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

While all NHS organisations are facing significant operational and financial challenges it is essential that we maintain good quality, safe care and continue with our commitment to improve services for our patients. Quality has been the number one priority for us during 2015/2016 and will continue to remain that way as we move into a new financial year.

As part of the Seven Day Services Review, we already meet three clinical standards around shift handovers, emergency access to mental health, and a number of specific quality improvements. Within the last year, we have made progress in another five standards around patients’ experience, time to first consultant review, diagnostics, access to consultant-delivered interventions and transfers to community, primary and social care. The detail will follow later in this Quality Report. In 2016/17 we will continue to deliver against these clinical standards and work towards the remaining two, around multidisciplinary team reviews and ongoing consultant reviews.

The NHS England Five Year Forward View focuses on the redesign of urgent and emergency care services, the development of new models of care and NHS Seven Day Services. We continue to deliver on our plans in these areas. While we narrowly missed our Accident and Emergency target of 95% of people being admitted, treated or discharged within four hours, we achieved 94.8%, which is an excellent performance by our staff bearing in mind that the vast majority of hospitals across the country failed to meet this target with a national percentage average of 87.9%. We met our key waiting time target of 92% of patients being treated within 18 weeks of a GP referring the patient to hospital and our cancer 62 day referral to treatment target. We have also made good progress around early diagnosis and prevention of cancer which are key factors in the national cancer strategy.

A fundamental emphasis on quality is at the heart of the Five Year Forward View and 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.

This can be seen following our Care Quality Commission inspection where we received an overall rating of good for caring and the effectiveness of our service and as part of this were rated as Good in 27 of the 39 elements covering our core services. While the inspection team identified areas of good practice, the overall rating for the Trust was still requires improvement, reflecting the rating given to the majority of Trusts inspected under this new rigorous inspection process. I was pleased to see that our patients and staff rate the care at Salisbury District Hospital highly and that the majority of feedback from patients and relatives was extremely positive. The report said that staff provided kind and compassionate care which was delivered in a respectful way, and that emotional support was recognised and provided. It was also pleasing to see that the report identified a strong culture of reporting and learning from incidents and that there was a culture of being open, with the Duty of Candour well understood. The report did identify areas for improvement and we acknowledged that use of temporary staff to ensure safe staffing levels on wards is currently an issue for the NHS and proactive recruitment is taking place locally to improve this situation. Mandatory training, some aspects of documentation, better linkages with other organisations when dealing with complaints that cover several organisations and the follow up of patients discharged from the spinal unit were among other areas highlighted by the CQC for action and we are now working with our partners on a formal action plan.
Our patient survey results evidence a positive patient experience. Parents, children and young people rated their experience of care highly in the national children’s inpatient and day case survey, with safety, friendliness and pain control among the key positive findings. New mothers complimented our midwives and recognised the outstanding care and support that they received during labour and birth and after the baby was born.

Safety continues to remain a high priority for us and, as part of our ongoing commitment in this area I am pleased to see ongoing improvements in infection prevention and control with zero MRSA bloodstream infections and the lowest rate of clostridium difficile in the region. We have also seen a 35% reduction in the number of grade 2 pressure ulcers and the implementation of our Sepsis 6 campaign which ensures that appropriate treatment is delivered within one hour of patient with sepsis arriving in the Accident and Emergency Department, Medical Assessment Unit and the Surgical Assessment Unit. Mortality rates can fluctuate during the year and these are monitored regularly in several different ways. While the Hospital Standardised Mortality Rate (HSMR) went beyond the expected range within the year there were very low levels of avoidable deaths. The Standardised Hospital Mortality Index which compares the number of deaths in hospital or within 30 days of discharge, was in the expected range.

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 or on NHS Choices.

Quality of care is included in each Directorate’s 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. This enables the Board members to hear about any quality or safety issues in the areas and these reviews are now based on the CQC’s five domains of safe, effective, responsive, caring and well-led.

Quality is monitored regularly by the Board through a number of quality measures and indicators. For example, the Trust Board receives a quality indicator report every month and a patient story is heard at alternate 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. One patient described his experience of a new treatment called ElectroMotive Drug Administration given for a recurrent form of bladder cancer. The patient had chemotherapy directly instilled into his bladder and a small electric current applied which allowed the chemotherapy drug to be better absorbed. This is now in routine use and has improved outcomes for patients.

While the focus remains on quality of care it is important that we continue to tackle some of the financial challenges that we face and that we are contributing to the NHS Productivity and Efficiency Programme. The aim is to ensure that all hospitals are as efficient and productive as they can be. We have been very fortunate to be in the first cohort of 22 Trusts working with Lord Carter on this work programme.

One of the key work streams of Lord Carter’s review has been on the nursing workforce. As part of this we have focused on efficient rostering practices to ensure we are using our workforce as effectively as possible. We have also been involved in the development and testing of the metrics - care hours per patient day. This is to be reported nationally by all Trusts in 2016/2017.

Sharing information is essential for the future of the NHS, as is partnership work in general and the development of new models of care. From 1 July 2016 onwards we will be part of a new partnership called Wiltshire Health & Care which will provide adult community services in Wiltshire. This involves the Trust, Great Western Hospitals NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust. It marks an exciting new period of change where we will be able to work through organisational barriers, join up care and expand the amount of care being offered in the community. It provides a positive example of how NHS organisations can work together to improve the quality of care for patients.

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 2016/2017. 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 2015/2016 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 2016

On behalf of the Trust Board, 20 May 2016

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 2015/2016 priorities as published in the last Quality Account

The Trust’s priorities in 2015/2016 were:

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.

The NHS England Mandate 2016/2017 sets out the goals for the NHS and improvements required against the NHS Outcomes Framework 2016/2017. The NHS Outcomes 2016/2017 Framework provides a national overview of how well the NHS performs 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 have linked each of our quality account priorities to one of these domains.

These domains are:

**Domain 1**  
Preventing people from dying prematurely – see priority 1 and 3.

**Domain 2**  
Enhancing quality of life for people with long term conditions – see priority 2 and 5.

**Domain 3**  
Helping people to recover from episodes of ill health or following injury – see priority 4.

**Domain 4**  
Ensuring that people have a positive experience of care – see priority 2.

**Domain 5**  
Treating and caring for people in a safe environment and protecting them from avoidable harm – see priority 1.

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 2015/2016:

The bullet points below indicate the quality priorities set for 2015/2016; the paragraph that follows is the progress made towards their achievement.

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

Description of the issue and reason for prioritising it:

Patients should 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. In 2015 we joined the ‘Sign up to Safety’ campaign which aims to cut avoidable harm by 50% over three years and we will report the progress against each element in our Patient Safety Improvement Programme every quarter. We are also an active participant in the Wessex Patient Safety Collaborative.

As part of our ongoing commitment to promoting a learning culture and keeping patients safe from avoidable harm, we have implemented the statutory Duty of Candour. While it is not significantly different from the way we were already working it means that when things go wrong and patients suffer moderate or severe harm, staff must be open and honest with the patient as quickly as possible after the incident, provide ongoing support and communication, and an explanation of what happened including an apology. The staff must provide the patient with support by allowing a member of their family or carer to be present with them if they wish. We have held education sessions with many of our clinical teams and departments on how staff should comply with the Duty of Candour and also held two Trust-wide learning events.

What we did to support this improvement priority:

- We continued to reduce the number of patients who have preventable falls and fracture their hip in hospital.

Since April 2015 there have been 7 patients who have had a fall resulting in a fractured hip which required surgical treatment; a reduction from 12 patients in the same period in 2014/2015. Our detailed investigations showed that these patients often fell when they were walking on their own, close to the time when they were ready to leave hospital. We have started to trial some sensors which trigger an alarm when a patient starts to get out of bed or get up from a chair. This then ensures they have the right support when walking around.

- We continued to reduce the number of patients who develop grade 2, 3 or 4 pressure ulcers in hospital.

This year we have reduced by 35% the number of grade 2 pressure ulcers from 244 in 2014/2015 to 158 in 2015/2016. In the same period there have been three grade 3 pressure ulcers and one grade 4 pressure ulcer. A detailed review is undertaken of all pressure ulcers acquired in hospital. Through an education programme we have improved the prevention, recognition and treatment of pressure ulcers. For example, to prevent heel pressure ulcers we ensure patients keep their legs elevated in bed and are provided with protective boots.

The chart below shows the total number of hospital acquired grade 2, 3 and 4 pressure ulcers between April 2014 and March 2016

- We continued to reduce the number of patients who develop a urine infection associated with a catheter.

Since April 2015 our Safety Thermometer data shows we have reduced by 37% the number of patients with a new catheter-associated urine infection from 75 in 2014/2015 compared to 47 in 2015/2016.

The chart below shows the total number of new catheter-associated urine infections between April 2014 and March 2016

We improved 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.

Since April 2015 we have continued to use Sepsis Six practices in the Emergency Department and introduced them in the Medical Assessment Unit, Surgical Assessment Unit and the Children’s ward. We have used a severe sepsis screening tool, both for adults and children. This helps doctors and nurses to recognise a patient who has a severe infection and ensures they receive the right investigations and treatment within one hour of arrival at hospital.
We have measured two key components of Sepsis Six – sepsis screening and treatment with antibiotics within an hour of arrival at hospital. In 2015/2016 we screened 85.8% of patients and achieved an overall compliance of 61.3% of patients receiving antibiotics within an hour.

We have also measured compliance with the children’s severe sepsis screening tool separately, whilst it continued to be tested and developed across the children’s network. This was to ensure it was suitable to enable staff to recognise a child with a severe infection. In 2015/2016 we screened 39% of children but no children had severe sepsis or needed urgent antibiotics.

The line graph below showed our compliance with sepsis screening and antibiotic administration of adult patients in the Emergency Department, Medical Assessment Unit and the Surgical Assessment Unit between April 2015 and March 2016.

The chart below shows the percentage of patients who had the four elements of care recorded on the discharge summary from April 2015 to March 2016.

- We worked collaboratively with our South West regional network to improve the prevention, recognition and treatment of patients with acute kidney injury.

We continued to work with our staff to ensure that we had low numbers of patients with avoidable infections and reduced the number of patients with surgical site infections.

In 2015/2016 no patient had an MRSA blood stream infection. Four patients had an MSSA blood stream infection in 2015/2016 compared to 10 patients in 2014/2015. Fifteen patients developed C. difficile against an upper limit given of 19 patients for the year compared to 21 patients against an upper limit of 18 cases in 2014/2015. Clinical teams have worked with our Infection Prevention and Control team to ensure best practice. This includes a variety of measures. For example, good hand hygiene practice, a deep cleaning programme of all our wards and good antibiotic stewardship.

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

In 2008 the World Health Organisation launched a Global Patient Safety Challenge, ‘Safe Surgery Saves Lives’, to reduce the number of surgical deaths across the world. As part of this initiative they devised a checklist to be used by all hospitals. The checklist identifies three phases of an operation and in each phase it must be confirmed that the surgical team has completed the tasks on the list before the next stage can start. The checklist is a tool to initiate discussions between members of the theatre and clinical teams to improve the safety of surgery. We have reviewed our processes for this initiative and have updated the checklist to ensure it is carried out consistently by all surgical teams.
The whole theatre team also takes part in a safety briefing at the start and end of each theatre list, to ensure everything that is needed for each patient is ready and available during the operation.

- We have implemented the Gestation Related Optimal Weight (GROW) programme to identify babies who are smaller than expected for their stage of pregnancy to reduce the risk of stillbirth.

We have trained our midwives, obstetricians and ultrasoundographers in the GROW programme to ensure every woman has a standard measurement of the size of her womb from 24 weeks onwards. The measurement is plotted on a chart individualised to each woman, and this can improve the prediction of a small baby. If the measurement shows the baby is growing slowly or has remained the same over a number of measurements the woman is offered an ultrasound scan or a series of scans to measure the baby. Interventions, such as more detailed scans, medication, or early delivery are then discussed with the woman.

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).

Research suggests there is a strong link between satisfied, well-motivated and supported staff and a positive patient experience. National staff survey results in 2015 covered the four NHS pledges around their jobs, career opportunities and development, support and engagement in decisions that affect them. The Trust was better than average when compared to other Trusts on the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months at 23% compared to 26% nationally. The percentage of staff who believe that the Trust provides equal opportunities for career progression or promotion is 89% compared to 87% nationally. Full details of the survey can be found in the staff report section of the annual report 2015/2016.

