SALISBURY NHS FOUNDATION TRUST

TRUST BOARD

MONDAY 2 FEBRUARY 2015, 1.30PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
1.30pm	**1**	**APOLOGIES FOR ABSENCE**			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES**			1
		Public Board Meeting held on 8 December 2014			
	4	**MATTERS ARISING**			
1.35pm	**5**	**CHIEF EXECUTIVE**			
		1. Chief Executive's Report	PH	SFT 3618	9
1.45pm	**6**	**STAFF**			
		1. Nurse Staffing	LW	SFT 3619	11
		2. Equality & Diversity 6 month update	AK	SFT 3620	19
2.00pm	**7**	**PATIENT CARE**			
		1. Quality Indicator Report to 31 December (month 9)	CB/LW	SFT 3621	47
		2. Customer Care Report - Quarter 2 2014/15	LW	SFT 3622	55
		3. Patient Safety update	LW	SFT 3623	67
2.30pm	**8**	**PERFORMANCE AND PLANNING**			
		1. Finance & Performance Committee Minutes 22 December 2014	NM	SFT 3624	71
		2. Financial Performance to 31 December (month 9)	MC	SFT 3625	75
		3. Progress against Targets and Performance Indicators to 31 December (month 9)	LA	SFT 3626	85
		4. Update on Planning Process	LA	SFT 3627	

		5. Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 – Fit and Proper and Good Character	NM	SFT 3628	93
3.00pm	**9**	**PAPERS FOR NOTING OR APPROVAL**			
		1. Capital Development Report (including Maternity Development)	LA	SFT 3629	95
		2. Draft Minutes from Public Section of Council of Governors Meeting 24 November 2014	NM	SFT 3630	105
		3. Minutes from Clinical Governance Committee 23 October (confirmed) and 27 November 2014 (draft)	LB	SFT 3631	109
3.45pm	**10**	**ANY OTHER URGENT BUSINESS**			
	11	**QUESTIONS FROM THE PUBLIC**			
	12	**NEXT MEETING**			

The next ordinary meeting will be held on Monday 13 April 2015, in the Board Room at Salisbury District Hospital starting at 1.30pm

13 CONFIDENTIAL ISSUES

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

SALISBURY NHS FOUNDATION TRUST

Minutes of the meeting of Salisbury NHS Foundation Trust Board Held on Monday 8TH December 2014

Board Members Present:	Dr N Marsden	Chairman
	Mr N Atkinson	Non-Executive Director
	Mr L Arnold	Acting Chief Operating Officer
	Dr L Brown	Non-Executive Director
	Dr C Blanshard	Medical Director
	Mr M Cassells	Director of Finance & Procurement
	Mr A Freemantle	Non-Executive Director
	Mr P Hill	Chief Executive
	Mrs A Kingscott	Director of Human Resources and Organisational Development
	Revd Dame S Mullally	Non-Executive Director
	Mrs L Wilkinson	Director of Nursing
Corporate Director:	Mr M Ace	Associate Executive Director
In Attendance:	Mr P Butler	Communications Manager
	Mr D Seabrooke	Secretary to the Board
	Mr P Lefever	Wiltshire Health Watch
	Mr M Wareham	Staff Side
	Cllr John Noeken	Governor
	Mrs J Sanders	Governor
	Mr B Fisk	Governor
	Mr R Jack	Governor
	Mr J Carvell	Governor
	Mrs L Taylor	Governor
	Mr A Lack	Governor
	Mrs C Martindale	Lead Governor
	Mrs S Bealey	Governor
	Mr P Kemp	Non-Executive Director - Designate

2027/00 Introduction and Welcome **ACTION**

The Chairman welcomed observers from the Thames Valley and Wessex Leadership Academy, Maggie Woods and Sue Mortlock to the meeting. He welcomed Paul Kemp who had been appointed as a Non-Executive Director from 1 February 2015.

As it was his last public Board meeting, the Chairman thanked Nigel Atkinson for his contribution over the past 8 years.

2028/00 Declarations of Interests and Fit and Proper/Good Character

It was noted that the new Fit and Proper requirements had come into force from 27 November 2014. The members of the Board were reminded that they have a duty to declare any impairment to being fit and proper and of good character as well as to avoid any conflicts of interest and to declare any interests arising from the discussion. No member present declared any such interest or impairment.

2029/00 Minutes - 6 October 2014

Subject to a minor amendment to minute 2020/00, third bullet point, the minutes of the meeting held on 6 October were agreed as a correct record.

2030/00 Matters Arising

It was noted under minute 2013/00 that equality and diversity training compliance was running at 69%.

2031/00 Chief Executive's Report - SFT 3596 - Presented by PH

The Board received the report of the Chief Executive and Peter Hill highlighted the following principal points:

- The risk to the UK from the Ebola virus continued to remain very low but along with other hospitals, the Trust continued to monitor and develop its own arrangements to manage any suspected incidents.
- A recently published survey by the CQC of people attending the Trust's A&E department in summer 2014 had scored very well and the results were especially pleasing giving significant pressures that continue to be experienced by the department throughout the year.
- The Striving for Excellence Awards had recognised achievements across 11 categories and there had been good coverage in the Salisbury Journal.
- It was also noted that the advert for a Chief Operating Officer had recently closed and applications were currently being assessed with interviews planned for 7 January.
- There were discussions with other NHS bodies in future provision of community services across Wiltshire.

The Board noted the Chief Executive's report

2032/00 Friends and Family and Staff Survey Results Update SFT 3597 - Presented by AK

The Board received the Friends and Family test and staff survey results report for Quarter 1 and Quarter 2 and details of the action plan in relation to the 2013 staff survey.

There had been a 27% response rate in the staff friends and family test, with 93% of respondents saying they were likely or extremely likely to recommend the Trust as a place to receive care or treatment and 82% as a place to work. Free text responses have been circulated to managers for discussion.

It was also noted that the comments were circulated to the Executive Workforce Committee and AK undertook to circulate these to the Board for information. **AK**

In relation to the update on the 2013 staff survey action it was noted that 41% of appraisals were rated as satisfactory and that the second phase of the SpIda system would allow further reporting of the quality of the appraisal. It was noted that a number of controls were in place to quality assure medical appraisal and that revalidation for nurses was expected to start in 2015.

The Board noted the report.

2033/00 Ward Staffing - SFT 3598 - Presented by LW

The Board received the nurse staffing report to October 2014. This indicated that fill rates were just over 100% for both nursing assistants and registered

nurses. There were some acceptable variations in for example Radnor Ward, Neonatal Intensive Care and Maternity and these were managed as exceptions. LW also reported that recruitment hot-spots in MSK and Medicine were being addressed in part by overseas recruitment and it was again confirmed that English language requirements were part of the recruitment process.

Records were being kept of instances where Sisters were working clinically and where staff were recalled from scheduled training. Displays of staffing levels on wards have not prompted much reaction so far from patients.

The Board noted the Nurse Staffing Report.

2034/00 Quality Indicator Report to 31 October - SFT 3599
Presented by CB and LW

The Board received the Quality Indicators Report to October 2014. It was noted that a serious incident enquiry was in progress in relation to a retained throat pack incident which had been touched on at the previous meeting. It could now be confirmed that this was a never event however this patient came to no harm. A new serious incident has also been reported.

As previously discussed the HMSR (Hospital Standardised Mortality Rate) was reducing and the rebasing of this was shown in the report. Under the rebased information the HMSR was at 109 and was decreasing.

The Clinical Risk Group would be receiving a report on increased global trigger tool events – the most common of these were related to catheter UTI and dehydration.

There have been two falls resulting in fracture, pressure ulcers were down and there was 88% compliance with the 36 hour fractured neck of femur standard. Delivering same sex accommodation breaches were in relation to recovering ITU patients and it was noted that the Trust had been using escalation capacity for many months to varying degrees.

There had been no new C-Diff cases. The response to real-time feedback was good and response rates to the friends and family tests were also improving.

The Board noted that Quality Report.

2035/00 Report of Director of Infection Prevention and Control - SFT 3600
Presented by LW

Fiona McCarthy attended the meeting in support of this item.
As noted in previous monthly reports there have been two outbreaks of C-Diff in the Medicine directorate during quarters 1 and 2.

External support had been obtained in relation to concerns about C-Diff and the Trust has strengthened and reviewed processes including cleaning training and education.

There had been two cases of MRSA in July and in September, the second of which was a contaminant.

The Trust's PLACE score published in August was 95.4 which was below average. The Trust continued to carry out a rigorous self-assessment in accordance with the published guidance. Results for mandatory surveillance on surgical site infection were considered to be relatively low.

A suspected Ebola case had presented in A&E during quarter 3 which had tested the preparations in place and in this instance staff had responded very well. There had been no unexpected confirmed cases nationally so far. Any suspected case would be tested with results available within 6 – 8 hours and if positive, the patient would be appropriately and safely transferred to the specialist unit at the Royal Free Hospital in London.

FMcC undertook to check whether the take up of the infection control on-line training through the managed learning environment was available and in percentage form.

The Board noted the report of the Director of Infection Control and Prevention.

2036/00 Sign Up to Safety - SFT 3601 - Presented by LW

The Board received the report on sign up to safety setting out the Trust's pledges under the headings of Put Safety First, Continually Learn, Honesty, Collaborate and Support.

The Patient safety collaborative in the region was being led by the Wessex Academic Health and Science Network. The Trust was required to submit its delivery plan by 19 December and this would be monitored by the Clinical Governance Committee. The delivery plan would reflect the higher risks applicable to vulnerable patient groups.

The Board approved the sign up to safety pledges described in the report.

2037/00 Finance and Performance Committee Minutes - 20 October 2014

The Board received the confirmed minutes of the Finance and Performance Committee – the new name and role of the committee was noted. The committee continued to monitor the Trust's financial position and A&E performance.

The Minutes were noted.

2038/00 Financial Performance to 31 October 2014 - SFT 3603 - Presented by MC

The Board received the financial performance report. It was noted that the Trust at month 7 showing a deficit of £368,000. Income was rising, but expenditure was rising further. Over performance was being discussed with CCG's.

Additional winter pressures money of £1.6million had been received and the Trust continued to forecast a surplus of £0.8million. The quarter 2 feedback had recently been received from Monitor which had confirmed a "green" rating for Governance and a continuity of service rating of "4".

On sales, non-elective activity, at which the Trust was paid at a marginal rate, was up, and in out-patients, first appointments were up but follow-ups were down. The Medicine and Clinical Support and Family Services directorates were both over spent. Agency use had reduced but remained too high.

The Trust's work on the savings plans was paramount but it was struggling to meet the target of £9 million – achievement was phased to the last few months of the financial year.

In response to a question from Sarah Mullally, MC explained that people in the Trust needed to continue to drive out the savings. The Trust had with the support of the winter pressure money allocated been able to employ more nurse

practitioners to improve patient flow where there were shortages of consultants. Pressure continues on reducing agency spend. Spending on medical locums continued to be a concern as there were a number of national shortages in some specialties. The Trust continued to look at innovative ways to recruit the medical staff it needed. The junior doctor fill rate from the Deanery had improved.

It was also noted that each principal staffing group was reporting to the Executive Workforce Committee on its issues and it was noted that a report from the committee would be made to a future meeting of the Board. ***AK***

The Board noted the Finance Report.

2039/00 Progress Against Targets and Performance Indicators to 31 October 2014 SFT 3604 Presented by LA.

The Board received the report to 31 October.

It was noted that the hospital was using escalation capacity in October and November, including Wilton Ward. There were 25 delayed transfers of care as at 5 December, 16 of these related to social care and 9 were NHS. Of the total, 19 related to Wiltshire patients.

The A&E indicator was considered to be at risk for quarter 3 but the department continued to build capacity and improve practice. The 62 day cancer target was challenged due to the small numbers of patients on the pathway.

The Trust was seeing improved performance on the two week cancer wait and on six weeks diagnostic waits, this was challenged by an increase in primary care referrals but continued to be met. Cancelled operations had seen an increase in November.

Staff appraisal rates were considered to be, in reality, higher than was reported by SpIda system.

The Board noted the Performance report.

2040/00 Update on Planning Process - SFT 3605

This item was dealt with under the half yearly update (SFT 3609)

2041.00 Proposed Capital Programme 2015/16 - SFT 3606 - Presented by MC

The Board received the draft capital programme for 2015/16.

It was noted that the value of the programme was about £8 million. Medical equipment and health and safety measures continued to be prioritised by the capital control group and other groups that had scrutinised the programme.

It was noted that the programme did not include provision for IT developments such as electronic patient record. This was likely to require loan finance.

The Board approved the Capital Programme 2015/16.

2042/00 Papers for Noting or Approval

2042/01 Assurance Framework Update - SFT 3607 - Presented by LW

The Board received the updated Assurance Framework following the workshop held in September. LW highlighted the introduction linking the corporate objectives with the new Care Quality Commission lines of enquiry. The assurance committees would continue to monitor the assurance framework on a quarterly basis and it was reviewed monthly by a group of executives.
It was agreed that the Assurance Framework should be revisited in June or July. **DS/LW**
Some staffing matters could be referred to the Executive Workforce Committee to review on behalf of JBD.

The Board approved the Assurance Framework.

2042/02 Estates Strategy Update - SFT 3608 - Presented by LA

The Board received the update on the Estates Strategy. LA reported that many of the actions set out in the strategy had been completed included the improvement of energy efficiency across the site. There was a general need to improve the standard of accommodation in the SDH central area and updating required in the Spinal Unit and Day Surgery.

The demolition of the central boiler house presented new opportunities in that vicinity. Work continued to optimise the design of the level to Springs redevelopment. Competitive dialogue with interested parties in the SDH South redevelopment proposals was continuing. Hillcote will be closing in June and work was underway to identify the future of this property.

CB highlighted the need to additional space for Gynaecology in relation to the breast unit development being supported by the hospital charity and the need to improve the surgical admissions lounge and surgical assessment unit.

It was noted that in relation to the south side development the Trust had one chance to encourage a suitable development and new opportunities continued to arise potentially affecting that choice. The need to obtain long-term benefits of the development for the Trust was emphasised.

The Board noted the Estate Strategy Update.

2042/03 Trust Strategy – Half Yearly Update - SFT 3609 - Presented by LA

The Board received the mid-year review of the strategic plan 2014/15. It was noted that Monitor had recently given feedback on the Trust's submission of its five year plan which was considered to be positive. It was also noted that a two year plan was required to be submitted by 10 April 2015.

The Board noted the report.

2042/04 2014 PLACE Results - SFT 3610 - Presented by LA

Ian Robinson Head of Facilities attended for this item. The Board received the update on the PLACE assessment which had been undertaken in May 2014. The Trust's scores were generally in line with the 2014 national averages although slightly behind in relation to food and hydration provision. It was noted that the scope of the matters assessed by the PLACE audit continued to evolve.

The Board emphasised the need to continue to carry out a rigorous and compliant self-assessment.

The report set out the 2015 PLACE programme which would be held between March and June and would include public areas and car parking as well as the existing elements of cleanliness, food and hydration, privacy dignity and well-being and condition appearance and maintenance.

The Board noted the report.

2042/05 JBD Minutes Evidencing Presentation of Assurance Framework and Risk Register - SFT 3611 - Presented by PH

The Board received the update from the Joint Board of Directors noting new positive assurances around the mortality rate, the Engage project and the friends and family test.

The Board noted the report.

2042/06 Minutes of Clinical Governance Committee 25 September - SFT 3612 - Presented by LB

The Board received the confirmed minutes of the Clinical Governance Committee. Hot topics included end of life care, customer care, nurse documentation, progress with the mock CQC report action improvements, responses to patient buzzers and cleanliness.

The Board noted the Minutes.

2042/07 Minutes of Audit Committee 13 October 2014 - SFT 3613 - Presented by NA

The Board received the draft minutes of the minutes of the meeting of the Audit Committee and it was noted that the committee had asked the head of IT to give account in relation to a limited assurance report on systems development.

The Board noted the draft minutes.

2043/00 Questions from the Public

In relation to a question from John Carvell, it was noted that the Trust's vision continued to be to provide a range of District General Hospital services supplemented by specialist services, to provide an emergency department and other support services.

In relation to dermatology efforts to recruit two consultant posts were continuing however the plastic surgeons had continued to support this area. The recruitment difficulties have been discussed with neighbouring Trusts.

In relation to a question from Alastair Lack it was noted that there were demonstration sites for the implementation of the electronic records. The implementation was considered to be cost effective and beneficial to patients.

In relation to a question from Raymond Jack it was noted that 47 nurses had been initially recruited from Portugal in 2013, more recently, 20 had been recruited from Spain and that the Trust was currently interviewing in Italy with a view to around 20 appointments. It was noted that the Executive Workforce Committee looked in detail at the Agency use rates.

2044/00 Date of Next Meeting

It was noted that the next public meeting of the Trust Board will be on Monday 2 February 2015, in the Board Room at 1.30pm.

CHIEF EXECUTIVE REPORT

MAIN ISSUES:

APPOINTMENT OF NEW CHIEF OPERATING OFFICER

Andy Hyett has been appointed as our new Chief Operating Officer. Andy has a wide range of NHS experience and is currently Deputy Chief Operating Officer at University Hospital Southampton NHS Foundation Trust. He started his career as a biomedical scientist at Dorset County Hospital in the 1990s and moved into NHS management in Winchester. He continued to progress his career through senior management positions with Portsmouth Hospitals NHS Trust and then University Hospital Southampton NHS Foundation Trust. Andy will start in his new role in Salisbury on 13 April 2015.

SIGN UP TO SAFETY

Safety continues to remain a high priority for us and, as part of our ongoing commitment in this area, we have joined the national Sign Up To Safety Campaign which aims to halve avoidable harm within the NHS over the next three years. This involves signing up to five pledges which strengthen patient safety under the following headings, together with a number of actions that complement our Trust strategy and priorities. The headings are:

- Put patient safety first
- Continually learn
- Honesty
- Collaborate
- Support

This builds on the fantastic work that has been undertaken as part of the South West Programme over the last five years. The details of all our pledges are now published on our website.

ADULT COMMUNITY SERVICES

In April 2011 the management of adult community services was transferred to the Great Western Hospital NHS Foundation Trust following a tendering exercise held by NHS Wiltshire. This contract will now end in 2016, and there is the potential for flexibility and a real opportunity to develop more innovative and better care pathways with primary care. We have decided to work together with Great Western Hospital and Royal United Hospitals in Bath on a joint bid to create a new model for adult community services across Wiltshire. The aim is to increase integration across hospital and community settings and deliver care that focuses on the needs of patients, rather than those of individual organisations and wider engagement with staff will be taking place over the coming months.

PRAISE FOR NHS STAFF AND PATIENTS DURING WINTER PRESSURES

The Trust Board and Governors took the opportunity to thank staff publicly through the local media for responding so positively to the recent pressure on hospital services and to remind people of how best to access health services over the winter. Emergency attendances remained quite high and the hospital saw an increase in the number of people with serious and complex conditions coming through its Medical Assessment Unit who needed to be admitted to hospital. While we have been working closely with colleagues in the community and in social care to ease the

pressure on hospital services it was important to praise our staff who have worked tirelessly to provide the very best care that they can for their patients and to thank local people who have been very understanding and thought very carefully about the best use of NHS services this winter.

IMPROVEMENTS TO RADNOR WARD

We have made major changes to the layout and decoration on Radnor Ward following a £1.2 million investment in intensive care facilities. This includes £300,000 left by a former patient in her Will to the Stars Appeal which has provided additional state-of-the-art equipment. As part of the improvements the ward has been expanded and refurbished using space, light and "spring" colours in the design to provide a calm, sensitive and therapeutic environment for patients and more comforting surroundings for relatives and carers. There are now four new side rooms which make it easier for the clinical management of patients and new quiet room has also been created so that relatives and carers can spend time away from the bedside for reflection, with a separate family room, social area and kitchen which is important where people need to spend long periods on the ward with their loved ones.

PREVENT - COUNTER TERRORISM PROGRAMME

All NHS Trusts are involved with the 'Prevent' element of the Government's counter-terrorism strategy, which aims to stop people from being drawn into terrorism. It is possible that healthcare professionals could come into contact and treat people who are vulnerable to radicalisation and Prevent is about safeguarding individuals from exploitation. Our challenge here is to recognise signs that someone is being drawn into terrorism, be aware of the support available and have the confidence to seek advice or refer for further support. Referrals are made to the Channel programme which is a multi-agency programme that provides bespoke support to children and adults who have been identified as at risk from any form of radicalisation and the Trust will be providing training for key staff through a series of workshops over the coming months.

POSITIVE ENVIRONMENTAL HEALTH INSPECTION

In addition to the local authority inspection, each year the Trust commissions an independent Environmental Health inspection of its catering facilities and ward kitchens. This year's unannounced inspection included the Main Kitchen, Springs Restaurant, Hedgerows and some ward kitchens and covered food production processes, cleaning, training and personal hygiene practices. In his feedback the Environmental Health Officer noted that the Trust is achieving a very high standard, comparable with the best practice observed within the NHS this year, providing our staff, patients and visitors with an excellent independent assurance of our management controls for food production and delivery.

ACTION REQUIRED BY THE BOARD:
To note the report of the Chief Executive.
ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:
n/a

AUTHOR: Peter Hill
TITLE: Chief Executive

Safe Staffing NQB Report - December 2014

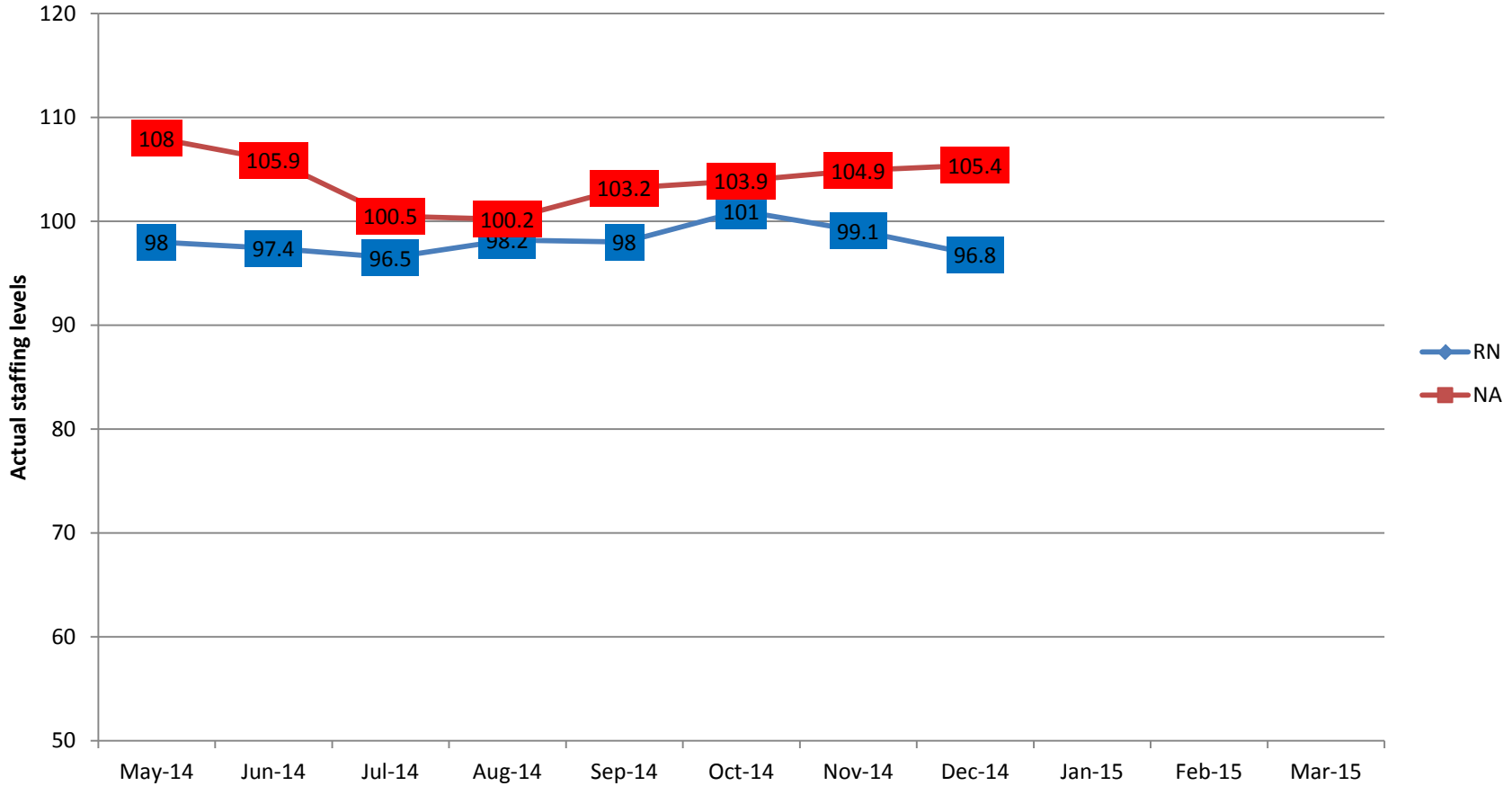
SFT 3619

Presentation for Trust Board
February 2015

Fiona Hyett
Deputy Director of Nursing

Monthly Comparisons – Actual Staffing Levels

Registered Nurses			Nursing Assistants			Combined			Planned Skill Mix		Actual Skill Mix	
P	A	%	P	A	%	P	A	%				
56671.9	54847.8	96.8	34190.9	36046.5	105.4	90862.8	90894.3	100.03	62	38	61	39



Overview of Nurse Staffing Hours – December 2014

	RN	NA
Total Planned hours (day shift)	34678.9	22669.4
Total Actual hours (day shift)	33571.4	23217.5
Percentage	**96.8**	**102.4**
Total Planned hours (night shift)	21993	11521.5
Total Actual hours (night shift)	21276.4	12829
Percentage	**96.7**	**111.3**

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

Nursing Hours by Day Shifts

	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**14059**	**13434.93**	**95.6%**	**10286**	**11066.75**	**107.6%**
Durrington	1161.5	1075.76	92.6%	885.5	1190.25	134.4%
Emergency Department	356.5	356.5	100.0%	356.5	356.5	100.0%
Farley Ward	1886.5	1828.5	96.9%	1523	1650	108.3%
Hospice	981.5	844.5	86.0%	663.5	699.75	105.5%
Pembroke Ward	966.5	961.5	99.5%	420	417.5	99.4%
Pitton Ward	1626	1412	86.8%	1136.5	1258	110.7%
Redlynch Ward	1587	1451.5	91.5%	1141	1257	110.2%
Tisbury Ward	2075	1840.67	88.7%	713	655.5	91.9%
Whiteparish Ward	1682.5	1848.5	109.9%	1079.5	994	92.1%
Winterslow Suite	1736	1815.5	104.6%	2367.5	2588.25	109.3%
Surgery	**6736**	**6289**	**93.4%**	**2874.5**	**2492.92**	**86.7%**
Britford Ward	2254.5	2218.25	98.4%	1263	1175.75	93.1%
Downton Ward	1466.5	1456	99.3%	1213.5	983	81.0%
Radnor	3015	2614.75	86.7%	398	334.17	84.0%
Clinical Support	**3941.5**	**4851.79**	**123.1%**	**1992.5**	**1523.5**	**76.5%**
Maternity	2231	2547.25	114.2%	1279.5	1094.5	85.5%
NICU	713	1088.54	152.7%	356.5	88	24.7%
Sarum Ward	997.5	1216	121.9%	356.5	341	95.7%
Musculo-Skeletal	**9942.44**	**8995.66**	**90.5%**	**7516.37**	**8134.31**	**108.2%**
Amesbury Suite	2001	1763.34	88.1%	1582.5	1644.09	103.9%
Avon Ward	1528.67	1184.28	77.5%	1565.67	1925.66	123.0%
Burns Unit	1583.5	1555	98.2%	590.25	620.51	105.1%
Chilmark Suite	1490.25	1387.44	93.1%	1136.75	1367.3	120.3%
Laverstock Ward	1943.75	1881.5	96.8%	1109	1069.01	96.4%
Tamar Ward	1395.27	1224.1	87.7%	1532.2	1507.74	98.4%
Grand Total	**34678.94**	**33571.38**	**96.8%**	**22669.37**	**23217.48**	**102.4%**

Nursing Hours by Night Shifts

	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**9425.5**	**9032.5**	**95.8%**	**5485.5**	**6412**	**116.9%**
Durrington	713	713	100.0%	713	713	100.0%
Emergency Department	356.5	356.5	100.0%	356.5	356.5	100.0%
Farley Ward	1069.5	1033.5	96.6%	713	723	101.4%
Hospice	513	560	109.2%	494.5	412	83.3%
Pembroke Ward	713	713	100.0%	0	33.5	
Pitton Ward	1069.5	920	86.0%	713	941.5	132.0%
Redlynch Ward	1069.5	954.5	89.2%	356.5	613	171.9%
Tisbury Ward	1426	1322.5	92.7%	356.5	400	112.2%
Whiteparish Ward	1426	1414.5	99.2%	713	782	109.7%
Winterslow Suite	1069.5	1045	97.7%	1069.5	1437.5	134.4%
Surgery	**4402**	**4146**	**94.2%**	**850**	**997.5**	**117.4%**
Britford Ward	930	939.5	101.0%	540	630	116.7%
Downton Ward	620	620	100.0%	310	339	109.4%
Radnor	2852	2586.5	90.7%	0	28.5	
Clinical Support	**4278**	**4190.5**	**98.0%**	**1483.5**	**1427**	**96.2%**
Maternity	2495.5	2304.5	92.3%	1069.5	914.5	85.5%
NICU	713	828	116.1%	356.5	259.5	72.8%
Sarum Ward	1069.5	1058	98.9%	57.5	253	440.0%
Musculo-Skeletal	**3887.5**	**3907.38**	**100.5%**	**3702.5**	**3992.5**	**107.8%**
Amesbury Suite	588.5	588.5	100.0%	883.5	902.5	102.2%
Avon Ward	620	640	103.2%	930	940	101.1%
Burns Unit	620	622	100.3%	310	330	106.5%
Chilmark Suite	589	577.88	98.1%	589	862.5	146.4%
Laverstock Ward	850	860	101.2%	370	347.5	93.9%
Tamar Ward	620	619	99.8%	620	610	98.4%
Grand Total	**21993**	**21276.38**	**96.7%**	**11521.5**	**12829**	**111.3%**

Overview of Areas with Red/Amber

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	Avon	77.5	√		Day	Staffing vacancies – all shifts assessed by DSN
Red	NICU	24.7		√	Day	Very small numbers of NAs, replaced by RNs
Red	NIU	72.8		√	Night	Very small numbers of NAs, replaced by RNs
Amber	Hospice	86	√		Day	All shifts assessed and staffing appropriate to patient need
Amber	Pitton	86.8	√		Day	Staffing vacancies – shifts assessed on daily basis
Amber	Tisbury	88.7	√		Day	All shifts assessed and staffing appropriate to patient level
Amber	Radnor	86.7	√		Day	All shifts assessed and staffing appropriate to patient level
Amber	Amesbury	88.1	√		Day	Staffing vacancies – shifts assessed on daily basis
Amber	Tamar	87.7	√		Day	Additional RN shifts not always filled
Amber	Downton	81		√	Day	Additional NAs to not always filled
Amber	Radnor	84		√	Day	Very small numbers of NAs
Amber	Pitton	86	√		Night	Staffing vacancies – shifts assessed on daily basis
Amber	Redlynch	89.2	√		Night	All shifts assessed and covered by NAs
Amber	Hospice	83.3		√	Night	Very small numbers of NAs
Amber	Maternity	85.5		√	Night	Very small numbers of MAs

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

Mitigation of Risk

There are several wards this month flagging amber/red against our internal measures, slightly higher than previous month.

- Vacancies remain high in medicine and MSK– on-going recruitment initiatives. All shifts are assessed daily by Directorate Senior Nurses to ensure they are safe.
- Additional escalation beds open impacting on staffing across the wards
- Maternity has had high sickness levels, internal escalation process used
- NA remains over 100% - this is due to NA's being used on unfilled RN shifts and specials.
- Agency fill rates remain challenging but all shifts are assessed daily by Directorate Senior Nurses to ensure they are safe.
- Wards often use staff on long days to cover 2 shifts – ward has the required level of staff but uses less hours resulting in shortfall in actual hours. DSNs monitoring to ensure appropriate numbers on shift.

Actions taken to mitigate risk

- Patient acuity assessed for staffing levels by individual wards by nurse in charge
- Trust wide staffing levels assessed against patient acuity and staff moved across wards by Directorate Senior Nurses and Clinical Site Team as required
- Staffing levels reduced when beds empty/ procedure lists reduced whilst maintaining appropriate staffing ratios
- 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.
- Additional NAs rostered to support unfilled RN shifts
- CCOT team support wards where acuity of patients high

Trust Board meeting SFT 3620

Equality & Diversity 6 Month Update

Date: February 2015

Report from: Pamela Permalloo-Bass **Presented by: Alison Kingscott**

Executive Summary:

This paper provides one of the regular six monthly equality and diversity updates to the board.

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

This report provides the board with an update and progress report in relation to the EDS2 (Equality Delivery System) annual review and our PSED (Public Sector Equality Duties).

Proposed Action:

To note the report and its contents.

To note in particular the implications of the EDS2 & WRES and approve the ongoing development and implementation of the EDS2 within the Trust.

To agree and endorse the updated and reviewed RAG ratings under Appendix 1.

Links to Assurance Framework/ Strategic Plan:

AF3 – Our staff we will make SFT a place to work where staff feel valued to develop as individuals and as teams.

Appendices:
Appendix 1 – EDS2 Synopsis (Final Version Dec 2014)
Appendix 2 - EDS2 Evidence file (Final Version Dec 2014)
Appendix 3 – WRES (Workforce Race Equality Standard)

Supporting Information

Equality & Diversity 6 Monthly Update Report 2015

PURPOSE:

This paper provides one of the regular six monthly equality and diversity updates to the board.

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

This report provides the board with an update and progress report in relation to the EDS2 (Equality Delivery System) annual review and our PSED (Public Sector Equality Duties).

MAIN ISSUES:

EDS2 (Equality Delivery System) Annual Review 2014

As part of our implementation and ongoing commitment to use the EDS2 process, the E&D Manager and the Trusts EDS2 Leads reviewed our performance against the refreshed EDS2 criteria and guidance. These grades were then determined by gathering evidence against each of the 17 outcomes within the EDS2. We then assessed our evidence against the given criteria, a synopsis and our final assessment can be viewed in Appendix 1, for the full assessment and detailed evidence please refer to Appendix 2.

As part of our consultation exercise we contacted our database of local interest groups in December requesting feedback on the gradings, to date we have not received any indication that the grades should be altered. As a result we have accepted this updated version as an accurate and fair assessment of our current position.

The 2014 EDS2 annual review RAG gradings are predominately green coloured which illustrates that the Trust is in the 'achieving' category. In one area we are graded as purple, which is the highest grading colour and illustrates that we are 'excelling' in this particular objective, Outcome 3.2, 'The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations.' Our assessment shows that we have adopted national terms and conditions that ensure staff that are doing equal work have the same terms and conditions and pay. Jobs are graded according to a nationally recognised job evaluation system which has recently been highlighted in the high courts as being resistant to equal pay claims.

The final 2014 assessment shows positive examples of good practice, including equality becoming mainstreamed within services and processes at the Trust.

PSED (Public Sector Equality Duties)

The PSED requires public bodies to prepare and publish one or more specific and measurable equality objectives which will help the organisation further the three aims of the Equality Duty.

