Quality Account
2014 - 2015
Quality Report

Introduction

This is our annual report which looks at the quality of our services over the previous year and also includes plans for quality improvement next year.

Quality accounts, which are also known as quality reports, cover three components; patient safety, clinical effectiveness and patient experience. These reflect the quality of care adults, children and young people receive and each of our priorities is linked to one of these three components.

Part 1

Our commitment to quality - the Chief Executive’s view

The NHS continues to attract widespread interest highlighting the enormous loyalty, affection and pride that so many people have for their local hospitals and the NHS as a whole.

This year NHS England published its Five Year Forward View and at its heart is an understanding that the culture of healthcare in this country and the way it is provided needs to change. The ambitions include a greater emphasis on the prevention of illness and on encouraging more people to take responsibility for their own health. Better access to support and information and a bigger role for public health will be key. The Five Year Forward View also sets out a need to redesign urgent and emergency care services, so that there is better integration between A&E departments, GP out of hours services and support through other services such as NHS 111. The report from the Seven Day Services Forum by the National Medical Director highlights the need to examine the key issues which affect delivery of a seven day service and also to make improvements in access to diagnostics seven days a week for patients receiving urgent and emergency care.

The aim is to achieve better working relationships between health and social care, with shared budgets and more care provided in the community to support the development of new “Models of Care”. In some areas this could even involve the creation of new organisations that provide both GP and hospital services, together with mental health, community and social care.

While the NHS has already gone through a period of significant structural change, we must not forget the fundamental priority for us all – the delivery of high quality, safe patient care. This care is our priority whether it is provided in hospital, or the community, or a combination of organisations.

Delivering high quality, safe care, with a positive patient experience are the main factors that drive our organisation and continued improvements in these areas will remain a key priority for the Board. I am pleased with the progress we have made over the last year in so many areas that affect the quality of care that we give to our patients. I also feel that we have done much to improve their experience with us and this extends to their families, friends, carers and visitors to the hospital.

A positive patient experience can be seen in patient surveys, inspections and reviews and was highlighted by the Care Quality Commission (CQC), which has again placed the Trust in band 6, which is the rating given to the lowest risk hospitals. Monitor, the independent regulator, also gives us a Green (Best) Governance Risk Rating.

Good quality care is also reflected in a number of positive improvements that have taken place across the hospital. A key area for us continues to be the care of older people, in particular those with dementia. We have continued to implement the eight South West Regional Standards for dementia care, which focus on all aspects of care and treatment and how well hospitals create a ‘dementia-friendly’ environment. We have expanded our programme of psychological support for older people from 12 to 14 wards and introduced a number of new and exciting developments to increase social stimulation and support for patients in hospital. This includes the introduction of 1950s style tea parties, which was described as “truly inspiring” by National Patient Safety Lead for NHS England, Caroline Lecko,
when she visited the hospital to meet staff and see the outstanding work taking place to ensure older patients receive the right food and nutrition while in hospital.

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. This aims to halve avoidable harm within the NHS over the next three years. It involves signing up to five pledges focusing on patient safety first, continually learning, collaborating, supporting, and being honest. This builds on the fantastic work that has already been undertaken as part of the South West Programme over the last five years.

The Trust has continued to make significant progress in other areas. Good examples of this can be seen in our reduction in the number of serious pressure ulcers and positive progress in our Hospital Standardised Mortality Ratio.

As I stated above, high quality care is a key priority for the Trust and the Trust Board is committed to improving quality through a ‘whole organisation approach’. Three years ago we developed a ‘risk tool’ for each service, which is a method that enables teams to assess themselves against key quality performance criteria. The tool was redesigned and further changes were made this year to reflect the Care Quality Commission’s (CQC) inspection model and its five domains on whether a service is safe, effective, caring and responsive to people’s needs and also well-led. Another example of this ‘whole organisation’ approach can be seen in the implementation of the Sepsis Six campaign, which ensures that appropriate treatment is delivered within one hour of a patient receiving an initial diagnosis of a severe infection in Accident and Emergency. The learning from this campaign is being used to extend it to the whole hospital.

The Trust uses clinical audit results, patient feedback and information from complaints and safety reports to show where improvement is needed. For example all wards develop an action plan based on feedback from their patients. This could be through the Trust’s own real-time feedback, where volunteers and Governors regularly gather views directly from patients on wards, or through comments made by patients as part of the Friends and Family Test.

Quality of care is included in Directorate level plans and reporting processes. It is measured as part of Directorate service reviews, and mid and end of year reports. Members of the Trust Board regularly walk round the hospital and talk with patients and staff enabling them to raise any quality or safety issues in their own areas and these reviews will now be based on the CQC’s five domains.

Quality is monitored regularly by the Board through a number of quality measures and indicators. For instance, the Trust Board receives a quality indicator report every month and a patient story is heard at Clinical Governance Committee meetings. These stories may have come from complaints, incidents or from service improvement projects. The quality indicators and patients’ stories ensure that the Trust keeps focused on the things that are important to our patients. A good example of action arising from this initiative is the plan to introduce patient diaries on the intensive care ward. As part of the patient’s recovery staff will record, on handheld computers, all that has happened to them while they are unconscious so that staff can later share this progress with patients when they regain consciousness.

Patients and staff are also involved in service improvement work that covers their own areas. For instance, the new Rapid Access Care of the Elderly initiative on Durrington Ward. Prompt therapy is used to increase mobility and to help patients to go home sooner.

While the Trust Board has overall responsibility for quality, safety and patient experience, leadership for these areas is delegated to the Director of Nursing and the Medical Director.

Our emphasis on quality will continue through a number of priorities for 2015/2016. Views and comments from clinical staff, local people, commissioners and the Trust’s Governors have been used in the development of these priorities, which will be addressed later in this Quality Report.

Our staff work hard to provide excellent standards of care, and constantly assess their practices in order to make any changes that could benefit their patients. On behalf of the Board, I want to thank them for their commitment and professionalism in 2014/2015 and the very positive contribution they make to the Trust and our patients.

To the best of my knowledge the information in this document is accurate.

Peter Hill
Chief Executive
22 May 2015

On behalf of the Trust Board, 22 May 2015
Part 2:

Priorities for improvement and statements of assurance from the Board

2.1 This section provides a review of the progress we have made in our 2014/2015 priorities as published in the last Quality Account

The Trust’s priorities in 2014/2015 were:

- **Priority 1**: Reduce the number of patients dying from preventable conditions
- **Priority 2**: Ensure all patients receive high quality care including those with long term conditions.
- **Priority 3**: Continue to help patients recover from illness or injury
- **Priority 4**: Ensure that every patient has individualised co-ordinated care
- **Priority 5**: Continue to keep patients safe from avoidable harm

The NHS Outcomes Framework 2014/2015 provided a national overview of how well the NHS performed by focusing on patient outcomes and experience. The framework sets out five domains where health improvement could be achieved over a number of years and we linked each of our quality account priorities to one of these domains.

These domains were:

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

Both the Director of Nursing and the Medical Director have responsibility to lead in these priority areas. The Medical Director leads on Domain 1, 2 and 3 and the Director of Nursing leads on Domain 4 and 5.

**What we did in 2014/2015:**

**Domain 1**: Preventing people from dying prematurely

**Priority 1**: Reduce the number of patients dying from preventable conditions

The Trust has continued its work to reduce the number of deaths in hospital. We have done this by monitoring the Hospital Standardised Mortality Ratio (HSMR), the Summary Hospital Level Mortality Indicator (SHMI) and the actual number of deaths.

At the end of 2013/2014 the Trust’s HSMR was 109* which was higher than expected. HSMR is a complex indicator and compares the number of deaths in hospital with the expected number of deaths. The expected number takes into account the age of the patient, their complicating medical problems and whether they were admitted for end of life care. SHMI compares the number of deaths in hospital and within 30 days of discharge against expected levels. It is not “corrected” for patients admitted for end of life care, for example to Salisbury Hospice. Our SHMI for April 2013 to March 2014 was 103. Currently 31.8% of our deaths are patients admitted for palliative or end of life care compared to 28.9% in 2013/2014.

If the number of deaths was exactly as expected the HSMR and SHMI would be 100. However, some natural variation is to be expected, and a number above or below 100 can still be within the expected range. Our HSMR for January 2014 to December 2014 is 101 and our SHMI for October 2013 to September 2014 is 104. Both these levels are within the expected range.

We regularly review deaths within the hospital and following a review of the 2014/2015 figures we have not identified a pattern of preventable deaths or patient care and safety issues that were contributing to our HSMR.

However, as part of the review we started to make further improvements that benefit patients and their care. We implemented the Sepsis Six campaign which ensures that patients admitted to the Emergency
Department with severe sepsis have a blood test and receive antibiotic treatment, fluids and oxygen within an hour of diagnosis (see priority 5). We have maintained a low number of patient moves and handovers within the hospital and have continued to work with our commissioners and community partners to reduce unnecessary admissions. We have also improved the availability of community palliative care nursing care at the weekend.

Current status

![Annual HSMR & SHMI](image)

**HSMR per year from 2011/2012 to 2014/2015. SHMI is published 6 months in arrears.**

*In our quality account 2013/2014 we reported our HSMR from April 2013 to January 2014 as 107. The final HSMR for 2013/2014 was 109.*

In July 2013 Professor Sir Bruce Keogh, the NHS Medical Director reviewed the quality of care and treatment provided to patients at 14 hospitals 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 hospitals on the road to improvement.

In his report Keogh set out eight ambitions for improvement. The Trust has continued to use these ambitions to improve the way we review and learn from deaths more quickly. We regularly use data to alert us to potential quality problems. Every six months we review ward nurse staffing levels to ensure patients receive the right level of care. This year the Board invested £1 million in more nursing staff. A junior doctor and junior nurse now regularly attend our Clinical Governance Committee so that their experiences are heard and used to drive improvements. We also provide open forums where junior doctors can alert us to safety concerns and describe their experience of front line care. Junior doctors also take part in improvement projects, supported by senior doctors and managers.

What we did in 2014/2015 to support this improvement priority:

The bullet points below indicate the quality priority set for 2014/2015; the paragraph that follows is the progress made towards their achievement.

- With our community partners we focused on preventing ill health by helping patients to stop smoking, drink less alcohol, eat healthily, exercise more to tackle obesity and improve bone health.

Since April 2014, we have continued to ask inpatients and outpatients if they smoke. Patients were also asked if they were ready to stop smoking and 1373 patients said they wanted to stop. 1051 patients received information and support on how to stop at the time. 871 patients were referred to community NHS stop smoking services for a more intensive programme of support.

Through the year 25,291 (73%) patients who attended the Emergency Department were asked how much alcohol they drink. We found that 773 (3%) patients drank alcohol to a level that put their health at risk. Of these, 571 (66%) patients were given information about drinking less alcohol and all 773 (100%) patients were referred to their GP for follow up. Any patient who is admitted to hospital with an alcohol related condition is contacted by an Alcohol Specialist Nurse who provides advice and support. We have trained 21 alcohol advisors in 17 different areas in the hospital who are able to give patients advice on how to drink less alcohol or stop altogether. We are working with Wiltshire Council community health trainers who are able to help people make positive lifestyle changes such as drinking less alcohol, reduce or stop smoking, become more active, eat more healthily and improve general wellbeing.

In May 2014 the Trust took part in a Patient Led Assessment of the Care Environment (PLACE) audit. As a result, we have reviewed our patient menus and increased the range of foods for patients to choose, and the availability of snacks, fresh fruit and chilled water. The menu cards give information on healthy eating choices. Fruit is also on sale at all our shops and restaurants.

Our hospital leisure centre runs a Counter Weight programme enabling GPs to refer patients with a body mass index of 28 or more. Counter Weight is a structured two year lifestyle programme to help patients lose 5% to 10% of their body weight by helping them to change their behaviours around eating everyday foods and increasing activity through exercise. Patients receive one-to-one support with exercise, dietary advice and monitoring.
Osteoporosis, one of the causes of fragile bones can lead to painful and disabling fractures. Not all patients with osteoporosis suffer from a fracture. A range of bone protecting treatments have been shown to reduce a person’s chances of a fracture by up to 50%. We are supporting GPs by providing advice about bone health assessment of patients who have attended with a simple fracture or following a fall. In addition, since April 2014, we have assessed 270 (99%) of 271 hip fracture patients for bone health, started treatment, and a specialist nurse has given individual education sessions. To ensure we manage falls, fractures and osteoporosis effectively we are working with local commissioners and Wiltshire Council to set up a Fracture Liaison Service in 2015/2016 to ensure that all fragility fracture patients are identified and preventative treatment is started early.

- With our community partners we continued to support women to stop smoking in pregnancy and breast feed their babies for as long as possible.

All women are asked at the booking appointment whether they smoke. Since April 2014 347 (12.1%) women out of 2857 who booked for maternity care said they smoked. Women who smoke are also asked to do a breath test so the level of carbon monoxide can be measured and advice is given on how to stop smoking. Women are also referred to the NHS stop smoking service. We have trained all our community midwives in carbon monoxide monitoring and are working towards monitoring all women who smoke at every antenatal appointment. Since April 2014, 285 (11.8%) women out of 2424 who had had their baby were still smoking when their baby was born.

Since April 2014 1944 (80.1%) women out of 2424 were breast feeding 48 hours after the birth of their baby. Between April 2014 to September 2014 412 (46%) women out of 893 women in the area covered by the Salisbury community midwives were still breast feeding their baby. We recognise we need to do more and we are working in partnership with a community breast feeding co-ordinator who is training volunteers to give extra support to breast feeding women at home.

- We continued to improve the health of our staff through the ‘Shape-up at Salisbury’ campaign.

The ‘Shape-up at Salisbury’ campaign is a health and wellbeing programme for our staff. We know that helping staff to be happy and healthy improves the quality of patient care. A singing group was set up in November 2013 and has 30 staff who attend regularly. Singing in a group helps to improve morale and fitness. We have also continued to provide blood pressure and cholesterol check clinics for our staff. In 2014/2015 75 staff have attended these clinics. They are given advice about follow-up and life style choices. Stress awareness events have taken place throughout the year to help staff identify stress and relieve it. A mental health nurse is also able to give support and advice to staff on mental health issues. Psychological wellbeing courses are also held regularly for staff. A staff-led running club meets weekly throughout the spring and summer.

- We continued to work with GPs to ensure that patients who wanted to record their wishes about their end of life care had an advance care plan in place which was used and respected by doctors and nurses.

In South Wiltshire patients who live in some nursing or care homes now have a dedicated GP who visits every week. Each patient, in discussion with their family and GP, has a care plan which sets out their wishes should they become unwell and also their wishes for end of life care.

- We continued to improve patient care at the end of life and improved communication with families.

Since April 2014 we have introduced a Conversation Project to help patients talk about their wishes for end of life care. It is important to recognise when a patient is approaching end of life as delays may prevent timely involvement in the planning of their care. Since the phasing out of the Liverpool Care Pathway we have trialled a new personalised medical and nursing care plan which prompts a conversation with the patient and their family about their wishes for end of life care. This includes a discussion about food and hydration, pain relief, symptom management, spiritual needs and communication with the family and where they want to die. We will introduce this care plan document throughout the hospital. We will also introduce an End of Life Care Specialist Nurse to support patients and families at the end of life and to train staff to have end of life care conversations.