In response to comments made by staff in the 2014 staff survey, we now have 15 Dignity at Work Ambassadors who can offer a confidential, supportive and impartial service for staff and managers on any issues around bullying, harassment or discrimination. In addition, the Trust also now has a Freedom to Speak Up Guardian who can act as an independent point of contact for staff about quality and safety concerns, direct them to Dignity at Work Ambassadors where appropriate and feedback concerns directly to the Chief Executive.

The Trust also continues to take a positive approach to Equality and Diversity (E&D) within the hospital. As part of this we have provided additional support for staff through the publication of accessible E&D handbooks on the staff intranet. These create greater awareness of E&D, highlight why it matters and what behaviours are expected from all staff. They also provide a quick references guide for staff who may meet patients from diverse backgrounds and gives them useful insight into sexuality, disability, race and culture. The introduction of new equality champions, monthly awareness events
and a reapplication for the Mindful Employers Charter, which shows a commitment to increasing awareness of mental health in the workplace, are further examples of other improvements made in which the Trust embraces E&D within the organisation.

The Trust is actively working with our partners in health and social care and the public to improve services for patients. This includes our work with E&D leads across Wiltshire and Swindon who developed a charter for collaborative working. Support by the E&D team for a music workshop called ‘Magna Songs’ was performed by pupils from Exeter House special school, is another example of collaborative work around E&D. The team has also developed a quarterly newsletter published both internally and externally where people can contribute articles and engage with our services through its publication.

What we did to support this improvement priority:

- We continued 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 received effective care and treatment.

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

The table below shows how we have sustained the improvement in dementia screening, assessment and referral between April 2015 to March 2016

- We worked with GPs and voluntary organisations to do more to identify carers and provide them with better support, advice and information.

With Carer Support Wiltshire and Healthwatch, Wiltshire we developed a survey with the help of carers of people with dementia, to find out the issues they face. Since April 2015, 60 carers have given their feedback and have been offered information and advice on support services. Carers told us that most are registered with their GP as a carer, and some have had a carer’s assessment. Carers said they were concerned about what would happen to the person they cared for, should anything happen to them. We have started to provide information on how to apply for a Carer’s Emergency Card. The Card will ensure that help will be quickly in place in the event of something happening to the carer.

Carers said they were not always involved in the person’s care as much as they wanted to be during their stay in hospital. We have introduced ‘John’s campaign: for the right to stay with people with dementia in hospital’ throughout the 24 hour period in two of our wards. Involving carers from the moment of admission to discharge can improve the quality of care and patient outcomes.

People with dementia can be confused and frightened during a stay in hospital. This may prompt them to wander around the ward, looking for familiar things and comfort. We have introduced memory boxes on four of our wards. This allows familiar items to be given to the patient to reduce feelings of anxiety and abandonment.

In July 2015 we launched a Carers’ Café for carers of any age whose relatives or friends are in hospital, to give them the opportunity to share their experiences and get advice and support from specialist staff. The café is run every week by volunteers from the Alzheimer’s Society, Age UK and Carers Support Wiltshire who are on hand to answer any questions or to direct them to the appropriate help in the community.

- We wanted to focus more on learning from patient complaints, concerns and feedback so we could make improvements when issues are identified.

Our clinical teams and customer care advisors aim to contact patients and families as soon as a concern or complaint is known about so that where possible, they can try to understand the concern more clearly and to resolve it as soon as possible. Some patients and their families are offered a meeting with the clinical team so they have the opportunity to have questions answered. This year the most frequent theme from complaints and concerns has been poor communication and attitude. The teams and staff involved in the complaints have had customer care training and in these areas we have seen an improvement in the number of positive comments made by patients in the Friends and Family Test.

- We wanted to continue to ensure that patients, their families and carers are involved in decisions
about their care, treatment and on-going care. We compared patient feedback from those admitted during the week with those admitted at the weekend and made improvements.

We have tried out a new ‘This is my usual life’ document on one of our wards to ensure our staff know about the patient’s normal life before they came into hospital. This includes the patient’s life at home and the care they need. The information can be used with the patient and carers to plan their discharge. We have also used the bed boards to improve communication with relatives and carers. For example “the Occupational Therapist would like to speak to you” or “could Jack have some slippers please” or “we would like to discuss discharge plans today”. In 2015/2016 our inpatient real time feedback had an average mean score of 7.9 (maximum score is 10) for patients knowing what is planned for their care and treatment and 8.4 for patients feeling involved in decisions about treatment and care. The scores for 2014/2015 were 8.8 and 8.4 respectively.

In April 2015 we added a new question to our real time feedback to find out whether patients noticed any difference in care between weekdays and weekends in specific areas. To date the results at weekends show that the average mean score for care is 8.2 (maximum score is 10), for help with eating and drinking is 9.6, and response to call bells is 9.0. This tells us that patients felt the care provided at weekends was the same as during the week. Some patients commented that they liked the peace and quiet at weekends but others felt they received less care at this time. Plans are in progress to ensure, where appropriate, patients are seen every day by a senior doctor.

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

We have started to plan a new building for a midwife-led unit, which will give women greater choice in where to have their baby. We will listen to the views of women and their families and design the new building around their needs. Work on the new building was due to begin in the summer of 2016 but has been temporarily delayed until proposals for the return of the armed forces from Europe are clear. This is because we anticipate an increase in the number of babies born here each year. We have also increased the number of midwives to support women in pregnancy, labour and after the baby is born.

- We worked 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.

What our patients and public have told us and what we did to improve

- ‘I want to commend the staff who were very kind and understanding to a lady with dementia’.
- ‘There was a more relaxed atmosphere at the weekend’.
- ‘Call bells are answered more slowly at weekends’. The ward sister said that she will be using the next skill mix review to consider the need for the same level of staff seven days per week.
What we did in 2015/2016:

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 is crucial in preventing ill health.

What we did to support this improvement priority:

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

All women are asked at the booking appointment whether they smoke. In 2015/2016 371 (12.4%) women out of 2998 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. Since April 2015, 278 (11.7%) women out of 2383 who had their baby were still smoking when their baby was born.

The chart below shows a reduction over 6 years of women smoking at booking and at the birth of their baby.

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

Since April 2015, 30,055 (85%) patients who attended the Emergency Department were asked how much alcohol they drank. We found that 658 (2.1%) of patients drank alcohol to a level that could damage their health. Of these, 343 (52%) patients were given information about how to drink less alcohol and get help if needed. All 658 (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 our Alcohol Specialist Nurse who provides advice and support. Some patients take up the option of a referral to the Wiltshire Substance Misuse Service which designs a personal recovery plan for the specific needs and lifestyle of each patient.

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

In May 2015 the Trust took part in a Patient Led Assessment of the Care Environment (PLACE). As a result, to encourage patients to eat fresh fruit we have introduced fruit bowls onto ward tea trolleys. Our patient menus are also published with information on healthy eating choices. Cakes and biscuits are available to our patients but are no longer printed on our menu. We have started to replace our vending machines with ones that provide healthier snacks and drinks.

Our hospital staff club runs a GP referral programme that helps patients with exercise, weight management and specific exercise programmes. The centre also runs a Counter Weight programme to which GPs can refer overweight patients. The programme 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 healthily and increasing activity by exercise. Patients receive one to one support with exercise, dietary advice and regular monitoring.

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

In September 2015 we recruited a specialist nurse to start a Fracture Liaison Service. The aim is to improve the bone health of patients who have already had a fragility fracture. The nurse is able to advise on investigations, bone protection medication, falls prevention and therapy to prevent more serious fractures in the future. There is good evidence that this type of service can result in a reduction in the number of future fragility fractures in the local population.
• We continued to support patients with long term conditions such as diabetes, heart disease and chronic breathing problems to manage their own health and avoid complications.

This year, 16 patients with type one diabetes have attended a Freedom for Life course to learn how to adjust their insulin in relation to diet and exercise. 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. 190 patients with recently diagnosed type two diabetes have also attended a DESMOND structured education programme which supports patients in making lifestyle changes. These patients are less likely to develop complications of diabetes, compared to patients who don’t attend an education programme. Patients and GPs are able to obtain telephone advice from our specialist diabetes team if they need to adjust their insulin regime or are worried about low blood sugar levels.

Patients who are admitted to hospital with heart failure receive a visit from a specialist nurse who involves them in devising their management plan and gives advice on healthy eating, exercise and medication. Patients are able to keep track of their plan with their own patient-held record. The plan also advises the patient what to do if they become more breathless or unwell. Once the patient has left hospital the specialist nurse telephones them a week later to check on their health. If the patient becomes unwell, an urgent outpatient appointment or a visit from the community matron is arranged to advise on treatment and care.

Patients with long term lung conditions, such as chronic obstructive pulmonary disease (COPD), can attend a pulmonary rehabilitation programme. The aim of the programme is to help patients learn more about their condition, the proper use of inhalers, benefits of exercise, breathing control and what to do should they become unwell. Patients can also spend time in the gym doing exercises supervised by an instructor. After the course, patients are able to walk an average of 82 metres further, and usually report being less breathless, less tired and an improved emotional state.

Patients with Obstructive Sleep Apnoea are able to attend a master class clinic to set up their therapy. Patients learn how to use a breathing mask and equipment. Patients have recently been able to use breathing machines with a remote monitoring facility and a ‘MyAir’ App. The App enables the patient to take control of their therapy, gives daily reports via a smart phone or computer and contains video clips on mask care.

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

The ‘Shape up at Salisbury’ campaign is a health and wellbeing programme for all our staff. We know that helping staff to be happy and healthy improves the quality of patient care. We encourage our staff to walk or cycle to work and we have continued a weekly staff-led running club during the summer. Staff have access to a mental health nurse and a counsellor who are able to give support and advice on mental health issues. Physiotherapy is also available for staff who have muscular or back problems. We have increased the number of clinics for staff which provide blood pressure, weight and cholesterol checks, and run stress awareness events, including mindfulness sessions, to help staff identify stress and relieve it. Staff have also joined a choir and are also able to undertake art activities.

In September 2015, a team of Salisbury staff won the South West NHS Military Challenge on Dartmoor. The ten strong team beat 14 other hospitals in seven of the nine challenges, which included an assault course led by the Royal Marines, and in awarding the team their medals, 243 (Wessex) Field Hospital praised Salisbury’s team work and leadership, which was put to the test under the most extreme conditions.

• We have published the outcomes of our bowel screening programme and planned new public health campaigns.

The bowel cancer screening programme has seen a 5.6% rise in the number of patients who have attended for a bowel screening assessment in 2015/2016 compared with 2014/2015. In addition, there has also been a 15.5% increase in the number of patients attending for diagnostic tests in 2015/2016 compared with the same period in 2014/2015. This year, 1111 patients had a diagnostic test and 904 patients had abnormal results. Of these, 59 cancers were found and patients have gone on to have treatment. The team also started to provide health promotion information in 2016.

We have also introduced a bowel scope programme for men and women who are invited for screening around the time of their 55th birthday. Bowel scope screening is an examination which looks inside the lower bowel to find any small growths, called polyps. Polyps may develop into bowel cancer if left untreated. In 2015/2016, 447 patients attended for screening and 100 patients were found to have polyps. 76 patients had their polyps removed at the time of the examination.
24 patients were referred for a full examination of the bowel (colonoscopy). 2 cancers were found, and the patients offered treatment.

What our patients and public have told us and what we did to improve

• ‘Healthcare here is brilliant’.  
• ‘The food should be healthier with more fresh food and fruit’. We have introduced fruit bowls onto ward tea trolleys. Our patient menus are also published with information on healthy eating choices. Cakes and biscuits are available to our patients but are no longer printed on our menu.

What we did in 2015/2016:

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 did to support this improvement priority:

• We worked towards ensuring all emergency patients admitted to the Medical and Surgical Assessment Units were seen and assessed by a consultant within 14 hours of arrival.

We introduced a measurement dashboard for consultants to record the time when they have assessed a patient. For patients admitted to the Medical Assessment Unit, 89% are assessed by a consultant within 14 hours of arrival, seven days a week. For patients admitted to the Surgical Assessment Unit, 74% are assessed by a consultant within 14 hours of arrival, seven days a week. 100% of patients at high risk of death are assessed by a consultant within 6 hours of admission.

The chart below shows the percentage of patients assessed by a consultant within 14 hours of admission both in the Medical and Surgical Assessment Units

Most women with a gynaecological emergency can safely receive their care and treatment in an outpatient setting. Women will be referred directly to the emergency gynaecology clinic and will be assessed by a doctor and a nurse who is trained to undertake ultrasound scans. A treatment plan will be decided at the appointment and in most cases the woman will be able to go home. This service is planned to start in 2016/2017.