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Equality data that specifically relates to PSED (Public Sector Equality Duties) has been published within our Equality and Diversity Annual Report dated August 2014, which is available on the hospital website:
www.salisbury.nhs.uk/AboutUs/EqualityAndDiversity

At SFT we expect all policies to include an Equality Analysis (formerly Equality Impact Assessment). We have included this requirement within our 'Procedural document development and management policy'. We publish some of policies on our external website and further Equality Analysis's available on request.
www.salisbury.nhs.uk/AboutUs/OurPoliciesAndProcedures

Detailed workforce data breakdowns covering the protected characteristics can be viewed under the hospital website pages:
www.salisbury.nhs.uk/AboutUs/TrustReportsAndReviews

SFT regularly engages with a variety of organisations some of which are listed on the hospital website pages:
www.salisbury.nhs.uk/InformationForPatients/SupportGroups

Our Customer Care Team provides a range of various services, examples of this work is available within our EDS2 assessment evidence. In the first instance if members of the general public would like to contact our customer care team information is available on our hospital website:
www.salisbury.nhs.uk/InformationForPatients/CustomerCareDept

The Workforce Race Equality Standard (WRES) will be a new requirement for NHS organisations to demonstrate progress against a number of indicators of race equality within the workforce. The Standard will be used by organisations to track what progress they are making to identify and help eliminate discrimination in the treatment of BME staff. The metrics will focus upon bullying and harassment, access to promotion and career development, and experience of discrimination, as well as local workforce measures including the likelihood of being recruited from shortlisting. It will use a number of workforce indicators, including a board membership metric to gauge the current state of workforce race equality within provider organisations.

Seven metrics are being proposed within which the differences between the treatment and experience of white and BME staff are expected to be the same:

3 NHS Staff Survey indicators

- KF19 (difference between % white staff and % BME staff experiencing harassment, bullying or abuse from staff in last 12 months)

- KF27 (difference between % white staff and % BME staff believing the trust provides equal opportunities for career progression or promotion)
- KF 28 (difference between % white staff and % BME staff experiencing discrimination at working last 12 months)

4 workforce indicators

- Ratio of proportion of BME staff on grades 8C-9 to the ratio of BME staff in all grades
- Likelihood of shortlisted BME applicants being appointed compared to white applicants
- Likelihood of BME staff entering disciplinary process compared to white staff
- Access to non-mandatory training and CPD

The WRES will be a requirement as from April 2015, please refer to Appendix 3 for detailed information. The board will be presented with the data in the August annual board paper. The EDSG and Workforce Development Committee will ensure the organisation analyses and assesses best outcomes for race equality, which may include working with specific departments within the organisation.

Workforce Development Strategy

The role of the Workforce Development Committee is to oversee the delivery of the PSED and best practice in pursuance of the Trust's vision. The EDSG, (Equality & Diversity Steering Group) ensures that it contributes to developing a high quality innovative workforce, proud to work at SFT. The EDSG monitors progress through ongoing communication with the directorates.

Positive Equality Outcomes

Rainbow SHED

The Rainbow SHED and the E&D Manager have continued to work with Stonewall a national LGBT charity on the Health Champions programme. We provided bespoke training as part of our LGBT allies' continuous development. We plan to submit to the Stonewall Healthcare Equality Index in January, which will measure the impact our work has on sexual orientation and identify further improvements.

Equality for Everyone Event

The Trust held its annual Equality & Diversity event in October 2014 which was attended by approximately 50 delegates, held in Springs Restaurant. The theme this year was celebrating our diverse workforce.

Striving for Excellence Award

A specific award for equality and diversity was made as part of the 'Striving for Excellence Awards' in November 2014. We received a number of high calibre nominations for this award and it was an excellent opportunity to collate examples of good practice and raise the profile of equality and diversity both internally and externally.

ACTION REQUIRED BY THE BOARD:

To note the report and its contents.

To note in particular the implications of the EDS2 and WRES approve the ongoing development and implementation of the EDS2 within the Trust.

To agree and endorse the updated and reviewed RAG ratings under Appendix 1.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

Appendix 1 – EDS2 Synopsis (Final Version Dec 2014)
Appendix 2 - EDS2 Evidence file (Final Version Dec 2014)
Appendix 3 – WRES (Workforce Race Equality Standard)

AUTHOR:	**PAMELA PERMALLOO-BASS** **EQUALITY & DIVERSITY MANAGER**
EXECUTIVE DIRECTOR:	**ALISON KINGSCOTT** **DIRECTOR OF HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT**

FINAL EDS2 OBJECTIVES AND OUTCOMES – SALISBURY NHS FOUNDATION TRUST (based on evidence gathered by EDS Leads) – Dec 2014

The analysis of the outcomes must cover each protected group

Objective	Outcome	Grade			
1. Better health outcomes	1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities.				
	1.2 Individual patients' health needs are assessed and met in appropriate and effective ways.				
	1.3 Transitions from one service to another, for people on a care pathway, are made smoothly with everyone well informed.				
	1.4 When people use the NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.				
2. Improved patient access and experience	2.1 Patients, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.				
	2.2 People are informed and supported to be as involved as they wish to be in decisions about their care.				
	2.3 Patients report positive experiences of the NHS.				
	2.4 People's complaints about services are handled respectfully and efficiently.				
3. A representative and supported workforce	3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.				
	3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations.				
	3.3 Training and development opportunities are taken up and positively evaluated by all staff.				
	3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source.				
	3.5 Flexible working options are available to all staff consistent with the needs of the service and the way that people lead their lives.				
	3.6 Staff report positive experiences of their membership of the workforce.				
4. Inclusive leadership	4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.				
	4.2 Papers that come before the Board and other major Committees identify equality related impacts including risks, and how these risks are to be managed.				
	4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.				

EDS Outcome 1.1 (EDS Goal 1 – Better health outcomes)
"Services are commissioned, procured, designed and delivered to meet the health needs of the local communities."

Name: **Salisbury NHS Foundation Trust**	**Lead Contacts: Maggie Cherry and Pamela Permalloo-Bass (Formerly Head of Public, Patient and Involvement and Equality & Diversity Manager)**

The Trust services are commissioned by Wiltshire CCG, Hampshire CCG, Dorset CCG and specialist commissioner services for Burns and spinal services. The Director of Public Health, Maggie Rae, holds a joint position with Wiltshire CCG and Wiltshire Council and is responsible for the Joint Strategic Assessment and chairs the Health and Well Being Board

SFT has a Public Health Steering Group which aims to improve and protect the health of the population, especially those with the poorest health. The key to success will be through integration, localism, partnership and collaboration with the local communities. SFT multiagency steering group will drive the agenda forward.

The Trust works closely with commissioning teams from the CCG's to ensure the contract requirements set by them each year are met. The health needs of local people set out within these contracts cover some of the nine characteristics protected by the Equality Act.

The trust successfully implemented the friends and family test on all wards, ED and maternity. We are currently achieving all the DOH national target sets.

With the results of the national patients survey we develop action plans with key themes which we use to inform real time feedback on all wards. Quality accounts consultations are held each year with AgeUk, local interest groups and governors, who receive an update and help to set priorities for the forthcoming year.

The Sexual Health Manager Henry Wilding was responsible for a contract application to increase the capacity and breadth of the Sexual Health services. We were asked to provide examples of how the Trust supports and engages in E&D to support the contract application. Sexual Health were successful with their application. Information was shared via the cascade brief.

We've been successful with our application for Stonewall's Healthy Champions programme which is funded by the DOH. It has allowed us to have access to 1 years support from Stonewall, which would usually be charged at £6K. We have agreed an action plan with Stonewall the support will run for 1 year until March 2015.

EDS grade:	**Achieving**

EDS Outcome 1.2 (EDS Goal 1 – Better health outcomes)
"Individual people's health needs are assessed and met in appropriate and effective ways."

Name: Salisbury NHS Foundation Trust	**Lead Contacts: Maggie Cherry and Pamela Permalloo-Bass (Formerly Head of Public, Patient and Involvement and Equality & Diversity Manager)**

Involving patients in their care is a key element of the Trust Organisational Development Strategy, 'Striving for Excellence', and the requirements set out in Real Involvement Section 242 (1b) of the NHS act 2006. There is a strong culture of involvement in the Trust, as evidenced in the Patient and Public Involvement work described later in section A. It is regarded as a valuable source of information where patient insights into their needs and wants and the ability to feedback on their experiences is used to drive service improvement. Positive outcomes include improvements to ward areas to help with privacy and dignity, reduced mortality rates, and reduced length of stay, low infection rates and high standards of cleanliness.

The Trust has clear processes for learning and action planning from National Patient Survey results, gathers Real Time Feedback from patients and undertakes patient and public involvement activities. These processes are measured and action taken to improve patient experience and progress is monitored by teams, Directorates and the Trust Board.

All inpatients have an assessment of their risks and care needs on admission, a treatment plan written and delivered in accordance with the plan. The outcomes can be seen in the patient's health care record in the initial assessment and treatment plan and in the nursing assessment, reassessment and daily management plans.

Ward leaders, allied health professionals and consultant teams actively listen to and involve patients, their families and carers in decision making and ensuring they know what is planned for their care. One example of how this happens can be seen in the work of the elderly care team, who make regular diary slots available to meet with patients and their families, to ensure they are involved in what is planned for their care in hospital and for their discharge.

Outpatients receive information before their appointments and are given the opportunity to discuss their treatment choices. Patients are entitled to a copy of any letter we write about them. Teams who routinely copy patients into their letters are Dermatology, Gynaecology and Oncology.

If particular concerns about a patient's mental health or patient safety is apparent an individual risk assessment is undertaken to determine the safety of the environment, staffing levels or specific care needs. Staff across the Trust have had training and regular information updates about the Mental Capacity Act 2005. There is a mental capacity resource area for staff on the integrated clinical information database (ICID). In the Emergency Department all team members, including receptionists and secretarial staff receive training in Mental Health, vulnerable adults and child protection. There are robust processes in place to ensure policy and procedures are followed.

The Trust has undertaken an extensive environment improvement programme in 2010 to ensure provision of single sex toilets and bathrooms. Privacy and dignity is a key element of the PLACE assessment and local PLACE inspections have resulted in improvements to ward furniture, decorating programmes and provision of enough pillows for all patients. Governors, LINk members, representatives from Age UK and Carers groups participate in the annual PLACE inspection.

There is an interpreter service for patients with hearing impairments and for those whose first language is not English. Patients with learning disabilities (LD) often bring a patient passport with them to identify their needs and are frequently accompanied by carers. The Trust has a LD working group which has been in place since April 2010.Membership is made up of nursing staff, community LD nurse responsible for hospital liaison, Lead Nurse for Safeguarding, Easy Read Group representative, carers and is chaired by the Deputy Director of Nursing. There is a full work plan in place which is reported to the Clinical Governance Committee.

Key achievements to date: publication of a policy for patients with LD in the Acute Hospital, Care Cards, production of a patient passport system holding key information which should travel with the patient across care settings. The policy and passport are currently being launched across the Trust with awareness raising sessions delivered by working group members. The Trust also has an active Easy Read Group who produces patient information resources. The Trust took part in a regional peer review co-ordinated by the SHA in September 2010 which examined all aspects of acute care for patients with LDs, this was a helpful exercise allowing us to further identify areas for improvement and has led to sharing and learning across the region.

The trust has successfully implemented the government initiative “Family and Friends” test April 2013. Feedback is passed to wards immediately with any action required. Overwhelmingly the comments were positive and can be viewed on our hospital website.

We currently collect data on patients for most of the equality groups. However we do not collect data on sexual orientation. Following on from our meetings with IS and IG, we are in the process of completing a Privacy Impact Assessment, in order to move forward with this process.

Psychologists are expanding their award winning ‘Engage’ programme. The project initially started in 2 areas but has been so successful that it is now being used in 12 wards. Volunteers provide support for patients during their hospital stay by visiting different wards and sitting with the patients, talking to them and using techniques such as quizzes, discussion groups and memory games that help keep patients motivated.

EDS grade:	**Achieving**

EDS Outcome 1.3 (EDS Goal 1 – Better health outcomes)
“Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.”

Name: Salisbury NHS Foundation Trust	Lead Contacts: Maggie Cherry and Pamela Permalloo-Bass (Formerly Head of Public, Patient and Involvement and Equality & Diversity Manager)

Continuity of care is provided by a named consultant and the number of ward moves is monitored by the Trust board. Safety briefings and handovers are held daily on most wards. A formal Hospital at Night (H@NT) handover is in place morning and evening. Transfer documentation is available in the health care record. Multidisciplinary white board rounds are in place in most wards. Complex discharges are supported by input from the discharge team to ensure a safe and timely discharge.

Quality is measured by the Board through a number of measures and indicators and shown in the annual Quality Accounts. Priorities are developed in accordance with views and comments from clinical staff, local people, Commissioners, the Trust's Governors and LINks. For the 2013/14 account we started work and planning early to enable local stakeholders such as Age UK and the Warminster Health and Social Care Group to contribute to the quality priorities the Trust need to take action on to improve in year.

The outcomes can be seen in the patients' health care records, the initial assessment, treatment plans, nursing and allied health professional and medical management plans.

The Trust has a Learning Disabilities Working Group which has been in place since April 2010. Membership is made up of nursing staff, community learning disabilities nurse responsible for hospital liaison, Lead Nurse for Adult Safeguarding, Easy Read Group representative, carers, and is chaired by the Deputy Director of Nursing. There is a full work plan in place which is reported to the Clinical Governance Committee. Key achievements to date: publication of a Policy for Patients with a Learning Disability in the Acute Hospital, production of a patient passport system holding key information which should travel with the patient across care settings. A new Care Card has been introduced which patients with particular needs can apply for and can show a member of staff when they arrive at the hospital in order to extra help. The Trust also has an active Easy Read Group who produces patient information resources. The Trust has retained the Patient Information Standard for the last 3 years.

The Dementia Strategy and action plan strives to improve the quality of care for people with Dementia in the Trust. It includes 8 standards: Respect, dignity & appropriate care, assessments, admissions & transfer/discharge processes, access to mental health liaison, dementia friendly environment, nutrition & hydration, contribution to volunteers, quality of End of Life Care, training & workforce development. Improving the quality of care for people with dementia and safeguarding vulnerable adults throughout their hospital stay are key priorities for the Trust and the national dementia care strategy. The Trust ensures 'Dementia is Everyone's Business' through ongoing training programmes.

EDS Grade:	Achieving

EDS Outcome 1.4 (EDS Goal 1 – Better health outcomes
"When people use the NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse."

Name: Salisbury NHS Foundation Trust	Lead Contacts: Fenella Hill (Head of Risk Management)
The Trust is committed to the ongoing development of an organisational culture that continuously strengthens patient safety. Safety is seen as the key driver to improvement work. The Trust has a robust Quality Framework as outlined within the Quality Account and patient safety is fundamental within this. The Trust risk management process is supported by approved policies and procedures and applies to all staff and visitors to the Trust without exceptions. The risk management process is reviewed by both internal audit and external bodies and all policies and procedures are subject to internal approval and review. It is acknowledged that there are occasions when mistakes will be made and the Trust actively promotes an open and fair culture within risk management that encourages the honest and timely reporting of all adverse events and near misses in order that learning can occur and risk is minimised. Adverse incident data is analysed monthly at the Clinical Risk Group and reported Trust wide to identify key trends and themes. The Trust encourages staff to be proactive in reducing the risk to patients and themselves from incidents relating to abuse, harassment, bullying and violence. These are supported by the security policy, raising concerns policy 'Whistle blowing' and bullying and harassment processes within HR as well as established safeguarding procedures. At the monthly CLIP meeting Equality & Diversity is raised with regards to incidents, complaints and litigation perspective.	
EDS grade:	**Achieving**

EDS Outcome 2.1 (EDS Goal 2 – Improved patient access and experience)
"Patients, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds."

Name: Salisbury NHS Foundation Trust	Lead Contacts: Hazel Hardyman, Claire Gorzanski, Bob Dennes (Head of Customer Care, Head of Clinical Governance and Transport and Communication Manager)
Comments, Concerns, Compliments and Complaints leaflet and Customer Care (easy read leaflet developed by local people with learning disabilities) - These leaflets are displayed on all wards/departments, are available on the website and are given to visitors to the Customer Care Department. The Customer Care Administrator checks the wards/departments have stock of the leaflets once every 2 months and the wards/departments can request leaflets if they run out. All complaints are acknowledged in writing from the CEO and a copy of the leaflet is enclosed, stating that making a complaint will not prejudice their care and treatment in any way. Patients, carers and communities can contact Customer Care in person, by e-mail, by telephone (freephone), online feedback form, in writing and through an advocate either from the Independent Complaints Advocacy Service (Hampshire patients), SWAN Advocacy (Wiltshire patients) or Dorset Advocacy (Dorset patients). Interpreting and translating services can be booked through the Customer Care Department (Big Word) Interpreters are used in managing patient complaints, the Customer Care team also work in collaboration with local voluntary sector organisations such as Hampshire Deaf Society and Wiltshire Sense. Out of hours, telephone interpreting and a hearing loop is available by contacting the Site Team. If a person making a complaint cannot attend the hospital then a home visit can be arranged.	

The Trust has made progress with the learning disabilities peer review action plan. A 'Hospital Passport' has been developed which holds key information regarding a patient with learning disabilities for staff to use within the care planning in hospital. Training and awareness sessions have been run by the Community Learning Disability Team and Adult Safeguarding Lead. A Learning Disabilities policy has been ratified and was disseminated alongside 'Top Ten Tips' poster which distils 10 key messages for staff should they have a patient admitted with a learning disability. Significant work has progressed to improve dementia care. A local baseline assessment for the future benchmarking purposes has been completed by participating in the first round of the National Dementia Audit. This will show us where we need to make further improvements. We have established partnership working with the completion of a Trust wide self assessment of compliance against the regional standards in March 2011. A peer review took place in November 2011 and the Trust was praised for the leadership and commitment to improving care for this group of patients and the excellent progress made in the last 18 months. To raise dementia awareness across the workforce we now have 55 dementia champions who work clinically and non clinically. These champions will work within the Dementia Education strategy. Strong links have been forged with the Food and Nutrition Steering Group and the End of Life Care Strategy Steering Group to improve these important aspects of care. The Trust plan to set up a Public Health Steering Group to help reduce inequalities and progress equality in the new NHS Outcomes Framework, Public Health Outcomes Framework and Adult Social Care Framework, with the E&D manager contributing on the steering group.

The Trust operates a Patient Transport Service, the criteria for using this service is as follows: The Patient is required to attend for treatment under the Mental Health Act or has been assessed under the CPA process, as at risk, if they do not attend for treatment, the Patient is a child whose mental and/or physical wellbeing has been assessed to be at risk and their Guardian is unable to bring them in for treatment, unless Hospital transport is provided, the Patient has received bad news or is shocked, on a course of chemotherapy, sedation, or has been given drugs, which affects their eyesight, The Patient cannot walk without the assistance of two people, the Patient needs to travel in a wheelchair, the Patient needs to travel on a stretcher.

We ran a Sighted Training workshop twice in 2014, working with Voluntary Services and the National Association of Guide Dogs Association. Staff from a variety of directorates attended this session which involved sighted staff wearing a bling fold and experiencing walking around the hospital with sighted staff. The experience was challenging and enabled staff to appreciate the how language and touch is important for a blind or partially sighted person.

EDS grade:	**Achieving**

EDS Outcome 2.2 (EDS Goal 2 – Improved patient access and experience)
"Patients are informed and supported to be as involved as they wish to be in decisions about their care."

Name:	**Lead Contacts: Maggie Cherry and Pamela Permalloo-Bass**

Salisbury NHS Foundation Trust	**(Formerly Head of Public, Patient and Involvement and Equality & Diversity Manager)**
Involving patients in their care is a key element of the Trust Organisational Development Strategy, 'Striving for Excellence', and the requirements set out in Real Involvement Section 242 (1b) of the NHS Act 2006. There is a strong culture of involvement in the Trust as evidenced in the Patient and Public Involvement work. It is regarded as a valuable source of information where patient insights into their needs and wants and the ability to feedback on their experiences is used to drive service improvement. Positive improvements include improvements to ward areas to help with privacy and dignity, reduced mortality rates, reduced length of stay, low infection rates and high standards of cleanliness. The Trust has clear processes for learning and action planning from National Patient Survey results, gathers Real Time Feedback from patients and undertakes patient and public involvement activities and has introduced the Friends and Family test in 13/14. These processes are measured and action taken to improve patient experience and progress is monitored by teams, Directorates and the Board. Specific examples of these are given and described in more detail later in this section. All inpatients have an assessment of their risks and care needs on admission, a treatment plan written and delivered in accordance with the plan. The outcomes can be seen in the patients health care record in the initial assessment and treatment plan and in the nursing assessment, reassessment and daily management plans. Ward leaders, Allied health professionals and consultant teams actively listen to and involve patients, their families and carers in decision making and ensuring they know what is planned for their care. One example of how this happens can be seen in the work of the Elderly Care team, who make regular diary slots available to meet with patients and their families, to ensure they are involved in what is planned for their care in hospital and for their discharge. Outpatients receive information before their appointments and are given the opportunity to discuss their treatment choices. Patients are entitled to a copy of any letter we write about them. Examples of teams who routinely copy patients in to their letters are Dermatology, Gynaecology and Oncology.	
EDS grade:	**Achieving**

EDS Outcome 2.3 (EDS Goal 2 – Improved patient access and experience)
"People report positive experiences of the NHS."

Name: Salisbury NHS Foundation Trust	**Lead Contacts: Maggie Cherry and Pamela Permalloo-Bass (Formerly Head of Public, Patient and Involvement and Equality & Diversity Manager)**

The Real Time Feedback (RTF) questionnaire is developed using analysis of the National Patient Survey results, CQUINS requirements and the Quality Account Priorities. These are analysed with the trends from Complaints, Risk, and patient feedback to direct areas of improvement for wards and directorates. This is the responsibility of the Patient Experience Action Group (PEAG) with leads from Customer Care, PPI, Risk and Patient Information. RTF is undertaken in adult inpatient wards, paediatrics and outpatient settings. It is also used for reporting patient experience with Discharge planning. Volunteers and Governors visit these areas across the Trust on a daily basis and areas of concern are immediately sent to the ward leader and an action plan agreed. Teams are also made aware of compliments. A diary is kept to help plan where RTF is needed, the wards and departments are not aware of when they will be surveyed. Volunteers and Governors are trained to ensure they do not contravene Infection Control or the Privacy and Dignity policy. They always introduce themselves to the ward leader and always give patients the option not to participate in RTF.

These are some examples of improved outcomes for patients as a result of what we learnt from their feedback;
Improved patient information being made more accessible via our website, better access to translation services, face to face, written information, hearing loops installed in key areas and portable system available, involving people with Learning Disabilities in helping us write patient information, keeping the messages clear about all we are doing to prevent infection in the hospital, local children designed the latest hand gel stations, responding to the demand to deliver single sex accommodation, clearly telling people why and what we were doing where this was disruptive to services, responding to the National Patient Survey feedback on food in hospital, improving on gluten free service, monitoring our food using governors and volunteers and mystery shoppers, increasing cleaning activity (especially in bathrooms) in response to real time feedback form patients on wards, introducing partial booking to Rheumatology after an experienced based design event with patients and staff involved together, Stroke patients day – volunteers, art care and staff working together to liven up each day with a range of different activities.

Patient experience is reported and monitored by the Clinical Governance Committee who meet every two months, this includes a patient attending and telling their story of care, they are often supported by their relatives, carers or an advocate. Lessons learnt from the themes in stories are always fed back to the team or action group. For example a carer of a gentleman with dementia recently shared a powerful story that is being used within staff dementia training. Patient experience is reported at the Directorate Quality meetings and as part of the Quality Walks which take place on all wards and departments and involve Executive and Non-Executive Directors. An annual Patient Experience Report is produced by the Head of Customer Care and the Head of Patient and Public Involvement, this is publically available and is used by LINks and Governors to enable them to participate in commenting on the Quality Account and CQC requirements.

Friends and family results http://www.salisbury.nhs.uk/AboutUs/Documents/Friends_and_Family_Test_Results_for_June_2013_v2.pdf

In 2014, new mothers have rated the quality of care and level of support they receive highly in an independent CQC survey of NHS maternity units. The survey looked at womens experience of labour and birth, staff and care in hospital after birth. When compared with all 137 providers of maternity services, the Trust received the highest score in the country over these categories.

EDS	**Achieving**

grade:	

EDS Outcome 2.4 (EDS Goal 2 – Improved patient access and experience
"People's complaints about services are handled respectfully and efficiently."

Name: Salisbury NHS Foundation Trust	Lead Contacts: Hazel Hardyman, Maggie Cherry, Pamela Permalloo-Bass (Head of Customer Care, Formerly Head of Public, Patient and Involvement and Equality & Diversity Manager)

Comments, concerns, compliments and complaints leaflet and Customer Care (easy read leaflet developed by local people with learning disabilities).These leaflets are displayed on all wards/departments, are available on the website and are given to visitors to the Customer Care Department. The Customer Care Administrator checks the wards/departments have stock of the leaflets once every 2 months and the wards/departments can request leaflets if they run out. All complaints are acknowledged in writing from the CEO and a copy of the leaflet is enclosed, stating that making a complaint will not prejudice their care and treatment in any way.

Handling comments, concerns, complaints and compliments policy is available on the Intranet and Internet. Training is provided to staff to ensure they understand how to deal effectively with concerns and complaints that are brought to their attention.

The Customer Care page on the Internet provides information on how to make comments, concerns, compliments and complaints. www.salisbury.nhs.uk/InformationForPatients/CustomerCareDepartment/Pages/Home . There is also a template to help people write a letter of complaint, for example, if they are making a complaint on behalf of the patient they should ask them to sign the letter to agree that we can correspond with someone else on their behalf, to order their concerns clearly in chronological order and state what outcome they want.

Interpreting and translating service can be booked through customer care. interpreters are used in managing patient complaints, the customer care team also work in collobration with local voluntary sector organisations such as ' Big Word' 'Hampshire Deaf Society' 'Wiltshire Sense'.

If patients, relatives or carers have visual impairments the Customer Care team will increase the font size on request.

Customer Care have several examples of respecting patients eg: a bereaved relative did not want to meet in the patient area of hospital as it caused emtional discomfort, the team always check if disability adjustments are needed prior to meeting with patients, carers and relatives, the team have supported a family regarding the issues of dementia and as an outcome family members and representative are now working with the Trust on the Dementia Steering group and the Trust dementia training.

In the annual survey of complaints handling, equality data is requested and collected on the following equality grousp; sex, age, disability, ethnicity. DH annual reporting – KO41 report also includes equality data monitioring. The Head of Customer Care will engage with local equality groups when invited and link with health colleagues regionally. Quarterly customer care report forwarded to governors meetings and governor

complaints and compliments on behalf of the public.	
EDS grade:	**Achieving**

EDS Outcome 3.1 (EDS Goal 3 – A representative and supported workforce)
"Fair NHS recruitment and selection processes lead to a more representative workforce at all levels."

Name: **Salisbury NHS Foundation Trust**	**Lead contact:** **Lucy Coombes (Bank HR Manager)** **Jenny Hair (Deputy HR Director)**

Salisbury NHS Foundation Trust (SFT) is committed to equal opportunities and has well established recruitment and selection processes in place to show inclusiveness and equity at all stages ie: application, shortlisting and appointments. The recruitment and selection policy was revised and updated in 2013 to incorporate the process for medical HR in order to ensure consistent practice for all staff groups. The Trust has embedded the Equality Analysis process into all policy development work and this is complete for the current revision. Staff side are always consulted for any policy development work.
SFT has access to data relating to applicants from six of the nine protected characteristics through NHS Jobs, where all posts are advertised. A new version of NHS jobs will be launched in 2014 which will enable more sophisticated reporting in this area. Evidence for 2012/13 indicates a lower share of appointments of BME staff compared with their share of applications, but the workforce consists of over 8% BME which is disproportionate in the Trust's favour to the local community, currently at 4%. ESR data analysis also shows that BME staff are in post across all the bands and occupational groups although numbers do reduce at band 7 and above. This trend is also seen for other groups including women, although there is a significant increase in numbers of female doctors in training which will improve the figures up to and including consultant level over time. Nearly 20% of the workforce have chosen not to disclose information about their sexual orientation. These findings are monitored by the Equality & Diversity Steering Group on an annual basis.

The Trust's recruitment and selection training addresses unconscious bias in selection outcomes and is under regular review. Managers are encouraged to look at gender balance when using interview panels. The 2012 Staff Survey illustrates a high percentage of staff from reported protected groups (age groups, gender, disability, ethnic background) believing the Trust provides equal opportunities for career progression or promotion, although for BME staff this figure is slightly lower at 74%. Evidence for religion and belief, sexual orientation, marital status and maternity and pregnancy is not available via the staff survey results but religion and belief and sexual orientation were evaluated through the NHS Jobs analysis described above. Outcomes look positive in respect of appointing staff with a range of religions but the numbers are very small relating to sexual orientation.

Active forums exist for LGBT, disabled and BME staff and the Trust engages with these groups along with community groups about all practices including recruitment and selection. Advertising through social media is currently being explored, which may widen the field for potential applicants from protected groups. The Trust was revalidated in 2013 for Disability Two Ticks status, after evidencing how it takes

account of disabled applicants in the recruitment process. Disabled applicants who meet the required criteria are guaranteed an interview and the NHS jobs data shows that 50% of those shortlisted were appointed. Again, numbers are very small and monitoring will always rely on what people are prepared to disclose. The Employment of People with Disabilities Policy (also revised in 2013) takes account of this key protected group but the effectiveness of this policy has not been tested. A grievance process is available to all staff if dissatisfied and the Trust complaints procedure is open to external parties. If individuals request feedback following an interview this is pursued proactively from the recruiting manager. No formal complaints have been received this year. The Trust has signed up to the Mindful Employer initiative and charter, aimed at increasing mental health awareness at work. The programme will provide support for the Trust in recruiting and retaining staff. The Trust has recruited 3 Equality Champions who act as advocates for minority staff if they have concerns about the whole range of equality issues including recruitment and selection. The current champions support staff from the LGBT, disabled and BME groups. During 2011/2012, the Trust was awarded E&D partner status by NHS Employers.

EDS grade:	**Achieving**

EDS Outcome 3.2 (EDS Goal 3 – A representative and supported workforce)

"**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations."**

Name: **Salisbury NHS Foundation Trust**	**Lead contact:** **Lucy Coombes (Bank HR Manager)** **Jenny Hair (Deputy HR Director)**
At Salisbury NHS Foundation Trust, national terms and conditions of employment and levels of pay are applied locally through "Agenda for Change" and for medical staff through the National Health Service Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service (England and Wales) terms and conditions. These national terms and conditions are based on staff who are doing equal work having the same terms and conditions and pay. Jobs are graded according to a nationally recognised job evaluation system which has recently been highlighted in the High Courts as being resistant to equal pay claims. Local allowances or bonuses that could be open to discriminatory practice are not possible within national terms and conditions. The Trust does collate data to evidence that staff from protected groups enjoy levels of pay and related terms and conditions that are no different from those experienced by staff as a whole, doing the same job. An analysis of starting salaries for staff appointed in 2013, showed a level playing field for both females versus males and white versus BME. This is achieved through a robustly applied policy on starting salaries. Pay progression may be affected next year following the implementation of a new appraisal system which will be linked to incremental progression. An equality impact assessment has been completed on the framework and this will influence the development of the detailed policy. There is an established policy and procedure for getting the grading of posts reviewed should the requirements of any job change. The policy requires job grading changes to have a clear rationale and for the job description to be submitted to a panel of staff who are trained	

job evaluators who objectively determine the grade of a post according to nationally set criteria. All jobs assessed by the job evaluation panels are checked for consistency in partnership with staff side representatives. At a local level, there is staff side involvement if local terms and conditions need to be negotiated. The Trust has an established appeals process in place to allow members of staff to appeal if they feel that the outcome from their Clinical Excellence Award outcome is incorrect or if the member of staff has requested a banding review via the Trust's Control of Grading Policy, and they also feel the outcome is incorrect they can appeal. In 2013 a census was undertaken on all staff and to date there has been a 73% return of this data. Data has been requested on all protected characteristics available on our central staff database, Electronic Staff Record (ESR) to enable any analysis or evaluation to be as comprehensive as possible. Those characteristics without supplied fields on the database are logged separately and reports may now be carried out on all nine of the minority groups.

EDS grade:	**Excelling**

EDS Outcome 3.3 (EDS Goal 3 – A representative and supported workforce)
"Training and development opportunities are taken up and positively evaluated by all staff."

Name: **Salisbury NHS Foundation Trust**	**Lead contact:** **Lucy Coombes (Bank HR Manager)** **Jenny Hair (Deputy HR Director)**
The organisation continues to make good progress in improving access to staff training, support and development through investment in a learning management system (LMS) and a suite of on-line learning including Equality & Diversity and Safeguarding. On day one of the induction programme all staff must pass tests and assessments on Moving & Handling, Information Governance, Fire Training and Infection Control. Face to face training is also provided on IG and safeguarding on day one. Staff induction takes place once a week. The 2012 staff survey shows that 71% of the respondents had undertaken equality and diversity training, significantly above the national average and an increase of 8% from 2011. In addition, members of staff must complete other mandatory training which includes Mental Capacity Act, Consent and Conflict Resolution within 12 months. Non compliance is monitored via the LMS and executive performance meetings. Staff appraisals should happen at least annually and it is expected that staff have a personal development plan in place that will help them improve their professional development. The uptake of appraisal is being closely monitored and has remained fairly constant in the last year at around 80%. The appraisal process has this year been linked to pay progression and relies on staff completing all mandatory training which will assist the Trust in overall compliance. For medical staff, a new IT system was put in place in 2013 (Premier IT) which helps to monitor appraisal take up, essential now for the medical revalidation process. In addition the Trust has recruited a lead appraiser for doctors, who provides one to one support and coaching as well as training for appraisers and appraisees.	

All staff have equitable access to training and development opportunities regardless of age, disability, gender and ethnicity. Findings in the staff survey relating to accessing training are slightly lower for those with disabilities, numbering 13% of the respondents. In 2013 a second cohort of staff training to be coaches took place. This cohort had a contingent of BME and male staff who were underrepresented in the first cohort trained.

EDS grade:	**Achieving**

EDS Outcome 3.4 (EDS Goal 3 – A representative and supported workforce)
"When at work, staff are free from abuse, harassment, bullying and violence from any source."

Name: **Salisbury NHS Foundation Trust**	**Lead contact: Lucy Coombes (Bank HR Manager) Jenny Hair (Deputy HR Director))**
The Trust collects data from a number of sources which are relevant to this outcome. These include the annual national staff survey and internally from data generated by the HR department regarding staff involved in formal disciplinary and grievance processes, as well as anonymous data about those staff who access the staff mediation and counselling services. These data sources monitor some of the protected characteristics such as sex, age, ethnicity and disability. In 2013 there have been 26 discipline and grievance cases of which the majority apply to staff who describe themselves as White/British. 13 of these entries relate to female staff. None of the cases related to staff with a disability or who have declared a non-heterosexual orientation. 2 of these cases related to bullying and harassment resulting in formal action. Both of these cases applied to staff from a white background (one male, one female). The 2012 staff survey results show figures which, whilst small, indicate staff are experiencing violence and harassment from both staff and patients in the workplace and 10% of the respondents said they had experienced discrimination. These figures are proportionately higher in the staff groups who have disclosed a disability and those from a BME background. This has been given attention in the overall Trust action plan and more detailed analytical work has been carried out in the work areas where harassment and bullying appears to be more prevalent (surgery and facilities). This work is still to be evaluated. The Trust has in place equality champions for three key minority groups (disability, LGBT and race) as well as two bullying and harassment advisers. Anecdotal evidence suggests access to the advisors has been low. The Trust continues to seek input from and consult with its staff side body and the relevant interest groups on the drafting or revising of all relevant policies, including the Bullying and Harassment policy, which was revised in the last year. It is anticipated that a more detailed booklet on how to recognise and deal with bullying behaviour will be released to managers within the next 4 months The Trust's Mediation Scheme, run by selected members of staff who have been trained by ACAS, continues to operate, the object of which is to allow staff to be pro-active in matters which affect them and to facilitate them in seeking successful resolution to issues before they escalate into formal processes. In 2013 there have been 5 requests for mediation, including one for a patient. Out of 143 new referrals for counselling in 2013, 14 reported bullying and harassment in the workplace.	

