NHS
Salisbury
NHS Foundation Trust

Quality Account
2017 to 2018

Quality Account 2017/18

Contents

NHS Salisbury NHS Foundation Trust

Quality is our number one priority

Achievements in 2017/2018

Learning from deaths

90%

The percentage of deaths that were screened

The number of learning points identified

56

Our analysis shows our establishments are set to achieve appropriate staffing levels on our wards

We are seeing improvements in our sepsis screening, antibiotic administration and antibiotic review of patients admitted as an emergency

22.7%

The percentage reduction we saw in women smoking at the time of their delivery compared to the time they were booked in

99%

The percentage of women who understood the message about reduced fetal moments and attended for a fetal heartbeat trace on the same day

An Older Person's Assessment & Liaison Team was introduced in January 2017

1098

patients wereassessed

49%

patients went home on the same day with community support

A 15% reduction in the number of patients who had a fall in hospital which resulted in a fracture

40%

The percentage reduction of patients with a catheter with a new urinary tract infection

2%

reduction from 2016 antibiotic prescribing levels

We are making great progress on changing prescribing practice to help slow the emergence of antimicrobial resistance & ensure that antimicrobials remain an effective treatment for infection.

Personalised care plans made with 33 patients with mental health needs who had frequently attended A&E in 16/17 resulting in a

46%

reduction in their attendances in 17/18

NHS 7-Day Services

Ensuring emergency admissions receive high quality consistent care, whatever day they enter hospital

95%

of all patients admitted as an emergency were assessed by a consultant within 14 hours of admission

92% were reviewed at the weekend (national average 69%)

Quality Account 2017/18
Introduction

Quality accounts which are also known as quality reports are annual reports for the public that detail information on the quality of services the Trust provides for patients. They are designed to assure patients, families, carers, the public and commissioners that the Trust regularly scrutinises the services it provides and concentrates on those areas that require improvement.

Quality accounts look back on the previous year's performance explaining where the Trust is doing well and where improvement is needed. They also looks forward, explaining the areas that have been identified as priorities for improvement as a result of consultation with patients and the public such as the Warminster Health, Wellbeing and Social Care Forum, our staff and governors in 2017/18.

Part 1

Our commitment to quality - the Chief Executive's view

I am pleased to introduce the 2017/2018 quality account for Salisbury NHS Foundation Trust, in what has been an exciting and busy time in my first year here in Salisbury.

Along with the rest of the region and the country we have seen unprecedented demand and pressure for our emergency and urgent care services this year, with high numbers of unwell patients needing hospital admission.

Our staff have responded to these pressures by continuing to put patient safety and the quality of care as our number one priority. I am extremely proud of the professionalism and commitment of our staff, and the passion for our patients has been fantastic. Right from the start I've been impressed by the way in which everyone works as a team to support our patients across all of our services. I think that this is a particular strength of our hospital and one that makes us stand out.

We performed well on national quality and operational standards and were able to cope with the increased demand from improvements in the emergency care pathway and the reconfiguration of the hospital site, to bring on line extra beds in 2018/2019. We were able to do this with greater involvement of our community and social care partners in the redesign of patient pathways to provide patients with the best possible care in the most appropriate setting.

It is extremely important to us that our patients have an outstanding experience of care. By listening to the views of our patients through surveys and real time feedback and acting on that feedback, we are able to continually improve the care we provide. I was delighted that some of our patients have been directly involved in the transformation of some pathways and we plan to strengthen this next year.

Our staff are crucial to providing patients with high quality care. Their commitment is reflected in the national NHS staff survey which showed that the Trust is in the top 20% of hospitals for staff feeling engaged in improvements. This clearly has an impact on the way we care for our patients, with 90% of staff feeling that their contribution made a difference to patient care.

We look forward to continuing to build on the successes of this year, strengthening our partnership working even further and continuing to provide an outstanding experience for every patient.

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

Cara Charles-Barks
Chief Executive
22 May 2018
On behalf of the Trust Board

Part 2A: Priorities for improvement and statements of assurance from the Board

This section of the quality account describes the progress made against the priority areas for improvements identified in the 2016/2017 quality account and the priorities identified for 2018/2019. It includes why they were chosen, how the Trust intends to make the improvements and how it plans to measure them. It also sets out a series of statements of assurance from the Board on key quality activities and provides details of the Trust's performance against core indicators.

2.1 Progress against the priorities in 2017/2018

The quality account for 2016/2017 outlined the Trust's priorities for quality improvement for the year ahead (2017/2018). These priorities were identified by speaking to patients, families and carers, the public, our staff and governors, Age UK, Salisbury Branch, Warminster Health, Wellbeing and Social Care Forum, our partners, local GPs and our commissioners through face to face meetings and surveys.

The Trust's priorities in 2017/2018 were:

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

2.2 Quality priorities in 2018/2019

A similar process has been used to identify the quality priorities for 2018/2019. These priorities fit with our strategic objectives and were considered by the Clinical Governance Committee and recommended to and agreed by the Trust Board. We have also taken into consideration the NHS Five Year Forward View, the Government's Mandate to NHS England 2020 goals and the B&NES, Swindon and Wiltshire Sustainability and Transformation plan (STP) in deciding our quality priorities in 2018/2019 to ensure we continue to provide an outstanding experience for every patient.

The Trust's quality priorities for 2018/2019 are:

Priority 1 – Identify frail older people to ensure they receive effective care and treatment and reduce the number of patients who fall and injure themselves in hospital (links to the local strategic objective).

Priority 2 – improve the flow of patients through the hospital to ensure the right patient is cared for in the right place by the right team at the right time (links to the local strategic objective).

Priority 3 – improve the recognition and management of deteriorating patients as well as treatment of adults and children with severe infections using Sepsis Six practices on our inpatient wards (links to the care strategic objective).

Priority 4 – improve the engagement with and the health and wellbeing of our staff (links to the people strategic objective).

What we did in 2017/2018:

The numbered points below indicate the quality priorities set for 2017/2018; the paragraph that follows is the progress made towards their achievement.

Priority 1: Continue to keep patients safe from avoidable harm

Description of the issue and reason we prioritised it:

The safety of our patients is a key aim in our quality improvement work. We are actively engaged in the 'Sign Up to Safety' programme as an active participant in the Wessex Patient Safety Collaborative. Our aim is to reduce avoidable levels of harm to patients whilst in hospital by 50% over a 3 year period 2015 – 2018. We measure this through quality indicators such as infection rates, pressure ulcers, and the number of patients who fall and injure themselves in hospital. All these can lead to extra time in hospital and pain and distress for patients and their families. Creating a culture of learning from incidents to reduce the risk of the same thing happening again is important. Set out below is the progress of each element of the 'Sign Up to Safety' programme.

What we did to improve in 2017/2018:

1.1 Introduced the new national structured mortality review tool to help us identify any deaths that could have been prevented or that alert us to any patient care and safety issues that need to be improved

A new screening process was introduced in August 2017 for patients who died in hospital. The aim of the screening process is to identify any unexpected deaths, deaths where there were problems in care or where relatives expressed concerns about care. This has resulted in deaths being appropriately selected for a case record review to help doctors and senior nurses to understand which aspects of patient care, if any, contributed to a death, and what lessons can be learnt, as well as identifying areas of good practice.

Some of the key themes arising from these reviews include the need for better advanced care planning for patients with long term conditions, improved recognition of deteriorating patients and timely referral for a medical review, recording treatment escalation plans to reduce the number of patients admitted to hospital as an emergency at the end of life, timely ceiling of care reviews and resuscitation decisions, and procedural documentation regarding risks and benefits. Improvement actions are set out in an action plan and progress monitored by the Mortality Surveillance Group. The learning is shared via quarterly mortality bulletins and educational events. We are also working with our community partners, GPs and the Wiltshire End of Life Care Steering Group to improve these aspects of care.

In February 2018 we started to report our data shown in table 1, learning and improvement actions to the Trust Board. The report is available at the following link:
http://www.salisbury.nhs.uk/AboutUs/TrustBoard/AgendaBoardPapersAndMinutesTrustBoard/Documents/PaperPackPublicTrustBoardmeeting5February2018f.pdf

Table 1: Deaths subject to a case record review, avoidability score and learning points

	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Total
Number of deaths	185	205	211	240	841
1st screen*		117*	194	218	529/586 (90%)
Case record review	60	86	88	68	302 (36%)
Deaths with a Hogan score 1 – 3**	0	0	0	0	0
Deaths with a Hogan score 4 – 6**	2	10	13	4	29
Unexpected deaths	0	0	3	2	5
Learning points identified	9	18	20	9	56

*From 1 August 2017 – there were 346 deaths between 1 August and 31 December 2017 eligible to be screened.

**Deaths with a Hogan score of: 1) Definitely avoidable 2) Strong evidence for avoidability 3) Probably avoidable, more than 50/50, but close call 4) Possibly avoidable but not very likely, less than 50/50 but close call. 5) Slight evidence of avoidability 6) Definitely not avoidable.

In October 2017, we trialled asking bereaved relatives and carers to complete a survey called 'Your views matter' about the care their loved one received during their last admission to hospital and the support they received leading up to and around the time of their death. The results of the survey identified that the majority have been very positive about the care and treatment of their loved one. Four people wanted the opportunity to talk further to help them understand what happened and were contacted by specialist nurses. As an outcome, small changes have been made at the Registrar's office in the hospital to ensure relatives have a private room to wait in. One learning point has been the availability of a side room for patients at the end of their life. The survey will be rolled out once resources have been identified to properly support families.

1.2 Continued to work on reducing the number of patients who have preventable falls and fracture their hip in hospital.

The rate of falls resulting in patients fracturing their hip showed a small reduction from last year. We have found that these patients often have delirium as a result of their illness, surgery or medication. Some patients, who were admitted following a fall at home, had recovered, and were ready to go home, but were waiting for a care package when they fell and suffered a fracture.

Table 2: Number of patient falls resulting in a fractured hip and rate of all fractures per 1000 bed days

Measure	2017/18 target	2016/17	2017/18	2017/18 overall performance
Number of patients who fell in hospital which resulted in a fractured hip	0	18	17	⇧
Rate of all hip fractures per 1000 bed days	0	0.108*	0.103	⇧
⇧ Better ⇔ Unchanged ⇩ Worse				

*In 2016/2017 the rate of all fractures per 1000 bed days was reported incorrectly as 0.18. The actual figure was 0.108

However, table 3 below shows that when comparing the number of patients who fell that resulted in all fractures (not just hip fractures), we have reduced the number from 33 in 2016/2017 to 28 in 2017/2018, representing a 15% overall reduction in falls resulting in harm.

Table 3: Number of patient falls resulting in a fracture and rate of all fractures per 1000 bed days

Measure	2017/18 target	2016/17	2017/18	2017/18 overall performance
Number of patients who fell in hospital which resulted in a fracture (all fractures)	0	33	28 (15% reduction)	⇩
Rate of all fractures per 1000 bed days	0	0.198	0.170	⇩
⇩ Better ⇔ As expected ⇧ Worse				

We achieved this by taking a fresh look at our approach to falls prevention and introduced a new risk assessment. This focused on a wider range of risks including removing trip hazards around the patient's bed space and putting the beside locker and belongings on the same side as the patient gets out of bed at home. We also focused on taking a patient's blood pressure when lying down and standing up to spot whether the blood pressure falls when the patient stands up. If so, medication that could be causing it is reviewed. We introduced double grip slipper socks on every ward to help prevent a patient slipping on the floor. We wanted to improve the observation of patients with delirium and have successfully tested an updated pressure sensor mat on one ward to alert staff when a patient gets out of bed or stands up from a chair. New updated pressure sensor mats will be in place in early 2018/2019. We also plan to introduce a delirium care bundle which is a set of practices to investigate, manage and plan care and treatment in early 2018/2019.

1.3 Ensured that where a urinary catheter is required it will be inserted and cared for using evidenced based practice, and will be removed as soon as possible to reduce the chance of infection

We have now introduced both the insertion and on-going catheter care bundles. These are a set of practices which, when used together, help reduce urine infections when a catheter is first put in and ensures it is promptly removed when no longer needed. We have achieved this by providing training to all our ward staff on the safe insertion of a catheter and the on-going care.

We have continued to audit compliance with the catheter care bundles. The combination of education sessions, catheter bundles and the use of new catheter packs have reduced the number of hospital catheter associated urinary tract infections. Our Safety Thermometer data in table 4 shows the excellent improvement we have made in this area.

Table 4: Safety Thermometer data of the number of inpatients with a catheter with a urinary tract infection and a catheter with a new urinary tract infection

Measure	2017/18 target	2016/17	2017/18	2017/18 overall performance
Number of inpatients with a catheter with a urinary tract infection.	0	153	102 (33% reduction)	⇩
Number of inpatients with a catheter with a new urinary tract infection	0	97	58 (40% reduction)	⇩
⇩ Better ⇔ As expected ⇧ Worse				

1.4 Continued to improve the recognition and treatment of adults and children with severe infections using Sepsis Six practices which are designed to reduce the number of people who die from severe infections.

We have made significant and sustained improvements in screening and treating adults and children with sepsis within an hour of arrival at hospital through all of our emergency routes. However, further improvement work is required in the screening and treatment of inpatients through an ongoing education and audit programme.

Table 5: Sepsis screening, antibiotic administration and antibiotic review of patients admitted via emergency routes

Measure	2017/18 target	2016/17	2017/18	2017/18 overall performance
% of patients who met the criteria for sepsis screening and were screened for sepsis admitted via emergency routes	90%	96%	93.5%	⇔
% of patients with severe sepsis who received antibiotics within 1 hour of arrival via emergency routes	90%	76%	86%	⇧
% of patients with severe sepsis who had their antibiotics reviewed by the 3rd day of treatment admitted via emergency routes	Q1 – 25% Q2 – 50% Q3 – 75% Q4 – 90%	95%	97%	⇧
⇧ Better ⇔ As expected ⇩ Worse				

Table 6: Sepsis screening, antibiotic administration and antibiotic review of inpatients

Measure	2017/18 target	2016/17	2017/18	2017/18 overall performance
% of patients who met the criteria for severe sepsis screening and were screened for sepsis - inpatients	90%	81%	83%	⇧
% of patients with severe sepsis who received antibiotics within 1 hour of diagnosis – inpatients	90%	74%	67%	⇩
% of patients with severe sepsis who had their antibiotics reviewed by the 3rd day of treatment - inpatients	Q1 – 25% Q2 – 50% Q3 – 75% Q4 – 90%	95%	97%	⇧
⇧ Better ⇔ As expected ⇩ Worse				

Table 7: Antibiotic consumption in 2017/2018

Measure	Target reduction on 2016 baseline	2017/18	2017/18 overall performance
Total antibiotics (all) consumption	2%	5% increase	⇩
Total piperacillin/ tazobactam consumption	2%	50.4% reduction	⇧
Total carbapenem consumption reduction	1%	12.5% reduction	⇧
⇧ Better ⇔ As expected ⇩ Worse			

1.5 Continued with good antibiotic stewardship to reduce antibiotic resistance

We have made good progress in reducing consumption of broad spectrum antibiotics within the hospital. This has been achieved by continued antibiotic stewardship by the pharmacy team, education sessions with senior and junior doctors and fortnightly audits and feedback to doctors who prescribe antibiotics.

1.6 Continued to work collaboratively with our network to improve the prevention, recognition and treatment of patients with acute kidney injury by the use of a care bundle which is a set of best practices designed to prevent and treat acute kidney injury.

This year, we introduced an acute kidney injury care bundle alongside an education programme. We undertook two audits this year and the results showed that the individual elements that make up the care bundle are being used in practice apart from the recording of a patient's urine test. We have revised the nursing documentation to prompt this test to be carried

out and provided a space for the results to be easily recorded. The new nursing documentation was implemented in February 2018 supported by specific training sessions. The education programme will continue to emphasise the importance of urine testing for protein and blood and further audits will take place in July 2018 and January 2019 to establish the level of improvement.

1.7 Sustained the use of the Saving Babies' Lives care bundle

We have continued to use the 'Saving Babies' Lives' care bundle which is designed to reduce stillbirths and early neonatal deaths. The care bundle has four elements:

1) To support women to stop or reduce smoking in pregnancy
2) Women are given information to ensure they act the same day if their baby is not moving as much as usual
3) Each woman is given a customised growth chart to measure the growth of her baby during pregnancy. If the baby is not growing as it should, additional scans, blood tests or delivery are arranged.
4) During labour, for those women who have their baby's heart beat monitored continuously, a second midwife or doctor should review the heart beat trace every hour to confirm it is normal or needs urgent action. This element also includes ensuring midwives and doctors are up to date with their training in interpreting the baby's heart beat trace in labour.

Our community midwives have made excellent progress in supporting women to stop smoking in pregnancy by asking them to give a carbon monoxide reading at booking. Women who smoke are referred to the maternity stop smoking service for support to stop smoking. All the community midwives have received annual training in stop smoking brief advice and 4 midwives who train other midwives have received annual advanced stop smoking training.

We have improved the detection of small for gestational age babies in pregnancy. Our detailed investigation of small babies that were not detected in pregnancy showed growth charts were not always plotted accurately and some scans did not always estimate the baby's weight accurately. A review was undertaken to understand the reason for this and improvement actions were taken. As an outcome the number and size of the discrepancies between the estimated baby's weight and the actual birth weight of the baby reduced between December 2017 and March 2018.

We have sustained a high percentage of women who received a leaflet and understood the importance of acting on reduced fetal movements the same day.

For those women who had their baby's heart beat monitored continuously during labour, there was a decrease in the percentage of traces reviewed by a second midwife or doctor every hour. Urgent action was taken in all cases where it was needed. A new heart beat trace sticker has been introduced to prompt action to review the trace in a timely manner.

1.8 Continued to expand our Scan4Safety programme through the use of common barcodes. This technology ensures we can match our products such as surgical instruments and implants to our patients.

Our Trust is one of six demonstrator sites selected by the Department of Health to demonstrate the benefits of Scan4Safety and other safety standards. We have introduced point-of-use scanning in all theatres and the cardiology laboratory enabling 99.9% of the Trust's implantable devices, such as a hip or knee implant, or cardiac device to be accurately tracked to a patient. Scan at the point of use is now in place right across main theatres. In February 2018 it was also introduced in Day Surgery theatres. By the end of this year 100% of implants will be recorded to the patient.