We have increased the Surgical Assessment Unit from six to eight beds. There are also two side rooms, so patients can have the privacy they need for their care and treatment. In May 2016 the urology team will start to see patients to ensure they are able to pass urine after they have had their catheter removed in the privacy of the urology centre rather than the Surgical Assessment Unit. Also in May 2016 patients referred by their GP with lower urinary tract symptoms will be able to attend a one stop nurse specialist clinic at which patients will be able to have investigations, care and treatment decided in one clinic appointment.

• ‘Healthcare here is brilliant’.  
• ‘The food should be healthier with more fresh food and fruit’. We have introduced fruit bowls onto ward tea trolleys. Our patient menus are also published with information on healthy eating choices. Cakes and biscuits are available to our patients but are no longer printed on our menu.
• We ensured that when medical shifts change over twice daily handovers continue to be led by a senior doctor with multi-professional participation from the in-coming and out-going shifts seven days a week.

Every morning at 8.00 am and every evening at 8.30 pm the medical teams meet to handover the care of their patients from one team to another, seven days a week. The 8.30pm review is to ensure that sick patients or patients who need to be seen overnight are handed over to the night staff. The 8.00 am review is communicated to the day time medical team, so they know what has happened to the patients overnight, along with the treatment plan. The twice daily meeting attendance is monitored and shows a consistently good rate.

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

We are currently training more of our staff to perform ultrasound scans so that we can start to provide routine weekend ultrasound scans in 2016/2017. We already provide a routine outpatient MRI service at weekends. We have found there is only an occasional need for an emergency MRI scan out of hours.

• We have improved the efficiency of theatres.

Most patients now have their anaesthetic given in theatre after they have made themselves comfortable on the operating table. The theatre team continue to monitor prompt start times and turnaround times to make sure the operating list is fully used. Our surgeons are required to agree their lists two weeks in advance, to ensure all the necessary equipment and staff are available for the operation. This helps to reduce cancellations on the day of surgery.

• Throughout the hospital we introduced new personalised medical and nursing care plans for patients at the end of life to improve patient care and communication with families and GPs.

In June 2015, two new End of Life Care Specialist Nurses started in the Trust. Their role is to help ward staff support patients and their families at the end of life and to provide a training and education programme on every ward. We have introduced 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 preferences about where the patient would wish to die. We have also improved the rapid discharge process for patients who wish to die at home.

• We continued to support patients near the end of their life in their homes and on the wards with our community and hospital palliative care service seven days a week.

What our patients and public have told us and what we did to improve

• ‘For all the new patients that will be visiting the department to have a CT colonography, you will be treated with respect and dignity’.

• ‘Appointment brought forward as a result of short notice cancellation. Reception at day surgery was polite and efficient. Nursing staff cheerful, helpful and knowledgeable. Operation was very successful. Surgeon explained exactly what would happen and all went according to plan. Left hospital on time. As far as I can tell a faultless performance by all involved. After 10 days I have no reason to change my view’.

• ‘Over the last 5 years this hospital has cared for my father on and off for 3-4 separate periods of care until his final stay last month when he died having been admitted for a week or so. Our experience is that very busy staff do a fantastic job and have always been pleasant, co-operative and understanding and provided excellent care at all times and we were content that my father received the best possible care right up to the end’.

• ‘Two appointments made on the same day by hospital staff. Arrived for the first to be told I didn’t have one that it had been cancelled and the second appointment was the replacement. Both the letters were dated and received on the same day’.

We have continued to support patients with complex needs at the end of their life in their own home and on the wards seven days a week. For patients who wish to die at home we have continued to work with community partners to help get patients home as quickly as possible. We continued to support them in their own home.
What we did in 2015/2016:

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 saw the plans for the Better Care Fund take effect. The Better Care Fund joins up NHS health and social care funding 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 did to support this improvement priority:

• We provided 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 continued to provide support for GPs through a direct telephone line where GPs can speak directly to an Acute Consultant Physician for advice and guidance, so that investigations can be arranged before a patient attends hospital or continues to be managed at home. Similar advice is available from the Consultant Surgeon of the day. Our Clinical Haematology Consultants provide an email advice service to GPs to help them manage their patients in the community.

We have continued to run a number of rapid access clinics for conditions such as jaundice, hepatitis and hot joints. In addition, patients with a blood clot are now able to benefit from a one stop clinic. Patients are assessed by a specialist nurse who is able to start blood thinning treatment straight away, if needed. This year, 403 patients had a blood clot. Of these, 131 had a blood clot in the lung and 58 (44%) were able to go home the same day with treatment. 218 patients had a blood clot in their leg of which only 7 (3%) required admission to hospital. 54 patients had a blood clot diagnosed during their admission and were treated for it. In September 2015 the team won a national award for this service.

Since April 2015, all patients being discharged from hospital have an electronic discharge summary. These are sent securely, to the GPs electronic patient record, so information is available to GPs as soon as the patient leaves hospital.

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

In April 2015, we tried out a new discharge assessment referral team (DART) in the medical admission areas. The aim was to identify patients with complex needs early and what they needed to help them get home as soon as possible. On a weekday, during the day, patients with complex needs were seen within 6 hours of admission. At the weekend or out of hours, patients were seen within 14 hours of admission.

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

In two medical wards the discharge assessment referral team (DART) identified the help patients needed to get them home and to ensure the necessary equipment and support were available at home. The same assessment was used throughout the patient’s stay in hospital to ensure patients were not asked the same thing several times. By the end of August 2015, 319 patients had been assessed. Twenty five percent of these patients were discharged within a day of admission, and 41% were discharged in less than 5 days. We have now decided to combine the DART with our existing discharge team.

• With Wiltshire Council and the Clinical Commissioning Group we have worked 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.

Following the completion of the DART trial described above, the Better Care Fund recommended that the DART should be combined into the existing discharge team. As a result, a new combined Discharge Team was formed to enable patients to have a supported discharge from admission and across all wards throughout the Trust. This service will continue to be supported by the Better Care Fund until March 2016 and is directly linked to another trial called ‘Home First’.

In November 2015, we introduced ‘Home First’ whereby a patient is discharged for assessment at home, rather than in hospital. The team must ensure the patient is well enough to leave hospital, has no safeguarding issues and has a safe, accessible home to go to. Since then 155 patients have been discharged and assessed at home the same day. Of these, 146 (94%) patients were
able to stay at home, some with carer support and some with care from the Neighbourhood teams. 4 patients were unable to cope at home and were admitted to a community hospital and 5 patients were re-admitted to this hospital. We have also been successful in our bid to provide adult community services from 1 July 2016 as part of Wiltshire Health and Care. This is one of our priorities in 2016/2017 to join up care and expand the amount of care offered in the community.

2.2 This section sets out our quality priorities for 2016/2017

Our priorities for quality improvement in 2016/2017 and why we have chosen them

Looking forward to 2016/2017 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 and maternity survey and the Friends and Family Test.
- Learning from themes from comments, compliments, concerns and complaints and implementing the Duty of Candour in incidents where we have caused moderate or serious harm.
- Learning from risk reports.
- 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. In particular, what staff have told us about how they are treated by other staff and the opportunities they have for career progression or promotion.
- Talking to our GPs, local commissioners and Wiltshire Council and asking them about local people’s needs and improvements that could be achieved by working together.
- Setting up a new partnership called Wiltshire Health & Care which involves this Trust, Great Western Hospitals NHS Foundation Trust and the Royal United Hospitals Bath NHS Foundation Trust to provide adult community services in Wiltshire from 1 July 2016.
- 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 2014 to 2019 which sets out a national plan on how the NHS needs to change and improve over the next four years.
- Improvement actions from our Care Quality Commission announced inspection in December 2015.

We have consulted widely on the priorities and involved the local Age UK, Warminster Health and Social Care Group, our staff, governors to help us make the final decisions on our priorities for 2016/2017. 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 2016/2017 are the areas where we need to focus our quality improvement. The priorities are broadly similar to 2015/2016 to ensure we respond effectively to the Five Year Forward View and NHS England’s NHS Services Seven days a Week implementation of the four clinical priority standards. 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 2016/2017. 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 we provide an outstanding experience for every patient. 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 listening to our external stakeholders, 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.

The actions we plan to take in our quality priorities reflect the improvement actions the Care Quality Commission recommended we must take to improve safety, responsiveness and in the well-led domain. See section 2.3 Care Quality Commission for the actions the Trust intends take to improve.

Our priorities for 2016/2017* are:

Priority 1
Continue to keep patients safe from avoidable harm.

Priority 2
Ensure patients have an outstanding experience of care

Priority 3
Actively work with our community partners, patients and carers to prevent ill health and manage long term conditions

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

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

*These priorities are not ranked in order of priority. The Trust Board agreed the 2016/2017 priorities on 20 May 2016.

Progress in our priority areas will be measured and monitored through the Trust’s quality governance process. To enable the Trust Board to do this, the Clinical Governance Committee and Clinical Management Board 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 2016/2017 to achieve or improve the priority areas.

What we will do in 2016/2017:

Priority 1
Continue to keep patients safe from avoidable harm

Description of the issue and reason for prioritising it:

The safety of our patients is our first and most important priority in our quality improvement work. We continue to run the ‘Sign up to Safety’ programme (our Patient Safety Improvement Programme) to reduce avoidable levels of harm for patients in hospital by 50% over the course of this three year project 2016 – 2019. We measure this through indicators such as infection rates, hospital acquired pressure ulcer rates and the number of patients falling in hospital which result in a fracture or serious harm. All of these can lead to pain and distress for our patients and extra days or weeks in hospital. Improving patient safety involves many things, including, high quality nursing care and creating a culture of learning from incidents to prevent them happening again. We will report progress against each element of our Patient Safety Improvement Programme and continue to work as an active participant in the Wessex Patient Safety Collaborative.

What we will do in 2016/2017:

• We will continue to embed the statutory Duty of Candour.

• 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 pressure ulcers and have a zero tolerance on avoidable grade 3 and 4 pressure ulcers.

• We will continue to reduce the number of patients who develop a catheter-associated urine infection and improve documentation of catheter care.

• We will increase the number of patients admitted as an emergency who have a nutritional assessment and care plan.

• We will continue to 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 maintain low numbers of patients with avoidable infections and maintain responsible antibiotic prescribing. We will continue to ensure our staff adhere to infection control procedures.
• We will continue to improve surgical safety by the use of the World Health Organisation safety checklist and team safety briefings and show this through ongoing audit. This year we will extend this good practice to all areas of theatres where procedures are being carried out.

• We will be an early implementer of the ‘Saving Babies’ Lives’ care bundle.

• We will publish our avoidable death rate and make improvements where needed.

• We will continue to work with Lord Carter’s programme to ensure safe staffing levels and reduce the amount we spend on agency staff. We will use technology and validated measures to help us with this, such as, the use of the Safer Care nursing tool (recorded three times a day by nurses on the shift) as well as implementing the measurement of Care Hours per Patient Day.

How will we report progress throughout the year?

Safety work is overseen by the Patient Safety Steering group. Infection prevention is monitored by the Infection Control Committee. We measure our infection rates, 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 an outstanding experience of care

Description of the issue and reason for prioritising it:

It is important the Trust does everything it can to provide high quality care for all our patients so they have an outstanding experience of care. We need to make sure that care is effective, personal, safe and patients are treated with compassion, kindness, dignity and respect. Patients and carers have told us that we do not get everything right every time and if care falls below the standards we aspire to we will investigate, learn from mistakes and ensure they are not repeated.

What we will do in 2016/2017:

• We will start to screen patients for frailty syndrome and undertake a comprehensive geriatric assessment and personalised care plan for those with moderate or severe frailty and share this with their GP.

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

• We will continue to make reasonable adjustments for patients with learning disabilities.

• We will continue to eliminate patients being cared for in mixed sex accommodation.

• Funded by the Hospice charity from 1 April 2016, we will introduce a new Hospice at Home service to support patients with complex needs at the end of their life in their own homes.

• We will improve patient’s experience of waiting for our tertiary services, such as waiting for plastics trauma surgery and for patients with a spinal cord injury in another hospital being assessed by a spinal outreach specialist nurse within 5 working days.

• We will reduce the number of spinal cord injured patients waiting for a video-urodynamic test and outpatient appointment and manage risks appropriately.

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

• We will continue to use patient feedback from the Friends and Family Test, real time feedback and patient surveys to drive improvements on the wards and clinical services.

• We will ensure all our staff receive an annual appraisal and increase the number of staff who are up to date with their mandatory training.

How will we report progress throughout the year?

