews. The last review had been completed in December 2016 and information was given about performance during 2017.

In the discussion it was noted that the Trust was operating to a head room allowance of 19% which had previously been agreed by the Board. In response to questions from Paul Kemp the headroom allowance provided for 11–16% annual leave, 3% for sickness and 1% for study. The latter reflected the intake of newly qualified staff. There was no

specific allowance for parenting as this was centrally funded. Work continued to reduce the working day factor which was administration and other activities such as selection interviews.

The Skill Mix Review was not on this occasion requesting any further investment in the nursing establishment. The Board noted the analyses completed and the changes in the process described in the report and the continuing focus on recruitment and retention initiates. Following the ward reconfigurations taking place in summer 2017 the next Skill Mix report in December would reflect changes arising from this.

2311/00 PAPERS FOR NOTING OR APPROVAL

2311/01 Major Project Report – SFT3915 – Presented by LA

The Board received the Major Projects Report highlighting transformational projects including Electronic Patient Record and GS1, the Sterile Services Joint Venture continuing to deliver integrated adult community services in Wiltshire and a ward reconfiguration to improve the management of emergency and planned patients.

LA informed the board that there was good progress being made with system stabilisation following the implementation of the Lorenzo electronic patient records. Work continued with clinical areas supported by the supplier of Lorenzo, DXC. The Trust expected to cut over from the current warehouse to the replacement one in September. Mediation with the data warehouse supplier would be starting imminently. Appropriate steps to destroy any unused data in the outgoing warehouse would be taken. It was noted that the PTL was standing at around 18,500 and verification continued to reduce this to 15,000 to 16,000 by mid-September.

The Board received the Major Projects Report.

2311/02 Equality and Diversity and Inclusion Annual Report 2017 – SFT3916 – Presented by PH

The Board received the report and the Chairman welcomed the Head of Equality, Diversity and Inclusion, Pamela Permalloo-Bass.

The report reminded the Board of its obligation under the Equality Act 2010 to publish a range of monitoring information relating to workforce, patients and the local community. The EDI agenda was reviewed by the CQC as part of the Well Led domain and this was also reflected in commissioning contracts.

The gender difference in pay and pay grades was highlighted – the report indicated that the average salary for females was £28,000 and for males £37,000. The Chief Executive was the executive lead on the Workforce

ACTION

Race Equality Standard and the plan was to see a 5% reduction in reports of harassment and discrimination from black and minority ethnic staff. It was also the Trust's vision to have 10% black and minority ethnic staff at senior levels in the organisation. In preparation for the Sexual Orientation Standard in 2019 the Trust would be raising the awareness and supporting and promoting LGBT allies and the Rainbow Shed initiatives.

It was noted in a response to a question that the staff employed by the Trust's subsidiary companies was not included in the data.

It was agreed that there should be a Board development session at one of the development days. PHa

The Board received the Equality, Diversity and Inclusion Report.

2311/03 Revalidation – Annual Report – SFT 3917 – Presented by Sallie Davies

The Chairman welcomed Miss Davies to the meeting and the Board received the annual report on progress with the revalidation function carried on by the medical Director in her capacity as responsible officer. It was noted that there was a requirement for tighter management of appraisal dates and improving information on reasons for late appraisals for example sick leave or maternity leave. It was noted that the Trust had not so far escalated a doctor through the appraisal process. There was a good appraisal support system in place. A new lead appraiser had been appointed following a retirement. An assurance review taking a sample of 10% of completed appraisals had shown a generally good picture. There had been a peer review visit from NHS England.

Michael Marsh had been involved in an earlier internal evaluation of the scheme and had noted high engagement with the process but a large number of first line appraisers and insufficient case investigators. HR support to the Responsible Officer was being considered as part of work Paul Hargreaves was undertaking with regard to the HR Department.

It was noted that locums were linked to a separate Responsible Officer arranged by the agency deploying them.

The Board noted the report and agreed that it should be shared with the second level responsible officer, the Medical Director for NHS England South. The Board approved the statement of compliance confirming that the Trust as a Designated Body was in compliance with the regulations. DS

ACTION

2311/04 National in-patient survey – SFT 3918 – Presented by LW

The Board received the National In-Patient Survey report. The Trust had scored about the same as most other trusts in all eleven sections and better for two of these individual questions – confidence and trust in doctors and explanations of how operations or procedures had gone.

The Trust was developing means through its patient feedback to detect instances where patients were reporting that they felt uncertain about their procedure or what was happening in their treatment which was being piloted in two of the clinical areas.

In response to a question from Kirsty Matthews it was noted that the Trust had kept up with national trends in regard to its overall results. Patients individual comments tended to reflect the factors which were often lost during periods of escalation.

The Board received the National In-Patient Survey Report.

2311/05 Workforce Committee – SFT 3919 – Presented by PH

The Board agreed that a Workforce Committee would be formed and it was noted that the composition of this would be determined separately and that Terms of Reference would be approved at the October meeting of the Board.

2311/06 Council of Governors Draft Minutes – 17 July 2017 – SFT 3920

It was noted that the minutes of the Council of Governors would be circulated separately to the Board when they had been finalised.

2312/00 ANY OTHER URGENT BUSINESS

There was no urgent business.

2313/00 QUESTIONS FROM THE PUBLIC

There were no questions received.

ACTION

2314/00 MALCOLM CASSELLS

Directors joined the Chairman in acknowledging the exceptionally long service with the Trust and its predecessors accrued by Malcolm Cassells and also the support and drive he had brought to the Board during that time.

He thanked Malcolm Cassells for his contributions and wished him well in his retirement at the end of August.

2315/00 DATE OF NEXT MEETING

The next meeting of the Board would on Monday 2 October 2017, in the Boardroom at Salisbury District Hospital.

TRUST BOARD - 7 AUGUST 2017

ACTIONS

Part I		**responsible**	**Timescale**
Performance Report	Introduce reporting against bed stock and occupancy to reflect use of escalation	AH	Next report
Performance Report	NEDs to be appointed to new company board – bed stacker	LT/NM	
Performance Report	Follow up re data warehouse and destruction of data held by CACI	LA	Position clarified
Performance Report	Older People's Board – pathways review – feedback	AH	October Board
Facilities Presentation	Discussion re genetics to be scheduled for Board seminar	LA	Need to agree which seminar
	GIRFT presentation at Board Seminar and correlating opportunities for improving how we deliver our clinical services as effectively and efficiently as possible (as part of wider improving how we work)	CB	Need to agree which seminar
Skill mix	Finalise position re headroom investment for nursing to ensure it is reflective of required staffing requirements.	LW/LT	This will be provided in the skill mix review
CEO's report	Jeremy Hunt letter re Friends and Family Test result – circulate to trust board	DS	Completed

Report to:	Trust Board	**Agenda item:**	**SFT3929**
Date of Meeting:	2 October 2017		

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

Recommendation:
None

Executive Summary:
This report provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers: **Performance –** update on current performance **Financial Recovery –** update on our financial recovery plan **Workforce –** Update on workforce situation **Lorenzo** – Update on EPR system **Sustainability and Transformation Plans (STP) –** progress being made in our STP footprint **Site changes –** update on plans for the site changes we are making to improve the management of emergency and non-emergency patients next winter **Emergency Planning, Resilience and Response (EPRR)** – Trust compliance against standard **PLACE Assessment** – results of the Patient Led Assessment of the Care Environment (PLACE) **Seasonal flu campaign** – launch of staff flu vaccination campaign to protect patients and staff.

NHS Staff Survey 2017 – launch of this year's annual staff survey to gather staff views of working in Salisbury

Striving for Excellence Awards – launch of the Trust's staff awards, which are sponsored by the League of Friends this year.

Breastfeeding peer support - more support following an increase in breastfeeding peer support in hospital and the community

Staff achievements – staff do well in recent national awards

Performance

The trust has maintained good performance across a number of areas – achieving the standards required for cancer, diagnostics and waiting times. The trust had a challenging time with the emergency pathway in August, which saw us only seeing 91.4% of patients within 4 hours. Ensuring that we continue to deliver all required standards is a priority for the trust. We are working closely with the wider system to ensure that we are able to work together to ensure that we manage the expected increase in demand over winter. Nationally there is increased focus regarding delivery of the A&E target, and all trusts are attending forums with the Secretary of State to ensure that collectively the NHS and social care are working together to improve the experience for patients when attending our emergency services.

Financial Recovery

Following on from my last Chief Executive's update where I outlined the key elements of our financial recovery plan, our financial position for the year remains challenging. We have now launched the Outstanding Every Time Programme, which will address key aspects that need to be covered to deliver high quality services in the most cost effective way. Our programme will initially focus on theatres and this will look at how we can maximise throughput and efficiency for our patients. Over the next two months, we are developing the overall Transformation Programme, with a view to ensuring we have a sustainable financial plan going forward. We continue to be challenged and have taken steps to recover our position in year. Our financial recovery is a key priority for the Trust and will require focus and input across the entire organisation to return us to a long-term financially sustainable position.

Workforce

Like many trusts across the country we are challenged by our ability to recruit the staff we need to deliver our services. The Trust is undertaking a review of its recruitment processes in order to improve our "offer" to new staff and enable them to join us as soon as possible. Reducing our reliance on agency staff and attracting staff to work permanently at the Trust is a key priority for the executive team going forward.

Site changes update

We are at a very exciting stage in the redevelopment of the site, with the move of ophthalmology to a new purpose built outpatient department scheduled to take place on the 29 September, where it will then be fully operational. I and my board recognise that the entire project is having a significant impact on staff who are working hard to mitigate any impact on patients. The next key step will be when our Acute Medical Unit will move to a new layout on level 2 of the hospital at the beginning of December. Andy Hyett, Chief Operating Officer and Stuart Henderson, Clinical Director for Medicine gave a presentation on the changes at our Annual General Meeting, which was well received by the public. The site changes provide us with the opportunity to improve how we care for both our emergency and elective patients and are also an important part of ensuring that we deliver our key performance targets and sustainability in the future.

Lorenzo

It has been a year since we implemented Lorenzo and we acknowledge that the last year has been challenging for our staff, as we adjust to the new system. We will continue to work with our teams to make improvements to the way the system is working in local areas. The staff involved have worked tirelessly in what at times has been very difficult circumstances, so I would like to thank them for their patience and support. We will be running further open sessions for all staff in October, to ensure that we hear the views of our staff on the remaining issues and how we move the system forward.

Sustainability and Transformation Plans (STPs)

Over the past month, the B&NES, Swindon and Wiltshire STP has been refreshing its priorities to ensure that the benefits of working together are realised across all organisations. In addition to the work we are doing together on the workforce and sharing services, the STP has agreed that it will prioritize two clinical pathways going forward. These are mental health services and services for older people. I am pleased to report that the Trust and south Wiltshire will lead the work regarding older people and develop new ways of delivering services that will be implemented across the STP at a later date.

Emergency Planning, Resilience and Response (EPRR)

Under the Civil Contingencies Act we are a category one responder. As part of this, the Trust is required to have up to date policies and plans in place that are tested regularly for emergency situations. Wiltshire Clinical Commissioning Group, which has assessed us on behalf of NHS England, has recommended the Trust be rated as fully compliant against the national standards for emergency planning. The chemical incident exercise undertaken in 2017 was one of a number of tests we carry out throughout the year to ensure that our procedures work and that our staff are prepared to deal with a range of emergency situations. I want to use my report to thank our staff for their commitment to emergency planning and their professionalism and enthusiasm when taking part in essential training such as the exercise mentioned above.

Successful PLACE Assessment

I'm pleased to report that our patients have rated their overall experience of the hospital environment highly in the latest national report on the Patient Led Assessment of the Care Environment (PLACE). The aim of the PLACE inspection is to provide an assessment of how an organisation is performing against a range of non-clinical activities that impact on the patient experience of care. This includes cleanliness, the condition, appearance and maintenance of the hospital. It also covers other factors that support the delivery of care, such as privacy and dignity, environmental conditions for people who have a disability or dementia and the quality and availability of food and drink. The Trust was above the national average in five of the six areas covered, with cleanliness and food quality, in particular, rated highly by patients.

Seasonal flu campaign

We have a responsibility to protect our patients while they are with us in hospital and in early October we will be starting our staff seasonal flu campaign. While there will be a real focus to get staff in frontline roles vaccinated, the vaccine will be available for all Trust staff as it has been proven that comprehensive staff vaccination can help reduce the risk of flu spreading across patient areas and affecting vulnerable patient groups. It can also impact on staff sickness within the Trust. As part of our campaign we will be holding regular walk in clinics for staff. Flu nurses will tour wards and departments vaccinating staff and there will also be a number of trained peer vaccinators, making it easier for us to provide a more comprehensive programme that fits in with shift patterns. Information on this year's vaccine will also be available through the homepage of our Intranet and through our normal communication channels.

NHS Staff Survey 2017

In October, all staff will have an opportunity to complete the annual NHS staff survey. The survey highlights what we do well and, in previous years, staff have given a positive view of the hospital, the quality of care that they provide and the way in which we have looked to improve our engagement with them. The survey also gives staff an opportunity to highlight where we can make improvements to support them at work. For instance, in previous surveys we have improved on-site security, extended access to physiotherapy and psychological support, introduced Dignity at Work Ambassadors and expanded our health and wellbeing programme. The results of the survey will be published in the spring and any recommendations listed in the Trust's action plan will be monitored at Board level.

Striving for Excellence Awards

We have now launched our Striving for Excellence Awards, which this year is sponsored by the Salisbury Hospital League of Friends. The awards give our staff an opportunity to nominate colleagues in a range of categories that highlight our Trust values and recognise individual and team achievements. Members of the public can also nominate staff for a League of Friends Customer Care Award. This is for staff who have gone over and above what would normally be expected of them as part of

their role. Nominations will close on 30 November and the ceremony itself will take place at the Salisbury Racecourse on the afternoon and evening of Friday, 2 February 2018. In the meantime, I would personally like to thank the league of Friends for their ongoing support and their sponsorship of this year's award.

Increase in breastfeeding "peer support" for new mums

We are fully committed to increasing breastfeeding rates and support for women who need additional help to breastfeed, and new mums linked to our maternity services who need help to breastfeed can now get more support from other women following an increase in breastfeeding peer support in hospital and the community. Breastfeeding peer supporters now come into hospital regularly to talk to woman about their experiences of breastfeeding. As well as providing peer group sessions in Salisbury, Mere, Downton, Bulford, Wilton and Tisbury, the Salisbury team have set up new locations in Amesbury and Tidworth. Breastfeeding protects babies against a wide range of serious illnesses and can reduce the mother's risk of developing some cancers. Although over 80% of mothers start to breastfeed after birth, by 10 days this can drop by up to 30%. By expanding peer support in hospital and the number of locations where women can meet informally and share their experiences in the community, we hope to increase breastfeeding rates in women who could have difficulty in keeping breastfeeding going once they leave hospital.

SDH staff do well in national awards

I think it is important that we recognise the achievements of our staff and celebrate their success in local, regional and national awards. I want to congratulate our staff in the Procurement Department who have won a prestigious CIPS Supply Management Award. The awards are highly sought after within the procurement and supply chain industry and recognises the work of the department in improving procurement processes that support patient care, provide good value for money and deliver significant savings for the hospital. We are also doing well in other awards, with our Scan4Safety Programme shortlisted for a Health Service Journal (HSJ) Patient Safety Award. Nursing assistant Emma Ward has been nominated for the national Kate Granger Award for compassionate care. This is another achievement for Emma who has already been recognised nationally for an innovative new mouth care video which she developed here in Salisbury.

Cara Charles-Barks
Chief Executive

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	SFT3930
Date of Meeting:	2 October 2017		

Report Title:	Audit Committee		**Date:**	18 September 2017
Prepared by:	Paul Kemp			
Executive Sponsor (presenting):	Paul Kemp			
Appendices (list if applicable):	None			

Recommendation of items for escalation :
No items were raised that required escalation to the Board for action

At the Audit Committee meeting on the 18th September, the following items were discussed;

1. **Executive Summary**

   No items were raised in the meeting that required notification to or action at the Board.

2. **Deep dive review of 18 Week Administration (RTT)**

   Andy Hyett and three management team members attended to give a presentation of the process, the challenges inherent in managing it and management's approach to these challenges. This item had been requested, in part, in response to the external audit qualification of the annual audit of the area, which has occurred for each of the last three annual reporting periods.

   The presentation was comprehensive, covering both process issues and the patients experience of the process.

   The committee was satisfied that a number of process improvements had been made, in parallel with the implementation of the Lorenzo system, that tightened up on previous data inconsistencies. The team also described an improved and continuous regime of data validation that has been adopted that will also provide a subsequent quality check on the process.

3. **The annual review of the committee Terms of Reference**

   The main discussion regarding this item was in regard to the overall governance model of the Trust and what role of the Audit Committee should take in that overall scheme.

   The CEO explained to the committee that she was seeking to do a more comprehensive review of the overall governance processes of the Trust and that, separately, NHSI had indicated that a third party independent audit of governance would be required in the next financial year. *Note, this had been considered for the financial year 2016/17, but deferred with NHSI agreement in light of financial constraints*.

   A number of minor adjustments to the wording of the ToR were agreed as an interim measure, with an understanding that this document would need to be completely reviewed once any changes to the Trust governance framework were identified and agreed.

4. **The semi-annual review of the assurance framework**

   The processes for management of the current assurance framework was formally reviewed, as is required twice a year. However, it was noted that the next iteration of this document had already been informally discussed at the last Board seminar and that it was due for update and reissue in the near future.

   There was some discussion on the effectiveness and understandability of the high level risk registers presented to the three governance committees responsible for reviewing their content. In reviewing the documents as written, it was not possible, in the view of committee members, to properly understand what the risks were or the likely effectiveness of the

mitigating actions listed. This point was accepted by the Executive team members attending the meeting and further thought will be given to this as part of the overall BAF review process

5. **Regular update reports were received from external auditors, Internal auditors and Local Counter Fraud Officer**

   This was the first attendance at Audit Committee for BDO, our new external auditors.

   No major issues arose from these reports

6. **Any Other Business**

   The committee discussed what items should be put forward for future deep dive reviews. It was agreed that a brief will be worked up over the next few days for a review of the Lorenzo/Data Warehouse project, for presentation at December's Audit Committee. Other areas for consideration in the first half of next year were agreed as

   - How assurance can be provided around the processes to manage risks in cyber security
   - A non-financial item from the high risk area of the Trust risk register, such as capacity management.

   The possibility of seeking a deep dive review of the high level operational/financial planning process was also discussed, but it was thought that this might be better addressed in an appropriately timed Board seminar session.

Report to:	Trust Board	**Agenda item:**	SFT**3931**
Date of Meeting:	2nd October 2017		

Report Title:	Workforce committee Trust Board Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		**x**	
Prepared by:	Kirsty Matthews, Non-Executive Director Paul Hargreaves, Director of OD and People			
Non-Executive Sponsor (presenting):	Kirsty Matthews, Non-Executive Director			
Appendices (list if applicable):				

Recommendation:
It is recommended that the Board note the report.

Executive Summary:
The Workforce Committee focussed on a deep dive into sickness absence, hotspots around the Trust, both in skills groups, departments and directorates, key drivers for absence and changes to the process and policy of managing absence. A forward plan was also discussed. The Workforce KPI report was also discussed with nursing and medical showing a continued overspend on agency workforce, due to recruitment difficulties and increased sickness levels, leading to a trajectory of spend outside of the control target set for Agency spend by NHSI and therefore potential serious implications for the Trust's financial position. Good progress is being made on reducing medical locum usage reducing our weekly cost from an average of £70,887 to £44, 759 over August and September. Apprenticeships and alternative approaches to mentorship was also highlighted, the former will be presented at a future Board, as part of our emerging “grow your own” recruitment strategy, offering and supporting our local community to train and work at the hospital. The Committee acknowledged there are significant workforce challenges however, we are not unique in tacking similar recruitment and sickness issues to other Trusts. However the Board can be assured that the emerging workforce strategy is addressing immediate priority areas (recruitment, sickness and agency spend) whilst also addressing long term issues. Further co-ordinated work to build our capacity and improve our processes against trajectory KPI, in time, will deliver an increasingly sustainable workforce.

Report to:	Trust Board	**Agenda item:**	**SFT3932**
Date of Meeting:	2 October 2017		

Report Title:	Clinical Governance Committee		**Date:**	28 September 2017
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness			
Sponsor (presenting):	Professor Jane Reid, Non-Executive Director			
Appendices (list if applicable):	None			

Recommendation of items for escalation :
Items for escalation: • Positive presentation of improvement journey in maternity and neonatal and preparation for CQC. • Neonatal services future planning in line with demographic changes and specialist commissioning requirements. • Mortality review policy is in place which is in line with national requirements so can confirm we are complaint with required standards. • Customer care report – 1 case reviewed and upheld by the PHSO. • A task and finish group has been established to ensure a process to comply with the legislation for children with mental health issues. The CGC asked for an update on the process in December 17 and of the service in March 18.

1. Business Undertaken

1.1 A patient experience story was given at the Cancer Board about the pancreatic cancer pathway. It is a complex pathway crossing several organisations. Key message - earlier reassurance about pain management and explanation of the pathway. As an outcome the relative is working with the team on the redesign of the pathway. The CGC were assured that patients are being involved in the co-design of the pathway.

1.2 Patient Safety Programme – highlighted the impact of the GROW programme in reducing term stillbirths. Peri-operative safety – blood glucose normo-glycaemia during surgery is not consistent. An anaesthetist has been identified to lead improvement work. Mitigation is a diabetes education programme, out of hours advice from staff on Breamore ward and web based learning.

1.3 Maternity & gynaecology services presented on progress of their CQC action plan – positive assurance with recruitment of midwives and currently a midwife to birth ratio of 1:30 and 100% achievement of 1 to 1 care in labour. Gynaecology has introduced case management multidisciplinary team meetings.

1.4 Neonatal services presented on progress of their CQC action plan – positive assurance on staffing, appraisal, mandatory & equipment training. Currently designated as a Level 2 unit with network level discussions about future designation.

1.5 Wiltshire Health & Care – presented their quality dashboard. Plans are in place to ensure the dashboard is presented regularly at SFT. Areas for improvement - incident reporting, investigation and learning from incidents. Workforce issues – vacancies and turnover higher than expected. Falls higher than benchmark – focus on prevention. Action: WH&C and SFT to undertake a joint piece of work on falls.

1.6 Safeguarding Children and Young People annual report – positive assurance from the joint targeted area inspection of children living with domestic abuse. Level 3 training now over 90%. Current challenge is ensuring complex cases are managed in a multi-agency way. The CGC agreed that the named nurse should present 3 complex cases to the Board to understand how organisations work together.

1.7 Q1 Adult Safeguarding report – main issue is the capacity of the Local Authority to undertake best interest assessments within 7 days. Wiltshire is an outlier and escalated to the Board.

1.8 CQC action plan – a discussion took place about CQC preparedness and whether the Board is sighted on safety and quality concerns and improvements. All the 'should dos' are completed or in progress. Consistent messaging is required to ensure financial recovery is not having an adverse impact on quality.

1.9 The CGC were assured the NHS Improvement Quality Governance Framework self-assessment was comprehensive.

1.10 Children and young people mental health provision – a new CAMHS liaison nurse is in post. Potential gap with Oxford NHS Foundation Trust as no service level agreement in place for the administration of the Mental Health Act to ensure legal detention if needed.

1.11 Internal audit programme update - DBS policy under review – to prioritise groups for enhanced and frequency of checks. Report to workforce committee in November 17.

1.12 National clinical audit bi-annual report – National Joint Registry outlier for revision of hip replacements. Discussion took place as to the cause. Lead clinician is reviewing the patient pathway.

1.13 **Items for escalation**

- Positive presentation of improvement journey in maternity and neonatal and preparation for CQC.
- Neonatal services future planning in line with demographic changes and specialist commissioning requirements.
- Mortality review policy is in place which is in line with national requirements so can confirm we are complaint with required standards.
- Customer care report – 1 case reviewed and upheld by the PHSO.
- A task and finish group has been established to ensure a process to comply with the legislation for children with mental health issues. The CGC asked for an update on the process in December 17 and of the service in March 18.

2 Key Risks Identified and Impact

2.1 Capacity of the Local Authority to undertake best interest assessments within 7 days. Wiltshire is an outlier and escalated to the Board.

2.2 Potential gap with Oxford NHS Foundation Trust as no service level agreement in place for the administration of the Mental Health Act to ensure legal detention if needed. Mitigation - task and finish group to resolve.

3 Key Decisions

3.1 WH&C and SFT to undertake a joint piece of work on falls.

3.2 Named nurse to present 3 complex cases to the Board to understand how organisations work together.

3.3 DBS policy - report to workforce committee in November 17.

4 Exceptions and Challenges

4.1 Full agenda and time constraints meant that the CGC needed to prioritise the business at the end of the meeting. Pre-meet to decide the October agenda.

5 Governance and Other Business

5.1 None

6 Future Business

6.1 Meeting in October and November 2017 with items agreed at the pre-meet and reporting schedule.

Report to:	Trust Board	**Agenda item:**	**SFT3933**
Date of Meeting:	2 October 2017		

Report Title:	Report of Finance and Performance Committee	**Date:**	29 August 2017
Prepared by:	Nick Marsden, Chairman of Finance and Performance Committee		
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance		
Appendices (list if applicable):	none		

Recommendation of items for escalation :
The Committee has no formal items for escalation to the Board from this meeting.

1. Business Undertaken

1.1 At this meeting we received a further update on activity analysis and we were able to see that there had been a genuine dip in activity in winter 2016/17. We also saw the new measures developed to monitor more closely vacant clinic and theatre slots.

1.2 The Committee continues to monitor the Lorenzo stabilisation programme including the transition to the new data warehouse due to take place in September.

1.3 We discussed the Draft Financial Recovery Plan and this is on the 4 September agenda for the Board Seminar day.

1.4 We discussed the operational performance report which the Board will see as part of the Integrated Performance Report and were pleased to note that the Trust had delivered its principal operational targets in July. We have requested an update on length of stay to our October meeting.

1.5 We also noted in the Integrated Performance Report is the month 4 Finance and Contracting Report which shows a £4.4m deficit, year to date which is £1.8m away from the plan.

2. Key Risks Identified and Impact

2.1. No new risks were identified.

3. Key Decisions

3.1. We will continue to monitor the Financial Recovery Plan and the Data Stabilisation post-Lorenzo.

4. Exceptions and Challenges

4.1. We have made progress in addressing concerns about data quality in relation to activity reporting post-Lorenzo.

5. Governance and Other Business

5.1. There are no matters to report.

6. Future Business

6.1. In addition to the items mentioned above our regular agenda items are:

- Finance & Contracting Report
- CIP and transformation
- Operational Performance

6.2. September - Capital Development Report

6.3. October – CQUIN, Assurance Framework

Report to:	Trust Board	**Agenda item:**	**SFT3933**
Date of Meeting:	2 October 2017		

Report Title:	Report of Finance & Performance Committee	**Date:**	25 September 2017
Prepared by:	Lisa Thomas, Director of Finance		
Board Sponsor (presenting):	Nick Marsden Chairman		
Appendices (list if applicable):	none		

Recommendation of items for escalation :
That the report of the committee be noted

1. Business Undertaken

- The 2 October Board has nearly all the same items as we considered.
- Our agenda comprised the month 5 financial report (which is now identical to that presented to board), the operational performance report and an update on the draft financial recovery plan.
- We also had routine updates on major projects and capital developments. We are continuing to discuss progress towards closing the Lorenzo stabilisation phase.
- We were pleased to note compliant operational performance in most areas. We considered format of the new financial report to be a significant improvement.
- The Trust is targeting a £7m deficit this year and in M5 we had a year to date variance of c£1.9m.

2. Key Risks Identified and Impact

- As is highlighted in the new-style finance report, our principal concerns are:

  2..1. The projected year-end financial position and the risk to not achieving the Financial plan.

  2..2. The range of information and analysis that the Trust has available to support operational decision-making, and strategic planning

3. Key Decisions

No matters to report.

4. Exceptions and Challenges

- The Financial Recovery Plan will be submitted to NHS Improvement at the end of October. We are expecting a change in NHS I's assessed position to be confirmed imminently.
- We continue to explore causes and solutions in relation to the drop in activity and income experienced in spring 2017. The position has recovered and we are discussing what opportunities are available to drive up activity and make full use of available capacity.

5. Governance and Other Business

- No matters to report.

6. Future Business

- Financial Recovery plan
- Lorenzo project – exiting stabilisation
- Surgical Length of Stay – Case Mix Adjusted Information
- CQUIN
- Assurance Framework/Risk Register Quarterly Review

Report to:	Trust Board	**Agenda item:**	**SFT 3934**
Date of Meeting:	2 October 2017		

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

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

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

Performance Summary Narrative – August Performance, plus recent context

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
Local Services (COO)	• Total patients on waiting list waiting less than 18 weeks was 92% at the end of August • Diagnostic waits at 99.5% within 6 weeks • All cancer waiting time targets achieved, now have two-way link between Lorenzo and Somerset database (main cancer management system) • Upper limb orthopaedic surgeon appointed	• Pressures on referral to treatment times in some sub-specialty areas often as a result of emergency pressures • Emergency pressures fluctuate reflecting both changing levels of demand and internal and external capacity. Emergency Pathway performance for August was 91.3% • Diagnostic waits for MRI and audiology remain challenging • High levels of demand in a number of cancer pathways • Cover for interventional radiology	• Ward reconfiguration to improve management of emergency patients and create short stay surgery ward. Work started August • New ophthalmology outpatients department – building opens 2nd October • Outsourcing to other providers to maintain waiting times– elective work over summer, MRI • Plans in place for dedicated elective and trauma orthopaedic lists • Work with community providers to increase capacity and throughput through hospital • An urgent care steering group is being set up to lead the internal improvement of emergency clinical pathways
Specialist Services (COO)	• Plastics taken on melanoma service at UHS • Taking lead on plastics network across Wessex • Introduction of trauma surgeon of the day system in plastics – being piloted now • Inpatient assessment service for non-acute spinally injured patients	• Spinal unit improvements • Genomics tender – invitation to negotiate to be launched in November	• Developing business case to specialist commissioners for spinal services • Step down facility being commissioned for spinal unit which will increase overall bed capacity – starts November. • Work underway to recruit service

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
	• Cleft surgeon appointed		lead for spinal unit. No specific professional background prescribed. • Working with other genetics services to develop partnership approach to tender
Innovation (DoF)	• Ongoing success of laundry contracts. • OML continued work on R&D developments for products.	• Capacity for expansion in laundry services requiring capital investment.	• Opportunities for further laundry contracts. • Working across the STP on back office functions.
Care (MD/DoN)	• HSMR plateaued in latest figures. • 39 days without a fall resulting in moderate or severe harm • Excellent performance continues in infection control – benchmark in upper quartile • Mixed sex breaches at 0 – for last 6 months • Improved real time feedback in July. Friends and family feedback improved, but low numbers of respondents.	• Mortality rate remains above expected • Falls decreasing, but maintaining focus on this issue • Periods of intense emergency pressure at times when staffing is equally challenged • Stroke performance fell back in August	• Revised approach to mortality reviews. Coding review • Embedding learning from reviews • Falls reduction strategy in preparation
Staff (DoHR)	• Overseas nursing recruitment – to UAE and Australia • NHS Employers partner for diversity and inclusion • Health and wellbeing partnership with Loughborough University for study into factors causing absence • Appraisal rates increasing • Statutory and mandatory training compliancy maintained	• Level of vacancies, especially in nursing • Increased absence - above target. High levels in theatres, causing capacity issues • Use of temporary staff high and unsustainable. High cost of medical agency. • Month 5 control total exceeded	• Recruitment transformation strategy to commence in September – “grow your own” plan, 12 month plan to achieve fill to 95% for ward based nursing. • Engagement plan in development • Agency workforce control group in place. Reviewing master vendor arrangements – 3 month recovery plan due to end in

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
	• Locum agency spend beginning to fall • Better fill rates for locum junior posts		October. • Workforce strategy phase 1: recruitment and retention, diversity, health and wellbeing, business partnering • Appraisal trajectory to meet 85% compliance by March
Effective (DoF)	• Run rate deficit in month has reduced in August. • Trust launched Outstanding Every time Board meeting to track financial recovery plan progress. • Boston Consulting Group identified opportunities for further efficiencies.	• Achievement of full year financial plan given risks in year. • Identifying schemes for £2m CIP planned gap • Ongoing recruitment gaps resulting in agency use.	• Recovery plan completed by end of October to address the deficit position. • Establishment of additional support for PMO and financial recovery plan process.
Partnership (COO)	• 'Perfect weeks' – working with partner organisations to improve discharge • Workshop launching older people's development board – cross agency project • Attend joint board with CCG and WCCG • Commissioning community placements	• High numbers of delayed patients • Delays in introducing early supported discharge for stroke due to recruitment issues within the community • Promoting home first – go live in early September, but also subject to recruitment difficulties in the community	• PMO support to early supported discharge project

Integrated Performance Summary Report

Salisbury NHS
NHS Foundation Trust

Last printed: 25/09/2017 13:47

	Metric Name	Target	Last 3 Months: Jun-17	Jul-17	Aug-17	Pts affected in Aug-17	YTD
LOCAL	A&E - 4 Hour Wait from Arrival	95.0%	95.7% ↑	95.7% ↓	91.3% ↓	371	94.2%
	RTT - 18 Weeks from Referral to Treatment	92.0%	90.0% ↑	92.2% ↑	92.0% ↓	1,361	90.3%
	Cancer - 62 Day Wait for First Treatment from GP Referral	85.0%	89.8% ↑	85.2% ↓	89.7% ↑	6	87.1%
	Cancer - 62 Day Wait for First Treatment from Screening Referral	90.0%	100.0% ↑	100.0% →		0	83.3%
	Diagnostic - 6 Week Wait	99.0%	98.4% ↑	99.5% ↑	99.5% ↑	16	98.2%
	Diagnostic - 6 Week Wait - Compliance	10 out of 10	8 out of 10	6 out of 10	7 out of 10		

	Metric Name	Target	2016-17 Q2	2016-17 Q3	2016-17 Q4	Pts affected in 2016-17 Q4	Benchmark
SPECIALIST Burns Centre	% of adult resuscitation burns assessed by a consultant burns surgeon < 12 hours of admission	75.0%	No data	100.0% ▪	100.0% →	0	97.0%
	% of adult inpatients receiving daily pain assessment	80.0%	73% ↓	80.8% ↑	63.0% ↓	10	32.4%
	Number of non-resus patients no longer in therapeutic dressings <21 days of admission - non skin grafting		75 ▪	No data	No data ▪		20
	Number of non-resus patients no longer in therapeutic dressings <31 days of admission - receiving skin grafting		50 ▪	No data	No data ▪		22
	% patients screened for psychosocial morbidity prior to discharge from burns ward	75.0%	100% →	88.5% ↓	100.0% ↑	0	66.5%
	% of patients screened for functional morbidity < 2 working days of admission	80.0%	100% →	100.0% →	100.0% →	0	56.6%
	Number of adult inpatients admitted to an inappropriate level of care according to National Burn Care Referral Guidance (2012)	0	0 →	0 →	0 →	0	
	% IBID minimum dataset completed for adult inpatients		81.8% ↑	80.8% ↓	81.5% ↑	5	56.2%

	Metric Name	Target	2016-17 Q2	2016-17 Q3	2016-17 Q4	Pts affected in 2016-17 Q4	Benchmark
SPECIALIST Spinal Injuries Centre	Mean time from injury to referral (newly injured patients)		19.1 ↓	17.0 ↑	19.3 ↓		20.6
	Mean time from referral to admission into SCIC		55.9 ↓	51.2 ↑	41.8 ↓		34.7
	Mean LOS in acute phase for level of injury C1-C4		55.2 ↓	40.5 ↑	16.4 ↓		16.2
	Mean LOS in acute phase for level of injury C5-C8		26.7 ↓	18.2 ↑	19.2 ↑		18.5
	Mean LOS in rehab phase for level of injury C1-C5		125.9 ↑	106.0 ↑	113.5 ↑		94.4
	Mean LOS in rehab phase for level of injury C5-C9		153.0 ↑	114.3 ↑	109.7 ↓		101.2
	% of new injured patients receiving a face to face outreach visit from the SCIC outreach team <5 days of referral		95.0% ↑	78.1% ↓	85.3% ↑	5	87.2%
	% of newly injured patients who acquired a grade 3 or 4 pressure sore after admission to SCIC		0.0% ↓	0.0% →	0.0% →	0	1.2%

	Metric Name	Target	Jun-17	Jul-17	Aug-17	Reports outside RTG in Aug-17	
SPECIALIST Wessex Genetics Laboratory	Pre- + postnatal QF PCR + all molecular prenatal tests excluding Southern blotting		88.9% ↑	91.3% ↑	82.5% ↓	7	
	New-born screen for CFTR mutations (* working days)		100.0% ↑	66.7% ↓	73.3% ↑	4	
	Rapid oncology		100.0% →	100.0% →	100.0% →	0	
	Urgent postnatal		71.4% ↓	0.0% ↓	100.0% ↑	0	
	Prenatal array/karyotype + southern blot prenatal tests + urgent and predictive PCR-based molecular tests		84.1% ↑	79.5% ↓	79.7% ↑	16	
	Urgent oncology + molecular oncology testing in acute leukaemia		95.0% ↑	97.4% ↑	100.0% ↑	0	
	Routine oncology + routine PCR-based Haemato-oncology tests		95.5% ↑	97.7% ↑	96.7% ↓	12	
	Routine postnatal + routine PCR-based molecular tests		89.6% ↑	86.6% ↓	92.8% ↑	51	
	Mutation screening or tests which require Southern blotting + next generation sequencing of panels <10 genes		97.5% ↑	97.0% ↓	93.1% ↓	13	
	Mutation screening or tests which require Southern blotting + next generation sequencing of panels >10 genes		100.0% →	100.0% →	100.0% →	0	

	Metric Name	Target	Jun-17	Jul-17	Aug-17	Pts affected in Aug-17	YTD
CARE	Never Events	0	0 →	0 →	0 →		0
	Serious Incidents Rate		2 ↓	1 ↓	0 ↓		8
	Clostridium Difficile - notifications	19	0 →	0 →	0 →		1
	MRSA Bacteraemias - notifications	0	0 →	0 →	0 →		0
	% of births as emergency caesarean sections		15.2% ↑	10.8% ↓	10.7% ↓	20	13.5%
	% of harm-free care	95%	92.5% ↓	93.8% ↑	92.3% ↓	34	92.7%
	% of new harm-free care	95%	95.8% ↓	95.9% ↑	96.4% ↑	16	96.4%
	Venous thromboembolism (VTE) Risk Assessment	95%	99.6% ↓	99.7% ↑	99.6% ↓	5	99.5%
	Emergency re-admissions within 30 days following an elective or emergency spell at the Provider	TBC					
	Complaints - Total received	TBC	24 ↑	20 ↓	34 ↑		114
	Mixed Sex Accommodation breaches	0	0 →	0 →	0 →		0
	Inpatient Scores from Friends & Family Test - % Positive		96.7% ↓	98.0% ↑	96.4% ↓	280	96.9%
	A&E Scores from Friends & Family Test - % Positive		97.3% ↓	98.3% ↑	98.3% ↓	345	98.0%
	Maternity Scores from Friends & Family Test - % Positive		100.0% →	93.9% ↓	96.6% ↑	29	98.1%

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

	Metric Name	Target	Mar-17	Apr-17	May-17		
CARE	Medication Errors - % Harmful Events **NEW!**						
	Patient Safety Incidents - % Harmful **NEW!**						
	Potential Under-reporting of Patient Safety Incidents **NEW!**						
	Central Alerting System Alerts Outstanding **NEW!**						
	Hospital Standardised Mortality Ratio	100	117		114		
	Hospital Standardised Mortality Ratio - Weekend	100	125		124		
	Summary Hospital Mortality Indicator	100	106				

	Metric Name (000s)	Target	Jun-17	Jul-17	Aug-17		YTD
STAFF	Total Staff Costs		£ 11,271,211	£ 11,218,968	£ 11,419,835		
	Temporary agency staff costs (£)	£ 513	£ 746,142	£ 731,460	£ 762,217		
	Temporary agency staff WTE		3.3% ↓	3.0% ↓	3.4% ↑		
	Temporary bank staff costs (£)		£ 531,232	£ 547,400	£ 582,156		
	Temporary bank staff WTE		5.9% ↓	1.0% ↓	6.3% ↑		
	Staff Absence	3.00%	3.33% ↓	3.57% ↑	3.52% ↓		
	Appraisals - Medical	85.0%	93.0% ↓	95.0% ↑	95.0% →		
	Appraisals - Non-medical	85.0%	81.4% ↓	81.9% ↑	81.9% →		
	Mandatory training (MLE)	85.0%	85.1% ↓	86.6% ↑	85.8% ↓		

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

	Metric Name (000s)	Target	Jun-17	Jul-17	Aug-17	YTD plan	Variance
EFFECTIVE	Income & Expenditure - Surplus (+) / Deficit (-)	-£ 7,000	-£ 3,267 ↓	-£ 4,357 ↓	-£ 5,200 ↓	-£ 3,236	-£ 1,964
	Cost Improvement Plan	£ 7,500	£ 923 ↑	£ 1,333 ↑	£ 1,780 ↑	£ 2,325	-£ 545
	Cash Position	£ 2,009	£ 7,018 ↑	£ 9,638 ↑	£ 7,502 ↓	£ 4,455	£ 3,047
	Risk Rating	3	3 →	3 →	3 →		

	Metric Name	Target	Jun-17	Jul-17	Aug-17		YTD
PARTNERSHIP	Emergency admissions - Medicine & Elderly care (Over 65 years)		1021 ↑	1026 ↑	1069 ↑		5,133
	Delayed Transfers of Care (DToC) - NHS		9 ↓	6 ↓	15 ↑		90
	Delayed Transfers of Care (DToC) - Social Services		10 ↓	14 ↑	10 ↓		63
	Bed days consumed by DToC each month		821 ↑	629 ↓	531 ↓		3510

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

Acronyms

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

Report to:	Trust Board	**Agenda item:**	**SFT3934**
Date of Meeting:	2 October 2017		

Report Title:	Month 5 Operational Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:				
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):				

Recommendation:
That the report be noted

Executive Summary:
For Month 5 the trust successfully delivered the Referral to Treatment standard, the Diagnostic standard, all Cancer standards, and Urgent operation cancelation standard. Unfortunately the trust failed to deliver the ED standard of 95% reporting 91.3%.