EDS grade:	**Achieving**

Outcome 3.5 (EDS Goal 3 – A representative and supported workforce)
"Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives"

Name:	**Lead contact:**
Salisbury NHS Foundation Trust	**Lucy Coombes (Bank HR Manager)** **Jenny Hair (Deputy HR Director)**

Salisbury NHS Foundation Trust is committed to providing working options that are flexible, accommodating and consistent with the needs of patients. It recognises the need to offer flexible working under equality legislation relating to caring responsibilities and realises the benefits in employing a more motivated workforce as a result.

The trust has a Flexible Working Policy, which was revised extensively in 2013 to bring together a number of guidance documents on certain flexible working options such as job share. The policy applies to all protected characteristics and is accessible for all staff on the Trust's intranet. In addition there is a Flexible Working Choices leaflet which is provided to prospective applicants to the Trust. Benefits offered include flexible use of annual leave, either to buy some additional weeks or to sell up to two days; term time working and flexi-time.
The Trust has a range of additional policies to support flexible working such as a Leave policy, covering all types of leave to include special leave required for emergencies as well as paternity and parental leave. Policies are also in place to support flexible retirement, home working and employment breaks; along with a comprehensive maternity policy which is fully compliant with legislation. New or revised policies are presented to staff side groups for consultation, feedback and engagement.

54% of the total workforce works part time, which is an increase of 2% from last year. Workforce data indicates that part time working is taken up by the range of staff groups including those which fall under the protected characteristics. The workforce comprises more women than men and in the female group there are significantly more working part time than full time. More men work full time than part time. The Trust is currently unable to measure the take up of all the types of flexible working offered but anecdotally staff are taking up more options on flexible retirement ('retire and return') and the overall age of the workforce has increased. 35.9% of the Trust's workforce was aged 50 or over in March 2013. 47% of the 2012 staff survey respondents were 51 or over.

There were no formal grievances raised in relation to flexible working requests in 2013.
The 2012 staff survey did not cover questions on flexible working.

EDS grade:	**Achieving**

Outcome 3.6 (EDS Goal 3 – A representative and supported workforce)
"Staff report positive experiences of their membership of the workforce."

Name:	**Lead contact:**

Salisbury NHS Foundation Trust	**Lucy Coombes (Bank HR Manager)** **Jenny Hair (Deputy HR Director)**
Effective team working scores at 3.75 on a scale of one to five and this is higher than the national average for acute Trusts (3.57) and has remained constant since 2011. Scores are also at an equivalent level relating to support received from immediate managers and also for staff who would recommend the Trust as a place to work or receive treatment, again both higher than the national average. Looking at the breakdown of these three questions by the range of protected characteristics, the ratings do not vary significantly although for support from managers they dip slightly for the male staff and the BME respondents. On recommending the Trust, the BME group actually score an overall rate of 4.02. It is noted that the scores relating to recognition and being valued need addressing across all staff groups. Work is being undertaken on introducing new values and behaviours associated with them and this will be embedded in all HR processes. This will help to increase staff satisfaction levels and ensure staff and managers give appropriate feedback. The Trust scored highly under staff engagement which rated within the best 20% of acute trusts. Salisbury Foundation Trust was awarded by the HSJ, one of the top 100 places to work in the NHS. “There is an open and honest feel at Salisbury Foundation Trust and a genuine desire to give good quality care throughout all levels and departments of organisation. An annual “walk for wards” charity event is supported by patients, staff, families and friends. Staff are also offered psychological wellbeing training, including workshops on alleviating stress and yoga classes”	
EDS grade:	**Achieving**

EDS Outcome 4.1 (EDS Goal 4 – Inclusive leadership at all levels)
“Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.”

Name: **Salisbury NHS Foundation Trust**	**Lead contacts:** **Alison Kingscott (Director of HR & OD)** **and Steve Long (Non Executive Director)**
The Trust recognises the importance of ensuring that the services it provides are accessible and relevant to the diverse communities we serve, and this is a stated aim of our service strategy and delivery plans. We actively seek the engagement of individuals and groups representing the views and experiences of our service users through our public and patient involvement initiatives (PPI). Likewise, staff may also experience a range of inequalities at work, and it is recognised by senior leaders that we need to solicit the views and involvement of staff and their representatives from across the protected groups in order to improve their experiences. To that end the Board and senior leaders have endorsed and personally supported the establishment and maintenance of support groups for disabled, BME and LGBT staff.	

The Trust's Equality and Diversity Steering Group (EDSG) reports directly to the Board and is chaired by a non-executive Director. Its membership includes Executive Directors, Governors, senior managers and operational staff. The Board has adopted the Equality Delivery System its the main tool to review its equality performance and to identify future priorities and actions.

The Board has a history over several years of requiring reports on progress towards its equality and diversity objectives, initially identified through the three original equality strands, subsequently against its single equality scheme, and now using the EDS.

The Board has recognised that the engagement of staff and local interest groups is key to our being able to assess our performance and identify where we need to do better, and to that end we continue to hold events promoting Equality and Diversity. In September 2013 we worked with the Human Rights Conference with the BIHR (British Institute of Human Rights) to run a Conference promoted to a wide variety of local interest groups (locally and nationally).

The Director or HR & OD is the Trust LGBT executive lead and has promoted and supported local LGBT events. The Trust supported the Rainbow SHED (SFT LGBT Network) to attend Swindon & Wiltshire Pride 2014.

The Trust has the 'Two Ticks' standard as an employer of people with disabilities, has signed up to the Mindful Employers programme and has participated in the Stonewall 'Top 100 Index'.

The CEO has arranged coffee mornings with protected groups i.e.: Portuguese Nurses, RainbowShed members and regularly engages informally with a variety of groups and individuals.

We are a member of the E&D Lead Officer Public Service Group (Wiltshire) which has representation across public sector organisations in Wiltshire and Swindon.

The Trust's annual report contains a section each year reporting on the Trust's commitment to equality and diversity, and listing the systems in place and progress towards it equality objectives during the year.

The Trust had an announced visit by the CQC in March 2013 to review compliance against CQC standards. The published CQC review of compliance report for the Trust said the following in respect of Regulation 10 outcome 16 (which aligns with EDS outcome 4.1)
'*The provider had an effective system to regularly assess and monitor the quality of service that people receive. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.'*

Equality for Everyone Event (October) - This year's Equality for Everyone event was attended by approximately 60 people and showcased our diverse workforce in Springs restaurant. We had information stands that represented our BME workforce including i.e.: Eastern European, Portuguese, Filipino, South Asian.

Public Sector Equality and Human Right Charter - Following our ongoing work and commitment with the Swindon & Wiltshire E&D Public Sector Group, we have finally published this document which highlights our collaborative approach to E&D across the county. This document is available on request. Message sent by Peter Hill, the CEO in May, promoting International nurses day & cultural diversity. "*Historically we have recruited staff not just from Salisbury, but regionally, nationally and internationally. This week we will be welcoming a new group of nurses from Spain. They will join others from Portugal and the Philippines who have come here as part of our formal recruitment campaigns, as well as staff from across all continents of the world who see Salisbury as a great place to live and work, providing us with additional skills and experiences and enriching our hospital and local communities. "*

EDS grade:	**Achieving**

EDS Outcome 4.2 (EDS Goal 4 – Inclusive leadership at all levels)
"Papers that come before the board and other major committees identify equality-related impacts including risks, and say how these are to be managed"

Name: **Salisbury NHS Foundation Trust**	**Lead contact: Alison Kingscott (Director of HR & OD) and Steve Long (Non-Executive Director)ad contacts:**
The Trust has an established Equality and Diversity Manager (EDM) post. The post holder is line managed by the Director of Human Resources and Organisational Development (DHR&OD), and has a 'dotted line' close working relationship with the Non-Executive Director and Trust Board Champion for equality and diversity (Steve Long). This positions the role at an appropriate level within the organisation and signals the importance of the post holder's contribution as a leader for change. As part of the Trusts adoption of the EDS, the EDM and DHR&OD have agreed the job description (including the person specification) using the Competency Framework for Equality and Diversity Leadership. This has helped identify specific accountability for and role delivering the equality outcomes identified through the EDS process. It is used as a performance management tool within annual appraisals and to develop further areas of improvement for Equality & Diversity at the Trust. EDSG (Equality & Diversity Steering Group) minutes are sent to the Workforce Committee who meet quarterly and is chaired by the CEO. All E&D 6 monthly board reports are ratified by the Trust Board, JBD (Joint Board of Directors) and EDSG members.	

All policy authors complete an Equality Analysis template, which are then ratified by relevant committees i.e.: JBD and OMB. An equality & diversity commentary is featured in the majority of our main reports, particularly if the proposed change affects policy or practices that has an impact on patients or staff from different protected groups. The Trust board expect authors of the reports to hand pick the key issues prior to the lead-up to the board report and then to present the findings to the Trust Board. The Trust Board has a dedicated E&D Champion who is a NED (Non Executive Director), as a result specific questions and constructive challenges are raised as an when required. Public Sector Equality Duties used to be a specific risk that was overseen by the HR & OD Director Alison Kingscott within the assurance framework. However the Board agreed to remove it as a specific high level risk for the organisation at their workshop in September 2013. We currently do not have an open risks relating to equality.

EDS grade:	**Achieving**

EDS Outcome 4.3 (EDS Goal 4 – Inclusive leadership at all levels)
"Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination"

Name: **Salisbury NHS Foundation Trust**	**Lead contacts:** **Alison Kingscott (Director of HR & OD) and Steve Long (Non Executive Director)**
Middle managers use data from the annual staff survey to identify any differential experiences of staff from many of the protected groups which enables them to develop action plans to address any issues identified (this also is undertaken to provide an agreed Trust staff survey action plan each year) Currently in its fourth year, the Trust will made an award for Equality and Diversity, as part of its 'Striving for Excellence' awards programme, Nominations are received from members of staff and from the local community. Award winners' achievements are disseminated on the Trust's website and via a brochure describing the various categories, nominations and contributions recognised which is distributed internally, but also within the local community. The Trust NED and EDM have met with various directorates across the organisation. During the E&D road shows, staff have had the opportunity for an open dialogue and raise specific questions relating to E&D.	

The Education & Learning have developed a coaching programme that supports staff personal & professional development. The team identified protected groups that were not on the programme. As a result the programme was promoted to specific protected groups. The programme now has trained coaches from 4-5 of the protected groups.	
EDS grade:	**Achieving**

Further information on the Workforce Race Equality Standard and the Equality Delivery System – EDS2

The Equality and Diversity Council is committed to advancing equality and diversity for patients, communities and the NHS workforce. The Council has pledged its commitment, subject to consultation with the NHS, to implement two measures to improve equality across the NHS, which would start in April 2015. These measures are a proposed workforce race equality standard and the Equality Delivery System for the NHS – EDS2.

The Workforce Race Equality Standard

The Workforce Race Equality Standard would require organisations providing NHS services to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.

The Workforce Race Equality Standard will use a number of workforce indicators – and one Board membership metric – to gauge the current state of workforce race equality within provider organisations. The Standard will be used by organisations to track what progress they are making to identify and help eliminate discrimination in the treatment of BME staff. The metrics will focus upon bullying and harassment, access to promotion and career development, and experience of discrimination, as well as local workforce measures – including the likelihood of being recruited from shortlisting.

Seven metrics have been proposed within which the differences between the treatment and experience of white and BME staff are expected to be the same:

- *3 NHS Staff Survey indicators*
    - KF19 (difference between % white staff and % BME staff experiencing harassment, bullying or abuse from staff in last 12 months)
    - KF27 (difference between % white staff and % BME staff believing the trust provides equal opportunities for career progression or promotion
    - KF 28 (difference between % white staff and % BME staff experiencing discrimination at working last 12 months)
- *4 workforce indicators*
    - Ratio of proportion of BME staff on grades 8C-9 to the ratio of BME staff in all grades
    - Likelihood of shortlisted BME applicants being appointed compared to white applicants
    - Likelihood of BME staff entering disciplinary process compared to white staff

- Access to non-mandatory training and CPD

Additionally, the extent to which Board composition reflects local population would be an additional element.

Provider organisations will be expected to ensure they have this data, share it with their staff and commissioners, and then consider and act upon the differences between the white and BME staff experience and survey responses so that year on year the differences are seen to reduce. The smaller the differences between the BME and white workplace experience indicators and survey responses, the more likely it is that discrimination is declining.

The Equality Delivery System for the NHS – *EDS2*

The Equality Delivery System (EDS) was rolled out to the NHS in July 2011 and formally launched in November 2011, and is currently being implemented by the vast majority of NHS organisations across England. The design and implementation of the EDS was independently evaluated by Shared Intelligence in 2012. Based on this evaluation and subsequent engagement with a spread of NHS organisations and stakeholders, a refreshed EDS is now available. It is known as *EDS2*.

EDS2 is an inclusive equality tool designed for both NHS commissioners and providers. At the heart of *EDS2* are 18 outcomes, against which commissioner and provider organisations assess and grade themselves. These outcomes relate to issues that matter to people who use the NHS and who work in commissioner and provider organisations. Among other things they support the themes of, and deliver on, the NHS Outcomes Framework, the NHS Constitution, and the Care Quality Commission's key inspection questions set out in "Raising standards, putting people first - Our strategy for 2013 to 2016".

The main purpose of the *EDS2* is to help local commissioners and providers, in discussion with local partners including local populations and workforce, to review and improve their performance for people with characteristics protected by the Equality Act 2010. By using *EDS2*, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED). *EDS2* is aligned to the commitment for an inclusive NHS that is fair and accessible to all. Further information on *EDS2* can be found on the NHS England website at:
http://www.england.nhs.uk/ourwork/gov/edc/eds/

Trust Board meeting **SFT 3621**

Quality indicator report Q3 14/15

Date: 2 February 2015

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

Executive Summary:

- 1 case of C Difficile. YTD 14 cases against a target of 18.
- Four MSSA bacteraemias. None were line related.
- 6 new serious incident inquiries in Q3.
- A slight increase in the crude mortality rate from Q2. We have added a new measure of total admissions in order to correlate the crude rate against activity. Remodelled HSMR is 99 to August 14 which is as expected.
- A peak in the adverse event rate in August 14 as measured by the global trigger tool. Detail underlying this is to be discussed at the January Clinical Risk Group.
- Grade 2 pressure ulcers remain at a low level. One grade 3 pressure ulcer.
- Safety Thermometer - 93% - 97% 'new harm free care'. 88% - 91% 'all harm free care' which indicates a proportion of patients are admitted to hospital with a harm. A decrease in new hospital acquired pressure ulcers on this one day snapshot.
- Ten falls, two resulting in major harm (fractured hips requiring surgery), eight resulting in moderate harm; two fractured wrists, one finger, one pubic rami, two hip fractures managed conservatively and two head injuries.
- Fractured hip patients being operated on within 36hrs improved in October and November but dipped in December due to theatre capacity. Best practice tariff compliance improved to 88% in Q3.
- Escalation bed capacity has increased. Breamore ward opened on 1/1/15 as escalation capacity for 3 months to cope with winter pressures. 22 non-clinical same sex accommodation breaches for patients waiting for transfer out of the Intensive Care Unit (21) and AMU (1). Ward moves of patients moved more than twice remain at a low level.
- A decrease in patients arriving on the stroke unit within 4 hours but sustained performance of patients spending 90% of their time on the stroke unit and receiving a CT scan within 12 hours. High risk TIA referrals seen within 24 hours remains variable. A new measure of high risk TIA patients seen within 24 – 30 hours is shown. The main issue is referrals being received with only a few hours to spare or beyond 24 hours. Improvement work continues with GPs and within the Trust.
- Real time feedback showed a dip in December of patients who felt they were treated with care and compassion and rated the quality of care as good. However, the sample size was half that of usual. The Friends and Family test response rate was sustained above 20% for inpatients, but ED did not reach the 20% response rate. The Maternity Services although improved remain below target. Day cases and outpatient response rates remain variable. NHS England has withdrawn the net promoter score and replaced it with a percentage system of recommend/not recommend.

Proposed Action:

1. **To note the report**

Links to Assurance Framework/ Strategic Plan:

CQC registration

Appendices:

Trust quality indicator report – December 2014

Supporting Information

Salisbury NHS
NHS Foundation Trust

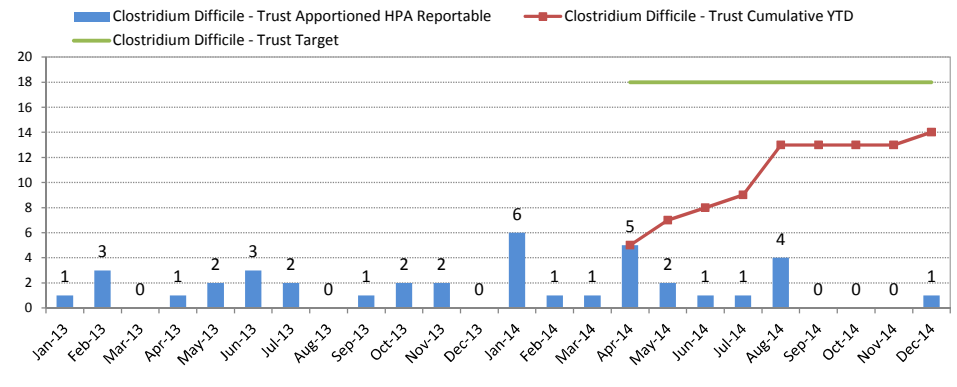
Trust Quality Indicators - December 2014

Quality Measures

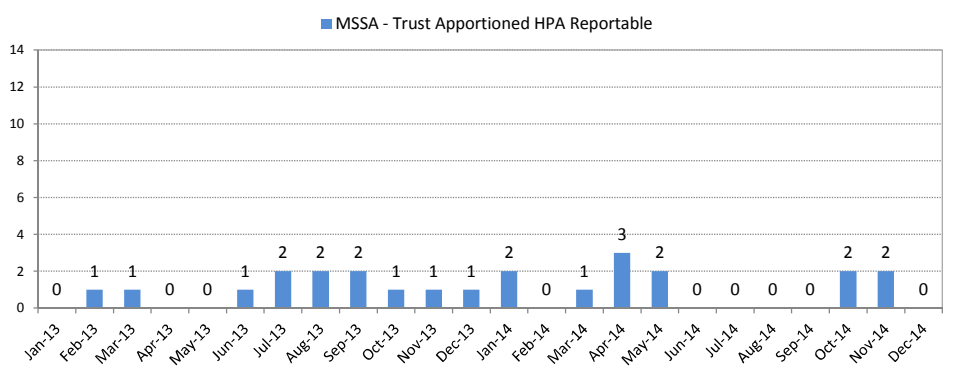
Infection Control	2012-13 Total	2013-14 YTD	2014-15 YTD
MRSA (Trust Apportioned)	3	0 (+2)	1 (+1)

Trust Incidents	2012-13 Total	2013-14 YTD	2014-15 YTD
Never Events	2	0	1
Serious Incidents Requiring Investigation	13	17	19

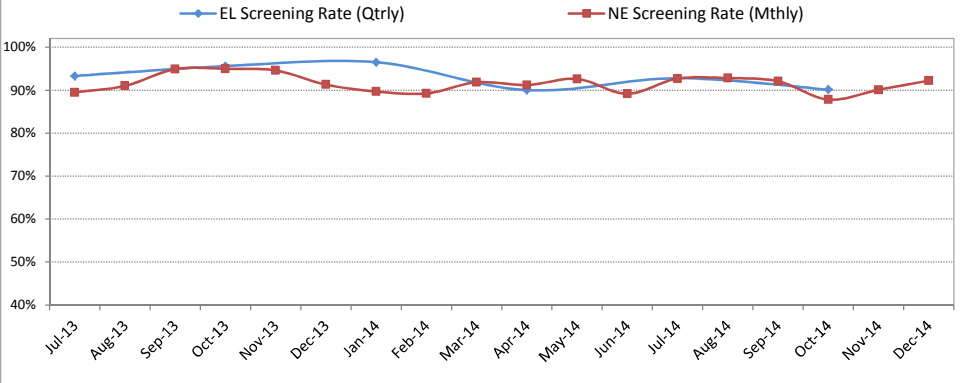
Clostridium Difficile - Trust Apportioned



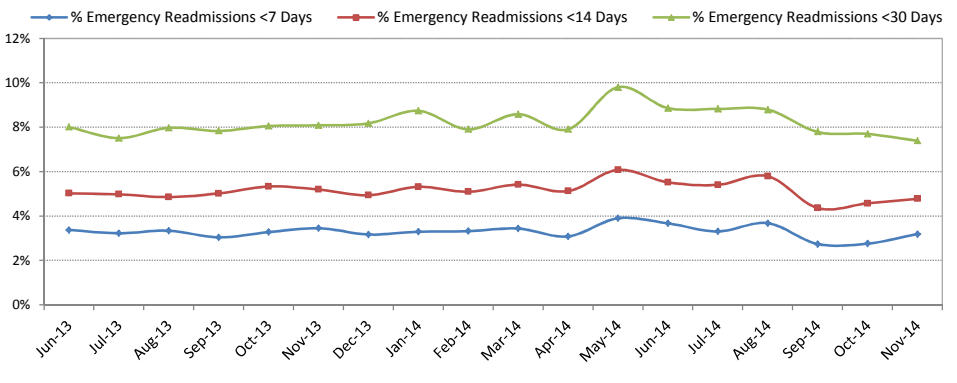
MSSA - Trust Apportioned



MRSA Screening



Emergency Readmissions within 7, 14 & 30 days of Discharge

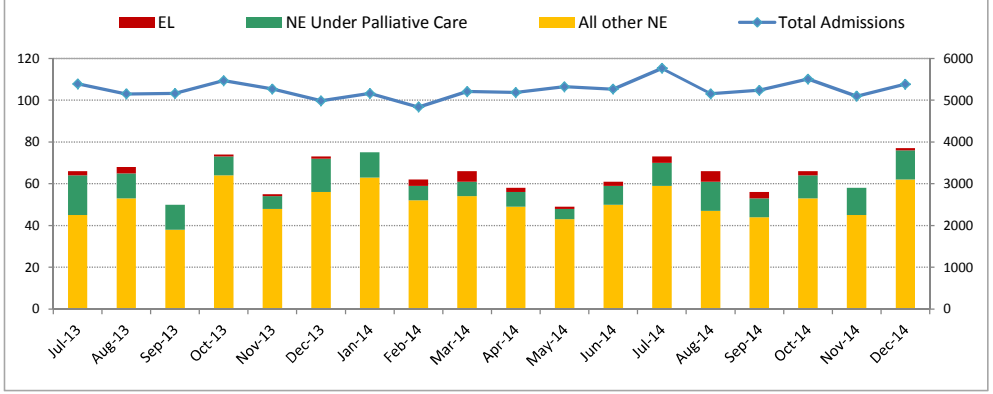


Salisbury NHS
NHS Foundation Trust

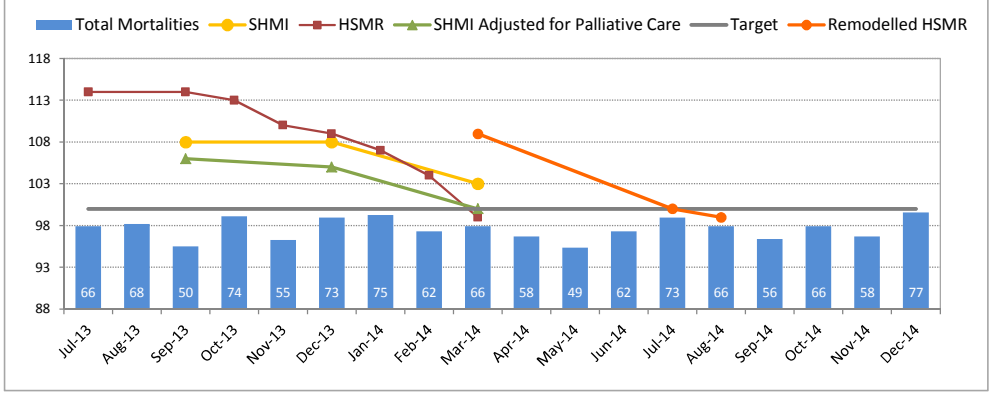
Trust Quality Indicators - December 2014

Quality Measures

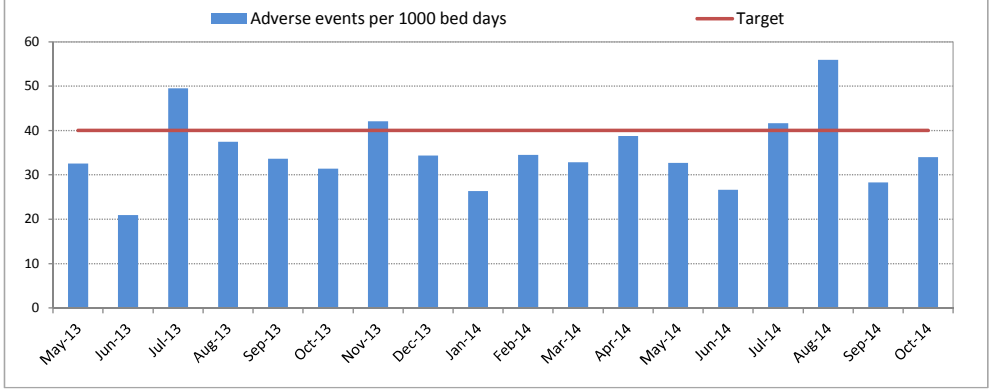
Hospital Mortalities



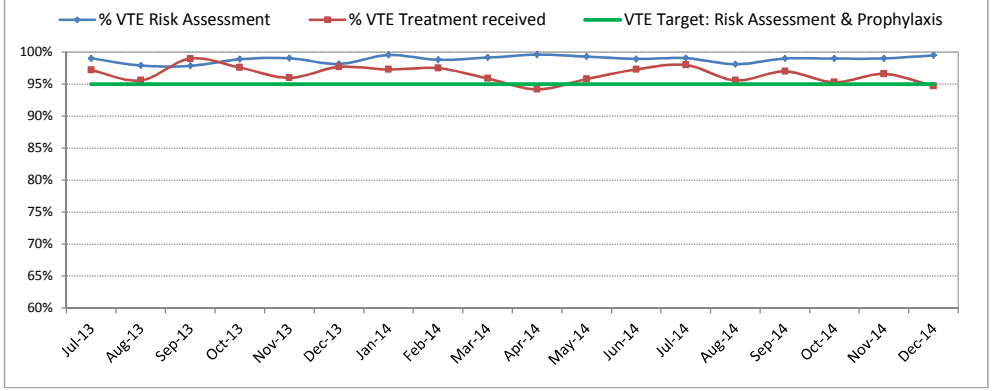
HSMR and SHMI



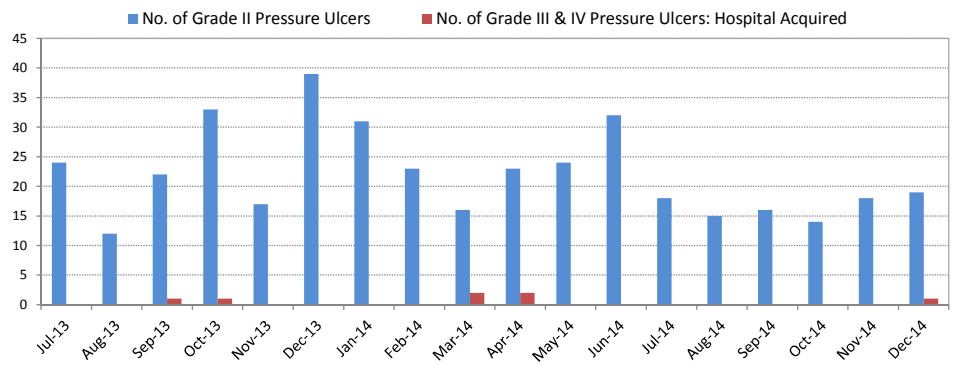
Global Trigger Tool



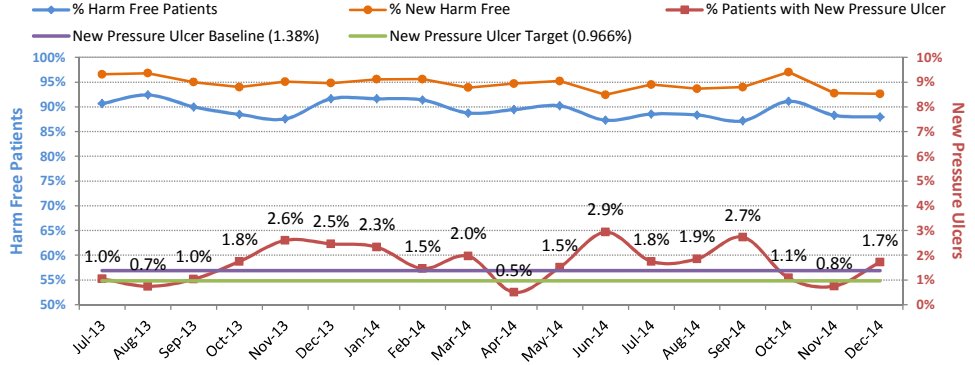
Venous Thrombous Embolism: Risk Assessment & Prophylaxis



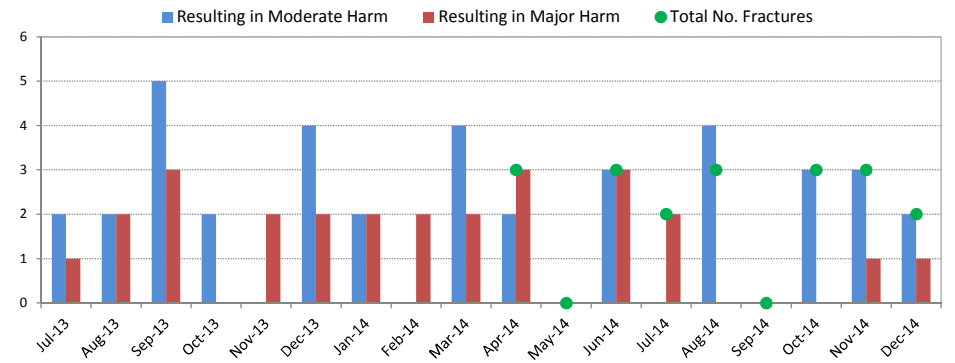
Pressure Ulcers - Total Number per Month



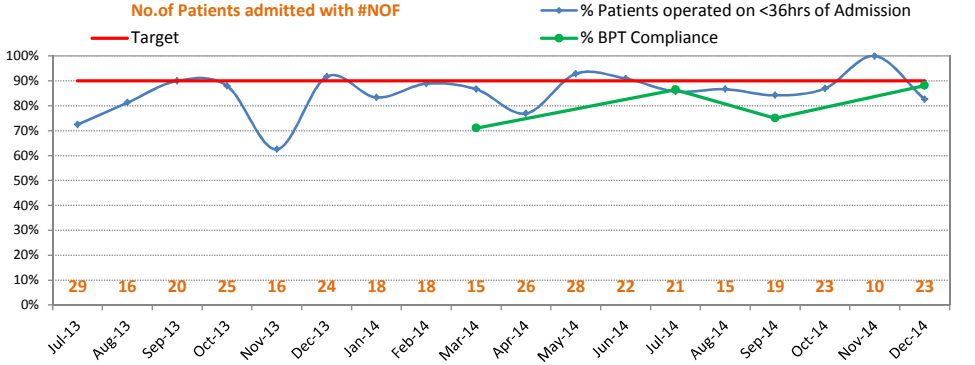
Safety Thermometer - One Day Snapshot per Month



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



Fracture Neck of Femur operated on within 36 hours

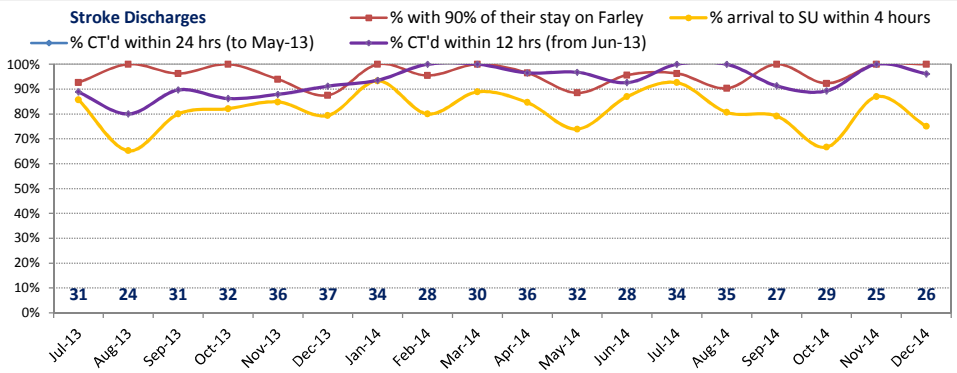


Salisbury NHS
NHS Foundation Trust

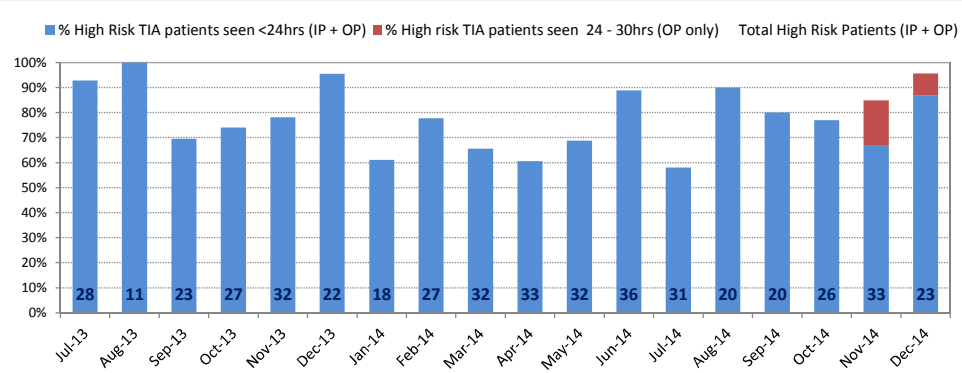
Trust Quality Indicators - December 2014

Quality Measures

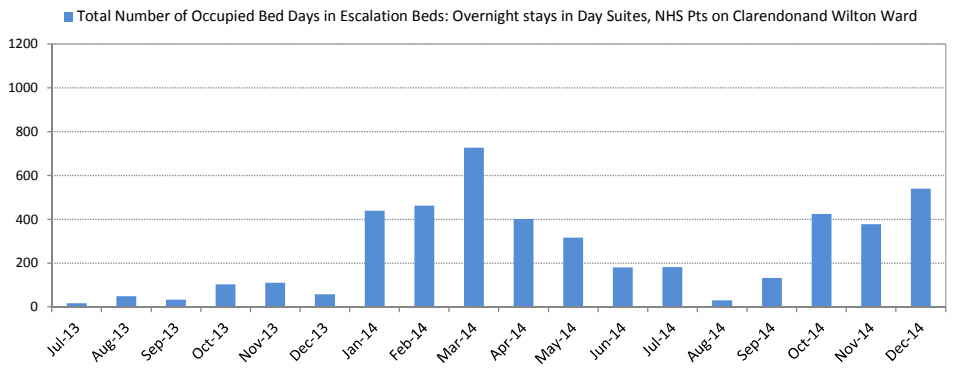
Stroke Care



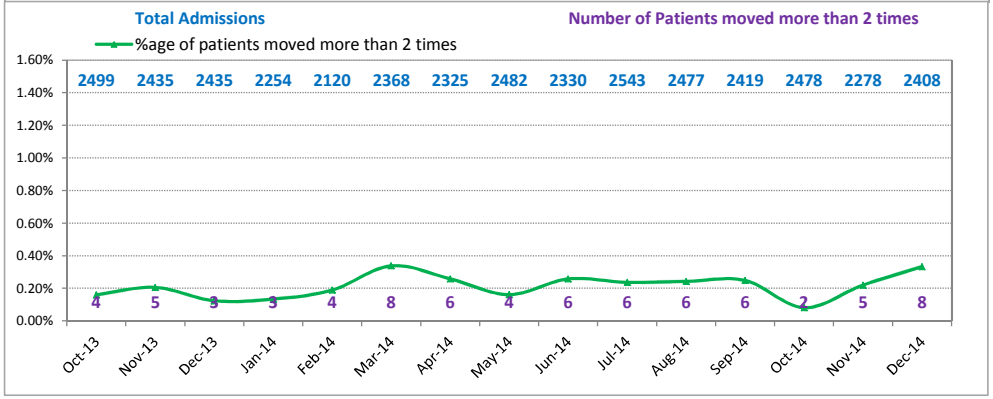
TIA Referrals



Escalation Bed Days

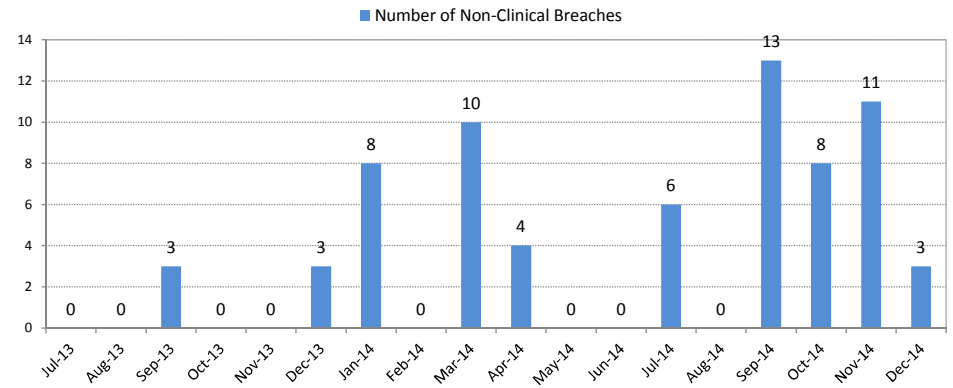


Patients moving multiple times during their Inpatient Stay

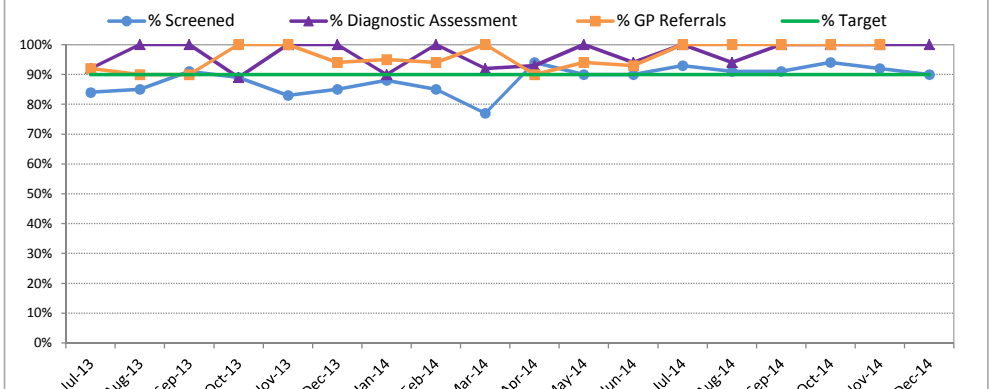


Please note, from Sep-14 escalation bed capactity is Winterslow 8 beds, Wilton 12 beds and DSU if it stays open at night. Breamore ward will be open from 1st January 2015 to 31st March 2015 with a further 27 escalation beds.