Performance reports, 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. Dementia and Learning Disability care will be reported to the Dementia Steering Group and the Learning Disabilities Working Group.
Priority 3
Actively work with our community partners, patients and carers to prevent ill health and manage long term conditions

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 and our community partners 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, patients and their carers stay in good health and to take responsibility for their own health. Better access to support and information is crucial in preventing ill health.

What we will do in 2016/2017:

- We will continue to work with our partners to respond to the 'Blood in your Pee' campaign. [www.cancerresearchuk.org/health-professional/early-diagnosis-activities/be-clear-on-cancer/blood-in-pee-campaign](http://www.cancerresearchuk.org/health-professional/early-diagnosis-activities/be-clear-on-cancer/blood-in-pee-campaign)

- With our community partners we will focus on helping women in pregnancy to stop smoking and for women with a high body mass index maintain a healthy weight in pregnancy.

- 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.

- We will work with GPs to support the implementation of the national diabetes prevention programme.

- We will continue to support patients with long term conditions to manage their own health and avoid complications through personalised care plans. Suitable patients will be able to initiate their own follow-up appointments when needed rather than fixed routine appointments.

- We will continue to support the health and wellbeing of our staff.

How will we report progress throughout the year?

We will measure and monitor improvements and report our progress through our Maternity Services dashboard and 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:

The NHS Services, Seven Days a Week Forum, chaired by the National Medical Director, was established in February 2013 to consider how NHS services could be improved to provide a more responsive and patient centred service across seven days a week. In December 2013, the Forum, as a first stage, focused on urgent and emergency care services and their supporting diagnostic services. The focus is across the whole system, not just hospitals.

The Forum’s review points to significant variation in outcomes for patients admitted to hospitals at the weekend in England. This variation is seen in mortality rates, patient experience, length of stay and re-admission rates. The Forum set 10 clinical standards, 4 of which are priority standards to be implemented for all the population by March 2020. We were already delivering three of the standards before the recommendations were published and, in 2015/2016 we have made good progress in a further five standards (see priority 4 in 2015/2016 on page 101-102). In 2016/2017 we aim to continue to implement the 4 priority clinical standards – standard 2) time to consultant review; standard 5) diagnostics; standard 6) intervention/key services; and standard 8) ongoing review.

What we will do in 2016/2017:

- 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 continue to ensure that all emergency patients admitted are seen and assessed by a consultant within 14 hours of arrival.

- We will introduce a one stop clinic for gynaecology emergency patients so they can be seen and assessed without admission to hospital.
• We will improve access to inpatient ultrasound scans at weekends.

• We will work with the University Hospital Southampton to ensure patients have access to a consultant-delivered interventional radiology service seven days a week.

• For patients with a gastro-intestinal bleed we will improve access to a consultant-delivered interventional endoscopy service seven days a week.

• We will work towards ensuring patients on a general ward are reviewed during a consultant ward round every 24 hours, seven days a week, unless it has been decided that this would not affect the patient's care.

• We will reduce delays in the progress of patients’ care plans by the introduction of electronic whiteboards on all the wards. These record and track the actions needed to be taken in real time.

• With our community partners we will work towards ensuring support services are available seven days a week to ensure the patients’ care plans are progressed.

How will we report progress throughout the year?

We will measure, monitor and report progress through the Joint Board of Directors and Clinical Governance Committee every six months and report directly to the Trust Board annually.

Priority 5
Provide co-ordinated care across the whole health and care 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 July 2016 the Trust will form a new partnership called Wiltshire Health & Care which involves this hospital, the Great Western Hospitals NHS Foundation Trust and the Royal United Bath NHS Foundation Trust. This marks an exciting new period of change where we will be able to work across organisational boundaries and join up care around the needs of patients and expand the amount of care being provided in the community so that people can be supported in their own home for longer rather than being admitted to hospital.

What we will do in 2016/2017:

• We will work with our partners in Wiltshire Health & Care to join up care and expand the amount of care offered in the community.

• We will work with our commissioners to provide more support for GPs and community care services by direct access to senior doctors via telephone, email and rapid access clinics.

• We will work with GPs to help to get home patients when they are fit for discharge.

• We will work collaboratively with our commissioners and adult social care to promote early discharge and reduce the number of patients whose discharges are delayed when they are fit to leave hospital.

• We will continue to work with the research network and increase the number of patients offered recruitment into clinical research trials.

• We will work with the University Hospital Southampton and the network to improve the provision of state of the art genetic testing across Wessex and the South Coast.

How will we report progress throughout the year?

We will measure, monitor and report progress through the Patient Flow Programme Management Board and research performance through the Clinical Governance Committee every six months and genetics to the Trust Board.

2.3 Statements of assurance from the Board

Review of Services

During 2015/2016 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 2015/2016 represents 100% of the total income generated from the provision of relevant health services by Salisbury NHS Foundation Trust for 2015/2016.

The Trust has published a Quality Strategy 2016 – 2019 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 three times a year at Directorate performance meetings and the Department Executive Safety and Quality walk rounds. Clinical teams present their quality and safety outcomes and improvement work and assess their service against the domains of safe, responsive, effective, caring and well-led. Clinical teams report 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 presented 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 October 2015 the Human Tissue Authority undertook an inspection of the care of patients who receive stem cell transplants for haematological conditions. The inspection team commented that they observed good practice, in particular, the integrated and committed team work, the thorough training programme and the regular reviews of standard operating procedures and discussions held with patients before the disposal of unwanted stem cells. The inspection team considered the Trust was suitable to be licensed for the activities specified and gave advice and guidance to improve practice further. Two improvement actions are planned: improve the temperature recordings of stem cells storage when they leave the Trust and when they arrive at University Hospital Southampton and purchase some new stem cell transport boxes. This is monitored by the Clinical Governance Committee.

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 2015/2016, 43 national clinical audits and 5 national confidential enquiries covered relevant health services that Salisbury NHS Foundation Trust provides.

During 2015/2016, Salisbury NHS Foundation Trust participated in 41 (95%) national clinical audits, and 5 (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 2015/2016 are as follows in the table below.

<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 Asthma</td>
<td>Yes but audit not taking place in 2015/16</td>
<td>N/A</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>Programme</td>
<td>Status</td>
<td>Completeness</td>
<td>Category</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>Child health clinical outcome review programme – Mental Health Conditions</td>
<td>Yes</td>
<td>Yes</td>
<td>On target data</td>
<td></td>
</tr>
<tr>
<td>in Young People</td>
<td></td>
<td></td>
<td>collection end</td>
<td></td>
</tr>
<tr>
<td>date not reached</td>
<td></td>
<td></td>
<td>date not reached</td>
<td></td>
</tr>
<tr>
<td>Child health clinical outcome review programme - Chronic Neurodisability</td>
<td>Yes</td>
<td>Yes</td>
<td>On target data</td>
<td></td>
</tr>
<tr>
<td>Mental Health Conditions in Young People</td>
<td></td>
<td></td>
<td>collection end</td>
<td></td>
</tr>
<tr>
<td>date not reached</td>
<td></td>
<td></td>
<td>date not reached</td>
<td></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>Diabetes (Adult) - National Diabetes Footcare Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>Diabetes (Adult) - National Pregnancy in Diabetes Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>Diabetes (Adult) - National Diabetes Inpatient Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>Diabetes (Adult) - National Diabetes Adults</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA)</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>Emergency Use of Oxygen</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP) - Falls</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Older People</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP) - Fracture Liaison</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>Older People</td>
</tr>
<tr>
<td>Service Database</td>
<td></td>
<td></td>
<td>Planned for</td>
<td>Older People</td>
</tr>
<tr>
<td>2016/17</td>
<td></td>
<td></td>
<td>2016/17</td>
<td>Older People</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Older People</td>
</tr>
<tr>
<td>Fracture Database</td>
<td></td>
<td></td>
<td></td>
<td>Older People</td>
</tr>
<tr>
<td>Programme</td>
<td>Participation</td>
<td>Compliance</td>
<td>Outcome</td>
<td>Category</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------</td>
<td>------------</td>
<td>---------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme</td>
<td>Yes</td>
<td>Yes</td>
<td>94%</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>35%</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's &amp; Children's Health</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Lower limb amputation</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Gastrointestinal Haemorrhage</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Sepsis</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Acute Pancreatitis</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Provision of Mental Health Care in Acute Hospitals</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>Audit/Registry</td>
<td>Yes</td>
<td>No (Planned for 2017/18)</td>
<td>N/A</td>
<td>Other</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>-----</td>
<td>--------------------------</td>
<td>------</td>
<td>-------------------</td>
</tr>
<tr>
<td>National Audit of Intermediate Care</td>
<td>Yes</td>
<td>No (Planned for 2017/18)</td>
<td>N/A</td>
<td>Other</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Heart</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary care workstream</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Pulmonary rehabilitation workstream</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 - 2015 Audit of Patient Blood Management in Scheduled Surgery</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Blood and Transplant</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion programme - 2015 Audit of the use of blood in Lower GI bleeding</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Blood and Transplant</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion programme - 2016 Audit of the use of blood in Haematology (submitted for all)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Blood and Transplant</td>
</tr>
<tr>
<td>National Complicated Diverticulitis Audit (CAD)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Acute</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 Heart Failure Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Heart</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 Ophthalmology Audit</td>
<td>Yes</td>
<td>No (planned for 2016/17)</td>
<td>N/A</td>
<td>Other</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Cancer</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Heart</td>
</tr>
<tr>
<td>Area</td>
<td>Participation</td>
<td>Compliance</td>
<td>Audit Type</td>
<td>Hospital Service Area</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>---------------</td>
<td>------------</td>
<td>-------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Neonatal Intensive and Special Care (NNAP)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Women's &amp; Children's Health</td>
</tr>
<tr>
<td>Non-Invasive Ventilation - adults</td>
<td>Yes but audit not taking place in 2015/16</td>
<td>N/A</td>
<td>N/A</td>
<td>Acute</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Cancer</td>
</tr>
<tr>
<td>Paediatric Asthma</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Women's &amp; Children's Health</td>
</tr>
<tr>
<td>Paediatric Intensive Care Audit Network (PICANet)</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>Women's &amp; Children's Health</td>
</tr>
<tr>
<td>Paediatric Pneumonia</td>
<td>Yes but audit not taking place in 2015/16</td>
<td>N/A</td>
<td>N/A</td>
<td>Women's &amp; Children's Health</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH)</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Renal replacement therapy (Renal Registry)</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>Procedural Sedation in Adults (care in emergency departments)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Acute</td>
</tr>
<tr>
<td>Pulmonary Hypertension (Pulmonary Hypertension Audit)</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>Heart</td>
</tr>
<tr>
<td>Rheumatoid and Early Inflammatory Arthritis</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Older People</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP) - Post Acute Organisational Audit</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>Older People</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP) - Clinical Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>UK Cystic Fibrosis Registry</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>Older People</td>
</tr>
<tr>
<td>UK Parkinson's Audit (previously known as National Parkinson's Audit)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
<td>Older People</td>
</tr>
</tbody>
</table>
The reports of 24 (100%) national clinical audits that were published in 2015 were reviewed by Salisbury NHS Foundation Trust in 2015/2016. Of these 18 (75%) 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 below.

The table below shows examples of national clinical audit reports reviewed during 2015/2016 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>
<tbody>
<tr>
<td>National Paediatric Diabetes Audit 2015</td>
<td>Clinical Management Board in 2015/2016</td>
<td>This audit looked at the outcomes of children and young people with diabetes. This hospital’s performance was the best in Wessex. In the majority of areas the hospital was graded at or above the national average. Two areas needed improvement. These related to a discussion about the management of low blood sugar and provision of patient information. 4 improvement actions are required: 1) A keyworker for children with a high HbA1C. 2) Set up a clinic for glucose monitoring for those who need most help with day to day management. 3) Amend the annual review to include a discussion of glucose monitoring. 4) Develop patient information.</td>
</tr>
<tr>
<td>Audit report</td>
<td>Reviewed by whom</td>
<td>Action taken or required to improve</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>College of Emergency Medicine 2013/14 Moderate or severe asthma in children (care in A&amp;E) 2015</td>
<td>Clinical Management Board in 2015/2016</td>
<td>This audit looked at the immediate care of children who attended the Emergency Department with moderate or severe asthma. Overall, the Department improved performance compared to national standards, except in two areas. Nebuliser treatment should be started within 10 minutes of arrival and children should be given oral steroids within 30 minutes. 2 improvement actions are required: 1) Redesign the Emergency Department triage model to reduce delays in treatment time. 2) Provide a multidisciplinary education session.</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme: National Hip Fracture Database 2015 (data: 2014)</td>
<td>Clinical Management Board in 2015/2016</td>
<td>This audit examined whether patients with a hip fracture received 6 best practice standards. This hospital maintained performance in achieving most clinical criteria for best practice in over 80% of cases. 2 improvement actions are required: 1) Improve theatre capacity to ensure patients receive surgery within 36 hours of admission. 2) Continue to work with community services to reduce patient's length of stay in hospital.</td>
</tr>
</tbody>
</table>

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 above.