The link below shows the Scan4Safety programme in action at the Trust:
http://www.scan4safety.nhs.uk/case_studies/scan4safety-enables-product-patient-tracking/

Table 8: Women who stopped smoking in pregnancy

Measure	2017/18 target	2016/17	2017/18	2017/18 overall performance
% of women recorded as smoking at booking compared to their smoking status at the birth of the baby	15% reduction	12.5% reduction	22.7% reduction	⇧
⇧ Better ⇔ As expected ⇩ Worse				

Table 9: Small for gestational age babies detected in pregnancy compared to the national average

Measure	2017/18 target	2016/17	2017/18	2017/18 overall performance
% of SGA* babies detected in pregnancy compared to the national average	At or above the national average	Q1 23.8% vs 37.8% Q2 43.5% vs 39.1% Q3 39.2% vs 40.5% Q4 42.9% vs 39.7%	Q1 40.4% vs 41.4% Q2 40.3% vs 42% Q3 43.9% vs 41.7% Q4 48.1% vs 42.1%	⇧
% of SGA* babies not detected who had a case review	90%	89%	94%	⇧
⇧ Better ⇔ As expected ⇩ Worse				

*SGA = small for gestational age

Table 10: Women who understood the message about reduced fetal movements and acted on it the same day

Measure	2017/18 target	2016/17	2017/18	2017/18 overall performance
% of women who understood the message about reduced fetal movements and attended for a fetal heart beat trace the same day	95%	97%	99%	⇧
⇧ Better ⇔ As expected ⇩ Worse				

Table 11: 'Fresh eyes' review of the babies heart beat trace every hour in labour

Measure	2017/18 target	2016/17	2017/18	2017/18 overall performance
A 'fresh eyes' review of the babies heart beat trace was undertaken every hour in labour	90%	78%	76%	⇩
⇧ Better ⇔ As expected ⇩ Worse				

1.9 Continued to improve surgical safety. This year we will complement the use of the World Health Organisation safety checklist and team safety briefings with a programme of Human Factors and team based training for the theatre teams.

The aim of using the World Health Organisation surgical safety checklist is to reduce never events (an event that should never happen) to zero. The checklist identifies two 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 helps initiate discussions between members of the theatre and clinical team to improve the safety of surgery. Up until August 2017 monthly audits continued to show over 95% achievement of the 'sign in' phase and 'sign out' phase. However, the team had some quality issues of how the 'sign in' and 'sign out' briefing was being used and the team are working with all members to ensure they are involved in this process. In September 17, a new debriefing template was introduced in each operating room for staff to give their view on how effectively the operating list ran and this has led to improvements in quarter 4.

Human factors training commenced in April 2017 for a full range of theatre staff. The training focused on optimising staff performance through a better understanding of the behaviour of other staff, their interactions with one another and with the operating room. By understanding human limitations, the training offers ways to minimise human frailties, with the aim of reducing never events and its consequences for the patient. A total of 133 theatre staff attended one of 6 training days. Of these, 24 were senior doctors, 87 nurses and nursing assistants, 17 operating department practitioners and 5 administrators.

Unfortunately, we have had three never events associated with surgery this year, all were in different specialties and circumstances but the patients did not suffer any long term harm.

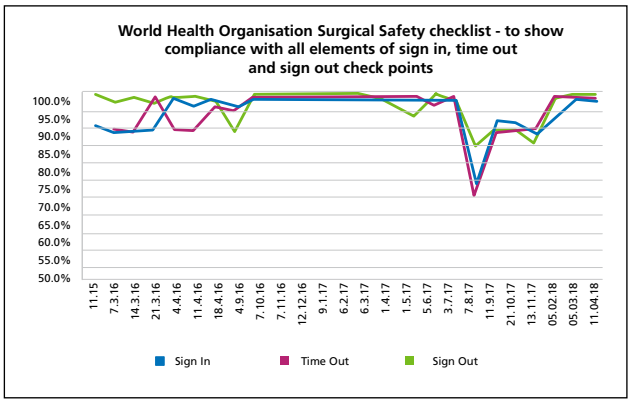
1.10 Continued to review nursing and midwifery staffing levels and skill mix to ensure that there are sufficient numbers of suitably qualified and experienced nurses and midwives to deliver safe, effective and responsive care.

We have continued with our six monthly skill mix reviews to ensure safe staffing levels on all our wards and reported these to the Board. The analysis shows our establishments are set to achieve appropriate staffing levels on our wards. Board skill mix reports in August 2017 and February 2018 can be seen at the following links:

http://www.salisbury.nhs.uk/AboutUs/TrustBoard/AgendaBoardPapersAndMinutesTrustBoard/Documents/3914SkillMix.pdf

http://www.salisbury.nhs.uk/AboutUs/TrustBoard/AgendaBoardPapersAndMinutesTrustBoard/Documents/PaperPackPublicTrustBoardmeeting5February2018f.pdf

Chart 12: World Health Organisation Surgical Safety checklist from November 2015 to March 2018



However, we continue to have vacancies, particularly amongst registered nurses and some speciality doctors, and are working hard to recruit permanent staff and reduce our reliance on temporary and agency staff. The Trust has been involved in collaborative work with NHS Improvement (NHSI) to support us deploy our staff effectively. As an outcome of that work NHSI confirmed we had 'an excellent grip and control of rostering and deployment of staff despite the vacancy situation'.

What our patients and public have told us and what we have done or will do to improve:

- "A staff nurse cared for my mother-in-law as she was coming to the end of her life. She and the nursing assistant on duty did a fabulous job in caring for her, and also making sure we were OK".
- A woman in pregnancy – "'very helpful with any questions, scans all good. Phone service very good, nice friendly staff"'.
- "The staff are rushed off their feet all the time. Not enough nurses". The Trust has an ongoing programme of recruitment of staff, both within the UK and overseas.

Priority 2 – ensure patients have an outstanding experience of care

Description of the issue and reason we prioritised it:

What we did to improve in 2017/2018:

It is important that the Trust does everything it can to provide the best possible experience for each patient. If our patients tell us that the quality of care is not as good as it should be then we must work to improve it. Our patients expect to be treated with dignity and respect, care and compassion. They should also expect services which are responsive to their needs. We have worked with local GPs and our community partners who have told us that the care of frail people, people with dementia, carers and people with mental health problems are a high priority.

2.1 We wanted to do more to identify patients with delirium to ensure they receive effective care and treatment.

It is estimated that 20 – 30% of patients on medical wards have delirium whilst 10 - 50% of people having surgery develop delirium. People who develop delirium may need to stay in hospital longer, have more complications such as falls and pressure ulcers, are more likely to die or be admitted to long term care. Delirium is not always spotted or is misdiagnosed and is very distressing to individuals and their families and carers. Our older people's specialist team have worked together to agree a new screening test which was introduced across the hospital in February 2018. For those patients with a positive score it prompts the need for a specialist assessment and treatment plan.

2.2 Funded by the Academic Health Science Network and with our community partners we developed the specialist frailty team to assess frail patients who attended the A&E Department to enable them to go home the same day.

In January 2017, a new Older People's Assessment and Liaison (OPAL) team was introduced as a weekday service. In November 2017, a weekend service was also started. The specialist team see older people to spot frailty, undertake a specialist assessment and personalised care plan of patients attending the acute medical unit. By seeing patients in the acute medical unit the specialist team is able to make a rapid assessment a nd enable suitable patients to go home the same day. In 2017/2018, the specialist team assessed over 1098 patients and 49% were able to go home the same day with support from the specialist team or community services. Patient, family and carer feedback has been very positive. One patient said: "Caring, thoughtful, everything was no trouble. Very caring and very thorough. They listened to what I was saying and answered my questions". Others said "Some elements of the discharge process could be improved, such as getting take home medication".

2.3 Funded by the Department of Health we participated in the 'what works in dementia workforce training and education' research project to inform best practice in this area.

Having staff with the right knowledge and skills to deliver good dementia care is a key priority for us. We are one of only 12 sites in England chosen to take part in this study 'what works in dementia workforce training and education'. We recruited 24 participants and were the second highest recruiting site nationally.

Participants undertook an online survey to explore their experiences of training, knowledge gained and attitudes towards dementia. An evaluation of the factors associated with success and their effectiveness are reported in the study outcome at the following link. http://www.leedsbeckett.ac.uk/school-of-health-and-community-studies/what-works/

2.4 Worked with our commissioners to improve access for children and young people to the adolescent mental health service.

During our Care Quality Commission inspection in December 2015 inspectors noted that the Child and Adolescent Mental Health Service (CAMHS) was only available during the day time hours. Patients often waited 24 hours or more for an assessment and there was limited emergency support available out of hours. Our commissioners have funded a children's specialist mental health nurse service, working 9 – 5 on weekdays, and this has improved the timeliness of assessments both in the A&E Department and the children's ward.

2.5 Improve the rapid discharge process for patients at the end of their life who wish to die at home to ensure they are able to do so.

In partnership with our community teams, we have provided very clear guidance for every ward team on the process to follow for a rapid discharge and supported this through an education programme. We have also introduced a new alert sticker for the medicines chart to ensure that take home medicines are available within 1 hour of prescription. As an outcome, 78 patients had fast track applications made for care in the community and 50 were successfully discharged to their preferred place of care. 19 of these patients were successfully discharged within 48 hours of the referral. However, 28 patients who wanted to die at home died in hospital before discharge could happen, so there is still

more to do. Wiltshire Clinical Commissioning Group have funded a new specialist nurse post to focus on improving the discharge process for patients at the end of their life who wish to die at home. Part of this role is to examine in detail successful and unsuccessful end of life care discharges and the barriers to achieving them. The themes arising will help drive further improvement whilst we continue to run the education programme.

2.6 Continued to reduce numbers of patients being cared for in mixed sex accommodation.

This year, we have reduced the number of patients being cared for in mixed sex accommodation to ensure we protect patients' privacy and dignity. However, between January and March 2018 during the unprecedented demand for emergency and urgent care, we saw a rise in the number of patients nursed in a mixed sex assessment area of our Acute Medical Unit. These occurrences coincided with peak demand and were to maintain patient safety. We have introduced privacy screens to protect patients' privacy and dignity.

Table 13: Delivering same sex accommodation

Measure	2017/18 target	2016/17	2017/18	2017/18 overall performance
Number of patients affected by a non-clinical mixed sex accommodation breach	0	235	143	⇩
Number of occasions patients were affected by a non-clinical mixed sex accommodation breach	0	32	13	⇩
⇩ Better ⇔ As expected ⇧ Worse				

2.7 Ensured our staff are aware of the Armed Forces Covenant to support improved health outcomes for the Armed Forces community

The Armed Forces Covenant is a promise by the nation that those who serve or who have served in the armed forces and their families are treated fairly and with respect in the communities and society for which they are prepared to give their lives. This particularly applies when serving personnel and their dependents move from one location to another and are not disadvantaged by losing their place on a waiting list. We have worked with our GPs to help us identify serving personnel and veterans and have trained our booking team to ensure these patients keep the same place on the waiting list, as they were before they were transferred to this hospital for surgery or an outpatient appointment. We have also introduced a system to alert our booking staff to veterans with war injuries to ensure their treatment is prioritised.

We have already achieved a silver award as part of the Defence Employer Recognition Scheme where we have pledged and demonstrated support to defence and the armed services community by offering the Step into Health programme. This helps military personnel to take up career opportunities in the NHS when they leave the services. We also support our staff to join the Army Reserve Medical Services. We are working towards becoming an accredited hospital to demonstrate our commitment to the Veteran Covenant Hospital Alliance. We will do this in partnership with local charities such as Help4Heroes, the Royal British Legion, BLESMA (a charity providing support to limbless and injured veterans).The Defence Medical Welfare Service will place a full time family liaison officer in the hospital in early 2018/2019 to support serving personnel and veterans.

What our patients and public have told us and what we have done or will do to improve:

- "Very pleasant informative staff - very considerate of Mum's dementia".
- "Kind & courteous staff, understanding of a patient with mental health disabilities".
- "Needed more explanation of my condition and how to get better and what to expect on leaving hospital" – we are training a range of staff in 'making every contact count' and encouraging our staff to discuss discharge arrangements soon after admission.

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 we prioritised it:

Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health significantly. Making every contact count (MECC) is an approach to behaviour change that uses the millions of day-to-day interactions that we have with people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. We need to work with our public health teams and all our partners and encourage everyone to take more responsibility for managing their own health and care.

What we did to improve in 2017/2018:

3.1 Worked with partners to train and support our staff to 'make every contact count' (MECC).

Two awareness-raising sessions were held by Health Education England, Wessex and the feedback was very positive. Several specialist nurses have undertaken a 'health coaching' course to help patients with the better management of their own health and care. These specialist nurses will train other staff in this technique. The Trust is an active partner with other organisations implementing MECC across our local Sustainability and Transformation partnership. Ongoing training on MECC is being arranged by our education team.

3.2 Continued to provide and promote healthy food for patients, visitors and our staff.

Last year we introduced a range of measures to offer healthier choices of food and drink for sale in our restaurants and cafes. Chocolate-based confectionery and biscuits with a sugar content over 52 grams are no longer sold and products with 22 grams of sugar are not sold within 2 metres of a till point or advertised for sale. Sugar sweetened drinks with a sugar content of 10 grams or more and crisps and snacks with a salt content greater than 1.5 grams are not sold at all. Sandwiches for sale are made with low fat spread and salads with low fat dressing. No advertising or promotions of foods high in fat, salt or sugar are permitted, instead promotions are for healthy alternatives.

This year we have gone further and 88% of our drinks lines stocked are sugar free and as from 1 May 2018 this will increase to 100%. 96% of our confectionery and sweets do not exceed 250 kcal and plans are in place for all our confectionery and sweets to meet this standard next year. Since June 2017, 71% of our pre-packed sandwiches and other savoury pre-packed meals such as wraps, salads, and pasta salads contain 400kcal or less and do not exceed 5 grams of saturated fat. In October we participated in the Health and Wellbeing Week and offered free fresh fruit with every meal purchased.

3.3 Worked with our partners, we started to ask patients admitted to hospital whether they smoked, offered stop smoking medication, gave advice on how to stop and referred patients to an NHS stop smoking service.

Smoking is England's biggest killer causing nearly 80,000 premature deaths a year and a heavy toll of illness. People who stop smoking reduce the risk of heart disease, stroke, and cancer and as an inpatient leads to a reduced rate of wound infections, improved wound healing and increased rates of bone healing. The quit rate of patients who want to stop smoking and take up a referral to a stop smoking service is between 15 – 20% compared to 3 – 4% amongst those without a referral.

Our data shows that whilst our staff have met the standard in giving patients who smoke brief advice and improved the offer of medication and a referral to stop smoking services, the proportion of patients recorded as being asked about their smoking status remains below the standard expected. In March 2018, our pharmacy team took on this responsibility as part of their discussions with the patient about their medicines and this is expected to improve performance (see table 15 on following page).

Table 14: Proportion of patient screened for smoking status, given brief advice and offered medication and a referral

Measure	Standard	2017/18	Overall performance 2017/18
Proportion of patients screened for smoking status	90%	16%	⇩
Proportion of patients who smoked given very brief advice	90%	97%	⇧
Proportion of patients who smoke offered a referral and medication	30%	25%	⇩
⇧ Better ⇔ As expected ⇩ Worse			

3.4 Worked with our partners, we started to ask patients admitted to hospital how much alcohol they drank, offered brief advice and a specialist referral where relevant.

Our data shows that whilst our staff met the standard in giving patients who drink alcohol above the lower risk level very brief advice or a specialist referral, the proportion of patients recorded as being asked about their alcohol consumption has remained below the standard. In March 2018, our pharmacy team took on this responsibility as part of their discussions with the patient about their medicines and this is expected to improve performance.

3.5 Continued to increase flu vaccination rates of our front line staff and offer the flu vaccination to pregnant women to protect them from developing serious complications of flu such as pneumonia

We have listened to our staff and this year run a very proactive 'Fighting flu this winter' vaccination campaign. We have promoted the message that vaccination can help keep staff fit and healthy throughout the winter and reduces the risk of spreading flu to others, particularly those who are vulnerable. Our Occupational Health team have run drop in flu clinics, trained peer vaccinators, provided information and weekly updates on our progress. In 2017/2018, 1820 (67%) of 2715 front line staff received the vaccine during the campaign. Women in pregnancy are at higher risk of complications from flu, such as bronchitis, chest infections and pneumonia because they have a weaker immune system. Women are advised that the best way to avoid getting flu is by getting vaccinated. The flu jab protects both the mother and baby. This year, our community midwives gave the flu vaccine to 211 pregnant women at antenatal clinics.

Table 15: Proportion of patients screened for alcohol consumption, given brief advice or offered a specialist referral

Measure	Standard	2017/18	Overall performance 2017/18
Proportion of patients screened for alcohol consumption	50%	15%	⇩
Proportion of patients who drank alcohol above the lower risk level and were given very brief advice or a specialist referral	80%	90%	⇧
⇧ Better ⇔ Unchanged ⇩ Worse			

3.6 Continued to support the health and wellbeing of our staff through physical activity, supporting mental well-being and reducing muscle and back injuries.

The 'Shape up at Salisbury' campaign is a health and wellbeing programme for all our staff. We know that helping our staff to be happy and healthy improves the quality of patient care. This year we have continued to provide a range of physical activities through gym and swimming pool membership and a large range of physical exercise classes at our staff club. We encouraged staff to walk or cycle to work and promoted the weekly national 'Park Run' on a Saturday morning. http://www.parkrun.org.uk/events/events/ We have increased the range of mental health initiatives available for staff including stress management events, psychological resilience training, mindfulness and meditation sessions to help staff identify and deal with stress. Staff can see a specialist mental health adviser and receive counselling advice if needed. Every member of staff is expected to complete on line training on handling loads to reduce the risk of muscle and back injuries. Rapid access to physiotherapy is available for staff suffering from muscular or back problems. Staff also have access to the Wiltshire Council health trainers who are able to support them make positive lifestyle changes to improve their health and wellbeing.

3.7 With our partners we continued to support patients with long term conditions with a personalised care plan to help them manage their own health and reduce complications.

A personalised care plan helps patients to gain greater control of their own care and transforms their experience from reacting to ill health to a more helpful preventative approach centred on their own care.

This has been particularly successful with patients with long term lung conditions, such as asthma who have been able to set their personal goals and manage their lifestyle better. For patients with chronic obstructive pulmonary disease (COPD) and other lung diseases, we have continued with a ward based pulmonary rehabilitation programme to help patients learn more about their condition, the benefits of exercise, breathing control and what to do if they should become unwell.

Patients with heart failure also have a personalised care plan which starts when they are first visited by a specialist nurse in hospital. The diagnosis of heart failure is discussed and advice is given on a healthy diet, exercise and medication and how to manage their condition. Patients have their own patient-held record to keep track of their plan. The plan also gives advice on what to do if they become more breathless or unwell so that treatment can be given to avoid a further admission to hospital.

3.8 Continued to recruit patients with Parkinson's disease into the National Institute for Health Research funds STEPS feasibility project to assess the effectiveness of functional electrical stimulation on walking and the prevention of falls.

People with Parkinson's Disease (PD) often have difficulty in walking. This causes them to walk slowly and often leads to falls and a reduced quality of life. Functional Electrical Stimulation (FES) can be used to produce movement in under active muscles by applying small electrical impulses to the nerves from a small battery powered device applied to the leg. In previous small studies, patients were able to walk faster and had reduced PD symptoms after using the stimulator. This is a bigger study of 68 people who have PD who either received routine care alone or routine care and the stimulator. In 2017/2018 we recruited 6 patients into this study. An evaluation of the effectiveness of routine care compared to routine care and the stimulator will be reported in the study report early next year.