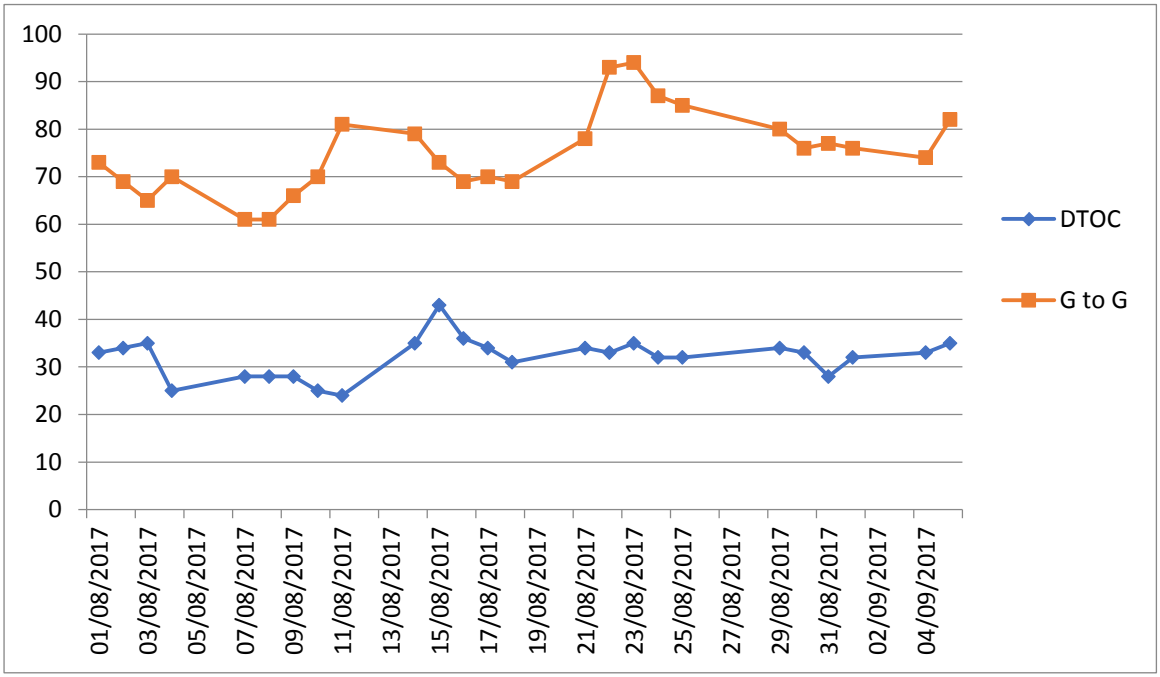
Emergency Pathway

4 hour performance for Month 5 was delivered at 91.3%. The number of patients with a delayed transfer of care increased throughout the month. Despite escalation in the second week of August there was no change in capacity to allow patients to be discharged from hospital. A task and finish group reporting to the ED local delivery board has been tasked with agreeing triggers and response of all providers in South Wiltshire.

Time to Triage - Aug		
	All	Ambulance
Longest (minutes)	182	127
Median (minutes)	**12**	**9**

Time to treatment		
	July	August
Longest (minutes)	318	454
Median (minutes)	**56**	**58**

National targets: 15 mins Time to Triage and 60 mins Time to Treatment
Ambulance breaches - 2 greater than 60 minutes and 7 less than 60 minutes.
There were no 12 hour trolley waits in August.



RTT

In August the trust reported RTT performance of 92%. The trust was able to report a day earlier than the deadline which again reflects the massive amount of work that has taken place to improve data quality.

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

- General Surgery
- Trauma and Orthopaedics
- Oral Surgery

- Plastic Surgery
- Gastroenterology

Performance in these specialties is between 80% and 90%. Each area has been asked to prepare a plan to deliver compliance at specialty level.

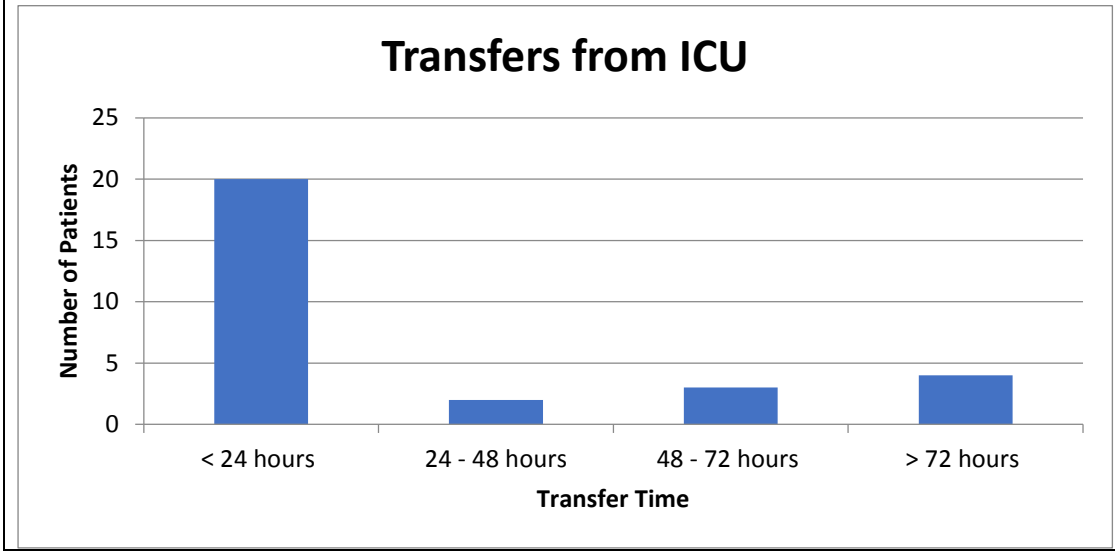
Diagnostic

The trust reported 99.55% of patients referred for a diagnostic test received it within 6 weeks. There were 16 breaches of the national standard (10 for MRI and 6 for Endoscopy).
Current wait times are 6 weeks in Radiology and less than 4 weeks for non General Anaesthetic Endoscopy
The position is being maintained by outsourcing MRI and Endoscopy.
We have a trajectory to decrease MRI wait times to under 6 weeks by the end of October.

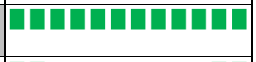
Cancer

All Cancer standards were delivered for July. Breast cancer and bowel cancer pathways remain areas on concern – referral pathways from outside south Wiltshire are being closely monitored.

ICU
The graph below is new to this report and shows the number of delays in transferring patients from Intensive Care to downstream wards. The target is 24 hours however this is not always achieved due to availability of beds in specific specialties. Of the 4 patients who were delayed for greater than 72 hours one had very specific clinical needs and the other three spanned a weekend period. This is managed through the daily bed meetings and an escalation process is in place for patients who are delayed beyond 24 hours.



Salisbury Hospital NHS Foundation Trust Board Report August 2017

			Reporting Month		Rolling 12 months
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Aug-17**	**Patients Affected in Aug-17**	**Trend Against National Standard**
Referral to Treatment Incomplete Performance	92%	STF = 92.0%	92.0%	1,361	
Referral to Treatment Incomplete Specialty Compliance	16 out of 16		11 out of 16		
Zero tolerance RTT waits > 52 weeks	0	0	0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Aug-17**	**Patients Affected in Aug-17**	**Trend Against National Standard**
A&E - Time in A&E department	95%	STF = 94.4%	91.3%	371	
12 Hour Trolley Waits	0		0		
Diagnostics - Patients waiting less than 6 weeks	99%		99.5%	16	
Diagnostic Test Compliance***	10 out of 10		7 out of 10		
Urgent Ops Cancelled for 2nd time (Number)	0		0		
Mixed Sex Accommodation Breaches	0		0		
Infection control – Clostridium difficile (YTD)	19		YTD: 1	0	
Infection control - MRSA*	0		0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Aug-17**	**Patients Affected in Aug-17**	**Trend Against National Standard**
All Cancer two week waits	93%		94.6%	41	
Symptomatic Breast Cancer - two week waits	93%		98.8%	2	
31 day wait standard	96%		98.9%	1	
31 day subsequent treatment : Surgery	94%		100.0%	0	
31 day subsequent treatment : Drug	98%		100.0%	0	
62 day wait standard	85%		89.7%	6	
62 day screening patients	90%			0	

Cells with black dotted outlines indicate provisional data

*Please note: MRSA is no longer monitored by Monitor

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

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

Report to:	Trust Board	**Agenda item:**	**SFT3934**
Date of Meeting:	2 October 2017		

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

Recommendation:

Recommendation – note Trust quality indicators and actions being taken to improve.

Information – positive indicators reflect sustained good infection control practice and a culture of avoiding non-clinical mixed sex accommodation breaches despite an increase in escalation bed capacity. HSMR has reduced and actions required to comply with the national mortality guidance are in place for Board reporting from October.

Indicators of concern remain falls resulting in harm and the reduction in stroke care indicators & high risk TIA performance. A new theme of an increase in complaints and concerns relating to clinical treatment, appointments and attitude of staff.

Executive Summary:

Please note: the readmission data & data for fractured neck of femur (except best practice tariff compliance) & multiple ward moves is unable to be extracted from the data warehouse currently. Reporting is expected to re-commence in October 17.

- No cases of Trust apportioned C difficile for the 4th month in a row.
- 1 MSSA bacteraemia, possibly line related. Case under investigation.
- HSMR decreased to 114 in May 17. In July, 37 (53%) of 70 deaths were reviewed. None had a greater than 50% chance of death due to problems in care. 4 learning points were noted for improvement action. A mortality policy has been published and a 2 stage review process implemented in August. Q1 mortality learning bulletin widely distributed.
- There were 2 falls resulting in fractures. One resulted in major harm (a fractured hip) and one moderate harm (fractured shoulder). The Trust falls reduction action plan was reported to the Clinical Risk Group and our commissioners in August 17.

- A reduction in stroke patients arriving on the stroke unit within 4 hours - waiting for doctor in ED (3), transfer on/close to 4 hours (3) and waiting for a bed (2). A reduction in patients spending 90% of their stay on Farley – bed capacity (3). A reduction in the percentage of high risk TIA patients seen within 24 hours due to the unavailability of morning clinics. A third stroke consultant starts in September.
- Complaints and concerns increased related to issues of unsatisfactory clinical treatment, outpatient appointments (14 areas), attitude of staff and communication.
- Escalation bed capacity increased in August. Ward moves between 22.00 and 06.00 reported by month only. The plan to reconfigure the bed base in preparation for next winter is mostly on track but the opening of the new Pembroke ward will be delayed.
- No non-clinical mixed sex accommodation breaches for the 6th month in a row.
- Real time feedback for patients rating the quality of their care decreased in August. The Friends and Family test of patients who would recommend ED, wards, the maternity service and care as a day case and outpatients was sustained.

Salisbury NHS
NHS Foundation Trust

Trust Quality Indicators - August 2017

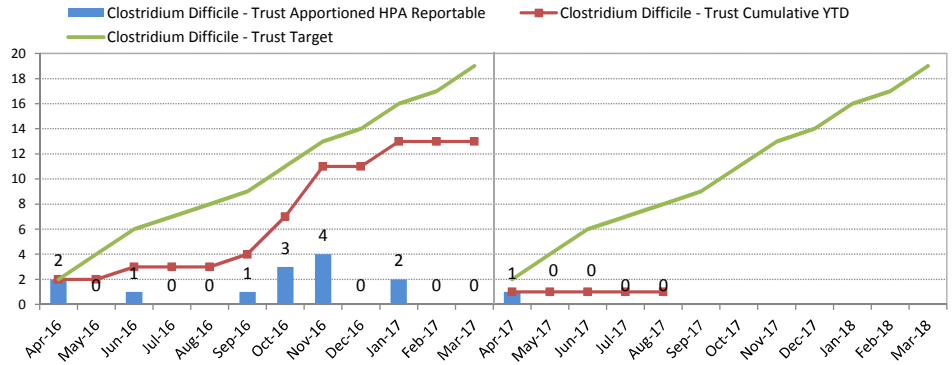
Quality Measures

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

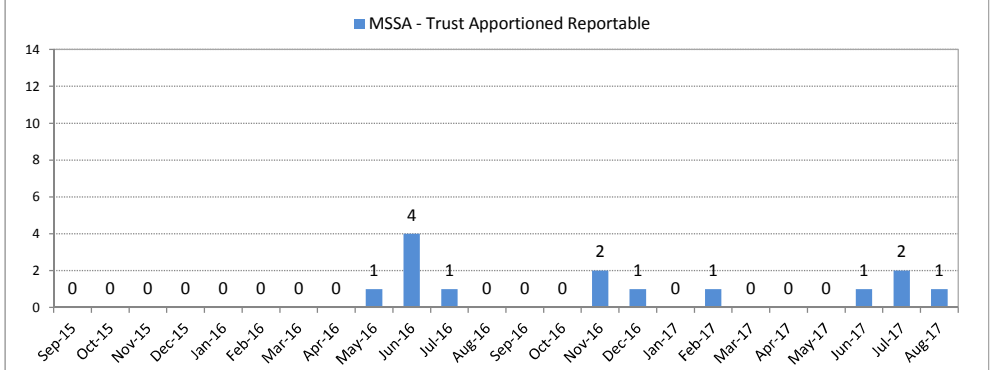
Trust Incidents	2016-17 YTD	2017-18 YTD
Never Events	2	0
Serious Incidents Requiring Investigation	47 *	8

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

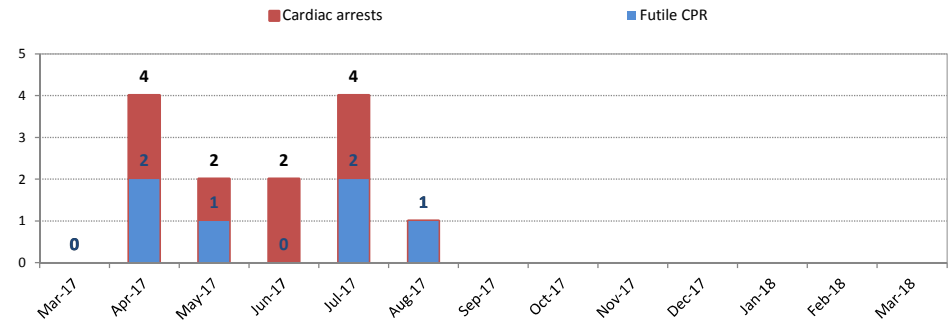
Clostridium Difficile - Trust Apportioned



MSSA - Trust Apportioned

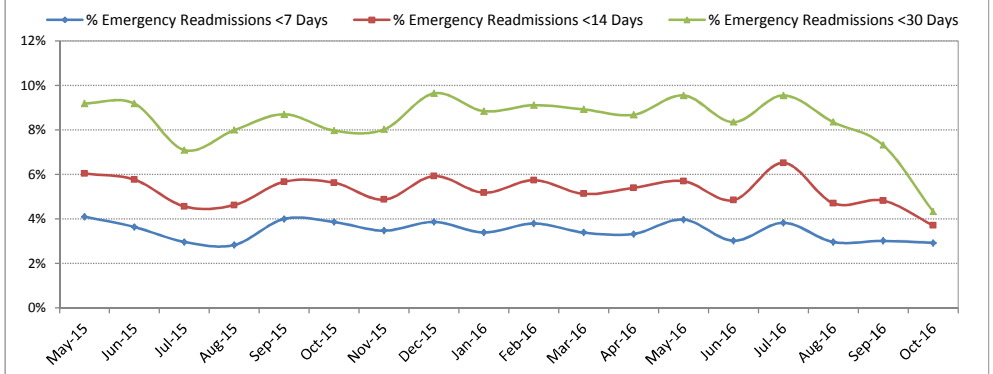


In hospital cardiac arrests and futile CPR

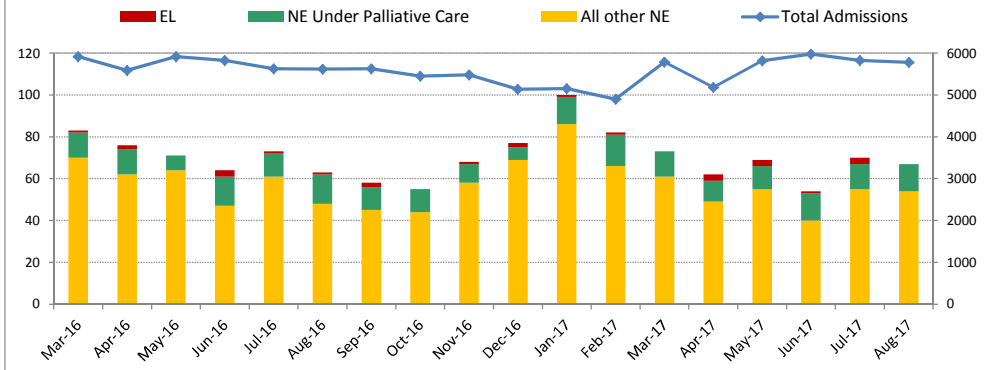


Please note cardiac arrests which occurred in ED, ITU, CCU and Paediatrics are excluded.
Data from Mar-17 onwards

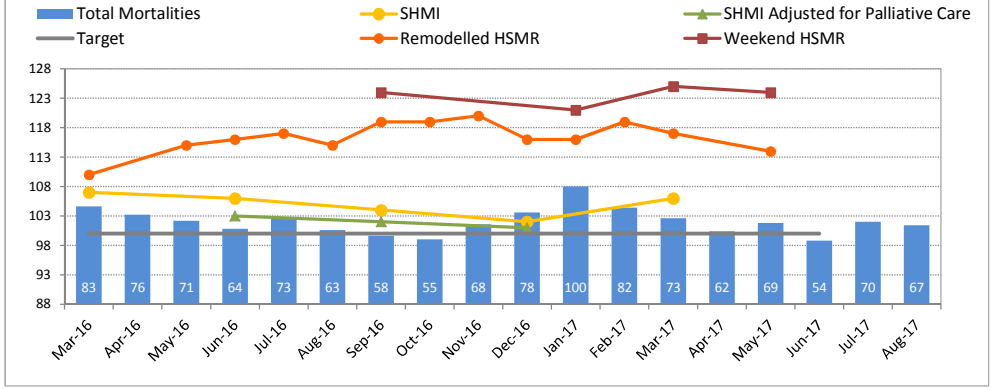
Emergency Readmissions within 7, 14 & 30 days of Discharge



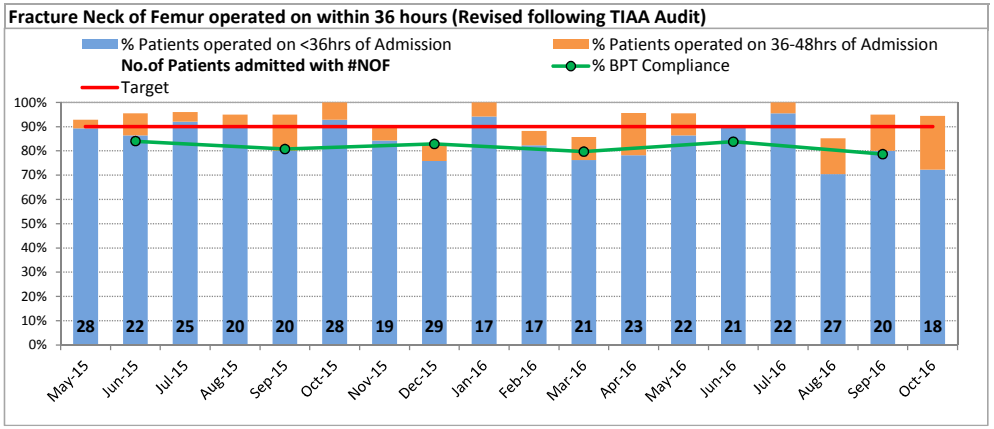
Hospital Mortalities



HSMR and SHMI



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

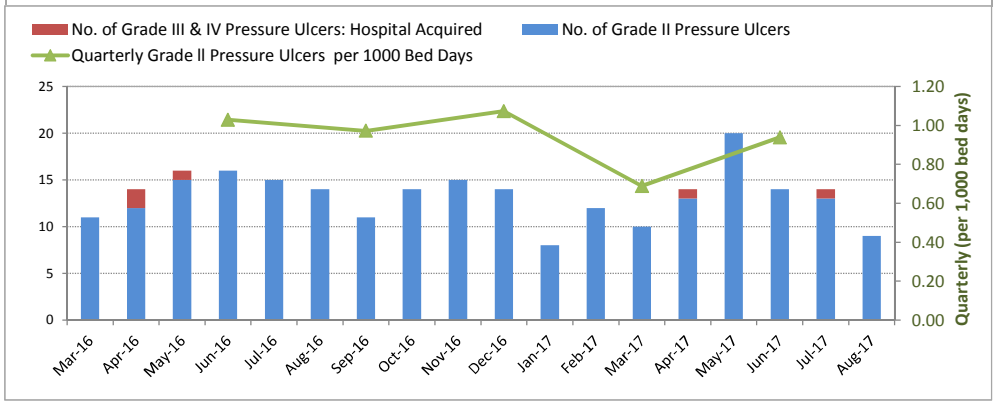


Salisbury NHS
NHS Foundation Trust

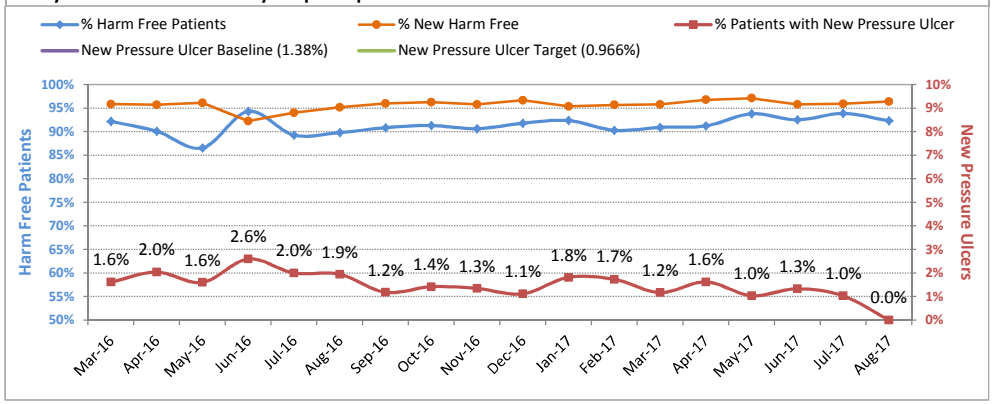
Trust Quality Indicators - August 2017

Quality Measures

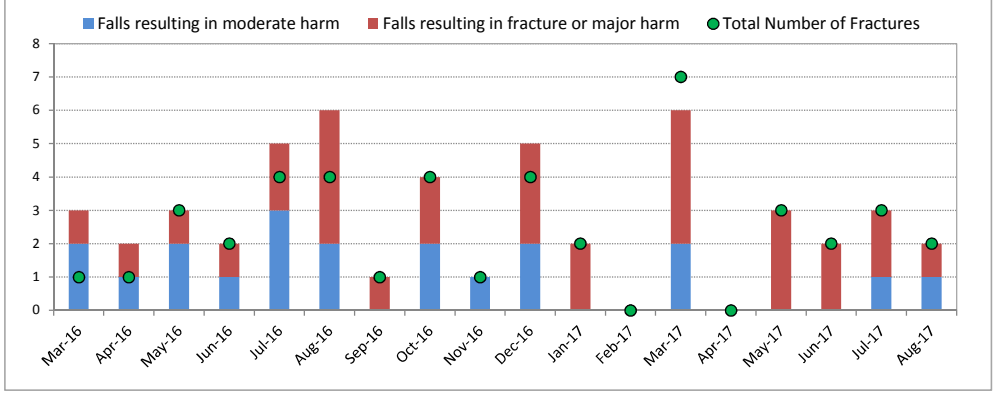
Pressure Ulcers



Safety Thermometer - One Day Snapshot per Month

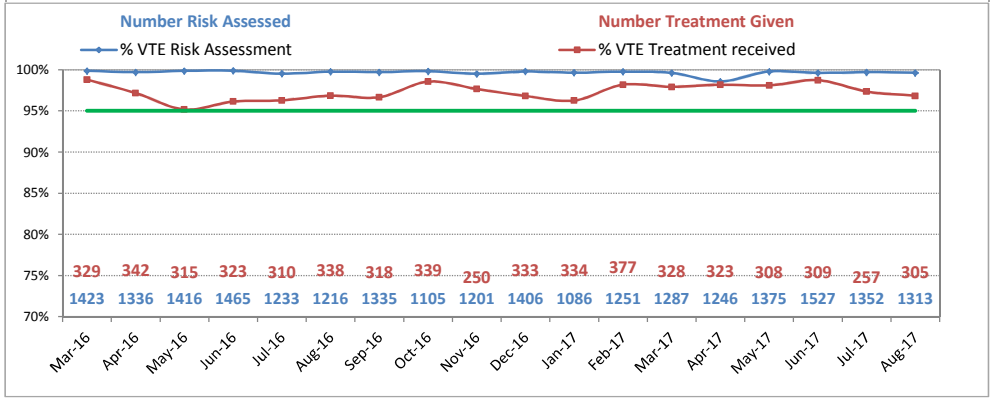


Patient Falls in Hospital



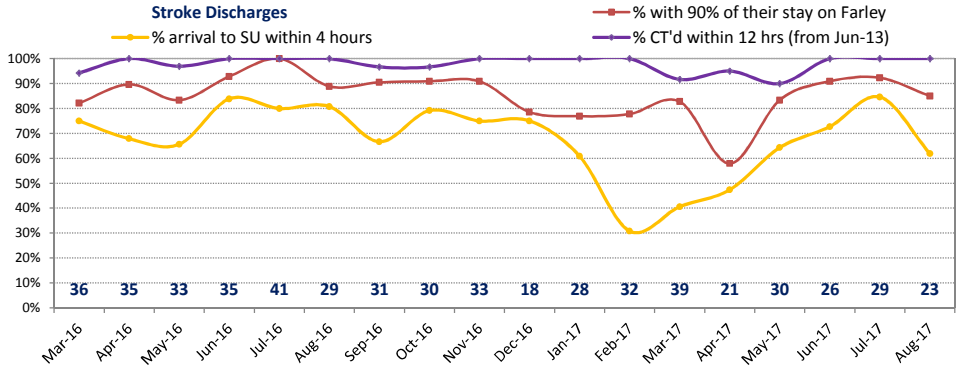
Please note, in Mar-17 1 patient has 2 fractures.

Venous Thrombous Embolism: Risk Assessment & Prophylaxis

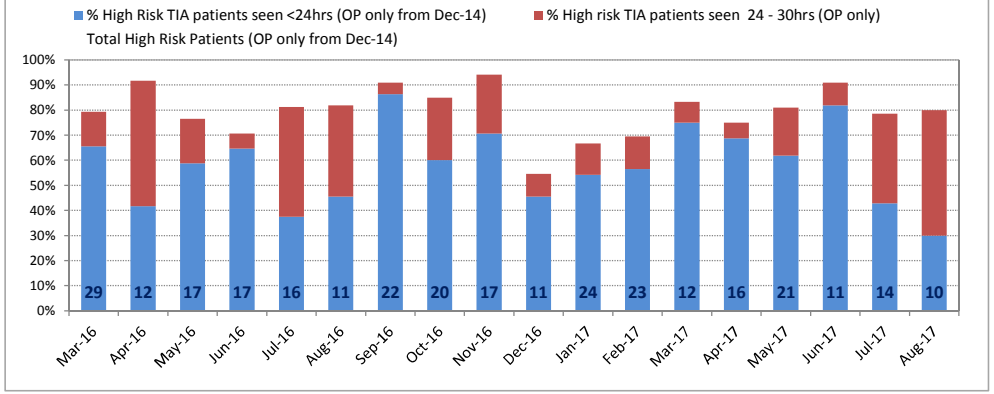


Please note, due to the time it takes to complete Clinical Coding, the current months Fracture Neck of Femur data will be subject to change over the following months.

Stroke Care



TIA Referrals



SSNAP Case Ascertainment Audit

Highest level = Grade A

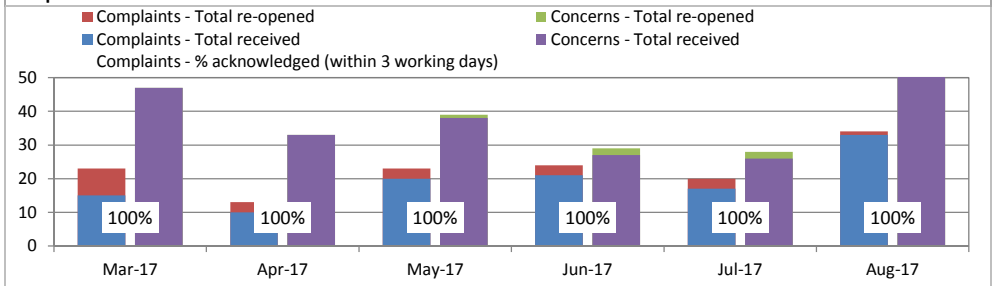
Lowest level = Grade E

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

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

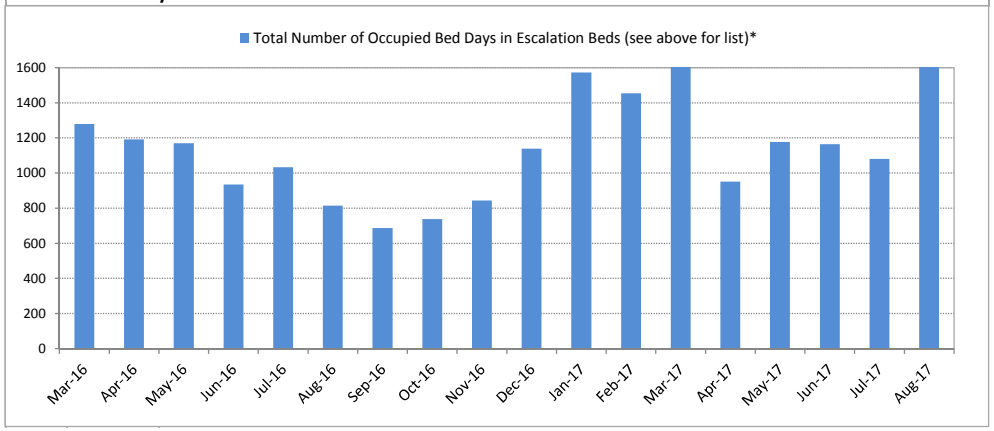
*From April 2016 escalation capacity includes beds on Breamore, DSU, Clarendon, Endoscopy, Avon, Britford SAU overnight stays, Whiteparish AMU overnight stays, Clarendon NHS, Pembroke Suite and Burns assessment room.