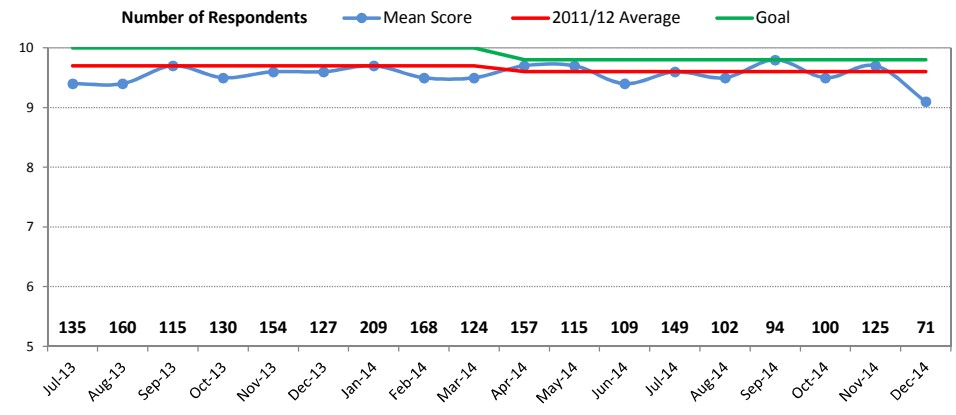
Delivering Same Sex Accommodation



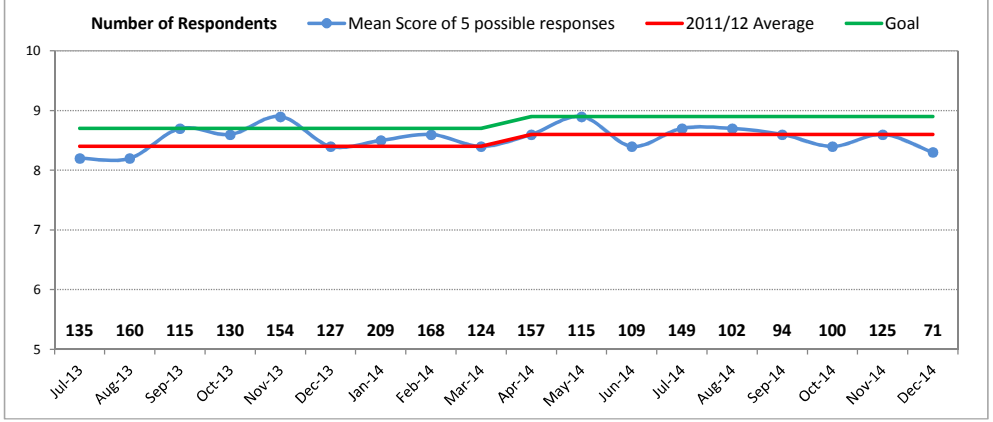
Dementia Audit of Patients Aged 75+



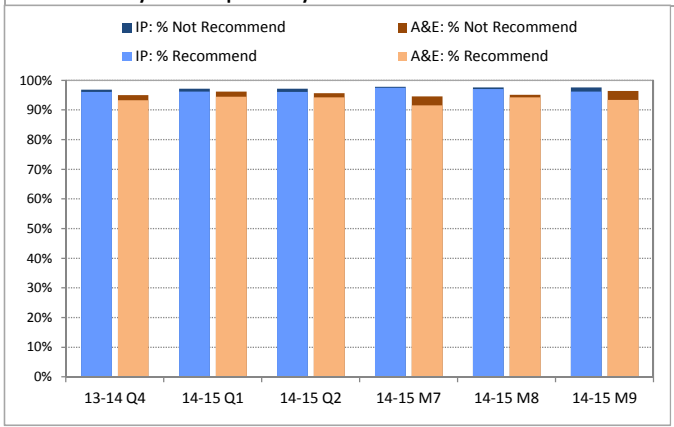
Real Time Feedback: Are you being treated with care and compassion?

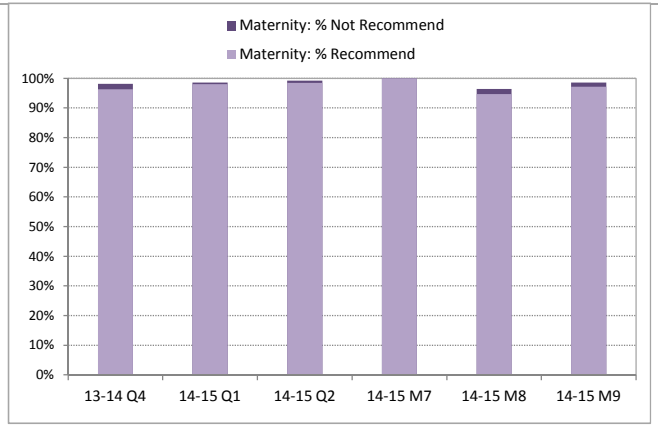


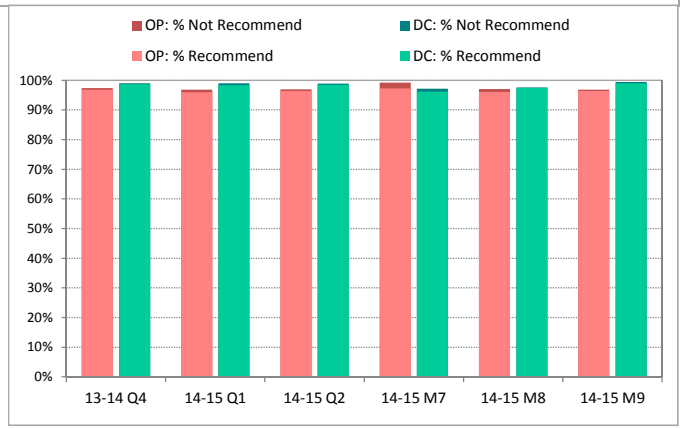
Real Time Feedback: Overall how would you rate the quality of care you received?



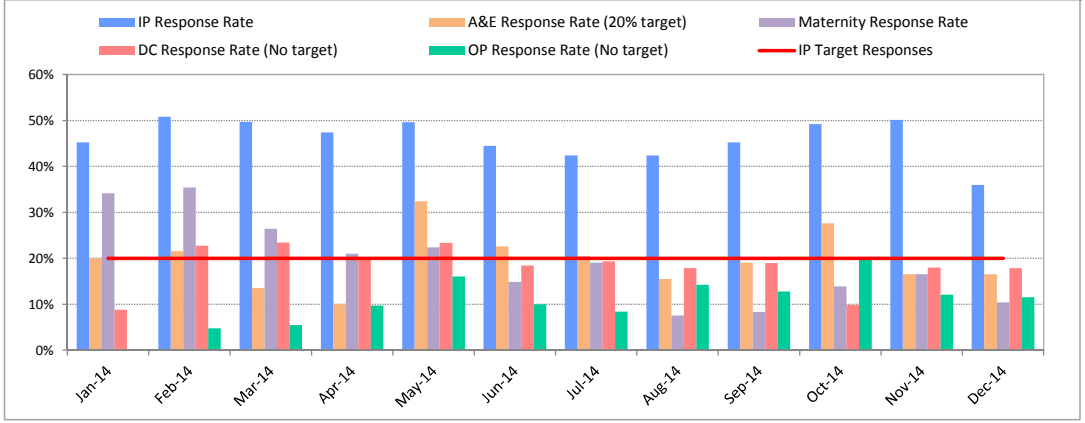
Friends & Family Test: Responses by Area



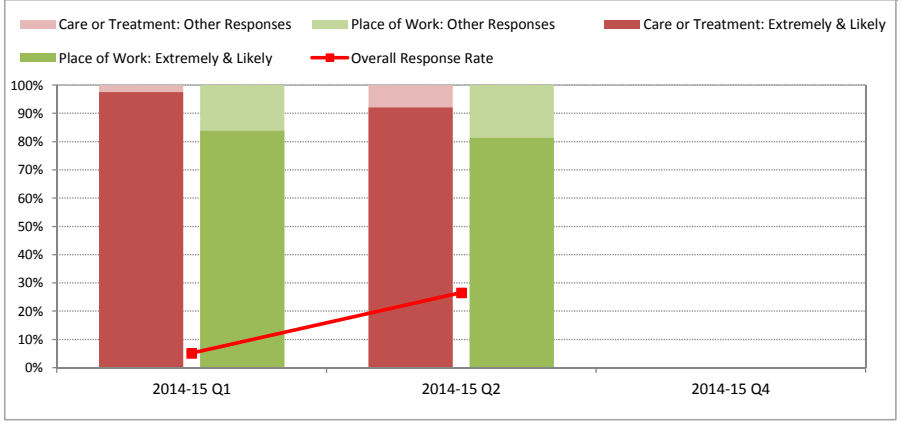




Friends & Family Test: Response Rates (%) by Area



Friends & Family Test: Staff (% Responses)



From October 2014 the Net Promoter Score (NPS) is no longer being used as a headline score.
The new score measures the % Recommended (Likely + Extremely Likely) and the % Not Recommended (Unlikely + Extremely Unlikely) to show the pecentage of responses that would or wouldn't recommend the Trust.
Don't Know and Neither Likely or Unlikely responses are excluded from this measure.

CUSTOMER CARE REPORT - Quarter 2 (1 July – 30 September 2014)

Date: 2 February 2015

Report from: Hazel Hardyman
Head of Customer Care

Presented by: Lorna Wilkinson
Director of Nursing

Executive Summary:
The main issues from complaints are:

- Clinical treatment (30) - sub-themes were 16 unsatisfactory treatment across 13 different specialties, 5 correct diagnosis not made, 4 further complications, 3 delay in receiving treatment, 1 pain management and 1 wrong information.
- Staff attitude (18) - 9 of these related to medical staff, 6 to nursing staff, 2 to administrative staff and 1 to other.
- Appointments (9) – sub-themes were 5 delays, 2 cancelled and 2 appointment procedures across 9 different specialties.
- Communication (9) – sub-themes were 2 information not given, 2 lack of communication, 2 wrong information and 2 insensitive communication and 1 delay in sending/receiving information.

Proposed Action:
To note the report.

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

Appendices:
None

Supporting Information
None

Customer Care Report - Quarter 2
1 July – 30 September 2014

PURPOSE OF PAPER:

- The purpose of the paper is to update the Board with an analysis of the Quarter 2 complaints data.

MAIN ISSUES:

The main issues from complaints are:

- Clinical treatment (30) - sub-themes were 16 unsatisfactory treatment across 13 different specialties, 5 correct diagnosis not made, 4 further complications, 3 delay in receiving treatment, 1 pain management and 1 wrong information.
- Staff attitude (18) - 9 of these related to medical staff, 6 to nursing staff, 2 to administrative staff and 1 to other.
- Appointments (9) – sub-themes were 5 delays, 2 cancelled and 2 appointment procedures across 9 different specialties.
- Communication (9) – sub-themes were 2 information not given, 2 lack of communication, 2 wrong information and 2 insensitive communication and 1 delay in sending/receiving information.

81 complaints were received in quarter 2. This compares to 79 complaints in quarter 1 (2014-15) and 88 complaints for the same period in the previous year. A breakdown of numbers and themes according to Datix is below.

	Clin Supp & Family Services	Contractor	Medicine	Musculo-Skeletal	Surgery	Total 2014-15	Total 2013-14
Admission	0	0	0	1	0	1	1
Appointments	3	0	0	3	3	9	8
Attitude of staff	4	0	9	1	4	18	15
Call bells	0	0	1	0	0	1	0
Child Protection	0	0	0	0	0	0	1
Clinical Treatment	5	0	9	8	8	30	36
Communication	2	0	1	2	4	9	9
Confidentiality	0	0	0	0	0	0	1
Delay	2	0	0	2	0	4	1
Dementia	0	0	0	0	0	0	1
Discharge arrangements	0	0	1	0	0	1	4
End of life care	0	0	2	0	0	2	2
Facilities on site	0	0	0	0	1	1	0
Falls	0	0	1	0	0	1	0
Infection Control	0	0	0	0	0	0	1
Information	0	0	0	0	0	0	2
Nursing Care	0	0	1	0	0	1	2
Operation	0	0	0	1	0	1	2
Privacy and Dignity	0	0	0	0	0	0	1
Property	0	0	0	0	0	0	1
Transport	0	1	0	0	0	1	0
Waiting time	0	0	0	0	1	1	0
Totals:	16	1	25	18	21	**81**	**88**
Patient Activity	6192	0	20324	17182	13648		

In Quarter 2, the Trust treated 16,206 people as inpatients, day cases and regular day attendees. Another 11,678 were seen in the Emergency Department and 45,669 as outpatients. 81 complaints were received overall which is 0.1% of the number of patients treated. 654 compliments were received across

the Trust in Q2, which represents 0.9% 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.

93.8% of complaints were acknowledged within three days. Improvements should be seen in Q3 with the Complaints Co-ordinator in post from 1st October 2014.

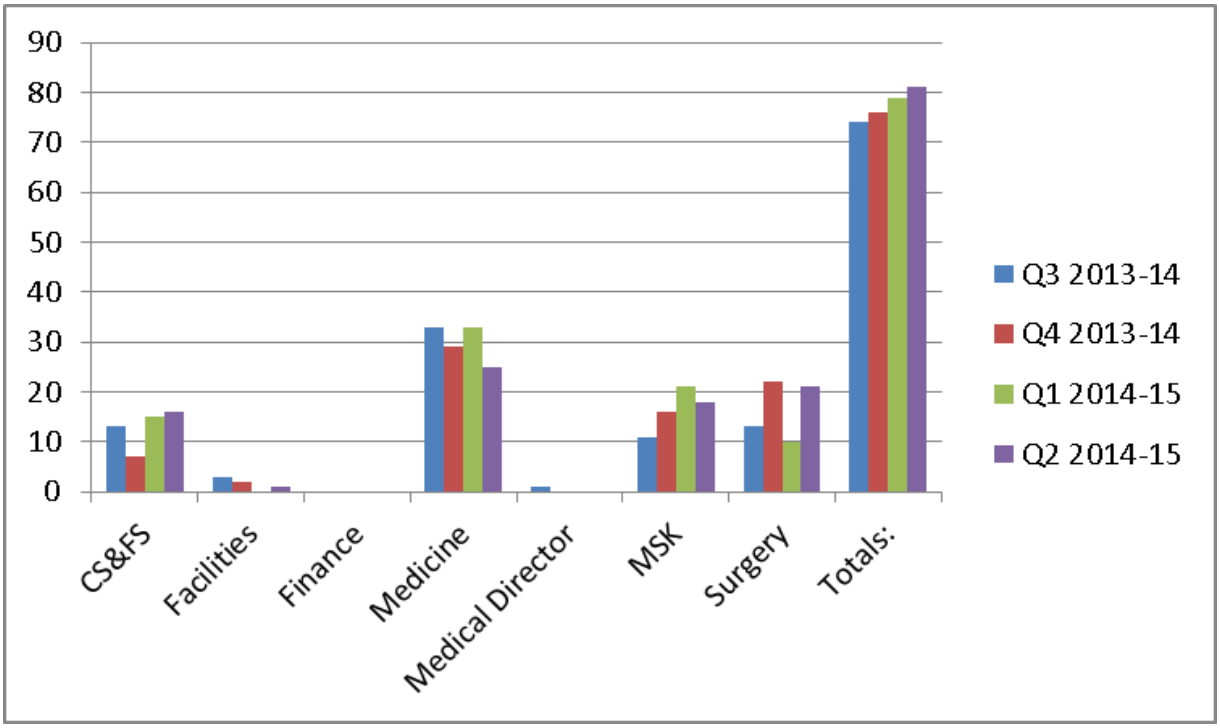
The overall number of enquiries, comments, concerns and complaints response times:

0-10 working days		10-25 working days		25+ working days	
271	68.09%	60	15.08%	67	16.83%

Reasons for some complaints taking more than 25 working days to respond to include: arranging meetings; joint investigation with another organisation; clinical review; and awaiting comments from key members of staff.

COMPLAINTS BY DIRECTORATE

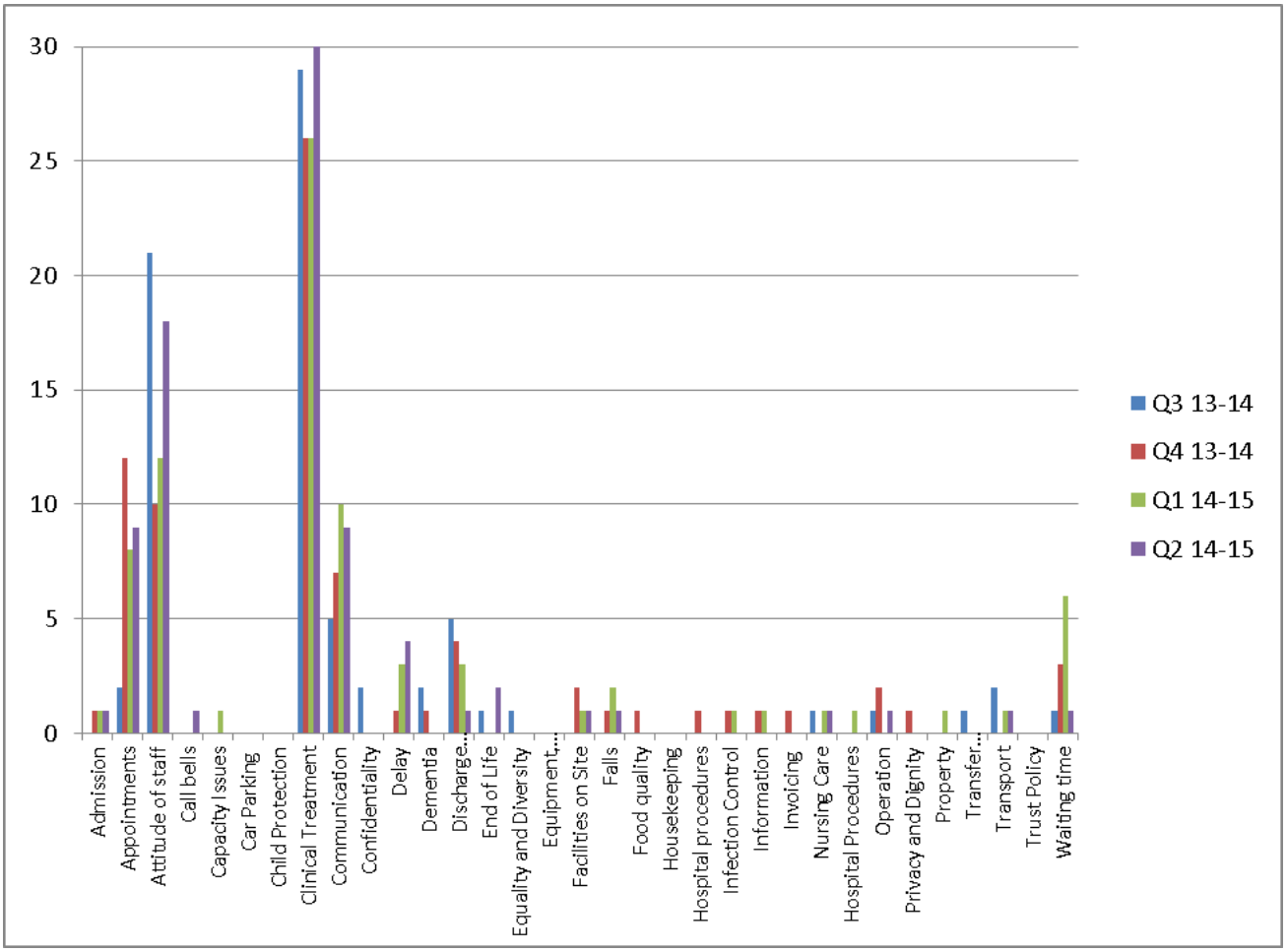
The following graph shows the trend in the number of complaints by directorate over the last four quarters.



A template has been trialled for the dip sampling exercise this quarter. The template is based on the Patient Association Standards and involves an assessment of the quality of the investigation, the judgement exercised by the decision maker/investigator, the level of detail contained in the investigation report, the response by the organisation to the complaint and evidence that lessons have been learnt. The use of the template and the findings from the complaints examined will be discussed with the Director of Nursing and Head of Customer Care.

COMPLAINTS BY SUBJECT

The following graph shows the trend in complaints by subject over the last four quarters. Complaints about staff attitude (18) have increased by 6 since Q1 (12). Mystery shopping has been undertaken in the Emergency Department and will be followed-up with customer care training at the end of January 2015. Waiting time complaints have dropped from 6 in Q1 to 1 in Q2.



CLINICAL SUPPORT AND FAMILY SERVICES

	Quarter 2 2013-14	Quarter 1 2014-15	Quarter 2 2014-15
Complaints	7	15	16
Concerns	24	15	16
Compliments	40	140	51

The Directorate received 16 complaints in Q2 and 16 concerns. Of the 16 complaints, 6 had a late response. Of the 16 concerns, 3 had a late response.

The most prominent department in this quarter was Radiology with 4 complaints and 8 concerns in the period. The issues were about appointments (5), attitude of staff (2), clinical treatment (2), communication (2) and invoicing (1). There was no particular pattern or theme identified for these but the numbers will be monitored carefully by the Radiology management team.

Gynaecology received 3 complaints, Fertility 2 complaints as well as one concern. The Fertility complaints relate to funding issues and this is a challenging area, given the number of self funding patients using the service. The NHS commissioned fertility work is also a complicated area with each CCG having differing commissioning criteria.

General actions

Review Quarter 2 complaints at the Radiology DMT meeting and to explore with the Fertility Service whether it is possible to communicate more clearly around funding arrangements. The DMT to raise the issue at regular monthly business meeting.

DMT to review their process for complaint management to ensure responses are out within the agreed timescale and explanations are provided for any predicted late responses before the due date.

MEDICINE DIRECTORATE

	Quarter 2 2013-14	Quarter 1 2014-15	Quarter 2 2014-15
Complaints	39	33	25
Concerns	26	35	27
Compliments	186	285	162

Summary

- Complaints reduced in Q2 despite the Directorate remaining very active.
- Directorate is proactive in trying to address potential complaints at source to prevent them becoming a formal complaint.
- The Directorate is trying to work closely with its named Customer Care Advisor to improve the management of complaints including early and local resolution with an aim to attend the DMT meeting monthly and undertake regular walkabouts in the Directorate.
- New Directorate Administrator developing a system to track and manage complaints and will work with the newly appointed Assistant Directorate Manager on this project.
- Highest number of complaints in Emergency Department (ED) - but this correlates to the number of attendances through the Department.
- Themes of all complaints in ED are displayed on the Matron's noticeboard within the Department.
- Ward with most complaints is Pitton – recently had leadership changes and new Band 7 has been appointed.
- More complaints relate to medical staff and care rather than nursing.

Themes and Actions

Department/Ward	Topic	Actions
Emergency Department	Attitude of reception staff	• Customer Care training for admin staff in the ED • Mystery shopper exercise to take place in the Department with Customer Care • All staff fully involved in the investigation • Feedback will be shared across ED team
Emergency Department	Missed or delayed diagnosis	• Lead Clinician for ED working with Radiology, ED Consultants and ENP team to improve accuracies and timely diagnoses although recognised incidents will occur on occasions
Complaints more common relating to medical teams and medical care	Various	• DMT and Customer Care Advisor to review themes of complaints to identify future actions
General Ward Areas	Discharge plans	• Discharge Planning Workshop originally planned for 8th September 2014 was cancelled due to staffing issues and now due to take place on 3rd December 2014

MUSCULOSKELETAL DIRECTORATE

	Quarter 2 2013-14	Quarter 1 2014-15	Quarter 2 2014-15
Complaints	20	21	18
Concerns	34	8	25
Compliments	140	156	86

- Many of the logged concerns were dealt with via the Customer Care team and Helpdesk (14) with 11 responses either written, verbal or both provided by the DMT.
- Seven complaints have been re-opened with four relating to further questions regarding treatment and three regarding delays or cancellation. One of these has resulted in three meetings with the family of a deceased patient. The re-opened complaints are within Orthopaedics, Plastics, Dermatology, Laverstock, Chilmark and Dermatology.
- Orthopaedics and Plastics continue with the highest numbers. Orthopaedics received five complaints and three concerns, Plastics received seven complaints and one concern.
- The Directorate is continuing to offer meetings to patients and families in an attempt to answer questions and help to clarify any possible resolution. There have been seven meetings this quarter with one patient who met with the DSN, DM and Deputy Director of Nursing on several occasions during admission (Spinal Unit).

General actions

- Eight of the complaints/concerns were in relation to delays or cancellation to planned procedures. Although an improvement on this theme from the previous quarter, this remains on the Directorate Risk Register.

- Work is ongoing with the Theatre Transformation Workstream and the review of job plans with recruitment of consultants. The DMT continue to address these by telephone contact where possible and expedite appropriate appointments.

Themes and actions

Department/Ward	Topic	Actions
Orthopaedic Inpatients	Staff attitude	Complaint shared with the team. Behaviours also discussed via appraisal.
Orthopaedic Outpatients	Unhappy with treatment	Meeting with complainant to discuss infection concerns. Ensure patients given clear information regarding infections.
Spinal	Concerns regarding psychiatric care	Meeting with family complete. Further review from Mental health Liaison Team.
Plastics Inpatients	No communication regarding change in treatment and pain during procedure	Discussed at Clinical Governance session. Agreed staff actions for future occurrences.
Plastics Outpatients	Incorrect referral for Orthotics Breakdown of consultant/patient relationship	• Dissemination of referral process. • Transfer of care within team.
Dermatology	No face guard provided during treatment (2 examples in this quarter)	Review of protocol completed and introduction of 'STOP' moment.

SURGICAL DIRECTORATE

	Quarter 2 2013-14	Quarter 1 2014-15	Quarter 2 2014-15
Complaints	20	10	21
Concerns	22	26	34
Compliments	305	430	347

- The Surgical Directorate received 21complaints and 34 concerns in quarter two.
- Three complaints were re-opened in this period. Two patients requested compensation and one was due to the patient's upset following an internal examination, which was subsequently considered resolved by the patient.

Directorate challenges

- The use of agency locums has caused delays in responding to some complaints within the required timescales. Partial responses are however sent where possible.
- Patients are raising concerns regarding their experience of some of the Ophthalmology locum staff in terms of high quality care and communication.

Themes and actions by area

- Ophthalmology has been highlighted this quarter with patients raising concerns regarding their experience under locum clinicians. All patient complaints are fed back to the appropriate locum agency and the locum staff approached for comment. Patient experiences have also been fed back to the Head of Service for Ophthalmology and the tasks of locum staff have been reviewed as a result. Ophthalmology is in the process of recruiting substantive and fixed term additional staff with one substantive Consultant taking up post in November.

TRUSTWIDE FEEDBACK

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 Communication	• No themes. • All patient complaints are fed back to staff/locum staff who are asked to comment. Mystery shopping is being undertaken to help inform training needs for a particular area/group of staff. • No themes. • No themes.
Inpatient RTF	Noise Environment Call bells	• These themes are the same as reported in the Q1 report. See below.
FFT Maternity Emergency Department Inpatients	 Delay in discharge Waiting Noise	• Actions taken as a result of negative feedback are currently not recorded. A 20% response rate must be achieved for these areas and those that did not meet it have been reminded of the importance of giving patients the feedback cards. See below.

Action is taken wherever possible to address patients' concerns. Specific actions taken for the four areas with the highest number of negative comments are detailed below.

Cleaning standards are regularly audited by all ward leaders. Housekeeping Services aim to resolve all issues raised immediately if possible or within 24 hours of being made aware. Feedback from patients is always taken very seriously and members of the public are involved in the internal Patient-Led Assessment of the Environment (PLACE) auditing system.

Audits on response times for call bells are regularly undertaken. A recent audit on Amesbury Suite showed that bells were responded to within five minutes in 96% of cases. Redlynch Ward has been able to significantly reduce the response times during the day. However, due to the current skill mix, call bell answering times have increased at night. This will be investigated further at their next skill mix review. Winterslow Ward are planning to trial a more interactive form of intentional rounding on a specific bay of patients to see if this will reduce the use of call bells. If this proves successful, it will be rolled out across the ward.

Environmental issues relate mainly to the condition of the bathrooms with some not being suitable for wheelchair access, and lights being left on at night.

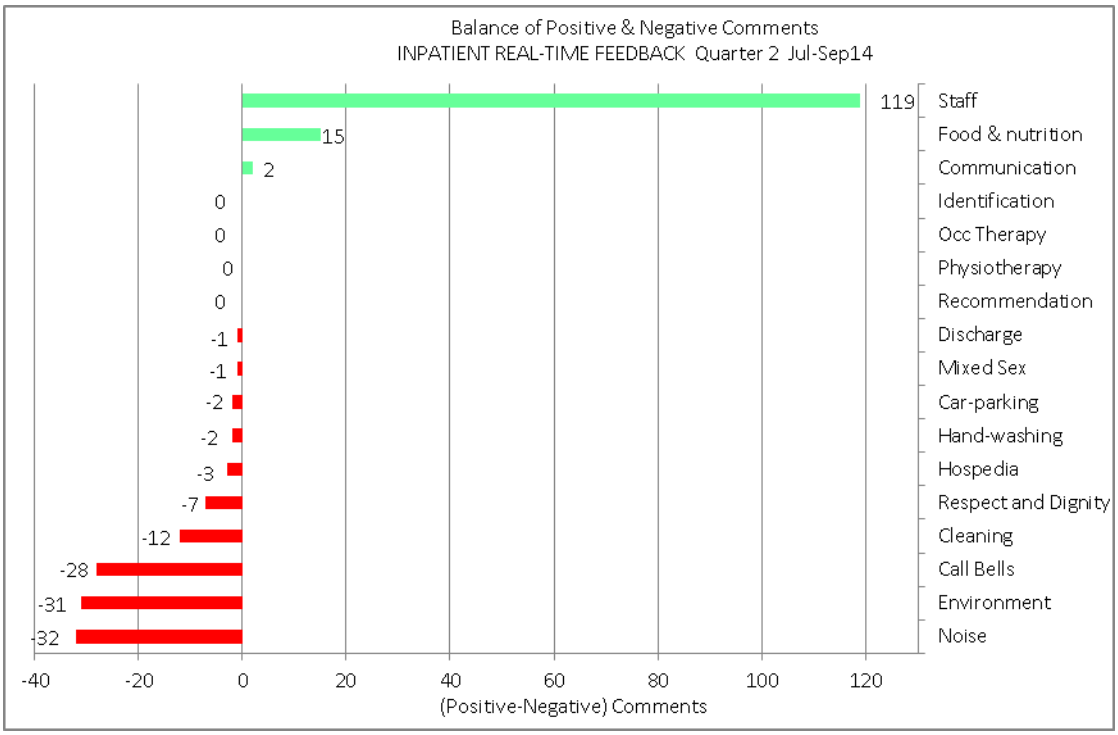
Redlynch Ward has recently been refurbished. Wet rooms, suitable for wheelchairs, are now accessible to all patients. Pitton Ward did have a period where the plumbing was frequently blocking and causing sewage leaks. This has now been rectified. The Senior Sister checks the bathrooms daily and has had no recent complaints. Unfortunately, the ensuite bathrooms are not large enough to easily manoeuver a wheelchair but there is access to a male and female bathroom for wheelchair users elsewhere on the ward.

The lights need to be kept on at night on Redlynch Ward due to the acuity of the patients and to ensure the safety of those who are confused and walking with purpose. However, the lights are dimmed and a risk assessment is carried out on each shift to see if they can be turned off for a period of time.

Patients on Britford Ward have complained about the noise from the Laundry. Work has been undertaken to reduce the noise levels as much as possible but difficulties remain when steam is released under pressure, particularly between 0100 and 0500 hours. This will continue to be monitored. For a period of time, the call bells on Pitton Ward were faulty and emitted a high pitched shrill. This problem has now been rectified.