What our patients and public have told us and what we have done or will do to improve:

- "Being one of those who wants to know and understand all about what is wrong with me, what treatment is available, what tests can be done and their details, and what the likely effects and possible outcomes are, I could not have been kept better informed at all times. For me, this is of great importance and very helpful. It also helps me to retain my positive attitude with regard to my condition".
- "In my case, I found that people were not listening to me about my long-term illnesses. I think that everybody involved in care should remember that people with long-term illness usually know a lot about their problem". We are training our staff in 'making every contact count' – see progress in point 3.1.

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

Description of the issue and reason we prioritised it:

In 2013, the NHS Services, Seven Days a Week Forum chaired by the National Medical Director set 10 clinical standards focused on urgent and emergency care services. The aim is to ensure that patients receive the same standards of care at a weekend as they do during the week. In our 2016 national survey results of NHS 7 day services, it showed we were better than the national average in all 4 priority clinical standards. In 2017/2018

we aimed to maintain this good progress. The 4 priority clinical standards are - 2) time to consultant review 5) access to diagnostics 6) access to interventional/key services and 8) ongoing review. The Trust was an early adopter of these standards and we also wanted to ensure these 4 priority standards are implemented in our stroke and heart attack service.

What we did to sustain the improvement in 2017/2018:

4.1 Ensure that all patients admitted as an emergency are seen and assessed by a consultant within 14 hours of admission.

Patients who are seen and assessed by a senior decision maker within 14 hours of admission are likely to have a better experience of care and are more likely to go home sooner. Our national NHS 7 day survey results consistently show that we exceeded the national standard and have significantly better performance than other Trusts. We have achieved this by consultant-delivered services in the A&E Department and acute medical and surgical assessment units and children's unit.

Table 16: Proportion of patients reviewed by a consultant within 14 hours of admission

	March 2017		September 2017	
	Trust	**National mean**	**Trust**	**National mean**
Proportion of patients reviewed by a consultant within 14 hours of admission to hospital on a **weekday (Standard = 90%)**	94%	73%	95%	72%*
Proportion of patients reviewed by a consultant within 14 hours of admission to hospital at a **weekend (Standard = 90%)**	87%	70%	86%	70%*

*Provisional national results

4.2 Improved access to inpatient cardiac echocardiograms at weekends

Clinical standard 5 is about access to diagnostics seven days a week for an ultrasound scan, CT scan, MRI scan, echocardiogram, endoscopy and microbiology within 1 hour for critical patients, within 12 hours for urgent patients and within 24 hours for non-urgent patients. Our survey results consistently show we provide all 6 of these tests during the week and 5 out of 6 at weekends, either on-site or by formal arrangement with other hospitals. Echocardiogram is the diagnostic test most commonly not available at the weekend at this hospital and nationally.

This year we planned to undertake a pilot of one four hour session at a weekend. This did not go ahead due to vacancies in the cardiac investigation team. However, our cardiology consultants undertake a ward round seven days a week and are able to undertake an urgent echocardiogram if it is needed. Our cardiology middle grade doctors also continued to provide an echocardiogram service on the 14 weekends they were on duty during the year. Patient feedback was very positive as it helped to reduce delays in discharge at the weekend.

Clinical standard 6 is about access to consultant-directed interventions seven days a week for critical care, interventional radiology and endoscopy, emergency general surgery, emergency renal replacement therapy, urgent radiotherapy, stroke thrombolysis, percutaneous coronary intervention and cardiac pacing. Our survey results consistently show we provide all 9 interventions seven days a week, either on-site or by formal arrangement with other hospitals.

4.3 Ensured patients on a general ward are reviewed during a consultant ward round every 24 hour, seven days a week, unless it has been decided that this would not affect the patient's care.

Ward rounds provide the opportunity to listen to patient and carer concerns and involve them in decision making and information about their care. The team are able to review progress, check vital signs, identify improvement or deterioration and refine or amend the patient's care plan following an examination, observation and further investigations. Evidence has shown that where there are two or more acute medical ward rounds a day reviewing all patients there was a lower mortality rate for patients who stayed in hospital longer than seven days.

Our national NHS 7 day service survey results show that we exceeded the national standard and have significantly better performance than other Trusts.

All patients with high dependency needs should be seen and reviewed by a consultant twice a day. These are patients being cared for in the Critical Care Unit, Coronary Care Unit, Surgical High Dependency Unit, Acute Medical Unit and the Children's ward. Our national NHS 7 day service survey results show that we exceeded the national standard and have significantly better performance than other Trusts (see table 18).

Table 17: Proportion of patients who required and received a once daily review 7 days a week

	September 2016		March 2017	
	Trust	**National mean**	**Trust**	**National mean**
Proportion of patients who required and received a **once** daily review on a **weekday (Standard = 90%)**	95%	71%	100%	90%
Proportion of patients who required and received a **once** daily review at a **weekend (Standard = 90%)**	94%	66%	92%	69%

NB: This standard was **not** measured in the September 2017 national survey

4.4 Continued to ensure that patients have their clinical observations recorded and acted upon if they deteriorate.

In this hospital doctors and nurses use the Early Warning Scoring system (EWS) to enable early detection of deterioration by categorising a patient's severity of illness which prompts nurses to request a medical review when the score is 3 or more. Patient's vital signs (pulse, blood pressure, respirations and oxygen levels) are recorded and each vital sign is given a score from 0 – 3 (a score of 0 is most desirable and a score of 3 or more is least desirable). The total score is the early warning score. The score can show a trend over time but also alerts when intervention is required quickly to prevent deterioration. Next year, we plan to introduce the National Early Warning Score (NEWS) to standardise the recording of clinical observations across the NHS.
Our performance in recording and scoring vital signs exceeds the standard but acting upon the score has not improved this year and is a quality priority in 2018/19. 16 of 19 ward teams are now able to record all vital signs electronically.

4.5 Ensured that the heart attack service and stroke service provided the 4 priority clinical standards 7 days a week.

Our national NHS 7 day service survey results for our stroke and heart attack patients showed that we exceeded the national standard except for our stroke patients at a weekend. A third stroke consultant started in September 2017 to ensure acute stroke patients are able to be reviewed twice a day during the week. The Trust is looking to improve the weekend service by the use of telemedicine with the stroke network. This means the ward doctor can seek advice from a specialist stroke consultant 24 hours a day 7 days a week.

Table 18: Proportion of patients who required and received a twice daily review 7 days a week

	September 2016		March 2017	
	Trust	**National mean**	**Trust**	**National mean**
Proportion of patients who required and received a **twice** daily review on a **weekday (Standard = 90%)**	100%	92%	100%	95%
Proportion of patients who required and received a **twice** daily review at a **weekend (Standard = 90%)**	100%	86%	100%	92%

NB: This standard was **not** measured in the September 2017 national survey

Table 19: Proportion of patients who had all vital signs scored and acted upon

Measure	Standard	2016/17	2017/18	2017/18 overall performance
All vital signs scored	95%	96%	97%	⇧
Escalation implemented	95%	83%	81%	⇩
⇧ Better ⇔ As expected ⇩ Worse				

Table 20: Proportion of stroke and heart attack patients who required and received a once daily review seven days a week

March 2017		
	Stroke patients	Heart attack patients
Proportion of patients reviewed by a consultant within 14 hours of admission to hospital on a **weekday (standard = 90%)**	100%	100%
Proportion of patients reviewed by a consultant within 14 hours of admission to hospital at a **weekend (standard = 90%)**	100%	100%
Proportion of patients who required and received a once daily review on a **weekday (standard = 90%)**	96%	100%
Proportion of patients who required and received a once daily review at a **weekend (standard = 90%**)	57%	100%

What our patients and public have told us and what we have done or will do to improve:

- "Had to wait too long for an endoscopy. Five days". We continuously monitor waiting times for all diagnostic tests and procedures so that action can be taken quickly to improve. We do this by arranging extra clinics or procedure sessions when needed.
- "I had an ultrasound over the weekend".
- "I am impressed by tests being done on Sunday".

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

Description of the issue and reason we prioritised it:

Health and care organisations across Bath and North Somerset (B&NES), Swindon and Wiltshire started working together in a new way last year to meet the challenges facing the health and care system. Overall, across the area the standard of health and care services are good compared to other areas in England. However, there are still improvements that need to be made to make sure that these services are the best they can be, both now and in future years. Our A&E Departments are under pressure and in some areas patients are waiting too long for planned care and treatment. There are gaps in quality with some parts of our region benefiting from better health and care services than others. The system is also under increasing financial pressure and we need to make choices over the next five years on how services are provided and the only way to do this, is to work more effectively and efficiently together.

That is why we have joined with other health organisation and local authority partners and other key stakeholders to agree a plan to improve local health and care services. This local plan for better health and care is known as a Sustainability and Transformation plan (STP). It means health care providers, commissioners and the council working together to try and prevent ill health and design services which better meet the needs of our patients.

What we did to improve in 2017/2018:

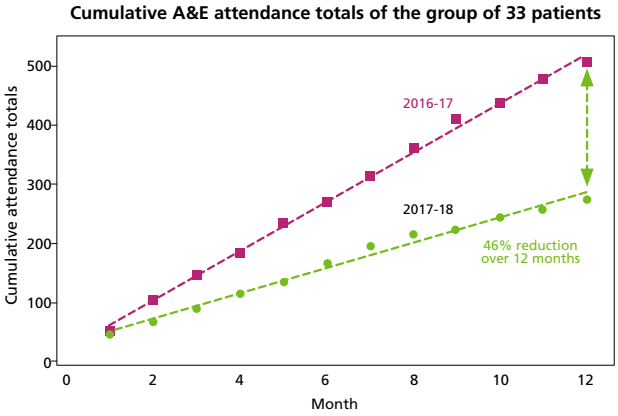
5.1 Worked with our STP partners to improve services for people with mental health needs who frequently attended the A&E Department.

We have worked together with our mental health,

primary care and community partners to improve our understanding of the needs of patients with mental health problems who frequently attended the A&E Department. A specialist team looked in detail at a group of 33 patients who had attended A&E 506 times in 2016/2017. We found that they have complex mental and psychological health needs, physical problems associated with long term conditions or substance abuse and alcohol problems. Specialist teams and GPs have worked with these patients to understand their priorities for care and together have agreed treatment and service preferences written in a personalised care plan.

One patient said *"the care I receive is tailored to my needs and circumstances at that time, and helps me reach my aspirations. It follows any plan I have agreed with support services and covers areas where I need assistance".*

Most of the patients met with a specialist team or GP and had a personalised care plan. The plan supports patients to gain greater control of their own care and transforms their experience from a reactive service, which responds when something goes wrong, to a more helpful proactive approach centred on the needs of each individual patient. The outcome saw a significant reduction of 46% in the number of times these patients attended the A&E Department.



5.2 Increased capacity for ambulatory care as an alternative to the A&E Department to treat patients and support them to go home rather than being admitted to hospital

Ambulatory emergency care enables patients requiring emergency care to be appropriately managed on the same day, either without admission to hospital at all, or admission for only a few hours. The key to success of ambulatory care is rapid assessment, diagnosis and treatment by a senior doctor in the Acute Medical Unit, Surgical Assessment Unit and Paediatric Department. Conditions such as chest pain, abdominal pain, uncomplicated infections and blood clots can all be managed safely in ambulatory care. Nationally, high performing Trusts are those who manage 30% or more of patients with these conditions as ambulatory care. At this hospital, 36% of medical and surgical conditions are managed in this way. In December, our new expanded Acute Medical Unit opened to increase the number of patients benefiting from ambulatory care and make it easier to manage the way emergency patients are treated in the hospital.

5.3 Worked with GPs to set up and offer advice and guidance so that GPs can obtain specialist advice for patients without the need to refer them to hospital.

Advice and guidance is a system which helps GPs to obtain consultant advice for patients with non–urgent problems without the need for an outpatient appointment. Patients are able to benefit from consultant advice within 5 working days of a GP request and if an appointment is needed, preliminary tests can be done before the patient attends the appointment. Our haematology, diabetes, cardiology and burns teams already provide this service. By the end of March 2018, GPs were also able to obtain advice and guidance from our audiology, orthopaedic, oral surgery, maxillofacial and orthodontic, gynaecology, ear nose and throat, ophthalmology, plastic surgery and paediatric teams. GPs are able to access it via the GP Portal at the following link:
http://nww.icid.salisbury.nhs.uk/gpportal_new/

5.4 Worked with GPs to enable them to make first out-patient appointments on the NHS e-referral service by 31 March 2018.

We have worked with GPs and our Clinical Commissioning Groups to enable referrals for a first outpatient appointment to be sent via a new national electronic referral system which must be in place by 1 April 2018, when paper referrals will no longer be accepted. We have made good progress and GPs are now able to refer patients to 100% of our services and clinics using the new system. This helps to reduce delays and improves the uptake of appointments. To reduce waiting lists we have increased the number of appointment slots in some services.

5.5 With our community partners, including care home providers, we mapped and streamlined our existing discharge pathways and designed new ways of proactive and safe discharge from hospital.

In April, we met with our community partners and care home providers to map the patient journey from the point of admission to discharge from hospital. This helped us to identify gaps and processes that

caused delays so that we could take improvement actions to reduce them. The map shows that patients with complex needs are involved with many different professionals which often lead to delays.

We found four key areas for improvement and took the following actions:

1) Reducing delays in prescribing take home medicines – we set standards to ensure that medicines are prescribed by 3.00 pm on the day of discharge. We measured this standard over one week in March 2017 and found 85% of prescriptions were dispensed by 3.00 pm on the day of discharge. We measured it again in September 2017 and found this had reduced to 77% of prescriptions being dispensed within the time frame. The pharmacy team continue to work with doctors to improve the timeliness of writing prescriptions so they are available for dispensing earlier in the day and the day before discharge.
2) Delays in patients making a choice about where to go after leaving hospital – we held education sessions with our staff to raise awareness of the importance of starting discussions about discharge at the point of admission and throughout the patient's stay along with the choices available once a patient is fit to leave hospital.
3) Delays in home care provision - these often occur whilst patients who are fit to leave hospital wait to be assessed for care at home. With our community partners we have introduced 'Home First' which enables patients to go home first, and be assessed the same day by a community professional, who is able to provide short term support and care if needed. In this way, long term care needs can be assessed later when the actual level of care required can be accurately predicted and avoids patients being admitted to nursing homes unnecessarily.
4) Delays in assessment by nursing home providers - patients are often delayed in hospital whilst they wait to be assessed for transfer back to an existing care package at home or to a nursing home. We have started to work with care homes and develop the concept of a trusted assessor who is authorised to carry out an assessment on behalf of care providers with the decision accepted by all. This new process will start in June 2018.

This year, we increased the percentage of patients aged 65 or over admitted as an emergency who were able to return to their home within 3 to 7 days of admission from 38.3% in 2016/2017 to 41.04% in 2017/2018. Delays in home care provision and patient's making a choice about where to go after they leave hospital remain an area for improvement. We will continue to report progress on these areas at the Integrated Discharge Board.

5.6 With Wiltshire Health & Care we introduced an early supported discharge service for patients who have had a stroke so that they can continue their rehabilitation when they get home.

Patients after stroke conventionally have received much of their rehabilitation in hospital. Early supported discharge enables stroke patients to receive their rehabilitation at home with the same intensity and expertise that they received in hospital. This may not be suitable for all patients with a stroke. The decision to offer early supported discharge is made by the specialist stroke team after discussion with the patient and their family or carer. In October 2017, we introduced a new early supported discharge service provided by a team of therapists. Although it is early days, 24 patients have been able to go home 2 to 3 days earlier than before the service was introduced.

What our GPs have told us and what we plan to do to improve:

- "The email advice is really helpful, so good to see this is being continued with the current specialties and expanded to new ones". We plan to offer 75% of our services providing advice and guidance in 2018/2019.
- "I feel very positive about the extension of the email advice service at the hospital being extended to include additional disciplines".
- Frequent A&E attendances of patients with mental health needs – "Where GPs are seeing patients, I have no doubt that for the majority they really benefit". We plan to continue working with GPs and our partners with this work in 2018/2019.

What we did in 2017/2018:

6.0 Care Quality Commission inspection improvement plan progress.

Salisbury NHS Foundation Trust had an announced inspection by the Care Quality Commission in December 2015 against the five domains of safe, effective, caring, responsive and well-led with the Trust rated as good in 27 of the 39 elements. While the inspection report identified areas of both outstanding and good practice across many parts of our services, the overall rating for the Trust was 'requires improvement'.

Since then the Trust has not had either an announced or unannounced inspection. The Medical Director and Director of Nursing meet monthly with the Care Quality Commission regional managers to appraise them of examples of innovative practice, quality improvements and patient feedback, progress and any current or emerging issues.

Table 22: Trust rating for each of the nine core services and for the Trust overall at the Care Quality Commission inspection in December 2015

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Requires improvement	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Spinal Injuries Centre	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

We have taken the following actions to improve in 2017/2018 (the numbered point is the 'must do' action required by the Care Quality Commission and the paragraph that follows is the progress we have made):

6.1 Continued to review nursing and midwifery staffing levels and skill mix every six months to ensure there are sufficient numbers of suitably qualified and experienced nurses and midwives to deliver safe, effective and responsive care and reported this to the Trust Board.

We have continued with our six monthly skill mix reviews to ensure safe staffing levels on all our wards and reported these to the Board. The analysis shows our establishments are set to achieve appropriate staffing levels on our wards. Board skill mix reports in August 2017 and February 2018 can be seen at the following links:

http://www.salisbury.nhs.uk/AboutUs/TrustBoard/AgendaBoardPapersAndMinutesTrustBoard/Documents/3914SkillMix.pdf

http://www.salisbury.nhs.uk/AboutUs/TrustBoard/AgendaBoardPapersAndMinutesTrustBoard/Documents/PaperPackPublicTrustBoardmeeting5February2018f.pdf

We continue to have vacancies, particularly amongst registered nurses and are working hard to recruit permanent staff and reduce our reliance on temporary and agency staff. The Trust has been involved in collaborative work with NHS Improvement (NHSI) As an outcome of that work NHSI said we had 'an excellent grip and control of rostering and deployment of staff despite the vacancy situation'.

6.2 Increased the number of staff who are up to date with mandatory training.

In December 2015, the inspectors found that the Trust was not meeting its target of 85% for the percentage of staff receiving mandatory training. At the end of 2017/2018, 85.4% of staff were up to date with their mandatory training compared to the Trust target of 85%. The clinical directors and education team are working with clinical leaders to improve this further.

6.3 Ensured our staff received an annual appraisal.

The inspectors found that 59% of our staff had received an annual appraisal and 92% of our doctors had received a medical appraisal in December 2015. By the end of 2017/2018, this improved to 84.7% of our non-medical staff having an annual appraisal and 91% of our doctors had received a medical staff appraisal.

6.4 Improved the documentation of care given including care of intravenous cannulas, urinary catheters and patients' weight.

The new nursing assessment and care planning document was launched in February 2018. A space for recording the appearance of intravenous cannula insertion sites has been added to prompt nurses to review the site up to three times a day and take action as needed. Nurses are also required to undertake a nutritional risk assessment and weigh the patient to inform the nutritional care plan. If the patient has a urinary catheter the daily catheter care bundle must be completed.