The reports of 216 (100%) local clinical audits were reviewed by the Trust in 2015/2016 and Salisbury NHS Foundation Trust intends to take or has taken the following actions to improve the quality of healthcare provided.

- A structured nurse-led Ear, Nose and Throat pre-operative assessment clinic was introduced to ensure patients received appropriate investigations and medication reviews before surgery. The first audit showed 9 (22%) out of 40 patients were assessed prior to surgery but, following the introduction of an assessment clinic, 33 (82%) out of 40 patients were assessed prior to surgery thereby ensuring patients were safely prepared for surgery.
- All infection control audits reports were reviewed at the Infection Control Working Group. Examples of this work are a continued focus on maintaining high standards of practice through compliance with hand hygiene, staff being bare below the elbow, MRSA screening for patients admitted as an emergency (87% to 97% of patients were screened) and good antibiotic stewardship (96% compliance with 4 standards).
- Patients admitted for a planned operation or as an emergency had a blood clot risk assessment undertaken in 98 – 100% of cases. Of those who are considered at high risk of a blood clot 95 – 100% received a preventative dose of anticoagulation treatment. The audits were reviewed at the Thrombosis Committee.

**Research**

The number of patients receiving relevant health services provided or subcontracted by Salisbury NHS Foundation Trust in 2015/2016 that were recruited during that period to participate in research approved by a research ethics committee were 1788 patients* into 70 studies*. This compares to 886** patients recruited into 55** studies in 2014/2015.

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 treatment possibilities and active participation in research leads to improved
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 2014/2015 we reported that 877 patients were recruited into 54 studies. The final number of patients recruited was 886 patients into 55 studies.

Goals agreed with Commissioners

A proportion of Salisbury NHS Foundation Trust’s income in 2015/2016 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 2015/2016 and for the following 12 month period are set out in the tables below. The planned income through this route for 2015/2016 was £3,657,554 (In 2014/15 it was £3,667,616). The amount the Trust actually received in 2015/2016 was £3,657,554. The Trust has invoiced for non-contracted CQUINs of £39,209.

CQUIN contracts were signed with our commissioners during 2015/2016 as part of their overall contract. The Trust did not achieve all of the quality improvements as set out in the table below.

CQUIN indicators (Wiltshire, Dorset, Bournemouth Poole, Somerset, Southampton City, Isle of Wight, Portsmouth) 2015 – 2016. West Hampshire had separate local CQUINs

<table>
<thead>
<tr>
<th>Goal name</th>
<th>Description of goal and number</th>
<th>Target in 15/16</th>
<th>Performance in 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Goals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Acute Kidney Injury | 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 | Q1 baseline
Q2 – 30%
Q3 – 80%
Q4 - 96% | Q1 – 9.3%
Q2 – 70.6%
Q3 – 95.3%
Q4 - 97.7% |
| **Sepsis** | 2A) The total number of patients presenting to A&E and other units that directly admit emergencies who met the criteria of the local protocol and were screened for sepsis. | 2A:
Q1 baseline
Q2 – 30%
Q3 – 75%
Q4 – 95% | 2A:
Q1 – 16.6%
Q2 - 66.5%
Q3 - 94.9%
Q4 - 99% |
| | 2B) The number of patients who present to A&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. | 2B:
Q2 baseline
Q3 -65%
Q4 – 70% | 2B:
Q2 – 60%
Q3 – 68%
Q4 - 74.2% |
| Dementia | 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. | 3A:  
1) 90%  
2) 90%  
3) 90% in Q4  
B) Q2 – 120 staff  
Q3 – 250 staff  
Q4 – no target  
C) Survey of carers bi-annually | 3A  
1) 93.2%  
2) 99.4%  
3) 100%  
B) Q2 – 196 staff  
Q3 – 293 staff  
Q4 – 364 staff  
3C) Q2 – 14 carers  
Q3 & Q4 – 46 carers responded |
| --- | --- | --- |
| Urgent and Emergency care | To increase the numbers of non-elective patients (excluding patients under 18 years old) being treated through an ambulatory care pathway to reduce, where possible, preventable A&E attendances and non-elective admissions to hospital | Q2 project plan in place with identified pathways & baseline data  
Q3 - Propose top 3 pathways for development and 1 pathway for implementation  
Q4 - Pilot Implementation of the 1 agreed pathway. Submit Q4 data. | Q2 project plan with 5 pathways submitted with baseline data.  
Q3 – Proposal for pathway development submitted to CCG.  
Q4 – Pathway implemented and data submitted. |
| Urgent and Emergency care | Part A: Quarterly audit the number of A&E records with a valid diagnosis code.  
Part B: A quarterly audit of the number of records in a sample of 45 A&E records (25 with a mental health diagnosis and 20 with other diagnostic codes) where the codes are matched with the diagnosis in the patient records. | Part A: 85% or over each quarter  
Part B:  
Q1 baseline  
Q2 – 85%  
Q3 – 95%  
Q4 – 95% | Part A:  
Q1 – 86.1%  
Q2 – 86.7%  
Q3 – 85.2%  
Q4 – 85.2%  
Part B:  
Q1 – 95.5%  
Q2 – 95.5%  
Q3 – 97.7%  
Q4 – 97.7% |
### Local CQINN

<table>
<thead>
<tr>
<th>Goal name</th>
<th>Description of goal and number</th>
<th>Target in 15/16</th>
<th>Performance in 15/16</th>
</tr>
</thead>
<tbody>
<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.</td>
<td>8 measures sustained and exceeded Q3 &amp; Q4 14/15 measures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>83% of patients discussed with the GP.</td>
<td>89% patients discussed with the GP.</td>
</tr>
</tbody>
</table>

### West Hampshire local goals (only)

<table>
<thead>
<tr>
<th>Goal name</th>
<th>Description of goal and number</th>
<th>Target in 15/16</th>
<th>Performance in 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient follow up reform</td>
<td>Continue to reduce routine face to face follow ups and continue patient initiated follow up.</td>
<td>Continue improvement actions</td>
<td>5 specialities reduced new to follow up rates from 14/15. Improvement actions reported.</td>
</tr>
<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>Q1 &amp; Q2 reduction in the number of patients delayed. Q3 increase in number of patients delayed. Q4 increase in the number of patients delayed. Improvement actions reported.</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.</td>
<td>8 measures sustained and exceeded Q3 &amp; Q4 measures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>83% patients discussed with the GP.</td>
<td>89% patients discussed with the GP.</td>
</tr>
</tbody>
</table>

### Specialist Commissioning CQUIN indicators 2015 – 2016

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 15/16</th>
<th>Performance in 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal care: 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 age 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 Badgernet 2 year follow up fields</td>
<td>8 children to be assessed and data entered onto Badgernet</td>
<td>100%</td>
</tr>
<tr>
<td>Neonatal care: 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>100%</td>
</tr>
<tr>
<td>Neonatal care: 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>100%</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Critical Care: Increase effectiveness of rehabilitation after critical illness by completion of a 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% in Q4</td>
<td>100%</td>
</tr>
</tbody>
</table>

Our quality priorities in 2016/2017 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 2016/2017 as set out in the table below:

CQUIN indicators (Wiltshire, West Hampshire, Dorset, Bournemouth Poole, Somerset, Southampton City, Isle of Wight, Portsmouth) 2016 – 2017.

<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>1A Option B Introduction of health and wellbeing initiatives Develop a plan and ensure the implementation against the plan which will be subject to peer review. The plan should cover 3 areas: a) Introducing a range of physical activity schemes for staff. b) Improving access to physiotherapy services for staff. c) Introducing a range of mental health initiatives for staff.</td>
<td>Q1 develop a plan and promote the 3 initiatives that are peer reviewed and signed off. Q4 Implemented the initiatives and actively promoted them to staff to encourage uptake of them</td>
<td>Domain 1, 2, 5</td>
</tr>
<tr>
<td>NHS Staff health and wellbeing</td>
<td>1B Healthy food for NHS staff, visitors and patients</td>
<td>Domain 1, 2, 5</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------------------------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>Part A Achieve a step-change in the health of the food offered on the premises in 2016/2017 including;</td>
<td></td>
<td>Q4 Delivery of the 4 outcomes in Part A.</td>
<td></td>
</tr>
<tr>
<td>a) The banning of price promotions on sugary drinks and foods high in fat, sugar and salt.</td>
<td></td>
<td>Q1 &amp; Q4 The collection of the 11 data points outlined in Part B and submitted to UNIFY</td>
<td></td>
</tr>
<tr>
<td>b) The banning of advertisements on NHS premises on NHS premises of sugary drinks and foods high in fat, sugar and salt.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) The banning of sugary drinks and foods high in fat, sugar and salt from checkouts and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Ensuring that healthy options are available at any point including for those staff working night shifts.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B Submit national data collection returns by July based on existing contracts with food and drink suppliers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The data collected will include the name of the franchise holder, food supplier, type of outlet, start and end dates of existing contracts, remaining length of time on existing contract, value of contract and any other relevant contract clauses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1C Improving the uptake of flu vaccinations for frontline clinical staff</td>
<td>Uptake of 75% of the flu vaccination over a 4 month period.</td>
<td>Domain 1, 2, 5</td>
<td></td>
</tr>
<tr>
<td>Timely identification and treatment of sepsis</td>
<td>2A Timely identification and treatment for sepsis in Emergency Departments</td>
<td>Domain 1, 4, 5</td>
<td></td>
</tr>
<tr>
<td>• The % of patients who met the criteria for sepsis screening and were screened.</td>
<td>Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The % of patients who presented with severe sepsis, red flag sepsis or septic shock and were administered intravenous antibiotics within an hour of arrival and had a review within 3 days of the prescribed antibiotics.</td>
<td>Targets to be confirmed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment and day 3 review</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Targets to be confirmed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Timely identification and treatment of sepsis | 2B | Timely identification and treatment for sepsis in acute inpatient settings.  
- The % of patients who met the criteria for sepsis screening and were screened.  
- The % of existing inpatients in whom a decision to treat with intravenous antibiotics is made and are administered within 90 minutes of the possibility that the patient has red flag sepsis or septic shock and an antibiotic review is carried out by a competent decision maker by day 3 of them being prescribed. | Domain 1, 4, 5 |
| --- | --- | --- |
| Antimicrobial resistance and antimicrobial stewardship | 5A | Reduction in antibiotic consumption per 1000 admissions  
- Reduction of 1% or more in total antibiotic consumption against baseline  
- Reduction of 1% or more in Carbapenem  
- Reduction of 1% or more in Piperacillin-Tazobactam | Domain 1, 4, 5 |
<p>| | | | |
|  |  |  |  |
|  |  |  |  |</p>
<table>
<thead>
<tr>
<th>Antimicrobial resistance and antimicrobial stewardship</th>
<th>5B: Empiric review of antibiotic prescriptions</th>
<th>Domain 1, 4, 5</th>
</tr>
</thead>
</table>
| Percentage of antibiotic prescriptions reviewed within 72 hours of a minimum of 50 antibiotics prescriptions across wards. | Q1 – audit 25% of cases in the sample  
Q2 – audit 50% of cases in the sample  
Q3 – audit 75% of cases in the sample  
Q4 – audit 90% of cases in the sample | |

<table>
<thead>
<tr>
<th>Frailty identification and care planning</th>
<th>21. Promote a system of timely identification and proactive management of frailty in community, mental health and acute providers.</th>
<th>Domain 1, 4, 5</th>
</tr>
</thead>
</table>
| Introduce and measure:  
1. Number of patients aged 75 and above with a frailty syndrome who are screened for frailty on presentation  
2. Number of patients aged 75 and over who screen positive for frailty and have severity grade recorded in the patient notes.  
3. Number of people aged 75 and above who screen positive for moderate or severe frailty who have a personalised care and support plan in place.  
4. Number of people aged 75 and above who screen positive for moderate or severe frailty for whom a Comprehensive Geriatric Assessment has been initiated with information on this shared with their GP.  
5. Number of patients aged 75 and above who screen positive for frailty who are provided with a personalised care plan according to moderate-severe needs. | To be confirmed following baseline measures in Q1 | |