INPATIENT REAL TIME FEEDBACK

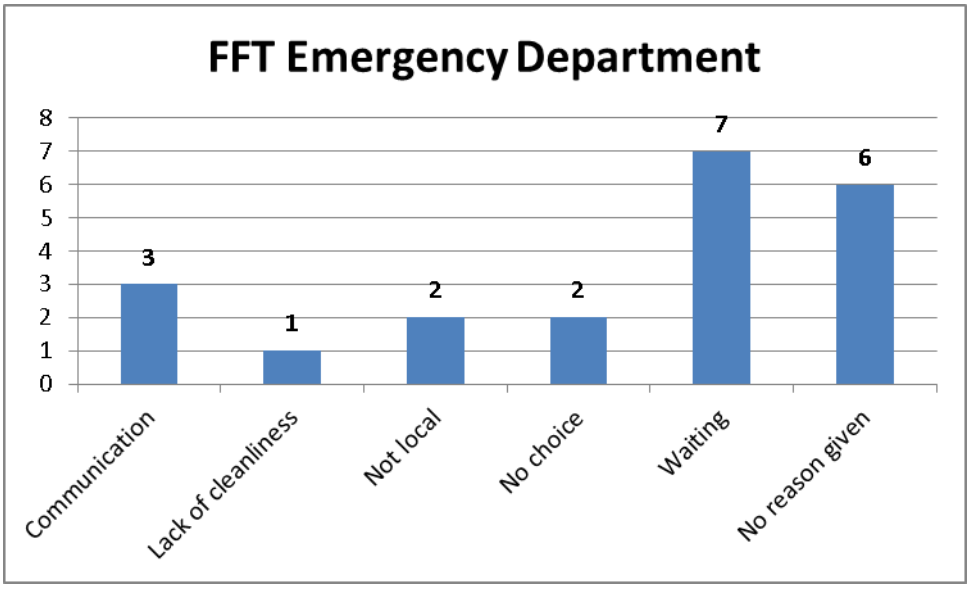
A total of 332 inpatients were surveyed in the quarter. They made 219 positive and 192 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below. The three main areas of concern were noise, environment (mainly fabric of ward, lights on at night, noise from faulty call bells) and call bells.

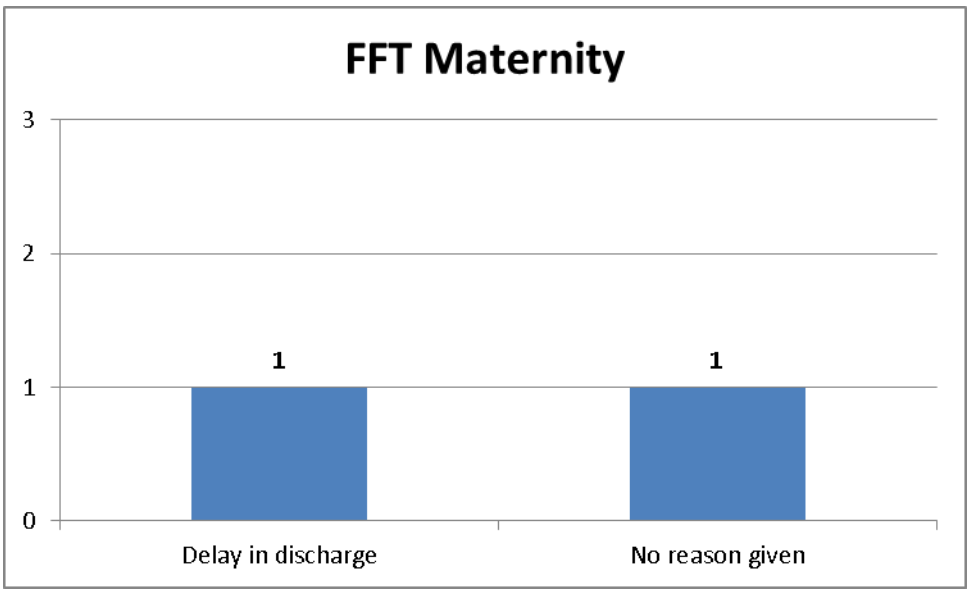


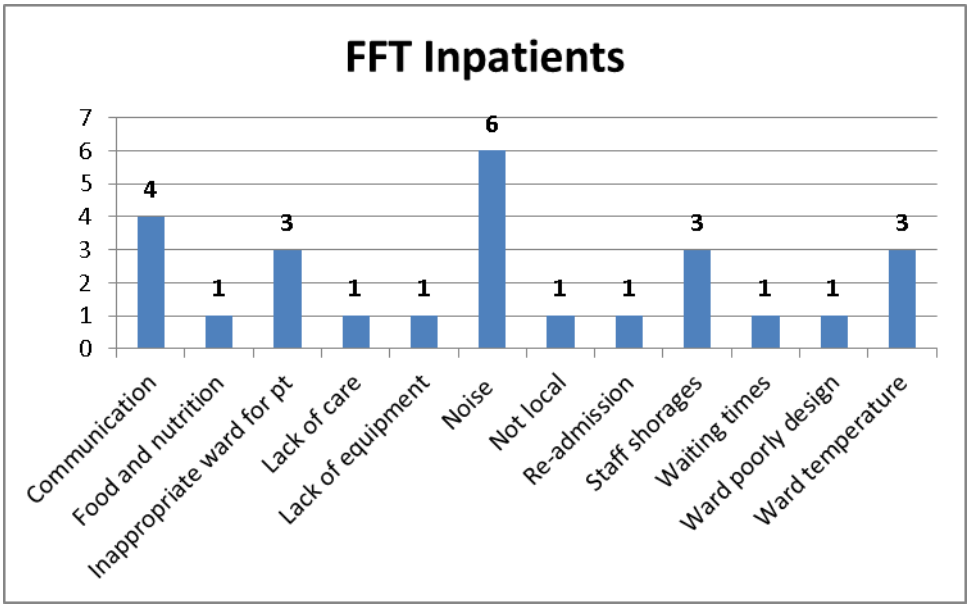
FRIENDS AND FAMILY TEST
Responses for the period were as follows:

		Rating			
	Total Responses Received	Extremely Likely	Likely	Unlikely	Extremely Unlikely
Inpatients	1511	1180	272	11	6
Emergency Department	1398	1035	283	7	13
Maternity	263	220	39	1	1

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.







COMPLAINTS WORKSHOP

A complaints workshop was held on 9th October 2014 which was well attended. The objective was to agree minimum standards for the complaints process going forward and an action plan has been developed. It was agreed that a resource page on the Intranet would be useful for staff dealing with concerns and complaints. Good practice for sharing complaints with staff was discussed by individual areas and this is currently being reviewed through the nursing strategy meetings.

PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

In Q2 there were two new requests for independent review (one for Clinical Support and one for Musculo-Skeletal). Of the two outstanding cases from 2013-14, the Trust has had the opportunity to comment on both draft reports.

The PHSO has launched 'My expectations for raising concerns and complaints' in conjunction with the Local Government Ombudsman and Healthwatch. It describes what good looks like from the perspective of people who wish to raise a concern or make a complaint about health or social services. The report is available at http://www.ombudsman.org.uk/myexpectations

The PHSO has also published a report on 'Complaints about acute trusts 2013-14' which provides a summary of the key statistics collected about enquiries they receive and the investigations they undertake. As part of their move to provide regular statistics on the information they get from trusts, the report also discusses the complaints received in Q1 and Q2 2014-15. The report is available at http://www.ombudsman.org.uk/reports-and-consultations/reports/health/complaints-about-acute-trusts-2013-14-and-q1-and-q2-2014-15

REVISIONS TO THE NHS WRITTEN COMPLAINTS DATA COLLECTION (KO41A)

As part of the Government's response to the Francis and Clwyd/Hart reviews, complaints data will be published quarterly for all NHS organisations. The current K041A data collection is not fit for purpose as it does not put the number of complaints received into context for example, the size or an organisation or the number of patients seen.

The Department of Health have been working with the Health and Social Care Information Centre (HSCIC) to review the complaints data currently collected. The proposed changes will come in on 1st April 2015 and the collection will move from annually to quarterly.

The main aim of the revisions to the complaints data collection is to provide more relevant data without imposing an undue additional burden on data providers.

The HSCIC is in discussion with the major system providers on the development of a script to automatically extract the data. These changes should make data more accurate and relevant to the NHS and its service users, for example, complaints data can be seen in context and comparisons between similar organisations can be made.

NHS CHOICES WEBSITE

In Q2 there were 15 comments posted on the NHS Choices website relating to nine different areas. Of the 11 positive comments, one person said “I was looked after superbly by a dedicated team of professionals who did their job on their long shifts with dignity, pride and delicate, gentle care”. There were also four negative comments and these people were invited to raise their concerns via the Customer Care Department. One person said “My mother’s experience as an elderly patient with dementia has been awful and what I have seen with my own eyes happening to other patients being left in toilets with buzzers going for 15 minutes or so, mixed up notes etc.” All the feedback was shared with the departments.

ACTION REQUIRED BY THE BOARD: to note the report

AUTHOR: Hazel Hardyman
TITLE: Head of Customer Care
DATE: January 2015

Trust Board meeting **SFT 3623**

PATIENT SAFETY UPDATE

Date: 2 February 2015

Report from: Lorna Wilkinson, Director of Nursing

Presented by: Lorna Wilkinson, Director of Nursing

Executive Summary:
The Trust has had an extensive patient safety programme in place for five years which has made positive improvements in patient safety. This programme was initially facilitated and hosted by the South West Strategic Health Authority.

During 2014 a national 'Sign up to Safety' campaign was launched as well as 15 regional Patient Safety Collaboratives, hosted by Academic Health Science networks.

This paper provides a briefing on the Trust's sign up and inclusion in both of these initiatives.

Proposed Action:
The Board is asked to note:

- The positive progress made through the South West Patient Safety Programme which ran from 2009-2014.
- That the Trust has now made public it's Sign up to Safety pledges and has produced a detailed underpinning Safety Improvement Plan 2015-2018, which is being presented to Clinical Governance Committee in January 2015.
- The Director of Nursing is a representative on the regional Patient Safety Collaborative Steering Group

Links to Assurance Framework/ Strategic Plan:
Care – we will treat our patients with care, kindness, and compassion, and keep them safe from avoidable harm

Appendices:

Salisbury NHS
NHS Foundation Trust

Sign up to SAFETY
LISTEN LEARN ACT

Patient Safety Update – Briefing to Board

February 2015

At the Trust Board meeting in August 2014 the national Sign up to Safety Campaign was presented. It was agreed that the Trust (SFT) would sign up to this campaign during the latter months of 2014.

This paper provides a briefing as to how this work has progressed.

1. Background:

The Trust has been an active partner in the South West Patient Safety Programme for its 5 year duration 2009-2014. This programme was initially facilitated and hosted by the South West Strategic Health Authority and latterly Royal United Hospital Bath. This programme has underpinned the safety improvement work which has seen ongoing reductions in hospital acquired pressure ulcers, falls, cardiac arrests, and infections.

During 2014 Sign up to Safety was launched as a national campaign with an aim to:

- Halve avoidable harm over the next 3 years
- Save 6000 lives as a result

In order to sign up to the campaign each organisation must describe its pledges under the following 5 headings:

- Put Safety First
- Continually Learn
- Honesty
- Collaboration
- Support

In order to identify the patient safety workstreams described within our Sign up to Safety pledges the Trust has carried out an in depth stock take of the results from the 5 year south west programme, internal incidents, complaints and claims data, and consulted with key staff groups, facilitated through the Clinical Risk Group. This work has been completed and was

ratified at the December Trust Board with subsequent posting onto the Trust website.(http://www.salisbury.nhs.uk/whychooseus/pages/keepingyousafe2.aspx)

Next Steps:

- A Safety Improvement Plan setting out the detail of what SFT is aiming to achieve over the next 3 years has been produced and is being presented to the Clinical Governance Committee in January 2015. Workstream clinical leads have been identified.
- In order to raise internal awareness this information is also being presented at the January Clinical Governance half day
- The Safety Steering Group is being re-established from February 2015, to ensure that there is ongoing drive and monitoring of the safety work. This group will be chaired by the Director of Nursing as the Executive lead.

Wessex Patient Safety Collaborative:

In parallel to Sign up to Safety, 15 regional Patient Safety Collaboratives have been identified across the country. These are hosted by the Academic Health Science Networks (AHSN) so for Salisbury this is the Wessex AHSN. The Patient Safety Collaboratives will support safety workstreams across the region and across organisational boundaries. Lorna Wilkinson has been invited to be the acute Director of Nursing representative on the Wessex Patient Safety Collaborative Steering Group. This ensures that Salisbury maintains an active role in the regional work.

Conclusion:

The Trust has a positive track record in improving patient safety, as evidenced through the outcomes of the South West programme. SFT has now joined the national Sign up to Safety campaign and published the 5 pledges which are available on the Trust website. Detailed work has been undertaken in order to ensure appropriate workstreams have been prioritised to achieve the stated aims of halving avoidable harm in NHS care and a Safety Improvement Plan has been developed in order to detail how this will be achieved.

SFT is well placed with executive level representation on the regional Patient Safety Collaborative Steering Group.

Therefore in conclusion the Trust is in a good position to continue to drive patient safety improvements across the Trust.

Trust Board meeting **SFT 3624**

Draft Finance & Performance Committee minutes – 22 December 2014

Date:	2 February 2015

Report from:	Nick Marsden, Chairman

Executive Summary:

The draft minutes, due to be confirmed by the Committee on 2 February are attached.

There is good progress on achieving CQUIN. The committee continues to monitor the progress of the transformation and cost improvement schemes.

The committee approved the formation of a new company to take forward the My Trusty brand.

The consultation on the 2015/16 tariff was discussed, along with other anticipated budget pressures. The committee agreed that the Director of Finance & Procurement should submit an objection to the 2015 tariff proposals.

Proposed Action:

To note the minutes and endorse the action taken in relation to responding to the consultation on the 2015/16 tariff.

Links to Assurance Framework/ Strategic Plan:

Appendices:
Finance & Performance Committee – draft minutes 22 December 2014

SALISBURY NHS FOUNDATION TRUST

SFT 3624

Minutes of the Finance and Performance Committee held on 22 December 2014

Present:	Dr N Marsden	Chairman
	Mr A Freemantle	Non-Executive Director
	Mr L Arnold	Acting Chief Operating Officer
	Mr P Hill	Chief Executive
	Mr I Downie	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
Apologies:	Dr L Brown	Non-Executive Director
	Rev S Mullally	Non-Executive Director
In Attendance:	Mr D Seabrooke	Head of Corporate Governance
	Mr M Ace	Associate Executive Director
	Mrs L Wilkinson (for item 4)	Director of Nursing
	Mrs C Gorzanski (for item 4)	Head of Clinical Effectiveness

1. MINUTES – 24 NOVEMBER 2014

The minutes of the meeting held on 24 November 2014 were agreed as a correct record.

2. MATTERS ARISING

It was noted that a proposal regarding the Sterilisation and Disinfectation Unit development proposals is due to be made at the 26 January 2015 meeting of the Committee.

3. CQUIN – MONTHLY UPDATE

The Committee received the CQUIN update for Month 8.

The following principal points were made –

- There was good progress on the national CQUINs – there was a requirement to raise the level of participation in the A&E Friends and Family Test to 20%.
- The Trust continued to work towards targets related to Sepsis 6 – it was noted that the hour target ran from when Sepsis was diagnosed.
- There was good progress on CQUINs from West Hampshire.
- Both Wiltshire and West Hampshire had made Quarter Two CQUIN payments.
- Discussions about 2015/16 CQUINS had begun with Acute Kidney Injury, the Deteriorating Patient, Mental Health Clarity and End of Life Care as potential themes.

The Committee noted the CQUIN Report.

4. FINANCE REPORT TO 30 NOVEMBER (MONTH 8)

The Committee received the Finance Report. It was noted that there was now a deficit of £576,000, which reflected a deteriorating position. Variations in reported activity on individual wards were being investigated.

On cost improvement programmes the Trust was £600,000 behind plan. A £1.1m reduction in agency spend had been targeted but this simply reduced budget overspends rather contributing to cash releasing savings. Nursing budgets were within expected parameters but the reflected the additional £800,000 investment agreed by the Board. There continued to be good engagement and clear messaging from the Programme Steering Group and the Executives were considering where additional specialist resources could be deployed to drive out further savings.

There was still concern about the spend on medical locums. For example spend in Gynaecology was due to the requirement to cover long term sickness. It was also noted that there had been a 13% increase in clinical supplies costs which was attributed to more day case activity and more outpatient initial attendances, more diagnostics and more chemotherapy. MC undertook to report back via email on the costs included in 'secondary commissioning of mandatory services'. MC

It was noted that Wiltshire CCG was now classed as challenged due to their missing financial targets by £2m. This was attributed to care home costs and GP prescribing.

Details were given about Monitor's 2015/16 tariff consultation. It had been recently confirmed that a 3.8% real terms reduction in the value of the National Tariff was proposed. The Tariff made no allowances for service developments such as seven day working and the impact of specialist commissioning was unclear at this stage. Approximately £140m of the Trust's income was gained via the Tariff. NHS providers (formerly the Foundation Trust Network) were engaging with the sector on its response to the Tariff proposals. It was agreed that MC would raise a formal objection to the 3.8% deflator based on the methodology used. MC

The Trust had been notified of a proposed increase of £2.3m in the CNST Premium following the removal by the NHSLA of the discount they had previously applied. MC would respond to this proposal but a significant increase could not be avoided. MC

The NHS Contract for 2015/16 had been published and it was noted that this now required providers to except all referrals made and made it mandatory for commissioners to raise fines on providers.

It was noted that the Trust would be required to fund the GHX Procurement system valued at £84,000 per year.

MC would explore obtaining a loan in 2015 up to £4m from the Independent Trust Financing facility in support of existing and emerging capital schemes. The Committee supported this. MC

The Committee agreed a proposal for MC to form a company to take

forward the My Trusty brand. It was noted that the company would be dormant initially.

With these actions approved, the Committee noted the Finance Report.

5. TRANSFORMATION AND COST IMPROVEMENT

The Committee received the report submitted to the December meeting of the Programme Steering Group. It was noted that the Transformation Schemes were £350,000 down against the planned (phased) Month 8 position. Existing savings schemes had been reviewed and the Programme Management Office had been further strengthened to support directorate management with key projects. Progress was being made with the centralisation of outpatients bookings but this was expected to be a challenging project. Outpatient kiosks had recently been implemented with good initial take up by patients.

Operational pressures had led to more cancellations of elective orthopaedic procedures resulting in lost income. However on outpatients there was more capacity for more new appointments because the rate of follow up appointments had been reduced.

Theatre productivity had improved but it was proving difficult to realise cash savings.

The Committee noted the Transformation and Cost Improvement Report.

6. OPERATIONAL PERFORMANCE – MONTH 8

The Committee received the Operational Performance Report.

It was noted that the Accident and Emergency Department was responding to the challenge of additional activity by initiatives around the early transfer of patients to specialties, emergency nurse practitioners (for minors) and breach coordinators working during the evening.

It was noted that there currently 20 Delayed Transfers of Care, 18 of which were related to Wiltshire. It had recently been reported that the conditions in relation to new clients imposed by the Care Quality Commission on Mears in Wiltshire had been lifted.

Cancelled operations in November and December were up.

The Committee noted the Operational Performance Report.

7. DATE OF NEXT MEETING

Monday 26 January 2015 at 9.30 am in the Boardroom.

Trust Board meeting **SFT 3625**

FINANCE & CONTRACTING REPORT TO 31 DECEMBER 2014

Date: 2 February 2015

Report from: MALCOLM CASSELLS **Presented by: MALCOLM CASSELLS**

Executive Summary:
The Trust is £1.1m in deficit after 9 months of the financial year. The reasons are explained in the paper. Forecast outturn is subject to a range of factors but is likely to be in the range between break even and a £2m deficit.

Proposed Action:
To note the report and consider further action to address the deficit.

Links to Assurance Framework/ Strategic Plan:

Appendices:

Appendix 1 – Summary Financial Activity & Budget position

Appendix 2 – Income & Expenditure

Appendix 3 – Capital Programme

Supporting Information

TRUST BOARD
2nd February 2015

FINANCE & CONTRACTING REPORT TO 31st December 2014

1. Introduction (Appendix 1 & 2)

This paper outlines the main drivers behind the Trust's reported financial position for the month ending 31st December 2014.

The Trust's Income & Expenditure (I&E) position was a Year-to-Date (YTD) deficit of £1,098k (before adjusting for donated income of £1,141k), an adverse variance against the plan of £1,792k.

The main reasons for the YTD adverse variance were:

- Cost Improvement Plans (CIPs) being behind plan by £756k on a phased basis and £1,517k on a straight line basis.
- Agency pay spend being higher than anticipated.
- Non-pay adverse variances
- Payment for excess non-elective work at 30% of tariff
- Higher volumes of unprofitable non-elective work replacing profitable elective work

Summary of Key Financial Information	YTD (Cumulative to M9)			
	Plan £000s	Actual £000s	Variance £000s	Variance %
Income	143,147	150,542	7,395	5.2%
Expenditure	131,346	140,545	-9,200	-7.0%
EBITDA	**11,802**	**9,997**	**-1,805**	**-15.3%**
Finance Costs	11,108	11,095	13	0.1%
I+E Surplus (+) /Deficit(-) excl donated asset income	**694**	**-1,098**	**-1,792**	**-258.2%**
Donated Asset Income Adjustment	1,100	1,141	**41**	**3.7%**
I+E position including donated asset income	**1,794**	**43**	**-1,751**	**-97.6%**

Income received for over-performance is not sufficient to cover the current monthly run rate of costs and therefore there needs to be an increased focus on delivery of CIPs and this is a major task given the current position.

Whilst income is ahead of plan, this has not resulted in the planned surplus being achieved.

The Trust is performing well on all NHS contracts although we have some contract challenges which have been allowed for.

CQUIN targets are very important in our financial position. Q1 has been paid in full and we expect to achieve the same for Q2. However there is a lot of work needed to ensure this continues into the third and fourth quarters.

The Trust's cash position at 30th November 2014 was £15,327k, which was an increase on the November figure of £1,078k due to receiving the resilience funding of £1.5m in full via Wiltshire CCG.

In terms of the Trust's forecast outturn the position is complex due to the potential effect of continued high non-elective activity. The aim must be to maximise elective activity during

the next few weeks. If this is achieved and costs contained better than we experienced in December then achievement of breakeven is realistic but it is unlikely that the plan can be achieved unless substantial additional income is received possibly via a national allocation. The likely outturn is in the range break even to a deficit of £2m.

2. Sales

NHS activity revenue was ahead of plan by £2,195k due to continuing activity over-performance and un-delivered Commissioner's Quality, Innovation, Productivity & Prevention (QIPP) schemes. All known penalties and fines relating to contract performance to date have been included.

Contract Activity Performance 2014/15 (December 2014)	Actual 2013-14	Actual 2014-15	Trust Plan 2014-15	Comms Plan 2014-15	Year on Year Variance	Trust Plan Variance	Comms Plan Variance
Elective inpatients	4,668	4,443	4,711	4,689	-225	-268	-246
Elective PSDs/day attenders	20,385	21,227	19,994	19,914	842	1,233	1,313
Non Elective Activity	18,713	19,517	18,617	18,609	804	900	908
Outpatient initial attendances	47,347	49,343	47,643	47,643	1,996	1,700	1,700
Outpatient follow-up attendances	90,791	86,740	89,200	89,200	-4,051	-2,460	-2,460
Outpatient procedures	26,635	27,283	30,212	30,212	648	-2,929	-2,929
A&E attendances	32,825	33,855	32,755	32,755	1,030	1,100	1,100
Favourable Variances are shown as +ve							

Other clinical activities income and other operating income were ahead of plan by £2,337k and £2,904k respectively, and this relates to clinical and non-clinical services provided to other NHS organisations, Road Traffic Accident (RTA) and overseas patient income.

For excess non-elective activity above the baseline of 2008/09 the Trust receives only 30% of tariff and this means the work is loss making.

3. Cost of Sales including indirect costs

The total for all Directorates was an overspend position of £1,911k. The position is summarised below:

Directorates	In Month			Year to Date (Cumulative)		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Medicine	3,515	3,595	-80	29,090	29,642	-552
Musculo Skeletal	2,670	2,624	46	23,386	23,418	-32
Surgery	3,103	3,117	-14	26,019	26,238	-219
Clinical Support & Family Services	3,230	3,405	-175	25,780	26,418	-638
Facilities	443	460	-17	3,528	3,509	19
Corporate	3,575	3,411	164	20,519	20,508	11
Transformation savings	-325	-173	-152	-1,477	-977	-500
TOTAL	**16,211**	**16,439**	**-228**	**126,845**	**128,756**	**-1,911**

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

At the end of Month 9 nursing and healthcare assistants budgets were underspent by £362k, compared to £279k underspend last month. The nursing underspend has only been achieved because 'specialing' has been funded from reserves which are now expended. In Month 9 £59k was spent on 'specialing' patients compared to £90k in Month 8, the main areas that have used 'specialing' were Winterslow, Sarum and Chilmark Wards.

The YTD spend was £32,789k on nurses and healthcare assistants compared to £32,187k for the same period last year, an increase of £602k which is not affordable.

The use of Agency staff for nursing and healthcare assistants was £2,155k compared to £2,543k for last year a decrease of £388k, an encouraging reduction although less than achieved earlier in the year. Work continues to reduce agency spend further.

At the end of Month 9 Medical budgets were overspent by £367k, compared to £391k at the end of month 8. Part of the reason for the in-month under-spend was additional £42k was added to budgets in Medicine from resilience funding.

The YTD spend on medical staff is £25,056k compared to £24,622k for the same period last year, an increase of £434k which is concerning.

The use of Agency staff for consultants, specialty doctors and staff grades was £1,262k, compared to £408k for the same period last year, an increase of £854k. The agency cost for doctors in training was £945k, compared to £821k for the same period last year, an increase of £124k. The Medical Director, HR, and Procurement are currently in discussion with various agencies to explore obtaining medical staff from overseas.

In order to achieve break even additional controls are being considered and staff are being asked to: delay appointments, cut waste, delay orders, consider opportunities for more flexible working to avoid agency costs, save energy etc. We are seeking ideas from staff to cut spend over the next two months and potentially over the year ahead.

4. Cost Improvement Plan

The total cost improvement savings target for the year is £9.0m which includes revenue generation and expenditure reduction schemes. Monitor requires revenue generation and expenditure reduction to be separately reported. It should be noted that the £9.0m included £1.1m for a reduction in agency spend which was to reduce overspending rather than baseline budgets. This is not being achieved.

The Trust has achieved YTD savings of £4,443k against a planned target of £5,199k a shortfall of £756k (14.5%). The majority of the shortfall relates to slippage on transformation schemes.

It is recognised the CIP programme is significantly back loaded and therefore on a straight line basis the Trust is £1,517k (25.5%) below where it should be. Considerable work is needed to ensure the planned savings are achieved.

5. Statement of Financial Position

5.1 Non-Current Assets

Property, Plant and Equipment increased in the month by £781k, as a result of expenditure on the capital programme.

5.2 Current Assets & Liabilities (working capital)

The change in working capital this month when compared to the previous period was a decrease of £610k as a result of the deteriorating financial position.

5.3 Cash

The Trust's cash position at 31st December 2014 was £15,327k, which was an increase on the November figure of £1,078k due to receiving the resilience funding of £1.5m in full from Wiltshire CCG.

Cash is monitored on a daily basis and surplus cash is invested in the National Loan Fund scheme.

6. Capital Expenditure (Appendix 3)

The YTD Expenditure was £6,926k, a further £6,394k to be spent during the final three months of the year.

All schemes continue to be reviewed to ensure expenditure profiles are understood. There is likely to be slippage on the Capital Programme in 2014-15 and all schemes are scrutinised to see if they are necessary.

7. Financial Risks

The Trust's key financial risks for 2014-15 can be summarised as follows:

- Deliver the CIP target – this is probably the greatest financial challenge;
- Contractual data challenges from CCGs;
- Meet contractual obligations and avoid penalties such as on CDiff;
- Delivery of CQUIN targets;
- Escalation of non-elective activity which has had detrimental impact on elective work. Non-elective activity is only reimbursed at 30% and is not sufficient to cover costs;
- Manage budgets effectively particularly in respect of: nursing agency and 'specialing' costs, and locum doctors and additional payments to doctors;
- Match capacity to demand in the most cost effective way in order to avoid losing work to local competitors.

8. Conclusions

After nine months of the financial year the Trust is showing a deficit of £1,098k. It is unlikely the planned surplus of £800k will be achieved although we need to achieve breakeven if possible. It is important that the Trust continues to achieve savings, manage budgets tightly and undertake more profitable elective work. Additional actions are being proposed to cut expenditure over the next two months

The Trust has maintained a Continuity of Services Risk Rating of 4 (3.5 rounded up).

9. Recommendation

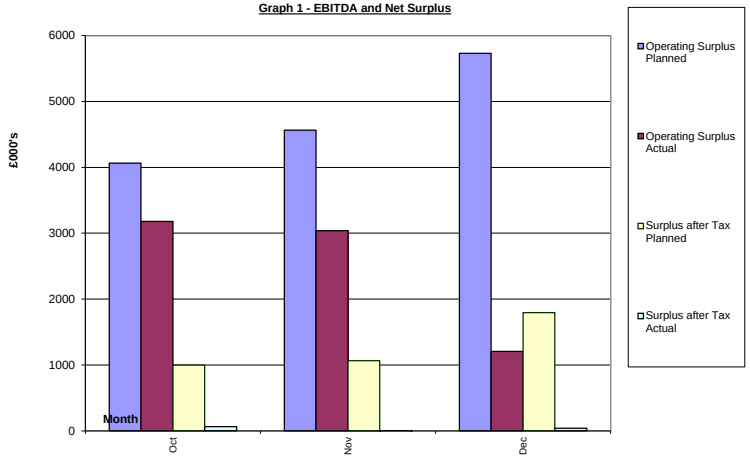
The Trust Board is asked to note the report and consider further actions needed to achieve plan.

Malcolm Cassells
Director of Finance and Procurement
23 January 2015

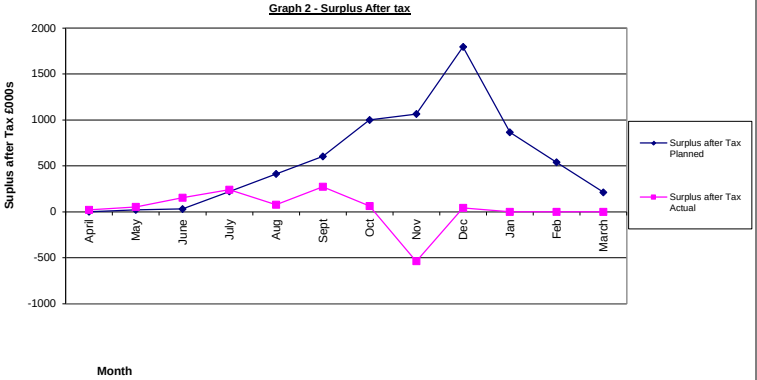
ATTACHMENTS TO VIEW ON WEBSITE
Appendix 1 – Summary Financial Activity & Budget position
Appendix 2 – Income & Expenditure
Appendix 3 – Capital Programme

APPENDIX 1 - FINANCIAL PERFORMANCE DASHBOARD - DECEMBER 2014

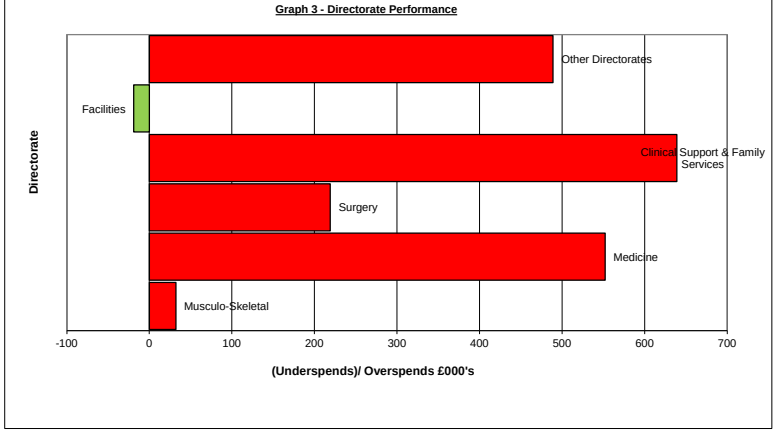
Graph 1 - EBITDA and Net Surplus



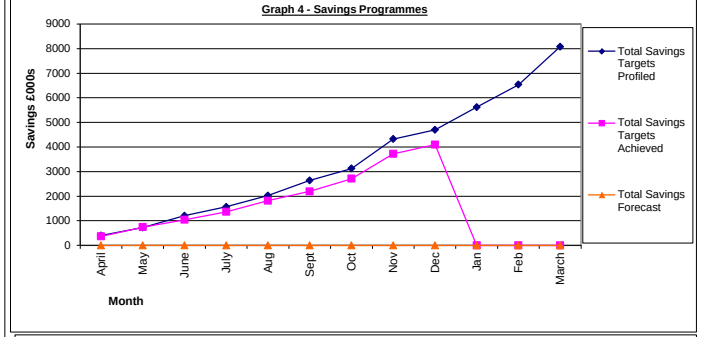
Graph 2 - Surplus After tax



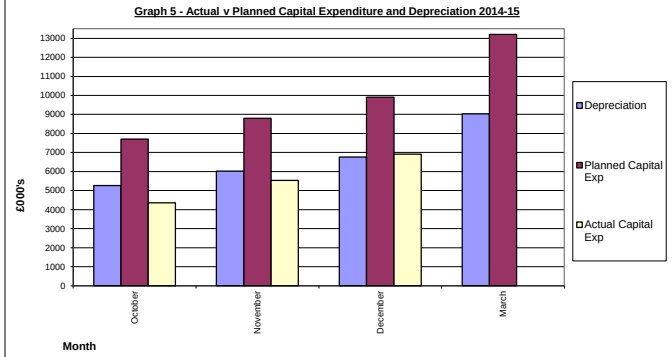
Graph 3 - Directorate Performance



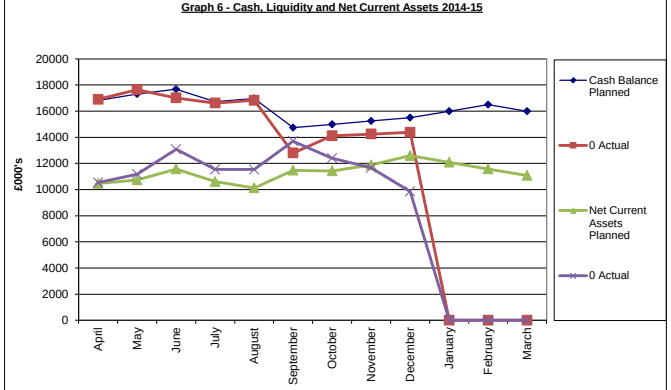
Graph 4 - Savings Programmes



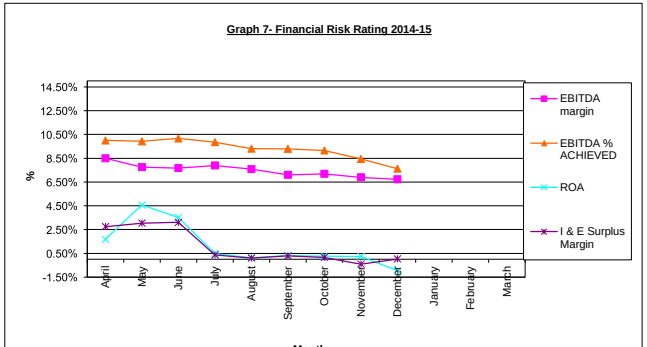
Graph 5 - Actual v Planned Capital Expenditure and Depreciation 2014-15



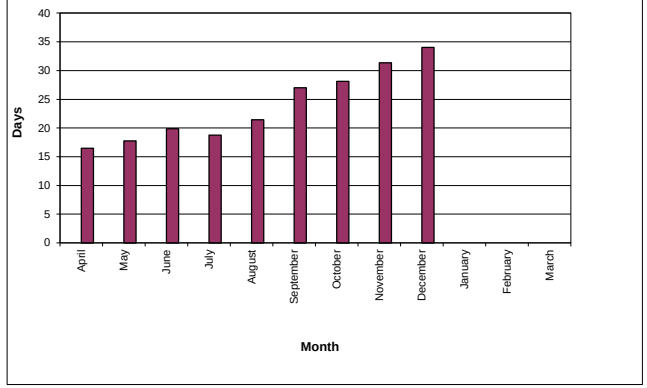
Graph 6 - Cash, Liquidity and Net Current Assets 2014-15



Graph 7- Financial Risk Rating 2014-15



Graph 8 -Liquid Ratio 2014-15



Continuity Service Risk Rating

Ratio	Description	Planned Risk Score	Actual			Rating	Risk Ratings Weight
Capital Service Capacity	Revenue Avaliable for Debt Service Divided by Capital Service Costs	4	9886.00 / 5296.00	=	1.87	3	50%
Liquidity	cash for liquidity purposes/operating expenses * no. of days in period	4	7.83 / 136.27	=	15.51	4	50%
Total Weighted Score		**4.0**				**3.5**	**100%**

Financial Risk Rating Calculations:

Ratio	Description	Planned Risk Score	Actual			Rating	Risk Ratings Weight
EBITDA Margin	EBITDA divided by Total Income *	0	9.84 / 146.11	=	6.7%	3	25%
EBITDA % Achieved	EBITDA Actual divided by EBITDA Plan	0	9.84 / 12.90	=	76.3%	3	10%
ROA	(Net Surplus/(Deficit) minus PDC Capital minus FA Impairments) divided by Total Average Assets Employed	0	-1.06 / 111.47	=	-1.0%	3	20.0%
I&E Surplus Margin	(Net Surplus/(Deficit) minus FA Impairments) divided by Total Income	0	0.04 / 147.00	=	0.0%	2	20.0%
Liquid Ratio**	See below	0	34.0 Days			4	25%
Total Weighted Score		**0.0**				**3.1**	**100%**

NB: The liquidity ratio is defined as cash plus trade debtors plus unused working capital facility minus (trade creditors plus other creditors plus accruals) expressed in number of days operating expenses that could be covered.