6.5 Continued to reduce numbers of patients being cared for in mixed sex accommodation.

This year, we have reduced the number of patients being cared for in mixed sex accommodation from 235 patients on 32 occasions in 2016/2017 to 143 patients on 13 occasions in 2017/2018. These only occurred in the ambulatory care bay on the Acute Medical Unit at times of peak pressure and to maintain patient safety. When this does occur mobile screens are used to maintain patients' privacy and dignity.

6.6 Ensured regular checks of resuscitation equipment are undertaken.

We have continued to monitor the daily and weekly checks of resuscitation equipment on all our wards and departments and found a high level of compliance with them.

6.7 Ensured staff adhere to infection prevention procedures.

We have continued to monitor hand hygiene practice which shows a high level of compliance and supported our clinical teams through an education programme in the use of personal protective equipment, such as gloves and aprons. We continue to monitor a range of other infection prevention and control practices, such as the practices of storage and use of clean and dirty laundry and the cleanliness of equipment and the ward environments. Infection control senior nurses undertake observational rounds with each Directorate Senior Nurse and ward based briefings to feedback their findings and improve practice. Flash cards with key messages have been developed to raise staff awareness at briefings.

6.8 Ensured patients are moved a minimal number of times during their stay.

We have continued to monitor the number of times patients are moved during their stay and reported this to the Board. We have found that when the hospital is under pressure patients are moved more frequently than we would like. We are working with our Sustainability and Transformation Partnership (STP) partners to try and reduce the number of patients attending the A&E Department who could receive care by their GP or community services. We have increased the number of ambulatory care pathways and rapid access clinics for GPs so their patients can be seen on the same day or within 48 hours. We have implemented the safer care bundle to ensure that every patient's care and treatment and discharge is managed in a timely manner. We are working with our partners to enable patients who are delayed, once they are fit to leave hospital, are able to do so in a more timely manner.

6.9 Ensured patient charts are kept secure and confidential.

Each ward makes sure that health care records are kept secure in a lockable trolley. Where patient charts are at the bedside they are either kept in a folder or covered with a privacy sheet so that other people are not able to see the information on the chart. This is monitored by the Directorate Senior Nurses during their Confidence in Care rounds of the wards.

6.10 Continued to help staff to understand the risks relevant to their areas of work and ensure they are able to manage these risks effectively.

We continue to work with teams and directorates to ensure that risk registers have breadth, are dynamic and risks are managed effectively and escalated, so the Board is routinely sighted on and involved in the mitigation of key risks.

6.11 Strengthened governance arrangements in A&E and Critical Care.

In the Critical Care Unit, the team have continued to hold clinical governance meetings attended by a team of doctors, nurses, and a pharmacist, to review patient safety indicators, such as infection rates, patient outcomes and patient feedback. The team also review adverse incidents and risks which helps the team identify opportunities to learn and take actions to improve the quality of care.

The A&E Department also hold similar governance meetings and separate mortality and morbidity meetings. The team also review adverse incidents and risks with the Directorate Management Team and escalate high risks to ensure the Board is routinely sighted on and involved in the mitigation of key risks.

6.12 Completed a review of the triage arrangements in A&E to ensure patients are assessed promptly.

The A&E team have tested out a 'navigator' role at the front door of the department to ensure that patients are seen within 15 minutes of arrival. This involves a nurse or paramedic undertaking an initial brief assessment and deciding whether the patient needs to be seen urgently. If so, the patient is moved straight to a triage cubicle for immediate assessment. If the patient is less urgent, such as for a minor injury, the patient can safely remain in the waiting room whilst clinical observations continue to be recorded at regular intervals. In some cases, a GP appointment is the most appropriate course of action, and the navigator can telephone the surgery to make an appointment for the patient. The test has been successful but will end on 31 March 2018. Ongoing arrangements are being considered to ensure patients are cared for safely.

Avon Wiltshire Mental Health Partnership provide the adult mental health team in the A&E department. This year, the hours available in A&E have increased to midnight, seven days a week so that patients who attend with mental health problems can be assessed and managed promptly. Oxford Mental Health Partnership provide the Children and Adolescent Mental Health Service in the A&E department. Children and young people with mental health problems are assessed and managed by a specialist mental health nurse during the week which has improved the timeliness and reduced admissions to hospital. This year a Paediatric Outreach Support Team of specialist nurses was set up to support the A&E Department, Day Surgery Unit and Theatres offering staff, parents and children guidance, support and, where needed, direct clinical care to improve the quality of care experienced by children and their families.

6.13 Approved the policy for the use of the World Health Organisation surgical safety checklist and continue to audit its use and report it to the Patient Safety Steering Group.

Whilst the World Health Organisation surgical safety checklist was implemented some years ago a new policy for its use and team brief was approved by the Clinical Management Board in January 2017. The whole theatre team attend a team brief before the start of the procedure to introduce themselves, share vital information about the patient and discuss any safety issues. The team brief is an opportunity to organise staff, implants and equipment to ensure everything is ready at the start. The sign in phase is carried out when the patient arrives for the procedure. The team check the identity of the patient, consent is valid and surgical markings are in place. This ensures the right patient is having the right operation on the correct side. At the end of surgery the sign out procedure is completed to ensure that instruments and swabs are all accounted for, specimens are labelled correctly and any equipment problems addressed. Theatre teams undertake regular audits which are shown in section 2.1 item 3.10. The audits are reported to the Patient Safety Steering Group.

6.14 Improved the processing of surgical instrument sets to avoid delays.

There has been ongoing work to improve the processing and turnaround of surgical instruments. Actions taken to address this issue have included education of theatre staff in the handling of trays, installing new storage shelving in theatres, the introduction of new transfer trolleys, and specific trays stored in caskets rather than wraps. Our monthly audit data shows this situation has improved significantly.

6.15 Ensured there is a safe pathway for discharging patients after surgery.

No patients have been discharged directly from main theatre recovery since the end of September 2017. The team are able to identify patients at the start of the list who are likely to need an overnight stay. When this is the case, patients are moved to the surgical short stay surgical unit which opened in January 2018 or to the Day Surgery Unit to recover after the operation, and are then discharged later in the day if the patient is well enough to go home.

6.16 Ensured patients are discharged from the Critical Care Unit in a timely manner and during the day.

Patients who are ready to be transferred out of the Critical Care Unit should be moved as early as possible in the day and within 24 hours of the patient being ready to be moved to a ward. This is because, once critical care is no longer needed, it can be psychologically harmful for a patient and their family to remain in the unit. It can also lead to patients being moved during the late evening, the cancellation of planned operations and delayed admissions of critically ill patients. Patients ready to be transferred out to a ward are raised at the twice daily bed meeting. This is to ensure that the most appropriate ward is identified to meet the patient's needs, but it remains a challenge due to Trust wide bed pressures. Monthly data on the timeliness of transfers is reported to the Board. We recognise there is more work to do to improve this and it will be a continued focus of action in 2018/2019.

6.17 Improved the process of booking a bed in critical care for patients requiring elective surgery to reduce the number of cancelled operations.

We have improved the process of booking a bed for a patient who needs a critical care bed after their planned surgery by limiting the number to two patients a day. The team make a joint decision a few days before the patient's operation to be sure that the patient actually needs a critical care bed. During 2017/2018, 49 patients who needed a critical care bed after their operation had surgery completed and were admitted to critical care afterwards. However, since September 2017, 8 patients had their planned operation cancelled because of a lack of a critical care bed. These patients were rebooked within 28 days of the cancellation.

6.18 Reduced the number of spinal injury patients waiting for a video-urodynamic test and outpatient appointment and manage risks appropriately.

In 2016/2017, we reduced the number of spinal cord injured patients waiting for a video-urodynamic test (VUD) from 467 patients to no patients by the end of March 2017 and this has been sustained in 2017/2018. The team did this by asking patients and clinical teams to meet and agree a change to the way care was given so that only patients who needed the test actually received it.

In the same time period, we reduced the number of spinal cord injured patients who were initially identified as waiting for an outpatient appointment from 1024 patients to no patients by May 2017. The team did this by increasing the number of consultant and specialist nurse clinics so more patients could be seen. Currently, we have 128 patients overdue an outpatient appointment from January 2018 and all these patients are currently being booked for an appointment. In response to patient feedback, the team introduced a short stay assessment of up to 5 days so that patients could have a VUD test, a bladder and bowel assessment and clinical psychology support rather than a series of outpatient appointments.

Patient feedback has been excellent. One young patient said: "Since my injury 8 years ago I had numerous problems with my bowels. I tried various remedies but these made me incontinent. This led me to eat very little with the view "the less that goes in, the less can come out". I feared going out, even to the shops because of the fear of incontinence. My life had been on hold. My GP didn't know what to do for the best. My care here has been a "revelation". For the first time my tummy feels normal. I feel I have finally found somewhere that understood me and I feel positive about my future".

In November 2016, the Care Quality Commission inspected the video-urodynamic service and the spinal cord injury out-patient service and reported that the Trust had met the previously reported enforcement notice in full.

6.19 Ensure care and treatment is person-centred to meet the needs and preferences of patients. This includes the availability of suitable activities for patients.

In response to concerns raised by spinal cord injured patients who reported being dissatisfied with the activities on offer in the spinal unit, patients were asked about what they enjoyed and what additional activities they would like provided. Since September 2016 regular events including music, singing, poetry and drama have taken place. A physical activity adviser is in post funded by the charity 'Wheelpower' to help with 'Fitness Friday' and wheelchair sports as well as supporting individual patients with their sport and fitness plans after they go home.

The progress of the Trust's action plan is regularly reported and monitored by the Clinical Governance Committee. The Care Quality Commission will undertake an unannounced inspection of up to four core services that requires improvement and an announced inspection of the well-led domain in 2018/2019. In the meantime, the Care Quality Commission monitor the Trust's performance and quality indicators and publish a quarterly 'CQC Insight for acute NHS Trusts' report. The Medical Director and Director of Nursing meet the regional CQC inspectors on a monthly basis to brief them on areas of excellence and good practice as well as concerns and actions being taken to improve.

Part 2B: This section sets out our quality priorities for 2018/2019

2.1 Our priorities for quality improvement in 2018/2019 and why we have chosen them.

Our quality priorities in 2017/2018 showed a positive picture of improvement in safety and patient experience along with improvements in the care of older people with early senior decision making, ongoing review and early supported discharge. However, more work is required to reduce falls resulting in harm, sepsis screening and treatment of inpatients, along with better identification and management of frailty, delirium and rapid discharge of patients at the end of life who wish to return to their own home to die. Looking forward we have combined the learning from last year with a broad range of methods to gather information and generate our quality priorities in 2018/2019.

Table 23: Care Quality Commission Insight report shows the Trust's composite score is among the highest 25% of acute Trusts to March 2018

Salisbury NHS Foundation Trust

Trust and core service analysis > Trust composite of key indicators

National Guardian Freedom to Speak Up

Insight

FACTS, FIGURES & RATINGS | TRUST AND CORE SERVICE ANALYSIS | FEATURED DATA SOURCES | DEFINITIONS

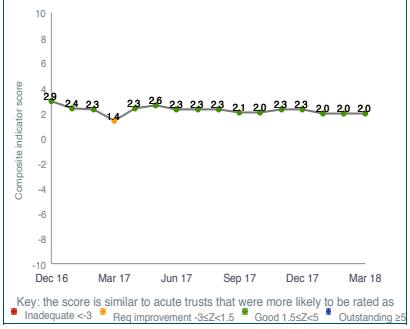
13 March 2018

OVERVIEW | TRUST COMPOSITE INDICATOR | TRUST WIDE | URGENT & EMERGENCY | MEDICAL CARE | SURGERY | CRITICAL CARE | MATERNITY | CHILDREN & YOUNG PEOPLE | END OF LIFE CARE | OUTPATIENTS

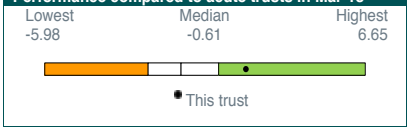
The trust composite is a pilot indicator created from 12 specific indicators within Insight. The composite indicator score helps to assess a trust's overall performance but it is not a rating nor a judgement. The composite should be used alongside other evidence in monitoring trusts.

- The latest trust rating is requires improvement published on 7/4/2016 (last inspection date 01/12/2015)
- This trust's composite score is among the highest 25% of acute trusts

Trust composite indicator score Dec-16 to Mar-18



Performance compared to acute trusts in Mar-18



Indicator	Performance			National comparison
	Previous	Latest	Change	
Patients spending less than 4 hours in major A&E, target 95 (%) NHS England - Monthly A&E SitReps (08 Mar 2018)	83.6% Jan 17	85.5% Jan 18	→	
Flu vaccination uptake (%) Department of Health - HCW Seasonal Influenza Vaccination Programme (07 Jun 2017)	41.7% Sep 15 - Feb 16	59.1% Sep 16 - Feb 17	↑	
Cancelled operations as a percentage of elective activity (%) Department of Health (DH) - Cancelled Operations (QMCO) (01 Mar 2018)	2.4% Oct 16 - Dec 16	1.1% Oct 17 - Dec 17	→	
Advice at the start of labour Care Quality Commission - Maternity survey (29 Jan 2018)	9.5 Feb 15	8.8 Feb 17	↓	
In-hospital mortality: Infectious diseases HES - Mortality (09 Sep 2016)	74.7 Apr 14 - Mar 15	94.4 Apr 15 - Mar 16	→	
Patient-led assessment of privacy, dignity, and well being (%) Information Centre for Health & Social Care (IC) - Patient-led assessments of the care environment (29 Aug 2017)	92.8% Feb 16 - Jun 16	85.6% Mar 17 - Jun 17	↓	
Support from immediate managers (1-5) NHS England - NHS Staff Survey (29 Mar 2017)	3.86 Sep 15 - Dec 15	3.81 Sep 16 - Dec 16	→	
Communication between senior management and staff (%) NHS England - NHS Staff Survey (24 Mar 2017)	42.9% Sep 15 - Dec 15	38.1% Sep 16 - Dec 16	→	
Fairness and effectiveness of reporting (1-5) NHS England - NHS Staff Survey (29 Mar 2017)	3.87 Sep 15 - Dec 15	3.83 Sep 16 - Dec 16	→	
Treatment with respect and dignity CQC - Inpatient survey (30 May 2017)	9.2 Jun 15 - Aug 15	9.3 Jun 16 - Aug 16	→	
Ambulances remaining at hospital for more than 60 minutes (%) NHS Ambulance Service - Ambulance Turnaround Times (07 Mar 2018)	2.1% Jan 17	2.3% Jan 18	→	
Confidence and trust in the doctors CQC - Inpatient survey (30 May 2017)	9.3 Jun 15 - Aug 15	9.4 Jun 16 - Aug 16	→	

These priorities were identified by listening to patient stories at the Board, speaking to patients, families and carers, the public, our staff and governors, Salisbury Branch, Warminster Health, Wellbeing and Social Care Forum, our community partners, local GPs and our commissioners through face to face meetings. Some of their comments are included in this report. Our priorities are also influenced by our need to improve and sustain the 'must do's identified by the Care Quality Commission and NHS Improvement.

We have used information from three national patient surveys published this year (In-patients, A&E Department and Children and Young People) and our staff survey and identified themes from mortality case reviews, complaints and concerns, adverse incidents where we have caused harm and clinical audit to help us decide on our quality priorities.

We have taken into consideration the NHS Five Year Forward View, the Government's Mandate to NHS England 2020 goals and the B&NES, Swindon and Wiltshire Sustainability and Transformation plan to ensure we continue to provide an outstanding experience for every patient. The priorities were considered by the Clinical Governance Committee and recommended to and agreed by the Trust Board.

In 2017/2018, we had five very broad priorities with nearly 40 different work streams. Many of these work streams will continue to be reported in this quality account in sections on our:

- Patient Safety Programme – to reduce avoidable levels of harm
- Mortality – learning from deaths and improvement actions
- Care Quality Commission improvements as an outcome of inspections.

We have reduced our quality priorities to four specific areas where patient safety and experience need to improve:

Our priorities for 2018/2019* are:

Priority 1 – Identify frail older people to ensure they receive effective care and treatment and reduce the number of patients who fall and injure themselves in hospital.

Priority 2 – improve the flow of patients through the hospital to ensure the right patient is cared for in the right place by the right team at the right time.

Priority 3 – improve the recognition and management of deteriorating patients as well as treatment of adults and children with severe infections using Sepsis Six practices on our inpatient wards.

Priority 4 – improve engagement with, and the health and wellbeing of our staff

*These priorities are not ranked in order of priority. The Trust Board agreed the 2018/2019 priorities on 10 May 2018.

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.
http://www.salisbury.nhs.uk/Pages/home.aspx

The following section describes the issue, the reason for prioritising it and what we are planning to do:

Priority 1 – Identify frail older people to ensure they receive effective care and treatment and reduce the number of patients who fall and injure themselves in hospital.

Description of the issue and reason for prioritising it:

It is important that the Trust does everything it can to provide the best possible experience for each and every patient. Frail older people form a significant proportion of emergency admissions. There is a growing need to plan and co-ordinate our services with our community partners so that frail older patients receive an early assessment, treatment and care plan by specialist teams to improve outcomes and reduce the length of time in hospital. We also need to do more to identify patients with delirium to ensure they receive effective care and treatment. We need to continue to reduce the number of patients who fall and injure themselves in hospital and for those at the end of their life who wish to die at home ensure a rapid discharge.

What we will do in 2018/2019.

- Improve the early identification of frail patients and ensure they receive a specialist review and a comprehensive assessment with a personalised care plan.
- Increase the number of frail patients who are able to go home from the A&E Department and Acute Medical Unit with appropriate follow up.
- Introduce a delirium care bundle which is a set of practices designed to improve the early identification of delirium so that patients receive appropriate treatment and care.
- Set up an Older Person's Steering Group with acute and community partners to develop a frailty pathway for timely discharge.
- Continue to work on reducing the number of patients who have preventable falls and fracture their hip in hospital.
- Increase the percentage of patients who have their hip fracture surgically repaired within 36 hours of admission from 78.6% to 90% by March 2019.
- For patients at the end of their life who wish to die at home increase the number of rapid discharges.

How will we report progress throughout the year?

We will report and monitor progress of the care of frail patients to the Older Person's Steering Group. Progress of our falls reduction strategy will be reported to the Clinical Risk Group and patients who wish to die at home at the End of Life Care Strategy Steering Group.

Priority 2 – improve the flow of patients through the hospital to ensure the right patient is cared for in the right place by the right team at the right time.