- We continued to work with GPs and senior doctors to investigate the care of patients who died in hospital to see if there were any changes or improvements we needed to make.

We have continued to regularly review deaths within the hospital and have not found a pattern of preventable deaths or patient care and safety issues. In 2013/2014 our HSMR was 109 and our SHMI was 103. Since then we have seen a reduction in our HSMR to 101 up to December 2014. Our SHMI up to September 2014 was 104. Both these levels are within the expected range.
With the information we have collected from these reviews we have continued to make further improvements to patient care and implemented the Sepsis Six campaign. This ensures that patients admitted with severe sepsis have a blood test and receive antibiotic treatment, fluids and oxygen within an hour of diagnosis. We have also continued to maintain a low level of patient moves within the hospital and continued to improve the availability of community palliative care at the weekends to support end of life care at home. We have started work to improve the prevention and treatment of acute kidney injury.

**What we did in 2014/2015:**

**Domain 2**  
Enhancing quality of life for people with long term conditions

**Priority 2**  
Ensure all patients receive high quality care including those with long term conditions

**Description of the issue and the reason we prioritised it:**

All our patients will be treated with compassion, dignity and respect and with care that is personal to their individual needs. We have worked with local GPs, Age UK and Governors who have all told us that the care of vulnerable older people, people with dementia and people with learning disabilities need to be key priorities. In particular, giving priority to ensure that all patients have help to eat and drink, that staff have time to meet relatives and that all patients know what is happening in their care.

**What we did to support this improvement priority:**

- We worked with GPs, care co-ordinators and senior doctors to support people with heart failure, diabetes and chronic breathing problems to stay healthier for longer and seek help earlier to better manage their own care.

Patients who are admitted to hospital with heart failure often suffer from shortness of breath or leg swelling. They receive a visit by a specialist nurse who involves them in devising their management plan and gives advice on healthy eating, exercise and medication. Patients can keep track of their plan in their own patient-held record. The plan also advises them what to do if they become unwell. Once a patient has left hospital they will receive a telephone call a week later to check on their health. If necessary, an outpatient appointment or a visit by the community matron is arranged to assess and advise them in their own home.

Since April 2014 17 patients with type one diabetes have attended a Freedom for Life course to learn to adjust their insulin, food, exercise and lifestyle and 9 patients have attended a carbohydrate counting course. These patients are better able to control their blood sugar levels and are less likely to be admitted to hospital than patients who do not attend the course. Patients with type two diabetes can attend a structured education programme similar to the Freedom for Life course. These patients are less likely to develop complications of diabetes compared to patients who do not attend the programme. Patients and GPs can also obtain telephone advice from our specialist diabetes team about adjustment of insulin regimes and how to help patients who are unaware of low blood sugar levels.

People with chronic breathing problems who are restricted in their normal activities can attend a pulmonary rehabilitation programme. The programme includes a home exercise and self management plan should they become unwell. Over the last year, 62 patients successfully completed a programme and improved their symptoms and fitness. Patients who are admitted to hospital with a lung problem are advised on exercise and are also offered a pulmonary rehabilitation programme. Patients with asthma and other chronic breathing problems also have a self management rehabilitation programme to help them stay healthier for longer and manage their own condition. Our respiratory team work closely with GP’s and community matrons to offer patients education and advice.
• We continued to improve the identification of patients with dementia and delirium and referred them to their GP or specialist mental health team when needed, to ensure they received effective care and treatment.

With the support of our dementia champions we have consistently improved the number of patients screened for a diagnosis of dementia when they are admitted to hospital as an emergency. If a patient is screened and dementia is suspected they are assessed either by the in-house specialist mental health team or referred to their GP.

The table below shows how we have improved (Purple line is the target of 90%)

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• We continued to improve the support we offered carers of people with dementia by giving advice and information.

We continue to find out from carers of people with dementia whether they get the right support to provide care, have access to information and advice, and whether they know how to seek respite care. We have published an information booklet called ‘Understanding and managing the symptoms of dementia’ which is given to carers of people with dementia. Since April 2014, 17 carers have given their feedback and have been offered information and advice on support services. Two dementia advisors employed by the Alzheimer’s Society continue to provide support for carers. We are working with Wiltshire Council to do more to help identify, support and recognise the vital role carers play; to help them to provide care, and stay well themselves.

• In partnership with the Alzheimer’s Society we continued to train our dementia champions and staff in dementia care.

Working with the Alzheimer’s Society we continue to provide basic dementia awareness training for our staff. We have held 6 training days since January 2014 attended by 57 members of staff.

• With funding from the Arts Council, the Stars Appeal, the League of Friends, and the Salisbury Independent Hospital Trust we continued to support a programme called ‘Elevate’ to help lift people’s spirits by using music and movement, creative stories, nature, poetry and reminiscence.

Specially trained volunteers have continued to support patients through the enjoyment of singing, music, dance and story telling to help keep their minds active and provide a distraction from hospital life. We have introduced 1950s-style tea parties with vintage china and activities linked to years gone by. This proved particularly beneficial for patients with dementia and was also enjoyed by other patients.

• We helped patients manage their own care so that they were able to decide whether to arrange their own outpatient follow up appointment or simply receive telephone advice from a nurse or doctor.

We have started to offer patients with ear, nose and throat and orthopaedic conditions the choice of receiving a follow-up appointment by telephone from a nurse or doctor instead of attending a face-to-face appointment. We have also started to offer patients with straightforward conditions the choice of attending an outpatient follow-up appointment only if they feel they need it. Since April 2014 584 orthopaedic patients and 28 ear, nose and throat patients have been given the choice and so far 25 orthopaedic patients have booked and attended an appointment. One ear, nose and throat patient booked and attended an appointment.

• We introduced an improved care pathway for children with cystic fibrosis and eating disorders.

Significant changes have occurred in the pathway to manage children with cystic fibrosis. This means that children and young people are cared for at this hospital by a specialist team and once a year are assessed at Southampton General Hospital. We are planning to increase the provision of physiotherapy and dietician time at this hospital. We are also moving towards a best practice model, which is a set of practices which, when used together, help keep children with cystic fibrosis as healthy as possible.

We have also developed an improved care pathway for children and young people with eating disorders. Young people are regularly seen by a senior paediatric doctor together with a member of the Child and Adolescent Mental Health team. As a result we have a low admission rate for children and young people with eating disorders compared to other hospitals.
What we did in 2014/2015:

Domain 3  Helping people recover from episodes of ill health or following injury

Priority 3  Continue to help patients recover from illness or injury

Description of the issue and the reason we prioritised it:

The length of stay in hospital can vary between patients with similar conditions for a number of reasons including the way in which we manage ward rounds and arrange tests and medicines. There can also be delays when patients are ready to be discharged, but the support they need at home is not yet available. We are working with our community and social care colleagues to integrate services and to make changes which will benefit our patients.

• With our community partners we enabled early supported discharge for stroke patients so they spent less time in hospital and continued rehabilitation at home.

Since April 2014 we have referred 67 patients to the early supported discharge team. However, some of these patients told us that they waited over 6 weeks to start their rehabilitation. We are working with NHS Wiltshire and Wiltshire Council to resolve this problem.

• We improved access to rehabilitation for patients who have suffered a major traumatic injury and ensured they had a named therapist co-ordinating their care.

We have been working collaboratively with the Trauma Centre at Southampton General Hospital since April 2012. We have increased the number of trauma patients who have had rehabilitation by our specialist team at our Wessex Rehabilitation Centre from 3 patients in 2013/2014 to 13 patients in 2014/2015. Each patient benefits from a programme of physical therapies, pain management and psychological support designed for their specific needs. Each programme is co-ordinated by a key therapist. In November 2014 we had a very positive peer review which is reported on page 82-83.

• We introduced a specialist fragility fracture clinic to ensure patients were investigated and have bone protection medication, information and advice to prevent more serious fractures in the future.

What our patients and public have told us?

‘My husband was brought to the Accident and Emergency ward following a fall at home. He had suffered concussion and had experienced a horrible kind of nightmare and so was very frightened. I wanted to write to express my appreciation of the way we were all looked after. The nurses and doctor were so kind and comforting; we couldn’t have received better care and consideration. Nothing was too much trouble’.

‘My 84 year old mother-in-law underwent an operation on her leg following a fall at home. All the staff were excellent - helping my mother-in-law regain her mobility very quickly whilst being very aware of her needs and dealing sensitively with her dementia-related issues. The staff kept us informed about what was happening on a daily basis and assisted with her smooth transition to a nursing home for convalescence prior to returning home. The staff were all very efficient, professional and caring. We were very impressed - especially since the recent bad press concerning care of the elderly. It is good to know that Salisbury Hospital has excellent standards’.

‘The food is just warm and could be hotter. Two patients were very noisy at night and I have not been able to sleep’.

In October 2013 we introduced a specialist nurse outpatient clinic for patients who have recovered from a hip fracture and other low impact fractures. So far 29 patients have been investigated and started on bone protection medication as well as receiving advice on eating a healthy diet, exercise and preventing falls.

Patients who attend the Rheumatology Department who have been found to have a low bone density can have an annual infusion of Zoledronic Acid which helps build up bone density. To ensure we manage falls, fractures and osteoporosis effectively we are working with NHS Wiltshire to set up a Fracture Liaison Service in 2015/2016.

• We expanded the ‘Keep active campaign’ for older people to another ward to help them maintain their independence.

We have introduced the Keep Active campaign onto a second ward; Durrington ward, to help older people keep active and maintain their independence. Patients are encouraged to help with their recovery by being active throughout the day. This helps to stop their muscles from becoming weak and can help patients go
home more quickly. In December 2014, staff helped all eligible patients to keep mobile on average 4.8 times a day during the week compared to 3.7 times in August 2014. At the weekends staff helped patients to move on average 5.7 times a day at weekends compared to 3.8 times a day at weekends in August 2014.

• We continued the Rapid Access to Rehabilitation for the Elderly project (RARE) so that older people with problems such as a simple fracture were moved directly from A&E to Winterslow ward to start immediate rehabilitation.

We have changed the RARE project to the Rapid Access for the Care of the Elderly (RACE) project. The project involves patients with simple fractures or conditions where a rapid recovery is expected being moved directly to Durrington Ward to start immediate rehabilitation. This means patients are able to leave hospital sooner.

• We continued to support patients undergoing cancer treatment with a programme of physical activities, information, and shared support to help decrease anxiety, tiredness and feelings of helplessness.

For the past year, clinical psychologists and gym staff at the hospital have delivered this unique programme, funded by Macmillan Cancer Support, which educates and supports patients to keep them physically and emotionally healthy, aiding their recovery. The eight week group programme covers topics such as diet, sleep problems and relaxation, a range of tailored exercise including gym and swimming sessions, and support with financial issues from the Macmillan Benefits Adviser.

• With GPs and the community network we continued to reduce the number of children and young people with diabetes, asthma and epilepsy admitted to hospital as an emergency.

Children with diabetes, asthma and epilepsy are only admitted to hospital when absolutely necessary and usually stay only one day or less. Children, young people and parents can now seek rapid advice from a newly appointed community diabetes specialist nurse. One of our senior paediatric doctors has taken part in a regional audit about the management of common childhood reasons for admission to hospital. We have started to work with GPs in managing the seven most common conditions.

What we did in 2014/2015:

Domain 4  Ensuring that people have a positive experience of care

Priority 4  Ensure that every patient has individualised co-ordinated care

Description of the issue and the reason we prioritised it:

It is important the Trust does everything it can to provide high quality care for all our patients and make sure that the care is effective, personal, safe and patients are treated with compassion, dignity and respect. Patients have told us that we do not get everything right every time and we must therefore find out what happened, learn from it, and continuously work to improve care.
Whilst these results are very good, the survey shows that:

- Not all patients liked the quality of the food.
- Noise, especially at night is disturbing sleep.
- Patients are sometimes delayed on the day of leaving hospital.

**What we did in 2014/2015 to support this improvement priority:**

- We ensured that all patients had a named consultant in charge of their care.

  We are testing out a board placed at the end of each patient’s bed so that the name of the consultant can be written on it which is visible to the patient whilst in bed. This will help patients know which senior doctor is in charge of their care.

- We also ensured that every patient had a care plan that they had been involved in developing which recognised their individual needs and that of their families and carers.

  We have updated our nursing assessment documentation to ensure patients are asked about how they were before they came into hospital compared to how they are now. This ensures the patient receives the right care for their needs. A group of senior nurse leaders have looked at the daily management plan. The plan will become an electronic process later in 2015 which will enable the patient to be more involved in planning their care. We have started to ask patients with long term conditions, such as diabetes, chronic lung problems and heart failure to bring their care plans into hospital with them so that care specific to their needs is continued during their stay.

- We ensured that on every shift every patient had a named nurse who was co-ordinating and responsible for their care.

  We are testing out a board placed at the end of each patient’s bed so that the name of the nurse coordinating their care can be written on it which is visible to the patient whilst in bed. This will help patients know which nurse is in charge of their care. On some wards we have a board at the entrance to each bay giving the names of the nurses responsible for the care of the patients in that bay.

  - We ensured that the named nurse reviewed and was familiar with every patient’s care plan on every shift.

All patients have a treatment and care plan which is reviewed by each nurse on every shift. Our senior nurses and charge nurses now work in a supervisory capacity to ensure essential standards of care are maintained. Part of the supervisory role is to make sure patients are involved in their treatment and care plan and they know what to expect next. It ensures our ward leaders can be much more visible and accountable to all our patients on the wards and their families. In addition, when nurses change shifts they handover to the next nurse at the patient’s bedside so the patient can be involved in the discussion about their care.

- We introduced an in-depth enquiry into poor discharge planning and multiple ward moves to learn and improve.

We have looked at incidents of poor discharge planning and found that poor communication between the wards and community services were a common factor. We ran a discharge planning workshop with a broad range of staff in December 2014 to understand the problem in more detail. We identified areas for improvement which includes a redesigned discharge checklist.

### National Inpatient Survey question

<table>
<thead>
<tr>
<th>Overall, how would you rate the quality of care you received?</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean score</td>
<td>7.9</td>
<td>7.8</td>
<td>8.1</td>
<td>8.1</td>
<td>8.3</td>
</tr>
</tbody>
</table>
We have also looked at why patients are moved from one ward to another. We have found that most patients are moved for good clinical reasons. However, some patients were moved at times of high activity to a ward that did not specialise in their condition which made their stay in hospital longer than necessary. We have started to use and monitor this information at the daily team meetings to ensure no patient is moved more than twice and that they are moved to the right ward straight away.

- We introduced an audit programme to review and improve care plan and discharge plan documentation.

In May 2014 we undertook an audit of the quality of nursing assessment on admission and found that 57 (81%) patient assessments on admission and 91% of patient care plans met all the standards in the audit. Ongoing work is undertaken by our supervisory ward leaders to improve standards of assessment and care planning.

A plan is in place to improve discharge planning documentation. This will include a redesigned discharge checklist and to work together with two local nursing homes to improve the transfer of care information.

- We introduced the Friends and Family test in day case areas and outpatient departments to monitor the quality of care.

Since April 2014 outpatients and patients who attend as day cases have been asked how likely they would be to recommend the outpatient department or day case area to friends and family if they needed similar care or treatment. Of those patients who responded 96.7% said they were extremely likely or likely to recommend the hospital to friends and family. Patients are also invited to comment and the vast majority of comments were very positive, with care, compassion, friendliness and helpful advice common themes.