Appendix 2 - SUMMARY STATEMENT OF COMPREHENSIVE INCOME

Annual Plan £000s		In month			YTD (Cumulative)		
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
	Operating Income						
169,439	NHS Clinical Income	14,219	14,559	340	127,463	129,658	2,195
4,440	Other Clinical Income	368	569	201	3,325	5,662	2,337
5,826	Research & Development & Education	486	485	-1	4,370	4,822	452
10,650	Other (Excluding Donated Asset income)	886	1,699	813	7,989	10,401	2,412
190,355	**TOTAL INCOME**	**15,959**	**17,312**	**1,353**	**143,147**	**150,543**	**7,396**
	Operating Expenditure						
111,963	Pay - In post	9,310	9,698	-388	84,284	86,318	-2,034
6,334	Pay- Agency	519	680	-161	4,858	5,933	-1,075
16,350	Drugs	1,370	1,472	-102	12,298	12,436	-138
18,068	Clinical Supplies	1,514	1,670	-156	13,590	15,362	-1,772
19,806	Non-Clinical Supplies	1,650	2,473	-823	14,854	16,137	-1,283
2,145	Other	181	516	-336	1,462	4,359	-2,898
174,666	**TOTAL EXPENDITURE**	**14,544**	**16,509**	**-1,966**	**131,346**	**140,545**	**-9,200**
15,689	**EBITDA (Earnings Before Interest, Tax, Depreciation & Amortisation)**	**1,416**	**803**	**-613**	**11,802**	**9,998**	**-1,804**
14,883	Financing Costs	1,236	1,324	-89	11,108	11,095	13
806	**SURPLUS / (DEFICIT) excluding DONATED ASSET INCOME**	**180**	**-521**	**-701**	**694**	**-1,097**	**-1,791**
1,200	Donated Asset Income	650	701	51	1,100	1,140	40
2,006	**SURPLUS / (DEFICIT)**	**-470**	**180**	**-650**	**1,794**	**43**	**-1,751**

Appendix 3 - CAPITAL EXPENDITURE

Project Name	14/15 Board Approved + 13/14 final slippage - 13/14 b/fwd	Adjustments to final Plan	Brought Forward from 2015/16	Slippage to 2015/16	Revised Plan	Spend to 31st December 2014	Under/(Over) spent on Project
Donated Assets							
Bariatric Bed	0	11,140	0	0	11,140	0	
Benson Suite - Donated	16,138	0	0	0	16,138	6,433	
Birthing Beds x8	60,000	-10,000	0	0	50,000	50,000	
Clinical Radiology 2 x Ultrasound	160,000	-22,992	0	0	137,008	0	
CT Scanner	0	1,013,251	0	0	1,013,251	1,013,251	
Dermatology UV Light		15,300	0	0	15,300	0	
NICU / Parents Accommodation - Donated Assets	15,769	0	0	0	15,769	0	
O&G Bladderscanner		6,985	0	0	6,985	0	
Orthodontics & Oral Surgery Cone Beam CT Scanner	110,000	0	0	0	110,000	0	
Small Donated Additions	0	75,719	0	0	75,719	75,719	
Spinal Refurb ADL Bathroom (LoF contribution)	0	10,792	0	0	10,792	0	
Vascular Unit Ultrasound Machine	90,000	-24,525	0	0	65,475	0	
VNG Vestibular Testing Equipment		31,550	0	0	31,550	0	
Donated Assets - Totals	**451,907**	**1,107,220**	**0**	**0**	**1,559,126**	**1,145,403**	**0**
Phase 3 Building Schemes							
CT Scanner Building and Enabling	149,470	165,530	0	0	315,000	3,256	
Helter Skelter Storage	150,000	0	0	-140,000	10,000	0	
Laundry Buildings	56,636	0	0	0	56,636	0	
Maternity - DoH Grant	30,367	0	0	0	30,367	58,769	-28,401
Radnor Ward Development	1,168,000	60,000	0	0	1,228,000	943,792	
Springs entrance development	1,389,924	30,000	0	-1,327,558	92,366	92,366	
Ward changes - Dementia Patient Care	627,156	0	0	0	627,156	589,612	
Building Schemes - Totals	**3,571,553**	**255,530**	**0**	**-1,467,558**	**2,359,525**	**1,687,795**	**-28,401**
Building and Works							
Accommodation - Langley House Kitchen Upgrade	29,000	0	0	0	29,000	23,540	
Accommodation - Replacement glazing units	3,023	0	0	0	3,023	2,062	
Accommodation & Leisure Centre Boilers	75,928	-5,300	0	0	70,628	69,461	
Accommodation key security	7,000	0	0	0	7,000	0	
AGSS Overhaul & Med Gas Racking	15,000	-15,000	0	0	0	0	
AHU replacement yr 3 (2014/15) of 7	420,593	3,034	0	0	423,627	341,234	
Asbestos management	22,217	0	0	0	22,217	3,995	
BMS upgrade 3rd year of 3 - invest to save	42,679	0	0	0	42,679	2,653	
Catering boiling pan replacement	3,153	0	0	0	3,153	0	3,153
Catering Dishwasher	126,000	0	0	0	126,000	0	
Catering - Oven Replacement	0	22,000	0	0	22,000	17,073	
Catering refrigeration upgrade	27,427	-17,427	0	0	10,000	0	
Catering Replacement Cooking Equipment	9,175	0	0	0	9,175	0	9,175
Catheter Suite - Rebalance of Heating System	20,000	0	0	0	20,000	1,600	
Central Clinical Notes Preparation	0	9,800	0	0	9,800	5,116	
Childrens OPD Audiology Soundproof Room	72,043	0	0	0	72,043	50,384	21,659
Decentralisation of Boilers	0	263,200	0	0	263,200	277,173	-13,973
DSU Replacement Insulation to Air Handling System	8,600	0	0	0	8,600	0	
DSU Roof Repairs	0	20,000	0	0	20,000	0	
DSU Theatres - Flooring	1,882	0	0	0	1,882	0	
Ductwork & Fire Damper Cleaning Whole Site 2nd year of 2	189,508	0	0	-80,000	109,508	58,615	
ED Data Centre Ventilation	40,000	40,046	0	0	80,046	1,047	
Education Centre Reception DDA Compliance	8,000	0	0	0	8,000	5,716	
Electricity at Work Regulations Compliance - Year 3 (2013/14) of 3	133,505	-7,000	0	-30,000	96,505	76,240	
Endoscopy Ensuite Enema Room	30,000	0	0	0	30,000	29,439	
Eye clinic expansion	4,377	0	0	0	4,377	0	
Fertility Air Conditioning	12,000	5,000	0	0	17,000	13,845	
Finance fire alarm system upgrade	21,600	0	0	0	21,600	0	
Finance Office Refurbishment	-1,899	1,899	0	0	0	0	
Fire alarms - detection & prevention equip - various	5,548	10,000	0	0	15,548	10,074	
Fire compartmentation SDH north - remedial works	58,013	-10,000	0	0	48,013	5,166	
Fire Suppression to Transformer Rooms	41,628	0	0	0	41,628	29,509	12,118
Gas mains test	7,000	0	0	0	7,000	7,848	-848
Genetics Air Conditioning	11,000	-5,000	0	0	6,000	2,365	
Hedgerows - Public WC's Refurbishment	2,598	-2,598	0	0	0	0	
Hedgerows extension	14,935	-14,935	0	0	0	0	
Hot Water Pipes - SDH Various Areas	165,990	-140,000	0	0	25,990	8,748	
IVF lab. Ventilation system modifications	854	0	0	0	854	0	
Lab Medicine Cold Room	0	36,000	0	0	36,000	0	
Legionella risks	85	0	0	0	85	0	
Level 2 Flooring	98,721	-68,721	0	0	30,000	14,707	
Level 4 Bedspace Power Sockets	69,460	-7,000	0	-61,610	850	850	
Lifts overhaul - year 3 (2014/15) of 3	156,298	25,000	0	-50,000	131,298	129,507	
Main Entrance L3 Upgrade	54,556	20,000	0	0	74,556	64,134	
Main Theatres 4th Laminar Flow System	185,000	0	0	-185,000	0	0	
Maternity Obstetric Theatre Refurbishment	78,000	0	0	0	78,000	0	
Maternity Post Natal Upgrade	122,000	0	0	-121,550	450	450	
Maternity Relocation - Enabling	1,622	0	0	0	1,622	0	
Mattress Laundering	2,521	0	0	0	2,521	0	
MDMC Infusion Device Analyser	8,000	0	0	0	8,000	7,824	
Medical Air (Dryers) SDH North	4,120	0	0	0	4,120	0	
Medical Gas Hoses 1st year of 2 (2014/15)	66,000	15,000	0	-40,000	41,000	0	
Medical Gas System	3,456	0	0	0	3,456	0	3,456
Microbiology - Category 3 Room	58,164	-13,034	0	-3,144	41,986	41,986	
Mortuary electrical installation compliance	11,673	2,500	0	0	14,173	12,221	0
Mortuary Refrigeration	15,901	0	0	0	15,901	10,109	5,792
Noise Reduction & Facilities Equipment	29,488	0	0	0	29,488	0	
Nurse Call System Upgrade - SDH North & Maternity - 2nd year of 2	173,397	0	0	-75,000	98,397	40,230	
Occupational Health Replacement Boilers	1,068	0	0	0	1,068	0	
Old GUM Clinic Demolition	0	0	50,000	0	50,000	0	
Oral Surgery - Theatre 9 (plus more dental chairs)	44,659	-44,538	0	0	120	120	
Orthotics Move and Radiology Bowel Screening Relocation	0	0	35,000	0	35,000	0	
Pathology & Histopathology OSNA Room (4.5.20) Air Conditioning	4,973	0	0	0	4,973	3,533	
Pathology Reception	0	44,000	0	0	44,000	0	
Piped medical gas system safety valves replacement	3,683	0	0	0	3,683	0	3,683
Powered Door Curtains Level 2	0	15,000	15,000	0	30,000	0	
Procurement Out of Hours Bay	5,642	0	0	0	5,642	6,919	-1,277
Productive Operating Theatres	27,415	0	0	0	27,415	8,873	
Public & Staff WCs L5,L4,L3	84,000	2,598	0	0	86,598	0	
Public Spaces Fund	18,404	0	0	0	18,404	5,924	
Radiology Recovery Area Improvements	60,000	-11,000	0	0	49,000	43,004	
Relocation of Liquid Oxygen VIE Plant	28,148	0	0	0	28,148	0	28,148
Rheumatology temperature control	17,079	0	0	0	17,079	0	
Roads and paving repairs	160,949	0	0	-80,949	80,000	5,580	
Roof Repairs - Various	20,866	0	0	0	20,866	28,098	-7,232
SDH Main Chillers Replacement	26,812	-25,046	0	0	1,766	1,828	-62
SDH North Drain Survey	0	0	15,000	0	15,000	0	
SDU X 2 Washers	100,000	52,000	0	0	152,000	15,411	
Security Improvements 2013/14	35,431	0	0	0	35,431	18,315	
Server Rooms - Air Conditioning	41,522	0	0	0	41,522	24,632	
Shower Cubicle Drainage Improvements	30,000	0	0	0	30,000	0	
Site Signage 2013/14	3,580	0	0	0	3,580	1,118	
Spinal treatment centre refurbishment	189,935	0	0	0	189,935	16,083	
Spinal Unit - wheelchair cleaning and storage	3,370	0	0	0	3,370	3,818	-448
Spinal Unit Double Glazing 1st yeat of 2 (2014/15)	60,000	0	0	0	60,000	0	
Spinal Unit Fire Escape	17,000	0	0	-12,000	5,000	0	
Spinal X-ray booking facilities and doors	28,677	0	0	0	28,677	26,642	2,035
Theatres 1 - 10 Replacement Taps	4,051	0	0	0	4,051	3,256	
Walls - repairs to failing walls	8,000	0	0	-8,000	0	0	
Wessex Rehab Windows and Cladding	11,466	0	0	0	11,466	0	
Wilton Ward Winter Pressures 13/14 (Block 79)	33,924	0	0	0	33,924	277	
Building Projects/Building and Works Totals	**3,837,494**	**200,478**	**115,000**	**-747,253**	**3,405,718**	**1,578,353**	**65,379**

Project Name	14/15 Board Approved + 13/14 final slippage - 13/14 b/fwd	Adjustments to final Plan	Brought Forward from 2015/16	Slippage to 2015/16	Revised Plan	Spend to 31st December 2014	Under/(Over) spent on Project
Information Technology							
ACS Licences	12,000	0	0	0	12,000	0	
AD Upgrade to 2008	28,827	4,461	0	0	33,288	33,288	
Allocate' Roster System	39,168	0	0	0	39,168	39,000	
Auditbase link to iPM	20,000	0	0	0	20,000	0	
Backup Tape Library Replacement	52,000	0	0	0	52,000	15,026	
Big Hand 15/16	0	0	50,000	0	50,000	0	
Blood Tracking	17,491	0	0	0	17,491	6,500	
Blood Tracking Phases 1 - 3	337,177	0	0	0	337,177	82,434	
BMS Network Upgrade	31,955	0	0	0	31,955	0	
Brocade Switch Replacement	7,513	0	0	0	7,513	1,069	
Clikview Reporting System	80,000	0	0	0	80,000	0	
Clinical Coding Encoder	23,692	0	0	0	23,692	12,260	
Community Midwifery system trial	35,748	0	0	0	35,748	0	
Connectivity Upgrade for Warminster & Shaftesbury	42,000	0	0	0	42,000	0	
COSD - Cancer Database	24,000	0	0	0	24,000	20,000	
Dell Kace Push Software	1,437	0	0	0	1,437	267	
Desktop PC Windows 7 Upgrade	12,472	0	0	0	12,472	3,133	
Diabetic Retinopathy Screening	1,621	0	0	0	1,621	2,630	-1,009
EDCR-Changes to improve air flow and balance	9,500	0	0	0	9,500	0	
Edge Security replacement	0	3,050	0	0	3,050	2,399	
Electronic Letters	24,160	0	0	0	24,160	4,012	
EPMA (Yr 2 (2014/15) of 7)	152,438	0	0	0	152,438	59,898	
Estates Management Information System	5,000	6,000	0	0	11,000	9,577	
Exchange 2010 Upgrade	23,301	-5,000	0	0	18,301	16,351	
Genetics High Spec Analysis Equipment & Software	86,000	0	0	0	86,000	0	
Histopathology Hardware	20,000	0	0	0	20,000	4,339	
Inhouse development team - applications, databases and Dashboards (subject to bus case)	92,176	0	0	-92,176	0	0	
iPad Security	22,000	0	0	0	22,000	21,840	
Lab Medicine-Tpath to Nxt Gen	0	0	0	0	0	0	
Maternity PC & Screens Replacement	22,000	0	0	0	22,000	4,892	
Mobile Computing	76,332	0	0	0	76,332	26,053	
Moorefield's Eye Hospital Software	27,000	-27,000	0	0	0	0	
Net Call	0	28,548	0	0	28,548	0	
Network Load Balancers	36,000	-2,511	0	0	33,489	8,629	
Network Upgrade Consultancy	91,500	0	0	0	91,500	5,603	
Neurophysiology Project	4,446	0	0	0	4,446	0	
Nexus 5 Expansion	49,000	0	0	0	49,000	1,942	
Open Eyes System	40,152	27,000	0	0	67,152	6,407	
Order Comms (includes System Admin Bid & Sexual Health Bid)	22,889	0	0	0	22,889	7,624	
PACS Reprocurement	78,940	-2,169	0	0	76,771	5,441	
Palliative Care EPR	4,437	35,000	0	0	39,437	0	
PAS 2016 Replacement - Consultancy Costs	70,000	0	0	0	70,000	42,126	
Patient Observations Monitoring and Decision Support/Early Warning System/POET	267,383	0	0	-20,000	247,383	130,942	
Patient Tracking	1,253	0	0	0	1,253	1,015	
Radiologists 'on-call' Laptops	12,000	2,169	0	0	14,169	14,168	1
Radiology - OrderComms	71,257	0	0	0	71,257	9,698	
Radiology Replacement PC's	10,000	0	0	0	10,000	0	
RAM Asset Maintenance Module	1	0	0	0	0	3,998	-3,998
Results System in GP Practices 'Review' System	30,000	0	0	0	30,000	10,322	
RIS patient self check in	7,848	0	0	0	7,848	6,250	
SBAR for PAS	0	100,000	0	0	100,000	27,883	
SBAR re NACS Update to ED Symphony	0	7,500	0	0	7,500	0	
SBAR re UPS Replacement (formerly UPS Replacement - Room based for Computer Rooms)	27,000	0	0	0	27,000	5,850	
Scanned Health Rtecords	7,418	0	0	0	7,418	5,100	
SDU Quality System	0	12,600	0	0	12,600	7,653	
SLAM	805	0	0	0	805	0	
Sophos Renewal	0	0	0	0	0	0	
Telecomms Voice Over IP - invest to save	16,397	0	0	0	16,397	13,600	
Telepath enhancements	46,365	0	0	0	46,365	8,000	
Telepath to NexGen (Phase 3 of 4 2014/15)	75,000	-75,000	0	0	0	0	
Theatre management system - balance	1,496	0	0	0	1,496	0	
Upgrade of low spec equipment (680 machines)	0	71,340	0	0	71,340	43,875	
UPS Replacement Programme	26,036	0	0	0	26,036	9,224	
VMWare Upgrade	20,000	0	0	0	20,000	225	
Wireless Expansion	2,710	0	0	0	2,710	128	
Information Technology Totals	**2,347,341**	**185,988**	**50,000**	**-112,176**	**2,471,152**	**740,671**	**-5,006**
Medical Devices							
Anaesthetic Machines	100,000	0	0	0	100,000	98,069	
B-Braun Review of Theatre Instruments	300,000	0	0	-200,000	100,000	42,389	
BED replacement programme - 2nd (2014/15) yr of 4	193,885	0	0	0	193,885	193,231	
DSU Operating Theatre Lights	110,000	0	0	0	110,000	69,245	
ED Trolleys x 20	0	66,347	0	0	66,347	50,621	
Fertility - Time Lapse Imaging (Primo Vision) x 2 Cameras	0	74,802	0	0	74,802	74,854	-52
Fluoroscopy Loop System in Room 7	0	9,750	0	0	9,750	9,570	180
Foetal Heart Monitors X 6	7,531	0	0	0	7,531	0	
ICSI Rig	0	0	0	0	0	0	
Laparoscopic instrumentation	53,902	0	0	0	53,902	4,838	
Laser Holmium Yag Machine - Urology	50,000	42,085	0	0	92,085	92,085	
Maternity Theatre Equipment	63,000	0	0	0	63,000	55,986	
Medical Equipment < £50k 12/13	73,800	-66,347	0	0	7,453	35,286	-27,833
Medical Equipment < £50k 13/14	115,234	0	0	0	115,234	52,472	
Medical Equipment <£50k 14/15	350,000	5,580	0	0	355,580	176,012	
O&G Ultrasound	0	0	70,000	0	70,000	0	
Patient monitoring and stations 2nd phase of 2	55,392	0	0	0	55,392	46,125	
Patient trolleys x 14 + 1 Radiology	69,000	0	0	0	69,000	66,517	
Replacement Mattresses (x 15)	0	30,000	0	0	30,000	29,443	
Retinal Screening Equipment	0	38,981	0	0	38,981	0	4,385
Revenue Grouped Items 2013/14	25,525	-17,794	0	0	7,731	7,731	
Revenue Grouped Items 2014/15	100,000	17,794	0	0	117,794	106,571	
Rigid hysteroscopes x 4 plus stack	39,842	0	0	0	39,842	24,927	
Scopes	0	162,000	0	0	162,000	161,995	
Spinal Bed	0	9,600	0	0	9,600	9,600	
Storz Theatre Camera Stacks	0	201,151	0	0	201,151	0	
Urology Laser Scope	0	0	28,000	0	28,000	0	
Ventillators Programme - 1st year of 5 (2014/15)	60,000	0	0	0	60,000	0	
Zimmer Meshers & Dermatones	4,382	0	0	0	4,382	0	4,382
Medical Equipment Totals	**1,771,493**	**573,949**	**98,000**	**-200,000**	**2,243,442**	**1,407,569**	**-18,938**
Other							
Bed Stacking	0	3,000	100,000	0	103,000	0	
Car Park Machinery	30,000	-30,000	0	0	0	0	
Catering Trolley Replacement x20	4,652	0	0	0	4,652	0	
Demand Response Generator Conversion	0	180,000	180,000	0	360,000	0	
Drinking Water Stations	700	0	0	0	700	0	
DSU Truck	0	0	8,000	0	8,000	0	
Efficiency schemes	338,370	-345,400	0	0	-7,030	2,023	-9,053
Endoscope Vacuum Pack System	0	35,000	0	0	35,000	33,881	
Finance systems 2011/2012	40,170	0	0	0	40,170	40,606	-436
Fire Safety Training Equipment	820	0	0	0	820	0	
Forklift Truck Replacement - Procurement	17,500	0	0	0	17,500	17,465	
LED Lighting	81,675	0	0	0	81,675	16,991	
Microfibre Cleaning	44,000	-44,000	0	0	0	0	
Outpatient Kiosks	198,000	0	0	0	198,000	85,649	
Phhotovoltaic's / Solarthermal PV	49,276	6,007	0	0	55,283	42,059	
Project costs 2013/14	14,715	0	0	0	14,715	11,727	
Staff Accommodation Fire Door Closers	0	16,000	0	0	16,000	15,685	
Telecoms Trunk Lines	0	10,000	0	0	10,000	0	
TRV's (details to be taken to CapCG Oct mtng)	17,500	-17,500	0	0	0	0	
Voltage Optimization	94,705	-6,007	0	0	88,698	88,699	
Ward Waste Bins	141,839	0	0	0	141,839	11,703	
Other Totals	**1,073,921**	**-192,900**	**288,000**	**0**	**1,169,021**	**366,486**	**-9,489**
TRUST TOTALS	**13,053,709**	**2,130,265**	**551,000**	**-2,526,987**	**13,207,985**	**6,926,278**	**3,545**
Outside of Trust Sourced Funding							
Laundry Equipment	112,500	0	0	0	112,500	0	112,500
Outside of Trust Sourced Total	**112,500**	**0**	**0**	**0**	**112,500**	**0**	**112,500**
	13,166,209	**2,130,265**	**551,000**	**-2,526,987**	**13,320,485**	**6,926,278**	**116,045**

Trust Board meeting

SFT 3626

Performance Report

Date: 2 February 2014

Report from: Laurence Arnold **Presented by: Laurence Arnold**

Executive Summary:

This details the Trust performance as at December 2014.

Proposed Action:

To note the report

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

Appendices:

Supporting Information

TRUST PERFORMANCE REPORT TO END OF DECEMBER 2014

PURPOSE: To provide summary information to the Trust Board on performance with regard to key activity and quality indicators.

MAIN ISSUES:

This report sets out the Trust's recent performance against a number of key indicators.

MONITOR

1. **A&E –** the Trust faced considerable operational difficulties from increased emergency demand in early to mid December and then again straight after Christmas. There was a clear increase in the acuity of patients presenting to ED and an increase in elderly admissions. At the same time it was proving more problematic to discharge patients as DTOC's rose. The Trust achieved 93% for the ED 4 hour target in December which meant that the quarter as a whole was not delivered.

2. **Cancer 2 week waits** – the target of 93% of patients being seen within 2 weeks of referral was achieved in December, and for the quarter as a whole, despite an increase in referrals.

3. **Cancer 62 day screening target** – the target of 90% of patients being seen within 62 days was not achieved for the quarter as the Trust treated one patient outside of the required timescale. As only one patient was affected the non-delivery of this target is not reportable to Monitor under their guidelines.

PATIENT CHOICE

4. **Diagnostics** – whilst all national targets have been achieved in December, the local target of no patients waiting in excess of 4 weeks was not achieved with 81% of patients being seen within 4 weeks. As in previous months, demand rises continue to exceed capacity despite additional lists being arranged within CT and MRI. Ultrasound remains an issue for a service which has seen difficulties recruiting ultrasonographers. Endoscopy continues to see growing demand, but waiting times have reduced due to the recruitment of locums and focused work on capacity and demand.

5. **Cancelled Operations –** the number of patients whose operation was cancelled on the day of planned surgery increased in December to 1.1% reflecting the emergency pressures described above. The most common reason for cancellation was due to post-operative beds not being available, but increases in emergency surgical work also contributed.

PARTNERSHIP WORKING

6. **Delayed transfers of care (DTOC)** – the number of DTOCs remains a constant focus of the patient flow team and workstreams established as part of the Better Care Fund and '100 day challenge' continue to review systems and processes to understand the bottlenecks to improvement and potential solutions to improve the experience for our patients**.** However the number of delayed patients has stayed very constant.

STAFF

7. **Appraisal rates** – the overall Trust position at the end of December is 52%. However recent figures from the national staff survey indicate a higher level of appraisals being carried out suggesting that reporting issues remain. Further developments of the system, including improving the reporting system, are planned and work is currently underway to ensure that appraisers, line managers and second in line appraisers are signing off appraisals. In addition further work is being carried out to promote appraisals across the Trust.

8. **Statutory Mandatory Training** – movement on performance in this area continues to be slower than expected. Reviews at performance meetings have highlighted a contributory factor is the reliability of the data for some of the modules reporting, eg members of staff not required to undertake a particular training component being included within the reports. The MLE system is due to be upgraded in February to be made more interactive and engaging and with more electronic assessments so staff can remain compliant by completing an online test.

ACTION REQUIRED BY THE BOARD: To note the Trust's performance.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:
Board Performance Report, December 2014

AUTHOR: LAURENCE ARNOLD
TITLE: ACTING CHIEF OPERATING OFFICER

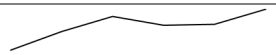
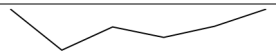
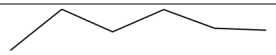
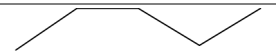
Trust Board Performance Report - December 2014

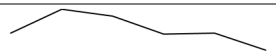
Salisbury NHS
NHS Foundation Trust

Monitor Assurance

Metric Name	Indicative Monthly Volume	Target Source	Ceiling	Dec-14	YTD	Benchmark	Trend
Infection control – Clostridium difficile	5,800 discharges	Contract	18 cases (deminimis volume 12)	1	14		
Infection control - MRSA	5,800 discharges	Contract	0 cases (deminimis volume 6) *	0	1 (+1) **		

Metric Name	Indicative Monthly Volume	Target Source	Target	Dec-14	Quarter 3 to date	Benchmark	Trend
Patients treated within 18 weeks requiring admission	1,000 patients	Contract	90% treated within 18 weeks	94.9%	93.7%	92%	
Patients treated within 18 weeks not requiring admission	3,500 patients	Contract	95% treated within 18 weeks	99.1%	98.5%	97%	
Proportion of patients waiting less that 18 weeks for first treatment	10,300 patients	Contract	92% still waiting within 18 weeks	95.5%	N/A	95%	
Zero tolerance RTT waits > 52 weeks		Contract	Zero	0	0		

Metric Name	Indicative Monthly Volume	Target Source	Target	Dec-14	YTD	Benchmark	Trend
All Cancer two week waits	450 patients	Contract	93% patients within 2 weeks	97.0%	94.7%	95.4%	
Symptomatic Breast Cancer - two week waits	85 patients	Contract	93% patients within 2 weeks	99.0%	95.4%		
31 day wait standard	110 patients	Contract	96% patients within 31 days	100.0%	98.1%	97.9%	
31 day subsequent treatment : Surgery	20 patients	Contract	94% patients within 31 days	100.0%	99.5%		
31 day subsequent treatment : Drug	20 patients	Contract	98% patients within 31 days	100.0%	100.0%		
62 day wait standard	50 patients	Contract	85% patients within 62 days	91.8%	90.8%	87.0%	
62 day screening patients	4 patients	Contract	90% patients within 62 days	100.0%	94.7%		
62 day patients waiting first definitive treatment after Consultant upgrade	3 patients	Contract	85% patients within 62 days	100% (Nov-14)	100% (to Nov-14)		

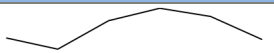
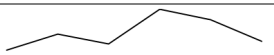
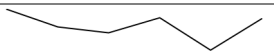
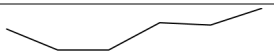
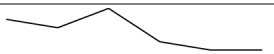
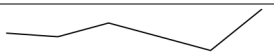
A&E - Time in A&E department	3,600 patients	Contract	95% patients leave within 4 hours of arrival	93.3%	94.9%	94%	

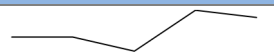
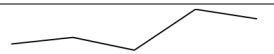
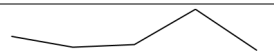
Quarterly Governance risk rate	Green: No evident concerns

Trust Board Performance Report - December 2014

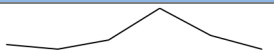
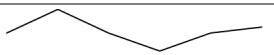
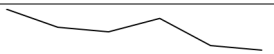
Salisbury NHS
NHS Foundation Trust

Patient Choice

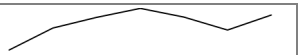
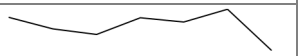
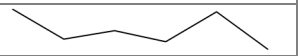
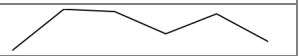
Metric Name	Indicative Monthly Volume	Target source	Target	Dec-14	YTD	Benchmark	Trend
Patients waiting less than 4 weeks for diagnostics	1,800 patients	Trust	98% of Diagnostic Waiting List <= 4 weeks	80.9%	85.4%	81%	
Patients waiting less than 6 weeks for diagnostics	1,800 patients	Contract	100% of Diagnostic Waiting list < 6 weeks	100.0%	99.98%	99%	
Friends and Family - % patients with feedback	1,400 discharges	Contract	15% patients offer feedback by end of Q1, 20% or more by end of Q4	36.0%	45.1%	N/A	
Friends and Family - % likely to recommend Hospital	1,400 discharges			96.2%	96.4%	N/A	
A&E Clinical Target 1 - Effectiveness of Care - unplanned reattendance rate	3,600 patients	Contract	<5% ED attendances to have unplanned return	2.5%	2.3%	7.2%	
A&E Clinical Target 2 - Left without being seen	3,600 patients	Contract	<5% patients to leave ED without being seen by clinician	1.5%	1.4%	2.7%	
A&E Clinical Target 3 - 95th Percentile time in A&E	3,600 patients	Contract	95th percentile ED wait to be less than 4 hours	04:51	04:16	04:11	
A&E Clinical Target 4 - Time to initial assessment	3,600 patients	Contract	95th percentile ED time to initial assessment < 15 minutes	00:07	00:08	benchmark data not fit for purpose	
A&E Clinical Target 5 - Time to treatment	3,600 patients	Contract	Median time to treatment in ED < 60 minutes	45	54	benchmark data not fit for purpose	
Ambulance Handover Breaches	970 arrivals by ambulance	Contract	Patients waiting > 20 minutes for Ambulance Handover	12	41		
Trolley Waits in A&E		Contract	Patients waiting > 12 hours on a trolley	0	0		
GUM % Offered appt within 48 hours	340 patients	Contract	100% patients offered appt within 48 hours initial referral	100%	100%	100%	
GUM % Accepted appt within 48 hours	340 patients	Contract	80% patients seen within 48 hours initial referral	83.5%	84.6%	89%	
Cancelled operations on the day of surgery	2,100 elective admissions (incl. daycase)	Trust	< 0.7% elective patients cancelled	1.1%	0.9%	0.77%	
Cancelled operations rebooked within 28 days	20 cancellations per month	Contract	100% patients rebooked within 28 days of cancelled surgery	100.0%	100.0%	96%	

Metric Name	Indicative Monthly Volume	Target source	Target	Aug-14	2013-14	Benchmark	Trend
Market Share: NHS Wiltshire - Elective		Strategy		33.8%	29.1%		
Market Share: NHS Wiltshire - Non-Elective		Strategy		35.7%	35.3%		
Market Share: Core Practices - Elective **		Strategy	Increase market share from 52% to 55% over 5 years	55.9%	52.0%		
Market Share: Core Practices - Non-Elective **		Strategy		63.7%	64.5%		

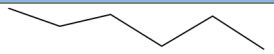
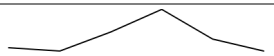
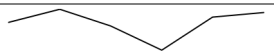
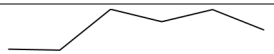
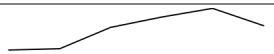
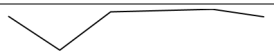
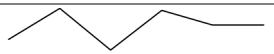
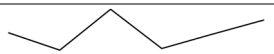
Partnership working

Metric Name	Indicative Monthly Volume	Target source	Target	Dec-14	YTD	Benchmark	Trend
Delayed Transfers of Care - NHS				5	N/A		
Delayed Transfers of Care - Social Services			4 DTOCs based on 3 Wilts SS delays and ~1 other	13	N/A		
Outpatient Follow Up rates	15,000 attendances	Contract	Aspire for Follow up -New Rate <=1:1.6	1.48	1.57		

Staff

Metric Name	Indicative Monthly Volume	Target source	Target	Dec-14	YTD	Benchmark	Trend
Staff absence rate		Strategy	2.87% absence rate	2.91%	3.21%		
Staff turnover	2731 FTE	Strategy	12% over 12 months as a cumulative figure	N/A	2.49% (to Dec-14)		
Appraisal rates		Strategy	90% of Appraisals completed (rolling 12 months compliance rate)	51.7%	N/A		
Statutory and Mandatory Training levels		Strategy	100% of Training completed (rolling 12 month compliance rate)	64.3%	N/A		
Registered Nurses Vacancy Factor		Strategy	10%	9.5%	7.7%		
Nursing Support Vacancy Factor		Strategy	10%	3.2%	8.2%		
Trustwide Vacancy Factor		Strategy	10%	-0.9%	2.7%		
Bank Spend		Strategy	To be determined	£437,792	£4,214,755		
Agency Spend		Strategy	To be determined	£647,194	£5,447,185		

Value and Effectiveness

Metric Name	Indicative Monthly Volume	Target source	Target	Dec-14	YTD	Benchmark	Trend
Elective Medical Length of Stay	40 Medical G&A overnight stays	Trust	3.48 days	2.9	4.2	Benchmark data not fit for purpose	
Non-Elective Medical Length of Stay	900 Medical G&A overnight stays	Trust	7.78 days	6.9	7.3	15.7	
Elective Surgical Length of Stay	480 Surgical G&A overnight stays	Trust	2.19 days	3.2	2.7	3.5	
Non-Elective Surgical Length of Stay	750 Surgical G&A overnight stays	Trust	3.15 days	4.0	3.5	3.0	
Hip replacements discharged within 5 days	25 patients	Trust	60% patients discharged within 5 days	72.4%	69.8%		
Knee replacements discharged within 5 days	24 patients	Trust	60% patients discharged within 5 days	65.5%	63.8%		
Coding - % coded within 1 week of discharge	5,800 discharges	Trust		61.7%	46.8%		
Coding - % coded within 5 days of month end	5,800 discharges	Trust		87.8%	74.2%		
NHS no. coverage	230,000 patients	Contract	95% of patients with activity in last 3 years to have validated NHS no.	98.2%	97.9%		
1st Outpatient DNA rate	5,500 appointments	Contract	No more than 7.5% patients to not attend 1st outpatient appointment	5.6%	5.8%	7.0%	
Elective Theatre Utilisation - Main Theatres	530 cases	Trust	Data recently obtained from new theatre system, no target set at this point	91.7%	94.6%		
Elective Theatre Utilisation - Day Surgery	860 cases	Trust	Data recently obtained from new theatre system, no target set at this point	85.1%	84.1%		
Non-elective Theatre Utilisation - Main Theatres	370 cases	Trust	Data recently obtained from new theatre system, no target set at this point	43.5%	43.0%		
Daycase Rates for selected procedures	350 patients	Trust	80% of selected elective surgical cases to be treated as daycase	84.7%	82.0%	81.2%	
Continuity of Service Risk Rating (CoSRR)	4. No compliance issues						

Cells with black dotted outlines indicate provisional data

*Please note: MRSA is no longer monitored by Monitor

** **Please note, the MRSA figures are showing as 1 (+1) because one of these cases was not a true bacteraemia but rather a contaminant and the patient was not unwell**

Trust Board Meeting **SFT 3628**

HEALTH AND SOCIAL CARE ACT 2008 (REGULATED ACTIVITIES) REGULATIONS 2014 – FIT & PROPER AND GOOD CHARACTER

Date: 2 February 2015

Report from: Nick Marsden, Chair

Executive Summary:

1. These regulations took effect in November 2014 and require providers of services registered with the Care Quality Commission to ensure that all existing and new directors of the Trust meet and continue to meet the definitions of Fit & Proper and Good Character.