<table>
<thead>
<tr>
<th>Acute Kidney Injury</th>
<th>24. Improving AKI diagnosis and treatment in hospital and care planning to monitor kidney function after discharge.</th>
<th>Domain 1, 4, 5</th>
</tr>
</thead>
</table>
| 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 tests required on discharge for monitoring | 90% per quarter | |
Local CQIN

<table>
<thead>
<tr>
<th>Saving Babies’ Lives</th>
<th>Implementation and roll out of the national stillbirth bundle – 4 elements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Reducing smoking in pregnancy</td>
</tr>
<tr>
<td></td>
<td>2. Risk assessment and surveillance for fetal growth restriction</td>
</tr>
<tr>
<td></td>
<td>3. Raising awareness of reduced fetal movements.</td>
</tr>
<tr>
<td></td>
<td>4. Effective fetal monitoring during labour</td>
</tr>
<tr>
<td></td>
<td>To be confirmed following baseline measures in Q1</td>
</tr>
<tr>
<td></td>
<td>Domain 1, 4, 5</td>
</tr>
</tbody>
</table>

Specialist Commissioning CQUINs 2016 – 2017

<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>Acute Spinal Cord Injury outreach visits to newly injured patients</td>
<td>Newly injured patients with traumatic and non traumatic spinal cord injury will receive a face to face outreach visit from the spinal cord injury outreach team within 5 days of the referral of the patient to the unit to support the patient and the treating team</td>
<td>To be confirmed</td>
<td>Domain 1, 4, 5</td>
</tr>
<tr>
<td>Timely discharges in Adult Critical Care</td>
<td>To reduce delayed discharges from Adult Critical Care to ward level care by improving bed management in ward based care, thus removing delays and improving flow. To remove delayed discharges of 24 hours or more within day time hours</td>
<td>To be confirmed</td>
<td>Domain 1, 4, 5</td>
</tr>
<tr>
<td>Local CQUIN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blueteq for devices</td>
<td>Blueteq for cardiac devices – detail to be confirmed</td>
<td>To be confirmed</td>
<td>Domain 1, 4, 5</td>
</tr>
</tbody>
</table>

Care Quality Commission (CQC) registration

Salisbury NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission in 2015/2016.

Salisbury NHS Foundation Trust had an announced inspection by the Care Quality Commission in December 2015.

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 taken enforcement action against Salisbury NHS Foundation Trust during 2015/2016 with a requirement to reduce the number of spinal injured patients waiting for a video-urodynamic test and outpatient appointment and manage risks appropriately.
The grid below shows how the Trust was rated for each of the nine core services and for the Trust overall

Salisbury NHS Foundation Trust intends to take the following actions to improve:

- Continue to review nursing staffing levels and skill mix to ensure there are sufficient numbers of suitably qualified and experienced nurses to deliver safe, effective and responsive care.
- Increase the number of staff who are up to date with mandatory training.
- Ensure all our staff receive an annual appraisal.
- Improve the documentation of care given including care of intravenous cannulas, urinary catheters and patients‘ weight.
- Continue to eliminate patients being cared for in mixed sex accommodation.
- Ensure regular checks of resuscitation equipment are undertaken.
- Ensure that staff adhere to infection prevention procedures.
- Ensure patients are moved a minimal number of times during their stay.
- Ensure patient charts are kept secure and confidential.
- Continue to support staff to understand the risks relevant to their areas of work and are able to manage these risks effectively.
- Strengthen governance arrangements in A&E and Critical Care.
- Complete a review of the triage arrangements in A&E to ensure patients are assessed promptly.
- Approve the policy for the use of the World Health Organisation surgical safety checklist and audit its use.
- Improve the processing of surgical instrument sets to avoid delays.
- Ensure there is a safe pathway for discharging patients after surgery.
- Ensure patients are discharged from the critical care unit in a timely manner and during the day.
- Improve the process of booking a bed in critical care for patients requiring elective surgery to reduce the number of cancelled operations.
- Reduce the number of spinal injured patients waiting for a video-urodynamic test and outpatient appointment and manage risks appropriately.
- Ensure care and treatment is person centred to meet the needs and preferences of patients.

The progress of the action plan will be monitored by the Clinical Governance Committee.

Care Quality Commission intelligent monitoring

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

In May 2015 Salisbury NHS Foundation Trust had an overall risk score of 1. This puts the Trust in band 6 which is the rating given to hospitals with the lowest risk. No further reports were published in 2015/2016.

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.
The table below shows the Trust’s national Data Quality Score compared to other local hospitals and nationally from April 2015 to December 2015

RNZ = Salisbury NHS Foundation Trust data quality score is 98.3% validity versus a national average of 96.2%.

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

- Undertake a monthly audit of ten positive stop dates to confirm the accurate recording of referral to treatment.
- We will continue to focus on data quality errors and use the themes to improve training and processes.
- We will improve controls through the new electronic patient record.

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 compare 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.

Salisbury NHS Foundation Trust submitted records during 2015/2016 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.

<table>
<thead>
<tr>
<th>Data item</th>
<th>Salisbury District Hospital *14/15</th>
<th>National benchmark *14/15</th>
<th>Salisbury District Hospital 15/16 as at month 10</th>
<th>National benchmark 15/16 as at month 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>% for admitted patient care with a valid NHS number</td>
<td>99.7%</td>
<td>99.2%</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>99.4%</td>
</tr>
<tr>
<td>% for Accident and Emergency care with a valid NHS number</td>
<td>98.8%</td>
<td>95.2%</td>
<td>98.5%</td>
<td>95.3%</td>
</tr>
<tr>
<td>% for admitted patient care with a valid General Medical Practice code</td>
<td>100%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>99.9%</td>
</tr>
<tr>
<td>% for outpatient care with a valid General Medical Practice code</td>
<td>99.9%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>99.8%</td>
</tr>
<tr>
<td>% for Accident and Emergency care with a valid General Medical Practice code</td>
<td>99.8%</td>
<td>99.2%</td>
<td>99.6%</td>
<td>99.1%</td>
</tr>
</tbody>
</table>

*2014/15 month 11 data was reported in the quality account last year and is now reported as at year end
Salisbury NHS Foundation Trust’s Information Governance Assessment report overall score for 2015/2016 was 81% 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 was 85% in 2014/2015. The Trust achieved the necessary standard for all areas assessed.

In the toolkit there are 6 initiatives with 45 separate requirements. Of these, 17 were subject to audit to demonstrate compliance in 2015/2016 and areas for improvement. There will be an ongoing audit programme of the requirements in 2016/2017.

<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>2016</td>
<td>98.0%</td>
<td>94.5%</td>
<td>97.8%</td>
<td>97.9%</td>
</tr>
<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 2016 were Obstetrics, well babies, Gynaecology, Paediatrics and Oral Surgery. The results should not be extrapolated further than the actual sample audited.

The following improvement actions were progressed in 2015/2016:

- We have introduced an electronic discharge summary on all the main inpatient 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 used it in the Medical Assessment Unit.

- A re-audit of palliative care coding of patients who had died was undertaken in July 2015. We found in a sample of 152 patient spells there were 6 (4%) instances where the patient should have had a palliative care code assigned to their care. This was an improvement on 2014 and 2013 where 10 – 20% of episodes audited had a missed palliative care coding. These were corrected retrospectively and further training provided to the coders.

Salisbury NHS Foundation Trust was subject to an external Information Governance clinical coding audit by an independent company during 2015/2016 and the correct coding rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was:

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 underpins quality assurance, 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 will be taking the following actions to improve data quality in 2016/2017:

- Continue to improve the month end coding rate by the 5th working day of the month.
- Continue refresher training with the coding team of current local policies and practices, coding of infants under 28 days of age in relation to national standards and checking all relevant clinical documentation to ensure full and accurate coding.
- Work with the Electronic Patient Record project team to ensure the efficient transfer of patient records to the new information systems.
- Continue to improve the quality of filing of health care records.

2.4 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:

- The Trust submits Hospital Episode Statistics to the Health and Social Care Information Centre who
calculate the SHMI and compare it with other acute Trusts in published, publicly available reports. SHMI compares the number of deaths in hospital and within 30 days of discharge against expected levels. It is not adjusted for patients admitted for end of life care, for example to Salisbury Hospice. Our SHMI for April 2014 to March 2015 was 107 and was as expected. If the number of deaths was exactly as expected the 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 SHMI for October 2014 to September 2015 is 109. This level is within the expected range. Currently 31.9% of our deaths are patients admitted for palliative or end of life care compared to 31.8% in 2014/2015.

Salisbury NHS Foundation Trust has taken the following actions to improve the SHMI 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 in A&E, the Medical Assessment Unit and the Surgical Assessment Unit and Children’s ward.
- 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 all the wards in the hospital.
- Continuing with other care bundles such as the ongoing catheter care bundle.
- Continuing to ensure early senior review of acutely ill patients seven days a week.
- Publish our annual avoidable mortality rate and strengthen our mortality governance.
- Undertake a prospective audit of 280 cases to establish whether patients received the 4 priority clinical standards set by the NHS 7 Day Services Forum.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: preventing people from dying prematurely</td>
<td>a) SHMI value</td>
<td>107</td>
<td>103</td>
<td>107*</td>
<td>109 to Sept 15</td>
<td>100</td>
<td>112</td>
<td>89</td>
</tr>
<tr>
<td>Domain 2: Enhancing quality of life for people with long term conditions</td>
<td>a) SHMI banding</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>
<tr>
<td></td>
<td>b) Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust</td>
<td>26%</td>
<td>28.9%</td>
<td>31.8%</td>
<td>31.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* In 2014/2015 SHMI was reported as 104 to September 2014. The full year SHMI was 107 to March 2015.
Patient Reported Outcomes Measures (PROMs)

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 with other Trusts. The outcomes are published on NHS Choices.

- The finalised (18 months in arrears) PROMs in England 2013/2014 national report showed 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:

- Work with Healthwatch, Wiltshire and hold a local focus group to ask patients who have had knee replacement surgery about their experiences and improvement actions required.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></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>i) groin hernia surgery</td>
<td>0.113</td>
<td>0.130</td>
<td>0.220**</td>
<td>0.088**</td>
<td>0.278</td>
<td>-0.17</td>
<td></td>
</tr>
<tr>
<td>ii) varicose vein surgery</td>
<td>0.035</td>
<td>0.070</td>
<td>0.173**</td>
<td>0.104**</td>
<td>0.282</td>
<td>-0.074</td>
<td></td>
</tr>
<tr>
<td>iii) hip replacement surgery</td>
<td>0.427</td>
<td>0.514</td>
<td>0.424**</td>
<td>0.454**</td>
<td>0.184</td>
<td>0.765</td>
<td></td>
</tr>
<tr>
<td>iv) knee replacement surgery</td>
<td>0.289</td>
<td>0.117</td>
<td>0.354**</td>
<td>0.334**</td>
<td>0.745</td>
<td>0.041</td>
<td></td>
</tr>
</tbody>
</table>

*In the quality account 2014/2015 provisional data was presented. The data presented is now the final position.

**Average health gain figures have been used for the Trust for 2015/2016, rather than adjusted average health gain, due to the total number of records being lower than 30 for the time period covered (1 April 2015 to 30 September 2015).
Emergency readmissions within 28 days of discharge

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 enable 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:

- Compared the first admission diagnosis with the re-admission diagnosis to see if they are the same or different.
- We have found that patients are often re-admitted because more support is required in the community.

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

- We will work with our partners in Wiltshire Health and Care to join up care and expand the amount of care offered in the community.

<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Indicator</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</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>Percentage of patients readmitted within 28 days of discharge from hospital of patients aged:</td>
<td>0 to 15*</td>
<td>0 to 15</td>
<td>0 to 15</td>
<td>0 to 15</td>
<td>6.14%</td>
<td>7.9%</td>
</tr>
<tr>
<td></td>
<td>i) 0 to 15</td>
<td>0 to 14*</td>
<td>4.1%</td>
<td>6.14%</td>
<td>8.8%</td>
<td>8.5%</td>
<td>7.6%</td>
</tr>
<tr>
<td></td>
<td>ii) 16 or over</td>
<td>15 or over*</td>
<td>5.84%</td>
<td>5.91%</td>
<td>11.7%</td>
<td>13.3%</td>
<td>7.6%</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

Responsiveness to the personal needs of patients

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 nationally agreed questionnaire was sent to a random sample of 1250 patients and the results were analysed independently by the Patient Survey Co-ordination Centre. 746 (60%) patients responded to the survey.