Description of the issue and reason for prioritising it:

Having a good flow of patients through the hospital is crucial to ensuring that patients are cared for in the right place at the right time by the right people. This improves patient outcomes and enhances patient experience. Over the last few years we have focused on 3 key work streams 1) Improving flow through the A&E Department (improved triage, rapid assessment and treatment) and flow into our ambulatory care areas (by reconfiguring our wards to increase the number of medical beds, expanding the acute medical unit and introducing a new short stay surgical ward, developing a new frailty assessment service and rapid access to outpatient clinics). 2) improving flow through the hospital wards (implementing the SAFER care bundle – a set of practice that reduces delays in a patient's journey) 3) Improving discharge - (set up of an Integrated Discharge Service to support patients and families with complex discharge needs and reducing the number of stranded patients who are fit to leave hospital). We need to do more to make sure patients are cared for on the right ward and are not moved from one ward to another during their stay. This can lead to delays and a poor experience of care.

What we will do in 2018/2019.

- ➢ Ensure patients are seen within 15 minutes of arrival in the A&E Department and divert them to the most appropriate service for their needs.
- ➢ Expand the Older People's Assessment Liaison team (OPAL) to a seven day service so that frail patients can go home earlier and be supported at home.
- ➢ Increase the number of ambulatory care pathways to enable patients to be assessed, treated and discharged on the same day.
- ➢ To measure the impact of the SAFER care bundle which is a set practices to ensure flow is appropriately managed
- ➢ To work collaboratively with our community and social care partners to develop an older persons pathway.
- ➢ Monitor the number of patients who have been in hospital for 7 days or longer and identify opportunities to reduce delays in discharge
- ➢ Working in partnership with care homes to introduce the concept of a trusted assessor to enable a patient to receive one assessment accepted by all providers.

How will we report progress throughout the year?

The work will be monitored and progressed via the Patient Flow Project Management Board which reports to the Outstanding Every Time Group.

Priority 3 – improve the recognition and management of deteriorating patients as well as treatment of adults and children with severe infections using Sepsis Six practices on our inpatient wards.

Description of the issue and reason for prioritising it:

Recognising and responding to clinical deterioration is a key patient safety and quality challenge to improving patient outcomes. A common problem identified in learning from deaths or clinical incidents is failure to recognise or act on deterioration. We plan to introduce the national early warning score which improves the detection and response to clinical deterioration. Severe sepsis is a time critical condition that can lead to organ damage, multi-organ failure, septic shock and death. Rapid diagnosis and treatment are crucial to survival. During 2017/18 we improved screening and treatment using the Sepsis Six practices through our emergency routes but we need to do more to improve screening and treatment of in-patients through an ongoing education and audit programme.

What we will do in 2018/2019.

- ➢ Introduce the National Early Warning Scoring system to standardise practice across the NHS.
- ➢ Undertake a quarterly audit of the recording of clinical observations and escalation of patients who need a review by a doctor and undertake a detailed analysis of patients who are not escalated in a timely manner and take improvement actions.
- ➢ Continue to audit and report the outcomes to the clinical teams on severe sepsis screening of inpatients using the 'sepsis six' pathway.
- ➢ Continue to audit on the percentage of inpatients with severe sepsis who received antibiotics within 1 hour of diagnosis and report the outcomes to the clinical teams.
- ➢ Test interventions to reduce hospital acquired pneumonia on one ward.
- ➢ Audit the compliance with the ongoing catheter care bundle and its effectiveness as measured by the Safety Thermometer.
- ➢ Refresh the profile of sepsis within the Trust including education and training.

How will we monitor and report progress throughout the year?

We will monitor compliance of the recording and escalation of patients who trigger an early warning score through a quarterly audit. We will continue to undertake a monthly audit of screening for sepsis and treatment with antibiotics within an hour of diagnosis and report it to the Sepsis Steering Group. The work of the Sepsis Steering Group is overseen by the Patient Safety Steering Group which reports quarterly to the Clinical Management Board and Clinical Governance Committee as well as our commissioners.

Priority 4 – improve engagement with, and the health and wellbeing of our staff.

Description of the issue and reason for prioritising it:

There is clear research evidence to show that staff who feel engaged and can contribute to improvements and are well supported provide better patient care. Improving the wellbeing of our staff not only improves their quality of life but also our patient's experience of hospital care. We need to do more work to support staff with long term conditions, such as diabetes and arthritis, and improve recruitment using innovative solutions, focus attention on supporting areas with high levels of sickness absence and continue to expand and improve our Shape Up @ Salisbury campaign.

What we will do in 2018/2019.

- ➢ Create a staff engagement group that is representative of every area of the hospital to collect and initiate ideas and innovations that can improve work life balance.
- ➢ As part of our Organisational Development strategy, develop a staff health and wellbeing programme which focuses on self-care, the prevention of ill health and the proactive management and treatment of ill health.
- ➢ Recruit staff into a research study run by Loughborough University into workplace wellbeing, working conditions and health support needs and use the learning to make improvements.
- ➢ Refresh and relaunch the 'Shape Up @ Salisbury' campaign to ensure our staff have access to health and wellbeing services.
- ➢ Continue to work with our partners to train and support our staff to 'make every contact count'

How will we monitor and report progress throughout the year?

Health and Wellbeing work will be led by a working group monitored by the Executive Workforce Committee.

2.2 Statements of assurance from the Board

Review of Services.

During 2017/2018 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 2017/2018 represents 100% of the total income generated from the provision of relevant health services by Salisbury NHS Foundation Trust for 2017/2018.

In April 2017, a new Integrated Governance Framework was introduced which sets out the principal processes by which clinical teams and Directorates report from ward to Board. At the same time, a new Accountability Framework was introduced which outlines how the Trust monitors and manages its own performance and the processes for escalating to the Board to ensure it is routinely sighted on and involved in the mitigation of key risks. One of the three themes of the Accountability Framework is the assessment of the quality of care demonstrated by performance and quality metrics on safety, clinical effectiveness and patient experience. This provides Executive Directors with a clear line of sight on current performance against targets or plan. For the purposes of oversight, each Directorate is assigned a rating of red, amber or green. The overall rating for each Directorate acts as a trigger for escalation or additional support as an outcome of the monthly Executive Performance meetings. This is the mechanism by which all services are reviewed and risks identified and acted upon at an appropriate level in the organisation.

The Clinical Governance Committee is the quality assurance committee of the Trust Board. It is responsible for overseeing the continuous improvement of the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care flourishes. The committee hears directly from clinical teams where risks to quality are identified to seek assurance that action is being taken to improve. Any recurrent themes are included as key objectives for improvement in the Trust service plan or in the Quality Account priorities. Our four quality priorities in 2018/2019 reflect these themes.

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 2017, NHS England undertook a peer review of the Neonatal Intensive Care service. Overall, the review team were impressed with the team working and relationships with other specialities in the Trust, the network, the facilities and the support for families. They praised the team for outstanding breast feeding rates of babies on discharge from the unit (87%) which placed this Trust in the top 4 units in the country for this standard. There were no serious or immediate concerns.

Participation in Clinical Audits

During 2017/2018, 42 national clinical audits and 2 national confidential enquiries covered relevant health services that Salisbury NHS Foundation Trust provides. During this period, Salisbury NHS Foundation Trust participated in 40 (95.2%) national clinical audits, and 2 (100%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries in which Salisbury NHS Foundation Trust was eligible to participate during 2017/2018 are listed in table 24.

The national clinical audits and national confidential enquiries that Salisbury NHS Foundation Trust participated in, and for which data collection was completed during 2017/2018, are listed in table 24 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 24: Eligible national audits and national confidential enquiries and those the Trust participated in during 2017/2018

National Clinical Audit/ Clinical Outcome Review Programme 2016/2017	Eligible	Participation	% of cases submitted	Purpose of the audit
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	100%	To examine the quality of the management of heart attacks in hospital
Adult Cardiac Surgery	No	N/A	N/A	NA
BAUS Urology Audits: Cystectomy	Yes	Yes	100%	To publish surgeon patient outcomes data to improve standards of surgery and help patients make informed decision about their care
BAUS Urology Audits: Nephrectomy	Yes	Yes	100%	
BAUS Urology Audits: Percutaneous nephrolithotomy	Yes	Yes	100%	As above
BAUS Urology Audits: Radical Prostatectomy	Yes	Yes	100%	As above
BAUS Urology Audits: Urethroplasty	Yes	Yes	100%	As above
BAUS Urology Audits: Female stress urinary incontinence	Yes	Yes	100%	As above
Bowel cancer (NBOCAP)	Yes	Yes	100%	Measures the quality of care and survival rates of patients with bowel cancer in England and Wales.
Cardiac Rhythm Management (CRM)	Yes	Yes	100%	Examines the implant rates and outcomes of all patients who have a pacemaker, defibrillators or cardiac resynchronisation therapy implanted in the UK.
Case Mix Programme (CMP)	Yes	Yes	100%	The CMP is an audit of patient outcomes from adult general critical care units.
Child health clinical outcome review programme 2 studies: 1) Chronic neuro-disability 2) Young People's mental health study	Yes	Yes	100%	The studies assessed the quality of healthcare to stimulate improvement in safety and effectiveness by learning from adverse events and other relevant data.
Congenital Heart Disease (CHD)	No	N/A	N/A	N/A

National Clinical Audit/ Clinical Outcome Review Programme 2016/2017	Eligible	Participation	% of cases submitted	Purpose of the audit
Coronary Angioplasty/National Audit of Percutaneous Coronary Intervention (PCI)	Yes	Yes	100%	The aim of the audit is to describe the quality and process of care and compare patient outcomes.
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	To assess the quality of paediatric diabetes care by comparing outcomes to NICE quality and clinical standards.
Elective surgery (National PROMs Programme)	Yes	Yes	2016/17 Pre-op 65.8% vs 75.7% nationally Post-op 62.8% vs 64.8% nationally	Patient reported outcome measures (PROMs) survey patients before and after surgery for the following planned procedures; 1) Groin hernia repair 2) Hip replacement 3) Knee replacement 4) Varicose veins
Endocrine and Thyroid National Audit	Yes	Yes	100%	Outcomes from endocrine surgery.
Falls and Fragility Fractures Audit Programme (FFFAP). 3 studies: 1) Fracture Liaison Service 2) Inpatient falls 3) Hip Fracture	Yes	Yes	Fracture Liaison Service -100% Inpatient falls – 100% Hip fracture – 100%	Fracture Liaison Service: Evaluates patterns of assessment and treatment for osteoporosis and falls across primary and secondary care. Inpatient falls: Evaluates compliance against best practice standards in reducing the risk of falls within hospitals. Hip Fracture: Provides data on the care of patients with fragility fractures and inpatient falls received in hospital to facilitate improvements.
Fractured neck of femur (care in A&E Departments)	Yes	Yes	100%	To identify current performance in EDs against Royal College of Emergency Medicine clinical standards and compare results with other departments.

National Clinical Audit/ Clinical Outcome Review Programme 2016/2017	Eligible	Participation	% of cases submitted	Purpose of the audit
Head and Neck Cancer Audit	Yes	Yes	100%	Aims to improve the quality of services and the outcomes achieved for patients with head and neck cancer in England and Wales.
Inflammatory Bowel Disease (IBD) programme	Yes	No	NA	NA
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	4 cases to 30/11/17	Aims to make improvements to the lives of people with learning disabilities by undertaking case reviews of patients who died.
Major Trauma Audit: The Trauma Audit & Research Network (TARN)	Yes	Yes	54%	Analyses data of trauma care to improve emergency care management and systems.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) 2 studies: 1) Perinatal mortality report of perinatal deaths of babies born in 2015. 2) Perinatal mortality surveillance enquiry – term, singleton, intrapartum stillbirth and intrapartum related death	Yes	Yes	99%	1) Analyses and reports national surveillance data in order to stimulate and evaluate improvements in health care for mothers and babies. 2) Identifies potentially preventable failures of care along the whole care pathway for improvement in care in the future.
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 2 studies: 1) Provision of mental health care in acute hospitals. 2) Non-invasive ventilation	Yes	Yes	100%	Explores the overall quality of care of patients who have died admitted to hospital
Mental Health Clinical Outcome Review	No	N/A	N/A	NA
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes	100%	Improves the quality of hospital care for older patients with breast cancer by looking at the care received by patients with breast cancer and their outcomes.
National Audit of Dementia	Yes	Yes	100%	Measures criteria relating to care delivery which are known to impact on people with dementia admitted to hospital.

National Clinical Audit/ Clinical Outcome Review Programme 2016/2017	Eligible	Participation	% of cases submitted	Purpose of the audit
National Audit of Intermediate Care (NAIC)	Yes	No	N/A	N/A
National Audit of Psychosis	No	N/A	N/A	N/A
National Bariatric Surgery Registry (NBSR)	No	N/A	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%	Audit of in-hospital cardiac arrests in the UK and Ireland.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: 2 studies: 1) Pulmonary rehabilitation 2) Secondary care	Yes	Yes	100%	To drive improvements in the quality of care and services provided for COPD patients.
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	N/A	N/A	N/A
National Comparative Audit of Blood Transfusion programme: 3 studies: 1) Audit of patient blood management in scheduled surgery 2) Audit of red blood cell transfusion in Hospices 3) Audit of red cell and platelet transfusion in haematology	Yes	Yes Yes Yes Yes Yes	1) 100% 2) 0% 3) 100%	Measures compliance with standards related to the recommended use of blood components.
National Diabetes Audit – Adults 4 studies: 1) National diabetes core audit 2) National pregnancy in diabetes audit 3) National diabetes foot care audit 4) National adult diabetes inpatient audit	Yes		100%	Measures the effectiveness of diabetes care compared to NICE guidance.
National Emergency Laparotomy Audit (NELA)	Yes		100%	Compares inpatient care and patient outcomes undergoing emergency abdominal surgery in England and Wales.
National Heart Failure Audit	Yes		100%	Focuses on the clinical practice and patient outcomes of patients discharged following an emergency admission with a primary diagnosis of heart failure

National Clinical Audit/ Clinical Outcome Review Programme 2016/2017	Eligible	Participation	% of cases submitted	Purpose of the audit
National Joint Registry (NJR)	Yes	Yes	99.6%	Data analysis of joint replacement surgery in order to provide an early warning of issues relating to patient safety.
National Lung cancer Audit (NLCA)	Yes	Yes	100%	Measure lung cancer care and outcomes to bring the standard of all lung cancer multidisciplinary teams up to that of the best.
National maternity and perinatal audit	Yes	Yes	100%	Evaluates a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services.
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	Yes	100%	To assess whether babies admitted to the neonatal intensive and special care units received consistent care.
National Neurosurgery Audit Programme	No	N/A	N/A	Neurosurgery is not undertaken at this hospital
National Ophthalmology Audit	Yes	Yes	100%	Assesses key indicators of cataract surgical quality.
National Vascular Registry	Yes	Yes	NA	NA
Neurosurgical National Audit Programme	No	N/A	N/A	N/A
Oesophago-gastric cancer (NAOGC)	Yes	Yes	100%	Investigates whether the care received by patients with oesophago-gastric cancer is consistent with national standards.
Paediatric Intensive Care Audit Network (PICANet)	No	N/A	N/A	Paediatric Intensive Care Unit is not provided at this hospital. Children requiring intensive care are referred to the University Hospital Southampton and transferred by a specialist paediatric retrieval team.

National Clinical Audit/ Clinical Outcome Review Programme 2016/2017	Eligible	Participation	% of cases submitted	Purpose of the audit
Pain in Children (care in A&E Departments)	Yes	Yes	100%	To identify current performance in EDs against Royal College of Emergency Medicine clinical standards and compare results with other departments.
Prescribing Observatory for Mental Health (POMH)	No	N/A	N/A	Applicable to Mental Health Trusts
Procedural Sedation in Adults (care in A&E Departments)	Yes	Yes	100%	To identify current performance in EDs against Royal College of Emergency Medicine clinical standards and compare results with other departments.
Prostate Cancer	Yes	Yes	100%	Data analysis on the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer and their outcomes.
Serious Hazards of Transfusion (SHOT): UK National haemo-vigilance scheme	Yes	Yes	100%	Analyses information on adverse events and reactions in blood transfusion with recommendations to improve patient safety.
UK Parkinson's Audit	Yes	Yes	100%	Outlines the state of Parkinson's services, and highlights areas for improvement.

Salisbury NHS Foundation Trust participated in a number of audits that are not in the Quality Account mandatory list. This activity is in line with the Trust's annual clinical audit programme which aims to make sure that clinicians are actively engaged in all relevant national audits and confidential enquiries as well as undertaking baseline assessments against all NICE guidelines and quality standards. This enables the Trust to compare our performance against other similar Trusts and to decide on further improvement actions. The annual programme also includes a number of audits agreed as part of the contract with our Clinical Commissioning Groups. The Trust took part in the following additional national audits:

- National Audit of Cardiac Rehabilitation
- National Audit of Dementia - Spotlight audit on Delirium
- UK Cystic Fibrosis Registry – Paediatrics
- British Thoracic Society - Paediatric Pneumonia
- British Thoracic Society - Adult Bronchoscopy

The reports of 39 (100%) national clinical audits and national confidential enquiries that were published in 2017 were reviewed by Salisbury NHS Foundation Trust in 2017/2018. Of these, 30 (76.9%) were formally reported to the Clinical Management Board by the clinical lead responsible for implementing the changes in practice, and Salisbury NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided set out in table 25.

Table 25: Examples of national clinical audit reports reviewed during 2017/2018 and examples of resulting actions either taken or planned by Salisbury NHS Foundation Trust.

Audit report	Reviewed by whom	Action taken or required to improve
National Diabetes Foot Care Audit published in March 2017	Clinical Management Board	The audit captures patients who were first seen by the diabetic foot care service with a new wound between July 2014 and April 2016. 185 patients with 202 ulcers were recorded. 55.4% of ulcers were severe compared to 45.6% nationally. Time of assessment within 24 hours - (3% vs 30% nationally), within 2 days (14.4% vs 13.4% nationally), within 3 – 13 days (71% vs 29% nationally). The outcome is the healing rate within 12 weeks (60% healed vs 40% nationally), within 24 weeks (73% vs 59% nationally). In December 2016, our diabetic team set up a 5 day a week foot clinic, but patients are not able to self-present. By February 2018 a telephone triage service was set up to encourage patients to self-present.
National Emergency Laparotomy Audit 2016 – 2nd audit	Clinical Management Board	The 2nd audit results were compared to 1st audit. We submitted more cases (80 vs 52). Timeliness of care all improved - CT scan reported (83% vs 69%), risk documented (74% vs 56%), time to surgery (73% vs 62%). Review by surgeon and anaesthetist pre-operatively (61% vs 65%), consultant surgeon present (92% vs 88% nationally), consultant anaesthetist (69% vs 58%). Critical care post-operatively (66% vs 52%), assessed by elderly care (6% vs 4%), return to theatre (1.3% vs 13%), unplanned critical care admission (2.5% vs 6%), Length of stay post-surgery (9.4 days vs 9.45 days), mortality (12% vs 13.46%). Improvements brought about by greater engagement and consultant led care especially for patients with a mortality risk of 10% or greater. By December 2017 an updated clinical pathway was developed by the team.
Elective surgery (national patient reported outcome measures programme) 2016/17 – published October 2017	Clinical Management Board	In May 2016, 195 patients who had a primary knee replacement responded to a pre and post-operative survey. The outcomes reported health gains slightly below the England average. In August 2016, Healthwatch Wiltshire held a focus group with these some of these patients. The main area for improvement was patient expectation about the need for physiotherapy following discharge. Three improvement actions were completed – patients who needed a physiotherapy outpatient appointment had it made before they left hospital. More information on exercises to do after the operation were discussed patient education session before the operation. An exercise programme App has been developed for patients to record their progress. In November 2017, 93 patients who had a primary knee replacement reported health gains slightly above the England average.