Complaints and Concerns

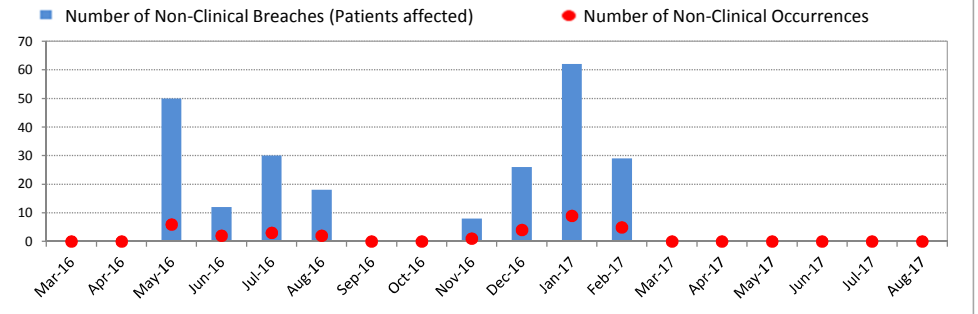


	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Complaints - Total received	15	10	20	21	17	33
Complaints - Total re-opened	8	3	3	3	3	1
Concerns - Total received	47	33	38	27	26	55
Concerns - Total re-opened	0	0	1	2	2	0

Escalation Bed Days

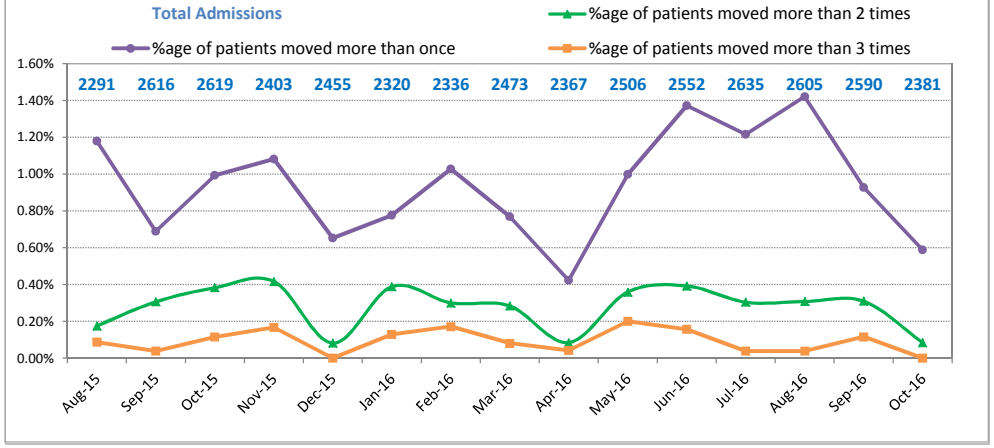


Delivering Same Sex Accommodation



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

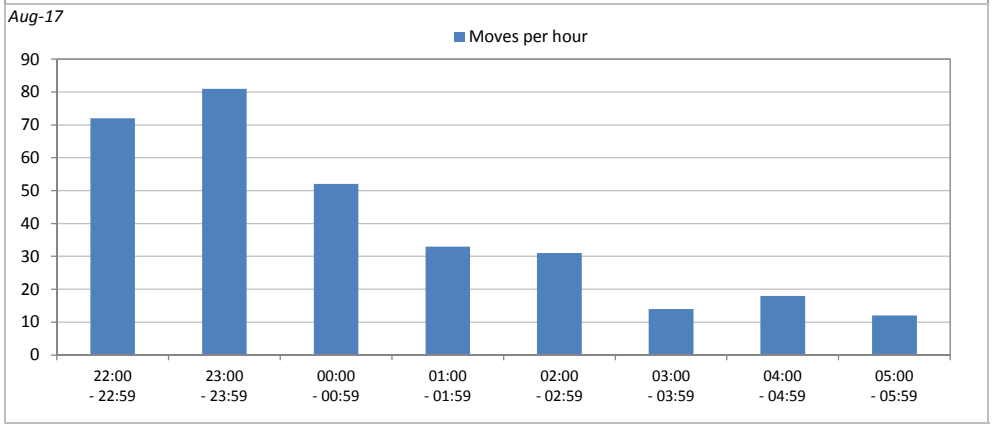
Patients moving multiple times during their Inpatient Stay



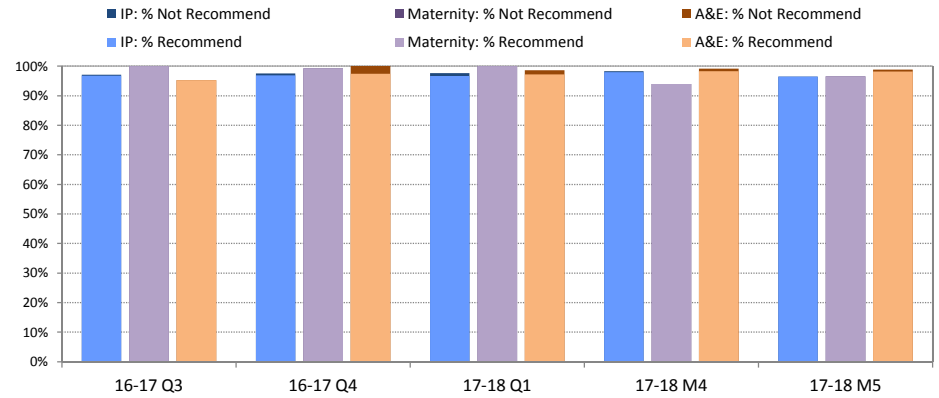
Please note, the number of Non-Clinical Breach Ocurrences is being reported from May 2016.

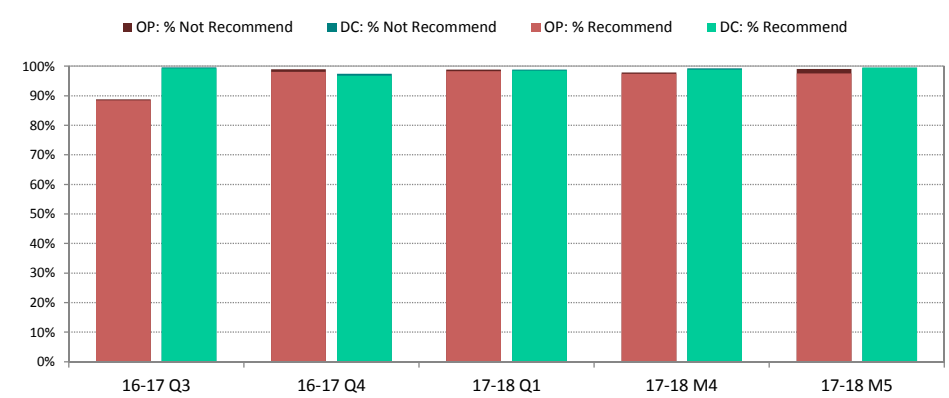
Ward moves between 22:00 and 06:00

Aug-17

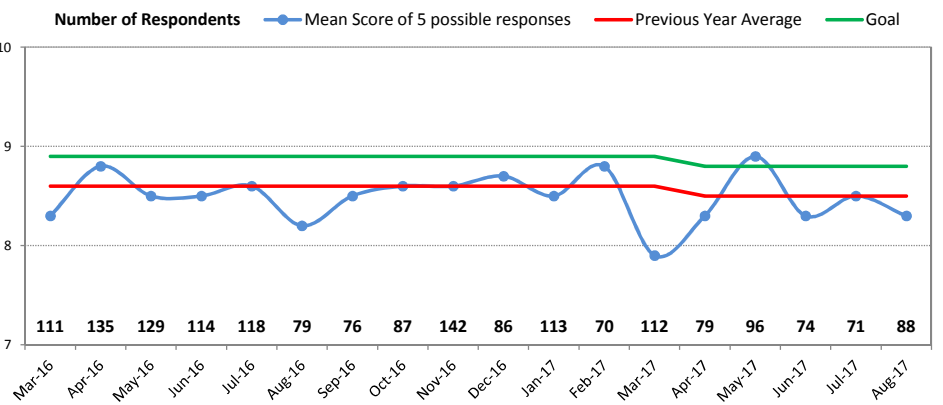


Friends & Family Test: Responses by Area

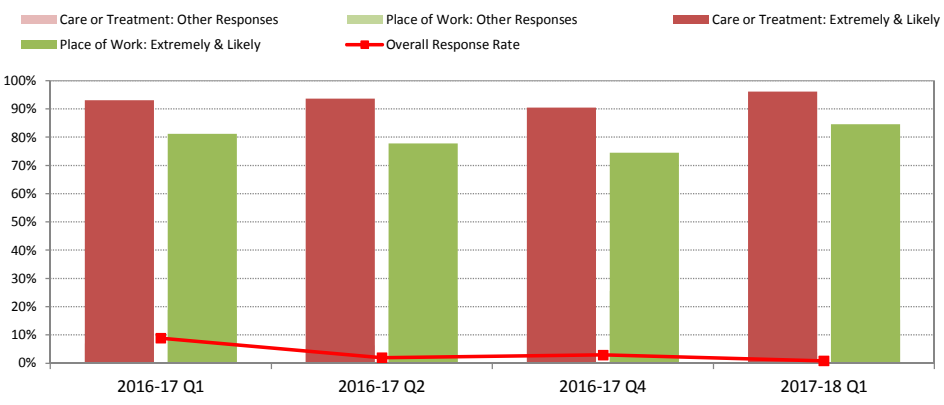




Real Time Feedback: Overall how would you rate the quality of care you received?



Friends & Family Test: Staff (% Responses)



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

Report to:	Trust Board	**Agenda item:**	SFT3934
Date of Meeting:	2nd October 2017		

Report Title:	Workforce Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x	**x**	**x**	**x**
Prepared by:	Mark Geraghty, Head of Workforce Information & Planning Paul Hargreaves, Director of OD and People			
Executive Sponsor (presenting):	Paul Hargreaves, Director of OD and People			
Appendices (list if applicable):	Workforce KPIs Month 5 2017/18 Areas of Concern Month 5 2017/18			

Recommendation:

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

Executive Summary:

The Workforce KPIs report (including appendix) shows a continued overspend on agency workforce, due to recruitment difficulties and increased sickness levels, leading to a trajectory of spend outside of the control target set for Agency spend by NHSI and therefore serious implications for the Trust's financial position. The work undertaken to reduce agency has reduced medical locum agency doctors booked each week from 20 down to 12, (since August) reducing our weekly cost from £70,887 to £44, 759. This is now continually updating a finance trajectory for performance management of Directorates.

The Areas of Concern report sets out the actions that are being taken or planned against performance outside of KPI.

1. Purpose

This report provides the workforce dashboard for month 5, which shows the performance against key workforce indicators at Trust and Directorate level, with trend analysis over time, and highlights the key exception areas and the actions that are in progress or planned to recover the position.

2. Background

The month 5 position shows a continued overspend on temporary staffing workforce, mainly due to recruitment difficulties and increased sickness levels, leading to over-reliance on agency, and if not reduced, will have serious implications for the Trust's financial position. Overall vacancy levels have increased slightly and remain high in some areas. Staff sickness is red rated at 3.52%, against an internal target of 3% which is slightly below average for surrounding Trusts (3.59%). An overall target of 3% was agreed by the Trust in 2016 as a challenging but potentially achievable target to maintain and improve the Trust's position among Trusts locally. Staff turnover is above target at 9.42%, the second lowest (positive direction) rate among surrounding hospitals. Mandatory training compliance levels have reduced slightly this month but remain above target. Appraisal compliance remains amber at 81.90%.

3. Key Areas of Concern

Please see attached appendix ('Areas of Concern Month 5 2017/18') which provides information about the actions in progress or planned to recover the position on the key areas for concern. Below is a summary of actions underway:

3.1 Recruitment

The emerging HR strategy – phase 1, (immediate operational recovery) is concentrating on recruitment and retention, reducing agency and improving attendance.

Specifically to ensure we stabilise the workforce and reduce agency spend to an absolute minimum we are tackling the drivers to meet immediate need and future proof our capacity and processes. This is in development but will cover:

- A review of recruitment process and systems
- A review of capacity in the recruitment service
- Development of a media and branding strategy
- Review the employment package offered to staff
- Partner with line managers to ensure a smooth and timely recruitment process and experience for candidates
- Greater use of apprenticeships and a "grow our own strategy"
- Open days for recruitment –Nursing assistants- 113 attended on 9 September, with 29 offers of employment (full and part time), 5 offers of employment for the Nursing Bank and a further 30 interviews to be held (3 interview dates scheduled).
- Recruitment plan to get to 95% fill. We are currently at 90% fill overall. The majority of our vacancies are in Nursing and achieving 95% for Nursing will take 18 months if we double our appointments on our current trajectory. For Consultant Medical Staff, we are already at 95% fill, with the challenge being recruiting to fill posts affected by national shortages.

- Working with the STP on a system wide recruitment plan and campaign.
- Investigating and tackling a nursing attrition rate of approximately 50% from invite to interview to offer of employment

3.2 Agency spend

- NHS Improvement has set Salisbury NHS Foundation Trust a control total of £6.2 million for 2016/17. Our current forecast spend gives a year end position of £7.3 million. In order to achieve the control target a 20% reduction in agency use is required, all usage must be to cap and an increase in recruitment by 25% to March 2018 is also needed. HR and Finance are working on agency reduction plans for the whole Trust, and specific plans for Directorates have been developed and are being actioned by directorates. Each Directorate management team is required to develop a final plan to reduce temporary spend, recruit to vacant posts and deliver agency spend to cap. Paper agreed at Joint Board of Directors Wednesday 20th September 2017.
- Weekly agency review meetings with the Medical Director and Director of OD and People to continue. The top 20 most expensive medical locum agency doctors have reduced from 20 to 12, reducing our weekly cost since August from £70,887 to £44,759.
- Our mastervend agency supplier (Total Assist) are being performance managed with a 3 month recovery plan – fill rates to reach 90% and associated delivery of assignments to cap. The current position (from July to August) is fill rates have increased to approximately 78% from an initial contract start of 48% (November 2016, 3 months into contract). Based on Total Assist data the 3 month recovery plan has resulted in costs reducing by 8% (average consultant pay rate). An average 19% cost reduction has been achieved for ST2 doctors. Refreshed trajectories are produced to ensure performance management against the control target. Total Assist data is being validated. For month 5, 91.47% of medical agency shifts breached cap, with 22.11% of nursing shifts breaching cap.
- Resourcing – as part of the HR restructure long term we are aligning key drivers closer together, joining the in-house bank with E-roster and our mastervend / locum nest resources. These will be linked to the emerging recruitment strategy and, in time, a workforce plan.

3.3 Sickness absence

- To achieve a 0.52% reduction in the Trust's sickness rate to 3%, a reduction of 14.45 FTE in the number of staff off sick is required and forms part of the action plan.
- Performance manage a rolling top 5 individuals in each Directorate with the most frequent short term sickness absence to ensure individuals identified are being managed through the sickness process, supported to either return to work or remain at work (if short term sickness). If non-compliant action will be taken.
- We are linking up with Loughborough University to participate in a study and analysis of the anxiety/stress/depression sickness absence (top reason) to inform the emerging Health and Wellbeing strategy.
- Data cleansing to ensure accurate information, moving to real time reporting and manager self service via the payroll system, (ESR.)

- The Sickness Absence Policy is being revised as part of a wider policy review by November 2017 with management input. Communications and awareness plan to be developed.
- Sickness Absence management guidance, toolkit and training to be developed to ensure revised policy is being used consistently across the Trust
- Refresh and re-launch the Health and Wellbeing Strategy
- Occupational Health Service Review

4. Summary

This is a challenging situation, and we are not unique in tacking similar recruitment and sickness issues to other Trusts. However, we are dealing with long term issues which will take some time to fix but we have already made some headway in recruitment and reduction in agency. Further co-ordinated work to build our capacity and improve our processes against trajectory KPI, in time, will deliver a sustainable workforce.

Salisbury NHS Foundation Trust Workforce Dashboard

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

	Strs/Lvrs		Turnover (FTE)			Vacancies				Temporary Spend					Sickness						Training	Appraisal		Employee Relations - Formal						
	Starters *(head count in month)*	Leavers *(head count in month)*	Average Heads *(in year)*	Number of Leavers *(in year)*	Turnover *(rolling year)*	Budget Wte (Ledger)	Staff In Post Wte *(Ledger - month end)*	Vacant Wte	Vacancy Rate	spend on Agency	% Temp Spend on Agency *(in month)*	spend on Bank	Total Temp Spend	Agency Budget	Long Term Sick WTE lost *(in month)*	%	Short Term Sick WTE lost *(in month)*	%	Total WTE lost to Sickness *(in month)*	Sickness Rate	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff	Performance	Short Term Sick	Long Term Sick	Disciplinary	Grievance	Bullying and Harassment	Total Caseload
YTD Trend	*Data excludes: Docs in Training & Tupe Transfers*																													
Month Trend																														
Target		29		240	8.50%			154.06	5.00%	£ 516,667	40.00%								84.70	3.00%	85.00%	85.00%	85.00%							0
Apr-17	69	36	2,827	272	9.61%	3,081.27	2,823.20	214.76	6.97%	£ 513,765	41.61%	£ 720,840	£ 1,234,605	Under	52.11	59%	36.92	41%	89.03	3.18%	84.12%	91.00%	80.40%	-	-	-	-	-	-	0
May-17	63	53	2,824	263	9.30%	3,078.73	2,777.53	268.47	8.72%	£ 692,515	53.84%	£ 593,693	£ 1,286,208	Over	56.60	58%	40.26	42%	96.86	3.47%	84.76%	93.00%	81.00%	2	-	-	-	-	-	2
Jun-17	52	50	2,822	272	9.65%	3,078.14	2,786.46	261.33	8.49%	£ 746,142	58.41%	£ 531,232	£ 1,277,374	Over	56.51	62%	35.28	38%	91.79	3.34%	85.14%	93.00%	81.40%	1	-	-	-	-	-	1
Jul-17	66	45	2,820	258	9.14%	3,052.55	2,782.64	269.91	8.84%	£ 731,460	57.20%	£ 547,400	£ 1,278,860	Over	60.94	62%	36.85	38%	97.79	3.57%	86.63%	95.00%	81.90%	1	-	-	3	2	1	7
Aug-17	50	70	2,816	265	9.42%	3,075.03	2,778.67	296.36	9.64%	£ 762,217	56.70%	£ 582,156	£ 1,344,373	Over	60.84	61%	38.49	39%	99.34	3.52%	85.79%	95.00%	81.90%	-	-	-	1	-	1	2
Sep-17																														
Oct-17																														
Nov-17																														
Dec-17																														
Jan-18																														
Feb-18																														
Mar-18																														
totals	300	254		Average	9.43%			Average	8.53%	£ 689,220									Average	3.42%	85.29%			4	-	-	4	2	2	12

Month 5 position shows a continued overspend on workforce, due to recruitment difficulties, leading to over-reliance on agency and serious implications for the Trust's financial position. Overall vacancy levels have increased slightly and remain high in some areas. Staff sickness is red rated at 3.52%. The Trust has the third lowest rate of the surrounding Local Acute hospital Trusts. Staff Turnover is above target at 9.42%, the second lowest (best) rate among surrounding hospitals. Mandatory training compliance levels have reduced slightly this month and remain above target. Appraisal compliance remains amber at 81.90%. 36 of the 70 leavers identified for month 5 were Therapy and Nursing Bank staff who had not worked. Key areas identified for action include :

Staff Sickness – We aim to bring sickness absence back to target. **We are :**
- Reviewing the top five individuals in each Directorate with the most frequent short term sickness in conjunction with Occupational Health.
- Undertaking focussed work in departments with high levels of sickness - Examples include: Maternity – monthly reviews of short term and long term sick cases; Facilities – action plans in place for long term sick cases
- Providing coaching and support to ensure managers have the right tools to manage sickness.
- Identifying the individuals with the highest level of absence in Theatres and conducting a 6 weekly meeting to review cases and ensure sickness is being managed with appropriate support.

Agency Spend - We aim to reduce our reliance on expensive Agency staff, and to meet our £6.2m NHSI Agency Spend Control Total. **We are** :
- Working on agency reduction plans for the whole Trust, and developing specific plans for Directorate. Each Directorate management team will develop a final plan to reduce temporary spend, recruit to vacant posts and deliver agency spend to cap.
- Holding weekly agency review meetings with the Medical Director and Director of OD and People. These are attended by each Clinical Director where agency spend is taking place.
- Performance managing our mastervend agency supplier (Total Assist) with a 3 month recovery plan to ensure fill rates reach 90% and all shifts are NHSI cap compliant.
- Resourcing – as part of the HR restructure long term we are aligning key drivers closer together, joining the in-house bank with E-roster and our mastervend / locum nest resources. These will be linked to the emerging recruitment strategy and, in time, a workforce plan.

Recruitment - We aim to ensure we stabilise the workforce and reduce agency spend to an absolute minimum. **We are:**
- Developing apprenticeships to help create our own pathway into Nursing,
- Holding Nursing and N/A careers fairs and open days,
- Travelling internationally to recruit Nurses and middle grade Doctors,
- Developing our social media profile and Micro Site development.

Musculo Skeletal Directorate Workforce Dashboard

	Strs/Lvrs		Turnover (FTE)			Vacancies				Temporary Spend				Agency Budget	Sickness						Training	Appraisal	
	Starters *(headcount in month)*	Leavers *(headcount in month)*	Average Heads *(in year)*	Number of Leavers *(in year)*	Turnover *(rolling year)*	Budget Wte (Ledger)	Staff In Post Wte *(Ledger - month end)*	Vacant Wte	Vacancy Rate	spend on Agency	% Temp Spend on Agency *(in month)*	spend on Bank	Total Temp Spend		Long Term Sick WTE lost *(in month)*	%	Short Term Sick WTE lost *(in month)*	%	Total WTE lost to Sickness *(in month)*	Sickness Rate (Rolling Year)	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
YTD Trend	*Data excludes: Docs in Training & Tupe Transfers*																						
Month Trend																							
Target		3		30	8.50%			20.87	5.00%		40.00%								10.01	2.75%	85.00%	85.00%	85.00%
Apr-17	4	3	351	28	7.88%	417.40	364.02	53.38	12.79%	£ 94,814	34.74%	£ 178,102	£ 272,916		6.19	50%	6.23	50%	12.42	3.41%	86.10%	95.00%	76.20%
May-17	-	5	351	30	8.42%	416.36	355.91	60.45	14.52%	£ 97,528	43.55%	£ 126,405	£ 223,933		6.16	47%	7.07	53%	13.23	4.05%	87.20%	95.00%	76.20%
Jun-17	5	5	351	33	9.38%	416.80	350.98	65.82	15.79%	£ 120,910	56.71%	£ 92,285	£ 213,195		6.73	53%	5.88	47%	12.61	3.70%	86.70%	95.00%	77.70%
Jul-17	3	1	350	30	8.50%	401.78	342.67	59.11	14.71%	£ 114,816	48.54%	£ 121,705	£ 236,521		11.23	75%	3.72	25%	14.94	3.88%	88.99%	98.00%	78.60%
Aug-17	3	3	348	28	8.15%	400.40	335.43	64.97	16.23%	£ 110,613	53.30%	£ 96,901	£ 207,514		10.42	70%	4.46	30%	14.88	4.31%	89.15%	98.00%	79.70%
Sep-17																							
Oct-17																							
Nov-17																							
Dec-17																							
Jan-18																							
Feb-18																							
Mar-18																							
totals	15	17		Average	8.47%			Average	14.81%	£ 107,736									Average	3.87%	87.63%		

Month 5 position shows a decrease in spend on Agency this month, sickness levels have increased. Overall vacancy levels have increased slightly this month and remain high in some areas. Staff sickness remains above target at 4.31%. Mandatory training compliance levels have improved again this month and remain above target. Appraisal compliance remains red at 79.70%.

Sickness

We have been closely managing frequent short term sickness by ensuring managers are following the process, and bringing cases to a conclusion appropriately. We are focussing on repeat offenders where there is an underlying medical problem.

Agency spend

Agency spend has been a topic for discussion at our Directorate Management Team meetings. Reasons for bookings are rigorously examined. We currently have five agency medical staff, 4 in spinal and 1 in Trauma and Orthopaedics. One of our Spinal bookings is coming to an end in September, the T&O booking is covering vacancies we can't recruit to. For nursing, our areas of high agency use are Orthopaedics and Spinal, with minimal Thornbury use.

Recruitment

Areas of difficulty remain Dermatology, Orthodontics and T&O medical staff. We made a substantive appointment to a Consultant Orthopaedics post (wrist and upper limb) with a likely December start date. We have Consultant Dermatologist and Orthodontist vacancies on NHS jobs due with no applicants. We had a T&O SPR start in September, and are interviewing for an LAS doctor in Plastics. Medical HR are continually working to anticipate and fill any gaps in the system.

Medicine Directorate Workforce Dashboard

	Strs/Lvrs		Turnover (FTE)			Vacancies				Temporary Spend				Agency Budget	Sickness						Training	Appraisal	
	Starters *(headcount in month)*	Leavers *(headcount in month)*	Average Heads *(in year)*	Number of Leavers *(in year)*	Turnover *(rolling year)*	Budget Wte (Ledger)	Staff In Post Wte *(Ledger - month end)*	Vacant Wte	Vacancy Rate	spend on Agency	% Temp Spend on Agency *(in month)*	spend on Bank	Total Temp Spend		Long Term Sick WTE lost *(in month)*	%	Short Term Sick WTE lost *(in month)*	%	Total WTE lost to Sickness *(in month)*	Sickness Rate (Rolling Year)	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
YTD Trend	*Data excludes: Docs in Training & Tupe Transfers*																						
Month Trend																							
Target		5		45	8.50%			31.41	5.00%		40.00%								19.00	3.40%	85.00%	85.00%	85.00%
Apr-17	8	6	526	52	9.86%	628.11	558.70	69.41	11.05%	£ 255,248	50.68%	£ 248,407	£ 503,655		9.55	58%	7.01	42%	16.56	3.00%	76.90%	92.00%	68.10%
May-17	4	4	527	49	9.28%	629.99	540.68	89.31	14.18%	£ 369,914	66.64%	£ 185,163	£ 555,077		10.63	56%	8.31	44%	18.94	3.49%	77.80%	96.00%	70.40%
Jun-17	7	7	527	54	10.23%	626.89	537.99	88.90	14.18%	£ 455,464	71.89%	£ 178,123	£ 633,587		12.28	64%	6.83	36%	19.10	3.65%	79.30%	92.00%	70.30%
Jul-17	12	8	529	53	10.08%	626.89	539.85	87.04	13.88%	£ 423,467	64.30%	£ 235,115	£ 658,582		10.55	60%	7.15	40%	17.70	3.44%	79.64%	96.00%	72.70%
Aug-17	7	9	530	56	10.66%	635.96	539.03	96.93	15.24%	£ 395,317	68.04%	£ 185,665	£ 580,982		10.10	57%	7.63	43%	17.73	3.25%	78.48%	96.00%	70.30%
Sep-17																							
Oct-17																							
Nov-17																							
Dec-17																							
Jan-18																							
Feb-18																							
Mar-18																							
totals	38	34		Average	10.02%			Average	13.71%	£ 379,882									Average	3.37%	78.42%		

Month 5 position shows a decrease in spend on Agency and reduced sickness levels. Overall vacancy levels have increased slightly and remain high in some areas. Staff sickness has decreased this month to 3.25%. Mandatory training compliance levels have decreased and are still below target. Appraisal compliance remains red at 70.30%.

Sickness

We have developed a sickness tracker system to keep track of individual long term cases. Our absence rate has come down and is now under target. Our long term sickness is starting to reduce. Main drivers for sickness continue to be anxiety, injury and gastro-intestinal reasons. HR are working with Occupational Health to help managers to manage individual cases, much detailed work is taking place which is being reflected in our sickness rates.

Agency

The number of our agency medical staff bookings stands at 9. However, some of these are high cost and long term, and are in areas such as Gastroenterology, Elderly Medicine, Heamatology and Respiratory Medicine.

All bookings are being regularly reviewed in the light of patient safety considerations. We are currently using around 120 agency nurse shifts on average per week, across the Directorate with Thornbury use occurring in areas such as Whiteparish, Emergency Department and Winterslow ward to fill those hard to cover shifts our main agency supplier has been unable to fill.

Recruitment

We are recruiting to vacancies across the Directorate. We have recently appointed an Elderly Care Consultant, a fixed term Consultant in ED, a Palliative Care Consultant and a Consultant in Stroke Medicine, who are all due to start in September. We have a Consultant in Cardiology due to start in October.

Surgical Directorate Workforce Dashboard

	Strs/Lvrs		Turnover (FTE)			Vacancies				Temporary Spend					Sickness						Training	Appraisal	
	Starters *(headcount in month)*	Leavers *(headcount in month)*	Average Heads *(in year)*	Number of Leavers *(in year)*	Turnover *(rolling year)*	Budget Wte (Ledger)	Staff In Post Wte *(Ledger - month end)*	Vacant Wte	Vacancy Rate	spend on Agency	% Temp Spend on Agency *(in month)*	spend on Bank	Total Temp Spend	Agency Budget	Long Term Sick WTE lost *(in month)*	%	Short Term Sick WTE lost *(in month)*	%	Total WTE lost to Sickness *(in month)*	Sickness Rate (Rolling Year)	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
YTD Trend	*Data excludes: Docs in Training & Tupe Transfers*				√				√	√	√	√	√		√		√		√	√	√	√	√
Month Trend					↑				↑	↑	↑	↓	↑		↑		↓		↑	↓	↑	↑	↑
Target		5		47	8.50%			29.54	5.00%		40.00%								18.78	3.40%	85.00%	85.00%	85.00%
Apr-17	8	3	555	53	9.46%	590.74	552.27	38.47	6.51%	£ 58,608	33.69%	£ 115,358	£ 173,966		14.80	59%	10.35	41%	25.14	4.55%	85.00%	89.00%	79.80%
May-17	9	4	555	52	9.41%	590.71	559.37	31.34	5.31%	£ 91,279	46.17%	£ 106,441	£ 197,720		15.98	57%	11.81	43%	27.79	5.02%	84.60%	92.00%	81.80%
Jun-17	10	5	556	51	9.23%	592.92	561.14	31.78	5.36%	£ 75,379	43.93%	£ 96,218	£ 171,597		14.67	59%	10.08	41%	24.75	4.57%	86.20%	95.00%	81.90%
Jul-17	9	7	557	53	9.52%	608.75	577.02	31.73	5.21%	£ 108,431	47.91%	£ 117,894	£ 226,325		18.07	64%	10.11	36%	28.18	5.21%	86.68%	96.00%	81.70%
Aug-17	7	7	557	56	10.04%	607.99	564.10	43.89	7.22%	£ 127,357	54.12%	£ 107,984	£ 235,341		20.89	72%	7.93	28%	28.82	5.15%	87.20%	97.00%	82.00%
Sep-17																							
Oct-17																							
Nov-17																							
Dec-17																							
Jan-18																							
Feb-18																							
Mar-18																							
totals	43	26		Average	9.53%			Average	5.92%	£ 92,211									Average	4.90%	85.94%		

Month 5 position shows an increase in spend on Agency, and decreased sickness levels. Overall vacancy levels have increased and remain high in some areas. Staff sickness remains above target at 5.15%. Mandatory training compliance levels have improved and are now above target. Appraisal compliance remains amber at 82.00%.

Sickness

We are carrying out a piece of work focussing on the management of frequent short term absentees. Short term sickness has now reduced as a proportion of our overall sicknes, and is now below the average rate for the Trust (28%). Our long term sickness has increased this month. We are monitoring and managing individual cases in conjunction with Occupational Health, using our sickness tracker system.

Agency

We had zero Medical Agency staff spend for August. We are currently using around 70 -80 agency nurse shifts on average per week, across the Directorate with main areas of Thornbury use occurring in areas such as Day Surgery. We currently have two non-clinical agency staff in our Central Booking department, these are going onto Trust contracts of employment in September.

Recruitment

We are running a generic advert for Nursing. Particular areas of difficulty include Day Surgery and Critical Care. We have recruited four staff nurses and 2 Theatre practitioners who are due to start in Theatres in September and October, 3 staff Nurses are due to start elsewhere in the Directorate in September.

Clinical Support and Family Services Directorate Workforce Dashboard

	Strs/Lvrs		Turnover (FTE)			Vacancies				Temporary Spend					Sickness						Training	Appraisal	
	Starters *(headcount in month)*	Leavers *(headcount in month)*	Average Heads *(in year)*	Number of Leavers *(in year)*	Turnover *(rolling year)*	Budget Wte (Ledger)	Staff In Post Wte *(Ledger - month end)*	Vacant Wte	Vacancy Rate	spend on Agency	% Temp Spend on Agency *(in month)*	spend on Bank	Total Temp Spend	Agency Budget	Long Term Sick WTE lost *(in month)*	%	Short Term Sick WTE lost *(in month)*	%	Total WTE lost to Sickness *(in month)*	Sickness Rate (Rolling Year)	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
YTD Trend	*Data excludes: Docs in Training & Tupe Transfers*																						
Month Trend																							
Target		7		65	8.50%			39.82	5.00%		40.00%								19.17	2.50%	85.00%	85.00%	85.00%
Apr-17	15	9	764	75	9.77%	796.30	766.98	29.32	3.68%	£ 90,975	42.84%	£ 121,389	£ 212,364		10.54	59%	7.35	41%	17.89	2.46%	86.80%	87.00%	83.00%
May-17	16	3	765	71	9.22%	801.01	767.61	33.40	4.17%	£ 96,376	51.29%	£ 91,514	£ 187,890		8.65	53%	7.56	47%	16.21	2.23%	85.40%	90.00%	82.20%
Jun-17	11	7	768	76	9.90%	807.94	782.93	25.01	3.10%	£ 113,177	57.30%	£ 84,351	£ 197,528		8.69	54%	7.43	46%	16.12	2.20%	85.40%	89.00%	82.50%
Jul-17	15	8	770	70	9.09%	812.23	777.40	34.83	4.29%	£ 57,167	37.25%	£ 96,284	£ 153,451		8.55	49%	9.01	51%	17.56	2.31%	86.57%	91.00%	85.00%
Aug-17	15	10	772	70	9.06%	811.48	781.41	30.07	3.71%	£ 109,371	56.29%	£ 84,915	£ 194,286		9.34	45%	11.24	55%	20.58	2.62%	86.40%	90.00%	85.80%
Sep-17																							
Oct-17																							
Nov-17																							
Dec-17																							
Jan-18																							
Feb-18																							
Mar-18																							
totals	72	37		Average	9.41%			Average	3.79%	£ 93,413									Average	2.36%	86.11%		

Month 5 position shows an increase in spend on Agency, and increased sickness levels. Overall vacancy levels have decreased and remain high in some areas. Staff sickness this month is at 2.62%. Mandatory training compliance levels have slightly decreased but remain above target. Appraisal compliance has increased to 85.80%. Key areas identified for action include :

Sickness

Our overall Directorate sickness rate is above target. We have a continuing focus on key areas of high sickness, e.g. Maternity, Endoscopy and our screening programmes, as well as a focus on frequent short term sickness (including the top 5 individuals by Bradford Factor score without underlying health conditions), through Occupational Health referrals, medical advice to enable managers to make a decision over whether to terminate contracts, or facilitate returns to work through alternative roles or phased return.

Agency

We have agreed a trajectory by the end of September to reduce agency Radiographer spend as part of our regular perfomance meetings with Executive Directors. We have recently recruited to vacant Radiographer posts to help with this. With regard to Medical Agency spend, our Radiologist team are doing additional PAs to help cover and reduce the need for Agency, alongside outsourcing reporting. Some Occupational Therapist agency spend has been removed, and the bulk of the rest will cease by the end of October as new starters join.

Recruitment

We have recruited to 2.0 FTE of our 3.6 FTE Radiologist vacancies, both are due to start by year end. We have a 1.0 FTE Histopathologist vacancy, which may be difficult to recruit to, so we are looking at other ways to support the service, e.g. Backlogs Ltd., which is an on-line commercial reporting service. We have 2 Midwives starting in September, and 6 preceptee Midwives appointed and due to start in October. We have 2.0 FTE Occupational Therapists recruited and due to start by the end of October to replace agency.

Corporate Directorates Workforce Dashboard

	Strs/Lvrs		Turnover (FTE)			Vacancies				Temporary Spend				Agency Budget	Sickness						Training	Appraisal	
	Starters *(headcount in month)*	Leavers *(headcount in month)*	Average Heads *(in year)*	Number of Leavers *(in year)*	Turnover *(rolling year)*	Budget Wte (Ledger)	Staff In Post Wte *(Ledger - month end)*	Vacant Wte	Vacancy Rate	spend on Agency	% Temp Spend on Agency *(in month)*	spend on Bank	Total Temp Spend		Long Term Sick WTE lost *(in month)*	%	Short Term Sick WTE lost *(in month)*	%	Total WTE lost to Sickness *(in month)*	Sickness Rate (Rolling Year)	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
YTD Trend	*Data excludes: Docs in Training & Tupe Transfers*																						
Month Trend																							
Target		7		33	8.50%			20.47	5.00%		40.00%								266.13	3.00%	85.00%	85.00%	85.00%
Apr-17	2	5	390	33	8.33%	409.43	385.69	23.74	5.80%	£ 3,361	7.44%	£ 41,788	£ 45,149		5.15	61%	3.30	39%	8.44	1.87%	78.90%	N/A	79.50%
May-17	5	3	388	31	7.96%	383.04	362.39	20.65	5.39%	£ 469	1.39%	£ 33,263	£ 33,732		7.68	77%	2.28	23%	9.96	2.72%	83.90%	N/A	81.30%
Jun-17	4	5	387	40	10.32%	380.27	362.37	17.90	4.71%	£ -	0.00%	£ 31,146	£ 31,146		6.24	72%	2.43	28%	8.67	2.30%	81.00%	N/A	81.50%
Jul-17	6	7	385	36	9.43%	386.31	357.89	28.42	7.36%	£ 11,702	22.76%	£ 39,702	£ 51,404		4.29	68%	2.06	32%	6.36	2.25%	88.15%	N/A	78.00%
Aug-17	3	4	384	40	10.50%	386.51	371.88	14.63	3.79%	£ 23,616	39.51%	£ 36,153	£ 59,769		3.01	47%	3.46	53%	6.47	2.13%	84.13%	N/A	78.90%
Sep-17																							
Oct-17																							
Nov-17																							
Dec-17																							
Jan-18																							
Feb-18																							
Mar-18																							
totals	20	24		Average	9.31%			Average	5.41%	£ 7,830									Average	2.25%	83.22%		

Month 5 position shows an increased spend on Agency. Overall vacancy levels have decreased . Staff sickness this month is at 2.13%. Mandatory training compliance levels have decreased this month. Appraisal compliance is in red at 78.90%. Key areas identified for action include :

Sickness

Sickness is below target and is reducing. The majority is long term. We are experiencing particular difficulties with sickness in Estates which is being actively managed. We are focussing on frequent high Bradford score individuals. Long term sickness cases are being formally reviewed at review meetings which involve individuals, managers and HR to facilitate an early return to work.