What our patients and public have told us?

- ‘Admitted via GP with suspected appendicitis. Resulted in an appendectomy that night. Received completely outstanding faultless care from beginning to end. I cannot recommend this hospital highly enough. Add to the high standards the hugely caring and thoroughly professional staff with a real team spirit’.

- ‘I was admitted for a total hip replacement and although my stay was brief, I cannot fault the treatment I received. Everybody on the orthopaedic unit, and all other staff I encountered, were highly professional in their approach, and those on the ward could not have been more attentive and caring. My needs were met with good grace and appropriate humour, and I was not fussed over but given just the right amount of encouragement and independence, whilst still feeling safe. The only negative I would like to mention is the poor signage in the corridors’.

- ‘I would like the consultant to talk to me a lot more’.

The bar chart below shows the response rate and the percentage of day case patients who would recommend the hospital to their friends and family if they needed similar treatment or care.

What we did in 2014/2015:

Domain 5  Treating and care for people in a safe environment and protecting them from avoidable harm

Priority 5  Continue to keep patients safe from avoidable harm

Description of the issue and the reason we prioritised it:

The safety of our patients is a key priority in our quality improvement work. We continue to run a patient
patient safety programme. Our aim is to reduce levels of harm to patients whilst in hospital and we measure this through harms like pressure ulcer rates, infection rates, thrombosis events, and the number of patients falling in hospital. All of these can lead to pain and distress for our patients and extra days or weeks in hospital. Our aim fits with a continuing national priority across the NHS to measure the incidence of pressure ulcers (sores), falls, urine infections from catheters, and blood clots, through a system called the Safety Thermometer.

We have reported on harm free care since April 2013. Since then we have seen a decrease in the number of patients acquiring a new pressure ulcer in hospital as measured by the Safety Thermometer. Our actual number of grade 2 pressure ulcers has reduced by 9% this year.

We have also started to measure the number of patients who are admitted to hospital with a harm, such as a pressure ulcer, catheter associated urine infection or blood clot. Working with our community partners to improve safety and reduce harm will be a priority action for 2015/2016.

The Safety Thermometer chart below shows we have sustained a high percentage of new harm free care. It also shows the percentage of patients who are admitted with a harm and the percentage of new pressure ulcers developed in hospital.

- We continued to make sure patients were assessed for their risk of developing a blood clot and given preventative treatment if at high risk. We conducted a detailed enquiry of patients who developed blood clots to ensure we learned and improved.

Since April 2014 we have assessed 99.1% of patients for their risk of developing a blood clot in hospital. We have given preventative treatment to 96.6% of patients at high risk. We have reviewed the care of all patients who developed a blood clot and found the vast majority of patients were managed appropriately. The Trust continues to be recognised as an exemplar site and shares knowledge and experience to help other hospitals achieve the best blood clot prevention for all patients.

- We aimed to reduce the number of preventable falls and undertook a detailed enquiry of patients who fell and injured themselves to ensure we learned and improved.

Since April 2014 there have been 29 incidents reported where a patient had a fall resulting in a fracture. Of these, 18 incidents resulted in a fracture which required non-surgical treatment and 11 patients had a fractured hip which required surgery. Our detailed investigations of all patients who fell and sustained a fracture or major harm showed that patients often fell when they were walking or standing during their rehabilitation phase. We also found that communication with families had improved. We should continue to improve assessment and re-assessment of a patient’s risk of falling, and ensure that patients have the correct footwear and walking aids.

- We continued to reduce the number of patients who developed grade 2, 3 and 4 pressure ulcers (sores) in hospital. We continued to conduct a detailed enquiry of patients who developed grade 3 and 4 pressure ulcers in hospital so we learned and improved. We aimed to do more work with our community partners to undertake reviews of patients who came into hospital with pressure ulcers.

This year we have reduced by 9% the number of grade 2 pressure ulcers from 269 in 2013/2014 to 244 in 2014/2015. This year there have been four hospital acquired grade 3 pressure ulcers (more serious), and no grade 4 pressure ulcers. A detailed review is undertaken if any one ward has three or more pressure ulcers in one month. As a result we have improved the recognition and treatment of moisture sores and introduced ear guards for patients with oxygen tubing to protect the skin on the ears which can be very thin. We have also introduced softer oxygen tubing on every ward this year.

The chart below shows the total number of hospital acquired grade 2, 3 and 4 pressure ulcers.
We aimed to reduce the number of catheter associated urine infections by continuing the use of the catheter care bundle and on-going catheter care.

We have continued to use the catheter care bundle. This is a set of practices which, when used together, help reduce urine infections when a catheter is first put in and guides on-going catheter care. We want to reduce the number of infections further and so this continues to be a priority in our ‘Sign Up to Safety’ Campaign.

We ensured adults and children were protected by aiming to increase to 80% the number of staff who were trained to safeguard adults and children.

Safeguarding adults training to protect vulnerable people from abuse is a high priority for the Trust. On their first day all new staff have a session on safeguarding adults and the Mental Capacity Act, and what action they should take if they are concerned a vulnerable adult is being abused. All new staff are given a Mental Capacity Act and adult safeguarding ‘prompt cards’ booklet. All staff must complete an adult safeguarding e-learning module. By the end of March 2015 79% of staff had completed this training. Staff are also able to attend teaching sessions. Completion of training is discussed at staff appraisals.

Safeguarding children’s training is also a high priority for the Trust. On their first day all new staff have a taught session on safeguarding children and what they should do if they are concerned a child may or is being abused. There are several levels of training dependent on the person’s job role and contact with children. Between April 2014 to December 2014 76% of appropriate staff completed level 1 training, 74% of appropriate staff completed level 2 training, and 97% of appropriate staff completed level 3 training.

Infection prevention and control – work plan for 14/15

We continued to use the Sepsis Six campaign to treat patients with severe infections within an hour of arrival in hospital.

Sepsis Six is the name given to a set of practices designed to reduce the number of people who die from severe infection. We introduced the Sepsis Six campaign in the Emergency Department at the end of 2013 through an education programme. Patients with severe infection must have their blood count, blood culture and blood acid measurement taken in the first hour. Treatment with oxygen, antibiotics and fluids must also begin in the first hour and urine output measured. Since April 2014 we have measured 3 key components of Sepsis Six – blood acid measurement (lactate), treatment with antibiotics and completion of the Sepsis Six pathway (proforma). Between April 2014 and September 2014 we achieved an overall compliance of 55%, between October 2014 and March 2015 we had an overall compliance of 83% and 72% for each quarter against a target of 65%.

The line graph below shows our overall compliance with the three measures in the Emergency Department from April 2014 to March 2015

We aimed to maintain low numbers of patients with avoidable MRSA bloodstream infections and avoidable C. Difficile infections through good infection control practice.

Between April 2014 and March 2015 2 patients had an MRSA bloodstream infection. Both of these were investigated and one was found to be a contaminant. This means it was not a true bloodstream infection. 23 patients developed C. difficile against a target of 18 patients for the year. We have worked collaboratively with our commissioners to ensure best practice and have a detailed action plan in place. This includes a variety of measures. For example, using different coloured aprons in each ward bay, Actichlor plus, (a combination of detergent and disinfectant) for cleaning and a trial of sporicidal wipes for cleaning commodes.

We continued to monitor infection control practice through audit and report findings to the Infection Prevention and Control Committee.

We continued to monitor hand hygiene practice which shows a high level of compliance. We also continue to monitor a range of other infection prevention and control practices such as commode cleanliness and the storage and use of clean and dirty laundry practices.
• We continued to review technologies into the prevention and control of infections and introduced new technologies where appropriate.

New innovations have been introduced such as a new alcohol hand gel dispenser which is part of the door handle at the entrance and exit to the Neonatal Unit. We have introduced Actichlor plus and disinfectant wipes for cleaning. We continue to use two Glosair machines to ensure beds, rooms and surfaces are properly decontaminated after use.

• We continued to use ATP monitoring (our hygiene monitoring system) to ensure the cleanliness of equipment and the environment.

We continued to routinely monitor the cleanliness of equipment and the environment using this system. It is used before and after an area is deep cleaned to highlight the standard of cleaning. This includes the main patient touch points such as bed frames, door handles and toilet areas.

• We continued to monitor hand hygiene practice, including a review of hand wash and alcohol hand rub facilities, to encourage staff and visitors to wash their hands.

We continued to monitor hand hygiene practice which showed a high level of compliance. We have introduced some new automated hand gel dispensers and made the signage more prominent at all the entrances and exits to the wards and outpatient departments.

• We reviewed cleaning products for use in sinks and bathrooms to use the best available.

We have looked into what other hospitals in the South West use to clean their sinks and bathrooms. We are now using Actichlor Plus throughout the hospital and for all our ward deep cleaning programmes.

• We aimed to complete the review of outpatient dirty utility rooms to make sure they met the required Trust standard.

We have focused our work on ward dirty utility rooms which are checked by a senior nurse every day. The review of outpatient dirty utility rooms will be progressed in 2015/2016.

2.2 This section sets out our quality priorities for 2015/2016

Our priorities for quality improvement in 2015/2016 and why we have chosen them

Looking forward to 2015/2016 we have used a broad range of methods to gather information and generate our quality priorities. These include:

• Speaking to patients and asking them to give us feedback on their experience of care during their hospital stay.
• Using information from the national inpatient survey and the Friends and Family test.
• Learning from themes from comments, compliments, concerns and complaints.
• Learning from risk reports and listening to what staff have told us during Executive Safety and Quality walk rounds. These rounds give staff the opportunity to talk face-to-face about safety or quality concerns with Executive Directors and Non-Executive Directors.
• Listening to what our staff have told us from the national staff survey and the staff Friends and Family test.
• Talking to our local commissioners and Wiltshire Council and asking them about local people’s needs and improvements that could be achieved by working together.
• Continuing to respond to the recommendations made into the failings at Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC (the Francis Report).
• Responding to NHS England’s NHS Services Seven days a Week Forum report with ten clinical standards to improve urgent and emergency care for patients seven days a week.
• Responding to NHS England’s Five Year Forward View which sets out a national plan on how the NHS needs to change and improve over the next five years.
We have consulted widely on the priorities and involved the local Age UK, Warminster Health and Social Care Group, our staff, governors and members to help us make the final decisions on our priorities for 2015/2016. The priorities have been discussed with clinical teams as part of the service planning process. Our Clinical Commissioning Groups have also helped us work out what our priorities should be and the work we need to do together. Some of their comments are included in this report.

This process confirmed that the priorities for 2015/2016 are the areas where we need to focus our quality improvement. We have changed them from 2014/2015 and given an explanation. The Board has agreed these priorities.

The Trust has made good progress on last year’s priorities however there are still further improvements that can be made and additional work has been identified for 2015/2016. A number of these areas are required for our Commissioning for Quality and Innovation (CQUIN) programme and support the Care Quality Commission (CQC) regulations.

The actions we plan to take in our quality priorities reflect the Trust’s vision to ensure that every patient has an outstanding experience. We will continue to listen to our patients so that we can understand if we are meeting their needs and expectations. We will do this by acting on patient real time feedback, the Friends and Family test comments, national survey results, concerns and complaints and listen to patient stories at the Clinical Governance Committee. We will continue to make sure staff voices are heard and that they know how to raise concerns. We will do this through members of the Trust Board actively talking to staff at ward and departmental level about any issues or concerns they may have as part of our quality and safety walks. We actively promote a culture of openness and honesty so that our staff feel able to report adverse incidents and we take action to improve our national staff survey results.

Our priorities for 2015/2016* are:

**Priority 1** - Strive to keep patients safe from avoidable harm

**Priority 2** - Ensure patients have a positive experience of care

**Priority 3** - Actively work with our community partners and patients to prevent ill health

**Priority 4** - Provide patients with high quality care seven days a week

**Priority 5** - Provide co-ordinated care across the whole health community.

*These priorities are not ranked in order of priority. The Trust Board agreed the 2015/2016 priorities on 22 May 2015.

Progress in our priority areas will be measured and monitored through the Trust’s quality governance process. To enable the Trust Board, the Clinical Governance Committee and Clinical Management Board to do this they will receive monthly reports and ask for further work where it is needed. The Trust Board minutes and reports can be viewed on the Trust website.

The following sections describe the work which will be undertaken in 2015/2016 to achieve or improve the priority areas.

**What we will do in 2015/2016:**

**Priority 1 - Strive to keep patients safe from avoidable harm**

**Description of the issue and reason for prioritising it:**

Patients should be able to expect to be treated in a safe and clean environment and be protected from avoidable harm. Improving patient safety involves many things, including, high quality nursing care and creating a culture of learning from incidents to prevent them happening again. As a Trust, patient safety is our first and most important priority so we will continue to implement national standards and monitor and report the level of harm free care in the Safety Thermometer and other key quality indicators. We have joined the ‘Sign up to Safety’ campaign which aims to cut avoidable harm by 50% over the next three years and we will report progress against each element every year. We are also an active participant in the Wessex Patient Safety Collaborative.

**What we will do in 2015/2016?**

➢ We will continue to reduce the number of patients who have preventable falls and fracture their hip in hospital.

➢ We will continue to reduce the number of patients who develop grade 2, 3 and 4 ulcers.
We will continue to reduce the number of patients who develop a catheter associated urine infection.

We will improve the recognition and treatment of patients with severe infections using Sepsis Six practices which are designed to reduce the numbers of people who die from severe infections.

We will work collaboratively with our network to improve the prevention, recognition and treatment of patients with acute kidney injury.

We will continue to work with our staff to ensure that we have low numbers of patients with avoidable infections and reduce the number of patients with surgical site infections.

We will continue to improve surgical safety by the use of the World Health Organisation safety checklist and safety briefings.

We will implement the GROW programme to identify babies who are smaller than expected for their stage of pregnancy.

How will we report progress throughout the year?

Safety work is overseen by the Safety Steering group. We measure our infection rates, blood clot assessment and treatment, pressure ulcers, falls resulting in harm and report them every month to the Trust Board, Clinical Management Board, Operational Management Board and to the Clinical Governance Committee at every meeting as well as our commissioners.

Priority 2 – Ensure patients have a positive experience of care

Description of the issue and reason for prioritising it:

Patients and their families should experience high quality care. No one going into hospital should have to worry about being left in pain, unable to eat, drink, or go to the toilet. Patients who are in need of support and their families, should have peace of mind that they will be treated with kindness, compassion, respect, dignity, understanding and honesty. We need to continue to measure and understand how patients really feel about the care they receive and take improvement actions. As well as our patient feedback surveys, our national staff survey provides important information on the health of the Trust, so too, does the staff Friends and Family test which asks staff whether they would recommend this hospital to their friends and family as a high quality hospital to receive treatment and care. Patients, their families and carers have told us that an area that needs improvement is for different services to work together so that their care is joined up or integrated. We are working closely with Wiltshire Council and our commissioners to improve the patient’s journey from admission to discharge home.

Timely access to services is a critical part of a patient’s experience of care. The NHS should be there for patients when they need it. This means providing equally good quality care seven days a week (see priority 4).

What we will do in 2015/2016:

• We will continue to improve the identification and diagnosis of patients with dementia and refer them to their GP or specialist mental health team when needed to ensure they receive effective care and treatment.

• We will work with GPs and voluntary organisations to do more to identify carers and provide them with better support, advice and information.