The Trust expects to formally review all national audits at the Clinical Management Board within three 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 national confidential enquiries published during the year. Monitoring of these actions is through the Trust's Integrated Governance Framework or through designated working groups. Examples are given in the table 25.

The reports of 194 (100%) local clinical audits were reviewed by the Trust in 2017/2018 and Salisbury NHS Foundation Trust intends to take, or has taken, the following actions to improve the quality of healthcare provided.

- Paediatric early warning score audit – the audit showed that 95% of children had clinical observations (temperature, heart rate, respiratory rate, oxygen saturations and consciousness level) recorded within 1 hour of admission. Two children required a medical assessment and review within 30 minutes and both received it. 95% of children had their weight recorded but it was not plotted on a growth chart. A growth chart is now displayed in the ward so that staff can record the weight in the notes and plot it on a chart if the child is above or below the expected weight for their age and height.
- Asthma audit – the aim of the audit was to establish whether patients with asthma had a written asthma action plan on how to manage their care on discharge from hospital and as an outpatient. The results showed that 60% of inpatients and 100% of outpatients had a written asthma action plan. The audit also examined whether patients were given an appropriate follow up appointment. 80% of inpatients had a community follow up arranged with the GP within 2 working days and a specialist referral follow up appointment arranged within 2 weeks of discharge. 100% of outpatients had an appropriate follow up arranged with the specialist team and all attended their planned appointment. Improvement actions planned are to test the British Thoracic Society asthma discharge care bundle on Pitton ward and use the learning for Trust wide roll out.
- Acute kidney injury (AKI) audit – the aim of the audit was to ensure that the care bundle document was used in practice and if not used, to ensure that elements making up the care bundle had been followed. The audit showed that the individual elements that make up the bundle are generally well known and implemented across the hospital. Record of urine dipstick results are difficult to find in the healthcare record, although it is clear that clinicians asked for this investigation to be carried out. The current nursing documentation does not prompt for this investigation nor is there a space for the results to easily be recorded. This has been rectified in the new nursing assessment document which was implemented in February 2018 along with specific training sessions. Education regarding the use of the AKI bundle document is ongoing. There will be a particular drive to increase awareness of the care bundle during the new doctors' induction programme at the beginning of August 2018.

Research

The number of patients receiving relevant health services provided or subcontracted by Salisbury NHS Foundation Trust in 2017/2018 that were recruited during that period to participate in research approved by the National Institute for Health Research were 1272 patients into 92 studies. This compares with 1599 patients recruited into 86 studies in 2016/2017.

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 to which our patients are recruited are available at http://public.ukcrn.org.uk/search/. Further information on research activity is in the annual report at http://www.salisbury.nhs.uk/AboutUs/TrustReportsAndReviews/Pages/landing.aspx

Goals agreed with Commissioners

A proportion of Salisbury NHS Foundation Trust's income in 2017/2018 was conditional on achieving quality improvement and innovation goals agreed between Salisbury NHS Foundation Trust and any person or body with whom 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 2016/2017 and for the following 12 month period are set out in the table 26. The planned income through this route for 2017/2018 was £3,756,651 (in 2016/17 it was £3,504,818). The amount the Trust actually earned in 2017/2018 was £3,403,741 (90.6%).

CQUIN contracts were signed with our commissioners during 2017/2018 as part of their overall contract. The Trust did not achieve all of the quality improvements as set out in table 26.

Table 26: Trust performance for all local commissioners CQUIN targets 2017/2018

CQUIN quality improvement target	% achieved*	2017/18 income earned
Improving staff health and wellbeing 1a) Improvement of health and wellbeing of NHS staff.	0%	£0
Improving staff health and wellbeing 1b) Healthy food for NHS staff, visitors and patients	100%	£171,049
Improving staff health and wellbeing 1c) Improving the uptake of flu vaccinations for front line staff	97%	£165,370
Supporting proactive and safe discharge 1) 2.5% increase in discharge to the usual place of residence in Q3 & Q4 2017/18 2) Plans in place to submit the Emergency Care Data Set weekly and 95% of patients have both a valid Chief Complaint and Diagnosis.	1) 100% 2) 95%	1) £440,549 2) £67,468
Reducing the impact of serious infections 1) Timely identification of sepsis in A&E departments and acute inpatient settings. 2) Timely treatment for sepsis in A&E departments and acute inpatient settings. 3) Antibiotic review 4) Reduction in antibiotic consumption per 1,000 admissions	1) 75% 2) 25% 3) 100% 4) 66%	1) £96,215 2) £32,071 3) £128,287 4) £85,525
Improving services for people with mental health needs who present to A&E 1) 20% reduction in A&E attendances of a selected cohort of frequent attenders to A&E in 2016.17 who would benefit from mental health and psychosocial interventions.	100%	£513,148
Offering advice and guidance 1) 75% of GP referrals made to elective outpatient specialties which provide access to advice and guidance.	100%	£513,148
NHS e-referrals 1) 100% of referrals to first outpatient services able to be received through e-RS 2) Slot polling ranges for directly bookable services match or exceed waits for paper referrals 3) Appointment slot issues reduce to 4% or less	100%	£513,148

*Note final payment is subject to official notification of payment from local commissioners

Table 27: Trust performance for NHS England Specialist commissioning CQUINS 2017/2018

CQUIN quality improvement target	% achieved*	2017/18 income earned
CA2 Nationally standardized dose banding for adult intravenous anticancer therapy 1) Local Drugs and Therapeutics Committees have agreed the principle of dose standardization and adjustments required. 2) Target achieved of the number of doses given of selected drugs that match the standardized dose	100%	£283,381
CA3 Optimising palliative chemotherapy decision making 1) Review of current practice in relation to peer decision making and shared decision making 2) Review of current practice in relation to 30 day mortality reviews	100%	£283,381
Armed Forces - Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community 1) Local action plan completion	100%	£111,001

*Note final payment is subject to official notification of payment from NHS England

Further details of the agreed CQUIN goals for Wiltshire, West Hampshire, Dorset, Bournemouth, Poole, Somerset, Southampton City, Isle of Wight and Portsmouth 2017 – 2019 are available electronically at the following link:

www.england.nhs.uk/wp-content/uploads/2016/11/cquin-2017-19-guidance.pdf

Further details of the agreed CQUIN goals for Specialist Commissioning Prescribed Services 2017 – 2019 are available electronically at the following link:

www.england.nhs.uk/wp-content/uploads/2016/11/ca2-nat-standard-dose-banding-adlt.pdf
www.england.nhs.uk/wp-content/uploads/2016/11/ca3-optimis-palliative-chemo-decisions.pdf

Care Quality Commission (CQC) registration

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

Salisbury NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission in 2017/2018. Following an investigation by NHS Improvement into the Trust's financial governance Salisbury NHS Foundation Trust have accepted enforcement undertakings with NHS Improvement.

From 1 October 2016, the Care Quality Commission monitored the Trust under NHS Improvement's new Single Oversight Framework. The Trust is segmented as a Level 2 provider where we are offered targeted support if needed.

Salisbury NHS Foundation Trust had an announced inspection by the Care Quality Commission in December 2015 and their report was issued in April 2016.

The Care Quality Commission has not taken any enforcement action against Salisbury NHS Foundation Trust during 2017/2018.

Table 28: Trust rating for each of the nine core services and for the Trust overall at the Care Quality Commission inspection in December 2015

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Requires improvement	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Spinal Injuries Centre	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Salisbury NHS Foundation Trust has taken action to improve and the progress of these actions are reported in section 2.1 point 6 of this quality report. The Trust will continue to work to improve these areas in 2018/2019.

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 Trust went live with a new electronic patient record and data warehouse at the end of October 2016. The new system has required staff to make significant changes in practice, from the need to enter and maintain accurate information within the patient record, to training staff to better understand the patient pathway and how the various codes and status' should be applied at each point to correctly show the progress of the clinical pathway.

New reporting functions have been put in place, including a daily patient tracking list snapshot, an action list for monitoring the current incomplete pathway position with patient level data, a booking list to keep sight of any booking back logs, and Executive level reports to allow regular operational monitoring of progress.

Salisbury NHS Foundation Trust submitted records during 2017/2018 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 table 29 on following page. 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 29: The percentage of records with a valid NHS number and General Medical Practice code

Data item	Salisbury District Hospital 16/17*	National benchmark 16/17*	Salisbury District Hospital 17/18 at M11	National benchmark 17/18 at M11
Valid NHS number				
% for admitted patient care	99.1%	99.0%	99.7%	99.4%
% for outpatient care	99.6%	99.5%	99.8%	99.6%
% for A&E care	98.4%	96.9%	98.8%	97.4%
Valid General Medical Practice code				
% for admitted patient care	99.9%	99.9%	99.9%	99.9%
% for outpatient care	99.9%	99.9%	99.9%	99.8%
% for A&E care	99.7%	99.2%	99.8%	99.3%

*2016/17 month 11 data was reported in the quality account and is now reported for the full year

Information Governance Toolkit Attainment levels

Salisbury NHS Foundation Trust's Information Governance Assessment report overall score for 2017/2018 was 77% 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 77% in 2016/2017. The Trust achieved the necessary standard for all areas assessed.

Clinical Coding Error Rate

Clinical coding translates the medical terminology written in a patient's health care record to describe a patient's diagnosis and treatment into a standard, recognised code. The accuracy of this coding underpins quality assurance, payments and financial flows within the NHS. Coding software is in place which ensures consistency of coding and provides an audit tool and a suite of data quality reports which enables local improvement actions to be taken. The coding software is embedded in the new electronic patient health care record (Lorenzo) and the coded information is available for clinical teams to view.

Salisbury NHS Foundation Trust was not subject to a payment by results clinical coding audit during the year.

Salisbury NHS Foundation Trust was subject to an external Information Governance clinical coding audit by an independent company during 2017/2018 and the correct coding rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Table 30: Overall results of coding accuracy between 2014 – 2018

Correct % 2014/15	Correct % 2015/16	Correct % 2016/17	Correct % 2017/18	
Primary Diagnosis	99.5%	98%	98.5%	99.0%
Secondary Diagnosis	98.9%	94.5%	95.1%	97.2%
Primary Procedure	96.2%	97.8%	99.7%	98.8%
Secondary Procedure	98.1%	97.9%	95.1%	97.8%

The speciality services reviewed within the sample in January 2018 were Trauma and Orthopaedics, Urology and Ear, Nose and Throat. The results should not be extrapolated further than the actual sample audited.

The following improvement actions were progressed in 2017/2018:

- Testing new software to improve the coding of co-morbidities.
- Senior coders met with the plastics clinical team to improve the coding of 'flaps' and grafts and coding in general.
- Senior coders also met with the Haematology consultants to ensure coding accuracy.
- A designated coder continued to work with the stroke team and the Mortality Surveillance Group to ensure the accuracy of coding.

Salisbury NHS Foundation Trust will be taking the following actions to improve data quality in 2018/2019:

- Meeting with clinicians to discuss full and complete documentation in the case notes and coding to national standards.
- Engaging with clinicians to improve the coding of co-morbidities.
- Increase the number of codes drawn from electronic sources such as Endoscopy database.
- Support the implementation of the Emergency Care Data Set and coding of the SNOMED code set including the chief complaint, diagnosis, acuity, discharging clinician and referral source.

Learning from deaths

During 2017/2018, 841 patients died in Salisbury NHS Foundation Trust. This comprised of the following number of deaths which occurred in each quarter of 2017/2018 set out in table 31.

Table 31: Number of deaths, case record review, investigations,

	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Total
Number of deaths	185	205	211	240	**841**
1st screen		117*	194	218	**529/586 (90%)**
Case record review	60	86	88	68	**302 (36%)**
Deaths with a Hogan score 1 – 3**	0	0	0	0	**0**
Deaths with a Hogan score 4 – 6**	2	10	13	4	**29**
Unexpected deaths	0	0	3	2	**5**
Learning points identified	9	18	20	9	**56**

*From 1 August 2017. **Deaths with a Hogan score of: 1) Definitely avoidable 2) Strong evidence for avoidability 3) Probably avoidable, more than 50/50, but close call 4) Possibly avoidable but not very likely, less than 50/50 but close call. 5) Slight evidence of avoidability 6) Definitely not avoidable.

By 31 March 2018, 529 (90%) of 586 deaths had been screened to ascertain whether each case required a full case review. By 31 March 2018, 302 (36%) case record reviews and 0 investigations (serious incident inquiries) had been carried out in relation to 841 of the deaths included in table 31. In 0 cases was a death subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 60 in quarter 1
- 86 in quarter 2
- 88 in quarter 3
- 68 in quarter 4

0 representing 0% of the patient deaths during 2017/2018 are judged to be more likely than not to have been due to problems in the care provided to the patient based on a Hogan score of 1 – 3.

In relation to each quarter this consisted of:

- 0 representing 0 % for the first quarter.
- 0 representing 0 % for the second quarter.
- 0 representing 0 % for the third quarter.
- 0 representing 0 % for the fourth quarter.

These numbers have been estimated using the Hogan scoring system of 1 – 6 identified in the Hogan (2014): Preventable Incidents, Survival and Mortality Study 2 (PRISM) https://improvement.nhs.uk/uploads/documents/PRISM_2_Manual_V2_Jan_14.pdf

The score of deaths are defined as: 1) Definitely avoidable 2) Strong evidence for avoidability 3) Probably avoidable, more than 50/50 but close call 4) Possibly avoidable but not very likely, less than 50/50 but close call. 5) Slight evidence of avoidability 6) Definitely not avoidable.

The Trust has learnt the following from case record reviews and investigations conducted in relation to the deaths in 2017/2018:

- Failure to recognise a deteriorating patient and escalation for senior review.
- Importance of early senior decision making.
- Over use of urinary catheters leading to infection
- Delays in sepsis treatment in adult inpatients.
- British Thoracic Society guidance on management of exacerbation of chronic obstructive pulmonary disease (COPD) and asthma not consistently followed.
- Inappropriate use of non-invasive ventilation of patients at the end of life.
- Improvements needed in the diagnostic pathway for pancreatic cancer
- Resuscitation status not always discussed in a timely manner.
- Community treatment escalation plans not always in place leading to unnecessary hospital admission.
- Initiating and documenting ceilings of care early and continuing to review the ceiling of care regularly as the patient's condition changes.
- Need to improve documentation of consent, risk and benefits of ward based procedures such as chest drains, lumbar puncture and ascitic taps.

The Trust has taken or is proposing to take the following actions as an outcome of the learning identified from case record reviews in 2017/18.

- Introduction of the national early warning scoring system (NEWS) to standardise recording of clinical observations across the NHS by March 2019 supported by an education programme to ensure appropriate escalation of deteriorating patients.
- Introduce a detailed analysis of patients who deteriorated who were not escalated in a timely manner to drive further improvements.
- Continue to undertake a bi-annual audit of the NHS 7 day survey standard of an initial consultant review within 14 hours of admission.
- Continue to audit the use of the catheter care bundles and report the findings to the Patient Safety Steering Group.
- Monthly audits of sepsis treatment of adult and child inpatients and report the findings to the Patient Safety Steering Group.
- Audit of the use of the COPD admission and discharge checklist and the asthma discharge checklist.
- Consider the introduction of the national ReSPECT form.
- Ongoing education programme for senior doctors and nurses on ceilings of care and resuscitation status.
- Introduction of national safety standards for invasive procedures (NatSSIPs).

The impact of the actions taken in 2017/18:

- A 40% reduction in catheter associated new urinary tract infections.
- A family was involved in the redesign of the pancreatic cancer pathway.
- Sustained 93% of patients being seen and assessed by a consultant within 14 hours of admission.
- Improvement in the quality of end of life care following the introduction in early 2017 of the personalised care framework.

148 case record reviews and 7 investigations of deaths which occurred in 2016/2017 were completed by 2017/2018. These deaths are not included in the total number of deaths in 2017/2018 reported in table 31. The case record reviews were undertaken as a result of CUSUM (or cumulative sum) alerts (statistical quality control measures which alert the Trust to when the number of deaths observed exceeds the number expected in a diagnostic or procedure group) or as a request from the Care Quality Commission to investigate, or as a serious incident inquiry into an adverse incident that caused serious harm or death.

2 representing 1.3% of the 148 patient deaths subject to a case record review as a result of CUSUM alerts in 2016/2017 were judged to be more likely than not to have been due to problems in the care provided to the patient. The number has been estimated using the Hogan method already described in this section.

Of the 7 deaths investigated as a serious incident inquiry which occurred in 2016/2017, 2 were judged to be more likely than not to have been due to problems in the care provided to the patient. These two deaths were graded as catastrophic harm as they met the definition set out in the Serious Incident Framework published by NHS England in March 2015 http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/

Therefore in total, 4 of the patient deaths, representing 2.58% of the 148 case record reviews and 7 serious incident inquiries undertaken in 2016/2017 were judged to be more likely than not to have been due to problems in the care provided to the patient. These deaths were not included in the total number of deaths in 2017/18 reported in table 31.

Reporting against core indicators

This section of the Quality Account provides comparisons of quality standards common to all hospitals.

The standards are set by the Department of Health and the information and data used is from NHS Digital. All data can be found at https://digital.nhs.uk. The standards that are benchmarked are:

- Summary hospital-level mortality indicator
- Patient reported outcome measures
- Emergency re-admissions within 28 days
- Responsiveness to the needs of patients
- Staff who would recommend the Trust to family and friends.
- Patients who would recommend the Trust to family and friends.
- Venous thrombo-emobolism risk assessment
- C difficile
- Patient safety incidents.

Summary Hospital Level Mortality (SHMI)

Table 32 presents the Trust's performance against the SHMI. Salisbury NHS Foundation Trust considers that the SHMI data is as described for the following reasons:

- SHMI is published by NHS Digital and compares the number of deaths in hospital and within 30 days of discharge with expected levels. It is not adjusted for patients admitted for end of life care, for example to Salisbury Hospice. Our SHMI for October 2016 to September 2017 was 109 and is within the expected range. 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. Currently 48.5% of our deaths are patients admitted for palliative or end of life care compared to 28.7% in 2016/2017.

Salisbury NHS Foundation Trust has taken the following actions to improve by:

- In March 2017 the National Quality Board published guidance on learning from deaths which placed a number of new requirements on Trusts:

➢ Board leadership - the Medical Director is the executive lead for learning from deaths and a Non-Executive Director is the lead for oversight of progress.