Agency Spend

Agency use is minimal and has been restricted to Medical Coding and Payroll to cover for long term sickness and vacancies.

Recruitment

Staff turnover is still above target. Areas of high turnover include Estates Technical Services, where competition exists with other local employers. ETS have now made a number of appointments which will start in September.

Facilities Directorate Workforce Dashboard

	Strs/Lvrs		Turnover (FTE)			Vacancies				Temporary Spend				Agency Budget	Sickness						Training	Appraisal	
	Starters *(headcount in month)*	Leavers *(headcount in month)*	Average Heads *(in year)*	Number of Leavers *(in year)*	Turnover *(rolling year)*	Budget Wte (Ledger)	Staff In Post Wte *(Ledger - month end)*	Vacant Wte	Vacancy Rate	spend on Agency	% Temp Spend on Agency *(in month)*	spend on Bank	Total Temp Spend		Long Term Sick WTE lost *(in month)*	%	Short Term Sick WTE lost *(in month)*	%	Total WTE lost to Sickness *(in month)*	Sickness Rate (Rolling Year)	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
YTD Trend	*Data excludes: Docs in Training & Tupe Transfers*																						
Month Trend																							
Target		3		20	8.50%			11.22	5.00%		40.00%								7.80	3.50%	85.00%	85.00%	85.00%
Apr-17	6	1	238	13	5.52%	224.40	222.96	1.44	0.64%	£ 10,759	41.96%	£ 14,881	£ 25,640		6.48	72%	2.54	28%	9.02	4.32%	92.00%	N/A	97.70%
May-17	1	-	235	13	5.39%	224.40	217.13	7.27	3.24%	£ 5,045	30.98%	£ 11,239	£ 16,284		7.39	69%	3.27	31%	10.66	5.06%	94.00%	N/A	97.30%
Jun-17	3	2	231	14	5.97%	224.40	217.51	6.89	3.07%	£ 7,948	45.70%	£ 9,443	£ 17,391		8.11	72%	3.13	28%	11.23	5.30%	95.60%	N/A	97.80%
Jul-17	2	7	227	15	6.52%	224.40	218.52	5.88	2.62%	£ 18,237	53.25%	£ 16,010	£ 34,247		8.25	63%	4.80	37%	13.05	6.23%	95.59%	N/A	95.60%
Aug-17	5	1	223	14	6.07%	224.40	217.25	7.15	3.19%	£ 1,680	13.19%	£ 11,061	£ 12,741		6.48	68%	3.04	32%	9.51	4.60%	94.24%	N/A	95.30%
Sep-17																							
Oct-17																							
Nov-17																							
Dec-17																							
Jan-18																							
Feb-18																							
Mar-18																							
totals	17	11		Average	5.90%			Average	2.55%	£ 8,734									Average	5.10%	94.29%		

Month 5 position shows a decreased spend on Agency, and decreased sickness levels. Overall vacancy levels have increased. Staff sickness remains above target at 4.60%. Mandatory training compliance levels have remained above target. Appraisal compliance remains green at 95.30%. Key areas identified for action include :

Sickness

Our sickness is predominantly long term. As well as focussing on top five high Bradford score sickness, we are looking at long term sickness cases with a view to resolving those as soon as possible. Currently we are progressing two redeployments and one retirement.

Agency Spend

Agency use is minimal and has reduced in month 5. Use fluctuates in response to demand for one off events such as deep cleans or "PLACE" audits.

Recruitment

We still have particular recruitment difficulties with Chefs, due to competition from the private sector. We have been working with our Recruitment Team to improve the speed of our process to offset competition from other employers.

Key Areas of Concern

KPI	Overall Commentary
Turnover *(measured in a rolling year)* ***Target 8.5%***	Turnover increased slightly this month but remains green rated. **Actions Underway:** • 'Fresh Eyes' sessions held with the Chief Executive monthly (to meet with new starters to understand their experience • engagement strategy, media strategy **Planned Actions:** • 30 day and 100 day questionnaires • Introducing 'transfer windows' for nursing staff to aid retention
Vacancies ***Target 5%***	The vacancy rate has increased this month by 0.80% to 9.64%, a red rating. **Actions Underway:** • Developing apprenticeships to help create our own pathway into Nursing • Holding Nursing and Nursing Assistant careers fairs and open days • Travelling internationally to recruit Nurses and middle grade Doctors **Planned actions:** • Review of recruitment processes and systems • Review of capacity in the recruitment service • Development of a media and branding strategy • Review the employment package offered to staff • Partner with line managers to effectively recruit • Greater use of apprenticeships and a "grow our own strategy" • Recruitment plan to get to 95% fill • Working with the STP on a system wide recruitment plan and campaign. • Open days for recruitment

highest Turnover rates

		Jul-17	Aug-17	T
1	Ophthalmology	16.97%	22.69%	↑
2	District Pharmacy	22.03%	19.21%	↓
3	Directorate of Operations	18.83%	18.56%	↓
1	Corporate Directorates	11.78%	13.43%	↑
1	Add Prof Scientific and Technical	14.34%	13.90%	↓

highest number of leavers

1	Theatres	21	25	↑
2	Elderly Care	15	17	↑
3	Pathology	15	17	↑
1	Clinical Support & Family Services	79	83	↑
1	Nursing and Midwifery Registered	77	86	↑

highest Vacancy rate

		Jul-17	Aug-17	T
1	Elderly Care	23.01%	27.60%	↑
2	Spinal Unit	23.04%	25.43%	↑
3	Adult Medical Wards	20.90%	24.87%	↑
1	Musculo-Skeletal Directorate	14.71%	16.23%	↑
1	Estates Staff	8.87%	17.99%	↑

highest WTE Vacant

1	Elderly Care	31.08	37.27	↑
2	Adult Medical Wards	28.25	33.66	↑
3	Spinal Unit	24.47	26.88	↑
1	Medicine Directorate	87.04	96.93	↑
1	Nursing and Midwifery Registered	137.58	152.51	↑

Key Areas of Concern

KPI	Overall Commentary
Temporary Spend ***Agency Control Total £6,200,000***	**Actions underway:** • Holding weekly agency review meetings with the Medical Director and Director of OD and People. • Managing our mastervend agency supplier (Total Assist) with a 3 month recovery plan. • Growing our own temporary locum bank through Locums Nest, and aligning with recruitment. **Planned actions:** • HR and Finance are working on agency reduction plans for the whole Trust, and specific plans for Directorates will be developed. Each Directorate management team will need to develop a final plan to reduce temporary spend, recruit to vacant posts and deliver agency spend to cap. Paper to Joint Board of Directors Wednesday 20th September 2017.
Sickness Year to date ***Target 3%***	Sickness is red rated at 3.52% but is below average of the surrounding Local Acute hospital Trusts. **Actions underway:** • Additional resource in place within HR team to support departments with high sickness absence • Theatres Working Group to tackle absence (as one of the highest areas) • The Sickness Absence Policy is being revised as part of a wider policy review **Planned actions:** • Undertake detailed analysis of the anxiety/stress sickness absence to feed into the Health and Wellbeing Strategy • Refresh and re-launch the Health and Wellbeing Strategy • Occupational Health Service Review

highest proportion of temporary spend on agency

		Jul-17	Aug-17	T
1	Geriatrics	100.00%	100.00%	→
2	Junior Doctors Medicine	100.00%	100.00%	→
3	Gastroenterology	100.00%	100.00%	→
1	Medicine Directorate	64.30%	68.04%	↑
1	Professions Allied to Medicine	100.00%	100.00%	→

highest £ spent on Agency

1	Clin Radiology Ex Spin/CT	£ 25,286	£ 69,757	↑
2	Gastroenterology - Medical Staff	£ 43,324	£ 57,173	↑
3	Orthopaedic - Medical Staff	£ 42,390	£ 47,219	↑
1	Medicine Directorate	£ 423,467	£ 395,317	↓
1	Medical and Dental	£ 343,290	£ 327,655	↓

highest Sickness rate

		Jul-17	Aug-17	T
1	Main Outpatients	7.53%	9.50%	↑
2	Theatres	7.14%	7.02%	↓
3	Screening Programmes	5.91%	6.26%	↑
1	Surgery	5.21%	5.15%	↓
1	Additional Clinical Services	5.46%	5.25%	↓

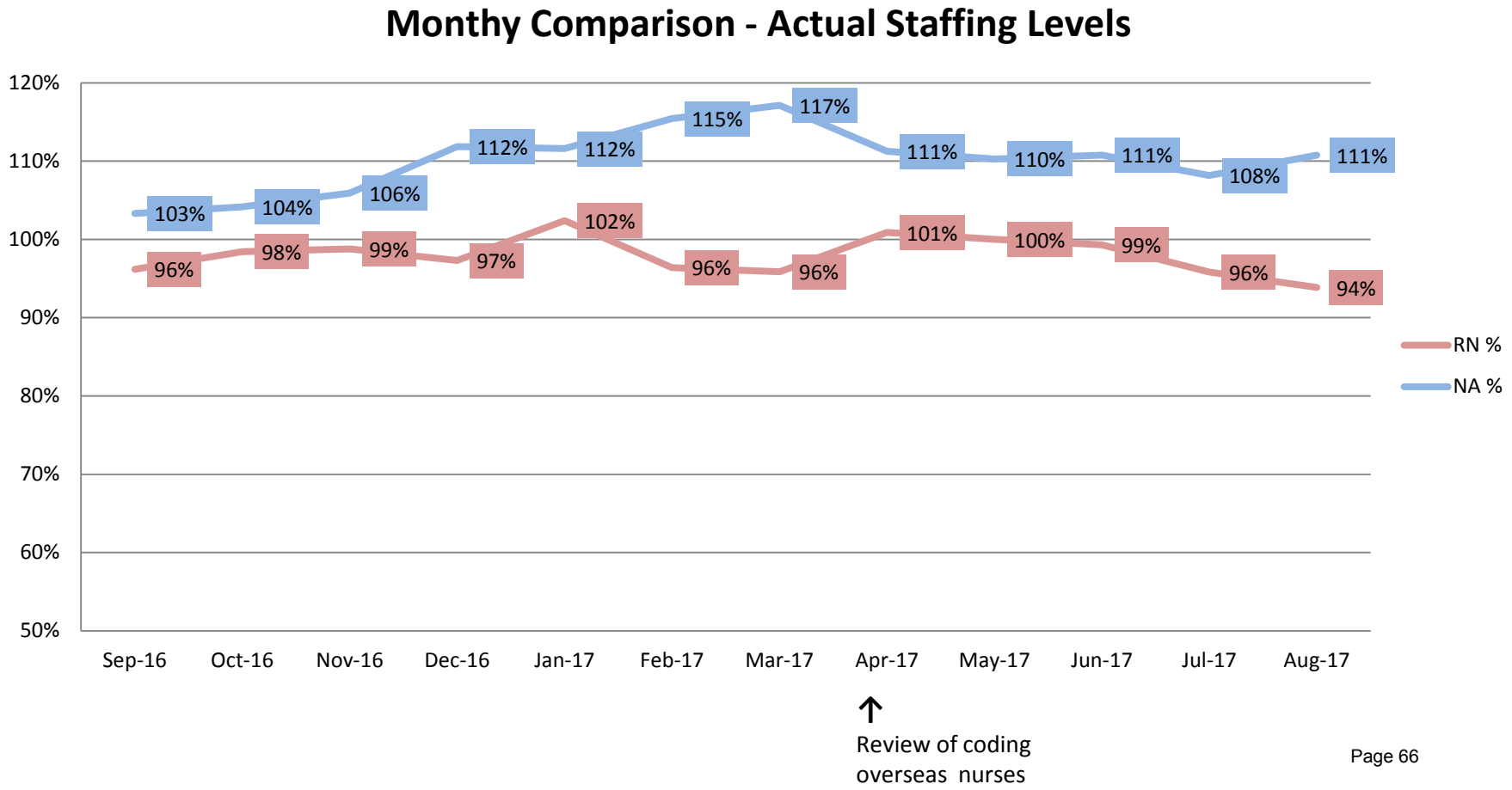
highest WTE sick in month

1	Theatres	13.55	13.20	↓
2	Obstetrics and Gynaecology	6.58	6.08	↓
3	Hotel Services	5.88	6.05	↑
1	Surgery Directorate	25.91	25.61	↓
1	Nursing and Midwifery Registered	31.06	30.06	↓

Safe Staffing NQB Report – August 2017

Monthly Comparisons – Actual Staffing Levels

	Registered Nurses			Nursing Assistants			Combined			Skill Mix	
Month	Planned hours	Actual Hours	%	Planned Hours	Actual Hours	%	Planned Hours	Actual Hours	%	RN	NA
Aug-17	58767.3	55159.7	94%	33082.2	36638.6	111%	91849.5	91798.3	100%	60%	40%



Overview of Nurse Staffing Hours – August 2017

Day	RN	NA
Total Planned Hours	34702.78	21082.50
Total Actual Hours	32084.73	22992.77
Fill Rate (%)	92.5%	109.1%

Night	RN	NA
Total Planned Hours	24064.5	11999.7
Total Actual Hours	23074.95	13645.83
Fill Rate (%)	95.9%	113.7%

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

Nursing Hours by Day Shifts

Row Labels	Day RN Planned	Day RN Actual	Day RN Fill Rate	Day NA Planned	Day NA Actual	Day NA Fill Rate
Medicine	**14702.82**	**13091.90**	**89.7%**	**10178.33**	**11761.30**	**121.7%**
Breamore	1081.50	752.75	69.6%	871.75	1332.75	152.9%
Durrington	1076.00	1003.25	93.2%	925.50	909.00	98.2%
Farley	2151.00	1838.25	85.5%	1554.00	1800.50	115.9%
Hospice	912.00	934.50	102.5%	664.00	667.50	100.5%
Pembroke	794.83	791.08	99.5%	352.00	761.50	216.3%
Pitton	1786.00	1528.75	85.6%	1182.08	1315.30	111.3%
Redlynch	1533.48	1421.48	92.7%	1135.50	1280.00	112.7%
Tisbury	2068.25	1811.75	87.6%	702.50	694.00	98.8%
Whiteparish	1796.50	1767.83	98.4%	1092.00	1036.50	94.9%
Winterslow	1503.25	1242.25	82.6%	1699.00	1964.25	115.6%
Surgery	**7085.25**	**6815.08**	**91.8%**	**2810.50**	**2878.75**	**103.7%**
Britford	2030.75	1984.00	97.7%	1190.00	1142.75	96.0%
Downton	1291.50	1124.00	87.0%	925.50	1009.50	109.1%
Radnor	3051.50	3139.50	102.9%	357.50	340.00	95.1%
DSU Inpatient Ward	711.50	567.58	79.8%	337.50	386.50	114.5%
MSK	**7581.75**	**7066.67**	**92.6%**	**6725.92**	**7072.38**	**110.8%**
Amesbury	1656.50	1702.50	102.8%	1424.00	1386.33	97.4%
Avon	1534.58	1473.92	96.0%	1952.17	1719.25	88.1%
Burns	1503.00	1347.50	89.7%	746.00	1105.47	148.2%
Chilmark	1572.75	1511.50	96.1%	1118.00	1245.75	111.4%
Tamar	1314.92	1031.25	78.4%	1485.75	1615.58	108.7%
CSFS	**5332.97**	**5111.08**	**98.9%**	**1367.75**	**1280.33**	**63.9%**
Maternity	3187.17	2903.92	91.1%	1030.25	942.08	91.4%
NICU	1076.30	1210.00	112.4%	0.00	0.00	0.0%
Sarum	1069.50	997.17	93.2%	337.50	338.25	100.2%
Grand Total	**34702.78**	**32084.73**	**92.0%**	**21082.50**	**22992.77**	**108.1%**

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

Nursing Hours by Night Shifts

Row Labels	Night RN Planned	Night RN Actual	Night RN Fill Rate	Night NA Planned	Night NA Actual	Night NA Fill Rate
Medicine	**9846.00**	**9527.00**	**97.5%**	**5410.20**	**6614.58**	**111.9%**
Breamore	712.50	701.00	98.4%	713.00	724.50	101.6%
Durrington	713.00	736.00	103.2%	713.00	746.00	104.6%
Farley	1069.50	1081.50	101.1%	713.00	770.50	108.1%
Hospice	589.00	591.00	100.3%	419.20	414.50	98.9%
Pembroke	713.00	725.00	101.7%	0.00	376.17	100.0%
Pitton	1069.50	1138.50	106.5%	713.00	928.08	130.2%
Redlynch	1069.50	977.50	91.4%	713.00	874.00	122.6%
Tisbury	1414.50	1299.50	91.9%	356.50	343.83	96.4%
Whiteparish	1426.00	1368.50	96.0%	356.50	390.50	109.5%
Winterslow	1069.50	908.50	84.9%	713.00	1046.50	146.8%
Surgery	**4955.00**	**4808.00**	**97.4%**	**1897.50**	**2035.25**	**112.7%**
Britford	1058.00	1010.00	95.5%	713.00	792.75	111.2%
Downton	713.00	678.00	95.1%	713.00	746.50	104.7%
Radnor	2563.00	2485.75	97.0%	356.50	333.50	93.5%
DSU Inpatient Ward	621.00	634.25	102.1%	115.00	162.50	141.3%
MSK	**4278.00**	**4016.70**	**94.7%**	**3564.50**	**3861.50**	**108.5%**
Amesbury	1069.50	1012.20	94.6%	713.00	729.50	102.3%
Avon	930.00	858.50	92.3%	930.00	900.00	96.8%
Burns	1069.50	954.50	89.2%	713.00	1023.50	143.5%
Chilmark	589.00	589.50	100.1%	589.00	589.00	100.0%
Tamar	620.00	602.00	97.1%	619.50	619.50	100.0%
CSFS	**4985.50**	**4723.25**	**96.1%**	**1127.50**	**1134.50**	**104.7%**
Maternity	2846.50	2627.25	92.3%	1070.00	1008.00	94.2%
NICU	1069.50	1060.00	99.1%	0.00	0.00	0.0%
Sarum	1069.50	1036.00	96.9%	57.50	126.50	220.0%
Grand Total	**24064.50**	**23074.95**	**96.7%**	**11999.70**	**13645.83**	**110.3%**

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

Reporting Information for August 2017

The reporting data crosses roster periods covering both July and August 2017.

As a result please note the following amendments continue into this month's submission due to temporary ward relocations:

DSU Inpatient Ward was opened 1st July.

Laverstock was open between 1st - 16th July then merged with Burns creating a new roster *Plastic & Burns*. This is displayed as **Burns.**

Winterslow moved to Laverstock on 21st July.

This roster was renamed *Laverstock 2* however the data has been merged under the name **"Winterslow".**

(Farley also moved on 21st July, but remains unchanged.)

Overview of Areas with Red

(Internal rating below 80%)

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	**Breamore**	69%	√		Day	The ward is running with RN vacancies. Each shift is risk assessed based upon patient acuity and dependency. NA day shifts are overstaffed (153%) evidencing the use of NA staff to support unfilled RN shifts
Red	**Tamar**	78%	√		Day	The unit continues to carry vacancies and works in conjunction with Avon and Spinal OPD staff to ensure shifts are supported and safe levels of care are provided. Following review of patient acuity , Late shift band 5 is occasionally filled with an alternative grade (band 2 or 3).

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

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

Overview of Areas with Amber

(Internal Rating 80-90%)

Flag	Ward	%	RN	NA	Shift	Mitigation
Amber	Farley	85%	√		Day	The unit carries vacancies and will cover any remaining RN shifts using a locally skilled band 2 staff to support staffing numbers. NA shifts are overstaffed to 115% reflecting the 15 % shortfall in RN shifts which been covered by the NA staff.
Amber	Pitton	86%	√		Day	As per Farley. NA uplift was higher for days with overstaffing at 111% to compensate for the reduced RN cover.
Amber	Tisbury	88%	√		Day	This unit has 5 designated level 2 beds. Following risk assessments, reduced staffing will be due to the reduction in patient acuity when the ward may be safely run 1 x RN short.
Amber	Winterslow (Laverstock 2)	83%	√		Day	Overstaffing of NA on days is 115% providing evidence that locally skilled NA staff are used to help cover unfilled RN shifts to support unfilled shift numbers
Amber	Winterslow (Laverstock 2)	85%	√		Night	As above. 3rd RN shift may be covered by locally skilled NA staff as per Farley and Pitton. Overstaffing for NA nights is 147% accounting for some of this**.**
Amber	Downton	87%	√		Day	The unit is carrying vacancies and so each shift is risk assessed at the twice daily operational meetings. Britford ward supports on a ah-hoc basis to support any shift needs.
Amber	DSU Inpatient	80%	√		Day	Extra shift cover was required due to escalation for increased bed demand. Unfilled agency shifts were supported as required by Britford wad and DSU clinical staff.

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

Overview of Areas with Amber

(Internal Rating 80-90%)

Flag	Ward	%	RN	NA	Shift	Mitigation
Amber	Burns	89%	√		Day	Shifts were not filled by agency and/or remained unfilled based on a risk assessment following a review of the skill mix plus patient acuity & demand. The burns clinic nurses and the Plastics & Burns CNS were utilised to support the ward work load .
Amber	Burns	89%	√		Night	Shifts were not filled by agency and/or remained unfilled based on a risk assessment following a review of the skill mix plus patient acuity & demand.
Amber	Avon	88%		√	Day	The unit continues to carry vacancies and works in conjunction with Tamar and Spinal OPD staff to ensure shifts are supported and safe levels of care are provided. Following review of patient acuity & demand the Late shift band 5 is occasionally filled with an alternative grade (band 2 or 3).

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

Mitigation of Risk for Red/Amber

The gap between RN and NA staffing is widening again with a further 3% uplift of NA staff to 111% and reduction of 2% RN cover to 94%.

The Trust is seeing an increase in RN vacancies with shifts being reviewed on a daily basis and skilled NA staff being used when unable to fill with an RN.

However the skill mix is RN/NA 60% /40% with the combined planned and actual cover being demonstrated at 100%.

The NA uplift is reflecting the use of locally skilled NA staff to cover some unfilled RN day shifts within several of the medical wards. To ensure safe care provision at all times, extra NA staff skills sets were enhanced by ward leaders supporting the shifts from within their supervisory role .

SafeCare is used daily on an operational basis.

Using the SafeCare system, patient acuity and dependency is assessed at least three times a day (covering all shifts) with any further risk assessments taking place at the twice daily operational staffing meetings

Overview of Overstaffed Areas >115%

Ward	%	RN	NA	Shift	Comments
Breamore	153%		√	Day	The ward is staffed for 20 beds but has been running as a 24 bedded unit therefore requiring some increased support in staffing levels . Overstaffing accounts for supporting unfilled RN shifts where required.
Pembroke	216%		√	Day	These are to cover 4 extra capacity beds with an extra NA within the numbers. This is a planned increase as part of the ward reconfiguration work this summer. This increase in establishment will align from September 2017 reporting.
Pitton	130%		√	Night	Overstaffing was to provide enhanced 1:1 care following risk assessments identifying patients at risk of falls or with confusion /mental health needs
Redlynch	122%		√	Night	As per Pitton
Winterslow (Laverstock 2)	147%		√	Night	This is due to a combination of the ward relocating and enhanced 1:1 care for patients deemed at risk of falls or with confusion /mental health needs.
DSU Inpatient	143%		√	Night	Extra staffing is to cover the flexing needs for beds. The commissioning of an extra beds (an increase from 11 to 18 beds) within the downstairs area of the unit occurred during this month.
Sarum	220%		√	Night	Routinely Sarum ward has one NA night shift per week to support cleft surgery undertaken during the previous day. During August, Sarum experienced increased levels of staff sickness, coupled with pre booked annual leave. Therefore options to cover the night shifts with 3 trained nurses as per standard, were limited. Skill mix, capacity/demand and acuity risk assessed, and 3rd RN covered shift by additional NA shift – resulting in increased percentage as per report
Burns (Laverstock, Burns & Plastics)	148%		√	Day	The overstaffing relates to on-going 1:1 enhanced care for a patient with mental health needs
Burns (Laverstock, Burns & Plastics)	143%		√	Night	

Over-staffing

91% of overstaffing was by NA staff for by two main reasons:

1. Enhanced 1:1 care for patients at risk of falls, mental health needs or confusion
2. Using extra NA staff or Band 4 Assistant Practitioners to support staffing levels where there are RN vacancies.

Escalation processes were invoked following risk assessments on a shift by shift basis based on patient acuity and demand.

Tamar is also supported by the Spinal OPD staff whose re-deployment is not currently captured within e-roster (this is being addressed).

Breamore and Pembroke:- As per last month. Both units have extra 4 beds within their capacity and this results in a need for an extra NA to support the extra patient demand.

Pembroke data for the extra beds will start to align within the September report.

Actions taken to mitigate risk

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

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

Report to:	Trust Board	**Agenda item:**	SFT3934
Date of Meeting:	2 October 2017		

Report Title:	Finance Report Month 5			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Prepared by:	Mark Collis- Deputy Director of Finance			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):	None			

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

Executive Summary:
The purpose of this report is to set out the Trust's financial performance for the period to 31st August 2017.

Executive Summary of Key Financial Performance - August 2017

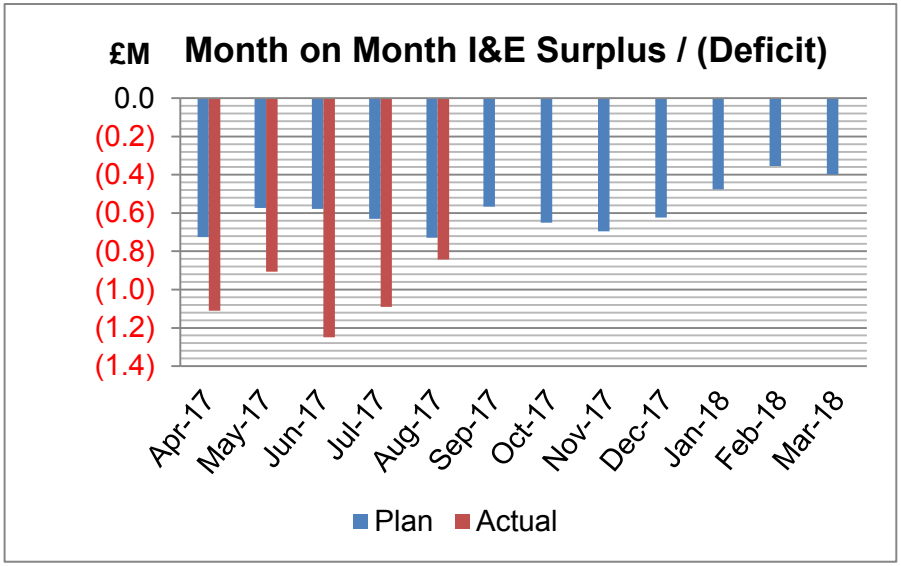
Page	Area of Review	Key Highlights	Status
1	Income & Expenditure	**In Month:** The Trust is reporting a £114k adverse variance against plan in August, this is an improvement on the run rate compared to the first quarter of the financial year. The key pressure in month remains the high cost of agency staff, which was exacerbated during the holiday period. **Year to Date:** The main cause of the YTD deficit relates to under delivery of NHS clinical income in the first three months of the year, (£2,002k behind the plan). CIPs are not being fully delivered and 46% are non-recurring with a similar proportion relying on income	RED
2	NHS Clinical Income	**In Month:** NHS clinical income in month is broadly consistent with last month, with improvements in outpatient activity and income in line with the improvement plan to increase utilisation. **Year to Date:** The most significant areas of underperformance relate to outpatients and elective work in the first quarter of the financial year. Excluded drugs and devices are behind plan but are offset by lower expenditure.	RED
3	Workforce	**In Month:** Pay has increased when compared to last month mainly due to the impact of the school's summer holiday and new GP trainees whihc is offset by income. **Year to Date:** Pay was broadly in line with plan but the adverse variance against the agency control total remains a concern.	GREEN
4	Non Pay	**In Month:** Non pay remains underspent against plan, this is across most areas including drugs and clinical consumables. **Year to Date:** Non Pay spend overall remains behind plan. This in part is due to lower levels of activity than planned. The Trust continues to deliver the procurement savings plan.	GREEN
5	Efficiency - Better Care at Lower Cost	**In Month:** In month the shortfall against plan is £65k, the two directorates with the greatest variances are Medicine and Surgery, mainly due to income CIP schemes not delivering. **Year to Date:** Savings were behind plan due to income generation schemes not delivering in line with lower than planned saving levels for quarter one.	RED
6	Use of Resources rating	The Trust's overall risk rating score remains at 3 under the new single oversight framework. This position is at significant risk if the Trust reports a year end variance significantly off plan. There continues to be on-going discussions with NHSI to develop a recovery plan and mitigate	AMBER
7	Cash Management	**In Month:** No significant change in the cash balance. **Year to Date:** Cash continues to be ahead of plan mainly due to the underspend on capital expenditure.however given the financial position of the Trust this needs to be monitored closely to mitigate cash flow shortfalls in year.	GREEN
8	Capital Expenditure	**In Month:** Spend was in line with plan. **Year to Date:** Although there is currently some in-year slippage on the capital programme the year end position is expected to be in line with the plan.	GREEN

Page 1 - Income & Expenditure

Status	Position	Trend

Income & Expenditure

	YTD (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s
Operating Income			
NHS Clinical Income	78,074	76,072	(2,002)
Other income	12,428	12,223	(205)
Total income	**90,502**	**88,295**	**(2,207)**
Operating Expenditure			
Pay	57,486	57,752	(266)
Non Pay	30,335	29,579	756
Total Expenditure	**87,821**	**87,331**	**490**
EBITDA	**2,681**	**964**	**(1,717)**
Financing Costs	5,917	6,164	(247)
Surplus/(Deficit)	**(3,236)**	**(5,200)**	**(1,964)**



Variation & Action

In Month: The in-month deficit was £843k which was an adverse variance against the plan of £114k. This was a significant improvement in the monthly variance run rate. Compared to the previous month operating income was up by £250k and overall costs remained the same.

Year to Date: The main cause of the YTD deficit was NHS clinical revenue being behind the plan. Of this sum 'excluded pass-through drugs' under-performance was £237k which was matched by expenditure, and as such has no impact on the bottom line. Other areas of concern include agency staffing and in particular locum doctor costs. Also savings were not fully delivered and 46% were non-recurring with a similar proportion relying on income. Efforts are being made to increase cost savings and a number of work streams are in place.

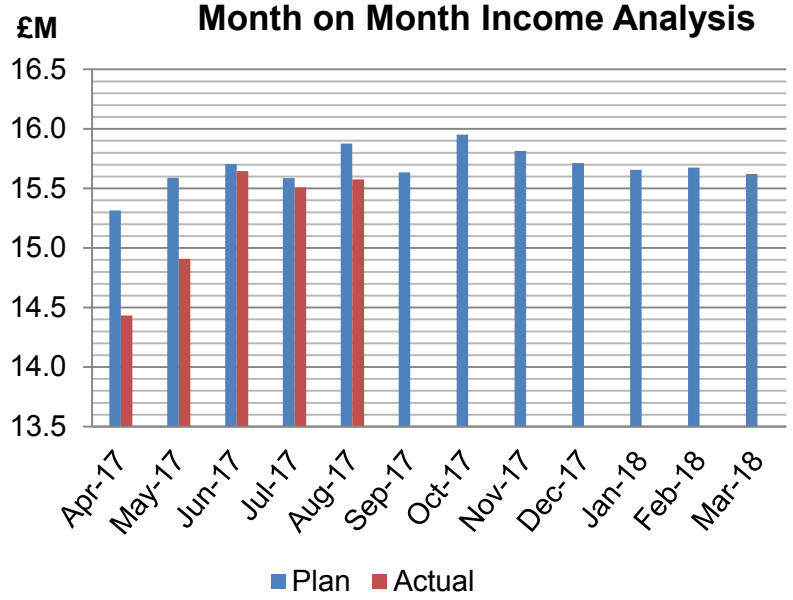
Action: There has been significant work undertaken with the development of the data warehouse and we have seen a material stabilisation of activity and income reporting over the past few months. There continues to be developmental work for the next two months but the confidence level in the data has increased significantly.

Page 2 - NHS Commissioner Income

Status	Position	Trend

NHS Clinical Income

By Point of Delivery	YTD (Cumulative) Plan £000s	Actual £000s	Variance £000s
Day Case	7,444	6,994	(450)
Elective inpatients	6,686	6,495	(191)
Non Elective inpatients	25,833	25,677	(156)
Outpatients	11,391	10,171	(1,220)
Excluded Drugs & Devices	7,256	7,019	(237)
Other	19,464	19,716	252
TOTAL	**78,074**	**76,072**	**(2,002)**
SLA performance			
Wiltshire CCG	39,355	38,902	(453)
Dorset CCG	8,060	8,537	477
Hants CCG	6,459	6,205	(254)
Other CCGs	11,844	9,242	(2,602)
Specialist Services	12,356	13,186	830
TOTAL	**78,074**	**76,072**	**(2,002)**



Variation & Action

In Month: NHS clinical income was broadly the same as last month and there has been a notable improvement in data quality over the past few months. This month there were improvements in same day inpatient and outpatient activity when compared to the previous month.

Year to Date: Income for quarter one was significantly behind plan and overall activity is lower when compared to last year. The main areas of underperformance are outpatients, and elective/day case work.

Action: There continues to be a push to improve theatre utilisation and outpatient capacity. There remain a few outstanding contract actions to be resolved and variations will follow. Work continues with NHS England on the Identification Rules (IR) exercise which will result in financial movements between commissioners. Wiltshire CCG confirmed that contractual fines relating to the achievement of the RTT national standard would be re-invested with the Trust. We are still waiting confirmation of this agreement with the associates of the Wiltshire contract and West Hampshire CCG. This will mitigate a significant risk for the Trust. The validation of readmissions should be resolved shortly as the report has now been made available to Directorates for validation purposes.

Page 3 - Workforce

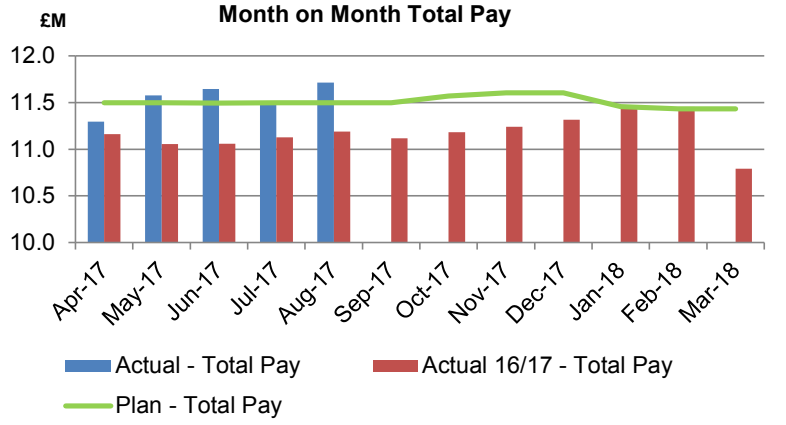
Status	Position	Position

PAY

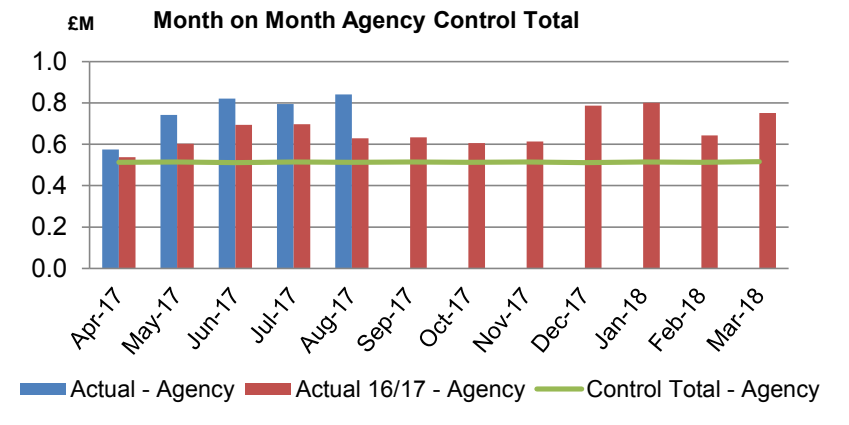
	YTD (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	51,795	51,010	785
Pay - Bank	3,126	2,969	157
Pay - Agency	2,565	3,773	(1,208)
TOTAL	**57,486**	**57,752**	**(266)**
Medical Staff	15,890	16,230	(340)
Nursing	15,847	15,074	773
HCAs	6,039	6,591	(552)
Other Clinical Staff	7,563	7,730	(167)
Infrastructure staff	12,147	12,127	20
TOTAL	**57,486**	**57,752**	**(266)**

Full Time equivalent	YTD		
	Plan FTEs	Actual FTEs	Variance FTEs
Pay - In Post	2,957.56	2,858.92	98.6
Pay - Bank	170.50	194.84	(24.3)
Pay - Agency	83.28	110.10	(26.8)
TOTAL	**3,211.34**	**3,163.86**	**47.48**
Medical Staff	359.87	371.31	(11.4)
Nursing	887.66	818.68	69.0
HCAs	569.63	613.46	(43.8)
Other Clinical Staff	400.75	412.90	(12.2)
Infrastructure staff	993.43	947.51	45.9
TOTAL	**3,211.34**	**3,163.86**	**47.48**

Trend



Trend



Variation & Action

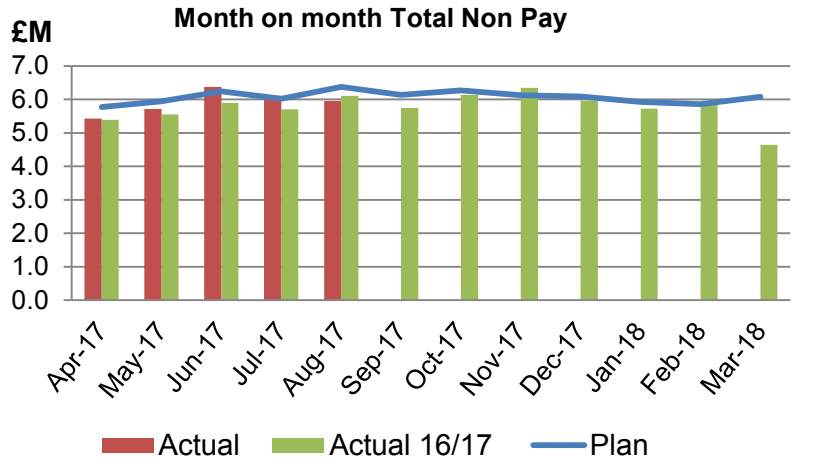
In Month: Overall pay has increased when compared to the previous month as a result of increase in GP trainees which was matched by income; additional extra duty payments for consultants and increase bank and agency costs to cover the holiday period.