• We want to focus more on learning from patient complaints, concerns and feedback so we can make improvements when issues are identified.

• We want to continue to ensure that patients, their families and carers are involved in decisions about their care, treatment and on-going care. We will compare patient feedback from those admitted in the week with those admitted at the weekend and make improvements.

• We will start to plan to improve the choices available to women during pregnancy about where they have their baby and who will lead their care.

• We will work collaboratively with our network to improve care for children as they move from children’s to adult services. This is called the Ready Steady Go Programme.

• We will introduce the Friends and Family test for children under the age of 16 to monitor the quality of care.

• We will continue to report on the staff Friends and Family test and make improvements where needed.
How will we report progress throughout the year?

Real time feedback and the Friends and Family test score will be measured and reported to the Trust Board, Clinical Management Board, Operational Management Board and our commissioners monthly and to the Clinical Governance Committee.

Priority 3 – Actively work with our community partners and patients to prevent ill health

Description of the issue and reason for prioritising it:

We want people to live longer and with a better quality of life. We want to continue to work with GPs in supporting the earlier diagnosis of illness and tackling risk factors such as high blood pressure and cholesterol and we want to ensure people have access to the right treatment when they need it. We want to do more to help people stay in good health and to take responsibility for their own health. Better access to support and information will be crucial in preventing ill health.

What we will do in 2015/2016:

• With our community partners we will focus on helping patients and pregnant women to stop smoking.

• We will continue to work with GPs to help patients to drink less alcohol and reduce the number of patients admitted to hospital with alcohol related problems.

• With our community partners we will help patients to eat healthily and exercise more to tackle obesity.

• With our local commissioners and Wiltshire Council we aim to set up a Fracture Liaison Service to improve bone health of patients who have had a simple fracture.

• We will continue to support patients with long term conditions such as diabetes, heart disease and chronic breathing problems to manage their own health and avoid complications.

• We will continue to support the physical and mental wellbeing of our staff in the ‘Shape up at Salisbury’ programme.

• We will publish the outcomes of our bowel screening programme and respond to new public health campaigns.

How will we report progress throughout the year?

We will measure improvements from the 2013/2014 figures, monitor and report our progress through the our Maternity Services dashboard, our Public Health Steering Group, our Staff Health and Wellbeing programme, local audits and quality indicator reports to the Clinical Management Board and to the Clinical Governance Committee.

Priority 4 – Provide patients with high quality care seven days a week

Description of the issue and reason for prioritising it:

We want to ensure all our patients have an outstanding experience of care. Over the next two years we want to work towards implementing the ten clinical standards described by the NHS Services, Seven Days a Week Forum. The Forum described the standard of urgent and emergency care that all patients should expect to receive seven days a week.

What we will do in 2015/2016:

• We will ensure that all emergency patients admitted to the Medical and Surgical Assessment Units are seen and assessed by a consultant within 14 hours of arrival.

• We will develop a one stop clinic for urology and gynaecology emergency patients so they can be seen and assessed without admission to hospital.

• We will ensure that when medical shifts change over twice daily handovers will continue to be led by a senior doctor with multi-professional participation from the in-coming and out-going shifts seven days a week.

• We will improve access to inpatient ultrasound scans and MRI slots at weekends.

• We will improve the efficiency of theatres.

• Throughout the hospital we will introduce new personalised medical and nursing care plans for patients at the end of life to improve patient care and communication with families and GPs.
• We will continue to support patients near the end of their life in their homes and on the wards with our community and hospital palliative care service 7 days a week.

**How will we report progress throughout the year?**

We will measure, monitor and report progress through the Hospital at Night Board and the End of Life Care Strategy Steering Group and to the Operational Management Board. The Hospital at Night Board and the End of Life Care Strategy Steering Group report to the Clinical Management Board every six months and to the Clinical Governance Committee annually.

**Priority 5 – Provide co-ordinated care across the whole health community**

**Description of the issue and reason for prioritising it:**

The Five Year Forward View has set the NHS the challenge of better integration of care across different services. From April 2015 we will see the plans for the Better Care Fund (the first joining up of NHS and social care funding) take effect. The Better Care Fund will join up health and care around the needs of patients, so that people can be supported in their own home for longer rather than being admitted to hospital.

**What we will do in 2015/2016:**

• We will provide more support for GPs and community care services by direct access to senior doctors via telephone, email, rapid access clinics and better information in the electronic discharge summary.

• We will ensure that all patients admitted to hospital as an emergency are assessed for complex needs within 14 hours by a team of doctors, nurses, therapist and social workers.

• With our community partners we will develop a single discharge assessment process which records all a patient’s assessments in one place.

• With Wiltshire Council and the Clinical Commissioning Group we will work together on improvements which are part of the Better Care Fund. The Better Care Fund was set up to reduce the number of patients delayed in hospital by testing out new services to see what works well and where community services can improve.

**How will we report progress throughout the year?**

We will measure, monitor and report progress through the Patient Flow Programme Management Board. It reports to the Operational Management Board every six months.

**2.2 Statements of assurance from the Board**

**Review of Services**

During 2014/2015 Salisbury NHS Foundation Trust provided and/or subcontracted 46 relevant health services. Salisbury NHS Foundation Trust has reviewed all the data available to us on the quality of care in all 46 of these relevant health services. The income generated by the relevant health services reviewed in 2014/2015 represents 100% of the total income generated from the provision of relevant health services by Salisbury NHS Foundation Trust for 2014/2015.

The Trust has published a Quality Strategy 2012 – 2015 which sets out a quality governance framework for the review of individual services. This includes the completion of the Salisbury Organisational Risk Tool which alerts us to risks relating to quality of care. Where risks are identified, plans are put in place for improvement. It also includes a review of quality information to provide assurance of effectiveness, safety and patient experience in each individual service. Information reviewed includes a Directorate Quality Indicator report, clinical audit results, patient survey feedback, real time patient feedback, the friends and family test, comments, complaints and compliments and a risk report highlighting adverse events. This information is discussed quarterly at Directorate performance meetings and the Department Executive Safety and Quality walk rounds. Clinical teams present their quality and safety outcomes and improvement work to the Clinical Governance Committee every year as part of the assurance process.

There is a clear quality reporting structure in the Trust where scheduled reports are presented and discussed at the Clinical Management Board or Clinical Governance Committee. Many of the reports are also reported to our commissioners as part of our requirement to provide assurance on contract and quality performance compliance.

Each year the Trust has a number of external agency and peer review inspections. The reports, recommendations and action plans are discussed at one of the assuring committees. For example, in November 2014 the Wessex Trauma Network undertook a peer review of
the care of patients with major trauma. The review team commented that they observed some excellent practice and performance and the hospital was commended for its care for patients with major trauma, particularly in the time of arrival in A&E to the time of a CT scan, access to rehabilitation and psychology services, and collaboration with the major trauma centre in Southampton with regard to the provision of plastic surgery. Two improvement actions are planned: the trauma leaders and managers to have deputies to step in if the need arises, and ongoing work with our partners to reduce the number of patients delayed in the spinal unit who are fit to be discharged from hospital.

Areas where problems or concerns have been identified have action plans for improvement and these are monitored through the Directorate performance management meetings. Any recurrent themes can be included as key objectives for improvement in the Trust service plan or the following year’s Quality Account priority areas.

### Participation in Clinical Audits

During 2014/2015, 28 national clinical audits and 2 national confidential enquiries covered relevant health services that Salisbury NHS Foundation Trust provides.

During 2014/2015, Salisbury NHS Foundation Trust participated in 27 (96%) national clinical audits, and 2 (100%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Salisbury NHS Foundation Trust was eligible to participate in during 2014/2015 are as follows in the table below.

The national clinical audits and national confidential enquiries that Salisbury NHS Foundation Trust participated in, and for which data collection was completed during 2014/2015, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>National Clinical Audit / Clinical Outcome Review Programme</th>
<th>Eligible</th>
<th>Participation</th>
<th>% of cases submitted to each audit</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Heart</td>
</tr>
<tr>
<td>Adult Community Acquired Pneumonia</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing</td>
<td>yes</td>
<td>no</td>
<td>N/A</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Cancer</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Heart</td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>Congenital Heart Disease (Paediatric cardiac surgery) (CHD)</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>Heart</td>
</tr>
<tr>
<td>Coronary Angioplasty/ National Audit of PCI</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Heart</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Diabetes (Adult) conditions</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA) conditions</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme)</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Other</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFAP)</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Older People</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>Lung cancer (NLCA)</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Cancer</td>
</tr>
<tr>
<td>Major Trauma: The Trauma Audit &amp; Research Network (TARN)</td>
<td>yes</td>
<td>yes</td>
<td>90% to 30/6/14</td>
<td>Acute</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Women and Children's Health</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>yes</td>
<td>yes</td>
<td>No national audit took place in 2014</td>
<td>Older people</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>yes</td>
<td>yes</td>
<td>Did not participate</td>
<td>Heart</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion programme</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Blood and Transplant</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>yes</td>
<td>yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
</tbody>
</table>
Salisbury NHS Foundation Trust participated in a number of audits that are not in the Quality Account mandatory list. This activity is in line with the Trust’s annual clinical audit programme which aims to make sure that clinicians are actively engaged in all relevant national audits and confidential enquiries as well as undertaking baseline assessments against all NICE guidelines and quality standards. This enables the Trust to compare our performance against other similar Trusts and to decide on further improvement actions. The annual programme also includes a number of audits agreed as part of the contract with our Clinical Commissioning Groups. The Trust took part in the following additional audits:

- British Association of Dermatologists national audit on Psoriasis
- British Association of Dermatologists national audit on use of Isotretinoin for the treatment of acne
- British Association of Dermatologists national audit on non melanoma skin cancer audit 2014
- Accidental Awareness during Anaesthesia
- National audit of Prostate Cancer
- National Care of the Dying audit Round 4

The reports of 18 (100%) national clinical audits that were published in 2014 were reviewed by Salisbury NHS Foundation Trust in 2014/2015. Of these 16 (89%) were formally reported to the Clinical Management Board by the clinical lead responsible for implementing the changes in practice and Salisbury NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided set out in the table overleaf.
The table below shows examples of national clinical audit reports reviewed during 2014/2015 and examples of resulting actions being taken by Salisbury NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Audit report</th>
<th>Reviewed by whom</th>
<th>Action taken or required to improve</th>
</tr>
</thead>
</table>
| Vascular Registry – Outcomes after Elective Repair of Infra-renal Abdominal Aortic Aneurysm (AAA) | Clinical Management Board in April 2014 | This national audit looked at the outcomes of planned aneurysm surgery. The dataset was of a high quality. The audit results showed a safe service. This hospital’s open AAA volume is comparable with peers whereas our mortality rate (0%) was much better than our peers. One improvement action was required:  
  • To improve patient pathways further by working together with the central vascular hub. |
| Falls and Fragility Fractures Audit Programme: National Hip Fracture Database 2014 | Clinical Management Board in October 2014 | The report showed that there were 287 patients at this hospital with a hip fracture. Readmission rates were low and a high rate of patients (77%) returned home within 30 days. The hospital achieved most of the criteria for the best practice tariff (patients operated on within 36 hours). However, achievement of the best practice tariff dropped from 84% to 78% mainly due to lack of theatre space. Improvement actions included:  
  • Reinstating the ‘golden patient’ initiative which ensures these patients take priority on the operating list.  
  • Routine trauma theatre lists at the weekends were introduced. |
| BTS Emergency Use of Oxygen                                                  | Clinical Management Board in October 2014 | This report showed our results for the prescription and administration of emergency oxygen were above the national average in key areas and had improved year on year. Further improvement actions included:  
  • Education sessions for doctors and nurses on the prescription of oxygen and nurse signature of oxygen administered. |
The Trust expects to formally review all national audits at the Clinical Management Board within two months of publication. This gives clinical teams time to discuss the findings and to develop an action plan which is presented to the Board for approval and support where actions are needed.

Action plans have been developed for all national audits and confidential enquiries published during the year. Monitoring of these actions is through the Trust’s quality performance management structure or through designated working groups. Examples are given in the table on the previous page.

The reports of 183 (100%) local clinical audits were reviewed by the Trust in 2014/2015 and Salisbury NHS Foundation Trust intends to take or has taken the following actions to improve the quality of healthcare provided.

- Thickened drinks are recommended for some patients with swallowing difficulties, but these should match the consistency required from swallowing assessments. Staff and patient questionnaires showed improvement after training and clearer information about how to thicken drinks.
- An internal electronic referral system was implemented to enable medical and surgical teams to obtain a senior doctor clinical opinion from another speciality instead of using a paper copy. To date over 700 referrals have been successfully completed with patients being seen faster and more efficiently.
- Patients had their temperature taken every 30 minutes during operations (98%) and were warmed with heated air (86%) if their temperature fell below 36 degrees. Delays in patients leaving the recovery room due to a low temperature fell from 4% to 1.6%.

**Research**

The number of patients receiving relevant health services provided or subcontracted by Salisbury NHS Foundation Trust in 2014/2015 that were recruited during that period to participate in research approved by a research ethics committee were 877 patients into 54 studies*. This compares to 912** patients into 44 studies in 2013/2014.

The level of participation in clinical research demonstrates Salisbury NHS Foundation Trust’s commitment to improving the quality of care we offer and to making a contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes. Summary information and contact details of study co-ordinators of all clinical research trials our patients are recruited to are available at http://public.ukcrn.org.uk/search/

*End of year recruitment figures will not be finalised until later in the year.
** In the quality account 2013/2014 we reported that 908 patients were recruited into 42 studies. The final number of patients recruited was 912 patients into 44 studies.

**Goals agreed with Commissioners**

A proportion of Salisbury NHS Foundation Trust’s income in 2014/2015 was conditional on achieving quality improvement and innovation goals agreed between Salisbury NHS Foundation Trust and any person or body the Trust entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2014/2015 and for the following 12 month period are set out in the tables below. The planned income through this route for 2014/2015 was £3,667,616 (In 2013/14 it was £3,756,771). The amount the Trust actually received in 2014/2015 was £3,635,520. The Trust has invoiced for non-contracted CQUINs of £35,440.