➢ Publish a mortality review policy – the Trust published its policy which sets out the method for identifying deaths that require review and case record review. The policy is available at the following link:

http://www.icid.salisbury.nhs.uk/ClinicalManagement/OperationalIssues/Pages/MortalityReviewPolicy.aspx

➢ Pay particular attention to the care of patients who die with a learning disability or mental health need. In 2016/2017, five patients with learning disabilities died and these cases were subject to a full case review by a Consultant in Intensive Care Medicine. The overall view was that all cases demonstrated thoughtful, patient and family centred care, led by senior medical and nursing staff and good communication with families every step of the way. End of life care was recognised and the relevant teams involved. None of the deaths were felt to be avoidable. There was one learning point about the balance of risk of a patient at high risk of venous thrombo-embolism without anticoagulation treatment due to a low platelet count. In 2017/18, four patients with learning disabilities died and all these have been reported to the Learning Disabilities Mortality review programme, hosted by the University of Bristol, which aims to guide improvements in the quality of health and social care services for people with learning disabilities across England. None of the deaths were considered avoidable. Two patients with a serious mental illness died in 2017/18. Both cases were subject to a full case review. In one of these cases, a best interests meeting was held about treatment. The death was not considered avoidable and there were no learning points.

➢ Publish information on deaths, reviews and investigations via a quarterly report to a public board meeting. The first report was presented in February 2018 at the following link:

http://www.salisbury.nhs.uk/AboutUs/TrustBoard/AgendaBoardPapersAndMinutesTrustBoard/Documents/PaperPackPublicTrustBoardmeeting5February2018f.pdf

In 2017/18, 302 (36%) deaths had a full case review. The introduction of a first screen has resulted in deaths being screened promptly and appropriately selected for a full case review but also identifies any family concerns at an early stage. It also enables learning from deaths to be implemented in a timely manner and early engagement with families and carers. None of the deaths had a greater than 50% of death being due to problems in care. Themes arising from the learning points were recognising deteriorating patients and acting on it within 30

minutes, recording treatment escalation plans in a timely manner, timely ceiling of care reviews and DNACPR decisions and procedural documentation regarding risks and benefits. Improvement actions are set out in an action plan and progress monitored. The learning is shared via quarterly mortality bulletins and educational events.

➢ Offer timely, compassionate and meaningful engagement with bereaved families and carers. Bereavement support is offered to families and carers of patients who die in the A&E Department, Acute Medical Unit, Intensive Care Unit and Specialist Palliative Care Service. Families and carers are offered the opportunity to talk to the consultant responsible for the care of the patient to help them understand what happened and to be able to ask questions.

Our bereavement suite staff also support families and carers who express concerns at the time of collecting the medical certificate and can be offered an appointment with the clinical team. From 1 October 2017, our bereavement staff started to offer relatives a bereavement survey called 'your views matter'. So far, the results of the survey showed that the majority of people have been very positive about the care and treatment of their loved one. Four people wanted the opportunity to talk further to help them understand what happened and were contacted by specialist nurses. As an outcome, small changes have been made at the Registrar's office in the hospital to ensure relatives have a private room to wait in. One learning point has been the availability of a side room for patients at the end of their life.

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

- Test interventions to reduce hospital acquired pneumonia on one ward in the hospital.
- Undertake a training session with the specialty mortality leads to strengthen the clinical case notes reviews and learning
- Take action on the themes arising from the bereavement survey offered to bereaved families and carers.
- Continue to participate in the West of England Academic Health Science Network mortality work to share best practice and improve learning from deaths.

Table 32: Performance against the Summary Hospital-level mortality indicator (SHMI) core quality indicator

NHS Outcomes Framework Domain	Indicator	2014/15	2015/16	2016/17	2017/18	National average	Highest & lowest average other Trusts 2017/18
Domain 1: preventing people from dying prematurely	SHMI value	107	107	*106	109 to Sept 17	100	113 higher than expected
	SHMI banding	As expected	As expected	As expected	As expected	As expected	88 lower than expected
Domain 2: Enhancing quality of life for people with long term conditions	Percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust.	31.8%	31.9%	28.7%	48.5%	Not available	

* In 2016/2017 SHMI was reported as 104 to September 2016. The full year SHMI was 106 to March 2017.

Patient reported outcomes measures (PROMS)

Table 33 presents the Trust's performance against the PROMS. Salisbury NHS Foundation Trust considers that the PROMs are as described for the following reasons:

➢ PROMs measure health gain in patients undergoing hip and knee replacements, varicose vein treatment and groin hernia procedures in England, based on responses to questionnaires before and after surgery. The responses are analysed by an independent company and compared with other Trusts. The outcomes are published by NHS Digital and on NHS Choices.

➢ The finalised PROMs report in England from April 2015 to March 2016 showed that across all procedures the majority of patients reported that their condition specific problems were much better following surgery. The average health gain was positive for most patients with the exception of groin hernia procedures.

➢ Overall, Salisbury NHS Foundation Trust PROMs provisional data for 2016/2017 shows there were insufficient patients in the groin hernia and varicose vein category to provide a measure of health gain. Patients who had a hip replacement had scores equal to the England average and those who had a knee replacement had scores slightly above the England average.

Salisbury NHS Foundation Trust will be taking the following actions:

➢ Encourage patients to undertake self-directed hip and knee exercises after the operation taught at the joint school before surgery or during their stay in hospital.

➢ Encourage patients to use the App to record their hip and knee exercises after the operation and the progress they have made.

➢ NHS England no longer require Trusts to ask patients having a varicose vein or groin hernia surgery to report their outcomes as the numbers are too small for a meaningful analysis.

Table 33: Performance against the Patient Reported Outcome Measures (PROMs)

NHS Outcomes Framework Domain	Indicator	2015/16**	2016/17*** Indicative	2017/2018	National average April 17 – Sept 17	Highest average other Trusts April 17- Sept 17	Lowest average other Trusts April 17- Sept 17
Domain 3: helping people to recover from episodes of ill health or following injury	Patient reported outcome measures scores for:	Average health gain where full health = 1					
	i) groin hernia surgery	0.220	0.095	From 1 October 2017 NHSE no longer report this data			
	ii) varicose vein surgery	0.173	0.743	From 1 October 2017 NHSE no longer report this data			
	iii) hip replacement surgery	0.424	0.714	NHS Digital indicated there is insufficient data to present on hip and knee replacement surgery in 2017/18			
	iv) knee replacement surgery	0.354	0.359				

**In the quality account 2015/2016 provisional data was presented. The data is now finalised.

*** Data for 2016/2017is indicative. Final data will be available in November 2018.

Emergency re-admissions within 28 days of discharge

Table 34 presents the Trust's performance on emergency re-admissions within 28 days. 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 re-admitted 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 re-admissions within 28 days of discharge to improve the quality of its services:

- Increased ambulatory models of care: these provide timely, accessible, specialist assessment in our Acute Medical Unit, Surgical Assessment Unit and Emergency Gynaecology Clinic. The ambulatory care approach provides crucial support needed for GPs, nurses and therapists working in primary and community care to be able to help patients remain at home and avoiding unnecessary admission or re-admission to hospital.

- Early supported discharge: frail older patients and patients following a hip fracture are able to be discharged from hospital early and allows rehabilitation, support and confidence building to remain at home and reduces re-admissions.

- Follow up telephone calls of patients who have had planned surgery after discharge to ensure their recovery is on track. If a patient requires further support they are offered either a visit at home or an outpatient appointment.

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

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

- We will continue to work with our partners in the B&NES, Swindon and Wiltshire STP to provide suitable pathways and models of care as an alternative to a hospital admission.

- Carry out an analysis to understand the reason for an increase in the adult re-admission rate and take improvement actions where needed.

Responsiveness to the personal needs of patients

Table 35 on the following page presents the Trust's performance on the responsiveness to the personal needs of patients. Salisbury NHS Foundation Trust considers that the mean score of responsiveness to in-patient personal needs is as described for the following reasons:

- Each year the Trust participates in the National In-patient 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. 61% of patients responded to the survey in 2017.

Table 34: Performance of emergency re-admissions within 28 days of discharge

NHS Outcomes Framework Domain	Measure:	2015/16	2016/17	2017/18	National average 2017/18	Highest average other Trusts
Domain 3: helping people to recover from episodes of ill health or following injury	0 to 15	6.14%	6.56%	6.54%	Not available	Not available
	16 or over	5.91%	6.18%	6.39%	Not available	Not available
Indicator: Percentage of patients readmitted within 28 days of discharge from hospital of patient by age group						

- Themes from the National In-patient Survey, real time feedback, the Friends and Family Test, complaints and concerns are identified by each ward and an improvement plan prepared.

- In 2017 we also took part in the national Maternity Survey to collect feedback on women's experiences of the maternity service and improve the quality of care.

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

- Reducing the number of patients in mixed sex accommodation from 235 patients on 32 occasions in 2016/17 to 143 patients on 13 occasions in 2017/18.

- Ensured more midwives were available to provide one to one care of women in labour – women said they felt supported in decision making and made their husband or partner feel part of everything.

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:

- Asking relatives of patients who have delirium or are confused for five key things that matter to that patient and record it in the nursing assessment document so that care can be planned around their preferences.

- Improving communication about discharge arrangements from hospital by agreeing an expected date of discharge with the patient and their family soon after admission.

- Reducing noise at night.

- Developing our Maternity Care Assistants to provide consistent advice on infant feeding and time to listen to women on the postnatal ward and in the community.

Table 35: National inpatient score of responsiveness to the personal needs of patients.

NHS Outcomes Framework Domain	2014/15	2015/16	2016/17	2017/18	National average 2017/18	Highest average other Trusts 2017/18	Lowest average other Trusts 2017/18
Domain 4: ensuring that people have a positive experience of care	7.0	7.3	7.1	6.9*	The national inpatient survey report is not due for release until June 18		
Indicator: Responsiveness to the personal needs of its patients (mean score)							

*Provisional figure until the national inpatient survey report is published in June 18

The Friends and Family Test – Patients

Table 36 and 37 presents the Trust's performance on patients who would recommend the Trust to family and friends. Salisbury NHS Foundation Trust considers the data collected from inpatients and patients discharged from the A&E Department and wards who would recommend them if they needed similar care or treatment is as described for the following reasons:

- The Trust follows the Friends and Family Test national technical guidance published by NHS England to calculate the response rate and the percentage who would recommend the ward or the A&E 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 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 percentage who would recommend every month by ward and department with patient comments and the improvements we have made in response to feedback.

- Displaying the results in wards and departments with 'you said, we did' feedback.

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

- Encouraging our patients to complete the Friends and Family Test in the A&E department and the wards.

Table 36: The response rate of patients who would recommend the ward or A&E department to friends or family needing care

NHS Outcomes Framework Domain	Response rate:	2015/16	2016/17	2017/18	National average 2017/18 (Feb 18)	Highest other Trusts 2017/18 (Feb 18)	Lowest other Trusts 2017/18 (Feb 18)
Domain 4: ensuring that people have a positive experience of care	Wards:	35.9%	28.4%	21.0%	23.9%	100%	3.6%
	A&E:	11.4%	4.1%	3.5%	13%	69%	0%
	Trust Overall:	18.7%	6.6%	5.4%	Not available as Trust overall average		
Indicator: Response rate of patients who would recommend the ward or A&E department to friends or family needing care							

Table 37: Friends and Family test score of patients who would recommend the ward or A&E department to friends or family needing care

NHS Outcomes Framework Domain	Response rate:	2015/16	2016/17	2017/18	National average 2017/18 (Feb 18)	Highest other Trusts 2017/18 (Feb 18)	Lowest other Trusts 2017/18 (Feb 18)
Domain 4: ensuring that people have a positive experience of care	Wards:	95.9%	96.9%	97.1%	96%	100%	82%
	A&E:	94.1%	93.3%	98.3%	85%	100%	67%
	Trust Overall:	96.3%	96.6%	97.7%	Not available as Trust overall average		
Indicator: Score of patients who would recommend the ward or A&E department to friends or family needing care							

The Friends and Family Test – Staff

Table 38 presents the Trust's performance on staff who would recommend the Trust to family and friends. Salisbury NHS Salisbury NHS Foundation Trust considers that the percentage of staff employed by, or under contract to the Trust during 2017/2018 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. All staff are sent a nationally agreed questionnaire and the results are analysed by the Staff Survey Co-ordination Centre. The response rate of our staff survey was 46%. This was above average when compared to other Trusts.

- The Trust has an engaged workforce that is committed to delivering an outstanding experience for every patient.

Table 38: The score of staff employed or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends in the National Staff Survey 2017.

NHS Outcomes Framework Domain	2014/15	2015/16	2016/17	2017/18	Average Median for acute Trusts in 2017/18
Domain 4: ensuring that people have a positive experience of care	4.02	3.91	4.01	3.93	3.75
Indicator: The score (out of 5) of staff employed, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends.					

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

- ➢ Develop our patient and public engagement programme and involve our staff, Healthwatch, Wiltshire and other stakeholders in collecting patient feedback to drive quality improvement.
- ➢ Develop and deliver quality improvement training to 10% of our staff in 2018/19.
- ➢ Embed quality improvement within the culture of the Trust.
- ➢ Continue to develop the staff health and wellbeing programme.

Venous thromboembolism (VTE)

Table 39 on the following page presents the Trust's performance on VTE risk assessment. Salisbury NHS Foundation Trust considers that the percentage of patients admitted to hospital and who were assessed for the risk of VTE (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. The work is overseen by the Trust's 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 VTE to improve the quality of its services:

- Salisbury NHS Foundation Trust continues to be an exemplar site for the prevention and treatment of VTE (blood clots) and has continued to achieve 99.5% of patients being assessed for the risk of developing blood clots and 97.5% 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.

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 VTE and given preventative treatment.

Clostridium difficile infection

Table 40 in the following page presents the Trust's performance C difficile. Salisbury NHS Foundation Trust considers that the rate per 100,000 bed days of cases of C.difficile infection are as described for the following reason:

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

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

- Maintaining and monitoring good infection control practice including hand hygiene, prompt isolation and sampling of patients with suspected C. difficile.
- Maintaining and monitoring standards of cleanliness and taking actions to improve.

- Improved best practice in antibiotic prescribing, a review by the third day of the course and monthly audits of practice.
- In-depth analysis of patients who develop C. difficile infection in hospital to learn and improve.

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

- Continued vigilance through the above actions.
- Designated ward rounds to support doctors in best practice in antibiotic prescribing and review of antibiotics by day three to ensure an appropriate course.
- Ongoing monthly audits of antibiotic prescribing practice and improvement actions. See table 40.

Table 39: The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism

NHS Outcomes Framework Domain	2015/16	2016/17	2017/18	National average 2017/18 (Dec 17)	Highest other Trusts 2017/18 (Dec 17)	Lowest other Trusts 2017/18 (Dec 17)
Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm	99.7%	99.7%	99.4%	95.8%	99.4%	76.1%
Indicator: Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism						

Table 40: The rate per 1000,000 bed days of C difficile infection reported within the Trust amongst patients aged 2 or over

NHS Outcomes Framework Domain	2014/15	2015/16	2016/17	2017/18	National average 2017/18	Highest average other Trusts 2017/18	Lowest average other Trusts 2017/18
Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm	15.3	9.9*	8.4	5.1	Not available as Trust overall average		
Indicator: The rate per 100,000 bed days of C difficile infection reported within the Trust amongst patients aged 2 or over							

*In 2015/16 data was reported incorrectly as 6.6 per 100,000 bed days. The final figure was 9.9 per 100,000 bed days

Patient safety incidents

Table 41 presents the Trust's performance on 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 incidents and sharing the lessons learnt across the Trust and ensuring recommendations are implemented through the Directorate Executive Performance meetings.
- Continuing to monitor the completion of recommendations from reviews at the Clinical Management Board and Clinical Governance Committee.
- Ensuring timely identification of themes, trends and learning.

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:

- Reviewing data from the National Reporting Learning System (NRLS) shows that the Trust has equivocal 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 national staff survey 2017 also showed that the hospital is better than average of Trusts for staff feeling that procedures for reporting errors, near misses or incidents are fair and effective and staff feel confident and secure in reporting errors, near misses and incidents. However, the national staff survey 2017 also showed that we are in the lowest 20% of acute Trusts for the percentage of staff reporting errors, near misses or incidents in the last month. This is also shown in the rate of patient safety incidents reported within the Trust between

Table 41: The rate of patient safety incidents reported within the Trust and the percentage of such incidents that resulted in severe harm or death

NHS Outcomes Framework Domain	Indicator	2015/16	*2016/17	2017/18 (Apr–Sep 17)	Median for acute (not specialist) organisations 2017/18 (Apr–Sep 17)
Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm	The number and rate of patient safety incidents reported within the Trust.	40.39 incidents per 1000 bed days	*46.01 incidents per 1000 bed days	41.99 incidents per 1000 bed days	Not available
	The number and percentage of such incidents that resulted in severe harm or death	11 incidents 0.2%	*37 incidents *0.53%	10 incidents 0.12%	Not available

* In the quality account 2016/17 data was only available from 1/4/2016 to 30/9/2016 and the rate of patient safety incidents. Data was reported as 47.68 incidents per 1000 bed days and the number and percentage of such incidents that resulted in severe harm or death was reported as 19 incidents and 0.5%. The full year 2016/2017 is now reported.

1 April 2017 and 30 September 2017. We will do more to encourage staff to report adverse incidents and near misses in 2018/2019 using education sessions and social media.

Duty of Candour

As part of our ongoing commitment to promoting a learning culture we have implemented the statutory Duty of Candour when patients suffer moderate or severe harm. Whilst our staff have always complied with their professional duty of candour, the statutory duty requires clear documentation of our explanation and an apology followed up by a letter. This year we have continued education sessions with many of our clinical teams and departments on how staff should comply with the Duty of Candour and also held Trust-wide learning events. We have provided learning resources for our staff and support from the quality team to enable our clinical teams to exercise their Duty of Candour.

Part 3: Other information

Review of Quality Performance

This section gives an overview of the quality of care offered by Salisbury NHS Foundation Trust based on performance in 2017/18 against a range of selected indicators on 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.