Year to Date: Pay was broadly in line with plan but the adverse variance against the agency control total remains a concern.

Action: A weekly meeting has been set up with Clinical Directors chaired by the Medical Director to review and challenge all agency staff. The Director of OD & people has been tasked to develop an action plan to reduce agency spend.

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

Status	Position				Trend
		YTD (Cumulative)			
		Plan £000s	Actual £000s	Variance £000s	
Non Pay	Drugs	8,600	8,304	296	
	Clinical Supplies	8,709	8,184	525	
	General Supplies	2,181	2,068	113	
	Outsourced healthcare	1,820	2,063	(243)	
	Other Non Pay expenses	9,025	8,960	65	
	TOTAL	**30,335**	**29,579**	**756**	



Variation & Action

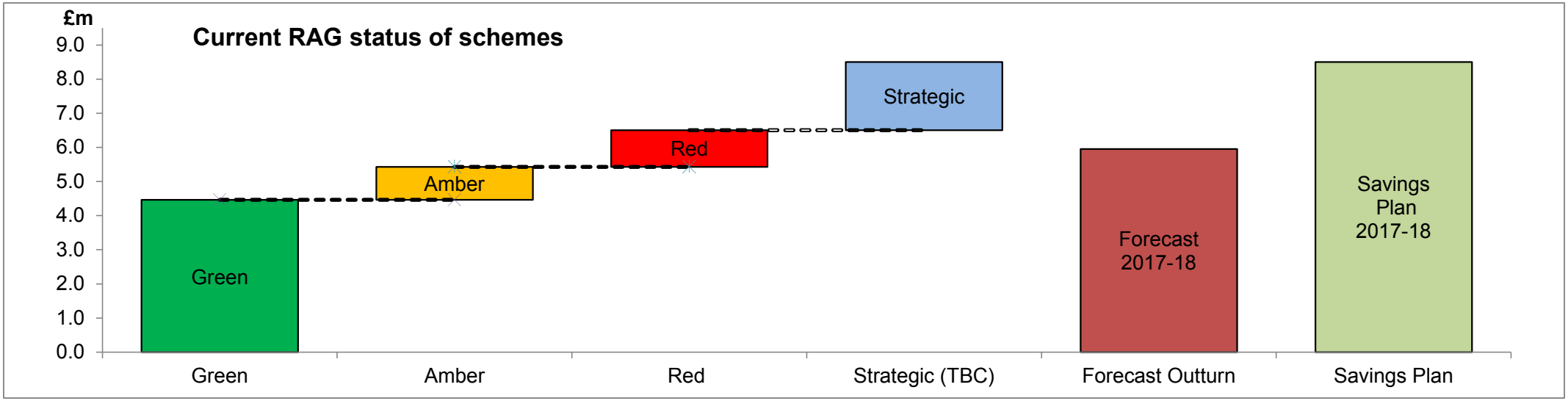
In Month: Overall non pay costs have not changed when compared to the previous month, the main drivers of underspend continue to be activity levels being lower than planned for the first quarter.

Year to Date: Non Pay spend remains underspent against plan overall. The Trust year to date has an adverse variance of £243k on outsourcing clinical activity to external providers for mainly endoscopy and orthopaedics activity.

Action: The non-pay savings work stream continues to be on plan. The Trust needs to review the current use of outsourcing to achieve performance and access targets and ensure capacity is fully utilised internally. The non pay work stream of the CIP programme continues to deliver in line with

Page 5 - Efficiency - Better Care at Lower Cost

Status	Position								
	Directorate	Annual Plan £000s	In Month			Year to Date			Forecast	
			Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Outturn £000s	Variance £000s
Efficiency	Medicine	1,089	89	25	(64)	399	99	(300)	401	(688)
	Musculo Skeletal	933	56	56	0	275	276	1	933	0
	Surgery	1,425	121	41	(80)	478	220	(258)	762	(663)
	Clinical Support & Family Services	1,823	145	131	(14)	707	555	(152)	1,546	(277)
	Corporate Services	1,230	103	131	28	461	567	106	1,588	358
	Strategic Schemes (Incl NHSI Plan phasing)	2,000	-2	63	65	5	63	58	722	(1,278)
	TOTAL	**8,500**	**512**	**447**	**(65)**	**2,325**	**1,780**	**(545)**	**5,952**	**(2,548)**



Variation & Action

In Month: Savings were short by £65k and this included the strategic savings associated with the competitive tendering of the nursery. The adverse variances continues to be driven by medicine and surgery predominately.

Year to Date: Savings were behind plan due to income generation schemes not being delivered.

Action: The Trust's overall activity and income performance it is unlikely to yield any local benefit for the Directorates and the forecast has been adjusted accordingly. The original plan was dependant on the delivery of significant income generation schemes (£2.3m) and this is looking increasingly unlikely to be achieved. Efforts are being made to identify new cost saving schemes and a number of new work-streams are being reviewed with the help of Boston Consulting Group.

Page 6 - Use of Resources

Status	Description	Position			
		Metric	Definition	YTD Plan Number	YTD Actual Number
	NHSI measures an organisation use of resources on a scale of 1-4 with 4 being the highest risk and 1 the lowest risk	Capital service cover rating	Degree to which income covers financial obligations	4	4
		Liquidity rating	Days of operating costs held in cash	2	2
		I&E margin rating	I&E surplus/deficit / total revenue	4	4
		I&E margin: distance from financial plan	YTD actual I&E surplus/deficit compared to YTD plan		4
		Agency rating	Distance from cap	1	3
		Risk rating after overrides			3

Variation & Action

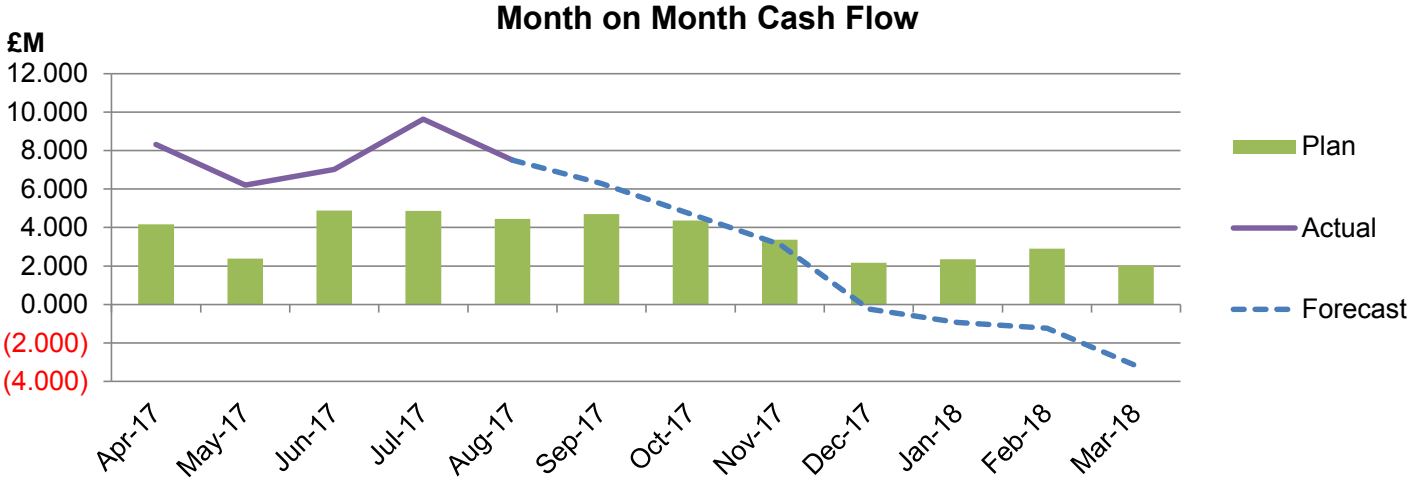
The Trust's overall risk rating score remains at 3 under the new single oversight framework, 1 being the highest score with maximum autonomy. A score of 3 may result providers receiving mandated support for significant concerns but the Trust is not in breach of its licence.

A number of meetings have been held with NHSI to look at the financial sustainability of the Trust. This built upon a separate visit designed to challenge whether we are doing everything possible to address the financial position. The current position and challenges around CIP delivery will no doubt invite further scrutiny from the regulator. The Financial recovery plan clearly needs to both address the year to date shortfall of delivery, but also look to put the Trust back on a sustainable financial pathway.

Page 7 - Cash & Working Capital

Status	Position						Variation & Action
Cash & Working Capital		Opening Balance April 2017 £000s	Plan £000s	Current Month Balance £000s	Variance £000s	Actual In Year Movement £000s	**In Month:** The Trust did not receive any further working capital loans in the month. A further loan of £1, 432k was received in September and an additional £164k requested for October 2017. Monthly cash flows are currently being submitted to NHSI, forecasting forward 3 months. The forecast below does not include any loans required from November 2017 onwards. **Year to Date:** The Trust had received working capital loans of £1,845k to the end of August. These are included in long term borrowings. **Action:** Cash requirements to be monitored monthly.
	Inventories (Stock)	4,950	2,950	5,472	2,522	522	
	Debtors	14,968	12,829	12,354	(475)	(2,614)	
	Cash	7,660	4,455	7,502	3,047	(158)	
	TOTAL CURRENT ASSETS	**27,578**	**20,234**	**25,328**	**5,094**	**(2,250)**	
	Creditors	(20,515)	(18,236)	(20,344)	(2,108)	171	
	Borrowings	(1,140)	(1,159)	(1,159)	0	(19)	
	Provisions	(344)	(214)	(344)	(130)	0	
	TOTAL CURRENT LIABILITIES	**(21,999)**	**(19,609)**	**(21,847)**	**(2,238)**	**152**	
	TOTAL WORKING CAPITAL	**5,579**	**625**	**3,481**	**2,856**	**(2,098)**	

Trend

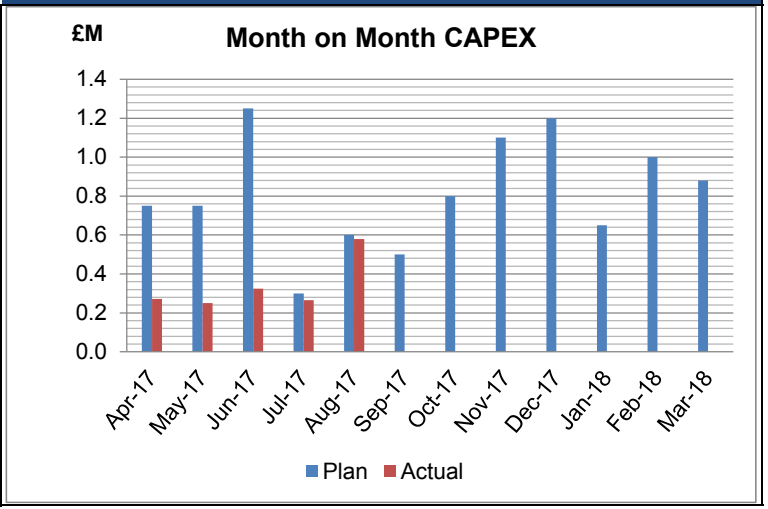


Other Indicators

BPPC % of bills paid in target	Current Month	Previous Month	Movement
- By number	81.0%	81.0%	0.0%
- By value	86.4%	86.0%	(0.4%)
Creditor days	36	36	0
Debtor days	21	21	0

Page 8 - Capital Expenditure

Status	Position							Trend
	Schemes	Annual Plan £000s	YTD (Cumulative) Plan £000s	YTD (Cumulative) Actual £000s	YTD (Cumulative) Variance £000s	Forecast £000s	Variance £000s	
Capital Expenditure	Breast Unit	89	88	88	0	89	0	
	Other	28	17	17	0	28	0	
	Donated: TOTAL	**117**	**105**	**105**	**0**	**117**	**0**	
	Estates - Ward Relocation Project	2,364	1,340	597	743	2,138	226	
	Other Estates Projects	1,328	466	191	275	1,632	(304)	
	Estates: TOTAL	**3,692**	**1,805**	**788**	**1,017**	**3,770**	**(78)**	
	IM&T - EPR / Data Warehouse	2,356	982	532	450	2,182	174	
	IM&T - Other	1,496	512	147	365	1,670	(174)	
	IM&T: TOTAL	**3,852**	**1,493**	**679**	**814**	**3,852**	**0**	
	Medical Equipment: TOTAL	**1,353**	**178**	**84**	**94**	**1,462**	(109)	
	Other: TOTAL	**561**	**74**	35	**39**	**561**	0	
	Contingency	**218**	**0**	**0**	**0**	**0**	218	
	TOTAL	**9,793**	**3,655**	**1,691**	**1,964**	**9,762**	**31**	



Variation & Action

In Month: Capital expenditure increased by £579k in the month. Work is underway on the larger building projects involving the Ophthalmology and AMU schemes and expenditure is expected to increase in the coming months as invoices are received.

Year to Date: Although there is currently some in-year slippage on the capital programme the year end position is expected to be in line with the plan. The capital programme will continue to be monitored on a monthly basis to identify any potential changes to the plan.

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

Report to:	Trust Board	**Agenda item:**	SFT 3935
Date of Meeting:	2 October 2017		

Report Title:	Customer Care Report – Q1			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			**X**
Prepared by:	Hazel Hardyman, Head of Customer Care			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):				

Recommendation:
To note the report.

Executive Summary:
This report provides an overview of the patient experience feedback received in Q1 with the trend in overall contacts (enquiries, comments, concerns and complaints) increasing by 63 from Q1 2016-17 but complaints have decreased by 19. 60 complaints were received which is 0.09% of the number of patients treated and 421 compliments were received which represents 0.6% of the number of patients treated in Q1. There was a reduction in re-opened complaints in Q1 (9) compared to Q4 (20). The main issues from complaints are: • Clinical treatment (23), the same as Q4 but down markedly on last year - sub-themes were 9 unsatisfactory treatment across 9 different areas, 4 delay in receiving treatment, 4 correct diagnosis not made, 3 further complications, 2 inappropriate treatment and 1 treatment unavailable. The Emergency Department received 4 complaints about clinical treatment and 3 each for Cardiology and Orthopaedics. • Staff attitude (11), 1 more than Q4 (10) – 6 related to nursing staff, 4 medical and 1 administrative staff across 8 different areas. • Appointments (9), 3 less than Q4 (12) – sub-themes were 3 appointment date required, 3 appointment procedures, 2 cancelled appointments and 1 appointment delay, across 4 different specialties.

The main issues from concerns were appointments (35), attitude of staff (14), clinical treatment (13) and communication (13). The main area for concerns and complaints about appointments was the Central Booking Department and for staff attitude it was the Emergency Department and Central Booking.

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

A total of 249 inpatients were surveyed in the quarter through real time feedback. They made 179 positive and 151 negative comments. The main areas of concern were food and nutrition on the ward, communication, call bells and environment.

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

There have been 10 PPI new projects, plus one National Patient Survey and 2 completed projects.

NHS Choices received 20 comments in Q1 with 17 positive and 3 negative comments relating to 13 different areas.

Customer Care Report - Quarter 1
1st April – 30th June 2017

PURPOSE OF PAPER

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

1. COMPLAINTS

The main issues from complaints are:

- Clinical treatment (23), the same as Q4 - sub-themes were 9 unsatisfactory treatment across 9 different areas, 4 delay in receiving treatment, 4 correct diagnosis not made, 3 further complications, 2 inappropriate treatment and 1 treatment unavailable. The Emergency Department received 4 complaints about clinical treatment and 3 each for Cardiology and Orthopaedics.
- Staff attitude (11), 1 more than Q4 (10) – 6 related to nursing staff, 4 medical and 1 administrative staff across 8 different areas.
- Appointments (9), 3 less than Q4 (12) – sub-themes were 3 appointment date required, 3 appointment procedures, 2 cancelled appointments and 1 appointment delay, across 4 different specialties.

The main issues from concerns were appointments (35), attitude of staff (14), clinical treatment (13) and communication (13). The main area for concerns and complaints about appointments was the Central Booking Department and for staff attitude it was the Emergency Department and Central Booking.

60 complaints were received in Q1 compared to 65 complaints in Q4 and 79 complaints for the same period in the previous year. The activity from comments, concerns and enquiries has increased from 530 in Q1 last year to 593 in Q1 this year. A breakdown of numbers and themes from complaints according to Datix is below:

	CS&FS	Corporate	Facilities	Medicine	MSK	Surgery	Q1 total 2017-18	Q1 total 2016-17
Admission	0	0	0	0	0	0	0	1
Appointments	0	0	0	1	3	5	9	7
Attitude of staff	3	0	0	4	1	3	11	13
Car parking	0	0	1	0	0	0	1	1
Clinical treatment	4	0	0	11	3	5	23	33
Communication	1	0	0	3	0	3	7	9
Confidentiality	1	1	0	0	0	0	2	2
Delay	1	0	0	0	0	1	2	4
Discharge	0	0	0	2	0	0	2	1
End of life care	0	0	0	0	0	0	0	2
Falls	0	0	0	0	0	0	0	1
Hospital procedures	0	0	0	0	0	0	0	1
Nursing care	0	0	0	0	0	0	0	1
Operation	0	0	0	0	0	1	1	2
Property	0	0	0	0	0	1	1	0
Transfer arrangements	0	0	0	0	0	0	0	1
Trust policy	0	0	0	1	0	0	1	0
Totals:	**10**	**1**	**1**	**22**	**7**	**19**	**60**	**79**
Patient Activity	**9,571**	**0**	**0**	**26,927**	**14,933**	**14,090**		

In Q1 the Trust treated 16,715 people as inpatients, day cases and regular day attendees.
Another 12,683 were seen in the Emergency Department and 36,123 as outpatients. 60 complaints were received overall which is 0.09% of the number of patients treated. There were no complaints about mental health issues this quarter. 421 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. 9 complaints were re-opened in Q1 compared to 21 in Q4 (see below in the directorate section). The overall number of enquiries, comments, concerns and complaints falling into the 25+ working days has decreased from 14% in Q4 to 11.5%:

0-10 working days		11-24 working days		25+ working days	
452	80%	48	8.5%	65	11.5%

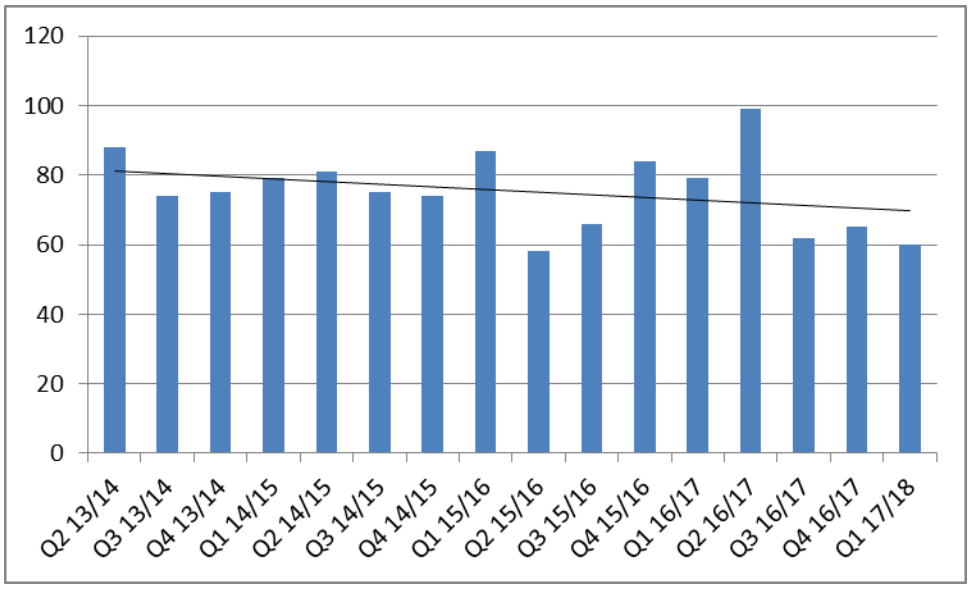
However, response timescales for just complaints beyond 25 working days is unacceptably high and will be the directorates focus:

0-10 working days		11-24 working days		25+ working days	
5	8%	20	34%	35	58%

Reasons for some complaints taking more than 25 working days to respond to is: arranging meetings; operational pressures; and key members of staff on leave.

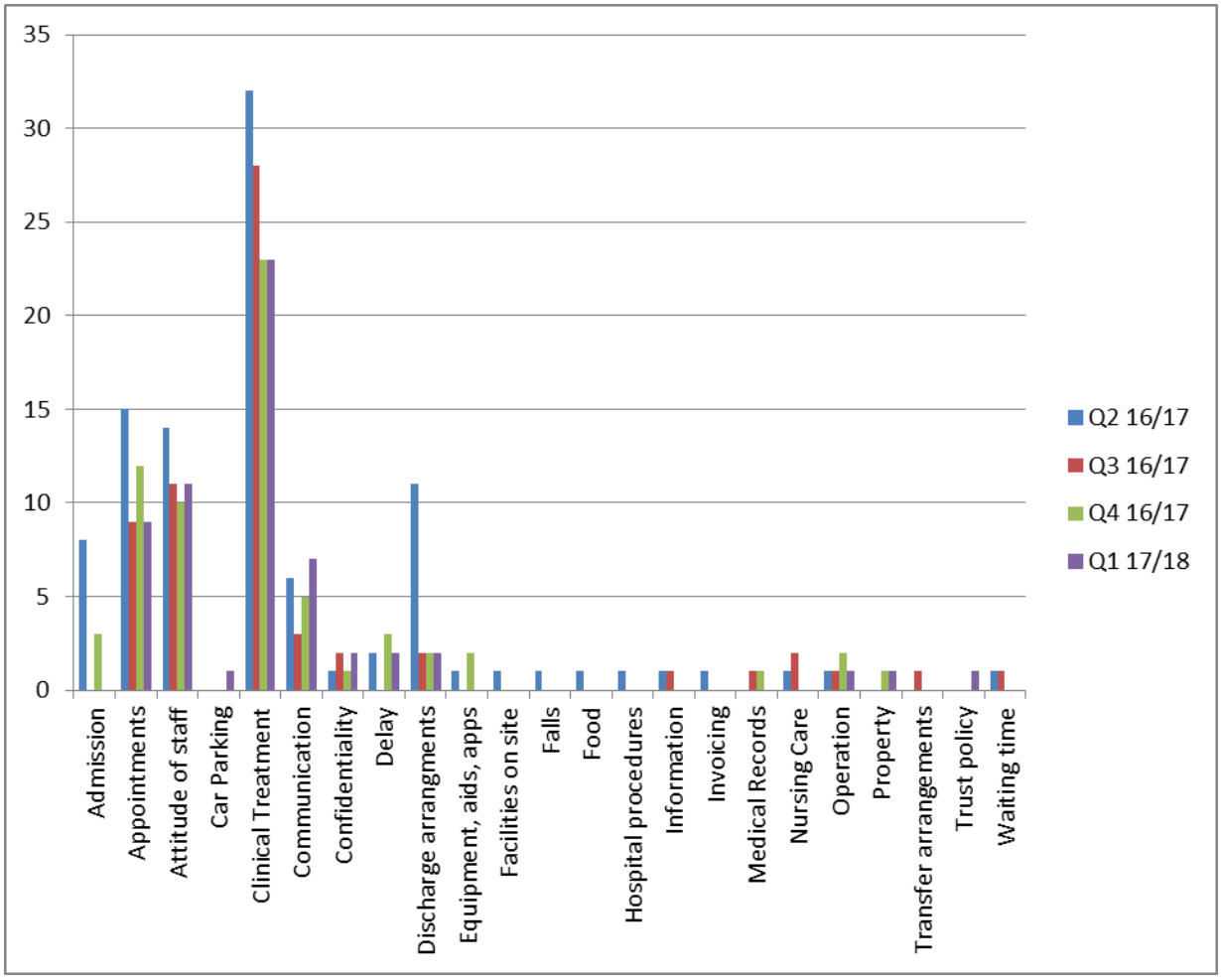
COMPLAINTS BY QUARTER

The following graph shows the trend in complaints received by quarter. There has been a slight decrease in complaints in Q1 compared to Q4. The specialty areas with the most complaints are the Emergency Department (9), Orthopaedics (6) and 5 each for Maternity and the Central Booking Department, with 8 related to clinical treatment.



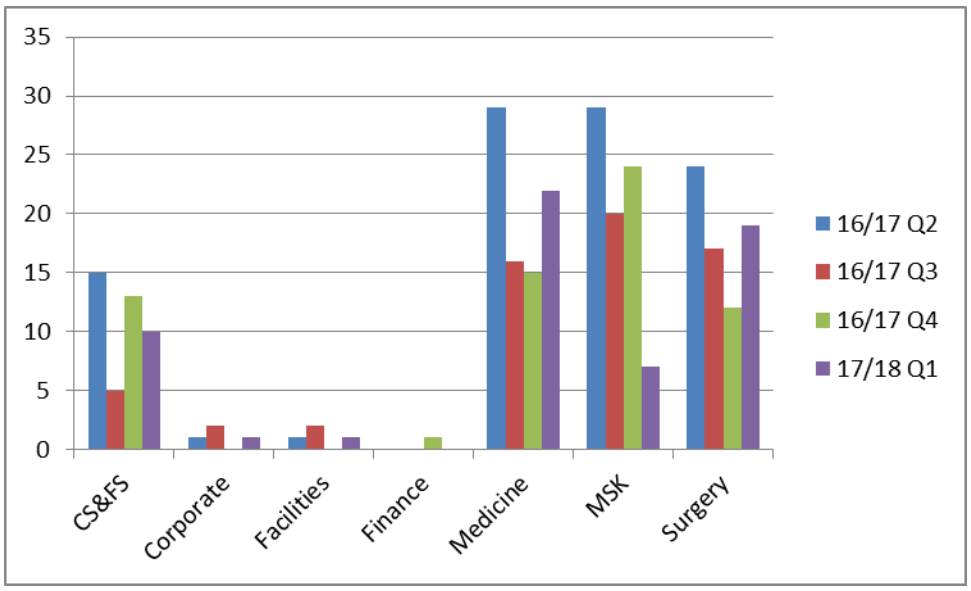
COMPLAINTS BY SUBJECT

The following graph shows the trend in complaints by subject over the last four quarters. Complaints have decreased slightly from the previous quarter with most subject areas remaining static. Complaints about clinical treatment have remained the same as Q4.



COMPLAINTS BY DIRECTORATE

The following graph shows the number of complaints by directorate over the last four quarters. Medicine and Surgery have both seen an increase in complaints in Q1 compared to Q4, whereas Musculo Skeletal has seen a large decrease (from 24 in Q4 to 7 in Q1) with the main reduction in complaints about clinical treatment and staff attitude; and CS&FS had a slight decrease in complaints.



CLINICAL SUPPORT AND FAMILY SERVICES

	Quarter 1 2016-17	Quarter 4 2016-17	Quarter 1 2017-18
Complaints	18	13	10
Concerns	26	21	16
Compliments	100	94	70
Re-opened complaints	0	1	0
% complaints responded to within 25 working days	50%	31%	40%

- The number of complaints has decreased by 3 from Q4, and there is a decrease of 8 compared to Q1 2016-17.
- The Maternity Department received the most complaints, 3 for Antenatal and 2 for the Labour Ward; these were due to lack of appropriate treatment, delays and attitude of staff.
- No complaints were re-opened in this quarter and no meetings took place.
- There has been a decrease of 5 concerns compared to Q4 with no particular theme.
- Reduction in response compliance was due to delays in receiving statements from staff.
- Total activity within the directorate was 9571 and of this number 0.1% raised a complaint.

Themes and actions

Department/Ward	Topic	Actions
Maternity	Lack of appropriate treatment, delays in receiving appropriate treatment and attitude of staff.	• Out of the 5 complaints received by the Maternity Department, 2 were not upheld. These were in relation to a perceived breach in confidentiality and an unfounded allegation that a member of staff inappropriately 'pushed' a partner. • A complaint was raised regarding the booking system of urgent growth scans. This has highlighted a need to review the booking process for obstetric ultrasound scans, in order to provide a more effective service. • A further complaint related to intrapartum care, specifically surrounding the management decision made in the latent phase of labour. Although the clinical decisions were considered appropriate, it was apparent that the mother's preferences were not fully appreciated. This has resulted in the member of staff reflecting on their practice. • There is still an ongoing complaint from this quarter. The actions of which have not been finalised as management staff are due to meet with the family.

Compliments

In total 70 compliments have been received across the directorate with the breakdown as: Sarum Ward = 30, NICU = 13, Endoscopy = 7, Labour Ward and Radiology = 5 each, Child Health = 3, Beatrice Ward = 2, Maternity Admin, Bowel Screening, Gynaecology, Pharmacy and Speech and Language = 1 each.

MEDICINE DIRECTORATE

	Quarter 2 2016-17	Quarter 4 2016-17	Quarter 1 2017-18
Complaints	18	15	22
Concerns	27	28	19
Compliments	153	112	189
Re-opened complaints	1	7	2
% complaints responded to within 25 working days	50%	40%	41%

- The number of complaints has increased significantly by 7 from Q4.
- The Emergency Department received 9 complaints compared to 3 the previous quarter, followed by Winterslow Ward with 3.
- The themes for the Emergency Department were staff attitude (any received are followed up with the line manager), misdiagnosis, delays and lack of treatment. The theme for Winterslow Ward was lack of appropriate care and communication issues.
- 2 complaints were re-opened in Q1 which is a decrease from Q4 (7). Complainants felt that their concerns had not been satisfactorily answered and had some concerns over comments raised in the final responses.
- One meeting was held in Q1.
- The number of concerns has decreased significantly from Q4 by 9. The Emergency Department, Farley and Winterslow wards had the highest with 3 each.
- Reduction in response compliance was due to delays in receiving statements from staff. The Emergency Department failed to respond to 5 out of 9 of their complaints within the 25 working day timescale.
- Total activity within the directorate was 26,927 and of this number 0.1% raised a complaint.

Themes and actions

Department/Ward	Topic	Actions
Emergency Department	Delays in receiving treatment and misdiagnosis. Attitude of consultants.	• Many complaints have involved orthopaedics – ED Lead Clinician has discussed with orthopaedics. Customer Care will contact ED to clarify ED involvement on receipt of the complaint. • Lead Clinician for ED aware and following up. Complaints themes will form part of appraisal.
Winterslow Ward	Lack of appropriate care and communication errors.	• Clarification of the use of Pembroke Unit for escalation beds with the limit now set at only using 5 beds for escalation.

Compliments

In total 189 compliments have been received across the directorate with the breakdown as: Hospice = 46, ED = 39, Whiteparish Ward = 19, Farley Ward = 18, Winterslow Ward = 16, Durrington Ward = 14, Pembroke Ward, Tisbury Ward and Redlynch Ward = 8 each, Cardiology = 3, Breamore Ward, Oncology, Pitton Ward and Respiratory = 2 each, CCU and CIU = 1 each.

MUSCULO-SKELETAL DIRECTORATE

	Quarter 1 2016-17	Quarter 4 2016-2017	Quarter 1 2017-18
Complaints	29	24	7
Concerns	25	27	23
Compliments	107	60	63
Re-opened complaints	1	7	4
% Complaints responded to within 25	21%	50%	57%

working days			

- The number of complaints received in Q1 has decreased from 24 (Q4) to 7 which is a significant decrease.
- The amount of concerns received in Q1 has decreased from 27 to 23 and this is also a decrease in number for the same period last year.
- The total activity in the Directorate was 14,933 and of this number 0.05% raised a complaint
- There have been four re-opened complaints. Three meetings were offered and we are awaiting confirmation from the complainants regarding dates. The remaining complaint came via Wiltshire CCG and a meeting has been offered if there are any further issues.
- Five complaints were received for Orthopaedics, one for Amesbury Ward and one for Oral Surgery. The main themes for the complaints was unsatisfactory treatment (3), appointment date required (2), attitude of nursing staff (1) and the appointment system (1).
- There were eight concerns received for the Plastics Department, five for Orthopaedics, four for the Spinal Unit, three for Oral Surgery, one each for Avon Ward, Cleft Lip and Palate Service and the Burns Unit
- Nine concerns related to appointments. Medical staff attitude was raised in two concerns and nursing attitude in another.

General actions

- Daily telephone contact still working well and has helped resolve immediate concerns and de-escalated complaints.

Themes and actions

Department/Ward	Topic	Actions
Orthopaedic, Plastic Surgery and Oral Surgery	Concerns relating to appointments	• Continue to review long waiters. • Increase capacity in specialities through additional sessions. • Informatics support to provide accurate waiting list information by speciality.
Orthopaedics and Plastic surgery	Staff attitude	• No theme with individuals so managed through investigation process and 1:1's. No further action.
Orthopaedics and Plastic surgery	Unsatisfactory treatment	• No themes of treatment or individual clinician so individual actions relating to complaint taken to resolve issues.

Compliments

In total 63 compliments have been received across the Directorate with the breakdown as:
Chilmark Suite, Orthopaedics and Wessex Rehabilitation Centre = 12 each, Oral Surgery = 8, Plastics = 5, Burns = 4, Laverstock Ward = 3, Amesbury Suite and Spinal Unit = 2 each, and Dermatology, Fracture Clinc and Tamar Ward = 1 each.

SURGICAL DIRECTORATE

	Quarter 1 2016-17	Quarter 4 2016-2017	Quarter 1 2017-18
Complaints	11	12	20
Concerns	32	35	36
Compliments	76	77	93
Re-opened complaints	3	4	3
% complaints responded to within 25 working days	54.5%	66%	35%

- A significant increase in complaints received in Q1 with only 7 complaints closed within 25 working days.
- Total inpatient and outpatient activity within the Directorate was 14,090 and of this number 0.14% raised a complaint.

- Three complaints were re-opened in this quarter with one meeting held to reach local resolution.
- The highest number of complaints were for the Central Booking Department (7), followed by Urology (3).
- The theme for complaints was the appointments system.
- The highest number of concerns was for Ophthalmology (12) followed by Central Booking (11).
- There has been an increase in the number of compliments received in Q1 compared to Q4 2016-17 and on Q1 2016-17.

Themes and actions

Department/Ward	Topic	Actions
Central Booking	Appointment issues	• Additional complaint handling support being arranged. • Review of outstanding issue log for Lorenzo. • Escalation of clinic template change backlog. • Review of Directory of Services information on ERS.

Compliments

In total 93 compliments have been received across the Directorate with the breakdown as: Britford Ward = 32, Downton Ward = 18, Urology = 15, ENT = 8, DSU and General Surgery = 4 each, Clarendon Suite and Ophthalmology = 3 each, and Anaesthesia, Audiology, Breast Service, Medical/Surgical Outpatients, Main Theatres and Vascular and Diabetes Unit = 1 each.