CQUIN contracts were signed with our commissioners during 2014/2015 as part of their overall contract. The Trust achieved all of the quality improvements as set out in the table overleaf.
<table>
<thead>
<tr>
<th>Goal name</th>
<th>Description of goal and number</th>
<th>Target in 14/15</th>
<th>Performance in 14/15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Goals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends and Family Test – implementation of staff Test</td>
<td>1a) All staff groups are asked the Friends and Family test quarterly except for Q3 during the national staff survey</td>
<td>Staff are given the opportunity to answer the Friends and Family test questions once in quarter 1, 2 and 4.</td>
<td>Q1 – 204 responses, 97% recommended the hospital as a place to receive care and treatment. 83% recommended the hospital as a place of work. Q2 – 653 responses, 92% recommended the hospital as a place to receive care and treatment. 81% recommended the hospital as a place of work. Q4 – 314 responses, 92% recommended the hospital as a place to receive care and treatment. 82% recommended the hospital as a place of work.</td>
</tr>
<tr>
<td>Friends and Family Test – early implementation</td>
<td>1b) Early implementation of outpatients and day cases</td>
<td>Implementation in all outpatients and day case departments by 1 October 2014</td>
<td>Outpatient response rate – 11% Day case response rate – 18%</td>
</tr>
<tr>
<td>Friends and Family Test – increased or maintained response rate</td>
<td>1c) Increased or maintained response rate in A&amp;E and inpatient services</td>
<td>In quarter 4 a response rate at least 20% for A&amp;E services and at least 30% for inpatient services</td>
<td>Q4 – A&amp;E – 24% response rate Q4 – Inpatients - 47% response rate</td>
</tr>
<tr>
<td>Friends and Family test: increased response rates in acute inpatient services</td>
<td>1d) Increased response rate</td>
<td>A response rate of at least 40% of inpatients in the month of March 2015</td>
<td>March 2015 - 47.9% response rate</td>
</tr>
<tr>
<td>NHS Safety Thermometer – improvement goal</td>
<td>2) Reduction in the prevalence of new hospital acquired grade 2 to 4 pressure ulcers</td>
<td>10% reduction on the median value of 2.14% to 1.93% median value in the last 5 months of 2014/2015</td>
<td>1.5%</td>
</tr>
<tr>
<td>Dementia – find, assess, investigate and refer</td>
<td>3a) 1. Number of patients over 75 years admitted as an emergency who have a known diagnosis of dementia or clinical diagnosis of delirium who have been asked the Mental Test Score within 120 hours of admission.</td>
<td>1) 90%</td>
<td>1) 92%</td>
</tr>
<tr>
<td><strong>Local Goals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Dementia – clinical leadership</strong></td>
<td>3b) Named lead clinician for dementia and a training programme for staff</td>
<td>Clinical lead in place.</td>
<td>Consultant in Elderly Medicine is the clinical lead.</td>
</tr>
<tr>
<td><strong>Dementia – supporting carers of with dementia</strong></td>
<td>3c) Ensuring carers feel supported people</td>
<td>Monthly audit to find out if carers feel supported, were given advice and information</td>
<td>17 carers</td>
</tr>
<tr>
<td><strong>Functional movement in hospital for elderly care patients</strong></td>
<td>4) To reduce the functional decline of elderly patients whilst in hospital through increased mobilisation on two wards</td>
<td>Q1 audit of number of patients appropriate to mobilise and frequency of mobility during the day</td>
<td>Q1 audit was carried out in Q2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3 sustain numbers of patients with a mobility plan.</td>
<td>Durrington ward – 16 patients mobilised 3.7 times a day during the week and 3.8 times a day at the weekend.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Winterslow ward – 17 patients mobilised 2.9 times during the week and 2.4 times a day at the weekend.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Q3 audit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Durrington ward - 34 patients mobilised 4.8 times a day during the week and 5.7 times a day at the weekend.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Winterslow ward - 35 patients mobilised 3.5 times during the week and 2.5 times a day at the weekend.</td>
</tr>
<tr>
<td><strong>End of life care</strong></td>
<td>5) To improve the care of patients and families as end of life approaches by implementing the conversation project</td>
<td>Quarterly audit of implementation of standards associated with the conversation with patients and families. Target 50% by Q3, 65% by Q4 of discussion with primary care.</td>
<td>Discussion with the patient - 85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Discussion with the family – 94%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Discussion with Primary care – Q3 – 51%, Q4 – 69%</td>
</tr>
</tbody>
</table>
| **Sepsis Six** | 6) To increase the percentage of acute patients admitted through A&E with severe sepsis who received the Sepsis Six bundle within 1 hour. | Monthly audit of 3 measures – proforma use, lactate measured and IV antibiotics. Achieve 65% overall by 31/12/14 and sustain in Q4. | Q3 = 83% overall  
Q4 = 73% overall |
|---|---|---|---|
| **Appropriate antibiotic prescribing** | 7) To measure whether antibiotics are prescribed and reviewed appropriately. | Annual South West region prevalence audit and a monthly audit of whether antibiotics are prescribed and reviewed appropriately on 2 wards to achieve 80% per quarter. | Annual audit in May 14 – completed – 79%  
Monthly audit of 2 wards – 28 audits in year. Q1 – 81.3%, Q2 – 96.7%, Q3 – 93.6%, Q4 – 91.9% |

| **West Hampshire CCG Local Goals** | | |
|---|---|---|---|
| **Outpatient follow up reform** | Reduce routine face to face follow up and commence patient initiated follow up. | Commence and increase non face to face appointments in Trauma and Orthopaedics and Ear Nose and Throat outpatients | Trauma & Orthopaedics  
Telephone appointments – 46 patients  
Patient initiated follow ups – 584 patients were given the choice & 25 patients booked and attended an appointment.  
ENT  
Telephone appointments – 10 patients.  
Patient initiated follow ups – 28 patients were given the choice & 1 patient booked and attended an appointment. |
| **System wide delayed transfer of care** | To ensure effective joint working of hospital services and community based care in facilitating timely and appropriate transfer from hospital for all adults | Improve the information supplied to the commissioner, internal flow process and hip fracture pathway and report improvements. | NHS delays Q3 – 2 patients, Q4 – 16 patients  
Social Services delays Q3 – 6 patients, Q4 – 28 patients.  
Improvement report completed. |
| **Reducing ward moves** | To minimise clinically unnecessary ward moves for patients within their hospital stay | Sustain ward moves at less than 1% as a 12 month rolling average | 0.89% |
| Time from arrival to initial consultant assessment | To ensure patients admitted via the Acute Medical Assessment Unit and Surgical Assessment Unit are seen by a consultant within a maximum of 14 hours of initial arrival at hospital | a) Acute Medical Assessment Unit – 90% of patients seen within 14 hours by a consultant  

b) Surgical Assessment Unit – 55% of patients seen by a consultant within 14 hours by the end of Q3 and 60% by the end of Q4 | a) 90%  
b) Q3 = 67%, Q4 = 79% |

**Specialist Commissioning CQUIN indicators 2014 – 2015**

The Trust achieved the quality improvements as set out in the table below.

<table>
<thead>
<tr>
<th>Goal name</th>
<th>Description of goal and number</th>
<th>Target in 14/15</th>
<th>Performance in 14/15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Goals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 3 national CQUINS | Friends and Family Test Safety Thermometer  
Dementia care | The same as the Wiltshire, Dorset and West Hampshire CQUINs above | The same as the Wiltshire, Dorset and West Hampshire CQUINs above |
| **Local goals** | | | |
| Quality dashboards | To maintain and further enhance quality dashboards for the following services:  
- Adult Critical Care  
- Specialised vascular  
- Specialised orthopaedics  
- Complex spinal surgery | Quarterly publication of quality dashboards | Data submitted to 2 of the quality dashboards. The specialised orthopaedics & complex spinal surgery dashboard remained in development by NHS England and was not available to enter data. However, the Trust submitted data to the British Spine Register and National Joint Registry from which the dashboards will be populated. |
| Patient held records | To introduce patient held self care plans including contacts to access care in emergencies in breast cancer and haematology patients | 90% of patients to have a patient held self care plan from Q2 to Q4 | Breast cancer patients – 90.8% had a patient held self care plan  
Haematology patients – 92% had a patient held self care plan |
| Improved access to breast milk in preterm infants | Increase in the percentage of preterm babies born at less than 34 weeks gestation who are receiving some of their own mother’s breast milk at final discharge home from the neonatal unit | Increase from 54% baseline in 2013/2014 to 59% for the full year | 68.1% |
Our quality priorities in 2015/2016 reflect the need to continue to work with our partners to improve these aspects of care. The Trust has agreed CQUINs with our commissioners for 2015/2016 as set out in the table below:

<table>
<thead>
<tr>
<th>Goal name</th>
<th>Description of goal and number</th>
<th>Target</th>
<th>Quality Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Goals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Acute Kidney Injury</td>
<td>The percentage of patients with AKI treated in hospital whose discharge summary includes each of the 4 key items: 1. Stage of AKI 2. Evidence of medicines review having been undertaken 3. Type of blood tests required on discharge for monitoring 4. Frequency of blood test required for discharge for monitoring</td>
<td>To be confirmed following baseline measures in Q1</td>
<td>Physical health</td>
</tr>
<tr>
<td>1. Sepsis</td>
<td>2a) The total number of patients presenting to A&amp;E and other units that directly admit emergencies who met the criteria of the local protocol and were screened for sepsis. 2b) The number of patients who present to A&amp;E and other wards/units that directly admit emergencies with severe sepsis, Red Flag sepsis or septic shock and who received intravenous antibiotics within 1 hour of presenting.</td>
<td>To be confirmed following baseline measures in Q1</td>
<td>Physical health</td>
</tr>
<tr>
<td>1. Dementia</td>
<td>3a) The proportion of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to hospital. 2. The proportion of those identified as potentially having dementia or delirium who are appropriately assessed. 3. The proportion of those identified, assessed and referred for further diagnostic advice in line with local pathways agreed with commissioners, who have a written care plan on discharge which is shared with the patient’s GP. 3b) To ensure that appropriate dementia training is available to staff through a locally determined training programme. 3c) To ensure that carers of people with dementia and delirium feel adequately supported.</td>
<td>1) 90% 2) 90% 3) 90% in Q4</td>
<td>Mental health</td>
</tr>
<tr>
<td>7. Urgent and Emergency care</td>
<td>To decrease the proportion of avoidable emergency admissions to hospital</td>
<td>To be confirmed following baseline measure in Q1</td>
<td>Urgent and Emergency care</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>8. Urgent and Emergency care</td>
<td>To improve the recording of diagnosis in A&amp;E</td>
<td>85%</td>
<td>Urgent and Emergency care</td>
</tr>
</tbody>
</table>

**Local CQUIN**

| End of life care | To improve the care of patients and families as end of life approaches by implementing the conversation project | Sustain Q3 & Q4 14/15 measures. 83% patients discussed with the GP. | End of life care |

**West Hampshire local goals (only)**

<table>
<thead>
<tr>
<th>Outpatient follow up reform</th>
<th>Continue to reduce routine face to face follow ups and continue patient initiated follow up.</th>
<th>Continue improvement actions</th>
<th>Outpatient follow up reform</th>
</tr>
</thead>
<tbody>
<tr>
<td>System wide delayed transfer of care</td>
<td>To ensure effective joint working of hospital services and community based care in facilitating timely and appropriate transfer from hospital for all adults</td>
<td>Continue improvement actions</td>
<td>System wide delayed transfer of care</td>
</tr>
<tr>
<td>End of life care</td>
<td>To improve the care of patients and families as end of life approaches by implementing the conversation project</td>
<td>Sustain Q3 &amp; Q4 14/15 measures. 83% patients discussed with the GP.</td>
<td>End of life care</td>
</tr>
</tbody>
</table>

**Specialist Commissioning CQUINs 2015 – 2016**

<table>
<thead>
<tr>
<th>Goal name</th>
<th>Description of goal and number</th>
<th>Target</th>
<th>Quality Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Goals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 year outcomes for infants born at 30 weeks or less gestation</td>
<td>All infants born at 30 weeks or less gestation discharged home from the hospital who remain alive at 2 years corrected aged who have been assessed and have data entered in the neuromotor, malformations, social, respiratory, cardiovascular system, gastrointestinal, renal, neurology, auditory, vision and communication fields in the Badger net 2 year follow up fields</td>
<td>To be confirmed following baseline measure</td>
<td>Neonatal care</td>
</tr>
<tr>
<td>Prevention of hypothermia in preterm babies</td>
<td>To achieve a reduction in the number of preterm babies (34 weeks or less) admitted to the neonatal unit with hypothermia</td>
<td>95%</td>
<td>Neonatal care</td>
</tr>
<tr>
<td>Reduce separation of mothers and babies and reduce demand on neonatal services by improving learning from avoidable term admissions (babies over 37 weeks) into the neonatal unit</td>
<td>All babies admitted to the neonatal unit for medical care of babies over 37 weeks will have a joint clinical review by the maternity and neonatal service within one month of the admission. The review should aim to identify the learning points to improve care provision and service design.</td>
<td>95%</td>
<td>Neonatal care</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Increase effectiveness of rehabilitation after critical illness by completion of rehabilitation assessment 24 hours after admission</td>
<td>All adult patients have a completed assessment of rehabilitation needs 24 hours after admission to Critical Care.</td>
<td>95%</td>
<td>Critical care</td>
</tr>
</tbody>
</table>

**Care Quality Commission (CQC) registration**

Salisbury NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without conditions.

The Care Quality Commission has not taken enforcement action against Salisbury NHS Foundation Trust during 2014/2015.

Salisbury NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2014/2015.

**Care Quality Commission intelligent monitoring**

The Care Quality Commission are using a new report based on a wide range of indicators which they use to analyse the quality and performance, patient and staff experience of acute hospitals.

In July 2014 Salisbury NHS Foundation Trust had an overall risk score of 4 and in December 2014 an overall risk score of 1. This puts the Trust in band 6 which is the rating given to hospitals with the lowest risk.

**Data quality**

Good quality information (data) underpins the effective delivery of patient care and is essential if improvements in the quality of care are to be made. Improving data quality will improve the delivery of patient care and improve value for money.

Following the auditor’s findings of some weaknesses in the design of the control environment in regard to the ‘referral to treatment - incomplete pathways’ and 62 day cancer waits indicators, Salisbury NHS Foundation Trust will continue to take the following actions to improve data quality:

- Continue to increase the number of reports sent to clinicians and managers to help them make decisions on areas in their service which need to improve.
- Continue to integrate IT systems to reduce duplication and risk of errors.
- We will continue to focus on data quality errors and use the themes to improve training and processes.
- We will implement new national best practice data quality guidance to improve patient care.

To ensure our data quality is able to support the assurance of overall care quality the Trust manages a Data Quality Service. The Data Quality Service aims to ensure staff record clinical information accurately on every occasion. The service achieves this by supporting good practice in the process of data collection, this ensures the person coding the episode of care has the right information about the care given and the appropriate training to ensure accurate data capture.

The Data Quality Service staff spend time working with doctors and administrative staff to demonstrate best practice as well as correcting errors made. Errors are detected through the use of automatic electronic data quality reports and rectified by the person who...
recorded the data incorrectly. Data quality reports include volumes and types of errors and are reported to the Data Quality Improvement Group, Directorate performance meetings and the Information Governance Steering Group. The Data Quality Service continually monitors and audits data quality locally and participates in an external audit which enables the Trust to benchmark its performance against other Trusts.

The use of these techniques gives the Trust assurance that the information regarding quality of care given is an accurate representation of performance.