2. The requirements, summarised below, will be met by (i) the continued application of due diligence procedures in relation to new appointments, (ii) existing directors affirming in writing their compliance with the requirements (iii) monitoring continued compliance via appraisal and (iv) confirmation of continued compliance at public board meetings through the declarations of interest process.

3. **Fit & Proper**
   To meet this requirement, it must be ascertained that:
   a. The person is not bankrupt, disqualified, barred or otherwise prohibited from holding the role
   b. The person has the relevant qualifications, competence, skills and experience for the role
   c. The person's health does not prevent them from carrying out the role
   d. The person has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity

4. **Good character**
   This requirement would <u>not</u> be met if:

   - the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.
   - the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

Proposed Action: That the board approves the compliance actions described in paragraph 2 above

Links to Assurance Framework/ Strategic Plan:

Appendices:
None.

Supporting Information

1. There is a general requirement under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which form the basis of the "old" CQC regime, for people carrying on regulated activity to be of good character, mentally and physically fit and qualified to undertake their role. This was regulated through Outcome 12, Requirements Relating to Workers.

2. It is common practice for foundation trusts to have provisions in their constitutions in respect of director disqualifications for matters such as bankruptcy, barring and disqualification as a company director. Monitor introduced a narrower Fit & Proper requirement for directors in the provider Licence in October 2013.

3. If after appointment, a concern arises that a director is not meeting the requirements, notwithstanding previous due diligence, then the guidance gives scope for the provider to investigate and to reach a judgement as to whether it is appropriate for the director to continue in office.

4. The CQC intend to review providers' arrangements for compliance with the new requirements through their routine inspections.

Trust Board meeting **SFT 3629**

Capital Development Report

Date: 2 February 2015

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

Executive Summary:

The Capital Development Report describes the improvements that have been made in the last four months to the Estate, across buildings, information technology, medical equipment and infrastructure. Highlights have included the opening of the new expanded Radnor ITU, the installation of the two CT scanners following the highly successful Stars campaign and the in-house development of a tool to record at the bedside patient's observations which will begin pilot stage on Laverstock ward from 26th January.

Approval has been given to proceed with the development of the design for an extension of the maternity unit to create a low risk birthing unit to prepare for the projected increase in the local army population from 2018.

Proposed Action:

To note the report and to confirm the approval to proceed with the design work for the low risk birthing unit.

Links to Assurance Framework/ Strategic Plan:

Choice – "Delivering an estates strategy which ensures patient care is provided from the highest possible quality accommodation and which makes optimal use of the Trust's estate"

Appendices:

Supporting Information

CAPITAL DEVELOPMENT REPORT
FOR THE PERIOD OCTOBER TO DECEMBER 2014

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 (Sept 2014).

MAIN ISSUES:

Springs main entrance redevelopment

This project will comprise two single storey extensions to the existing SDH North building, internal alterations close to the corridor end of Springs restaurant, creation of a new main entrance lobby with retail space, replacement of the covered pedestrian walkway and minor alterations within car park 8. Full ground survey investigations have now been completed and the revised plans are now being finalised before being submitted for planning permission this month. Work on site is now expected to start on site in late spring 2015.

Further Improvements to Phase 1 Wards

Following the success of the recent refurbished Pitton and Redlynch wards, plans for further improvements to the Phase 1 wards in SDH North will see the Downton ward being the next ward to undergo refurbishment. Work is expected to start early summer 2015 to be completed early autumn.

ITU Expansion

A £1.2m major redevelopment of Radnor Ward Intensive Therapy Unit began in mid-September increasing the potential bed capacity from 8 to 12. The building work was completed in December and the Radnor ward was successfully returned to its new accommodation just before Christmas, allowing Braemore ward to open early on 2nd January to help with winter pressures. The support and responsiveness of all staff involved, but particularly those on Radnor ward, was exceptional and much appreciated in the context of the hospital's bed situation at that time.

Other SDH Site Redevelopment schemes

Work is continuing to investigate development opportunities for the vacated areas of SDH South. The approval of the Trust's strategic service review and the estates review now gives the opportunity to engage with the two preferred bidders in detail dialogue. An initial list of potential schemes has been shared with each bidder for further joint working. An invitation to negotiate was published during May outlining how the proposed joint venture will work and provide a basis for the Trust to appoint a preferred partner.

Second CT Scanner

Both new CT scanners have been successfully installed and are now fully operational.

Maternity Unit

At its private meeting on 19th January, the Trust Board approved in principle that preliminary planning work should begin on the development of an expanded maternity unit. The final business case for this scheme is still being assessed and will be informed by the service review underway in obstetrics and gynaecology. In the meantime more detailed design work will begin to ensure that the expanded facilities are available for when the local military population is due to expand in 2018.

IT Schemes

Single Sign On (SSO)

SSO roll-out to outpatient areas was due to undertaken in late 2014, but due to issues with how staff used a range of software products in clinic this has been placed on hold while bridges are developed to a number of products (eg IE9 and to OWA(Outlook Web Access) so the users can get outside internet and also their emails on the SSO machines. These bridges are currently being developed pending the resolution of an issue with the Trust's firewalls.

Once these issues have been resolved the IT department will continue the roll-out with a programme agreed once one clinical area has received the new functionality successfully.

Patient Observation and Escalation Tool (POET)

The first phase of this development is near completion. An initial proof of concept was undertaken in December on Laverstock ward. A small number of aesthetic changes have been made as a result of this. A more formal pilot will start on Laverstock Ward on the 19th January. The pilot will focus on showing that connectivity is sufficient, integration with other trust systems (IPM/BATS/Consultant List) works effectively and that the solution is clinically safe to use. In order to ensure patient safety nursing staff will be entering data both electronically and via paper. This initial solution focuses on the recording of patient observations and assessments and the creation of a track and trigger score. An automated escalation function will be developed in phase 2 of the project.

The system includes the ability to record data, flag patients according to different risk criteria and link to systems which will assist with other Trust priorities, e.g. infection control and the sepsis six.

Electronic Discharge Summaries

The Trust is now recording more than 90% of its discharge summaries from inpatient wards electronically, with many of these being transmitted directly into Wiltshire practices' IT systems.

Electronic Patient Record (EPR)

Procurement work for EPR was initiated based on the "PAS Replacement Options Appraisal" with approval to advance the procurement to the Invitation To Tender (ITT) stage given by the Trust's Information Systems Strategy Group (ISSG) in November 2014.

A Strategic Outline Case (SOC) will be taken for approval at the next ISSG meeting. Responses to the ITT are due to be received in late February with

contracts to be approved, subject to the usual due diligence and rigorous assessment of both cost and intended benefits, in July 2015. The current focus in on ensuring both the development of a rigorous process to achieve that and ensuring that there is sufficient input from users of the systems, particularly from clinical staff.

Blood Tracking Phase 2

This is the bedside administration of Blood Transfusions. The order has now been placed with the software supplier (Msoft) , following successful trials of the Miocare mobile devices that will be used in conjunction with the POET and Mobile Devices projects. Joint workshops and project meeting are being held with Msoft starting in January with a view to a pilot in Spring. The majority of the financial spend will be on mobile devices and printers - pooled with and driven by the Mobile Device & POET projects which will implement ahead of Blood Tracking.

ACTION REQUIRED BY THE BOARD:

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

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

Other significant schemes in the Approved Capital Programme for 2014/2015 (Appendix A to C inclusive)

Laurence Arnold
Director of Corporate Development

APPENDIX A

Other significant schemes in the Approved Capital Programme for 2014/15

Building and Works schemes	Completion date	Budget cost incl VAT
Efficiency schemes (7703C0) Funding available to support efficiency projects with rapid payback revenue savings.	March 2015	£238k
Main Theatres Laminar Flow system (7070C0) This scheme will see Theatre 5 converted into a laminar flow facility. Scheme subject to OJEU as no framework agreement for Laminar Flow and therefore likely to Slip into 2015-16.	Slipped to 2015	£185k
Spinal Treatment Centre refurbishment (7049C0) Replacement of single glazed windows with double glazed units along with range of smaller refurbishment items prioritised in the 2014/15 programme. Works ongoing to Nurses stations. Start date of 3/11/14	2014/15	£190k
Main Entrance Level 3 upgrade (7098C0) Scheme to improve patient flow and service and accommodate centralised outpatient reception. The building works completed in March with a new reception desk installed in August. The self check in kiosk has now been installed and is fully operational.	Summer 2014	£75k
Main Chillers replacement (7212C0) Project 1st phase to replace the main chiller units located in SDH north with modern compliant and energy efficient plant.	March 2014 (now complete)	£484k

Rolling work programmes (multi year projects)

Building and Works schemes	Completion date	Budget cost incl VAT
Air Handling Units (7041C0) This is the third year of a 7 year (£2m) programme to replace the 50 specialist ventilation systems supporting SDU, Pharmacy, ED/SSEU, Pathology, Spinal X ray and all the Theatres.	March 2020	£423k this year
Ductwork and fire damper cleaning (7093C0) Across whole SDH site, ventilation ductwork and fire dampers will be cleaned out to comply with fire and health and safety legislation. 2nd year of 2.	March 2015	£110k (this year)
Nurse Call System upgrade (7202C0) Project to replace ageing nurse call systems through out wards in the main SDH north building and maternity wards. 2nd year of 2. £75k slipped to 15-16 to link with refurbishment requirements	March 2015	£98k (this year)
Lift Refurbishment Programme (7056C0) A programme to upgrade all the lifts in Phase 1 building. Year 3 of 3. Lifts 3 & 4 completed work in progress on lifts 1 & 2	March 2015	£131k
SDU – x2 New Washers (7006C0) To replace two of the five SDU washers which are more than ten years old	November 2014	£152k
Decentralisation of Boilers (7079C0) To provide local boilers to the central area administration blocks following the failure of the aged distribution pipework.	Sept 2014	£263k

APPENDIX B

Information Technology schemes	Completion date	Budget cost incl VAT
Clinician's View (7932C0) Phase 2 (Single Sign On (SSO)) allows staff to log in once and access the same patient's records from various systems has now been rolled out to the ward areas. Plan in place to rollout to Outpatients in late October 2014. Phase 3 (Electronic Document Management) – Supplier is reviewing our existing letter processing configuration with a view to recommending changes to speed the import of letters. Options paper being written for EPR PMB to advise on best options for use of product.	Early 2015 Spring 2015	
PACS/RIS (7943C0) Main project now complete. A planned upgrade was undertaken in January with another to follow in February. Work on XDS (Cross Data Sharing) is accelerating with end to end testing in March and plan for go live in May.	May 2015	
Order Comms and Results Reporting (7942C0) About to go live with primary care TQuest upgrade to new version which will enable us to deliver Review and Radiology requesting to GP's in March 2015. Discussions are ongoing with clinical staff about turning off paper reports. A further upgrade of the Review system will take place in early summer.	March 2015	£100k
Blood Tracking Phase 2 (7996C0) Project to allow tracking of blood from "vein to vein". 100 % Traceability is a regulatory requirement under the Blood Safety and Quality regulations (2005). Phase 2 "Bedside Administration" is due to be implemented in January with Phase 3 "Sampling" being scheduled for the first quarter of 2015.	Early 2015	£337K
Electronic Prescribing and Medicines Administration (EPMA) (7961C0)		

SFT is currently considering its involvement in the EPMA project given the six shortlisted EPR bidders all feature electronic prescribing in their offering.	April 2015	£152K
Patient Observation and Escalation Tool (POET) An initial proof of concept was undertaken before Christmas. On 27th January a pilot stage whereby patient observations are recorded both electronically and written on the charts will be undertaken on Laverstock ward.	January 2015	£267k

APPENDIX C

Medical Devices schemes	Completion date	Budget cost incl VAT
Bed Replacement Programme (7131C0) The bed replacement programme is now in it's second year. So far, 192 beds have been replaced. 124 beds will be purchased in 2015/16.	Years 2 and 3 of a 4 year programme	£150k (2014/15) £204k (2015/16)
Flooding in the Radiology Department A leak has caused damage to equipment in the Radiology Department. An insurance claim has been submitted for the replacement of both a mammography machine and a general x-ray machine for Room 2.	March 2015	TBC
Endoscopy stack and scopes (7132C0) Owing to the introduction of the Bowel Scope project in March 2015 it has been necessary to purchase an additional stack and 8 new slim colonoscopes. They have been delivered and will be installed in February.	February 2015	£162k
Ultrasound machine – EPU (7147C0) The purchase of a replacement ultrasound machine was brought forward from the 2015/16 capital programme owing to the current machine becoming unreliable for the Early Pregnancy Unit. The machine has been ordered and will be delivered in February.	February 2015	£70k
Orthodontics and Oral Surgery Cone Beam CT Scanner (7127C0) The scanner produces images which are used to aid diagnosis and treatment planning of orthodontic and orthognathic cases. Evaluations are currently being undertaken and a specification finalised in order to go to tender.	June 2015	£110k
Review of Theatre Instruments (7122C0) The Trust commissioned an external review of instrumentation. All trays have been reviewed and procedure specific cards are being agreed by the Theatre staff which will form the basis for the specification. The specification will be drafted and a tender issued by the end of the financial year.	December 2015	£300k (2014/15) £500k (2015/16)

Medical Devices schemes	Completion date	Budget cost incl VAT
Clinical Radiology 2x ultrasound machines (7124C0) The orders have been placed for these machines, delivery is expected in March 2015. Replacement machines for Ante-Natal clinic and Room 1.	March 2015	£160k
Vascular unit ultrasound machine (7125C0) The order has been placed for this replacement machine, delivery is expected in March 2015.	March 2015	£90k

SALISBURY NHS FOUNDATION TRUST

Minutes of the Council of Governors Meeting – Part 1
At Salisbury District Hospital
Held on Monday 24 November 2014

SFT 3630

Governors Present:	Nick Marsden (Chairman) Sarah Bealey John Carvell Mandy Cripps Brian Fisk Shaun Fountain Chris Horwood Raymond Jack Alastair Lack John Markwell Colette Martindale (Lead Governor) John Noeken Carole Noonan Beth Robertson Janice Sanders Nick Sherman Lynn Taylor Chris Wain Christine White	**Apologies:**	Mary Monnington Lynda Viney June Griffin

In Attendance:
Peter Hill (Chief Executive)
Malcolm Cassells (Director of Finance and Procurement)
Fiona Hyett (Deputy Director of Nursing)
David Seabrooke (Head of Corporate Governance)
Isabel Cardoso (Membership Manager)
Lydia Brown (Non-Executive Director)
Nigel Atkinson (Non-Executive Director)
Sarah Mullally (Non-Executive Director)
Andrew Freemantle (Non-Executive Director)
Ian Downie (Non-Executive Director)
Patrick Butler (Communications Manager)

ACTION

1. MINUTES 21 JULY 2014

The Minutes of the meeting of the Council of Governors held on 21 July 2014 were agreed as a correct record.

2. TRUST PERFORMANCE TO 31 OCTOBER (MONTH 7)

The Council received the Performance Report. It was noted that in October the Trust had missed the Four Hour Performance Target which was a concern but was also a common problem nationally. The Hospital was operating at capacity and was using a range of its escalation capacity to meet the challenge of admitting patients to the most appropriate ward.

Activity levels on Cancer were up following an increase in Cancer diagnosis by GPs brought on by national political pressure and health

promotion campaigns. It continued to be a challenge to encourage all patients eligible for a two week appointment to book this.

Work continued to control C-Diff rates and there had not been a new reportable case for several weeks now. This position continued to show as red on NHS choices.

Following on from discussions at the 21 July meeting of the Council it was noted that the Trust was working to raise productivity in surgical areas particularly with regard to Orthopaedics and Day Surgery. This included more efficient pathways and prompter starts to surgery sessions.

The Trust's Clarendon Suite was not generally used as an escalation area and work was underway to improve its usage to secure non NHS income.

It was noted that Radnor Ward was currently undergoing refurbishment and that Downton Ward had been decanted to the Breamore area.

The Council noted the Performance Report.

3. FINANCE REPORT

The Chairman welcomed Malcolm Cassells to the meeting. The Council received the Trust's Finance Report to 30 September. At that stage the Trust was reporting a deficit of £149,000 and this had subsequently deteriorated and was being discussed by the Finance and Performance Committee. The Trust's subsidiary companies were assumed in the Report to be breaking even.

Commissioner contracts were all signed. There were some challenges coming from Commissioners which were being discussed positively. Wiltshire CCG had paid CQUIN in Quarter 1 in full.

The delivery of savings targets continued to be a challenge. The Trust had received at 30 September £250,000 resilience money which supplemented the marginal rate paid for non-elective activity over a pre-set level. A more recent payment of £1.5m to support the Emergency Department in relation to winter pressures had been received in relation to bids totalling £2.3m.

John Noeken undertook to circulate a briefing note about the 100 Day Challenge on the Better Care Fund which had been considered by the Health and Well Being Board.

The Council noted the Finance Report.

4. CUSTOMER CARE REPORT FOR QUARTER 1

The Council received the Customer Care Report for Quarter 1 which had been considered by the Board in September.

It was noted that the Trust always reviews the complaints for themes and trends. Where these arise they are addressed and current issues include the temperature of hospital food, addressed by the purchase of new food trolleys, cancelled operations and staff attitudes. A recent workshop conducted by Lorna Wilkinson had highlighted the benefits of early communication with complainants.

Governors highlighted that complaints were received in relation to appointments, for example the new partial booking and from real time feedback noise in inpatient areas, from a variety of sources was also mentioned.

The Council noted the report.

5. APPOINTMENT OF NEW NON EXECUTIVE DIRECTOR

The Council received a report presenting the recommendation from the Nominations Committee. The report described the process followed by the Nominations Committee, which had selected Gatenby Sanderson as an independent advisor following a competitive process. The Non-Executive Director post had been advertised in September and of the responses received nine were selected for interview by Gatenby Sanderson. Three candidates were shortlisted for panel interviews on 11 November. The unanimous recommendation was that Mr Paul Kemp be appointed from 1 February 2015 for an initial period of three years at an annual remuneration of £13,000. A copy of the draft appointment letter was provided to the Council of Governors for information.

The Council of Governors agreed that Paul Kemp should be appointed as a Non-Executive Director.

Peter Hill updated the Council on the appointment of a Chief Operating Officer following Kate Hannam's departure on 5 December. Interviews were set for early January and it was hoped that the new person could take up their duties in April. In the interim, Mandy Cripps would be Head of Operations and Laurence Arnold would take on the Interim Chief Operating Officer role. Lorna Wilkinson would oversee the Directorate Senior Nurses, Maternity and Therapy Leads.

6. MAKE UP OF COMMITTEES AND WORKING GROUPS

The Council received a report enclosing a protocol on the composition of committees, working groups and Patient Experience Sub groups attended by Governors.

Governors were invited to provide any comments on the draft protocol within two weeks and the composition of the sub groups etc was noted.

It was noted that a committee was usually formed to undertake a particular task on behalf of the Council of Governors and to make a recommendation as to for example the review of Non-Executive Director remuneration, appointment of Non-Executive Directors and to comment on the draft of the Annual Plan. Working groups of the Council of Governors were more flexible in their activities, and were designed to be discursive.

The Patient Experience Sub Groups were internal working groups of the hospital led by an officer of the Trust to which governors were invited. The Council expected to receive reports from its representatives on the PEG sub groups.

7. FEED BACK FROM OTHER MEETINGS

In relation to the Informal Meeting of the Governors and Non-Executive Directors held on 13 October the Chairman suggested that in summing up these meetings in future he would ask those present if there were any specific issues they wished to see carried forward. The informal meetings were considered to be working well and would continue.

A report from the 22 July meeting of the South West Governor Engagement Network held in Taunton was received and Beth Robertson commented on the 12 November meeting of South West Governor Engagement Network.

8. COMMITTEE AND WORKING GROUP REPORTS

The Council received the minutes and reports of the Membership and Communications Working Group, Strategy Committee and reports from PEG sub-groups.

It was noted that Raymond Jack had been appointed to the Performance Committee following Robert Coate's retirement as a Governor.

In relation to the Membership and Communications Working Group Andrew Freemantle undertook to explore with local armed forces contacts whether there was any appetite for an appointed governor. AF

The Working Group had briefly discussed the future of the Medicine for Members initiative. Although the Council was grateful to John Carvell for his offer to continue to lead on these after he stood down in May 2015, the Council felt that this should be led by a serving governor in future. Governors were asked to volunteer their services to Colette Martindale, Lead Governor.

Included with the Strategy Group report was its revised terms of reference which were approved.

9. ANY OTHER BUSINESS

It was noted that in support of clinical leadership and engagement, four of the Trust's services had been invited to present to a Trust Board Away Day earlier in November. The success of this was being reviewed.

Causes for Concern Log – it was noted that this facility continued to be available to Governors and was supported by the Customer Care Team. It would be mentioned in the induction for new governors in 2015.

10. DATES OF MEETINGS IN 2015

The Council received details of the scheduled meetings of the Full Council for 2015 (next meeting 16 February 2015 at 4pm), the Trust Board Meetings and informal meetings of the Governors and Non-Executive Directors. The AGM was scheduled to be on 28 September 2015 and the next Medicine for Members was on 2 December 2014 at 5.30pm.

A provisional date for the Joint meeting with the Trust Board to comment on the draft of the 2015/16 Annual Plan had been set and would be finalised when the submission dates were confirmed by Monitor.

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 23rd October 2014, 10am-12pm
Boardroom, Salisbury District Hospital

SFT 3631

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair), Peter Hill, Dr Christine Blanshard, Claire Gorzanski, Kate Hannam, Steve Long, Nigel Atkinson, Sarah Mullally, Mark Stabb, Sally Tomlin, Lorna Wilkinson, Fiona Hyett and Jan Sanders (Governor).

In attendance:	Item
Jo Powell (minutes)	
Fenella Hill	CGC1015,16 &17

Apologies:

Denise Major and Helena Eagles (minute taker).

Lydia Brown welcomed everyone to the meeting, in particular Jo Powell who was taking the minutes in this instance.

CGC1001 – Minutes of the meeting held on 25th September 2014
LB bought to the attention of the Committee an email that had been received by Mandy Cooper, Senior Sister, Sarum Ward. LB expressed concerns about the minutes being amended to reflect Mandy's alternative wording.

The Committee agreed that the first two amendments suggested by Mandy would not be incorporated into the minutes.

Action: The Committee did agree the third amendment to be made. Post meeting note – complete. **HE**

Action: The Committee agreed for LW to discuss this further with MC. **LW/MC**

Page 2, CGC0903, 3rd paragraph, 1st sentence – LW asked for this to read ….."learning curve on Quality Impact Assessments.

Action: HE to amend. Post meeting note – complete. **HE**

Page 3, CGC0906, 2nd paragraph – LW asked for clarification regarding "the high patient turnover which can be affected by Cystic Fibrosis patients". CB confirmed that this related to the length of stay of this group of patients as it is usual for them to be long term inpatients.

CGC1002 – Matters Arising/Action Tracker

CGC0505 – Medical Workforce Report update. On agenda under item CGC1003.

CGC0904 – Committee Membership (Junior Doctor and nurse).

CB reported that she had met with Dr Claire Page regarding this matter and confirmed that there was only a small pool (7/8 in number) of Junior Doctors at the Trust for 2 years who meet the criteria required.

CB reported that the Educational Supervisor has incorporated this into the personal development of the Junior Doctors.

To date 1 Junior Doctor and 2 Junior Nurses have been put forward. Confirmation of posts is to

be agreed outside of the Committee.

CGC0911 – Antimicrobial prescribing. LW reported that she had met with Emma Taylor to enable full understanding of what is required. **Action: LW and CB to meet outside of the Committee to discuss this further.** **LW/CB**

CGC1003 - Update on the Medical Workforce Report, Christine Blanshard

CB reported that an increased fill rate of posts in August 2014 was noted with 41 new Junior Doctors recruited.

CB fedback that a drop in clinic had been held for the new Doctors and feedback had generally been very good with most of the new Doctors happy with their post.

The Committee noted the workload of the Medical F1 Doctors especially that weekend cover was a concern. CB reported that LW and herself had written to Ward Sisters to ask for their support in helping the medical F1 Doctors to manage their workload. CB advised that this matter is an agenda item for The next Hospital at Night Committee. CB

CB said there are a large number of medical outliers within Surgical wards at the Trust and that there were concerns with recruiting to posts within Ophthalmology, Geriatrics and Dermatology.

PH advised the Committee that Dermatology had now been removed from the "choose and book" option for patients and that this had also been the case in other Trusts.

CGC1004 - Spinal Unit Leadership Update, Kate Hannam

KH presented the outcome of the Spinal Unit Leadership programme. **Action: A copy of this presentation will be circulated with the minutes of this meeting.** **HE**

KH advised that Nikki Ward had spent 6 weeks on the Spinal Unit observing and speaking to patients and staff. A Clinical Governance session was used to feedback information to the staff from the sessions held by NW.

NA asked for confirmation of the timetable for this piece of work. KH advised that the purpose and function of the unit had to be understood and that some changes were already taking place within the Unit. LB noted that it is an agenda item bi-monthly for the Committee.

STRATEGY

CGC1005 - Hot Topics, Lydia Brown

LB reported that she had contacted all Non-Executive Directors following the last Committee meeting to ask what they would like to discuss in more detail. The Non-Executive Directors asked for end of life care following the withdrawal of the Liverpool care Pathway, Customer Care, cleanliness on wards, nurses' documentation, buzzers and progress post CQC mock inspection.

Action: LB asked CGz to introduce these topics to future Committee agendas. **CGz**

CGC1006, CGC Dates for following year, Lydia Brown

2015 dates will be Thursdays, 10am-12pm in the Boardroom:-

29th January, 26th February, 26th March, 28th May, 25th June, 23rd July, 24th September, 22nd October, 26th November. No meetings in April, August or December.

The Committee agreed the dates for 2015**.**

CGC1007, Terms of Reference & Reporting Schedule, Lydia Brown/Claire Gorzanski

Terms of reference – changes highlighted in blue italics in the report

- Additional members of the committee.
- Increase in the number of meetings from 6 to 9 a year.
- Increase in the requirement for NED attendance at 7 out of 9 meetings.
- Addition of the integrated safeguarding committee minutes for noting.
- Change to the CQC monitoring process in light of the national changes.

Reporting schedule

- The schedule has been updated for 2015 to provide assurance on patient safety, effectiveness and experience.

CGz reported that Junior Doctor and Junior Nurses representation had now been agreed.

Action: The Committee asked for representation from Patient Experience/Customer Care to be reinstated with Hazel Hardyman being asked to attend future meetings. **CGz**

The Committee agreed for attendance by Non-Executive Directors to be increased to reflect the increased frequency of the Committee meetings. NEDs

The Committee agreed for the minutes of the Trust's safeguarding Committee to be noted at future meetings.

The Committee noted that there was a new Trust Ethics Committee and asked for their minutes to be noted at future meetings. FH confirmed that an initial meeting of the group had been held and terms of reference, membership and frequency of meetings was to be agreed at the next meeting.

The Committee noted that the reporting schedule had been amended in line with the CQC information.

The Terms of Reference and reporting schedule were approved.

CGC1008, Effectiveness of the Committee including attendance monitoring, Lydia Brown/Claire Gorzanski

- The review period totalled 8 meetings held between September 2013 and July 2014.
- Overall the CGC is effective in providing assurance to the Trust Board and complies with it duties as set out in its terms of reference.

The CGC was attended by most members regularly. All the meetings were quorate and the committee met eight times in the specified period. In September 2013 it was agreed to increase the number of meetings from six to nine per year to ensure enough time was devoted to items for assurance purposes. The nine meeting schedule started in January 2014.

In addition, the Committee decided a Governor would be invited as an observer to each meeting and terms of reference were agreed. This arrangement started in September 2014. A decision was also made to include a junior Doctor and junior nurse as core members of the committee. This arrangement will start either in November 14 or January 2015.

CGz fedback that a visit had taken place at Frimley Park Hospital (who had received an Outstanding rating by the CQC) and it was felt that this Committee was on a par with the same meeting held there. LB suggested that another visit was undertaken next year to another Trust to review how Clinical Governance is undertaken and reported.

The Committee noted the report.

ASSURING A QUALITY PATIENT EXPERIENCE
CGC1009, Outcome of Complaints Workshop (Verbal Update), Lorna Wilkinson

LW reported that complaints Workshops had been held with approximately 20 attendees. Very good representation was noted from Ward Leaders, Therapists and Directorate Management Teams.

LW fedback that the Mid Staffordshire report had been reviewed at the workshop and a discussion had taken place into what the Trust does both good and bad.

LW confirmed that she had met with HH to discuss the feedback and to develop an action plan. The main points raised by staff were that easier access to the tools to investigate complaints was required. HH and Kate Stovin-Bradford have met and discussed the need for Customer Care to have a separate tab on the Trust's Intranet to make information more accessible to staff.

LW fedback that a follow up workshop is being considered.

ASSURING CLINICAL EFFECTIVENESS

CGC1010, Quality Indicator Report (for discussion), Lorna Wilkinson

- 1 MRSA bacteraemia in Q2 and another suspected contaminant going through arbitration.
- 5 cases of C Difficile in Q2. YTD total of 13 cases against an annual target of 18 cases.
- No MSSA bacteraemias.
- 1 never event.
- 8 new serious incident inquiries.
- An increase in the crude mortality rate from Q1 but a significant downward trend in SHMI to 103 to March 2014 and HSMR to 93 in May 14 and both are as expected. Anticipate up to an 11 point rise when figures are rebased. Sepsis Six is the key improvement action.
- A decrease in grade 2 pressure ulcers compared to Q1. No grade 3 or 4 pressure ulcers in Q2.
- Safety Thermometer - 94 - 95% 'new harm free care'. 86 – 88% 'all harm free care' which indicates a proportion of patients are admitted to hospital with a harm. An increase in new hospital acquired pressure ulcers on this one day snapshot, however total numbers have decreased.
- Six fractures of which four resulted in moderate harm and two resulted in a fractured hip.
- Fractured hip patients being operated on within 36hrs varied between 80 – 85% compliance. The 'golden patient' initiative was reinstated. Best practice tariff decreased to 75% in Q2.

  Escalation bed capacity has gradually decreased. 18 non-clinical same sex accommodation breaches for all, bar one, patient waiting for transfer out of the Intensive Care Unit. Ward moves now reported as two or more moves
- Inconsistent performance on the stroke 4 hour target due to stroke unit capacity. Patients spending 90% of their time on the stroke unit ranged from 90% to 100% due to patients being moved off the stroke unit for bed capacity reasons. CT performance within 12 hours was 100%. A wide variance in high risk TIA referrals seen within 24 hours due to late/wrong community pathway referrals or just missed within a few hours.
- Real time feedback showed patients felt they were treated with care and compassion and rated the quality of care as good. The Friends and Family test response rates were sustained in inpatients but declined in ED and in the Maternity Services.

CB discussed the never event in the Trust. No harm had been caused to the patient and a root cause analysis is being undertaken into the event. **Action: The Committee asked for the report to be fedback at the next Committee meeting.** **LW/FH**

CB reported that the CQC had requested a follow up report on the UTIs mortality red flag report which was now at an expected level.

CB reported that packages of care for stroke patients were being delayed and was a cause of concern for the Trust.

MRSA Bacteraemia – LW fedback that one MRSA Bacteraemia had been recorded in the Trust and this was currently going through the appeal process, as it was felt to be a contaminant issue. LW confirmed that the report into this case was being completed.

C.difficile – LW reported that there had been no Trust apportioned C.difficile cases recorded for September and October (to date). LW confirmed that good progress was being made with the C.difficile prevention action plan.

LW fedback that coloured aprons, sporicidal wipes and Actichlor Plus are currently being trialled with the Trust.

Grade 3 pressure sores – LW fedback that one grade 3 pressure ulcer had been recorded for October. A root cause analysis is being undertaken into the event.

Single sex breaches - LW reported that these were currently recorded when a patient is ready to leave the Intensive Care Unit and the patient is delayed over 12 hours in being transferred to a ward. Work was being undertaken to understand this.

Serious incident Inquiries – NA asked if more work was required by the Trust as this figure is increasing. LW clarified that the definition broadens each year leading to an increase in reporting. LW confirmed that the NRLS report shows that the Trust is a high reporter, but has a low number of incidents/level of harm.

Fractures – PH confirmed that 5 fractures had been reported and not 6.

The Committee noted the report.

CGC1011, CQC Dashboard 2014/15 (deferred to November 2014)

CGC1012, Dr Foster Report & Mortality Reviews

Mortality:

- SHMI is 108 to December 2013 and is as expected. HSMR has declined to 93 in May 14 and is as expected.

Care quality tracker:

- **Composite indicator of musculo-skeletal conditions** (1/5/13 – 1/4/14). There are 27 deaths versus an expected 16 with a relative risk of 167. There was a CUSUM alert in March 14 but since then it has declined. The mortality steering group have reviewed 7 of these deaths and will report when the review is completed.

Quality investigator mortality dashboard:

- **COPD and bronchiectasis patients** - these deaths were reviewed from the period February 2013 – January 2014 and showed a statistically significantly higher than expected relative risk. We had an observed mortality rate of 27 patients versus an expected mortality rate of 17. A relative risk of 152. 26 of the 27 case notes were reviewed. These deaths were reviewed by a Consultant for Respiratory Medicine and the Chair of the Mortality Steering group. Key learning points:
  - Early transfer of relevant patients to specialist teams.
  - Use of British thoracic Society COPD guidelines on admission and discharge.
  - Capacity for specialty ward based working – more respiratory beds.
  - Better communication with GPs in advance of a death of a patient when palliative decisions are made. We have a CQUIN target to drive improvement in this communication. A fax has been agreed with the CCG to help with this.