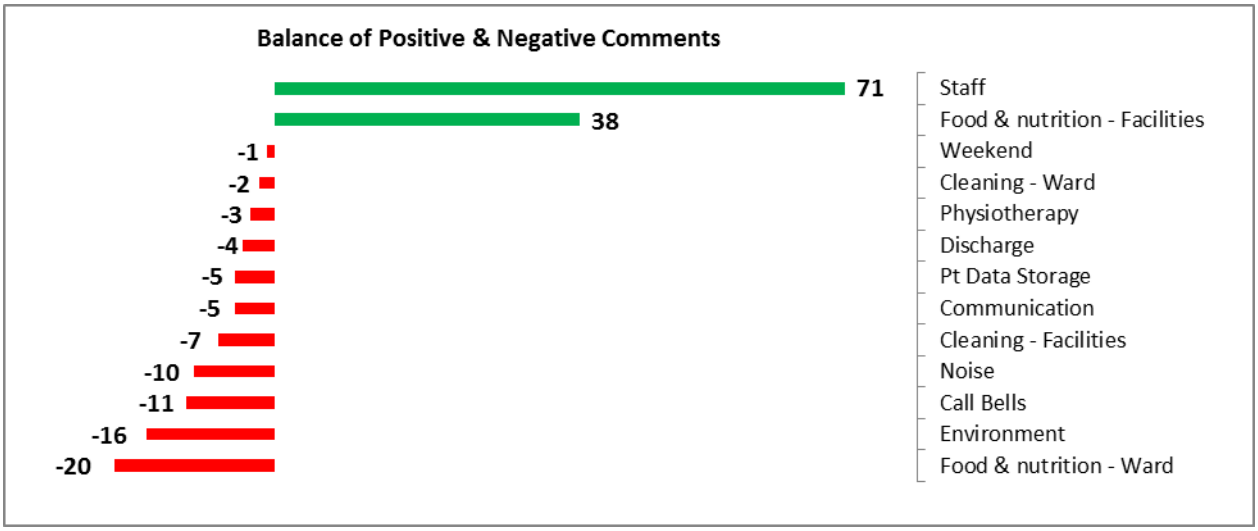
2. TRUSTWIDE FEEDBACK – INCLUDING REAL TIME FEEDBACK AND THE FRIENDS AND FAMILY TEST

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

Feedback area	Theme	Actions
Complaints	Clinical Treatment Staff Attitude Appointments	• Individual actions relating to complaint taken to resolve issues. • Discussed with the named individuals. • Reviewing outstanding issue log for Lorenzo; escalation of clinic template change backlog; and review of Directory of Services information on ERS.
Inpatient, Maternity and Spinal RTF	Food and nutrition on the ward Communication Call bells Environment	• Wards are currently reviewing progress on their action plans.
FFT	Numbers too low	• Wards are currently reviewing progress on their action plans.

3. INPATIENT REAL TIME FEEDBACK

A total of 249 inpatients were surveyed in the quarter. They made 179 positive and 151 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below.



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

Food and Nutrition on the Ward

A total of 5 positive and 25 negative comments were received regarding food on the ward. The negative comments have been categorised as set out in the table below.

REASON	WARD
Temperature (21)	Chilmark (4)
	Amesbury (2)
	Breamore (2)
	Laverstock (2)
	Whiteparish (2)
	Britford (1)
	Clarendon (1)
	Downton (1)
	Durrington (1)
	Farley (1)
	Pitton (1)
	Redlynch (1)
	Tisbury (1)
	Winterslow (1)

REASON	WARD
Not as ordered (2)	Burns (1)
	Whiteparish (1)
Availability of beverages (1)	Amesbury (1)
Portion size (1)	Pembroke (1)

Environment

A total of 1 positive and 17 negative comments were received regarding the environment. The areas of negative comments are as follows:

REASON	WARD
Bathrooms & toilets (9)	Tisbury (3)
	Redlynch (2)
	Britford (1)
	Pembroke (1)
	Pitton (1)
	Winterslow (1)

REASON	WARD
Other patients (3)	Burns (2)
	Breamore (1)
Lights (2)	Downton (1)
	Whiteparish (1)
Cramped (1)	Pembroke (1)
Heating (1)	Chilmark (1)
Lack of pillows (1)	Downton (1)

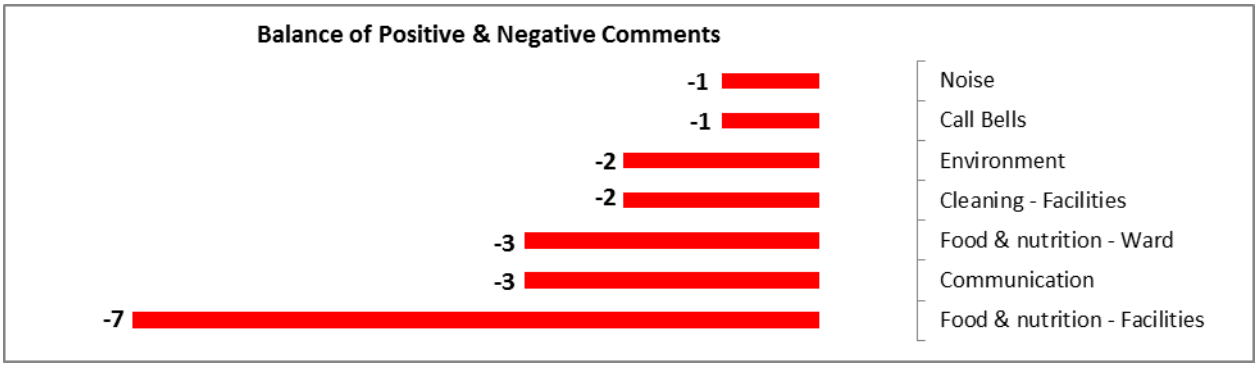
Call Bells

A total of 1 positive and 12 negative comments were received regarding response to call bells. The negative comments were made in the following areas:

WARD	WARD	WARD	WARD	WARD	WARD	WARD	WARD
Amesbury (2)	Chilmark (2)	Durrington (2)	Redlynch (2)	Britford (1)	Burns (1)	Farley (1)	Winterslow (1)

Spinal

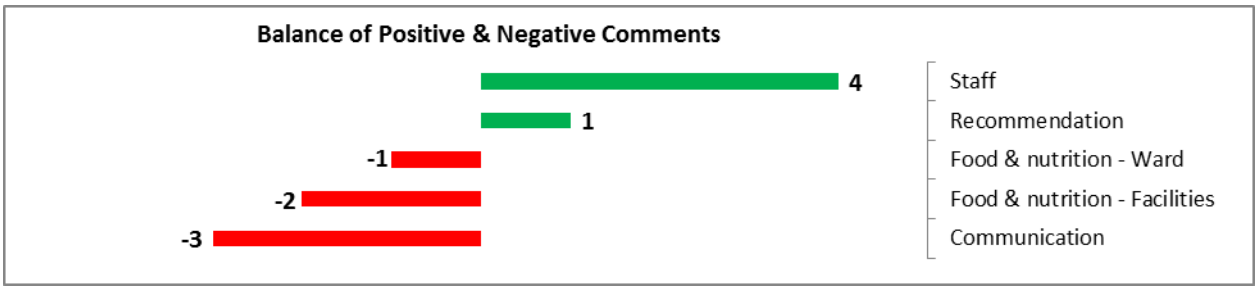
A total of 17 patients were surveyed in the quarter. They made 3 positive and 21 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below.



The main areas of concern were food and nutrition and communication.

Maternity

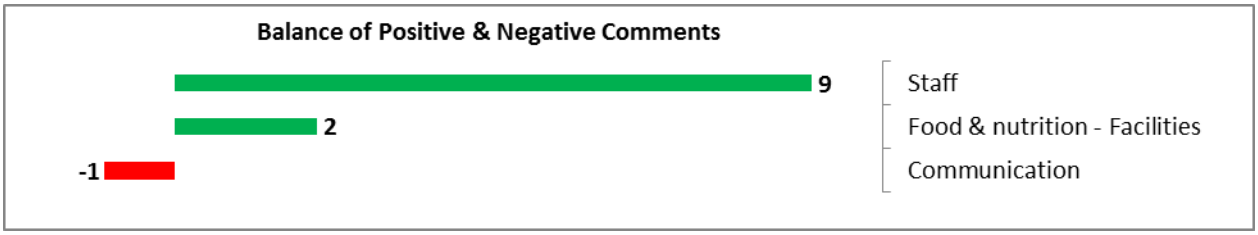
A total of 25 patients were surveyed in the quarter. They made 7 positive and 7 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below.



The main areas of concern were food and nutrition and communication.

Paediatrics

A total of 15 adults or carers and 8 children were surveyed during the period. They made 13 positive and 4 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below.

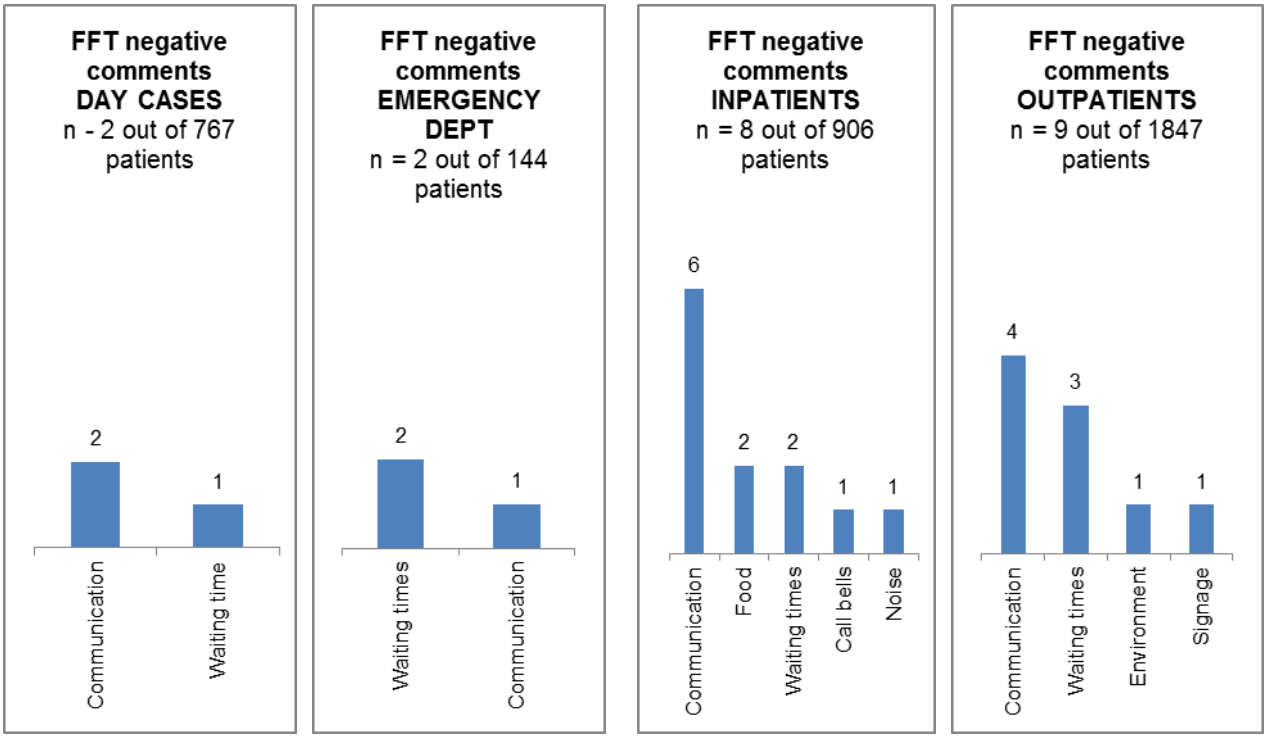


4. FRIENDS AND FAMILY TEST

Responses for the period were as follows:

		Rating		
	Total Responses Received	Extremely Likely	Unlikely	Extremely Unlikely
Day Case	767	689	2	1
Emergency Department	144	120	2	0
Inpatients	906	718	7	2
Maternity	92	78	0	0
Outpatients	1847	1615	5	6

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

Action taken on areas of concern
Ward action plans have been developed to address the main areas of concern for each area.

5. PATIENT AND PUBLIC INVOLVEMENT (PPI)

There has been 10 new projects, plus one National Patient Survey and 2 completed projects.

Clinical Support and Family Services
Two projects commenced: the Speech and Language Team are looking at communication skills training for patients with Aphasia. Aphasia is a language disorder and communication disability commonly caused by stroke. People living with aphasia often report feeling isolated, misunderstood and frustrated. Whilst all patients with Aphasia will be seen by the Speech and Language Therapist (SALT) on Farley Stroke Unit, the majority of interactions that happen will be between the patient and nursing assistants, nurses, occupational therapists, physiotherapists, therapy assistants and doctors. It is vital that everyone in the team is aware of the challenges that Aphasia causes and that they have the skills to support patients to participate fully in conversations, thereby ensuring that patients with Aphasia are fully involved in decision making, goal setting and any discharge plans. Patient volunteers with aphasia will deliver training to Farley Stroke Unit staff, including practical sessions where staff will use the skills they have been taught to support someone with Aphasia and will receive feedback after their conversation from the person with Aphasia regarding what they did that helped and what they could change.

The Medical Engineering team operate under the quality system ISO9001:2015. As a part of the quality system there is a requirement to gain customer feedback to evaluate the products and services. The feedback will be used for the continuous improvement of the service.

Musculo-Skeletal Directorate
Three projects commenced: the first is a questionnaire to gain feedback from the users of Horatio's Garden to ensure we are meeting the needs of the patients in the Duke of Cornwall Spinal Injury Centre.

The second is looking at staff knowledge of Autonomic Dysreflexia in Spinal Cord injury (SCI). SCI results in a loss of function through motor, sensory and autonomic routes, the number of secondary health

complications associated with this injury can have substantial detrimental health complications. The purpose of this evaluation will be to assess our SCI population's bowel management regimes in the community and to review our own community management and education with regards to this. This information will be used to review and improve the current educational programme for SCI individuals now and in the future.

The third was an ankle pathway questionnaire undertaken by the orthopaedic therapy team, to gain an understanding of patient satisfaction of their pre-operative management following an ankle fracture. The project was completed in Q1 and the department scored well with regards to the environment and all patients felt that they were listened to by the doctor and given opportunities to ask questions. One area for improvement was written information for patients.

The main outcome from this project is the development of a virtual fracture triage clinic. Patient information is being written for a wide range of injuries, including information on self-management, exercises and a timeline of expected progression and return to function.

Contact from the Orthopaedic Department with all patients prior to their appointment will result in an appointment being made at a more convenient time for them. Information will be sent out to the patient about this. This will also facilitate patients into the right clinic at the right time, to reduce the number of internal referrals between consultants and patients having to return several times.

Medicine Directorate
Two new projects commenced: the Carer's Questionnaire designed for those caring for patients with Dementia. The aim is to ensure we put both the carer and the patient at the centre of everything we do to improve our services. The Older Persons Advice and Liaison Team are gathering feedback via a questionnaire about the service to help improve it going forward and develop better communication with patients and their carers.

Quality Directorate
New projects included the National Maternity Survey 2017, Complaints Handling Survey and a pilot of the Patient Centred Escalation tool which was carried out for a month on the wards.

Surgery Directorate
Three projects commenced: the first is looking at patient flow in the age-related macular degeneration (AMD) clinics by the Ophthalmology team. AMD clinics are very busy and patients require several tests before they see the doctor. The clinic flow is sometimes slow and patients have to wait for long periods at different stages. This project will look at the factors which slow the clinic flow; develop standards for waiting times and improve the overall patient experience.

Ophthalmology has a second project to engage staff and patients in the co-design of the new Ophthalmology Department.

The hard data from the Diabetic Foot Ulcer Clinic demonstrates very good outcomes and performance data but the team want to know whether patients feel they have received good care. The team hope to highlight areas to improve the patient and relative experience of their service.

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

6. PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

In Q1 there was one new request for independent review. This was an orthopaedic case and the Trust is awaiting a decision.

The previously reported urology case was upheld and the Trust has written to the patient to acknowledge the failings identified and to apologise for the injustice that the patient suffered as a consequence.

The PHSO publishes complaints data on a quarterly basis that includes numerical information on the complaints received, assessed, and investigated and is available at:

http://www.ombudsman.org.uk/reports-and-consultations/reports/health/quarterly-reports-on-complaints-about-acute-trusts

7. NHS CHOICES WEBSITE

In Q1 there were 20 comments posted on the NHS Choices website relating to 13 different areas. Of the 17 positive comments, one person said “Thank you Salisbury Hospital, especially the Urology department. You are amazing and I will always be indebted to you. I would like to mention a few names but I know it's not allowed, but you know who you are and I will always see your faces whenever I think back to that time.” Of the 3 negative comments, one person said “I attended the eye clinic as an emergency appointment organised by my GP. It took over 2hrs to transfer my notes onto the hospital computer. The whole appointment took over 3hrs. The first doctor I saw, while perfectly polite, seemed distracted and hurried, eventually taking a telephone call before my consultation had ended. They sent no notes to my GP who had to chase them up”. All the feedback was shared with the departments.

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

Report to:	Trust Board	**Agenda item:**	**SFT3936**
Date of Meeting:	2 October 2017		

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

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

Executive Summary:
Extract from 27 July JBD minutes The Board received the Quarterly Update Review. There were no newly identified gaps in control/assurance and newly identified positive assurances included new online systems to support staff recruitment and the site reconfiguration plan to improve risks around skilled and staff workforce. On staff value and morale, staff turnover was averaging 9.8% which was consistent with previous months. Staff sickness was at 3.15% and the 2016 staff survey showed that the Trust was in the best 20% of acute trusts for 18 of the 32 key findings and above average for six. It was noted that the Board Assurance Framework continued to be developed in relation to the Draft Trust Strategy and this would be presented at the 2 October Trust Board meeting. LW requested that risk 4681 relating to escalation accommodation be reviewed. A new risk on these interventional radiology service provided by Southampton (5205) had been opened.

Report to:	Trust Board	**Agenda item:**	SFT3937
Date of Meeting:	2 October 2017		

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

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

Executive Summary:
The Risk Management Strategy sets out the strategic direction for Risk Management. It provides a framework for the Trust, specifying the direction of travel with clear objectives, responsibilities and monitoring mechanisms. The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place which will assure the Trust Board that as a Foundation Trust it is discharging its responsibilities. The Risk Management Strategy has been updated to reflect the ongoing promotion of a fair and open culture, participation in patient safety initiatives and the requirement for a robust and dynamic risk register. The Strategic Objectives and Key Performance Indicators (KPIs) have been updated for 2017/18 and include: • Monitoring of incidents to highlight trends and areas requiring further investigation/action • Embedding risk management at all levels of the organisation – creating a safety culture • Leading and supporting staff and promoting reporting • Ensuring there is appropriate provision of training

- Ensuring compliance with ‘Duty of Candour’ requirements

The following KPI’s are also in place:

- Achieve compliance with regulations and requirements as determined by NHSI
- Maintain full registration with the Care Quality Commission;
- 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;
- 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 ourwork in reducing patient harm;
- Compliance with contractual requirements associated with the reporting and management of Serious Incidents;
- Cascade and Timely response to NHS England Patient Safety Alerts.
- Evidence of shared learning from incidents through newsletters, departmental feedback, Executive Performance Meetings etc.

Risk Management Strategy

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

VERSION INFORMATION

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

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

			Executive Performance review process. Section 9 – Risk management strategic objectives reviewed. Appendices updated

Table of Contents

Salisbury NHS Foundation Trust

Risk Management Strategy

1) Introduction

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

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

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

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

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

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

1.7 The Trust Board recognises that complete risk control and/or avoidance is impossible, but the risks can be minimised by making sound judgments from a range

of fully identified options and having a common understanding 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 Board Assurance Framework (BAF) to ensure that organisation wide strategic risks are identified. The BAF enables the Board to

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

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

- All risks, including 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/incidents is encouraged and learning is shared throughout the organisation

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

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

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

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

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

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

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

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

6.7 It is the responsibility of the Assurance Committees to report to the Trust Board, 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 Board 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 relevant extract from the 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 (Director of Nursing), Medical Director, Chief Operating Officer, Director of Finance, Director of Organisational Development and People, Director of Corporate Development and Head of Corporate Governance to ensure that the 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 are held on Datix. A single framework for the assessment, rating, and management of risk is to be used throughout the Trust; this process is described in detail within the Risk Management Policy and Procedure (intranet), alongside how department risk registers are escalated, where appropriate to the directorate risk register.

7.2 Each Directorate will continue to maintain a comprehensive risk register, which will be formally reviewed in full at quarterly intervals, with key headlines and top risks presented monthly, through the Executive Performance Meetings. At these meetings the directorates will be expected to report on their directorate risk register

(risks scoring 12 or above that require executive knowledge and support), highlight any new or emerging risks that threaten their service delivery or Directorate objectives and present action plans for minimising and managing these risks. The performance meeting should identify those departmental risks which also pose a corporate threat and so require escalation to the Trust's Corporate Risk Register. The risk register should be seen as a dynamic process as ranking/prioritisation of risks that will change as risk reduction practices take place. The Directorate Management Committee (DMC) has responsibility for ensuring that all risks within the Directorate are appropriately graded and have sufficient actions in plan to mitigate/reduce the risk.

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

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

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

8) Risk Management Policy

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

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

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

9) Strategic Objectives 2017/18

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

- Monitoring of incidents to highlight trends and areas requiring further investigation/action
    - Provision of monthly incident report card at Clinical Risk Group to support theming of all incidents and monitoring of high harm incidents.

- Support to Directorates to enable them to monitor themes and trends in reporting within their directorate, departments and specialties' and take remedial action, evidence learning and support enable wider sharing.
- Working with departments to evidence learning from incidents and feedback to team.Linking with complaints and Litigation team to look at broader themes and learning.

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

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

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

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

The following KPI's are also in place:

- Achieve compliance with regulations and requirements as determined by NHSI
- Maintain full registration with the Care Quality Commission;
- 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;
- 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 Serious Incidents;
- Cascade and Timely response to NHS England Patient Safety Alerts.
- Evidence of shared learning from incidents through newsletters, departmental feedback, Executive Performance Meetings etc.

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 Organisational Development and People is responsible for managing the Trust's principal risks relating to Health and Safety and Workforce planning.
- The Medical Director is responsible for managing risks associated with Medical Workforce planning.

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 the update of the Board Assurance Framework as well as presenting the document quarterly 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;
- ensuring that Directorates know how to access their incident data;
- ensuring information is provided on incident data to the Clinical Governance Committee, and Trust Board;
- Presenting risk reports at the CCG Clinical Quality Review Meeting (CQRM) in line with contract requirements;
- Producing and coordinating Risk Management training programmes in conjunction with the Patient Safety Facilitator and other departments such as Customer Care.
- Collaborating with external stakeholders' key to Risk Management e.g. Commissioners, CQC, NHSI and other Trusts.
- Ensuring that there is an appropriate and named point of contact for patients and families during the Serious Incident review process.

10.4 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 Committees

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

- Work proactively to achieve the Trusts Key Performance Indicators for Risk Management.
- Understand and implement the Risk Management Strategy and related policies.

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

10.6 Departmental Managers/ Clinical Leads

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

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

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

10.7 All Staff

All Staff are required to:

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

11) Organisational Arrangements and Risk Management Structure

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

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

12) Ensuring Compliance with National Standards

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

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

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

13) Monitoring and Review

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

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

Report to:	Trust Board	**Agenda item:**	SFT3938
Date of Meeting:	2 October 2017		

Report Title:	Risk Management Annual Report 2016/17			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Prepared by:	Fenella Hill, Head of Risk Management			
Executive Sponsor (presenting):	Lorna Wilkinson, Director Of Nursing			
Appendices (list if applicable):				

Recommendation:
The Committee members are asked to note the achievements within the Annual Report and Strategy.

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 (2016), the lessons that have been learnt as a result of incident reviews undertaken, changes within the risk processes over the 2016/17 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 Improvement 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 2017/18 to ensure the implementation of the Risk Management Strategy.

SALISBURY NHS FOUNDATION TRUST

Risk Management Annual Report 2016/17

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 2016. 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 (2016) over the last financial year (1st April 2016 – 31st March 2017).

2. Risk Management Strategy Objectives

2.1 The Risk Management Strategy (2016) 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 (2016) are as follows:

- 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.

- 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 Sign up to Safety and Patient Safety Collaborative interventions.

- 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.

- 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 NHSI, Care Quality Commission registration requirements, and Health and Safety Standards.

3 Progress against Strategic Goals 2016/17

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

3.1.1 NHS Improvement (NHSI) 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 October 2016 (ratified at the December 2016 Board Meeting). Trust Board members agreed the principal risks for inclusion in the 2016/17 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 co-ordinating and updating 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 been added or amended, 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 2016 and March 2017. 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 2016/17. This included a full documentary evidence review. The subsequent report gave an overall opinion of 'reasonable assurance'. The conclusion of the auditors was:
'the 2016/17 Board Assurance Framework (BAF) is embedded within the governance structure of the Trust and BAF processes ensure that it is continually updated (for controls, assurances, risks and gaps) and therefore operates as a 'live' document. The overall rating given was of 'Reasonable Assurance' due to a number of new and existing (open) risks that require review by the risk owners and directorates. As a result of this an action plan is in place for the Director of Nursing and Head of Risk to work with all directorates to support the review of their risk registers. Non-compliance will be monitored via the directorate performance meetings.
Work is on-going with departments and directorates to review their risk registers and ensure that all relevant risks are identified and recorded and that the directorates have processes in place to escalate risks where support is required.

3.2.5 The Trust produced an Annual Governance Statement for 2016/17, 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 are all within their renewal dates.

3.3.2 All Directorates have risk registers and high risks (12+) and those requiring executive support are reported and monitored via quarterly executive performance meetings. During 2016/17 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. Following publication of the Trust's Accountability and Integrated Governance frameworks the Directorate risks shall be monitored monthly through 2017/18.

3.3.3 Reporting of incidents across the Trust increased during 2016/17. The increase of 19.23% has been seen as a positive reflector of the safety culture of the organisation and 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 Medical, Nursing/Midwifery/Medical, Allied Health Professionals, Ancillary staff, Admin and Clerical, Clinical Assistants and Bank/Agency/Locum reporting incidents. The only group of reporters to show a decrease are Managers however, managers report that this is due to frontline staff feeling able to report and being able to access the reporting forming easily via the intranet.

The 2016 Staff Survey indicated that one of the five Key Findings for which Salisbury NHS Foundation Trust compared most favourably with other acute trusts in England was the staff confidence and security reporting unsafe clinical practice (3.82 vs national average of 3.65). Disappointingly the Trust scored less favourably compared with other trusts on the percentage of staff reporting errors, near misses or incidents witnessed in the last month (88% vs national average of 90%) however this does not correspond to other data such as increase in numbers of incidents reported and National Reporting and Learning System (NRLS) data which relates to a similar time period that the 2016 Staff Survey was conducted in.

- The NRLS report for April 2015 - September 2016 identified the Trust to be in the upper part of the highest 25% of reporters of incidents with 47.68 incidents per 1000 bed days reported. The median for Acute (non specialist) organisations is 40.02 incidents per 1000 bed days. This is the first time that the Trust has been in this reporting quartile in over five years.

  89.4% of reported incidents resulted in no harm to patients against a national average of 76%. 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 2016/17 there were 47 Serious Incident Inquiries commissioned (3 were subsequently downgraded, in collaboration with the CCG, following completion of the investigation) and no Clinical Reviews. These figures compare with 28 Serious Incident Inquiries and 2 Clinical Reviews in 2015/16.

Of the 47 Serious Incident Inquiries, 2 were hospital acquired grade III pressure damage (there were no grade IV hospital acquired pressure ulcers). This compares to 3 grade III hospital acquired pressure ulcers in the previous year. Monthly 'share and learn' reviews continue to identify areas where 'clusters' of hospital acquired grade 2 pressure ulcers are identified to promote a proactive approach to learning and prevention.

2 'Never Events' were reported during the year, one relates to wrong level spinal surgery and the other to insulin administration 'when a health care professional fails to use a specific insulin administration device i.e. does not use an insulin syringe or insulin pen to measure insulin'.

5 maternity cases were reported as serious incidents (compared to 2 last year):

- Inadequate follow up of blood sample undertaken as part of routine sampling in pregnancy
- Baby born in unexpectedly poor condition
- 28 week stillbirth

- Sudden collapse at 4 hours of age
- Treatment delay following delivery.

Of these cases one has been subject to external review which concluded that with the knowledge of hindsight there were opportunities to have delivered the baby earlier however this was unlikely to have changed the outcome. In another case it was recognised that there were missed opportunities, which were compounded by the late booking of the woman and missed appointments, but again it was impossible to ascertain whether these would have changed the outcome. The review of the treatment delay following delivery ascertained that there were no management issues within the intrapartum and initial resuscitation however a delay in accessing the resident paediatrician did impact on the outcome.

5 cases were reported relating to safeguarding concerns. Safeguarding concerns are reported as soon as there is suspicion or an allegation is made as per the contractual requirements. Despite some of these cases being downgraded on review, they continue to provide learning for staff particularly in relation to communication between teams and external stakeholders about patients.

21 patients fell during 2016/17 and sustained an injury resulting in major harm (significant head injury or fracture requiring surgery). This is an increase on the previous year, 10 reported in 2015/16, and all of these cases had a falls root cause analysis investigation undertaken and learning has been used to inform the revised falls reduction strategy and new falls action plan. As a result of these investigations a number of interventions are being put in place to riase awareness and reduce falls including:

- 90 day challenge to raise awareness of patient falls;
- Trial of double grip socks (can be worn in bed and have non slip surface around the whole outside of the sock)
- Improved assessments and communication.

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 Management Board and Clinical Governance Committee with a quarterly report on compliance with the recommendations from these reviews. The themes arising from such reviews during 2016/17 have led to some key pieces of work being undertaken including:

- Revision of the falls reduction strategy and new falls action plan;
- Business case proposed and supported for an increase in Patient Safety Facilitator hours to support further falls work;
- Review of documentation to support comprehensive wound assessment;
- Plaster casts colour coded to indicate to staff where risk of skin compromise under cast has been recognised at application to support enhanced monitoring;
- Amendments to the POET (electronic observation system) to support staff further in recognising and escalating deteriorating patients;
- Ensuring emergency policies are appropriately flagged and remain available on the intranet at all times;
- Working with other Trusts and Providers of care to ensure that communication of treatment plans for follow up clear to all parties;
- Standardisation of equipment, training and documentation within specialities to reduce variation;

- Training for staff in the recognition and early management of sepsis;
- Development of guidelines for medical staff on prescribing steroid therapy in the event of critical illness
- Review of the use of the electronic observation system to ensure appropriate triggers are in place and these are used by teams across the trust that has responsibility for supporting staff in the management of deteriorating and critically unwell patients.

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 nominated point of contact takes place for staff, patients and families whilst they go through the Serious Incident Inquiry 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.

Work continues to support clinicians 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 web incident reporting form so that compliance can be monitored at all stages of the incident process. Duty of Candour outcomes 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 i.e. lower level of harm.

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

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.

1:1 sessions were also facilitated in 2016/17 by the Head of Risk Management and ward/departmental leads to identify key incident themes in their areas and actions that were being taken to address these. This was seen as a way of feeding back to staff actions that had been taken as a result of incidents reported. Whilst there was initially good engagement with this process, the focus will be sustaining it in 2017/18.

Reviews of complaints, litigation and incidents to try and triangulate data have proved unsuccessful. Whilst there are links between incidents and complaints within the timeframes reviewed, there is often disparity with claims data as there is frequently a

time lag between the incident and a claim being brought. However, web reporting does 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 2016/17 to meet the requirements of quality in line with commissioner contracts and the Quality Account. This work will continue in 2017/18 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 (0.5%) 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 a positive reporting culture 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 2016/17: Nursing/Midwifery, Medical and Ancillary, Allied Health Professionals, Clinical Assistants, Administrative/Clerical/Secretarial staff and Bank/Agency/Locum.

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 is a large piece of work and will continue to be a focus in 2017/18.

All risks are held within the risk module of Datix, regardless of score, resulting in departments and directorates being able to access all risks via a central database. Work continues to ensure that risks are carefully managed to ensure appropriate and timely escalation where required to allow the Trust to build a picture of organisational risks at all levels and support the allocation of resources to mitigate Trust wide risks.

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

During 2016/17 there was a 34% increase in sharps injuries which was disappointing as SFT have implemented a number of safe sharp devices. As a result of this the Medical Devices Safety Officer reviewed whether there were any trends in incidents that could be related to the devices in use. Comparison of figures shows the increase in sharps injuries sustained is from inappropriate disposal of both sharps and needles, but the biggest increase in sharps injuries is from non-clinical sharps such as razors, Stanley knife, metal chair, filing cabinet and a pen lid.

The number of needlestick incidents reported has remained static this year. All needlestick injuries are followed up by the Safety Advisor to ensure they have been seen by Occupational Health and Safety Services (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 Safe Sharps Steering Group. 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.).

3.4.5 The reduction of hospital acquired grade III and IV pressure ulcers has continued with 2 grade III pressure ulcers being reported in 2016/17. 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 ulcer 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 ulcers 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 33 fractures were reported in 2016/17 compared to 20 fractures in 2015/16, an increase of a third. Of the 33, 19 were categorised as major harm (patient required surgical repair) and all of these were subject to external reporting as a Serious Incident Inquiry. The remaining 14 (13 patients as one patient had 2 fractures) were graded as moderate harm (requiring conservative management such as immobilisation in plaster cast or monitoring only).

There were two patients last year where their fall resulted in them sustaining head injuries causing serious harm (reported as SI's), both of which were fatal and the subject of coroners inquests where the verdict of accidental death was recorded.

As a result of the increased number of falls across the Trust there has been a focus on reviewing and re-writing the Falls Reduction Strategy so that this can be used to develop the Trust wide falls action plan and be a focus in 2017/18.

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), aggregated themes from the quarters, sign up to safety falls workstream, and the new falls trustwide action plan. Key findings from these aggregated reports have demonstrated:

- A number of the patients are frail and elderly;
- Many have a history of falls including this being their reason for admission;
- Many of the patients are fit for discharge and awaiting either a package of care for support in their own home or placement to a residential setting with care.

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 **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.*

3.5.1 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 risk and governance executive performance meetings and stocktakes with the Executive Directors.

3.5.2 Incidents reported within the Directorates are reviewed quarterly at the risk and governance executive performance meetings via the Risk Management Incident data.

3.5.3 Patient Safety and Risk Management continues to be integral to the educational programme for junior doctors, student nurses, specialist staff groups, staff development programmes and the induction of all new staff.

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

3.6.1 It was recognised that additional Patient Safety Facilitator hours were required to support the risk agenda, particularly falls. A business case was submitted for 0.6 wte hours which was supported by the board and agreed in April 2017. Recruitment to this post is in progress.

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

3.7.1 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.

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

3.7.3 The Risk Team continues to collaborate with NHS Improvement. This includes the Trust's participation in the National Reporting and Learning System as well as co-ordinating a Trust response to the NHS Improvement Patient Safety Alerts. This activity is co-ordinated by the Head of Risk and Patient Safety Facilitator and overseen by the Clinical Risk Group. The Trust currently has no open NHS England Patient Safety Alerts, which are beyond their due date.

4 Future Developments

4.1 2017/18 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. This will include consideration of moving to Datix Cloud IQ that supports additional modules, reporting functionality and remote reporting of incidents via an app.

4.2 2017/18 will see ongoing development of the Assurance Framework to bring it in line with the Trusts refreshed strategy and 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 2017/18 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 minimising harm from falls.

4.6 The Risk Team will work with departments and Directorate Management Committees 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 bi-monthly basis. The session is set out to engage participants in the contribution that Root Cause Analysis (RCA) has to make to investigations and to help develop the skills needed to conduct RCA systems-based investigations. Training is built around a case study.

Report to:	Trust Board	**Agenda item:**	**SFT3939**
Date of Meeting:	2 October 2017		

Report Title:	Annual quality governance report 2016 - 2017			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Christine Blanshard, Medical Director Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Annual quality governance report 2016 - 2017			

Recommendation:

Recommendation – the report is presented for assurance along with areas of risk and associated mitigation.

Assurance – positive assurance in improving the quality of care and good progress made in the 'must do' elements of the Care Quality Commission Trust wide action plan.

Risks – reducing falls that result in harm mitigated by a refreshed Trust wide falls action plan. Sustaining zero tolerance on mixed sex accommodation breaches and maintaining patient flow during the site reconfiguration.

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. It takes into account the new Integrated Governance Framework and Accountability Framework to ensure the Board has a clear line of sight on the issues and attention is given to the most significant areas of risk.

- The Quality Account is the key driver for improvement and overall the Trust has made good progress in improving the quality of care in 2016/17. Nevertheless, there are still improvements to be made which are reflected in the quality priorities and work streams for 2017/18.

- Good progress has been made in the 'must do' and 'should do' elements of the Care Quality Commission Trust wide action plan. It continues to be robustly monitored to ensure progress is sustained in practice. Preparation of the organisation for a CQC inspection in 2017/18 is underway.

SALISBURY NHS FOUNDATION TRUST

ANNUAL QUALITY GOVERNANCE REPORT 2016 – 2017

1.0 Purpose

This annual report sets out the progress made between April 2016 and March 2017 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.

2.0 Quality governance

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

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

Quality governance is achieved through a 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, comply with duty of candour

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 NHS Improvement 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 2016/17 and the quality priorities selected for 2017/18. 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.

From April 2017 a new Integrated Governance Framework and Accountability Framework was introduced to ensure the Trust monitors and manages its own performance and the Board is routinely sighted on and involved in the mitigation of key risks. The Quality Strategy will need to be updated in light of these frameworks.

4.0 Quality account

The Trust is required by NHS Improvement to provide a Quality Account to inform patients and the public about progress made in improving the quality of care in 2016/2017 and quality priorities in 2017/2018.

Overall, the Trust has made good progress in improving the quality of care in 2016/2017 but there is still work to do. In setting the quality priorities for 2017/2018 we have listened to a broad range of stakeholders in helping us to decide the priorities along with the work streams that support 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 2016/2017

5.1 Patient safety

- Two consecutive years without a Trust apportioned MRSA blood stream infection.
- Maintained the reduction in hospital acquired C.difficile, at 13 cases against an upper limit of 19 cases.
- A 10% reduction in all antibiotic consumption whilst improving the timely treatment of sepsis.
- A sustained reduction in grade 2 pressure ulcers from 1.01 per 1000 bed days in 2015/16 to 0.95 in 2016/17.
- Implementation of best practice 'Saving Babies Lives' care bundle, the outcome of which was a 78% reduction in intra-uterine deaths and stillbirths (14 in 15/16 vs 3 in 16/17) and a 66% reduction in early neonatal deaths (3 in 15/16 vs 1 in 16/17).