<table>
<thead>
<tr>
<th>Data item</th>
<th>Salisbury District Hospital *13/14</th>
<th>National benchmark *13/14</th>
<th>Salisbury District Hospital 14/15</th>
<th>National benchmark 14/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>% for admitted patient care with a valid NHS number</td>
<td>99.7%</td>
<td>99.1%</td>
<td>99.7%</td>
<td>99.2%</td>
</tr>
<tr>
<td>% for outpatient care with a valid NHS number</td>
<td>99.8%</td>
<td>99.3%</td>
<td>99.8%</td>
<td>99.3%</td>
</tr>
<tr>
<td>% for Accident and Emergency care with a valid NHS number</td>
<td>98.9%</td>
<td>96.0%</td>
<td>98.8%</td>
<td>95.2%</td>
</tr>
<tr>
<td>% for admitted patient care with a valid General Medical Practice code</td>
<td>99.1%</td>
<td>99.9%</td>
<td>100.0%</td>
<td>99.9%</td>
</tr>
<tr>
<td>% for outpatient care with a valid General Medical Practice code</td>
<td>98.9%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>99.9%</td>
</tr>
<tr>
<td>% for Accident and Emergency care with a valid General Medical Practice code</td>
<td>99.1%</td>
<td>99.1%</td>
<td>99.8%</td>
<td>99.2%</td>
</tr>
</tbody>
</table>

*2013/14 month 11 data was reported in the quality account last year and is now reported as at year end

**Salisbury NHS Foundation Trust submitted records during 2014/2015 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient’s valid NHS number and General Medical Practice Code is set out in the table below. These are important because the NHS number is a key identifier for patient records and an accurate record of the General Medical Practice Code is essential to enable the transfer of clinical information about the patient.**

**Information Governance Toolkit Attainment levels**

Salisbury NHS Foundation Trust’s Information Governance Assessment report overall score for 2014/2015 was 85% and was graded as satisfactory (green). The assessment provides an overall measure of the quality of data systems, standards and processes within the organisation. The Trust’s score improved from 81% in 2013/2014. The Trust achieved the necessary standard for all areas assessed.

In the toolkit there are 6 standards with 45 separate requirements. Of these, 17 were subject to audit to demonstrate compliance in 2014/2015 and areas for improvement. There will be an ongoing audit programme of the requirements in 2015/2016.

**Clinical Coding Error Rate**

Clinical coding translates the medical terminology written in a patient’s health care record to describe a patient’s diagnosis and treatment into a standard, recognised code. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records and underpins payments and financial flows within the NHS. The Trust introduced new coding software in 2012. This has improved consistency of coding and provides an audit tool which enables local improvement actions to be taken.
Salisbury NHS Foundation Trust was subject to an external Information Governance clinical coding audit by an independent company during 2014/2015 and the error rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

<table>
<thead>
<tr>
<th></th>
<th>Primary diagnosis</th>
<th>Secondary diagnosis</th>
<th>Primary procedure</th>
<th>Secondary procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>99.5%</td>
<td>98.9%</td>
<td>96.2%</td>
<td>98.05%</td>
</tr>
<tr>
<td>2014</td>
<td>96.5%</td>
<td>95.4%</td>
<td>93.8%</td>
<td>94.6%</td>
</tr>
<tr>
<td>2013</td>
<td>98%</td>
<td>97.5%</td>
<td>98.6%</td>
<td>97.5%</td>
</tr>
</tbody>
</table>

The speciality services reviewed within the sample in January 2015 were Gastroenterology, Cardiology, Plastics, Urology and Haematology. The results should not be extrapolated further than the actual sample audited.

The following improvement actions were progressed in 2014/2015:

- We have introduced an electronic discharge summary on most of the wards and ensured they contained information regarding active co-morbidities and other conditions treated whilst an inpatient.

- We continued to improve the coding of co-morbidities of patients. A coder is present at the weekly mortality review meeting and we have successfully used a co-morbidity checklist to record long term conditions accurately and have started to extend its use in the Medical Assessment Unit.

- A re-audit of palliative care coding of patients who had died was undertaken in November 2014. We found in a sample of 137 patient spells there were 14 instances (10%) where the patient should have had a palliative care code assigned to their care. The re-audit showed an improvement on the 2013 audit which showed of 212 patient spells there were 40 instances (20%) where the patient should have had a palliative care code assigned to their care. This was corrected retrospectively and further training provided to the coders.

Salisbury NHS Foundation Trust will be taking the following actions to improve data quality in 2015/2016:

- Continue to improve the quality of filing in health care records.
- Develop an internal audit programme to ensure the quality of coding is maintained throughout the year.
- Ensure that comorbidities are included on all GP discharge summaries and complete the full roll out to all wards.
- Monitor the completion of coding for the 5th working day of the month.

### 2.3 Reporting against core indicators

#### Summary Hospital Level Mortality (SHMI)

Salisbury NHS Foundation Trust considers that the SHMI data is as described for the following reasons:

- See explanation under description of the issue and reason for prioritising it in priority one.

Salisbury NHS Foundation Trust has taken the following actions to improve the SHMI of 104 to improve the quality of its services by:

- A senior doctor has continued to lead weekly mortality reviews with clinicians and coders. We did not find any serious failings in care but have found areas where we could improve. For example, applying the use of the Sepsis Six care practices within an hour of diagnosis of severe sepsis.

- Since October 2013 we have extended our specialist palliative care services to seven days a week. This has enabled more people to be cared for at home or in the community.

Salisbury NHS Foundation Trust intends to take the following actions to ensure the SHMI remains as expected by:

- Continuing the implementation of Sepsis Six in the Medical and Surgical Assessment Units
- Continuing with other care bundles.
- Continuing to reduce patient moves.
- Continuing to ensure early senior review of acutely ill patients seven days a week.
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: preventing people from dying prematurely</td>
<td>a) SHMI value</td>
<td>105</td>
<td>107</td>
<td>103*</td>
<td>104 to Sept 14</td>
<td>100</td>
<td>112</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>b) Percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust.</td>
<td>As expected</td>
<td>As expected</td>
<td>As expected</td>
<td>As expected</td>
<td>As expected</td>
<td>Higher than expected</td>
<td>Lower than expected</td>
</tr>
</tbody>
</table>

* In 2013/2014 SHMI was reported as 108 to September 2013. The full year SHMI was 103 to March 2014.

<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Indicator</th>
<th>2012/13</th>
<th>*2013/14</th>
<th>2014/15 Provisional</th>
<th>National average</th>
<th>Highest average other Trusts</th>
<th>Lowest average other Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 3: helping people to recover from episodes of ill health or following injury</td>
<td>Patient reported outcome measures scores for:</td>
<td></td>
<td></td>
<td></td>
<td>Average health gain where full health = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>i) groin hernia surgery</td>
<td>0.079</td>
<td>0.113</td>
<td>0.130**</td>
<td>0.081</td>
<td>0.125</td>
<td>0.009</td>
</tr>
<tr>
<td></td>
<td>ii) varicose vein surgery</td>
<td>0.089</td>
<td>0.035</td>
<td>0.070**</td>
<td>0.100</td>
<td>0.142</td>
<td>0.054</td>
</tr>
<tr>
<td></td>
<td>iii) hip replacement surgery</td>
<td>0.440</td>
<td>0.427</td>
<td>0.514**</td>
<td>0.442</td>
<td>0.501</td>
<td>0.350</td>
</tr>
<tr>
<td></td>
<td>iv) knee replacement surgery</td>
<td>0.333</td>
<td>0.289</td>
<td>0.117**</td>
<td>0.328</td>
<td>0.394</td>
<td>0.249</td>
</tr>
</tbody>
</table>

*In the quality account 2013/2014 provisional data was presented. The data presented is now the final position.

**Average health gain figures have been used for the Trust for 2014/2015, rather than adjusted average health gain, due to the total number of records being lower than 30 for the time period covered (1 April 2014 to 30 September 2014).
Patient Reported Outcomes Measures (PROMs) - Please see table page 97.

Salisbury NHS Foundation Trust considers that the Patient Reported Outcomes Measures (PROMs) are as described for the following reasons:

- We introduced PROMs in 2010 for patients who had hip and knee replacement surgery, groin hernia and varicose vein surgery. These measure a patient's health gain after surgery. The information is gathered from the patient who completes a questionnaire before and after surgery. The responses are analysed by an independent company and compared against other Trusts.

- The finalised (18 months in arrears) PROMs in England 2012/2013 national report concluded that based on patients’ responses to questionnaires before and after surgery, the proportions reporting improvements in their conditions, and the average health gains reported, were in line with previous years for all procedures. Proportionally, more patients reported improvement on measures focussed specifically on their condition than reported improvement on more general health measures. Overall, Salisbury NHS Foundation Trust compares favourably on all four procedures which were similar to previous years.

Salisbury NHS Foundation Trust has taken the following action to sustain the improvement in the health gain of patients having groin hernia surgery to improve the quality of its services by:

- The senior doctor for groin hernia repair and gall bladder disease has continued to prepare and follow up patients for surgery by a telephone consultation before and after the operation. This saves patients a trip to the hospital. Patients often prefer a telephone call in the privacy of their own home.

Salisbury NHS Foundation Trust considers that the percentage of emergency re-admissions within 28 days of discharge is as described for the following reasons:

- Every time a patient is discharged and readmitted to hospital the staff code the episode of care. The Data Quality Service continually monitors and audits data quality locally and we participate in external audits which enables the Trust to compare its performance against other Trusts.

Salisbury NHS Foundation Trust has taken the following actions to reduce readmissions of patients within 28 days of discharge to improve the quality of its services:

- The haematology team have continued to provide a daily email advice service for GPs which has helped reduce re-admissions.

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Domain 3: helping people to recover from episodes of ill health or following injury</td>
<td>Percentage of patients readmitted within 28 days of discharge from hospital of patients aged: i) 0 to 14*</td>
<td>5.11%</td>
<td>4.69%</td>
<td>4.1%</td>
<td>6.3%</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td>ii) 15 or over*</td>
<td>5.87%</td>
<td>5.74%</td>
<td>5.84%</td>
<td>10.6%</td>
<td>Not available</td>
<td>Not available</td>
</tr>
</tbody>
</table>

*In MONITORs detailed requirements for quality reports 2014/2015 it has been acknowledged that an error was made in the drafting of the regulations and that the split of patients for this indicator should be (i) 0 to 15 and (ii) 16 or over.

Emergency readmissions within 28 days of discharge - Please see table above.

Salisbury NHS Foundation Trust considers that the percentage of emergency re-admissions within 28 days of discharge from hospital is as described for the following reasons:

- Every time a patient is discharged and readmitted to hospital the staff code the episode of care. The Data Quality Service continually monitors and audits data quality locally and we participate in external audits which enables the Trust to compare its performance against other Trusts.
"The acute medicine team continue to provide telephone advice for GPs which has helped reduce re-admissions.

Salisbury NHS Foundation Trust intends to take the following actions to reduce readmissions to improve the quality of its services:

- We will continue to review groups of patients with diagnoses and procedures where readmission rates are higher than expected and take improvement actions.

Responsiveness to the personal needs of patients - Please see table below.

Salisbury NHS Foundation Trust considers that the mean score of responsiveness to inpatient personal needs is as described for the following reasons:

- Each year the Trust participates in the National Inpatient Survey. A random sample of 850 patients are sent a nationally agreed questionnaire and the results are analysed independently by the Patient Survey Co-ordination Centre.

<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Indicator</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>National average</th>
<th>Highest average other Trusts</th>
<th>Lowest average other Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 4: ensuring that people have a positive experience of care</td>
<td>Responsiveness to the personal needs of its patients (mean score)</td>
<td>6.9</td>
<td>7.1</td>
<td>7.2</td>
<td>7.0</td>
<td>7.2</td>
<td>8.8</td>
</tr>
</tbody>
</table>

The Staff Friends and Family Test – taken from our local quarterly survey and our national staff survey results

Salisbury NHS Foundation Trust considers that the percentage of staff employed by, or under contract to the Trust during 2014/2015 who would recommend the hospital as a provider of care to their friends and family is as described for the following reason:

- Each year the Trust participates in the National Staff Survey. A random sample of 800 staff are sent a nationally agreed questionnaire and the results are analysed by the Staff Survey Co-ordination Centre.

- In 2014/2015 we also introduced the staff Friends and Family test and gave every member of staff the opportunity to answer the questions once a year. Staff were asked two questions. Firstly, we asked them whether they would recommend the hospital as a place to work and secondly whether they would recommend the hospital to their friends and family if they needed care or treatment.

- We have reviewed the skill mix and numbers of nursing staff on each ward every six months and reported these to the Board. The Board has invested £1 million in additional ward nursing staff this year. We continue to publish the actual number of staff on duty against the expected number on our website.
The table shows how staff responded to the Friends and Family test in the national staff survey 2014. The Trust was in the top 20% of hospitals nationally for this indicator

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 4: ensuring that people have a positive experience of care</td>
<td>Percentage of staff who would recommend the hospital to friends or family needing care</td>
<td>76%</td>
<td>82%</td>
<td>83%</td>
<td>68%</td>
<td>93%</td>
<td>38%</td>
</tr>
</tbody>
</table>

The table below shows how staff responded to the two questions in Quarter 1, 2 and 4. Quarter 3 was excluded due to the national staff survey taking place.

<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Indicator</th>
<th>2014/15*</th>
<th>National average in 2014/15</th>
<th>Highest average other Trusts</th>
<th>Lowest average other Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 4: ensuring that people have a positive experience of care</td>
<td>Percentage of staff who would recommend the hospital to friends or family needing care</td>
<td>93.1% (Q1, Q2 &amp; Q4 surveys combined) Q1 = 97.5% Q2 = 92.0% Q4 = 92.1%</td>
<td>77% (2014-15 Q2 survey)</td>
<td>98% (2014-15 Q2 survey)</td>
<td>41% (2014-15 Q2 survey)</td>
</tr>
</tbody>
</table>

*The staff Friends and Family test was introduced locally from 1 April 2014

Salisbury NHS Foundation Trust plans to take the following actions to improve the percentage of staff who would recommend the hospital as a place to work and improve the quality of its services by:

- Continuing to train our staff in preventing and dealing with violence and aggression and supporting our staff who experience violence and aggression from patients or visitors.

**Venous thromboembolism**

Salisbury NHS Foundation Trust considers that the percentage of patients admitted to hospital and who were risk assessed for venous thromboembolism (blood clots) is as described for the following reasons:

- Patient level data is collected monthly by the ward pharmacist from the patient’s prescription chart.

The data is captured electronically and analysed by a senior nurse linked to the Thrombosis Committee.

Salisbury NHS Foundation Trust has taken the following actions to improve the percentage of patients admitted to hospital who were risk assessed for venous thromboembolism to improve the quality of its services:

- Salisbury NHS Foundation Trust is an exemplar site for the prevention and treatment of venous thromboembolism (blood clots) and has continued to achieve 99.1% of patients being assessed for the risk of developing blood clots and 96.6% receiving appropriate preventative treatment. We will continue to monitor our progress and feedback the results to senior doctors and nurses.
• We continued to conduct detailed enquiries of patients who develop blood clots to ensure we learn and improve.
• We introduced a ward based anti-coagulant nurse to provide patient and staff education.

Salisbury NHS Foundation Trust intends to continue with the actions described above to sustain the percentage of patients admitted to hospital who are risk assessed for venous thromboembolism and given preventative treatment.

<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Indicator</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>National average</th>
<th>Highest average other Trusts</th>
<th>Lowest average other Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm</td>
<td>Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism</td>
<td>98%</td>
<td>98.7%</td>
<td>99.1%</td>
<td>96.2% (2014-15 Q2)</td>
<td>100% (2014-15 Q2)</td>
<td>86.4% (2014-15 Q2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Indicator</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>National average</th>
<th>Highest average other Trusts</th>
<th>Lowest average other Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm</td>
<td>The rate per 100,000 bed days of C. difficile infection reported within the Trust amongst patients aged 2 or over</td>
<td>30.0</td>
<td>16.9</td>
<td>14.2</td>
<td>15.3</td>
<td>14.7</td>
<td>37.1</td>
<td>1.2</td>
</tr>
</tbody>
</table>

### C. difficile infection

Salisbury NHS Foundation Trust considers that the rate per 100,000 bed days of cases of C. difficile infection are as described for the following reason:

- The Trust complies with Department of Health guidance against which we report positive cases of C. difficile. We submitted our data to the Health Protection Agency and are compared nationally against other Trusts. C. difficile data is subject to external audit for assurance purposes.