Salisbury NHS Foundation Trust has taken the following actions to improve responsiveness to inpatient personal needs and improved the quality of its services by:

- Patients cared for on the Short-Stay Emergency Unit who needed help with eating and drinking at meal times received more assistance than before.
- Patients who needed extra emotional support were visited regularly by the ‘Engage’ volunteers to help improve their mood and reduce anxiety.
Salisbury NHS Foundation Trust intends to take the following actions to improve responsiveness to inpatient personal needs and improve the quality of its services by:

- Continuing to eliminate mixed sex accommodation.
- Reducing noise from the laundry at night for patients on the surgical wards.
- Improving communication with patients and their families about discharge arrangements.

<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 4: Ensuring that people have a positive experience of care</td>
<td>Responsiveness to the personal needs of its patients (mean score)</td>
<td>7.1</td>
<td>7.2</td>
<td>7.0</td>
<td>7.3</td>
<td>7.3</td>
<td>8.7</td>
<td>5.8</td>
</tr>
</tbody>
</table>

The Friends and Family Test – Patients

Salisbury NHS Foundation Trust considers the data collected from inpatients and patients discharged from the Accident and Emergency department 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 department. The score 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, child-friendly 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 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:

- Encourage our patients to complete the Friends and Family Test.
- Publicise the improvements we have made from patient comments.

See table at top of page 131.

The Friends and Family Test – Staff

Salisbury NHS Salisbury NHS Foundation Trust considers that the percentage of staff employed by, or under contract to the Trust during 2015/2016 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 staff are sent a nationally agreed questionnaire and the results are analysed by the Staff Survey Co-ordination Centre.
<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Indicator</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</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>Response rate and score 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%</td>
<td>Response rate: Wards: 45.5% A&amp;E: 20.6%</td>
<td>Response rate: Wards: 35.9% A&amp;E: 11.4%</td>
<td>Response rate: Wards: 25.3% A&amp;E: 13.9%</td>
<td>Response rate: Wards: 100% A&amp;E: 43.7%</td>
<td>Response rate: Wards: 6.0% A&amp;E: 0.2%</td>
</tr>
<tr>
<td>Trust overall response rate: 24.3%</td>
<td>Trust overall response rate: 28.5%</td>
<td>Trust overall response rate: 18.7%</td>
<td>Overall response rate: 12.7%</td>
<td>Overall response rate: N/A</td>
<td>Overall response rate: N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table shows how staff responded to the Friends and Family test in the national staff survey 2015. The Trust was in the top 20% of hospitals nationally for this indicator.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<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>85%</td>
<td>70%</td>
</tr>
</tbody>
</table>

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

- Continuing to promote the Dignity at Work Ambassadors who can offer confidential, supportive and an impartial service for staff and managers on any issues around bullying, harassment or discrimination.

- Continuing to promote the Freedom to Speak Up Guardian who can act as an independent point of contact for staff about quality and safety concerns, signpost to Dignity at Work Ambassadors where appropriate, and feedback concerns directly to the Chief Executive.

**Venous thromboembolism**

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

- Patient level data is collected monthly by the ward pharmacist from the patients’ prescription chart. The data is captured electronically and analysed by a senior nurse who is a member of 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 99.7% of patients being assessed for the risk of developing blood clots and 97.3% 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.

- Our venous thromboembolism service and anticoagulation outreach service won a national Quality in Care Programme award in 2015. These two services cover all aspects of a patient’s anticoagulation journey, with the service seeing patients assessed in clinic, and the anticoagulation service operating on hospital wards. The award recognised good practice in patient care and joint working in key therapy areas. The judges were impressed by the streamlined integrated care pathway, collaboration with other departments, the assessment of care and the involvement of people who use the service – all supported by good patient experience and satisfaction levels.

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.

### Clostridium difficile infection

Salisbury NHS Foundation Trust considers that 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, the use of different coloured aprons for each bay and Actichlor Plus for cleaning.
- 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 infection in hospital to learn and improve.

<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Indicator</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</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>98.7%</td>
<td>99.1%</td>
<td>99.7%</td>
<td>95.8%</td>
<td>100%</td>
<td>74.2%</td>
</tr>
</tbody>
</table>
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 ward 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 reviews compliance 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 Clinical Governance Committee.
- Ensuring more timely identification of themes and trends.

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 on page 134) 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, staff feeling secure to raise concerns about unsafe clinical practice and the fairness and effectiveness of procedures for reporting errors, near misses and incidents.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></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>16.9</td>
<td>14.2</td>
<td>15.3</td>
<td>6.6</td>
<td>15.1</td>
<td>62.2</td>
<td>2.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>National average</th>
<th>Highest average other Trusts</th>
<th>Lowest average other Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>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>16.9</td>
<td>14.2</td>
<td>15.3</td>
<td>6.6</td>
<td>15.1</td>
<td>62.2</td>
<td>2.6</td>
</tr>
</tbody>
</table>

### Highest and Lowest Average

- Average NHS Outcomes Framework Domain
- Average National Trusts
- Average Other Trusts
- Highest Average Other Trusts
- Lowest Average Other Trusts

- Average NHS Outcomes Framework Domain
- Average National Trusts
- Average Other Trusts
- Highest Average Other Trusts
- Lowest Average Other Trusts
NHS Outcomes Framework Domain

<table>
<thead>
<tr>
<th>Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of patient safety incidents reported.</td>
</tr>
<tr>
<td>The percentage of such incidents that resulted in severe harm or death</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8.04 incidents per 100 admissions</strong></td>
<td><strong>31.26 incidents per 1000 bed days</strong></td>
<td>41.44 incidents per 1000 bed days</td>
<td>38.25 incidents per 1000 bed days</td>
<td></td>
</tr>
<tr>
<td>0.45%</td>
<td>0.35%</td>
<td>0.2%</td>
<td>0.4%</td>
<td></td>
</tr>
</tbody>
</table>

**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 2013/2014 data with the 2014/2015 and 2015/2016 data. In addition, data was only available from 1/4/2014 to 30/9/2014. The full year 2014/2015 is now reported.**

**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></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mortality rate (HSMR)</td>
<td>104</td>
<td>114</td>
<td>109</td>
<td>*108</td>
<td>109 to Jan 16</td>
<td>100</td>
<td>Lower than 100 is good</td>
</tr>
<tr>
<td>SHMI</td>
<td>105</td>
<td>107</td>
<td>103</td>
<td>*107</td>
<td>109 to Sept 15</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>2. MRSA notifications**</td>
<td>4 (5)</td>
<td>3 (3)</td>
<td>2 (2)</td>
<td>2 (5)</td>
<td>0 (2)</td>
<td>Not available</td>
<td>0 is excellent</td>
</tr>
<tr>
<td>Clinical Patient Safety Indicators</td>
<td>Effectiveness indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. C. difficile infection per 1,000 bed days</td>
<td>4. Global Trigger adverse events rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust and non Trust apportioned</td>
<td>0.51</td>
<td>0.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust and non Trust apportioned</td>
<td>0.29</td>
<td>0.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust and non Trust apportioned</td>
<td>0.19</td>
<td>0.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust and non Trust apportioned</td>
<td>0.19</td>
<td>0.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust and non Trust apportioned</td>
<td>0.10</td>
<td>0.06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not available</td>
<td>Lower than national average is good</td>
<td>National definition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. ‘Never events’ that occurred in the Trust****</td>
<td>6. Patient falls in hospital resulting in a fracture or major harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 (This was associated with surgery with no patient harm)</td>
<td>20.5%</td>
<td>20.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 (These were associated with surgery)</td>
<td>2 (These were associated with surgery)</td>
<td>271 never events</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 is good</td>
<td>Definition based on Sign up to Safety Campaign</td>
<td>Definition from National Patient Safety Agency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.19 Trust apportioned only</td>
<td>0.15 Trust apportioned only</td>
<td>0.06 Trust apportioned only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Patients having surgery within 36 hours of admission with a fractured hip</td>
<td>87%</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>81%</td>
<td>87.1%</td>
<td>86.08%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90%</td>
<td>Higher number is good</td>
<td>Based on national definition with data taken from hospital system and national database.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient experience indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. % of patients who had a risk assessment for VTE (venous thromboembolism)</td>
<td>92%</td>
<td>98%</td>
<td>98.7%</td>
<td>99.1%</td>
<td>99.7%</td>
<td>90%</td>
<td>Higher number better</td>
</tr>
<tr>
<td>9. % patients who had a CT scan within 24 hrs of admission with a stroke</td>
<td>92%</td>
<td>94.6%</td>
<td>91.6%</td>
<td>96.9% in 2014/15 measured as a CT scan within 12 hours</td>
<td>98.3% in 2015/16 measured as a CT scan within 12 hours</td>
<td>Not available</td>
<td>Higher number better</td>
</tr>
<tr>
<td>10. Compliance with NICE Technology Appraisal Guidance published in year</td>
<td>70%</td>
<td>72%</td>
<td>68%</td>
<td>73%</td>
<td>61%</td>
<td>Not measured</td>
<td>Higher number better</td>
</tr>
<tr>
<td>11. Number of patients reported with grade 3 &amp; 4 pressure ulcers</td>
<td>12</td>
<td>7</td>
<td>6</td>
<td>4</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>79% Yes always</td>
<td>83% Yes always</td>
<td>82% Yes always</td>
<td>83% Yes always</td>
<td>86% Yes always</td>
<td>Not available</td>
<td>Higher number is better</td>
</tr>
<tr>
<td>13. Mean score of patients’ rating of quality of care ##</td>
<td>7.8 #</td>
<td>8.1 #</td>
<td>8.1 #</td>
<td>8.3 #</td>
<td>8.4 #</td>
<td>Not available</td>
<td>Higher number is better</td>
</tr>
</tbody>
</table>

---

Based on national definition with data taken from hospital system and national database.
Patient Safety Indicators

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>National average</th>
<th>What does this mean?</th>
<th>Source of measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. % of patients in mixed sex accommodation</td>
<td>11%</td>
<td>7%</td>
<td>3%</td>
<td>11%</td>
<td>9%</td>
<td>Not available</td>
<td>Lower number is better</td>
<td>Data taken from national inpatient survey</td>
</tr>
<tr>
<td>15. % of patients who stated they had enough help from staff to eat their meals</td>
<td>63%</td>
<td>74%</td>
<td>75%</td>
<td>68%</td>
<td>68%</td>
<td>Not available</td>
<td>Higher number is better</td>
<td>Data taken from national inpatient survey</td>
</tr>
<tr>
<td>16. % of patients who thought the hospital was clean</td>
<td>65%</td>
<td>66%</td>
<td>69%</td>
<td>70%</td>
<td>73%</td>
<td>Not available</td>
<td>Higher number is better</td>
<td>Data taken from national inpatient survey</td>
</tr>
</tbody>
</table>

* In 2014/2015 HSMR was reported as 101 to December 2014. The full year rate was 108. In 2014/2015 SHMI was reported as 104 to 30/9/2014. The full year rate was 107.

** 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 2014/2015 was published as 48 up to 31 January 2015. The total figure for the full year in 2014/2015 was 37.1.

**** 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.

# In the national inpatient survey in 2012 the way patients were asked to answer the question was changed. To enable a year on year comparison the average score has been substituted with a mean score of patients asked the question.

## The patient safety indicator name has been changed from ‘13. Mean score of patients stating the quality of care was very good or better’ to ‘Mean score of patients’ rating of quality of care’ as it is no longer rated between excellent and poor but is on a sliding scale from 10 to zero.