5.2 Clinical effectiveness

- The hospital was in the top small acute Trusts nationally for the number of studies and recruiting specialities and the 4th highest for small acute Trusts nationally for the number of patients recruited into research trials
- High participation in national audits - 37 (97%) with broadly good patient outcomes and NCEPOD audits – 2 (100%).
- 28 (88%) national audits were presented to CMB by the clinical lead.
- Outcomes of the national paediatric diabetes audit showed children and young people's experience of care measures were overwhelmingly excellent.
- In the national end of life care audit the Trust met 7 out of 8 of the organisational indicators and were equal to or better than the national average in 3 out of the 5 clinical standards.
- Outcomes in the Royal College of Emergency Medicine venous thrombo-embolism (VTE) risk in lower immobilisation in a plaster cast were either better than or on a par with the national median for VTE risk assessment and 100% compliant for prophylaxis.
- The Trust was better than the national mean in the NHS 7 Day Services four clinical priority standards.

5.3 Patient experience

- A reduction in the number of patients being cared for in mixed sex accommodation from 312 patients on 60 occasions in 2015/16 to 235 patients on 32 occasions in 2016/17.
- VOICES (bereavement survey) results were generally very positive for the Trust and in comparison to national data.
- The Hospice at Home service was launched which supported 75 patients to die at home and over 5,600 hours of care has been provided.
- Our national cancer patient survey showed that 92% felt their care was very good or good and 90% felt they were always treated with respect and dignity by staff.
- A focus group of patients who had a primary knee replacement showed patients had many positive comments about their care and treatment.
- The national staff survey 2016 put the Trust in the top 20% of Trusts for staff who would recommend the Trust to their friends and family needing care and treatment with a mean score of 4.01 versus 3.76 nationally.

5.4 Risk management

- We have increased the rate of patient safety incidents reported within the Trust from 40.39 per 1000 bed days in 2015/16 to 47.68 per 1000 bed days in 2016/17 (to September 16). The Trust is now in the highest 25% of reporters of acute (non-specialist) organisations for the number of incidents reported with 89.4% resulting in no harm providing evidence of a positive learning culture.
- Continued focus on supporting staff to comply with the statutory duty of candour.
- Sustained a high level of follow up and completion of recommendations following serious incident inquiries and clinical reviews.

5.5 Care Quality Commission

Good progress has been made in the areas of 'must do' and 'should do' since the December 2015 inspection. The Trust was rated as requires improvement.

- Continuation of six monthly skill mix reviews to ensure safe staffing on all the wards. Significant investment in staffing in 3 acute medical wards, the Emergency Department and Spinal Cord Injury Treatment centre wards.
- Improvement in mandatory training to 83% against the Trust target of 85%.
- Improvement from 59% of staff receiving an annual appraisal to 79% in 2016/17.
- Governance arrangements strengthened in the Emergency Department and Critical Care.
- Improvement in the triage process in the Emergency Department with the introduction of a navigator role at the front door and extended hours of the 7 day service adult mental health team.
- Significant improvement in the processing and availability of surgical instruments for operations.
- Improved compliance with the World Health Organisation surgical safety checklist sign in and sign out process at 100% for the year.
- The video-urodynamic and outpatient waiting list for spinal cord injury patients enforcement notice was met in full.

6.0 Areas for improvement/development

These are described in the Quality Account priority work streams for 2017/2018 and our CQC Trust wide improvement plan with headlines set out below:

6.1 Patient safety

- Achieve a reduction in the number of patients who have preventable falls and suffer harm.
- Ensure that where a urinary catheter is required it will be inserted and cared for using evidenced based practice, and will remove it as soon as appropriate to reduce the chance of infection.
- Continue to expand our Scan4Safety programme through the use of common barcodes so we can match products to patients.
- Continue to improve surgical safety with a programme of Human Factors and team based training for the theatre teams.
- Continue to review nursing and midwifery staffing levels and skill mix to ensure that there are sufficient numbers of suitably quality and experienced nurses and midwives to deliver safe, effective and responsive care.

6.2 Clinical Effectiveness

- Comply with the new national mortality review process to identify any avoidable deaths, share learning and improve patient pathways. Develop a mortality dashboard and report to the Board quarterly from Q2.
- Develop the Older People's Assessment Liaison Team (OPAL) to assess and manage frail people who attend the Emergency Department to enable them to go home the same day.
- Introduce a chronic obstructive pulmonary disease admission and discharge checklist to ensure prompt initial treatment.
- Work with Wiltshire Health & Care to monitor and improve the quality of care across the patient pathway.

- Work with B&NES, Swindon and Wiltshire Sustainability and Transformation plan (STP) to undertake joint audits where patient outcomes and clinical effectiveness could be improved.
- Embed the new Integrated Governance Framework and Accountability Framework into practice.

6.3 Patient experience

- Continue to reduce numbers of patients being cared for in mixed sex accommodation within our Acute Medical Unit.
- Improve patient flow and reduce the number of times a patient is moved during their stay.
- Identify patients with delirium to ensure they receive effective care and treatment.
- Work with our commissioners to improve access for children and young people to the adolescent mental health service.
- Improve the rapid discharge process for patients at the end of their life who wish to die at home to ensure that they are able to do so.
- Work with Healthwatch and other external stakeholders to gain the views of a range of people and hard to reach groups to improve care.
- Ensure our staff are trained in the Armed Forces Covenant to support improved health outcomes for the Armed Forces community.

7.0 Capabilities and culture

7.1 Leadership

The Trust Board has overall responsibility for quality, safety and patient experience and 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 Integrated Governance Framework sets out the areas of accountability of the Medical Director.

The Director of Nursing is responsible for quality improvement through clinical leadership to achieve improved outcomes for patients by leading on Domains 4 and 5 of the Outcomes Framework. The Integrated Governance Framework sets out the areas of accountability of the Director of Nursing.

7.2 Culture

The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse incidents and near misses to ensure learning and improvement actions are taken. Our national staff survey 2016 showed that the hospital is in the top 20% of Trusts for staff feeling that procedures for reporting errors, near misses or incidents are fair and effective and staff feel confident and secure in reporting errors, near misses and incidents. The rate of reporting rose by 18% in 2016/2017 compared to the year before.

The Care Quality Commission noted in their inspection that the statutory duty of candour was well understood by staff. They also noted there was an extremely positive culture in the Trust and staff felt respected and valued.

A well-led organisation and workforce development 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. Many staff have attended leadership development opportunities via the NHS Leadership Academy and used the skills learnt to lead improvement projects. Examples are seen in our Health Improvement Projects (HIMP) and the Trust wide transformation programmes.

7.3 Sharing the learning

7.3.1 Clinical Governance half days

There are 6 clinical governance half days a year. They are protected time to allow teams to meet together to discuss, review and improve quality as well as attending the 4 core sessions which cover patient safety, effectiveness and patient experience. Core sessions are well evaluated by attendees; on average 95% of participants rate them as good or excellent.

Date	Topic
June 2016	Duty of Candour
July 2016	Patient Safety - celebrating progress
November 2016	Healthcare Improvement Programme – junior doctor presentations
January 2017	Informed Consent: The Interface with Capacity and other Dilemmas in Practise

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 at the core sessions. The newsletter is published on the intranet and a link to the publication is sent out by broadcast to all staff. Stakeholder feedback suggests the newsletters support best practice and are well received. Three were published in 2016/17 on the topics in the table above.

A new patient safety newsletter was launched this year. These will be published each quarter with a different strand of our patient safety programme covered each time. The first issue had a focus on our frailty work stream.

7.3.3 Striving for excellence awards

The Trust held its 10th annual awards day in November 2016 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 (Integrated Governance Framework)

The Trust Board is responsible for ensuring patients receive high quality care which is continuously improved and that it promotes a culture where patients are at the centre of everything we do, staff learn from experience and the Trust engages with patients and the public to develop services. Responsibility for the delivery of quality governance is delegated to the Clinical Governance Committee (CGC). The CGC provides assurance to the Board by ensuring the supporting processes are embedded in Directorates and the Trust wide quality groups promote learning, best practice and compliance with all relevant statutory duties. Quality is also 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 Trust manages the delivery of its services through a directorate structure with each accountable for its contribution to delivering an outstanding experience for every patient and business plan. Each directorate is clinically led and managed by a Directorate Management Committee responsible for providing leadership within their directorate, supported by lead clinicians and operational managers. The directorate ensures that robust governance arrangements are in place and high quality care is consistently delivered by providing information and assurance to the Board via executive performance meetings chaired by the Chief Operating Officer.

8.2 Quality processes and measurement (Accountability Framework)

Executive performance meetings are held monthly with the clinical directorates to review performance across quality, finance, operations and workforce. Each directorate is held accountable against a set of metrics on the quality of care, operational performance and finance and assigned a red, amber or green rating based on performance against the domains of safe, caring, responsive, effective, and financial performance. The rating is routinely reported to the Board to ensure a clear line of sight on quality and performance and that attention is given to the most significant areas of risk.

9. Quality priorities for 2017 – 2018

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.

10. Monitoring progress

Progress of the quality priorities will be monitored through the Trust's Integrated Governance Framework and Accountability Framework. A scorecard based on the quality of care, operational performance and finance will be used as part of the overall assessment of performance within the Trust. A mid and end of year Quality Account report will be presented to the CGC and our commissioners.

The delivery of the Care Quality Commission (CQC) action plan will continue to be monitored and managed via the following routes:

- At the monthly executive performance meetings – where each directorate management team will be held to account for the delivery of their core service actions.
- Oversight of the action plan as a whole and delivery of the Trust wide actions at the CQC Steering Group, chaired by the Director of Nursing.
- Board oversight of progress is through the Clinical Governance Committee (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 continues to assess levels of compliance to assure improvements are embedded in practice.
- Preparation of the organisation for an unannounced inspection in 2017/18.

11. Summary

Overall, the new Integrated Governance Framework and Accountability Framework will strengthen assurance of the quality of care and performance across the Trust by ensuring the Board has a clear line of sight on the issues and attention is given to the most significant areas of risk.

12. Recommendation

The report is presented for assurance along with areas of risk and associated mitigation.

Claire Gorzanski
Head of Clinical Effectiveness
June 2017

Report to:	Trust Board	Agenda item:	SFT3940
Date of Meeting:	2 October 2017		

Report Title:	Major Projects Report			
Status:	Information	Discussion	Assurance	Approval
	X			
Prepared by:	Laurence Arnold, Director of Corporate Development			
Executive Sponsor (presenting):	Laurence Arnold, Director of Corporate Development			
Appendices (list if applicable):				

Recommendation:

The Trust Board is asked to note the contents of the report and the updates on progress contained therein.

Executive Summary:

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

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

Introduction

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

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

Summary

Salisbury NHS Foundation Trust

Project	Lead	Status	Workstreams	Summary
EPR	LA	Improving at Amber	6 x green 3x amber	Good progress on system stabilisation. Data warehouse will cutover to Trust system during this month. Focus on prioritising the reporting for the organisation.
Ward changes	AH	Green	4 x green 1x amber	Work in MAU started 7th August. Major impact for the organisation over the summer with reductions in bed numbers.
Wiltshire Health & Care	LA	Reducing at Amber	1 x green 2 x amber 1 x red	Established southern locality group to promote integrated working locally. Major focus on working with primary care on managing the frail elderly. Recruitment issues hampering progress on some key projects. CEO to be SFT representative on the Board.
Scan for Safety	MC (LW)	Stable at Green	4 x green	Phase 3 completed – Final stage of implementation in Theatres Late October. Looking at options post March 18
SDU	MC	Improving at Green	3 x green	New service well established – good feedback from clinical departments. Site demolition complete with planning permission received. Tenders for building work being evaluated – two firms have been shortlisted, approval proceed will be sought by the end of September

Electronic Patient Record (EPR)

Salisbury NHS Foundation Trust

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

Workstream	Status	Trend	Actions
Stabilisation Plan	Amber	Improving	• Themed, more in depth support and training post go live, continues based on process reviews and feedback • Optimisation support in a number of services has been well received • Reducing trend of issues being raised
Data migration	Green	Improving	Issues with migrated data in the system now reducing through a combination of validation and system fixes
Data warehouse	Green	Improving	Data warehouse cutover to Trust DW due to happen at the end of September for all financial reporting from 1st October to be from Trust warehouse.

Electronic Patient Record (EPR)

Salisbury NHS Foundation Trust

Workstream	Status	Trend	Actions
Configuration	Green	Stable	Knowledge transfer and training to new starters underway, focus on the resolution of issues identified though process reviews and surveys
Benefits	Amber	Declining	Technology benefits achieved. Further analysis / review will be undertaken as part of the stabilisation activity.
Role based access	Green	Stable	Activity embedding into BAU.
Integration	Green	Stable	Integration to Somerset Cancer record now live. Work ongoing for bi-directional messaging with whiteboards.
Phase 2 planning	Amber	Stable	Phase 2 re-planning being reviewed in light of stabilisation requirements
RTT Reporting	Green	Stable	• PTL & RTT validation exercise underway, total number on the list has plateaued at c. 18,000. RTT return now being submitted on time and achieving 92% target. • Training, process & outcome forms changes also being implemented – still work in progress, but positive signs

Ward Reconfiguration Programme

Salisbury NHS Foundation Trust

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

Work stream	Status	Trend	Actions
Create an expanded acute medical unit	Green	Stable	Building work began in early August for November completion and commissioned early/mid December
Consolidate MSK beds into burns / orthopaedic template	Green	Stable	Change complete
Open new ophthalmology facility	Green	Stable	Units on site and being commissioned – service due to move 28/29th September, and will be operational 2nd October
Convert current eyes department to medical ward area	Amber	Stable	Delay in final clinical sign off meant went out to tender on 12th September. Tenders due back early October.
Short stay surgical ward in current Braemore ward	Green	Stable	Planning underway of types of patients who will be eligible for management through short stay ward. Due to open in late mid December

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

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

Scan for Safety

Salisbury NHS Foundation Trust

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

Work stream	Status	Trend	Actions
Global location numbering	Green	Stable	Physical locations at 80% completed Working with provider of hospital app to look at way finding addition to current functionality
Catalogue management	Green	Stable	Focus across final areas within Theatres increase quality of data ensuring ready for next stage of go live end of October
Patient identification	Green	Stable	Working with POET to increase utilisation and functionality within ward areas Reviewing areas where patient id can be used to increase patient safety and reduce never event
Purchase to pay/Inventory	Green	Stable	Ortho and Cardiology live Implementation pre go live for Theatres building procedure lists and items with Clinical teams

SDU Joint Venture

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

Workstream	Status	Trend	Actions
Commercial	Green	Stable	JV agreement , leases and service contract signed mid August '16
Operational	Green	Stable	KPI - Fast Track volumes should not exceed 9%: July = <4% KPI – Failed trays (SSF1) target <0.25%: July = 0.23% KPI - Turnaround time not achieved (SSF2) target < 5%: July = 22% Equipment failure being the key reason for the missed target.
Facility design	Green	Stable	Demolition work now complete. Planning permission received. Tender submissions received and currently being evaluated

Report to:	Trust Board	Agenda item:	SFT3941
Date of Meeting:	25 September 2017		

Report Title:	Capital Development Report, September 2017			
Status:	Information	Discussion	Assurance	Approval
	X			
Prepared by:				
Executive Sponsor (presenting):	Laurence Arnold, Director of Corporate Development			
Appendices (list if applicable):	Appendix A – other building and works schemes Appendix B – other information technology schemes Appendix C – other medical equipment replacement schemes			

Recommendation:
The Board is asked to note the progress of the Trust's significant capital schemes.

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. The last few months have seen the beginning of the work to reconfigure the ward environment and will see the opening of the new ophthalmology outpatients area. The EPR project continues to be a major focus in early 2017 (see also major projects report), but other systems are being upgraded and developed. In the coming year, a number of major infrastructure projects will challenge the organisation.

1. Purpose

The purpose of this paper is to update the Board on developments with some of the more significant capital schemes on the Salisbury District Hospital site since the date of the last report (May 2017).

2. Building Schemes

Acute Medical Unit (AMU) Project

Following the ward moves to facilitate major refurbishment of the former Farley Ward template, building work has now started and is progressing well. Work is expected to be completed by the end November 2017.

Following the completion of this work the following ward moves will be:

- AMU to move to refurbished ward on level 2 (former Farley template)
- Breamore Ward to move to former AMU L4 and is expected to take the Whiteparish Ward name
- Short Stay Surgical to open in the former Breamore Ward Central Corridor.

All these moves are expected to be completed by the 15th Dec 2017

Ophthalmology OPD

Following the successful delivery of 15 PortaKabin units mid-August, building work is currently underway fitting out the new Ophthalmology OPD unit and this is expected to be completed by 22d Sept.

The new Ophthalmology OPD is currently planning to move to the new facility on the 27th & 28th Sept and to be fully operational by the 2nd Oct 2017.

New Pembroke Ward/Suite Level 3 (former Ophthalmology OPD)

The design work for the new Pembroke Ward and Suite in the former Ophthalmology template is complete and is now out to tender.

Tenders are due back 2nd Oct and subject to the tender returns being successful and within budget, building work could start late October.

It is planned to do the work in two phases to facilitate ten beds being available for use by early Feb 2018.
The whole scheme is expected to be complete by late March 2018.

3. IT Schemes

The following are the major non-EPR projects also underway:

Single Sign On (SSO)

In use and well received – no recent updates at the user end but a large amount of upgrades to the server end.

Next steps:

- Pathology and ED to test out the new builds via laptops

Electronic Whiteboards
A trial of the integrated discharge form has taken place on Durrington Ward. This has enabled the ward to stop the use of faxes to outside organisations such as Medvivo and is being led by the Integrated Discharge Team. Maternity went live with E-Whiteboards in June and are actively monitoring their patients through the system. The E-Whiteboards Team organised an E-Whiteboards workshop with representation from Hospedia to look at ways to improve the use of the system. This was well attended with over 30 people attending from a cross section of the organisation and a number of actions were taken away to be worked on. Work is continuing on the testing of bidirectional functionality. This will streamline the process of transferring patients enabling transfers to be done either in Lorenzo or on the E-Whiteboard. In order to further improve utilisation, the idea of Whiteboard Wednesday has been introduced. The aim of this is that every Wednesday wards will be encouraged to have all discussions about patient care and discharge planning taking place at the Board.

Patient Observation and Escalation Tool (POET)
Implementation continues. The system is currently live in Laverstock, Britford, Britford Surgical Assessment Unit, Downton, Burns, Farley, Winterslow, Avon, Tamar, Chilmark and Amesbury. Training is taking place on Breamore and Pembroke. The scanning of patient wristbands in order to encourage positive patient identification, is being piloted on Britford and Downton. Additional functionality to support the management of patients requiring cannulation is being tested on Britford Ward. The Fluid Balance Chart has also been developed and is now in functional testing. Once this testing has been completed, it will be tested in a ward environment. Roll-out of this solution will be done in partnership with the CCOT team as additional training is required on Fluid Balance across the wards.

Electronic Discharge Summaries
The use of the EDS within the Day Surgery Unit was fully implemented during the last quarter.
The 'day case' version of the EDS has recently been enabled for use by areas who treat patients as day cases ie: SSEU, Endoscopy and Surgical Admissions Lounge.

Blood Tracking – Phase 2
The pilot was placed on hold whilst changes to the Bloodhound Bedside application requested by Scan for Safety were implemented. The changes introduced a number of bugs which are being worked on by the supplier. A new pilot is planned for the October/November period.

NHSmail 2
At ISSG an agreement has been initially given for a fully managed service to be provided to allow us to move to NHS mail 2. This is expected in early 2018.

Health and Social Care Network
The contract for N3 (the national NHS network) ended on 1 April 2017. The service is currently being run by NHS Digital who are moving us off of N3 onto HSCN. First year's funding (for the service) will come from NHS Digital, with subsequent year's funding being 75%, 50% for years 2 and 3 (beyond is currently unknown). We are working with our STP partners to ensure that we secure the best possible deal with the Salisbury Procurement Department taking the lead. Target is mid-2018.

Infrastructure Refresh
The internal consultation concluded with the external consultants delivering their report in April. A procurement to replace the infrastructure is now in progress. It is planned to

conclude the procurement and award a contract to supply in Q4 2017 to enable the implementation of the new infrastructure during Q1 2018 with production use commencing in Q2 2018.

4. Recommendations

The Board is asked to note the progress of the Trust's significant capital schemes.

Laurence Arnold
Director of Corporate Development

13th September 2017

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.		£200K (2017-18)
Road repairs and Pedestrian crossings (7020C0) Repairs to the roads on site and upgrading the pedestrian crossings to current standards – project slipped to 2017/18 and scope of works to be reviewed, and consideration made in respect of new developments on site such as the new Sterilisation Unit.	TBC	£214k (2017-18)
Accommodation upgrade (7011C0) Final works on this scheme nearing completion.	Oct 2017	£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. Funding for this financial year to be utilised for the AHU / Ventilation system for the new modular build for Ophthalmology. Work in Theatres 1 & 6 delayed due to clinical activity – date for installation TBC.	March 2020	£250k (2017-18)
Nurse Call System upgrade (7202C0) Nurse call system in the Spinal to be replaced in October / November 2017.	2017/18	£68K (2017-18)
Lift Refurbishment Programme (7056C0) **The majority of the work complete in Lift No 2, some outstanding works related to 'Duplexing' control with Lift No 1.**	October 2017	£66k

APPENDIX B

Information Technology schemes	**Completion date**	**Budget cost incl VAT**
PACS/RIS (7943C0) Cardiology migration has been successfully completed and the MEDCON archive is now in PACS and available via Uniview and XDS for our GP's and other consortium members. Vascular reports and images are now visible in PACS which also the Vascular network in Bournemouth can now view these via Uniview. Obstetric ultrasound reports will be the next integration into PACS/XDS.	November 2017	
Order Comms and Results Reporting (7942C0) GP T'Quest Work continues with GP T'Quest in order to define "copy to" solution and how this can be achieved. GP review continues its pilot and has now extended to two further GP's within the Amesbury practice. Access to GP review has also been extended to two renal consultants from Portsmouth (providing clinical care within Salisbury renal unit) as a way of providing patient centric data. Review The Review issue now appears resolved through investigative work undertaken by Salisbury IT team. It is expected that a Review upgrade will be required and the Trust are working with the supplier to make appropriate arrangements.	Autumn 2017	
Telecoms Voice Over IP (7948CO) Replacement of faulty Splicecomm system is planned for 22nd September after which final rollouts will continue to areas inc PFI	On-going roll out	£0
SpIda The removal of the 2nd Manager sign off has been built and tested but not deployed as waiting for formal confirmation. This has now been confirmed by the Execs (19-09-2017) and the functionality will be released asap.	Late 2017 (phase 3)	N/A
Cardiology PACS (7901CO) The cardiology order/report phase completed in early 2017 and has been successfully operating since. Cardiology DICOM migration and storage to SECTRA PACS has completed and cardiology studies can now be viewed throughout the hospital as well as across the SWASH Consortium. In 2Q2017 the industry standard protocol XDS was implemented which enables structured cardiology and vascular reports to be viewed also via SECTRA PACS.	August 2017 COMPLETE	
Genomics Bioinformatics software This project is to replace the existing software with software which meets the current and future requirements.	December 2017	£50,000

Information Technology schemes	**Completion date**	**Budget cost incl VAT**
Gynaecology System A delay with the contract and concern over the reporting side of the software has meant a rethink on which supplier to use. This is currently being progressed.	March 2018	£78,000
Network Maintenance To replace network hardware on the edge of the Trust's LAN, which either already have or are about to go end of support.	March 2018	£50,000
Network Security The current security environment for the Trusts connection to N3 and the internet will go end of extended support April 2020 and this project is to replace that product. Solution is out to tender currently and due back end of September	March 2018	£139,000
Partial off-line back –up of data to protect against malware The Trust's SAN storage solution has recently had an increase in storage capacity to meet the growing data needs of the Trust. The backup solution now needs to be increased in to ensure that the Trusts data is secure and available for recovery in the event of a disaster recovery situation occurring. Depending on the Infrastructure refresh solution this may not be required.	March 2018	£50,000

APPENDIX C

Medical Devices schemes	**Completion date**	**Budget cost**
Capital schemes		
Bed Replacement programme (7131C0) The bed replacement programme is progressing. 452 of the replacement beds have now been ordered. 20 additional beds have been ordered to address escalation needs, this funding has been taken from the 2017/18 capital allocation. A capital bid has been submitted for the 2018/19 capital round to complete the replacement programme.	Year 5 of a 5 year programme	£150k (2014/15) £204k (2015/16) £120k (2016/17) £55k (2017/18)
Review of Theatre Instruments (7122C0) The Trust commissioned an external review of instrumentation. The newly formed SSL will influence the future needs of the Trust. The joint SSL and SFT stakeholder group is working well and monitors and audits the emergency requirements and plans for the future needs. As a result, the total budget allocation from 2016/17 was not used and has been slipped to form the budget allocation for this project for 2017/18	Rolling programme	£300k (2014/15) £500k (2015/16) £500k (2016/17) £122k (2017/18)
Ultrasound machines (7173C0, 7177C0, 7178C0, part 7118C0) 5x ultrasound machines are being purchased as a result of successful bids in the 2017/18 capital programme. They will be used for: • AAA screening – 2 machines to replace those purchased when the service was implemented. There are 4 currently in use. The other 2 machines will be replaced next year. • Ultrasound machine for cross-Trust imaging support – a review of ultrasound efficiency has been carried out and the need for a multi functional machine has been identified. • Ultrasound machine for inpatients – as part of the above review, there has been a change in practice and a dedicated inpatient room established which has proven to improve patient flow and increase throughput. This machine is needed now that the pilot is to become permanent. • PICC line insertion – a transformational scheme being piloted by the Anaesthetics Lead ODP in conjunction with a Consultant Radiologist which requires a portable	August 2017 December 2017 December 2017 March 2018	£53k £80k £80k £26k

Medical Devices schemes	**Completion date**	**Budget cost**
ultrasound. A portable ultrasound is being clinically evaluated during the pilot phase.		
Replacement of Room 14 x-ray equipment in Radiology (7176C0) A capital bid was submitted for the replacement of this equipment owing to its age and decreasing performance which has led to safety concerns. The clinical evaluation has been completed. The costs are being finalised and an award will be made imminently. The project is planned for installation and completion by December 2017.	December 2017	£318k
Operating tables replacement (7172C0) A rolling replacement programme has been funded for the replacement of the operating tables in Main Theatres and DSU. 3 will be replaced in this financial year but a tender is being undertaken for all tables to enable a call off arrangement to be implemented. The clinical evaluation is due to start this month and will run for 3 weeks.	March 2018	£150k
<u>Donated Assets</u>		
Nothing to update in this quarter.		

Report to:	Trust Board	Agenda item:	SFT3942
Date of Meeting:	2 October 2017		

Report Title:	Appointed Auditor – Report to Council of Governors			
Status:	Information	Discussion	Assurance	Approval
	X			
Prepared by:	KPMG - Appointed Auditor			
Executive Sponsor (presenting):	Cara Charles-Barks, Chief Executive			
Appendices (list if applicable):	Presentation to Council of Governors			

Recommendation:
The report as given to the Council of Governors in July is presented here for information.

Executive Summary:
KPMG indicate that - Audit completed in line with agreed plan. - All timetables and deliverables met in accordance with regulatory requirements. - Key audit findings discussed with the Audit Committee on 19 May 2017. - Financial Statement and Quality Accounts opinions signed on 25 May 2017. A Qualified opinion given on the “referral to treatment” indicator in relation to the underlying data. This has been the subject of a deep dive by the Audit Committee.

Content

The contacts at KPMG in connection with this report are:

Rees Batley
Director

Tel: 07876 854886

Rees.batley@kpmg.co.uk

John Oldroyd
Senior Manager

Tel: 07826 903 829
John.oldroyd@kpmg.co.uk

Headlines from our work

Overview	- Audit completed in line with agreed plan. - All timetables and deliverables met in accordance with regulatory requirements. - Key audit findings discussed with the Audit Committee on 19 May 2017. - Financial Statement and Quality Accounts opinions signed on 25 May 2017.
Financial Statements	Unqualified (clean) opinion on the financial statements (2015-16 unqualified opinion). *Means we have checked that amounts the Foundation Trust says it has received and spent and money it owes and is owed are correctly recorded. We have also checked where Management has used judgement, that those judgements are well thought through and appropriate.*
Use of resources	Unqualified (clean) conclusion on the use of resources (2015-16 unqualified conclusion). *Means we have looked at how the Board works and what the Trust's main regulators, NHS Improvement and the Care Quality Commission, have said about it and found no significant concerns.*
Quality report	• Limited assurance (clean) opinion on the content of the quality report (2015-16 clean opinion). *This means that the Trust included everything it should have done within the Quality Report including both good performance, and areas for development.* • Limited assurance (clean) opinion given on the "A&E 4 Hour wait" indicator (2015-16 clean opinion). *This means no issues were found with the "A&E 4 Hour Wait" indicator.* • Qualified opinion given on the "referral to treatment" indicator (2015-16 qualified opinion). *Means that data quality issues were identified with the "referral to treatment" indicator which resulted in a qualified opinion being issued. The Trust are continuing to implement changes to its processes in order to address the issues relating to data quality.*

Financial statements detailed findings

Accounts

- ✓ Good first draft of accounts available for audit when due.
- ✓ Finance team responded positively to questions / queries from the audit team.
- ✓ No material adjustments noted.
- ✓ Clean opinion

Annual report

- ✓ All reporting requirements met.
- ✓ Missing disclosures highlighted to management as part of our review were corrected.
- ✓ Robust scrutiny and challenge by Audit Committee.

Remuneration report

- ✓ The financial data was requested early and completed on time.
- ✓ Disclosures made in first draft.

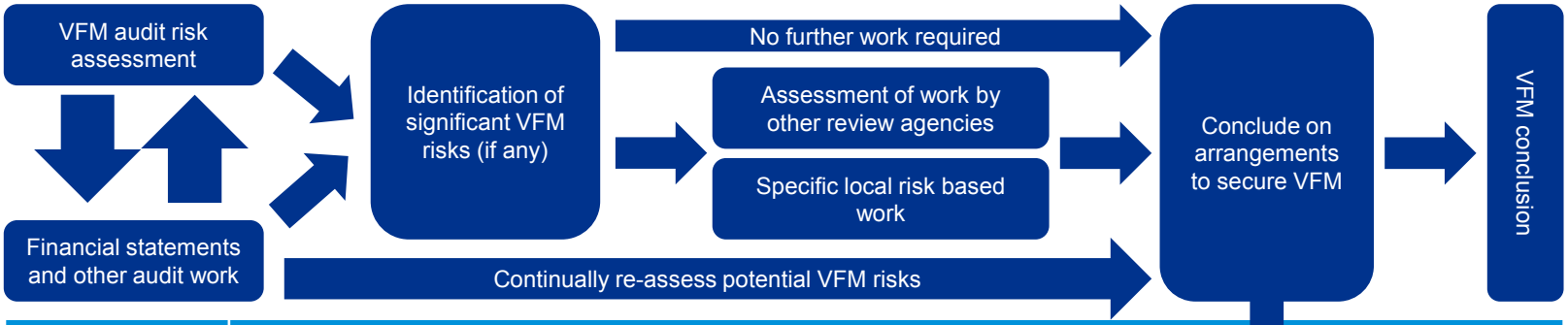
Long form audit report

- ✓ Content carefully focused on the Trust and its risks.
- ✓ Audit Committee also commented on audit risks in the Annual Report.

Recognition of NHS and Non-NHS income	✓ Reviewed key contracts with Commissioners and assessed income received against contracts. ✓ Tested NHS and non-NHS income. ✓ Tested bad debt provisions.
Valuation of land and buildings	✓ Reviewed the professional valuers report. ✓ Reviewed accounting entries regarding revaluations. ✓ Tested land and building additions and disposals.
Mandatory risk	✓ Fraud risk from revenue recognition. ✓ Fraud risk from management override of controls. ✓ We did not find any instances or indicators of either fraudulent revenue recognition or management override of controls.

Use of resources

Our approach is to consider:



Annual Governance Statement	• **Balanced narrative that reflects our understanding of the Trust's operations and risk management arrangements**
Work of other regulators	We considered the outcomes of relevant regulatory reviews (NHS Improvement, CQC, etc.) in reaching our conclusion. We reviewed the action plan which the Trust are progressing following the Care Quality Commission inspection in previous years 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 and are satisfied that the Trust is responding appropriately to the ratings to make improvements.
Other work	We have reviewed the Trust performance against the CIP target. The Trust achieved £8m of the CIP target which represents 84% of the target and 50% of these savings were recurring. We also considered reference costs and the Trust has a reference cost of 91, which is below the national average of 100. As part of our audit we considered the performance against the CIP total and how management monitored the shortfall. The additional CIP requirement was met as a result of a stock adjustment made during the year as part of the Scan4Safety project. This enabled the Trust to meet its control total and achieve the STF allocation for the year. The Trust has taken steps to ensure that it has in place the required level of funding that it will require during the coming financial year. This has been communicated to NHSI and discussions are ongoing in order to secure the funding required.

We have issued a clean Use of Resources conclusion for 2016-17 as we did in the prior year.

Quality Accounts

Content and consistency

Content and consistency – clean limited assurance opinion issued

A good first draft of the Quality Report was received.

National Indicators:

A&E 4 hour wait

Referral to treatment

A&E 4 hour wait – clean limited assurance opinion issued

The indicator is calculated in line with national guidance

Referral to treatment – qualified limited assurance opinion issued

We have identified issues in relation to the sample testing performed and these issues were also raised in the testing performed during the 2014-15 and 2015-16 audits. In addition we have identified issues with the underlying data in the current year, which is partly as a result of the implementation of the new data warehouse.

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.

Local Indicator:

TIA referrals within 24hrs

TIA referrals within 24hrs – no opinion required

- Our work on the local indicator has indicated that we would not be able to provide a clean opinion. From a sample of 25 cases selected, data quality issues were identified with 11 of the sample. These issues related to data entry errors and missing information on referrals.

SFT3943

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 27th July 2017, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – PROFESSOR JANE REID

Present:

Professor Jane Reid – (Chair) Non-Executive Director
Cara Charles-Barks – Chief Executive Officer
Dr Christine Blanshard - Medical Director
Lorna Wilkinson - Director of Nursing
Fiona Hyett - Deputy Director of Nursing
Claire Gorzanski – Head of Clinical Effectiveness
Hazel Hardyman – Head of Customer Care
Dr Michael Marsh – Non-Executive Director
Michael Von Bertele – Non Executive Director

In attendance:

Kate Williams	Minute taker
Jan Sanders	Governor
David Kelly – Fire Officer	CGC071202
Graham Lloyd-Jones – Consultant Radiologist	CGC071706
Sarah Cook – Consultant Radiologist	CGC071706
Alison Montgomery – Specialty Manager, Radiology	CGC071706
Dr Stef Scott – Head of Research	CGC071715 & CGC071716
Fenella Hill – Head of Risk Management	CGC071717, CGC071718 & CGC071719
Gill Cobham – Adult Safeguarding Lead	CGC071721

CGC071701 Apologies:

Andy Hyett – Chief Operating Officer
Steve Bleakley – Chief Pharmacist
Dr Samuel Williams – F1
Tania Baker – Non-Executive Director
Maria Poelvoorde – Staff Nurse
Mark Stabb – Head of TIAA

CGC071702 – Any Urgent Business – Estate Fire Regulation Compliance Report – David Kelly

DK reported that Salisbury NHS Foundation Trust buildings have been inspected and are compliant with regard to cladding. Following the Grenfell tower incident DK has been approached by members of staff for assurance that buildings are safe. CC-B stated that she would issue a broadcast to inform staff of cladding compliance. DK reported that the fire doors in the main hospital will be replaced over the next 2 years. Staff need to be encouraged to keep corridors free of clutter. DK reported that a test evacuation is scheduled to take place on Farley ward to assist in

CC-B (completed)

major incident planning. LW noted positively that there is increased activity in major incident planning overall.

GC071703 – Minutes of the meeting held on 22nd June 2017

The minutes were approved by the committee.

CGC071704 – Action Tracker

All items were agreed.

CGC071705 – Matters Arising – Falls resulting in harm – 90 day challenge update (verbal) – Lorna Wilkinson

LW reported that the number of falls in Q1 are similar to Q1 last year. However, there has been a dramatic reduction since Q4. There have been good discussions with the CCG and there has been implementation of SWARMs. Louise Roe in the Risk team has been heading up the falls group. There is a theme with falls in elderly care and particular challenges with the elderly population, and those with frailty and a history of falls. A bid has been made to the League of Friends for a computer on wheels containing diversion therapy software – families can add photos and the patient's likes and dislikes to help calm them. JR asked if volunteers were being recruited to sit on the wards and watch out for patients who may be at high risk of falling to which LW responded that this is being picked up in the Dementia Steering Group. LW confirmed that delayed discharges lead to a higher risk of falls once the patient has recovered from their original injury.