- **Liver cancer and bile duct cancer patients** – deaths between February 2013 to January 2014. There were 9 deaths observed against 3.5 expected giving a relative risk of 267. The gastroenterologists and the chair of the mortality steering group reviewed the 9 cases. They felt that none of the deaths were avoidable. A senior member of the team identified that all of the cases reviewed had a high risk of dying and that the relatives were informed of this risk prior to the patient's deaths in all cases. Key learning points:
  - The gastroenterologists now communicate the outcome of their MDT meeting to the GP as well as to the hospital team to enhance communication which is vital in end of life palliative situations. This is good practice which should be spread across the Trust.
  - There was evidence of a high quality caring approach in Salisbury with a nurse arranging for a terminally ill patient to see his dog in hospital.

CB reported that there are 2 different reviews taking place within the Trust. CB advised that general physicians are aware of the weak spots and the high risk patients requiring specialist care. The plan is to get the right expert care to the right patient at the right time.

SM asked for clarification into the delay of patients internally being referred to specialist care. CB said that a new internal e-referral system was in place to ensure this was not the case. The current capacity issues at the Trust means that patients move to the next available bed, rather than the correct available bed for their needs. This is also reflected in the need for inpatients to move around the Trust as little as possible.

CB reported that over 40% of all deaths at the Trust are reviewed every week which is considerably higher than other local Trusts. ITU deaths are not reviewed due to the nature of the illnesses of these patients. During the review process improvement have been noted in coding, documentation and clinically.

CB reported that a CQUIN requirement is to ensure that GP's are made aware of patients nearing the end of life in a timely manner. The Committee noted improvements with this requirement.

CGC1013, Keogh Report Update

- Keogh reviewed the quality of care and treatment provided to patients at 14 hospital Trusts in England that had persistently higher than average mortality rates. The aim was to understand whether there were any serious failings that needed immediate action, whilst setting the Trusts on the road to improvement.

- Although there were pockets of good practice there were common areas for improvement in all of the Trusts. Key to this was listening to patients and engaging the staff, a better understanding and implementation of a safety culture, better management of the emergency care pathway and improved leadership and governance.

- Although SFT has not have a persistently elevated HSMR, we recognise may of the challenges being experienced by the 'Keogh 14 Trusts' such as functioning at high levels of capacity in the urgent care pathway, reliance on bank and agency staff and difficulties discharging patients from hospital.

- Keogh set out eight ambitions for improvement over a two year period. He concluded by saying that it was time for a considered reflection and debate, a concerted improvement effort and a focus on clear accountability. The Trust can reflect that it has made good progress in responding to the eight ambitions. It has put quality and safety at the heart of everything we do, listened to our patients, developed our future leaders and staff and has a culture of transparency and learning.

The Committee noted this report and progress of the action plan.

ASSURING SAFETY
CGC1014, Sign Up to Safety & Safety Thermometer, Lorna Wilkinson

Sign Up to Safety:

Sign Up to Safety is a national campaign aimed at halving avoidable harm within the NHS over the next 3 years. Organisations are asked to sign up to 5 pledges which will strengthen patient safety. The 5 pledges are under the following headings:

- Put safety first.
- Continually learn.
- Honesty
- Collaborate
- Support

This document has been agreed through the Clinical Risk Group and is being presented to CMB for consultation on the pledges. Following sign off by the Trust Board this document will be published on our website.

The Trust will be required to produce a delivery plan alongside this document to detail how the pledges are to be achieved; this will underpin our safety programme over the next 3 years and the work undertaken as part of the Patient Safety Collaborative.

LW fedback to the Committee the background behind this piece of work.

The Committee agreed for the Safeguarding statement to be removed from the document.

The Committee agreed that acute kidney injury, medicines safety and peri-operative surgery safety information should be included within the document.

Action: LW/DM to remove Safeguarding statement and include acute kidney injury, medicines safety and peri-operative surgery safety information. **LW/DM**

Action: LW confirmed that quarterly updates on the action plan would be presented to the Committee and that the Safety Steering Group would be reinstated, to pick up this work. **LW**

Safety Thermometer:

The Committee noted the report and that the Clinical Commissioning Group (CCG) had noted concerns about the Trust being an outlier for harm free care.

It has been identified that SFT have been reporting all harms in comparison with new harms. This has now been corrected and the percent of harm free care (new harms) is consistently over 92%. This comparison will be shown in future graphsand has already been added to the Quality Indicator report

The Safety Thermometer will be included within the new safety programme to use more effectively at ward level for analysis of data

The Committee noted the report.

CGC1015, Assurance Framework

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 is also attached identifying key changes since the last meeting. Those changes are also highlighted in red within the main body of the document

The Trust Risk Register (extract of clinical risks scoring 12 and above) is submitted for reference so that the Assurance Committee can either be assured that specific risks are being managed effectively locally or if not to identify how this may be ascertained.

LW confirmed that a meeting would take place with FHi to renew the assurance framework to include information on the Infection Prevention and Control Team, up to date results for PLACE audits and to include the C.difficile prevention action plan. The Committee agreed that information on MRSA and Ebola (Viral Haemorrhagic Fever) should also be included.

The Committee agreed the paper and noted the work being undertaken.

CGC1016, SII/CR Report Q2

Updates since July 2014 CGC to outstanding recommendations:

CR 106 All recommendations completed
SII 127 All recommendations completed
SII 129 All recommendations completed
SII 127 All recommendations completed
SII 133 Recommendations 1-5 completed
SII 134 All recommendations completed
SII 138 Recommendations 1, 3-7, 10 and 11 completed
SII 139 Recommendations 1-7 completed
SII 140 Recommendations 2 and 4 completed
SII 141 All recommendations completed
SII 142 Recommendations 1-5 completed

Reviews with outstanding recommendations:
CR 108, SII 133, SII 138, SII 139, SII 140, SII 142

Reviews with recommendations added to Department/Directorate Risk Register
Nil

New Recommendations since July 2014 CGC
SII 133, SII 134, SII 138, SII 139, SII 140, SII 141, SII 142

Serious Incident Inquiry/Clinical Review for Closure
CR 106, SII 127, SII 129, SII 127, SII 134, SII 139, SII 141

FHi reported that there were 7 new reviews in progress with recommendations.

The Committee noted the delay in some of the reports being completed. LB assured the Committee that a new process was in place which will ensure such delays are shortened in future.

CGC1017, Annual CLIP Report

This report is provided to aggregate and distil the reporting processes from Risk, Customer Care and Litigation throughout the year. The report identifies any cross cutting themes for the organisation and the available information can be used for current service planning. The report covers the period from April 2013 – March 2014.

FH reported that there is currently a time delay in complaints and the legal process.

The Committee noted that there is a common theme in sub optimal diagnosis linked to imaging as this is not always picked up correctly.

Page 3, Graph 3 – The committee asked for clarification on the date period for this data collection. **Action: LW/FHi to clarify.** **LW/FHi**

ST advised the Committee that medicine discrepancies between pre admission and admission and being reviewed with Pharmacy presence at ward level and the introduction of an electronic system. PH fedback that the Junior Doctors currently have a HiMP project running around medicine management. Feedback from this project can be heard at the Service Improvement Awards in November.

The Committee noted the report and the work being undertaken.

CGC1018, Medication Governance Report

The report highlights areas of work being undertaken in the Trust to deliver the national, regional and local agendas regarding medicines management.

ST fedback that the TPP system is very useful for the Junior Doctors but that is was hard to use and was only as good as the GP updating it.

The Committee noted that extensive work is being undertaken with antibiotic stewardship.

ST raised concerns around the security of medicines at ward level and confirmed that this had now been addressed.

The Committee noted the report and the work being undertaken.

PAPERS FOR NOTING

CGC1019, Clinical Risk Group Minutes (Aug 2014)	Noted
CGC1020, CMB Minutes (Sept 2014)	Noted
CGC1021, Information Governance Group (Sept 2014 minutes available Jan 2015 CGC)	N/A
CGC1022, Integrated Safeguarding Committee (Sept 2014 minutes available for Nov 2014 CGC)	N/A
CGC1023, Children & Young People's Quality & Safety Board (Sept 2014 minutes available for Nov 2014 CGC)	N/A
CGC1024, Infection Prevention & Control Committee (July 2014)	Noted

CGC1025, ANY OTHER BUSINESS

Trust preparedness for Ebola

LW advised the Committee that regular meetings are held within the Trust with input from Whiteparish AMU, Emergency Department and Maternity.

LW confirmed that to date, the location of suspected Ebola cases in the Emergency Department has been agreed. Public Health England (PHE) posters are now displayed is public areas around The Trust. Information is available on the front page of the Trust's Intranet for staff to access.

LW confirmed that Personal Protective Equipment (PPE) in the form of gowns, wellies and masks were being sourced. Mask fit testing was being undertaken with key personnel. LW fedback that there was a national supply issue with the disposable onesies which was being investigated. LB suggested the procurement of veterinary style suits. **Action: LW to LW investigate this alternative.**

LW confirmed that de-robing technique training is being completed on a regular basis by the Microbiology Consultant and the Infection Prevention and Control Team with the Emergency Department to ensure no cross contamination.

The Committee noted that any patient identified to have suspected Ebola will only be in the Trust for 8/10 hours until confirmation is received regarding their status. If a positive status is reported, the patient will be moved to a specialist facility.

LW reported that data collection for NHS England would be completed on time.

SM asked if the walk in centre in Salisbury City Centre had been set up. KH confirmed that work was ongoing in this area.

NEXT MEETING

27th November. No meeting in December.

2015 dates will be Thursdays, 10am-12pm in the Boardroom:-
29th January, 26th February, 26th March, 28th May, 25th June, 23rd July, 24th September, 22nd October, 26th November. No meetings in April, August or December.

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 27th November 2014, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair), Lorna Wilkinson, Sally Tomlin, Hazel Hardyman, Fiona Hyett, Clare Holbrooke-Jones (shadowing), Steve Long, Nigel Atkinson, Sarah Mullally, Mark Stabb, Angela Clarke (representing Junior Doctors), Jan Sanders (Governor, observer)

In attendance:

	Item
Helena Eagles	Minute taker
Duncan Murray, Mandy Cripps, Louise Dennington	CGC1105 & 06
Helena Bridgman, Katrina Glaister	CGC1106

Apologies:

Peter Hill, Christine Blanshard, Claire Gorzanski, Fenella Hill, Kate Hannam, Carmen Carroll

Lydia Brown welcomed everyone to the meeting and confirmed the meeting was quorate. AC visit to the CGC.

CGC1101 – Minutes of the meeting held on 23rd October 2014

The minutes of the last meeting were agreed as an accurate record.

CGC1102 – Matters Arising/Action Tracker

CGC1117 (Nov 2013) – Clinical Audit report, follow up audit to be undertaken by internal Audit to see if new processes are working – on agenda under CGC1103

CGC0205 (Feb 2014) – Nursing, Midwifery & AHP Strategy Update – verbal update on agenda under CGC1104

CGC0911 (Sept 2014) & CGC1002 (Oct 2014) – Quality indicator Report – ribotyping and antimicrobial prescribing. Complete – the Infection Control Working Group will monitor the ongoing work,

CGC1001 (Oct 2014) – Amendments to minutes from Sept 2014. Complete.

CGC1004 (Oct 2014) – Spinal Unit Leadership Update, presentation circulated with the minutes of the meeting. Complete.

CGC1005 (Oct 2014) – Hot Topics are now on the 2015 reporting schedule. Complete.

CGC1007 (Oct 2014) – Terms of reference & reporting schedule. HH will now be attending CGC meetings. Complete.

CGC1010 (Oct 2014) – Quality Indicator Report. The root cause analysis report for the never event is still in progress and this item will not be ready until the January CGC.

CGC1014 (Oct 2014) – Sign Up to Safety. LW/DM made the required amendments and LW confirmed that quarterly updates on the action plan would be presented to the CGC and that the Safety Steering Group would be reinstated. Complete.

CGC1017 (Oct 2014) – Annual CLIP Report. F Hill provided an update - the report is being

written and should be available in Jan 2015. The CGC can be assured that immediate measures have been put into place to prevent recurrence. Complete

CGC1025 (Oct 2014) – The use of veterinary suits in Ebola was discussed and action completed.

CGC1103 – Clinical Audit report – follow up by Internal Audit, Mark Stabb

Fieldwork is near completion on the follow up audit which was designed to ensure that the agreed actions to the 2013/14 NICE Guidance and Clinical Audit Internal Audit Reports have been satisfactorily implemented. In addition, the audit will identify further improvements to processes which will be discussed with the Head of Clinical Effectiveness and Clinical Governance Facilitator in early December 2014, following which the report will be presented to the January 2015 Audit Committee.

We can report that agreed actions satisfactorily implemented include setting an agreed limit (five) of local audits per Directorate for inclusion in the Clinical Audit Annual Plan and to closing off 'uncompleted' audits that could not be finished or the time elapsed meant the outcomes were out of date.

There were three phases of work agreed that streamlined processes, and two of these have been completed. These were to upload the Annual Clinical Audit Plan into OSCA using unique identifiers for each audit and to migrate information from the three databases in use at the time of audit onto OSCA.

The remaining issue to be implemented relates to migrating the entire NICE Database onto OSCA (referred to as Phase 3) but this is dependent on IT support and clinician engagement regarding completion of NICE risk assessments when determining the compliance status of each applicable guideline. The implementation of 'Phase 3' and suggestions as to how to expedite this will be included in our current year audit report.

MS explained that this is a 'holding report' to update the Committee and a full report will be available in January 2015.

The Committee noted the report and its content and confirmed that they were assured..

CGC1104 – Nursing, Midwifery & AHP Strategy Update, Lorna Wilkinson

LW provided a verbal update.

LW and FHy are in the process of meeting with all the ward leaders and departmental leads and are currently around half way through the process. The timing is good as we are now 1 year post-launch of the Nursing Strategy. FHy has been collating examples of the great work that has been undertaken and this will feed into the Pride of Practice event on 13th March 2015.

LW has seen a number of very good and diverse pieces of work and the progress is good.

CH-J confirmed that the strategy has been launched in Britford and all staff have an input, LB felt it was positive that all staff feel engaged.

The Committee confirmed they were assured.

STRATEGY

CGC1105 – Surgery Core Services Report, Duncan Murray, Mandy Cripps, Louise Dennington, Clare Holbrooke-Jones

The Directorate provided a comprehensive report detailing their services and activity.MC explained that this was a new format report and the team would pick out the salient points.

The following items were highlighted by LD under the 5 key lines of enquiry from the CQC guidance:-

1. Safe – SII136 was discussed, this related to a fracture patient. LD discussed the learning outcomes and also identified good areas of practice at SFT.

2. Well led – Mock CQC inspection. 4 areas under the Surgery Directorate were assessed and the Directorate are very proud of these departments which showed very few areas to improve upon.
3. Confidence & Caring Ward Rounds – this covers all the key lines of enquiry. The rounds are based on some of the national requirements and the 6 Cs.

MC highlighted the pressures of activity and the issues this can cause.

Ophthalmology and Urology are struggling to recruit appropriate consultants after the retirement of previous consultants. The Directorate have looked at roles and responsibilities and moved these around under a competency framework but there is immense pressure on these services and we are unable to find a like-for-like replacement.

NA asked what can be done about improving the recruitment process and how they can be escalated.

MC replied that SFT are planning to approach recruitment agencies for the hard to recruit posts and Alison Kingscott is putting together a group to look at this.

DM discussed the problems with recruitment for Ophthalmology at some length. There has been a massive expansion in the past 5 years for treatment of macular conditions and this has caused a workforce issue as training has not kept up. SFT also need a non-macular specialist but the demographics of the department are atypical and this may hinder recruitment. DM is hoping to recruit a new consultant next week, and hopes to have 2 consultants in place by February 2015.

SM raised the matter of whether SFT can join with another hospital to help attract consultants for hard to recruit posts, LW stated that this was a wider problem not just related to Ophthalmology.

LB suggested that the recruitment issues should be raised at Trust Board level.

Action: LB asked for CB to return in January 2015 with a proposal for how to recruit the 3rd Ophthalmology consultant and more details about the wider recruitment problems SFT faces. **CB**

MC discussed the escalation process and use of day surgery beds overnight, which can then lead to impact on surgical lists. MC reported that Surgery have good higher level support from the Director and Deputy Director of Nursing.

DM highlighted p.7 of the report which discussed NCEPOD requirements regarding acute admissions to be seen within 12 hours. An action plan for Urology will be developed.

DM also discussed bullying and harassment in Theatres. Sickness levels in Theatres had been quite high and the team had received reports of bullying and harassment, there were allegations that medical and non-medical staff were being treated differently. DM has since launched an empowerment initiative to help staff challenge bad behaviour. DM wrote to all consultants theatre users to promote this initiative and has been using the recently launched values and behaviours to measure behaviour against. Staff have also been reassured that they will be supported. The empowerment initiative is also being followed up by assertiveness training for staff.

There is undoubtedly work to be done.

LB commended the team for taking these actions.

NA complimented the style of clarity and the report.

The Committee noted the report and the assurance it provided.

CGC1106, Patient Story, Helena Bridgman/Katrina Glaister

HB told her story about her time on Radnor Ward, when she was initially admitted and then on readmission after her stay in the Royal Brompton Hospital.

KG explained that this would be more of a structured conversation than a story and LB confirmed that the Committee will listen but will not ask questions during the Patient Story.

HB stated that it was very key that Radnor had approached the Royal Brompton for help when

they needed it. Royal Brompton had told HB that Salisbury is a very good hospital who always ask for help when needed and HB was assured by Royal Brompton that SFT would take good care of her when she returned here.

HB discussed the importance of patience and perseverance of staff, kindness, being talked to and the importance for patients to be able to control some aspects of their day, within parameters.

HB has a huge respect for Radnor's staff who have an incredibly tough job and have to deal with harrowing situations. There is enormous pressure to get things right.

HB highlighted what she learnt through her journey:-

1. Hospitals need a readiness to refer and ask for help.
2. Patience and perseverance with problems.
3. Human presence and little things count.
4. Champion the Patient Diary. Royal Brompton have iPads available to help document the patients' stay, these have been bought from charitable funds. Patients lose time when on ITU.
5. Air conditioning and heating vents – when a bed is placed beneath a vent it is very hard for the patient to feel a comfortable temperature.

Action: LD will feed back HB's idea regarding iPads being bought from charitable funds for Patient Diaries and the positioning of beds under vents. **LD**

HB felt that 12 hour shifts are very hard and tiring on staff.

HB summarised her experience as extraordinary, with extraordinary care.

LB thanked HB for attending and sharing her story.

LB asked AC for her response and AC agreed that 12 hour shifts were hard and by the 11th hour staff are very tired. A 10 hour shift does work better for staff but can be harder for hospitals.

SM asked to hear more about the impact of 12 hour shifts at SFT, patients can see that staff are getting tired at the end of a shift. SM would like to see a report brought to CGC.

FHy reported that there has been a move towards a mixed shift pattern, sickness absence and behaviour is monitored.

LW suggested that a report on 12 hour shifts could be included in the next Skill Mix report for CGC.

AC stated that at her last hospital the doctors were on call more frequently but in blocks of 2. It was more effective and the doctor can return to their ward faster.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC1107, National Inpatient Survey 2013 – Update on Action Plans, Hazel Hardyman

The over-arching theme of the action plans across the Trust was communication, both between all grades of staff working in clinical areas, and information given to patients and relatives particularly upon discharge. In general, the following changes have been made:-

- All wards now use electronic discharge which includes information being sent electronically to the patient's GP.
- Ward sisters or the nurse-in-charge carry out ward rounds with doctors wherever possible to ensure that they are aware of what is said to the patient and can answer any questions the patient may have.
- Winterslow ward has set up 'Sisters clinics' to give relatives the opportunity to talk to them about any questions or concerns they may have.
- Whiteparish AMU is looking to use the afternoon tea round as an opportunity for the nurse-in-charge to talk informally to patients and their relatives.

Details of actions taken by individual wards are contained in the appendices.
The results of the National Inpatient Survey 2014 will identify whether or not these actions have proved effective.

HH – there has been some good work on communication. Pembroke now have new drugs trollies which are quieter at night and are considering getting eye masks and earplugs for patients. The results of the 2014 survey should demonstrate progress.

LW stated that key work on communication has taken place at the Nursing Strategy Meetings. Feedback over the ward supervisory role has been positive and this has freed the ward leader up to focus on issues such as communication.

The Committee noted the content of the report.

ASSURING CLINICAL EFFECTIVENESS

CGC1108, Quality Indicator Report (for information), Lorna Wilkinson

- No cases of C Difficile for 2 months suggesting the action plan is having a positive effect.
- Two MSSA bacteraemias. Neither were line related.
- 1 new serious incident inquiry.
- An increase in the crude mortality rate but a downward trend in SHMI to 103 and SHMI adjusted for palliative care to 100 in March 2014. HSMR is 91 to July 14 but when remodelled is 100 for the same period which is as expected. The final remodelled HSMR for the financial year 13/14 is 109 and is higher than expected. Sepsis Six is the key improvement action.
- An increase in the adverse event rate in August 14 as measured through the global trigger tool.
- A decrease in grade 2 pressure ulcers. No grade 3 or 4 pressure ulcers.
- Safety Thermometer - 97% 'new harm free care'. 91% 'all harm free care' which indicates a proportion of patients are admitted to hospital with a harm. A decrease in new hospital acquired pressure ulcers on this one day snapshot.
- Two falls, one was a fractured pubic rami, the other a fractured finger. Both were managed conservatively.
- Fractured hip patients being operated on within 36hrs showed 88% compliance. The 'golden patient' initiative is in place.
- Escalation bed capacity has increased. 8 non-clinical same sex accommodation breaches all for patients waiting for transfer out of the Intensive Care Unit. Ward moves now reported as patients moved more than twice are at a low level.
- A decrease in the percentage of patients arriving on the stroke unit within 4 hours due to stroke unit capacity. A decrease in patients spending 90% of their time on the stroke unit. CT performance within 12 hours was 90%. 73% of high risk TIA referrals were seen within 24 hours. None were seen between 24 to 30 hours as 7 referrals were received with only a few hours to spare or beyond 24 hours. Improvement work continues with GPs and within the Trust.
- Real time feedback showed patients felt they were treated with care and compassion and rated the quality of care as good. The Friends and Family test response rates improved in inpatients and ED. The Maternity Services although improved remain below target. Day cases and outpatient response rates have declined. We will be trialling the use of an iPad in outpatients in November. NHS England has withdrawn the net promoter score.

LW highlighted the adverse event rate which spiked in August. This will be put on the agenda for discussion at the Clinical Risk Group. There is nothing new in terms of pattern but there have

been a higher volume of events.

The grade 3 pressure ulcer mentioned in the previous report was downgraded to a moisture lesion.

SFT is still struggling with time to theatre for fractured neck of femur patients.

The gold patient initiative and trauma lists were discussed. The stroke issues link to discharge problems. During this time of the year we would expect to see an escalation in bed days.

ITU mixed sex accommodation results were highlighted, LW feels that we could be more anticipatory with regards to patient flow from Radnor.

LB felt that overall this is a pleasing report but acknowledges some concern over the Global Trigger tool.

Action: SM asked for some clarity over the HSMR graph and LW will check on this and circulate an explanation and amended graph if necessary.

The Committee noted the report.

CGC1109, Quality Account Progress Report, Lorna Wilkinson

- Overall, there has been good progress in the priorities the Trust agreed for the year with a high level of patient satisfaction in key areas with work ongoing to improve areas still causing concern to patients.

- The process of engaging stakeholders in setting the priorities for the 2015 – 2016 Quality Account is about to start with visits to Age UK and Warminster Health and Social Care group, and commissioners already planned.

- The key will be to ensure the priorities reflect what patients have told us, fit with local need, the NHS Outcomes Framework 15/16, the Five Year Forward View and the NHS Mandate15/16.

LW stated that there is a huge amount of detail in this report and CGz has pulled it together well. We can see some good progress but there is more work to be done on Sepsis 6 and stroke. LW has confidence in the lead nurse and consultant in ED to take the Sepsis 6 bundle forward and we should see improvement over the next few months.

FHy asked those present to send any ideas for priorities for next year's Quality Account directly to Claire Gorzanski.

The Committee noted the report.

CGC1110, Major Issues Report, Lorna Wilkinson

The report highlighted the following major issues:-

1. Ebola preparedness.
2. The Better Care Fund.
3. The 5 Year Forward View.
4. The new duty of candour
5. The mock CQC inspection.
6. Quarter 2 staff Friends and Family test results.
7. NHS Choices website.
8. National cancer patients survey
9. The new urology centre opened
10. The new Pembroke Unit garden opened
11. Emergency Department wins local heroes award.

LW highlighted the Better Care Fund, 5 year Forward View (emphasising preventative medicine and integration of primary, secondary and community care), Duty of Candour (this comes

formally into power today), CQC Mock Inspection and the ED Team won the Salisbury Journal local heroes award.

SL expressed some concern over the NHS Choices website where SFT scores well for patient feedback but poorly for cleanliness and infection control. FHy explained that this was due to the fact that our C.difficile figures were higher in the earlier part of the year and these are always a reflection of previous 3 months, the PLACE audit is only updated annually and this also has an impact. Caroline Lecko is a national lead on Food & Nutrition and she will be visiting SFT in January; we hope her visit will help to promote aspects SFT does really well such as food & nutrition and our initiatives in this area.

The Committee noted the content of the report.

CGC1111, Dementia Strategy Mid-Year Report, Carmen Carroll

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

1. Use the experience of people with dementia and their carers to prioritise service improvements based on the results of the Trust dementia quality indicators
2. Celebrate success – the dementia training programme, outpatient standards, ENGAGE and ELEVATE projects have all been commended as positive practice on www.dementiapartnerships.org.uk
3. Improve compliance with the dementia screening and carer support CQUINs targets
4. Embed a dementia pathway and ways of identifying people with dementia to maintain dignity and to deliver care promptly and safely
5. Build on significant improvements demonstrated Trust-wide in the second rounds of the National Dementia Audit 2012 and SW dementia peer review 2013 and monitor progress via the dementia work programme
6. Participate in the development of the Wiltshire wide Dementia Strategy.

CC was unable to attend the meeting and LB asked for comments on the report.

SM raised a query over meeting hydration and nutrition needs – how do staff make an assessment to ensure the needs are met?

AC stated that some patients have a pink or yellow form above their beds that gives tips.

LW's view was that this should link into intentional rounding.

ST replied that some areas are starting to note this on the drug charts and it can be quite a good prompt.

FHy is currently undertaking a piece of work with the Food & Nutrition Steering Group around availability of snacks and fruit and how these are promoted to patients and relatives.

The Committee noted the content of the report.

CGC1112, CQC Intelligent Monitoring Draft Report, Lorna Wilkinson

- The overall risk score has decreased from 4 in July 2014 to 1 in December 2014.
- There are no elevated risks.
- There is one indicator rated as a risk.
  - Mortality associated with musculoskeletal conditions – the mortality working group are reviewing these deaths.
- SFT continues with a risk banding of 6 which puts us in the lowest risk cohort.

LW – the headline is that SFT continues to be in Risk Band 6. SL asked how many Trusts were in Band 6 and FHy confirmed that SFT is one of very few that have been consistently in Band 6.

The Committee noted the content of the report

ASSURING SAFETY

CGC1113, Executive Safety & Quality Walk Annual Report, Lorna Wilkinson

The Executive Safety and Quality Walkround Annual Report provides detailed evidence around the outcomes from departmental walkrounds, and how they are being achieved within the organisation.

Key Items to note are:

- The reliable completion of 3-4 walk rounds per month
- 37 actions were agreed during the 2013/14 period, of which 24 are still outstanding
- No Trust wide themes have been established however examples of actions taken are:
- Staff and patient complaints in relation to variations of heat in clinical areas – a bid has been submitted for consideration of air conditioning.
- Concerns raised over speed of car on site – speed cameras are being used to assess speed of cars on the site.
- Concern raised that areas used in escalation do not have equipment easily available – areas assessed for equipment availability and location
- Availability of chair scales raised in a clinical area – scales purchased

LW raised a query over the statistic of 37 actions with 24 outstanding when the graph shows over 90% are complete, LW will follow this up with Fenella Hill.

LB expressed concern over the number of actions which are not resolved from previous years; on a number of occasions LB has been on a walk round and staff have confirmed that problems carry on without resolution, even if they are risk assessed. SM, SL and LB would like a more robust stance on action resolution.

NA asked whether it may be something Internal Audit could review.

LW explained that she and Christine Blanshard are looking at refreshing the walk round system and MS felt that if the system was being refreshed then Internal Audit could have input and seek clarity on action resolution.

SL asked for a quarterly paper to be submitted to CGC regarding the number of outstanding actions and how long they have been outstanding for. This would not be for discussion but within the noting section to provide reassurance.

Action: LW will ask FHi for a re-work of this report and it will then be circulated via email to CGC members. **LW**

The Committee noted the content of the report

CGC1114, Risk Report Card Q2, Lorna Wilkinson

- 914 incidents reported over the quarter
- No incidents categorised as catastrophic
- 5 incidents categorised as major*
- 2 major incidents due to fractures within the quarter
- 1 Never Event reported within the quarter
- 2 new Clinical Reviews commissioned within the quarter
- No new Non-clinical Reviews commissioned within the quarter
- 8 new Serious Incident Inquiries commissioned within the quarter (1 removed in agreement with CCG following receipt of results)
- No new Local Reviews commissioned within the quarter

*Initial grading and subject to change following review.

LB and LW discussed the personal injury figures, LW explained that this is any accident involving staff or patients and falls are the largest number of incidents.

LW reported that there is a security group which Kate Hannam has been involved with and by March SFT should have a 24/7 security presence.

Committee members expressed concern over the level of violence and aggression incidents, LW noted that this links to the ongoing work the dementia team are doing including training staff on de-escalation techniques. LW stated that very few of the incidents relate to self-harm.

The Committee agreed the paper and noted the work being undertaken.

CGC1115, NPSA NRLS Report, Lorna Wilkinson

Updates since July 2014 CGC to outstanding recommendations:

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

Key items to note are:

- Patient accidents continues to be the top reported incident at SFT (23.8% against the cluster reporting 20.6%). Medication incident reporting continues to be positively high with the Pharmacy Intervention Reporting demonstrating reporting at 2.3% higher than other small acute organisations.

- Nationally 69.3% of reported incidents result in no harm, we reported 90.3% of incidents as resulting in no harm.

- Reporting rate per 100 admissions shows the Trust to be in the middle 50% of the cluster group. Although our reporting position has dropped on the Comparative reporting chart, our numbers of reported incidents per 100 admissions has increased compared to the same period last year.

- Incidents reported in 6 of the 6 months 1 October 2013 – 31 March 2014

This is a six monthly report. LW highlighted the fact that SFT have dropped in the rankings and we need to be aware that when organisations move the DATIX web there is often a temporary drop in reporting.

LB noted SFT is above the benchmark in a couple of areas and FHy explained that SFT is always over the benchmark due to the way that Pharmacy report which can be viewed as a good thing.

ST – SFT positively encourage reporting of incidents.

The Committee noted the content of the report.

CGC1116, Safeguarding (Adults & Children Q2), Lorna Wilkinson

<u>Adults</u>

- In Q2 a total of 25 patients had Safeguarding alerts raised during/ related to their admission.
- 23 alerts were raised with Wiltshire, 1 with Dorset and 1 with Hampshire Councils.
- All of the alerts were investigated using the Safeguarding Policies and Procedures, and were either followed up as care reviews by Social Care or had 'No Further Action'.
- 12 of these Safeguarding alerts were raised due to the patient being admitted from the community with a grade 3 or 4 pressure ulcer.
- Abuse themes this quarter are predominately neglect and financial abuse
- The Adult Safeguarding Lead Nurse attended 5 safeguarding investigation meetings and the Associate Senior Nurse in medicine has been attending. Nil MARACs during Q2 were attended by the Adult Safeguarding Lead Nurse due to absence but these have been fully covered by the Safeguarding Children's Nurse

<u>Issues and Developments in the local Health/ Social Care Community</u>

- Acute Mental Health Liaison Service
- Wiltshire Safeguarding Adult Board (WSAB)
- Prevent
- DoLS Best Interest Assessment

Challenges over the next 3 months
The challenges continue to be:

- Impact of the Supreme Court judgement on practice within the organisation
- Continued absence of the Safeguarding Adults & MCA lead and inability to fill the post
- Supporting of clinical to staff to provide consideration of a deprivation over the 24 hour period
- Unlawful/ lapsed deprivations due to local authority workload following Supreme Court ruling
- Accuracy with the MLE reporting system

FHy – this report has been a real challenge and Gill Cobham's absence has had an impact for us but has led to greater ownership at Directorate level and this is a good thing. In terms of the number of alerts raised these have dropped off over the last quarter but figures are up over the year as a whole.

Work continues on improving communication between SFT and Glenside.

DoLS – the rate continues to rise as a result of last year's Court decision. There is still a delay on the best interest assessment for DoLS being completed, this is currently taking around 4 weeks.

There is an ongoing problem with the software for the safeguarding training and this is causing some issues with compliance figures, we believe the compliance figure is actually higher.

Restriction and restraint – the data is being recorded manually until DATIX web is fully rolled out.

PREVENT training – SFT had a workshop delivered by the police and it was very well evaluated.

WSAB's annual report is now available on their website.

LW expressed her confidence that the day to day aspects of safeguarding are being managed well in GC's absence but has some concerns about the impact on the overall strategic level aspects. We are managing the day to day risk.

Training for safeguarding was discussed and AC reported that she did not receive any face to face safeguarding process as part of her induction. This raised concern within the Committee who had understood that this happens as part of every SFT staff member's induction and this needs to be monitored.

Action: FHy to feedback that there was no specific safeguarding training at AC's induction which was done in August. **FHy**

LB stated that overall the concern was whether the face to face training was happening for everyone and ensuring that SFT has a strong culture for safeguarding. The NEDs would like to receive face to face training on safeguarding and possibilities for this were discussed.

Action: FHy will discuss training for the NEDs with GC when she is next in. It is possible the training session could be tagged on after a CGC meeting or as part of a Trust Board workshop. **FHy**

The Committee noted the content of the report.

NB - The Safeguarding Children Q2 report has been deferred to January 2015.

PAPERS FOR NOTING

CGC1117, Clinical Risk Group Minutes (Sept 2014)	Noted
CGC1118, CMB Minutes (Oct 2014)	Noted
CGC1119, Integrated Safeguarding Committee (Sept 2014 minutes available for Jan 2015)	N/A
CGC1120, Children & Young People's Quality & Safety Board (Sept 2014 minutes available for Jan 2015)	N/A

CGC1121, ANY OTHER BUSINESS

1) JS raised a concern regarding the public Wiltshire CCG meeting held in Salisbury City Hall last week. Simon Truelove, CCG Chief Financial Officer, said that Salisbury has a high incident rate compared with Bath and Great Western and he then commented on the impact of cost improvement programmes at Salisbury and drew a parallel to Mid Staffs. Press were present at this meeting but there was no official representative for SFT to respond.

Action: LW will investigate what was said at the CCG meeting. **LW**

2) MS is drawing up next year's Internal Audit plan and asked for Execs and on-Execs to feed back any ideas directly to him.

3) LW discussed Ebola preparedness. A lot of work has taken place and SFT saw its first potential Ebola case last week which tested our systems effectively. SFT's systems were robust and worked well internally but there were some challenges with Public Health England and SFT has been in contact with PHE about this.

4) LB asked AC and CH-B for their feedback on the CGC. Both felt that there is a lot of information to cover and many reports to discuss and that it will be good to feed back some of the matters at ward level. AC felt that it is very beneficial to have a junior doctor on the Committee and this should continue.

NEXT MEETING
No meeting in December 2014.

2015 dates will be Thursdays, 10am-12pm in the Boardroom:-
29th January, 26th February, 26th March, 28th May, 25th June, 23rd July, 24th September, 22nd October, 26th November. No meetings in April, August or December.