Salisbury NHS Foundation Trust has taken the following actions to reduce the rate per 100,000 bed days of cases of C. difficile infection to improve the quality of its services by:
- Maintaining and monitoring good infection control practice including hand hygiene, prompt isolation and sampling of patients with suspected C. difficile, introduced different coloured aprons for each bay, introduced Actichlor Plus and trialled new sporicidal commode wipes.
- Maintaining and monitoring standards of cleanliness and taking actions to improve.
- Designated ward rounds and improved best practice in antibiotic prescribing.
- In depth analysis of patients who develop C. difficile in hospital to learn and improve.

Salisbury NHS Foundation Trust intends to take the following actions to reduce the rate per 100,000 bed days of cases of C. difficile infection to improve the quality of its services by:

- Continued vigilance through the above actions
- Ongoing designated wards rounds to support doctors in best practice in antibiotic prescribing.
- Ongoing monthly audits of antibiotic prescribing practice and improvement actions.

**Patient safety incidents**

Salisbury NHS Foundation Trust considers that the rate of patient safety incidents reported and the number and percentage of such incidents that resulted in severe harm or death are as described for the following reasons:

- The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning and improvement actions are taken.
- The Trust submits weekly patient safety incident data to the National Reporting Learning System. We are ranked against other Trusts in respect of the rate of reporting and category of harm.
- We work in partnership with our commissioners to share learning and improvement actions.
- The Trust complies with the duty of candour.

Salisbury NHS Foundation Trust has taken the following actions to reduce the rate of patient safety incidents and the number and percentage of such incidents that have resulted in severe harm or death to improve the quality of its services by:

- Investigating clinical incidents and serious incidents and sharing the lessons learnt across the Trust and ensuring recommendations are implemented through the Directorate quality performance meetings.
- Continuing to monitor the completion of recommendations of clinical reviews and serious incidents at the Clinical Management Board and

|-------------------------------|----------|---------|---------|-----------------------------|---------------------------------
| Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm | Rate of patient safety incidents reported. The percentage of such incidents that resulted in severe harm or death | 7.4 incidents per 100 | *8.04 incidents per 100 admissions | ***28.94 incidents per 1000 bed days | ***35.1 incidents per 1000 bed days |
| | | 0.8% | *0.45% | 0.4% | 0.5% |

*In 2013/2014 8.0 incidents per 100 admissions and 0.65% of such incidents results in severe harm or death were reported. Data was only available to 30/9/2013. The full year is now reported.

**The number of incidents per 100 admissions is taken from the National Reporting Learning System (NRLS) report. This shows the latest actual figures reported nationally for the Trust which are always 6 months in arrears.

***The comparative reporting rate was changed on 1/4/2014 from incident per 100 admissions to incidents per 1000 bed days. This does not allow a comparison of the 2012/2013 & 2013/2014 data with the 2014/2015 data.
Clinical Governance Committee.

- Ensuring more timely identification of themes and trends with the implementation of Datix web.

Salisbury NHS Foundation Trust intends to take the following actions to reduce the rate of patient safety incidents and the number and percentage of such incidents that result in severe harm or death to improve the quality of its services by:

- Data from the National Reporting Learning System (see table below) shows that the Trust has decreased levels of harm compared to the median for acute (non-specialist) organisations. The Trust will continue to actively promote reporting, investigation of clinical incidents and serious incidents and share learning across the Trust and with our commissioners to ensure improvement.

- Our staff survey also indicates that the hospital is in the top 20% of Trusts for staff feeling able to report errors, near misses or incidents witnessed and staff feeling secure to raise concerns about unsafe clinical practice.

**The Friends and Family Test – Patients**

Salisbury NHS Foundation Trust considers the data collected from inpatients and patients who attended the Accident and Emergency department, outpatient departments or had a day case procedure who would recommend the ward or department if they needed similar care or treatment is as described for the following reasons:

- The Trust follows the Friends and Family Test national technical guidance published by NHS England to calculate the response rate and the percentage who would recommend the ward or the Accident and Emergency Department or outpatient department or day case procedure. From 1 October 2014 NHS England withdrew the net promoter score and replaced it with a new score which measures the percentage of patients who were extremely likely or likely to recommend the hospital and the percentage of patients who were extremely unlikely or unlikely not to recommend the hospital. Don’t know and neither likely nor unlikely responses are excluded from the score.

Salisbury NHS Foundation Trust has taken the following actions to improve the response rate and the percentage of patients who would recommend the hospital to friends and family needing care and improve the quality of its services by:

- Providing a range of different methods for patients to give their feedback, such as postcards, the Trust website, a Friends and Family Test App for patients with a smartphone.

- Publishing the response rate and percentage who would recommend every month by ward and department with patient comments and the improvements we have made in response to feedback.

Salisbury NHS Foundation Trust intends to take the following actions to improve the response rate and percentage of patients who would recommend the hospital to friends and family needing care and improve the quality of its services by:

- In 2015/2016 we will introduce the Friends and Family test for children under the age of 16 years.

<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Indicator</th>
<th>*2013/14</th>
<th>2014/15</th>
<th>National average 2014/15</th>
<th>Highest average other Trusts</th>
<th>Lowest average other Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 4: ensuring that people have a positive experience of care</td>
<td>Response rate and net promoter score (graph overleaf) of patients who would recommend the ward or A&amp;E department to friends or family needing care</td>
<td>Response rate: Wards: 44.2% A&amp;E: 14% Trust overall response rate: 24.3%</td>
<td>Response rate: Wards: 45.5% A&amp;E: 20.6% Trust overall response rate: 28.5%</td>
<td>Response rate: Wards: 35.8% A&amp;E: 20.1% Overall response rate: 25.2%</td>
<td>Response rate: Wards: 100% A&amp;E: 80.3% Overall response rate: N/A</td>
<td>Response rate: Wards: 7.1% A&amp;E: 2.5% Overall response rate: N/A</td>
</tr>
</tbody>
</table>

* The Friends and Family test was introduced on 1 April 2013
The graph below shows the Trust's Friends and Family percentage of patients who would recommend the A&E department compared to the national average from April 2014 to March 2015.

Part 3: Other information

Review of Quality Performance

This section gives information relating to the quality of care that Salisbury NHS Foundation Trust provides through a range of selected measures of patient safety, effectiveness and experience. These areas have been chosen to cover the priority areas highlighted for improvement in this Quality Account, as well as areas which our patients have told us are important to them, such as cleanliness and infection prevention and control. Our commissioners measure a number of these areas and our CQUIN contract supports improvement measures.

These indicators are included in a monthly quality indicator report that is reported to the Board and Clinical Governance Committee.

### Patient Safety Indicators

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>National average</th>
<th>What does this mean?</th>
<th>Source of measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mortality rate</td>
<td>95*</td>
<td>104</td>
<td>114</td>
<td>*109</td>
<td>101 to Dec 14</td>
<td>100</td>
<td>Lower than 100 is good. Based on the national definition of HSMR &amp; SHMI.</td>
</tr>
<tr>
<td>(HSMR)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHMI</td>
<td>n/a</td>
<td>105</td>
<td>107</td>
<td>103 * &amp; *</td>
<td>104 to Sept 14</td>
<td>100</td>
<td></td>
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<tr>
<td>new measure</td>
<td></td>
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<td>2011/12)</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>2. MRSA</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>0 is excellent</td>
<td>National definition</td>
</tr>
<tr>
<td>notifications**</td>
<td>(5)</td>
<td>(5)</td>
<td>(3)</td>
<td>(2)</td>
<td>(5)</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td>3. C. difficile</td>
<td>0.32</td>
<td>0.51</td>
<td>0.25</td>
<td>0.19</td>
<td>0.19</td>
<td>Not available</td>
<td>Lower than national average is good. National definition</td>
</tr>
<tr>
<td>infection per</td>
<td></td>
<td>Trust and</td>
<td>Trust and</td>
<td>Trust and</td>
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<tr>
<td>1,000 bed days</td>
<td></td>
<td>non Trust</td>
<td>non Trust</td>
<td>non Trust</td>
<td>non Trust</td>
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<td>apportioned</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4. Global Trigger</td>
<td>31</td>
<td>41</td>
<td>32</td>
<td>34 ***</td>
<td>48 to 31/1/15</td>
<td>40</td>
<td>Lower score the better. Definition based on Patient Safety First Campaign</td>
</tr>
<tr>
<td>adverse events rate</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety Indicators</td>
<td>2010/11</td>
<td>2011/12</td>
<td>2012/13</td>
<td>2013/14</td>
<td>National average</td>
<td>What does this mean?</td>
<td>Source of measure</td>
</tr>
<tr>
<td>---------------------------</td>
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<td>-----------------</td>
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<td>-------------------</td>
</tr>
<tr>
<td>5. ‘Never events’ that occurred in the Trust****</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>271 never events (1/4/14-28/2/15)</td>
<td>0 is good</td>
<td>Definition from National Patient Safety Agency</td>
</tr>
<tr>
<td></td>
<td>(These were associated with surgery &amp; rectified with no long term harm)</td>
<td>(This was associated with surgery with no patient harm)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Patient falls in hospital resulting in a fracture or major harm</td>
<td>21</td>
<td>32</td>
<td>32</td>
<td>21</td>
<td>29</td>
<td>Not available</td>
<td>Low number is good</td>
</tr>
</tbody>
</table>

**Clinical Effectiveness indicators**

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>National average</th>
<th>What does this mean?</th>
<th>Source of measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Patients having surgery within 36 hours of admission with a fractured hip</td>
<td>74%</td>
<td>87%</td>
<td>80%</td>
<td>81%</td>
<td>87.1%</td>
<td>Higher number is good</td>
<td>Based on national definition with data taken from hospital system and national database.</td>
</tr>
<tr>
<td>8. % of patients who had a risk assessment for taken from VTE (venous thromboembolism)</td>
<td>91%</td>
<td>92%</td>
<td>98%</td>
<td>99.1%</td>
<td>90%</td>
<td>Higher number better</td>
<td>Based on national definition hospital system with data and national database.</td>
</tr>
<tr>
<td>9. % patients who had a CT scan within 24 hrs of admission with a stroke</td>
<td>90%</td>
<td>92%</td>
<td>94.6%</td>
<td>91.6%</td>
<td>Not available</td>
<td>Higher number better</td>
<td>Based on national definition with data taken from hospital system and national database.</td>
</tr>
<tr>
<td>Clinical Effectiveness Indicators</td>
<td>2010/11</td>
<td>2011/12</td>
<td>2012/13</td>
<td>2013/14</td>
<td>2014/15</td>
<td>National average</td>
<td>What does this mean?</td>
</tr>
<tr>
<td>----------------------------------</td>
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</tr>
<tr>
<td>10. Compliance with NICE Technology Appraisal Guidance published in year</td>
<td>80%</td>
<td>70%</td>
<td>72%</td>
<td>68%</td>
<td>73%</td>
<td>Not measured</td>
<td>Higher number better</td>
</tr>
<tr>
<td><strong>Patient experience indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Number of patients reported with grade 3 &amp; 4 pressure ulcers</td>
<td>19</td>
<td>12</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>Not available</td>
<td>Lower number is better</td>
</tr>
<tr>
<td>12. % of patients who felt they were treated with dignity and respect</td>
<td>81% Yes always</td>
<td>79% Yes always</td>
<td>83% Yes always</td>
<td>82% Yes always</td>
<td>83% Yes always</td>
<td>Not available</td>
<td>Higher number is better</td>
</tr>
<tr>
<td>13. Means score of patients stating the quality of care was very good or better</td>
<td>7.9 #</td>
<td>7.8 #</td>
<td>8.1 #</td>
<td>8.1 #</td>
<td>8.3 #</td>
<td>Not available</td>
<td>Higher number is better</td>
</tr>
<tr>
<td>14. % of patients in mixed sex accommodation</td>
<td>11%</td>
<td>11%</td>
<td>7%</td>
<td>3%</td>
<td>11%</td>
<td>Not available</td>
<td>Lower number is better</td>
</tr>
<tr>
<td>15. % of patients who stated they had enough help from staff to eat their meals</td>
<td>67%</td>
<td>63%</td>
<td>74%</td>
<td>75%</td>
<td>68%</td>
<td>Not available</td>
<td>Higher number is better</td>
</tr>
</tbody>
</table>
### Patient Safety Indicators

<table>
<thead>
<tr>
<th>Source of measure</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>National average</th>
<th>What does this mean?</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. % of patients who thought the hospital was clean</td>
<td>66%</td>
<td>65%</td>
<td>66%</td>
<td>69%</td>
<td>70%</td>
<td>Not available</td>
<td>Higher number is better</td>
</tr>
</tbody>
</table>

- In previous annual reports the HSMR was reported as 101 in 2009/10 and 97 in 2010/11. However, in 2011/2012 HSMR was rebased and our figures were rebased to 100 in 2009/2010 and 95 in 2010/2011. In 2013/2014 we reported our HSMR from April 2013 to January 2014 as 107. The final HSMR for 2013/2014 was 109.
- In 2013/2014 SHMI was reported as 108 to 30/9/2013. The full year rate was 103.
- In previous annual reports the Trust quoted Trust and non-Trust apportioned MRSA notifications as a total figure. This will have included community hospital and GP patients. The total figure is quoted in brackets in the table.
- The Global Trigger/adverse events rate in 2013/2014 was published as 34 up to 31 January 2014. The total figure for the full year in 2013/2014 was 34.
- Never events are adverse events that should never happen to a patient in hospital. An example is an operation that takes place on the wrong part of the body. The never events list increased from 8 to 25 on 1 April 2011.