STRATEGY

CGC071706 – Core Service presentation – Diagnostic Imaging – Graham Lloyd-Jones, Sarah Cook, Alison Montgomery

G L-J, SC and AM gave an overview of the CQC outcome for Diagnostic Imaging as a core service, and the achievements and challenges within the department. The team work well together and can demonstrate good responsiveness. There is to be a replacement of equipment over the next 3 years. Decisions need to be made in respect of the funding of a new MRI scanner in 18/19. CC-B noted that raising money for this will take time and asked the team to investigate if there are national funds. GL-J reported that there is a national staffing challenge in diagnostic imaging which is also reflected in Salisbury. CB observed that 3 overseas staff have recently been recruited which will improve the situation. GL-J reported that a member of staff is currently being trained to become a radiologist which is a lengthy process. Encouragement is given to staff to upskill. JR observed that there is no central focus on commissioning and asked that a workforce summit take place with JR, CC-B and Paul Hargreaves. CB will put the team in touch with the LMC. GL-J will attend the next meeting with GPs (LMC) to discuss improving communication and avoiding inappropriate requests for procedures. **JR, CC-B**

The committee thanked GL-J, SC and AM for their presentation.

CGC071707 – Hot topic – Nurse Documentation (verbal) – Lorna Wilkinson

LW reported that the ward leaders and nurses are meeting on a monthly basis to review documents and try to understand why there is poor compliance. The workflow around this has also been reviewed – traditionally paperwork is completed at the end of the day but some things should be done at the point of care. Best practice in other Trusts has been considered. A decision has been made that documents are brought back into one booklet. In the future, the documents will be completed electronically and decisions need to be made as to the most appropriate place to record them - Lorenzo or POET. Currently this service is not available on Lorenzo. If possible, the 'Nursing assessment plan and evaluation' would be on Lorenzo and bundles would be on hand held devices. It will take time to move from paper documents.

JR asked that this topic return before the committee in November 2017. Add to the action tracker. **KW (Completed)**

GC071708 – Hot topic – Medicines Storage – Lorna Wilkinson

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

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

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

This has been seen as a joint improvement programme between nursing and pharmacy, as the core staff groups involved. There is an improvement in practice. The action plan is on track. Progress can be seen in that we are now seeing awareness across all areas, all clean utility room doors are locked, all fridges locked, good controlled drug controls, good drug key stewardship, vast improvement in the locking of medicines cupboards. The inadequate bolts within the PFI have all been replaced with a more robust solution. Some remaining issues are identified in areas with recurring issues.

Next Steps:

- Controls will continue regarding monitoring
- Ward app being developed to allow continuous audit and sustain monitoring
- Downton refurbishment of clean utility room
- Within the planned ward refurbishments we are scoping locks which will have an automatic locking facility to ensure the default is to do the right thing i.e the cupboard is locked

Recommendation:

- An update has been presented to the Audit Committee who have agreed that this should now be monitored via the the Nursing and Midwifery Forum and as exception Clinical Governance Committee

LW reported that there will be a Trust-wide audit in August 2017. The committee agreed that this would come back to the committee by exception if needed.

CGC071709 – Spinal Unit Leadership (verbal) – Christine Blanshard

CB reported that a positive assessment has been received from the NHS England specialised commissioning assurance quality visit in respect of the current state and future plans. The Trust is seeking to recruit a clinical lead for the unit from any appropriate clinical background whilst NHS England have confirmed their preference for a doctor in this role. CB will write to the chair of the group to try to resolve this issue. JR asked that this matter is taken to the Trust Board to gain their support, and to move forward. **CB**

ASSURING A QUALITY PATIENT EXPERIENCE

CGC071710 – CQC inspection action plan update / May report plus verbal update – Lorna Wilkinson

- The document circulated to the committee contains a high level narrative on actions taken/completed since last report. This also contains an update on the approach to inspection preparation. There is detail of the 'must do's' within the CQC inspection report and current status at a glance. It can be noted that 2 areas have decreased in risk due to actions being taken. These are: discharges from theatres due to current pilot in place. 1 area has increased in risk and this is nursing documentation which is due to a disappointing level of compliance being identified in an internal audit report. Task and finish group for rapid improvement being chaired by DoN
- The CQC Steering Group meets monthly to review the action plan by core service area
- There is ongoing action across all areas, and it can be seen that more of the core service actions have taken a positive step towards completion, some of these have been challenging to achieve e.g. establishment of the navigator role in ED
- Workforce reviews for medical staffing in the Emergency Department and Care of Children across the Trust have been presented at appropriate committees and agreed.
- The Action Learning Group continue to carry out targeted visits to core service areas

- The executive team have completed a self-assessment exercise on the well led framework and have a resulting action plan
- There was a reinspection of the spinal warning notice in November 2016 – the final report has been received and concludes that the Trust has taken all appropriate actions.

LW reported that all core service workshops have been completed. The teams are producing posters to be taken back for discussion in clinical areas. CC-B noted that it is important to ensure that there is continuing work around those matters that are being done well. LW stated that it is important that 'resolved issues' are still considered and there need to be continued conversations in these areas. Drop in sessions have been arranged for staff to attend during August. The action learning group has expanded and has good engagement. Visits have been arranged with The Royal Berkshire Hospital, the first one is due to take place in August. As part of the pre-inspection return, mapping is being completed for those who would be responsible. Work is ongoing in ward reconfiguration and paediatric areas. The Navigator / GP function is working in ED and includes the paediatric area. There is a continuing challenge in discharging patients from theatre as there is no step down area and this is proving difficult to resolve. CC-B suggested that underutilised areas are considered as a potential solution. CB noted that it may be possible to move some procedures from day surgery to improve the situation but there are constraints. Work is ongoing.

CGC071711 – National ED Survey 2016 – CQC Benchmark Report and Local Action Plans

This item was deferred to September 2017 as not yet published.

CGC071712 – Annual Patient Experience Report – Hazel Hardyman

The purpose of this paper is to provide an update on lessons learnt and changes in practice as a result of feedback. The Customer Care 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. The report also complies with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, which requires each NHS Trust to produce regular reports about complaints received, including an annual report. It also fulfils the requirement of our commissioners.

HH reported that the Ombudsman upheld a urology complaint. Information is also to be shared from a respiratory case. The Complaints Co-ordinators will work with their directorates to adopt the weekly rota system that has been implemented in the Musculo-Skeletal Directorate to increase responsiveness to people's concerns.

ASSURING CLINICAL EFFECTIVENESS

CGC071713 – Quality Indicator including DSSA – discussion – Dr Christine Blanshard

- No MRSA bacteraemias in Q1. One Trust-apportioned MSSA bacteraemia in Q1 which is still being investigated.
- No Trust apportioned C. difficile cases in June. A total of 1 in Q1.
- 2 new serious incident inquiries commissioned in June. A total of 7 in Q1.
- 2 in-hospital cardiac arrests in May 17, of which 1 had a futile CPR attempt.
- A decrease in the crude mortality rate in June 17. SHMI decreased to 102 and to 101 adjusted for palliative care to December 2016. HSMR decreased to 117 in March 17 and is higher than expected. In April, 27 (43.5%) of 62 deaths were reviewed. None were considered avoidable. There were 5 learning points. Mortality newsletter drafted and will be published at the end of July 17.
- A decrease in Q1 of hip fracture patients being operated on within 36 hours. Those that waited beyond 36 hours were waiting for theatre (17) and for medical review/further investigations (2). Best Practice Tariff compliance decreased to 73% in Q1.
- A decrease in grade 2 pressure ulcers this month. There was one suspected deep tissue injury but the patient died before it could be staged. Share and learning meetings continue to drive improvements.
- In June 17 there were 2 falls resulting in major harm (both fractured hips requiring surgery). In Q1 there were 5 falls all resulting in major harm (all fractured hips/femur requiring surgical repair). A new falls reduction strategy and action plan was reported to the Clinical Risk Group and our commissioners in June 17.
- 100% delivery of CT scan within 12 hours and an improvement in stroke patients spending 90% of their stay on the stroke unit. Patients arriving on the stroke unit within 4 hours improved but

remains below the national benchmark – clinical reasons account for most exceptions (2 went to ITU, 1 delayed due to deteriorating condition & 1 no reason given). SSNAP case ascertainment decreased from a B to D (Dec 16 to March 17) – due to timeliness of transfer to the stroke unit, therapy and consultant vacancies & data quality issues. In response to this, ring fenced access bed agreed, therapy vacancies filled, 3rd consultant recruited.
- An increase in the percentage of high risk TIA patients seen within 24 hours.
- Escalation bed capacity decreased slightly in June. Ward moves between 22.00 and 06.00 reported by month only. The plan to reconfigure the bed base over the next 6 months in preparation for next winter has commenced.
- In Q1 there were no non-clinical mixed sex accommodation breaches and this is the 4th month in a row.
- Real time feedback for patients rating the quality of their care decreased slightly in June. The Friends and Family test of patients who would recommend ED, wards, the maternity service and care as a day case and outpatients was sustained.

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

CB reported that there have been extensive discussions regarding the screening of mortality reviews. 5 learning points will be shared with the teams and through a newsletter. The stroke service have successfully recruited. LW reported on the success of the Infection Prevention and Control team who have worked hard to achieve the lowest rates in the whole of the South for Q1. There have been no mixed sex breaches for 4 months which is a great achievement. The Trust Board have been informed.

CGC071714 – New Procedures Report – Dr Christine Blanshard

The New Health Technologies policy is next due for review in May 2018.

No new health technologies have been approved within the reporting period.
Four new health technologies are currently under development:
- High-throughput non-invasive prenatal testing for fetal RHD genotype (Obstetrics)
- Cone Beam CT (Oral & Maxillofacial Surgery)
- NIPT antenatal screening (Obstetrics)
- Prostatic Urethral Lift (Urolift®)

No audits were required within the reporting period.
Audits from Previous Reporting Periods -
One audit was completed and is compliant:
- MRI Arthrography (Clinical Radiology)

Two audits are in progress:
- Use of conscious sedation for adult patients only for oral and maxillofacial
- treatment/surgery in the Oral Outpatient Department (Oral Surgery)
- Blue light cystoscopy with Hexvix (Urology)
- Two audits are pending, awaiting sufficient cohort of patients:-
- Hycosy Procedure as part of a new One-stop Fertility Assessment Clinic (Fertility)
- Implantation and Follow-Up of Subcutaneous Implantable Cardioverter Defibrillators (SICDs) (Cardiology)

CB confirmed that the governance procedure is in place. CGz has a planned induction visit with one of the consultants.

CGC061715 – Annual Research and Development report – Dr Stef Scott

Clinical research is a vital part of the work of the NHS, and a commitment to conduct, promote and use clinical research to improve patient care is part of the NHS England Constitution. Dr Jonathan Sheffield, the chief executive of the National Institute of Health Research Clinical Research Network (NIHR CRN) has a vision "for participation in a clinical research study to be a treatment option for all patients, no matter where they are treated or what condition they have". The Annual Report describes the contribution that the Trust has made towards the NIHR CRN high level objectives. We are pleased to report an extremely successful year for Trust research. Highlights for the Trust during 2016/17 include:

- Recruiting 1599 study participants into 86 NIHR CRN portfolio studies across 23 specialties;
- Ranked top (number of studies) and 4th (recruiting) small acute trust nationally;
- Top small acute Trust in for;
    - Cardiology;
    - Children;
    - ENT;
    - Genetics;
    - Haematology;
    - Surgery &
    - Commercial
- Haematology was ranked 2nd for recruitment nationally (out of 499 Trusts)
- Meeting the following targets on time or ahead of schedule:
    - Increased recruitment into commercial contract portfolio research;
    - Recruitment of the first study participant within 70 days for 100% of eligible interventional studies;
    - 100% recruitment to time and target for commercial studies.
- Targets have been set for 2016/17 relating to consolidation of the above and alignment with the latest NIHR CRN high level objectives.

The report was approved by CMB at the June 2017 meeting.

MM expressed thanks to the team for their work. A suggestion was made to ascertain how the teams ranked 1-3 are working in relation to Figure 7 in the report. CB confirmed that the team undertake both wide-spread and focused studies. SS reported that there is a possibility of a spinal project next year although there are generally very few. MM to share spinal research suggestions with SS and CB outside of the meeting.

CGC071716 – Research Strategy 2017-2022 – Dr Stef Scott

NHS England has a statutory responsibility to promote research. The NHS Constitution for England (2015) has a commitment to "*promotion, conduct and use of research to improve the current and future health and care of the population' and to ensure that patients are made aware of research that is of relevance to them*". The National Institute for Health Research (NIHR) is funded by the Department of Health to "*deliver research to make patients, and the NHS, better*".
Professor Dame Sally Davies believes that *"every patient should have the opportunity to participate in appropriate research which is relevant to her or him…. if we all work together to ensure that the NHS plays its full part in promoting and supporting research, every patient can be offered this opportunity,…so that we can truly state: Every patient a research patient".*
This research strategy replaces the Trust Research Strategy 2011-2016. Detailed descriptions of the strategic achievements may be found in the Trust Research Annual Reports. The Strategy describes how we will build on our successes during 2017-22 and provide Trust patients and staff with more opportunities to take part in high quality NIHR portfolio research.
Strategic objectives will be set on an annual basis. Progress will continue to be reported to CGC and CMB on an annual basis as part of the Trust Research Annual report.

The strategy was approved by CMB at the June 2017 meeting.

The committee agreed that the strategy should go to the Trust Board for support. **CB**

ASSURING SAFETY

CGC071717 – Assurance Framework – Fenella Hill

The Assurance Framework must be reviewed and updated quarterly by the delegated Assurance Committees to ensure that scrutiny is applied to assure the Board that the Trust's principal risks are being managed and controlled effectively in order for the corporate objectives to be achieved.
A Trust Board reporting template was circulated to the committee identifying key changes since the last meeting.

JR noted that she was satisfied with the remedial actions taken. LW asked HH to update the report with the results of the 2016 surveys. FHi reported that there will be a new item on the Risk Register as the plastics skin service backlog has been escalated. CB reported that there have been some

challenges with the referral management service as it is only possible to accept electronic referrals. Work is being completed with the CCG to avoid delays with other types of referral.

CGC071718 – Risk Report Card Q1 – Fenella Hill

• 1843 incidents reported over the quarter
• 0 incident categorised as catastrophic*
• 6 incident categorised as major*
• 5 major incidents due to fractures within the quarter
• No new Never Events reported within the quarter*
• 7 new Serious Incident Inquiries commissioned within the quarter
• No new Clinical Review commissioned within the quarter
• No new Non-clinical Reviews commissioned within the quarter
• No new Local Reviews commissioned within the quarter

*Initial grading and subject to change following review.

The committee noted the report.

CGC071719 – SII/CR report Q1 – Fenella Hill

The Serious Incident Inquiry/Clinical Review Outstanding Actions Compliance Report provides progress on actions taken on recommendations.

Updates to outstanding recommendations: SII 206, SII 217, SII 220, SII 218, SII 222, SII 226, SII 229, SII 230, SII 232, SII 233, SII 234, SII 235, SII 236, SII 237, SII 238, SII 239, SII 240, SII 241, SII 242.

JR asked if it was known what long term issues arose from serious falls requiring surgery. LW responded that it was not. MM noted that some wards were populated by patients with a high risk of falls and that there is a need to consider the patient population.

CGC071720 – Risk Annual Report – Fenella Hill

This item was deferred to September 2017.

CGC071721 – Safeguarding Adults Annual Report – Gill Cobham

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

The Local Authorities continue to be unable to meet the demand to complete the Best Interest & Mental Health Assessments within the 7 day Urgent Authorization period.

Safeguarding Adults Level 2 training compliance has increased to 70%.

Attendance at face to face Domestic Abuse training has continued to fall in the last quarter. MCA & DoLS ½ day workshops have commenced, with good attendance and evaluation.

GC confirmed that face-face training in domestic violence is working well and most members of staff who need to complete it, have done so. There has been a change to DoLS so that a person who dies with a DoLS in place is not automatically categorised as a 'death in custody' which has to be referred to the Coroner.

CGC071722 - Items for escalation to Trust Board

- Clinical Leadership for the Spinal Unit – employment from any suitable clinical background.
- Research Strategy 2017-2022

REPORTS FROM BOARDS OR COMMITTEES BY EXCEPTION

CGC071723	Clinical Management Board meeting minutes (June 2017)	Noted
CGC071724	Clinical Risk Group meeting minutes (May 2017)	Noted
CGC071725	Infection, Prevention and Control Committee meeting minutes (April 2017)	Noted
CGC071726	Children and Young People's Quality and Safety Board meeting minutes (March 2017)	Noted
CGC071727	Supervision of Midwives Assurance meeting minutes (May 2017)	Noted

ANY OTHER BUSINESS

JS reported that she had experienced challenges in the pre-operative assessment unit when staff had been late due to traffic issues, and first impressions of the unit itself were unfavourable with faulty blinds.

CC-B will attend to this issue. JS to complete a PLACE assessment.

NEXT MEETING

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

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
Held on 26 June 2017

Present:	Dr N Marsden	Chairman
	Mr M Cassells	Director of Finance and Procurement
	Mrs C Charles-Barks	Chief Executive
	Mr P Kemp	Non-Executive Director
	Prof J Reid	Non-Executive Director
	Ms T Baker	Non-Executive Director
	Mrs K Matthews	Non-Executive Director
	Mr L Arnold	Director of Corporate Development
In Attendance:	Mrs L Arnett	Head of Transformation (for item 6)
	Mr P Holloway	Deputy Chief Operating Officer (for Mr A Hyett)
	Mr D Seabrooke	Head of Corporate Governance
Apologies:	Mr A Hyett	Chief Operating Officer

1. FINANCE & PERFORMANCE COMMITTEE MINUTES – 30 MAY 2017

The minutes of the meeting of the Committee held on 30 May 2017, were agreed as a correct record.

2. MATTERS ARISING

It was noted that OML would be reporting to the 24 July meeting and that there would be a further report on EPR. The Board Seminar day on 3 July would be considering site and facilities options.

3. ANNUAL REVIEW OF TERMS OF REFERENCE

The Committee received the Terms of Reference as part of its regular annual review and it was agreed that the newly appointed Deputy Chief Operating Officer would be reflected in the Terms of Reference and that the chair of the committee is a NED. **DS**

4. FINANCE REPORT

The Committee received the revised Finance Report outlining the main drivers behind the consolidated financial position to 31 May 2017. There was a year to date deficit of £2m which was an adverse variance against the plan of - £719k. There was concern that if this continues for the remainder of quarter one that this could have consequences for the Trust's rating under the single oversight framework.

Work continued on the data warehouse with a view to reporting of the required standard of accuracy being re-established fully from August. Signs of a reduction in activity through the hospital through reduced referrals or outpatient follow-ups were being investigated. There was a

long-standing concern from Kirsty Matthews that around reported levels of outpatient activity. She requested that the sources of referrals be reviewed.

There was a particular focus within the trust on activity through outpatients and theatres, including whether clinic and theatre lists were being booked appropriately. It was agreed that there would be an update to the 24 July meeting in this regard. **AH**

MC reminded the Committee that the Trust was prone to commissioner fines as it had not signed up to a control total for 2017/18 and the risk was thought to be around £3m. The Trust had highlighted to Wiltshire CCG a number of areas where it was believed the Trust was entitled to additional income. Discussions and challenges from West Hampshire CCG continued and there had been a performance notice served in respect of 2016/17.

It was MC's practice to provide a summary of financial risks as seen by him as part of the report and there was concern that this should be linked to the Assurance Framework. **MC**

There had been a recent meeting with representatives of NHS Improvement and NHS England and an update arising from this was given. The Trust was also considering engaging a consultancy firm to examine the workings of its Cost Improvement Programme.

MC undertook to resume a full year forecast with effect from month 4. **MC/LT**

Finally it was noted that NHS Improvement had changed the Trust's financial standing rating to 3.

5. OPERATIONAL PERFORMANCE

The Committee received the month 2 Operational Performance Report. The Chairman welcomed Peter Holloway, Deputy COO to the meeting.

It was noted that some elements of patient choice continued to affect the Trust's performance on the cancer metrics. The Trust was on trajectory for clearing its diagnostics backlog. Some MRI scanning activity was now being outsourced to New Hall. ED had performed at 93.1% in May. Activity and acuity had been affected by recent hot weather.

Delayed Transfers of Care were 46 at the end of May and had peaked at 58 in June. The most recent figure was 27. The Trust was likely to re-submit its reported RTT performance of 89.2%.

The Committee received the month 2 report.

6. PROGRAMME MANAGEMENT REPORT FOR MONTH 1

The Committee received the PMO report for month 1. It was noted that 105% of savings had been identified against the directorate and transformation target of £6.5m although only £4m was currently rated as green. About half of CIP schemes were income related and it had been noted at the PSG that of the £200,000 under achievement £140,000 had related to income based schemes which was now under investigation.

Two thirds of saving schemes were now recurring with Surgery being the most challenged directorate currently. Work continued to identify schemes to the value of 110%.

The Committee received the PSG report.

12. DATE OF NEXT MEETING

The next meeting will be on Monday 24 July 2017 at 9.30 am.

ACTIONS

Agenda Item	Action	Responsibility	Comments
3	The Committee received the Terms of Reference as part of its regular annual review and it was agreed that the newly appointed Deputy Chief Operating Officer would be reflected in the Terms of Reference and that the chair of the committee is a NED.	DS	Completed
3	Outpatient and theatre booking - It was agreed that there would be an update to the 24 July meeting in this regard.	AH	Completed on 24 July
4	It was MC's practice to provide a summary of financial risks as seen by him as part of the report and there was concern that this should be linked to the Assurance Framework.	MC/LT	This will be reviewed by LT in re-formatting the report
4	MC undertook to resume a full year forecast with effect from month 4	MC/LT	To take effect from M4's report

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
Held on 24 July 2017

Present:	Dr N Marsden	Chairman
	Ms T Baker	Non-Executive Director
	Mrs C Charles-Barks	Chief Executive
	Mr M Cassells	Director of Finance and Procurement
	Mr P Kemp	Non-Executive Director
	Mr A Hyett	Chief Operating Officer
	Mrs K Matthews	Non-Executive Director
	Prof J Reid	Non-Executive Director
	Mrs L Thomas	Director of Finance (Designate)
In Attendance:	Mrs C Gorzanski	Head of Clinical Effectiveness (for item 5)
	Mrs F Hill	Head of Risk Management (for item 6)
	Mr P Casson	Odstock Medical Limited (for item 3)
	Mr I Downie	Odstock Medical Limited (for item 3)
	Mr P Hargreaves	Director of People and Organisation Development
	Mr D Seabrooke	Head of Corporate Governance

1. FINANCE AND PERFORMANCE COMMITTEE MINUTES – 26 JUNE 2017

The draft minutes of the meeting of the Committee held on 26 June 2017, were circulated and Kirsty Matthews requested that the minutes be resubmitted to ensure that the full range of NED challenge in relation to the income and activity position was captured.

2. MATTERS ARISING

Matters arising and actions had been captured in the table appended to the minutes

3. ODSTOCK MEDICAL LIMITED – THREE YEAR BUSINESS PLAN

The Chairman welcomed Ian Downie and Phil Casson, Chairman and Managing Director of Odstock Medical Limited. An updated report on the company's three year outlook was circulated.

The three year plan set out a mission statement to maximise the market adoption of the product range and charted the growth of the business over the past four years. The company continue to grow its UK and export markets and to undertake the research leading to further product development.

New products were being brought out in the coming three years.

The company's position was affected by the resource required to address regulatory requirements in 2017/18 and 2018/19. The position strengthened from 2019/20 onwards.

Issues were raised about the accommodation used by the company as space was an issue and the condition of the exterior was not felt to be compatible with a national centre.

Andy Hyett undertook to discuss further with Phil Casson how to improve the Trust's collaboration with the company and to ensure that its offer was recognised within the hospital. **AH & PC**

The Chairman and Tania Baker would discuss further the Trust's aspirations for the company considering factors such as innovation in the Trust's strategic objectives, the company's contribution to reducing the trust's deficit and the benefit to patients receiving the company's products. **NM & TB**

4. ACTIVITY ANALYSES

Andy Hyett showed slides highlighting activity levels in elective day cases, elective inpatients and non-elective in-patients.

The charts indicated a reduction in elective day cases in winter 2016/17, a brief reduction in elective inpatients in the same period which had been substantially recovered in Spring 2017 and a steady state for non-elective inpatients. Within the non-elective inpatients numbers it was thought that the case mix had changed.

The investigation into activity levels had focused on Orthopaedics, births, Cardiology, ENT, Outpatients and Urology referrals. Information about the number of unfilled slots was shown indicating the effect of deep dive activity on reducing the number of unused slots.

In the areas of focus Orthopaedics Outpatients were thought to be down but there were sufficient referrals already made to continue the service for many months. Births appeared to be down in the quarter 1 to quarter 3. The local system in Cardiology was at present showing different numbers to that ascertained for income purposes which continued to be investigated. There had been an increase in medical length of stay which was due to a range of internal and external factors.

Kirsty Matthews requested that a further update on the steps towards resolving the differences should be given at the 29 August meeting of the Committee. She also asked whether the effect of the transition from a highly escalated situation may explain some of the concerns about productivity and activity levels. **AH**

It was noted that there were some consultant comparisons being initiated to look at concerns about differing operating rates for standard cases.

The Trust had received sales presentations for providers of the Financial Improvement Programme mark II which was a NHS Improvement Framework. The Trust and NHS Improvement felt that this programme was not the appropriate one for the Trust but Lisa Thomas continued to set out a financial recovery programme for the Trust for discussion at a later date. It was agreed that he Trust needed to resolve the issues around activity levels and reporting. The Committee's concern about the continuing effect on the Trust's reported income was noted.

5. CQUIN - QUARTER 1

The Committee received the Quarter 1 CQUIN Report. The total value of Wiltshire CQUIN's was £2.67m, for West Hampshire £409k and NHS England/Specialised Commissioning £567k. It was noted that the Trust expected to deliver on its targets for Quarter 1 in full, except for 2a, sepsis where £16,000 was thought to be at risk. In support of this the trust required a replacement to the Symphony system which depended on an upgrade to Lorenzo by October. The Trust had requested an extension to the deadline to February 2018.

PK felt that this was a common issue for all the hospitals using Lorenzo and that pressure should be exerted together. Issues around coding were being discussed by AH and LA. **LA**

In relation to discharge, £200,000 was at risk and CC-B asked as to the mitigating actions being taken. CG said that the Trust needed to improve the rate of discharges to patients own home which had not improved sufficiently in quarter 1. This was being looked at through the patient Flow Programme and may require some targeted work to ensure the target was met. On 1a, in the West Hampshire targets the requirement was to improve staff surveys scores in relation to Health and Well Being initiatives, MSK problems and work related stress by 5%. Paul Hargreaves reported that there was a focus on theatres and that that the Trust would be undertaking a study in conjunction with Loughborough University. **PHa**

The flu vaccine target for West Hampshire was 70% and it was noted that the 2017/18 flu campaign was currently being developed. Work on improving sepsis treatment and antibiotic review was continuing though the Pharmacy Department.

The target to reduce mental health related ED attendances by 20% was on-going with patients being reviewed and personalised care plans being given and individual cases discussed with GPs.

The Chairman emphasised the need to resolve the Lorenzo issue in relation to Wiltshire CQUIN number 3, supporting proactive and safe discharge.

6. ASSURANCE FRAMEWORK – QUARTERLY REVIEW

The Chairman welcomed Fenella Hill to the meeting. The Committee received the quarterly update. It was noted that this had not changed since the presentation to the last meeting of the Trust Board.

It was noted that Risk Register actions were all dated 31 March 2018 and FH asked if there should be incremental dates added to this. **MC/LT**

Paul Kemp expressed concern that the application of the actions to the initial risk assessment to produce the residual risk were not sufficiently convincing. It was agreed that this would be reviewed. AH would flag would flag some new performance risks through the Risk Register. **FHi** **AH**

Progress towards a refreshed board assurance framework linked more closely with the Trust's strategy was being made and non-Executive Directors would be pleased to review this. MC suggested that a risk around productivity could be added. **FHi**

7. FINANCE REPORT TO 30 JUNE (MONTH 3)

The Committee received the Finance and Contracting Report to 30 June. MC reported that at this point in the year there was a £3.3m deficit which was £1.3m away from the plan. An additional appendix to the report showed the pre and post Lorenzo position in relation to activity. It was noted that day case activity was close to last year's level at present. There was concern about the amount of agency use in the Medicine Directorate. The Trust's cash position was satisfactory. It had received Sustainability and Transformation funding for 2016/17 Q3 and Q4 of £3.2m.

The Trust had been given a great understanding of how marginal rate deductions were spent by Wiltshire CCG and was pressing for further assurance on the effectiveness of the schemes thus funded. There had been more honesty about the effectiveness of Better Care Fund spending. Discussions continued with West Hampshire CCG – at present there was a joint investigation under the contract with the trust having previously rejected a performance notice.

A critical friend visit from NHS Improvement was taking place in early August. The support services initiative with QEF was underway. The new income of £400,000 for the aseptic unit and Cancer MDT was being discussed.

In relation to a question about Commissioner penalties from Paul Kemp it was noted that these were not considered significant at present.

Kirsty Matthews asked about figures set out in appendix C to the report in relation to NHS England specialised commissioner activity. It was noted that there had been a slight settling of activity from West Hampshire following gains in 2016 from the Fordingbridge area.

In relation to a question from Jane Reid it was noted that the Lorenzo project team continued to work towards the end of July to complete the work on the financial elements of the data warehouse which would mean a clean month in August to be reported in September. It was not yet clear whether a year to date position would be reportable.

Paul Hargreaves added that on medical locums there was a £400,000 overspend which was being investigated. The Trust continued to discuss matters with its supplier and ensuring that agency requests were channelled appropriately.

There was concern from Jane Reid about the lack of regional workforce planning.

8. PERFORMANCE REPORT

The Committee received the month 3 Performance Report. It was noted that the ED performance was 95.7% for June and had continued to perform in July. The recovery of diagnostic was progressing well and performance was 98.4%. The Trust had submitted on time for RTT at 90%. Work with New Hall and with Dorchester continued to mitigate issues around MRI capacity. The Programme Steering Group was receiving recovery plans for a number of areas of concern.

The sequencing of Programme Steering Group meetings and the Finance & Performance Committee in relation to the monthly finance outturn had been discussed. The Trust's current governance process was that the PSG was the executive lead on the Cost Improvement Programme and the Finance and Performance Committee received its monthly report, one month in arrears. Cara Charles-Barks undertook to overseeing the producing of a high level report from the PSG for the Finance and Performance Committee for the preceding month. **CC-B**

9. DATE OF NEXT MEETING

The next meeting will be on Tuesday 29 August 2017 at 9.30 am.

Agenda Item	Action	Responsibility	Target Date	Outcome
3.	Andy Hyett undertook to discuss further with Phil Casson how to improve the Trust's collaboration with the company and to ensure that its offer was recognised within the hospital.	AH & PC		
3.	The Chairman and Tania Baker would discuss further the Trust's aspirations for the company considering factors such as innovation in the Trust's strategic objectives, the company's contribution to reducing the trust's deficit and the benefit to patients receiving the company's products.	NM & TB		
4.	Kirsty Matthews requested that a further update on the steps towards resolving the differences should be given at the 29 August meeting of the Committee. She also asked whether the effect of the transition from a highly escalated situation may explain some of the concerns about productivity and activity levels.	AH		
6.	It was noted that Risk Register actions were all dated 31 March 2018 and FH asked if there should be incremental dates added to this.	MC/LT		
6.	Paul Kemp expressed concern that the application of the actions to the initial risk assessment to produce the residual risk were not sufficiently convincing. It was agreed that this would be reviewed.	FH		

Minutes of the Finance & Performance Committee meeting held on 29 August in the Boardroom at Salisbury District Hospital

Committee Members Present:

Dr N Marsden	Chairman
Mr L Arnold	Director of Corporate Development
Ms T Baker	Non-Executive Director
Mr M Cassells	Director of Finance and Procurement
Mr P Kemp	Non-Executive Director
Prof J Reid	Non-Executive Director

In Attendance:

Mrs L Thomas	Director of Finance (Designate)
Mr P Holloway	Deputy Chief Operating Officer (for Mr A Hyett)
Mr D Seabrooke	Head of Corporate Governance

ACTION

FP 29/08/01 APOLOGIES:

Apologies were received from –

Mrs C Charles-Barks, Chief Executive

Mr A Hyett, Chief Operating Officer

Mr P Hargreaves, Director of People and Organisational Development

Mrs K Matthews, Non-Executive Director

FP 29/08/02 FINANCE & PERFORMANCE COMMITTEE MINUTES – 26 JUNE AND 24 JULY 2017

The minutes of the meetings held of the committee held on 26 June (amended) and 24 July 2017 were agreed as a correct record.

FP 29/08/03 MATTERS ARISING

The action log from 26 June was marked as completed. In relation to 24 July it was noted that discharges for non-elective patients was continuing with a higher rate of discharges and improved communications. It was noted that the timing of the CQUIN requirements in relation to the replacement of the Symphony system had been agreed and the upgrade to Lorenzo was scheduled.

The Chairman undertook to continue discussions about patient discharges from the hospital with the Urgent Care Delivery Board and to continue to raise this nationally at the NHS Providers Board.

Arising from minute 4 of the 24 July meeting, Paul Kemp expressed concern about the continuing slippage of the data warehouse cut over which was now due to take place in September.

ACTION

FP 29/08/04 ACTIVITY ANALYSIS

LA showed slides entitled activity investigation updating the Committee on changes to activity that had been experienced in winter 2016/17. The chart also highlighted the period of high inpatient escalation. Because in 2016/17 the Trust had been on a block contract there had been no direct loss of income.

LA undertook to discuss with Lorna Wilkinson whether in retrospect there had been any impact on quality of the period of escalation. LA

The investigation had looked at a number of areas where there was accessible information available from feeder systems to Lorenzo and this included Orthopaedics, Births and Cardiology. No material difference between these local systems and Lorenzo had been detected.

Tools to review rates of clinic usage had been developed and the rate of vacant slots was reducing from around 12% to around 8%. Work continued to assess whether there was a backlog in outpatient follow ups.

It was noted that in the 2016/17 budget setting there had been an allowance for a Lorenzo effect. There had been an assumption of growth in activity with a consequent growth in productivity.

It was noted that work continued to improve the management of emergency admissions and use of the Short Stay Surgical Unit, to improve the coding of co-morbidities and complexities, to improve data quality, improve clinic and theatre utilisation rates.

It was agreed that the issues described here would be reviewed again at the October or November meeting of the Committee DS

FP 29/08/05 FINANCIAL RECOVERY PLAN – FIRST LOOK

The Committee received an initial draft of the Financial Recovery Plan which was under development and due to be submitted to NHS Improvement in mid-September. Lisa Thomas showed slides in support of the draft report.

The recovery plan was set out in three key stages –

1. A clear understanding of the pressures facing the Trust and the collective financial challenges needing to be addressed.
2. In year actions to ensure recovery of the year to date variances and the delivery of the planned deficit for 2017/18.
3. Longer term actions to address the underlying deficit and to outline a longer term sustainable solution.

In the short term the Trust was reviewing the Grip and Control List as required by NHS Improvement. Transformation schemes were already underway and for 2018/19 it was proposed would include activity around job planning and Estates management. Partnership working and strategic planning around local demographics would also be significant.

ACTION

The next steps included developing the budget forecast out-turn scenarios for 2017/18, the work being undertaken by Boston Consulting and the development of action plans in support of the overall recovery plan.

Paul Kemp suggested a stronger focus on workforce planning including more creative approaches to recruitment, greater analyses of what had been achieved so far in terms of productivity and greater breadth in the reach of the strategy.

The Draft Recovery Plan would be discussed again at the Board Seminar day.

FP 29/08/06 FINANCE AND CONTRACTING REPORT FOR MONTH 4

The Committee received the Finance and Contracting Report. It was noted that the year to date deficit was now £4.4m which was an adverse variance against plan of £1.8m. Income was down against plan. Most day case activity was down on plan and against the previous year.

The report included three out turn scenarios.

An update was given on the meeting with NHSI which had looked at the sustainability of the Trust in the future.

The Trust had through Chairman's action entered into discussions to acquire the bungalow stock being disposed of by Scope which had originally been donated to the charity by the former Salisbury Health Authority.

An update was given on the result of the arbitration with the data warehouse supplier was also highlighted. The next step proposed was a discussion at Chief Executive level and there would be a further update at the October meeting of the Committee. DS

It was noted that the Trust's bleep system would require urgent action and a likely unavoidable cost in year would arise.

The Committee received the Finance Report.

FP 29/08/07 OPERATIONAL PERFORMANCE

The Committee received the month 4 Operational Performance Report. Peter Holloway reported that the Trust had delivered the principal operational targets in July. RTT was at 92.2%. Wiltshire and West Hampshire CCGs had issued challenge notices for April and May but were happy to see any potential fine reinvested in the services. The Trust had delivered on its cancer targets for July and for quarter 1. Diagnostics was at 99.1% and MRI continued to be supported by Newhall capacity. A & E had delivered 95.7% and was ahead of the trajectory. However in August activity levels had increased and the service was more challenged.

There was concern about length of stay in some areas and PHo was asked to bring back case mix adjusted information to the October meeting. **PHo**

The Committee received the Operational Performance Report.

ACTION

FP 29/08/08 CIP REPORT

The Committee received for information the report from the Programme Steering Group for month 3.

FP 29/08/09 DATE OF NEXT MEETING

The next meeting of the Board would on Monday 25th September 2017, at 9.30 am, in the Boardroom at Salisbury District Hospital.