### National Targets and Regulatory Requirements

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1a: Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway</td>
<td>91.5%</td>
<td>94.7%</td>
<td>96.3%</td>
<td>96.4%</td>
<td>94.0%</td>
<td>92%</td>
</tr>
<tr>
<td>1b: Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an admitted pathway</td>
<td>93.5%</td>
<td>93.4%</td>
<td>94%</td>
<td>91.6%</td>
<td>89.4%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an non-admitted pathway</td>
<td>98.2%</td>
<td>97.9%</td>
<td>98.2%</td>
<td>98.1%</td>
<td>96.7%</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>2.</td>
<td>A&amp;E: maximum waiting time of four hours from arrival to admission/transfer/discharge</td>
<td>97.86%</td>
<td>96.9%</td>
<td>96.3%</td>
<td>95.2%</td>
<td>94.8%</td>
</tr>
<tr>
<td>3a</td>
<td>All cancers: 62 day wait for first treatment from: urgent GP referral for suspected cancer</td>
<td>93.3%</td>
<td>90.5%</td>
<td>92.85%</td>
<td>90.6%</td>
<td>89.1%</td>
</tr>
<tr>
<td>3b</td>
<td>All cancers: 62 day wait for first treatment from NHS Cancer Screening Service referral</td>
<td>97.2%</td>
<td>100%</td>
<td>100%</td>
<td>95.2%</td>
<td>99.2%</td>
</tr>
<tr>
<td>4a</td>
<td>All cancers: 31 day wait for second or subsequent treatment comprising – surgery</td>
<td>98.9%</td>
<td>98.9%</td>
<td>97.6%</td>
<td>99.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td>4b</td>
<td>All cancers: 31 day wait for second or subsequent treatment comprising – anti cancer drug treatments.</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100.0%</td>
</tr>
<tr>
<td>4c</td>
<td>All cancers: 31 day wait for second or subsequent treatment comprising – radiotherapy</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>5.</td>
<td>All cancers: 31 day wait from diagnosis to first treatment</td>
<td>97.9%</td>
<td>97.9%</td>
<td>98.4%</td>
<td>98.4%</td>
<td>99.1%</td>
</tr>
<tr>
<td>6a</td>
<td>Cancer: two week wait from referral to date first seen comprising - all urgent referrals (cancer suspected)</td>
<td>94%</td>
<td>94.4%</td>
<td>94.4%</td>
<td>94.7%</td>
<td>94.3%</td>
</tr>
<tr>
<td>6b</td>
<td>Cancer: two week wait from referral to date first seen, comprising - for symptomatic breast patients (cancer not initially suspected)</td>
<td>97.3%</td>
<td>97.0%</td>
<td>94.9%</td>
<td>95.1%</td>
<td>94.5%</td>
</tr>
<tr>
<td>14.</td>
<td>C. difficile year on year reduction (from 10/11 positive samples taken within 72 hrs of admission are reported as non Trust apportioned)*</td>
<td>111</td>
<td>39</td>
<td>30</td>
<td>29</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>(44 Trust apportioned 67 non Trust apportioned)</td>
<td>(25 Trust apportioned 14 non Trust apportioned)</td>
<td>(21 Trust apportioned 9 non Trust apportioned)</td>
<td>(23 Trust apportioned 6 non Trust apportioned)</td>
<td>(15 Trust apportioned 6 non Trust apportioned)</td>
<td></td>
</tr>
</tbody>
</table>
**Indicators for acute Trusts from Monitors risk assessment framework updated August 2015**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Target for 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Certification against compliance with requirements regarding access to health care for people with a learning disability</td>
<td>Compliant</td>
<td>Compliant</td>
<td>Compliant</td>
<td>Compliant</td>
<td>Compliant</td>
<td>Maintain compliance</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).

---

**Statement from NHS Wiltshire Clinical Commissioning Group for Salisbury NHS Foundation Trust Quality Account 2015 - 2016 – 20 May 16**

NHS Wiltshire Clinical Commissioning Group (CCG) has reviewed Salisbury Hospital NHS Foundation Trust’s (SFT) 2015-16 Quality Account. In doing so, the CCG reviewed the Quality Account in light of information presented through intelligence indicators and the assurances sought and given at monthly Clinical Quality Review Meetings. Wiltshire CCG therefore confirms that the Quality Account is a representative account.

It is the view of the CCG that the Quality Account reflects the ongoing commitment from Salisbury Foundation Trust to quality improvement by tackling key areas of improvement in a focused and innovative way. It is evident that the Trust has 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 the reduction of avoidable infections, particularly in *C. difficile*. The CCG has worked with the Trust to eliminate mixed sex accommodation breaches, and is pleased to see a reduction in numbers of breaches reported and the continuation of working towards the elimination of breaches in the 2016-17 priorities.

The Trust has recently been rated by the CQC as ‘Requires Improvement.’ Within the report published by the CQC, the Trust was commended for the kind and compassionate care delivered by staff with examples of outstanding practice. The CCG will work with the Trust to review and monitor progress against the areas identified within the formal action plan.

The CCG are supportive of the priorities identified by the Trust for 2016-17, which align to many of CQUIN schemes for this year. The CCG values the work which the Trust completes in reviewing mortality and hopes to see a continued focus in 16/17 from the Trust on the review, monitoring and investigation of the Hospital Standardised Mortality Ratio (HSMR), which is currently above the expected range.

In response to the warning notice raised by the CQC in relation to spinal services provided by Salisbury Foundation Trust, the Trust has identified actions to reduce the numbers of spinal cord injured patients who are waiting for video-urodynamic testing and/or an outpatient appointment, which the CCG supports and will monitor progress against with the Trust. The CCG will also continue to monitor spinal services as a whole, and the environment the services provides, to ensure the welfare and safety of its patients. In addition, the CCG is supportive of planned work to address workforce concerns to improve recruitment and retention in the Trust.

The Trust has identified priorities for 2016-17, which align with system-wide objectives to improve quality and patient safety. Building on the accomplishments of 2015-16, the CCG anticipates that considerable achievements can be made in Sepsis and Acute Kidney Injury. The CCG looks forward to working collaboratively with the Trust and other partners towards achievement of improved patient outcomes and experience and the Trust’s identified priorities for the coming year.

Deborah Fielding  
Accountable Officer  
NHS Wiltshire Clinical Commissioning Group
Statement from Wiltshire Council Health Select Committee – 17 May 2016

The Health Select Committee has been given the opportunity to review the draft Quality Account for Salisbury NHS Foundation Trust 2015/16.

The Committee has not undertaken any detailed work on the Trust this year. However, we have scheduled an item for its meeting on 27th September to consider:

- The CQC inspection report of the Trust, following the inspection undertaken in December 2015, the result of which was a grading of ‘Requires Improvement’
- The Trust’s improvement plan for addressing issues identified by the CQC.

Cllr Chuck Berry, Chairman, Wiltshire Health Select Committee

Officer contact: Henry Powell, Senior Scrutiny Officer, 01225 718052, henry.powell@wiltshire.gov.uk

Statement from Healthwatch – 12 May 2016

Healthwatch Wiltshire welcomes the opportunity to comment on Salisbury Hospital NHS Foundation Trust’s quality account for 2015/16. Healthwatch Wiltshire 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.

Following a recent inspection by the Care Quality Commission (CQC), we were disappointed to see that the overall assessment of the Trust was that it requires improvement. In particular, we were concerned that the spinal injuries centre received a rating of inadequate for ‘responsive’ for their management of outpatients (appointments and video urodynamics). However, we were much encouraged that the Trust were rated as Good for caring and that the staff were described as kind, compassionate and committed and Good for effective care and treatment. We were also happy to see that a number of areas of excellence were identified. We note that plans are already in place to improve those areas identified by The CQC as requiring attention. We will continue to monitor their progress over the coming months and support the Trust where we can with this.

We welcome the work already carried out by the Trust to reduce the amount of falls resulting in hip fracture and the new initiatives such as sensor alarms that aim to prevent falls from occurring. We will monitor the outcomes of these initiatives going forward.

We note the reduction in the number of grade 2 pressure ulcers and hospital acquired infections and are pleased to see that further reductions and in particular, a zero tolerance of grade 3 and 4 pressure ulcers are priorities for the coming year.

It is pleasing to see that the Trust have taken into account the experiences of patients, their families and carers of discharge from hospital. Our own work at this and other Trusts, indicated that more could be done to improve the patients’ journey from admission to discharge home. We therefore, welcome the Trust’s commitment to working with external partners to improve the experience of those who are discharged from their care. This includes involvement in work commissioned through the Better Care Fund. Healthwatch Wiltshire is commissioned to evaluate services under the Better Care Fund and will feedback to the Trust any information that may assist in their continued work to improve patient experience in this area.

We welcome the Trust’s continued work that seeks to identify unpaid carers and the issues that are of most concern to them. We are pleased to see that as a result of feedback from unpaid carers, the Trust have introduced John’s Campaign that allows families or unpaid carers to stay with people with dementia over the 24-hour period. In addition, we note the collaborative working between the Trust and voluntary sector partners to provide support to unpaid carers in the form of a carer’s café. We are pleased to see that unpaid carers remain a priority for the coming year.

We were concerned that the most frequent theme from complaints and concerns were poor communication and attitude. However, we welcome the introduction of initiatives such as the ‘This is my usual life’ document and bed boards that aim to improve communication with and involvement of, relatives and unpaid carers. We will monitor the outcomes of these initiatives through our on-going engagement.

We see that the response rates for the Friends and Family Test remain low and that the overall response rate is down on last year. This is particularly so for A&E. Whilst recognising that response rates for the test are a national issue, we would like to see significant improvements if the tests are to give meaningful results. In addition, we are concerned to see that the percentage of patients stating that they had enough help from staff to eat their meals remains at 68%. This is unchanged from last year. Whilst recognising staff pressures, we would like to see further action to improve this situation.
We are pleased that the Trust has acknowledged the stresses involved for those children with long-term conditions, who are transitioning from children’s to adult services. We therefore welcome the introduction of the ‘Ready, Steady Go’ programme for children with diabetes and cerebral palsy and the planned development of this programme for young people who have physical disabilities.

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.

Healthwatch Wiltshire looks forward to working with the Trust over the coming year to ensure that the experiences of patients, their families and unpaid carers are heard and taken seriously.

**Statement from the Governors – 12 May 2016**

The NHS in general is of course under enormous pressure to cut costs, and Salisbury Hospital is no exception. What is so reassuring about this report is that it shows the enormous effort being made in every sphere of hospital activity to maintain and raise the quality of the care provided by our hospital to every patient, young and old.

There are many facets of this report that are particularly welcome.

- One of the most important is the further emphasis on the Duty of Candour – a duty to tell patients honestly about the course of their care, and in particular if they have suffered avoidable harm.

- Another is the tremendous effort being made to prevent complications arising during care – sepsis, falls, pressure ulcers etc. An important motto for care is ‘First, do no Harm’.

- Staff shortages and the continuing reliance on agency staff are still a concern, and although the Governors appreciate the difficulty of recruiting and retaining suitable staff, this issue should continue to be a priority throughout the coming year.

- There is a clear association between staff health and wellbeing and the quality of patient care. We are pleased to see that staff health is a quality indicator being assessed in the coming year.

- We would highlight the effort being made to care for patients with dementia, from screening through to involvement of carers from the moment of admission to the time of discharge.

- Finally, we are glad to note that the Trust is already taking steps to improve the areas highlighted by the Care Quality Commission as requiring attention. We believe that these areas have been assessed and plans outlined to address them.

We endorse the quality priorities and work streams set out in the Quality Account for 2016/17.

This is all made possible by the wonderful commitment of so many staff from cleaners to executives. Your governors, as representatives of your patients, thank you sincerely.

**How to provide feedback**

All feedback is welcomed, 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.

**Statements of Directors’ Responsibilities for 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 2015/2016 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 2015 to May 2016;
  - Papers relating to quality reported to the Board over the period April 2015 to May 2016;
  - Feedback from commissioners dated 20 May 2016.
  - Feedback from governors dated 12 May 2016.
  - Feedback from Local Healthwatch organisations dated 12 May 2016
- Feedback from Overview and Scrutiny Committee dated 17 May 2016.
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 5 October 2015, 8 February 2016, 4 April 2016.
- The 2015 national patient survey dated 8 June 2016 (will not be published until 8 June 2016)
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 13 May 2016.
- 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 in section 2.3 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 has improved since 2014/2015 and remains 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
20 May 2016

Peter Hill
Chief Executive
20 May 2016

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 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

• 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
20 May 2016

Peter Hill
Chief Executive
20 May 2016

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 2016 (the ‘Quality Report’) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

• percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
• A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge;
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 2015/16 (‘the Guidance’); and
- the indicator 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 and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners;
- feedback from governors;
- feedback from local Healthwatch organisations;
- feedback from Overview and Scrutiny Committee;
- the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2014 national patient survey;
- the 2015 national staff survey;
- the 2015/16 Head of Internal Audit’s annual opinion over the trust’s control environment; and

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 2016, 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 indicator;
- 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.

**Basis for qualified conclusion**

As a result of the procedures performed in relation to the referral to treatment within 18 weeks for patients on incomplete pathways quality indicator, we have not been able to gain assurance over the six dimensions of data quality as required by Monitor, with issues identified in relation to the operating effectiveness of the control environment.

**Qualified conclusion**

Except for the matter described in the ‘Basis for qualified conclusion’ section above relating to the referral to treatment within 18 weeks for patients on incomplete pathways quality indicator, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- 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 Guidance; and
- the remaining indicator in the Quality Report subject to limited assurance has not been 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.

Jonathan Brown  
for and on behalf of KPMG LLP, Statutory Auditor  
Chartered Accountants  
100 Temple Street  
Bristol  
BS1 6AG  
19 May 2016

The Annual Report has been approved by the Trust Board on 20 May 2016.

Peter Hill  
Chief Executive  
20 May 2016