# National Targets and Regulatory Requirements

<table>
<thead>
<tr>
<th>Target for 2015/16</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate - admitted</td>
<td>94.9%</td>
<td>93.5%</td>
<td>93.4%</td>
<td>94%</td>
<td>91.6%</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted</td>
<td>98.6%</td>
<td>98.2%</td>
<td>97.9%</td>
<td>98.2%</td>
<td>98.1%</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway</td>
<td>92.9%</td>
<td>91.5%</td>
<td>94.7%</td>
<td>96.3%</td>
<td>96.4%</td>
</tr>
<tr>
<td>A&amp;E: maximum waiting time of four hours from arrival to admission/ transfer/discharge</td>
<td>97.8%</td>
<td>97.86%</td>
<td>96.9%</td>
<td>96.3%</td>
<td>95.2%</td>
</tr>
<tr>
<td>All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer</td>
<td>92.7%</td>
<td>93.3%</td>
<td>90.5%</td>
<td>92.85%</td>
<td>90.6%</td>
</tr>
<tr>
<td>All cancers: 62 day wait for first treatment from NHS cancer screening service referral</td>
<td>100%</td>
<td>97.2%</td>
<td>100%</td>
<td>100%</td>
<td>95.2%</td>
</tr>
<tr>
<td>Category</td>
<td>2010/11</td>
<td>2011/12</td>
<td>2012/13</td>
<td>2013/14</td>
<td>2014/15</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>All cancers: 31 day wait for second or subsequent treatment – surgery</strong></td>
<td>98.5%</td>
<td>98.9%</td>
<td>98.9%</td>
<td>97.6%</td>
<td>99.6%</td>
</tr>
<tr>
<td><strong>All cancers: 31 day wait for second or subsequent treatment – anti cancer drug treatments.</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>All cancers: 31 day wait for second or subsequent treatment – radiotherapy</strong></td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>All cancers: 31 day wait from diagnosis to first treatment</strong></td>
<td>98.5%</td>
<td>97.9%</td>
<td>97.9%</td>
<td>98.4%</td>
<td>98.4%</td>
</tr>
<tr>
<td><strong>Cancer: two week wait from referral to date first seen for all urgent referrals (cancer suspected)</strong></td>
<td>94.7%</td>
<td>94%</td>
<td>94.4%</td>
<td>94.4%</td>
<td>94.7%</td>
</tr>
<tr>
<td><strong>Cancer: two week wait from referral to date first seen for symptomatic breast patients (cancer not initially suspected)</strong></td>
<td>96.6%</td>
<td>97.3%</td>
<td>97.0%</td>
<td>94.9%</td>
<td>95.1%</td>
</tr>
<tr>
<td><strong>C. difficile year on year reduction</strong></td>
<td>52 (31 Trust apportioned, 21 non Trust apportioned)</td>
<td>111 (44 Trust apportioned 67 non Trust apportioned)</td>
<td>39 (25 Trust apportioned 14 non Trust apportioned)</td>
<td>30 (21 Trust apportioned 9 non Trust apportioned)</td>
<td>29 (23 Trust apportioned, 6 non Trust apportioned)</td>
</tr>
<tr>
<td><strong>MRSA – maintaining the annual number of MRSA bloodstream infections at less than half of the 03/04</strong></td>
<td>0 (5)</td>
<td>4 (5)</td>
<td>3 (3)</td>
<td>2 (2)</td>
<td>2 (3)</td>
</tr>
<tr>
<td><strong>Certification against compliance with requirements regarding access to health care for people with a learning disability</strong></td>
<td>Compliant</td>
<td>Compliant</td>
<td>Compliant</td>
<td>Compliant</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

* From 2010/2011 the definition changed and this reflects the number of positive Trust in-patient cases split between Trust apportioned (over 72 hrs after admission) and non-Trust apportioned (less than 72 hrs of admission).

NHS Wiltshire Clinical Commissioning Group (CCG) have reviewed Salisbury Hospital Foundation Trust’s 2014-15 Quality Account. Our view is the Quality Account is presented in a clear and easy to read format, includes all essential elements and incorporates the NHS England’s 2014-15 presentation guidance. To the best of our knowledge, the report appears factually correct.

It is the view of the CCG that the Quality Account reflects the ongoing commitment from Salisbury Foundation Trust to quality improvement and addressing key issues in a focused and innovative way. It is evident the Trust have reflected the NHS Outcomes Framework in their Trust priorities, and the account summarises the achievements against quality priorities throughout the year. The CCG acknowledges and commends the improvement in reduction of hospital acquired pressure ulcers and the performance in the implementation of Friends and Family Test, both of which were maintained during a period of challenging demand. The CCG recognizes that achieving the 4 hours target in 14/15 has been challenging and will continue to support the Trust in achieving the required patient flow going forward into 15/16. We will also continue to support the Trust to drive improvements in patient safety through projects and collaboration to focus on local priorities and minimise potential risks. We have a structured monthly quality review meeting with the Trust, and review a range of indicators and metrics from a number of sources.

The Trust have continued to embed the recommendations of key national documents, such as the Francis Report, and ambitions of Keogh report. As such, the Trust have responded effectively to ensure timely review of staffing levels, and have significantly invested in staffing to ensure appropriate clinical skill mix, and continue to monitor trends and early warning signs of changes and staffing levels. The appropriate workforce with robust clinical leadership is key to delivering services effectively. Clearly the Trust places emphasis on ongoing monitoring of nursing and clinical skill mix to minimise any potential impact that staff shortages have on patient experience and outcomes. The CCG acknowledge that during 2014-15, SFT have reported challenges in eliminating mixed sex accommodation (MSA) throughout the trust, and are working closely with Commissioners to reduce avoidable MSA occurrences. The CCG note the Trust is committed to taking both immediate actions and seeking longer term solutions to ensure the privacy, dignity, safety and experience of patients is paramount.

The CCG acknowledge the quality improvements achieved, in particular improving communication across end of life care. NHS Wiltshire CCG are supporting the Trust to continue to build on this success through year two of a CQUIN scheme. The CCG is supportive of the priorities that Salisbury Foundation Trust have identified for 2015/2016. Sepsis and Acute Kidney Injury were rightly identified as priorities in advance of the National CQUIN frameworks being issued and the roll out of improved and electronic discharge summaries.

NHS Wiltshire CCG welcomes the specific priorities for 2015/16 which the Trust has highlighted in this report, all are appropriate areas to target for continued improvement and link with the Clinical Commissioning priorities.

Over the coming year, the CCG look forward to supporting the Trust, to further embed trust wide learning and improvement from incidents, including Never Events, themes from complaints and further development and expansion of ambulatory care services. The CCG will increase the frequency of Quality Assurance visits and engagement with the Trust to enable the Trust to showcase improvements and identify areas on which to focus.

Statement from NHS Dorset Clinical Commissioning Group for Salisbury NHS Foundation Trust Quality Account - 6 May 2015

Over the past 12 months Salisbury Hospital NHS Foundation Trust (SFT) has continued to focus on improving the clinical outcomes, safety and experience of patients within their services. The work that the Trust has done throughout the year on improving their mortality rates has been effective, achieving an eight point drop in Hospital Standardised Mortality Ratio. The Trust has also made good progress with their other priorities for the year including dementia diagnosis and treatment, harm free care and improving patient experience.

In relation to the priorities identified for 2015/2016 there is an ongoing focus on working with partners to improve the coordination of carers. The CCG recognises and endorses the continued focus on preventing avoidable harm, improving patient experience and access to services seven days per week.

The CCG looks forward to working with SFT over the coming 12 months to maintain and improve high quality healthcare services for the population of Dorset”
Statement from Wiltshire Council Health Select Committee - 14 May 2015

Wiltshire Council Health Select Committee has been asked to comment on the Trust’s quality account 2014/15.

The Committee believes this to be an accurate reflection of the Trust’s performance in 2014/15 as regards patient safety, clinical effectiveness and patient experience, the 3 overarching criteria for quality accounts.

We have noted the continued effort to achieve success in relation to particular priorities in 2014/15 these include:

Domain 1, Priority 1: the mortality trend is reducing year on year and is now within the expected range; many measures have been instigated to achieve this, the Sepsis Six campaign has seen real success.

Domain 2, Priority 2: the faster assessment of patients and the provision of dementia champions has improved the rate at which patients are referred when admitted to hospital; the Freedom for Life programme is helping patients to control their diabetes; and people with COPD can attend a pulmonary rehabilitation programme.

Domain 3, Priority 3: access to rehabilitation has been improved; you have expanded the Keep Active campaign; and are working with GPs to manage the 7 most common conditions for admission of children.

Domain 4, Priority 4: the national in-patient survey shows an increase in the quality of care and 96.7% of patients said they were likely to recommend SFT to friends and family.

Domain 5, Priority 5: the Trust have sustained a high percentage of new harm-free care; reduced pressure ulcers; and tackled cleanliness with even better and more rigorous measures being put in place.

During 2014/15 18 clinical audits were reviewed and 16 reported to the Board as a result of which trauma theatre lists at weekends were introduced and the number of patients leaving the recovery room with a low temperature dropped from 4 to 1%.

Just 2 never events were recorded; the number of patients who were in mixed sex wards increased but the number of patients who said they had been helped with meals decreased; cases of C.Difficile halved since 2012/13 and MRSA reduced as well from 3 to 2.

Your priorities for 2015/16 are 1) strive to keep patients safe from avoidable harm; 2) ensure patients have a positive experience of care; 3) actively work with partners and patients to prevent ill health; 4) provide patients with high quality care 7 days a week and 5) provide co-ordinated care across the community. The Trust are putting many measures and programmes in place to see that good outcomes are achieved and have joined the “Sign up to Safety” campaign, the GROW programme, “Shape up at Salisbury” initiative amongst many others and will measure, monitor and report progress to the Board and steering groups.

The committee would like to thank the Board for the transparency and co-operation afforded to them throughout the year.

Statement from Healthwatch – 11 May 2015

Healthwatch Wiltshire (HWW) welcomes the opportunity to comment on Salisbury NHS Foundation Trust’s quality account for 2014/15. HWW was established to promote the voice of patients and the wider public with respect to health and social care services. Over the past year we have continued to work with the Trust to ensure that patients and the wider community are appropriately involved in providing feedback and that this feedback is taken seriously by the Trust.

We are pleased to see that the Care Quality Commission have rated the Trust as being in the lowest band for risk in its provision of care services and that it has also been given a green (best) governance risk rating by Monitor. In addition, the Trust has joined the ‘sign up to safety’ campaign, which aims to halve avoidable harm within the NHS over the next 3 years. This is positive news for patients and shows that the Trust has committed to providing safe and good quality care and effective governance.

Care for older people and in particular for those with dementia continues to be a key area for the Trust. We welcome this commitment and in particular the Trust’s focus on creating dementia friendly environments, psychological support for older people, improvements in the number of patients screened for dementia on admission and their work to increase social stimulation for inpatients. This fits well with the new dementia strategy for Wiltshire and it is hoped these actions will significantly improve the experience of older and more vulnerable patients. We look forward to hearing about the outcomes of this work.

Results from the national inpatient survey showed that patients were sometimes delayed on the day of discharge. We know from our own engagement work
that this is a major issue for patients across the county. However, we are satisfied that the Trust has carried out work to identify the causes of the delays and that they have put in place actions that aim to improve the experience of discharge for patients and their families. We will continue to monitor the outcomes of the new initiatives.

We note that rates for C. Difficile infections are slightly higher than the national average but note that action has been taken to reduce the rates. We will continue to monitor these rates over the coming year.

The Trust has said it is committed to learning from incidents that resulted in harm and to share learning across the organisation. We particularly welcome this as we are aware that the two never events (by definition, events that should never happen) occurred over the past year within the Trust. We will be looking to see whether learning from these events has occurred and will continue to closely monitor any further occurrences over the coming year.

The results from the national inpatient survey show that 68% of patients said that they had had enough help from staff to eat their meals. We would like to see this figure improve over the coming year. The concern is that many more vulnerable patients (who may not have completed the survey) may be at risk. We do note the investment in more ward nursing staff and hope that this has a positive impact on these figures.

The Trust has introduced a number of different ways for patients to provide feedback. Friend and Family test feedback can be given online, via text and from a phone app as well as by more traditional methods. This may explain the increased response rate for the test. We welcome also the use of patient feedback being in the creation of ‘local’ ward-based action plans and to make improvements to patient care across the Trust.

We are pleased to see that the Trust is working more with their community partners to improve the health of local people. Much work has been done around smoking cessation, reduction in alcohol intake and obesity. We note that this partnership working around public health/prevention is set as one of the Trust’s priorities for the coming year. We welcome this commitment as we recognise that the wider health community has a role to play in the Trust’s performance.

We note the new priorities set by the Trust. Healthwatch Wiltshire will engage with patients, carers, and the wider community to support the Trust in meeting these priorities over the coming year.

**Statement from the Governors – 14 May 2015**

Thank you for inviting the Governors to comment on the quality account. The Governors were impressed with the wide range of quality improvements over the past year. We are particularly pleased to see the reduction in pressure ulcers, the innovative initiatives to encourage rehabilitation, a compassionate approach to end of life care and the continued improvements to the environment. Whilst the number of C Difficile cases was disappointing the action taken by the Board demonstrated a collaborative, open and positive attitude to learning and improving.

Going forward the Governors support the priorities in this year’s quality account. The Board’s continued focus on the care of older people, vulnerable adults and children is welcome. The Trust Board clearly have patient safety and patient experience at the centre of their priorities with commitment to the ‘Sign up to Safety Campaign’. We are pleased to see the Trust will continue to listen to patients and respond to this feedback as well as respond to national drivers that aim to improve the care for patients. We commend the recognition of the caring, compassionate and hard-working staff who strive to provide an outstanding experience for patients.

**How to provide feedback**

All feedback is welcomed and the Trust listens to these concerns and steps are taken to address individual issues at the time. Comments are also used to improve services and directly influence projects and initiatives being put in place by the Trust.

**Statement of Directors’ Responsibilities in respect of the Quality Report**

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, Directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/2015 and supporting guidance.
The content of the quality report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2014 to May 2015;
- Papers relating to quality reported to the Board over the period April 2014 to May 2015;
- Feedback from the commissioners dated 27 May 2015.
- Feedback from the governors dated 14 May 2015.
- Feedback from Local Healthwatch organisations dated 11 May 2015
- Feedback from Overview and Scrutiny Committee dated 14 May 2015.
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 14 May 2015.
- Care Quality Commission intelligent monitoring report dated December 2014.

The quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

**Data Quality**

The Trust acknowledges the finding of the audit set out overleaf in relation to data underpinning the measures of performance set out in this report, but remain satisfied that overall:

- The performance information reported in the quality report is sufficiently reliable and accurate to ensure appropriate management of the processes of the organisation;
- There are internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- The quality report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitornhsft.gov.uk/annualreportingmanual).

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Nick Marsden
Chairman
22 May 2015

Peter Hill
Chief Executive
22 May 2015
INDEPENDENT AUDITOR’S REPORT TO THE COUNCIL OF GOVERNORS OF SALISBURY NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Salisbury NHS Foundation Trust to perform an independent assurance engagement in respect of Salisbury NHS Foundation Trust’s Quality Report for the year ended 31 March 2015 (the ‘Quality Report’) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following two national priority indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways (“Referral to Treatment – incomplete pathways”); and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers (“62 day cancer waits”).

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2014/15 (‘the Guidance’); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2014 to May 2015;
- Papers relating to Quality reported to the Board over the period April 2014 to May 2015;
- Feedback from the Commissioners dated May 2015;
- Feedback from local Healthwatch organisations dated May 2015;
- The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2014/15;
- The 2014/15 national patient survey;
- The 2014/15 national staff survey;
- Care Quality Commission quality and risk profiles/intelligent monitoring reports 2014/15; and
- The 2014/15 Head of Internal Audit’s annual opinion over the Trust’s control environment.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Salisbury NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Salisbury NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’, issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included.
• evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
• making enquiries of management;
• testing key management controls;
• limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
• comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
• reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Salisbury NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

• the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual; and

• the Quality Report is not consistent in all material respects with the sources specified in the Guidance.

We identified weaknesses in the design of the control environment in regard to the “referral to treatment – incomplete pathways” indicator. As a result of our testing of this indicator we also identified data errors, where data included within the indicator could not be agreed to supporting patient records. As a result we are not able to issue a limited assurance opinion in respect of the “referral to treatment – incomplete pathways” indicator.

We identified weaknesses in the design of the control environment in regard to the “62 day cancer waits” indicator. As a result of our testing of this indicator we also identified data errors, where data included within the indicator could not be agreed to supporting patient records. As a result we are not able to issue a limited assurance opinion in respect of the “62 day cancer waits” indicator.

Jonathan Brown
KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL
22 May 2015