Table 42: Trust performance of patient safety, clinical effectiveness and patient experience indicators

Patient Safety Indicators							
Indicators	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**National average**	**What does this mean?**	**Data source**
1a.Mortality rate (HSMR)	108	110	*117	106.9 (Dec 17)	100	Lower than 100 is good	National definition of HSMR & SHMI
1b. SHMI	107	107	*106	109 (Sept 17)	100		
2. MRSA notifications**	2	0	0	0	0 (Jan–Dec17)	0 is excellent	National definition
	(5)	(2)	(2)	0			
3. C. difficile infection per 1,000 bed days							
a. Trust and non-Trust apportioned	0.19	0.13	0.12	0.12		Lower than national average is good	National definition
b. Trust apportioned only	0.15	0.10	0.08	0.05			
4. 'Never events' that occurred in the Trust****	2	2	2	3		0 is good	National Patient Safety Agency
	These were associated with surgery		1 related to surgery, 1 with an insulin device	These were associated with surgery			
5. Patient falls in hospital resulting in a fracture or major harm						Lower number is good	

Clinical Effectiveness indicators							
6. Patients having surgery within 36 hours of admission with a fractured hip	87.1%	86.0%	81.7%	78.6%	90%	Higher number is good	National definition with data taken from hospital system and national database
7. % of patients who had a risk assessment for VTE (venous thromboembolism)	99.1%	99.7%	99.7%	99.5%	90%	Higher number is better	
8. % patients who had a CT scan within 12 hrs of admission with a stroke	within 12 hours						
	96.9%	98.3%	98.7%	97.8%	Not available	Higher number is better	
9. Compliance with NICE Technology Appraisal Guidance published in year	73%	61%	80%	90%	Not measured	Higher number is better	Local indicator
Patient experience indicators							
10. Number of patients reported with grade 3 & 4 pressure ulcers	4	4	3	3	Not available	Lower number is better	National definition (data taken from hospital reporting systems)
11. % of patients who felt they were treated with dignity and respect							
a. Yes always:	83%	86%	88%	85%	Not available	Higher number is better	National in-patient survey
b. Yes sometimes:	15%	13%	10%	12%			
12. Mean score of patients' rating of quality of care #	8.3	8.4	8.2	8.2##	Not available	Higher number is better	
13. % of patients in mixed sex accommodation	11%	9%	9%	6%	Not available	Lower number is better	
14. % of patients who stated they had enough help from staff to eat their meals	68%	68%	68%	67%	Not available	Higher number is better	
15. % of patients who thought the hospital was clean	70%	73%	71%	69%	Not available	Higher number is better	

* In 2016/2017 HSMR was reported as 116.4 to January 2017. The full year rate was 117. In 2016/2017 SHMI was reported as 104 to 30/9/2016. The full year rate was 106.

** 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.

**** 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 national never events list increased from 8 to 25 on 1 April 2011.

The patient safety indicator name has been changed from 2013. 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. 8.2## to be confirmed on publication of the 2017 national inpatient survey results.

NHS Improvement Single Oversight Framework 2017/18

Indicators

Table 43: Trust performance indicators

Measure	2016/2017	2017/2018	Standard
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	91.4%	91.3%	92%
A&E maximum waiting time of 4 hours from arrival to admission/ transfer/ discharge*	90.8%	*93.59%	95%
All cancers: 62 day wait for first treatment from: - Urgent GP referral for suspected cancer - NHS Cancer Screening Service referral	 87.2% 92.6%	 86.0% 86.3%	 85% 90%
C.difficile: variance from plan	13 Trust apportioned cases Variance - 6.	8 Trust apportioned cases Variance -11	Upper limit of 19 cases
Summary Hospital-level Mortality indicator	106 as expected	109 as expected (Sept 17)	100 or lower
Maximum 6 week wait for diagnostic procedures	98.3%	98.7%	99%
Venous thromboembolism (VTE) risk assessment	99.7%	99.5%	100%

*This includes Type 1, 2, & 3 A&E attendances from 1 April 2017.

Type 1 = Attendances to the A&E department at Salisbury District Hospital

Type 2 = Attendances to the A&E department (Ophthalmology) Outpatient Clinic at Salisbury District Hospital

Type 3 = Attendances to the Salisbury Walk-in Clinic (offsite) and to the Hotkidz Clinic (offsite). Type 3 data is outside the scope of the Trust's external audit.

**Type 1 & 2 are under the management of Salisbury NHS Foundation Trust and the performance of the Trust only is 92.36%.

Table 44: Type 1, 2 and 3 attendance to the A&E Department

2017-18	Performance
Type 1	91.79%
Type 1+2	**92.36%
Type 1+2+3	93.59%

Part 3: Annex 1

Statement from Wiltshire Clinical Commissioning Group on Salisbury NHS Foundation Trust 2017 - 2018 Quality Account – 14 May 2018

NHS Wiltshire Clinical Commissioning Group (CCG) has reviewed Salisbury Hospital NHS Foundation Trusts' (SFT) 2017-18 Quality Account. In doing so, the CCG reviewed the Account in light of key intelligence indicators and the assurances sought and given in the bi-monthly Clinical Quality Review Meetings attended by SFT and Commissioners. This evidence is triangulated with information and further informed through Quality Assurance visits to SFT. The CCG supports the Trusts' identified quality priorities for 2018-19. To the best of our knowledge, the report appears to be factually correct.

It is the view of the CCG that the Quality Account reflects the Trusts' on-going commitment to quality improvement and addressing key issues in a focused and innovative way, as well as utilising the nationally set CQUIN schemes to support the achievement of many of the 2017-18 quality priorities. The Trust priorities for 2017-18 have outlined achievement in keeping patients safe from avoidable harm through the 'Sign Up To Safety' Quality Improvement work streams, and continue to demonstrate notable performance in the reduction of avoidable infections, particularly in C.difficile rates and zero (0) cases of MRSA for three consecutive years. The CCG welcomes the additional focus in 2018-19 on improving the recognition and management of deteriorating patients, through the planned implementation of NEWS2. We anticipate that through a focused work stream and supported through CQUIN monies, the Trust will improve its performance in screening and administering antibiotics within inpatient settings.

The CCG acknowledges the good work undertaken during 2017-18 to reduce the Hospital Standardised Mortality Ratio (HSMR) in 2017-18. The Trust has demonstrated that mortality reviews continue to be a priority area, further supported through the introduction of a review process for patients who have died in hospital. The CCG also welcome the Trusts' contribution to the national LeDeR programme.

The Trust has demonstrated it's continued to focus towards the elimination of mixed sex accommodation breaches. The CCG undertook a visit to AMU and was satisfied that the Trust had put appropriate mitigations in place when mixed sex breaches are unavoidable, during times of escalation and increased activity. During 2017-18, the Trust has seen a decrease in the number of patients who fell in hospital which resulted in a fracture, but have recognised that this needs to be a continued area of focus and will continue the improvement work as part of the frailty work stream in to 2018-19.

Wiltshire CCG acknowledges the increasing demand on the Trusts' Emergency Department (ED) and are keen to support the Trust in the implementation of the patient safety 'SHINE checklist' to ensure that the quality, safety and experience of patients in ED is maintained in periods of increased demand and throughout the year.

The CCG welcomes the continued focus on improving patients' experience; and in particular the emphasis on the experience of those who are frail, patients with dementia, carers, and people with Mental Health problems. The 2017-18 staff survey has identified a slight decline in the numbers of staff who would recommend the Trust as a provider of care to their friends and family. As a result of this, the Trust has responded by developing a number of actions, which include developing the staff health and wellbeing programme, and delivering quality improvement training to 10% of their staff. Recruitment of staff continues to be challenging for all providers, and the Trusts' effort to reduce the reliance on temporary and agency staff and increase the number of permanent staff employed by the Trust is welcomed.

The Trust has identified areas of improvement and learning required within serious incidents. Of particular relevance are those related to the timely diagnosis of cancer, and the Trust is providing the CCG with assurance on how they are addressing this area of improvement through both clinical governance and administrative process review.

Wiltshire CCG is committed to ensuring collaborative working with Salisbury NHS Foundation Trust to achieve continuous improvement for patients in both their experience of care and outcomes.

Statement from West Hampshire Clinical Commissioning Group on Salisbury NHS Foundation Trust 2017 - 2018 Quality Account – 14 May 2018

West Hampshire Clinical Commissioning Group (CCG) would like to thank Salisbury NHS Foundation Trust (SFT) for the opportunity to review and provide a response to the 2017/18 Quality Account. It is encouraging to see from the beginning of the quality account that the Trust is clear that providing high quality care to patients is their number one priority. This is demonstrated through the progress with the quality priorities for 2017/18 and the selection of new priorities for quality improvement for the next year 2018/19.

The Trust has previously acknowledged that in relation to their recorded mortality rates, and in particular the Hospital Standardised Mortality Rate (HSMR), their rate has been beyond the expected range within the year. The CCG would like to acknowledge the significant work that the Trust has undertaken over the last 12 months and the corresponding measurable reduction in this particular measure of mortality. The CCG has continued to receive regular updates on the Trust's work in relation to this area and has also seen the progress that has been made in regards to the introduction of the national structured mortality tool and ensuring that all relevant learning is captured following the review of patients who die in hospital.

One of the Trust's priorities for 2017/18 was to focus on the reduction in the number of patients who have preventable falls and fracture their hip. It is clear that this has been a challenging target for the Trust and although there has only been a slight improvement in the number of hip fractures, the overall rate of fractures in hospital has decreased significantly. The CCG has been encouraged to see the ongoing development of the Falls Reduction Strategy Action Plan and the improvements with the risk assessment of patients in the hospital and commends the Trust for its support of the Hampshire falls forum collaborative. We support the Trust's ongoing focus on this priority and are looking forward to seeing a continued reduction in the number of patients who have a preventable falls over the next 12 months.

The Trust continues to perform well against the NHS England set objective of 19 or fewer cases of Clostridium Difficile infection for 2017/18, and it has been confirmed that no patients have experienced a MRSA blood stream infection since April 2016. The significant reduction in use of specific broad spectrum antibiotics underlines the Trusts commitment to prudent prescribing and reducing antimicrobial resistance.

The CCG has continued to monitor the progress of the Trust in reducing the number of mixed sex accommodation breaches and was pleased to see that for the first nine months of 2017/18 no patients were affected by such a breach. Although there have been a number of breaches declared during a period of high demand for emergency and urgent care at the beginning of the year, it is evident that a number of actions have now been put in place to protect patients' privacy and dignity. The CCG is assured that this will remain a priority focus for the Trust in the coming year.

The ongoing focus for 2018/19 on the management of deteriorating patients and prompt identification and treatment of patients with sepsis is welcomed and the CCG recognises that the Trust has performed well in the screening and management of patients with potential serious infection. The CCG is supportive of the Trust's plan to adopt the National Early Warning Score System and is looking forward to see how this will benefit patients by enabling a "common language" across a wide range of healthcare providers both within and outside of the hospital environment.

The CCG would also like to positively recognise the response that the Trust has shown to the recent major incident, which has resulted in extensive and intense external interest, with the professionalism and commitment of all staff widely acknowledged.

Overall West Hampshire Clinical Commissioning Group is satisfied that the plans outlined in the Trust's quality account will maintain and further improve the quality of services delivered to patients and the CCG looks forward to working closely with the Trust over the coming year to further improve the quality of local health services.

Statement from Wiltshire Council on behalf of Councillor Jerry Wickham, Cabinet member for Adult Social Care, Public Health and Public Protection – 16 May 2018

Wiltshire Council thanks Salisbury NHS Foundation Trust for the opportunity to read and comment on the 2017/18 Quality Account. The review shows tremendous success across the hospital, not just in clinical care, but social support, prevention and early intervention. The vision of the Trust is clear and patient focused, this commitment is highlighted through the existing priorities and future direction. The success is amplified by the number of patients who would recommend the Trust through the Friends and Family Test. Positive feedback is also noted by staff and there is a clear plan for building on this further through a public engagement programme.

The hospital continues to engage with a range of public health initiatives and Smoking, England's biggest cause of preventable deaths has a dedicated section. This and consideration of other causal factors demonstrates a proactive commitment to improving outcomes for patients; preventing stay's in hospitals, making stays healthier through healthier food and drink choices for patients and visitors, a clear example of this is on sugar free drinks. Calorie levels are considered in snacks and this extends to sandwich fillings, already having an 88% of drinks being sugar free and the ambition to make this to 100% will really help the reduction in sugar intake. The role out of Making Every Contact Count training with staff and supporting this approach further with Specialist Nurses undertaking Health Coaching, is further demonstration of SFT's looking for opportunities to provide a holistic approach to care and prevention of escalation of ill health.

Care across the lifecourse is demonstrated through other key Public Health priorities captured in data showing the outcomes of smoking cessation services with pregnant women with 22.7% of women stopping smoking during their pregnancy. Through to a focus on reducing falls in the elderly whilst in hospital, the interventions here have achieved a 15% reduction. To the global priorities such as tackling the increasing risks of antimicrobial resistance and great progress with a 2% reduction in antibiotic prescribing.

The review presents the Trust as a learning organisation and the improvements made on the recommendations following serious incidents. The stand out area being that of timely diagnosis of cancer. Ongoing assessment of performance on this and other conditions are clearly stated in the Clinical Outcome review.

The area that is absent from the report, is sexual health. As this is the main area commissioned by the local authority and SFT is the lead provider it would be good to see some of the successes highlighted here, such as, availability and promotion of long acting reversible contraceptive methods, structured clinics to ensure sexual health and contraceptive needs can be met at the same time, reducing late diagnosis of HIV and increasing access to point of care testing. In the absence of the detail, as the commissioning authority I can vouch for a dynamic and progressive service, who is fully engaged with the local partnership and the commitment to improving the sexual health of the local population.

We know, and what is acknowledged throughout the review is the best outcomes for residents will be best achieved through a system wide approach to care. This is embodied in the joint working across the Trust and community teams. This is achieved through close partnership working and inclusion of the patient's voice and how they benefit from home based rehabilitation. The Trust are an intellectual partner to the STP and through this agenda work with partners towards greater integration and joint planning and working. The pressures across both the NHS and those of social care cannot be tackled in isolation of one another, but the pressures need to be understood from all sides, those that come from physical illness as well and mental health and social needs. The Trust, through this review shows that it plays a vital role in a complex agenda of improvement whilst under increasing financial pressure and constraints. The Trusts engagement in these partnership and joint working platforms engenders change and services coming together to solve a collective issue of increased and increasing demand against a framework of shrinking resources.

Any feedback this year cannot pass without the acknowledgement of the extraordinary work of the hospital caring for the people affected by the nerve agent attack. The contribution the hospital made during this incident is impressive and significant; not just the remarkable care to the patients leading to such a positive outcome, but also their engagement in the wider emergency planning response.

Wiltshire Council acknowledges the huge amount of work that has taken place over the past year and that the plans outlined have the aim of continuous improvement. The wider Council and in particular Adult Social Care and Public Health looks forward to working together over the coming year for further improvement to health and social care services and outcome for residents.

Statement from Healthwatch, Wiltshire – 11 May 2018

Healthwatch Wiltshire welcomes the opportunity to comment on Salisbury NHS Foundation Trust's quality account for 2017/18. Healthwatch Wiltshire exists 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 Salisbury NHS Foundation Trust to ensure that patients and the wider community are appropriately involved in providing feedback and that this feedback is taken seriously.

We are pleased to see the continued progress made by the Trust on the areas highlighted by the Care Quality Commission's inspection dated December 2015. We also acknowledge the work done by the Trust to reduce the number of falls resulting in harm by the introduction of a new risk assessment. We recognise the Trust commitment to keeping patients safe from avoidable harm by the engagement in the 'Sign up to Safety' initiative.

Progress made in areas of Priority 2 'Ensuring patients have an outstanding experience of care is acknowledged and we welcome some of the initiatives, including the introduction of the Older People's Assessment and Liaison team, tasked to spot frailty, undertake specialist assessments and carry out personalised care planning enabling some patients the opportunity of going home the same day. It is good to see the Trust has proactively asked patients and carers to provide feedback.

We are pleased that the Trust has made progress on discharging people safely and applaud their joint work with community teams and providers to enable this. Healthwatch Wiltshire has had the pleasure of working with the Trust and Wiltshire Health and Care to evaluate the new Home First service which aims to support patients medically fit for discharge to get home whilst rehabilitation and care planning can be take place. Feedback received from patients, their carers and staff

delivering this service has been overwhelmingly positive and we commend the work of the Trust and its partners in enabling better patient flow.

We have been welcomed onto hospital wards to talk directly to patients going through the discharge process and staff supporting them, specifically around their choices. Feedback has suggested that for patients who are facing a 'simple discharge' process staff are very proficient at involving patients in making decisions in advance of them being discharged and organising equipment, transport and medication. Challenge arises when patients are being supported through more complex discharges.

Healthwatch Wiltshire was also pleased to be asked to support and facilitate an independent review of the Trust's Early Supported Discharge service for patients with a fractured neck of femur. We worked with the therapies team to engage patients who had been through this new service. Feedback suggested that patients wanted to be supported to go home from hospital as soon as possible and were very pleased that the quantity and quality of support provided by the ESD team enabled them to do this.

It is positive to note the number of patients who would recommend the Trust's care under the Friend and Family Test. We note the Trust's plan to increase the number of staff who would recommend the hospital as a place to work and its action to develop a patient and public engagement programme. We are pleased that the Trust will be looking to work with Healthwatch Wiltshire on this.

Healthwatch Wiltshire would like to thank the Trust for enabling us to carry out the various engagement projects which we have undertaken this year. We also acknowledge the enormous pressure the Trust has been under in light of nationally recognised pressure and the major incident that took place in Salisbury earlier this year. We look forward to continuing working with the Trust over the coming year to enable patients and their carers to feed back on their care and have a voice in the evaluation of services.

Statement from the Governors – 14 May 2018

Our statement last year began "the last year has been as difficult for the NHS as any we can remember." For our Trust the year has been yet more difficult. We refer in particular to the problems caused by the influx of patients in December and January, the unique difficulties posed by the Skripal incident, and last but most important the action by NHSI requiring undertakings from the Trust in relation to its finances. Nonetheless despite severe restraints on staff numbers the quality of care provided throughout the Trust has been high, particularly the nursing care. That is a great tribute to our staff. Meanwhile, like most other Trusts, the Trust is undergoing a fundamental rethink about how it goes about its business. As the quality account sets out there are many areas where the Trust has achieved improvements, and of course some, where further work is required. In the background lies the on-going difficulties of recruiting clinical staff, difficulties which face all Trusts, to which our Trust is directing particular effort.

The governors have been given an opportunity to provide feedback on the Quality Account in draft and to make suggestions. But they are not in a position to provide a detailed critique of it. The contents are largely prescribed by Regulations and by NHSI. The governors find no reason to question the factual accuracy of the report. We endorse the priorities provided for 2018/9. We suggest for the future that, where comparisons are made between years, it would give a better idea of the underlying trend to include the two or possibly three previous years rather than just the previous year.

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.

Part 3: Annex 2

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. NHS Improvement 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 2017/2018 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 2017 to May 2018.

- Papers relating to quality reported to the Board over the period April 2017 to May 2018.

- Feedback from commissioners dated 14 May 2018.

- Feedback from governors dated 14 May 2018.

- Feedback from Healthwatch, Wiltshire dated 11 May 2018.

- Feedback from Wiltshire Council Overview and Scrutiny Committee dated 16 May 2018.

- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 3 April 2017, 7 August 2017, 2 October 2017, and 5 February 2018.

- The 2017 national staff survey dated 7 March 2018.

- The Head of Internal Audit's annual opinion of the Trust's control environment dated 23 May 2018.

- The Care Quality Commission inspection report for Salisbury NHS Foundation Trust dated 7 April 2016.

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

- The performance information reported in the quality report is reliable and accurate;

- There are proper 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 data underpinning the measures of performance reported in the quality report is robust and reliable and conforms to the specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The quality report has been prepared in accordance with NHS Improvement's annual reporting manual 2017/18 and supporting guidance (which incorporates the Quality Accounts regulations) published at https://improvement.nhs.uk/resources/nhs-foundation-trust-annual-reporting-manual-201718/ as well as the standards to support data quality for the preparation of the quality report (available at https://improvement.nhs.uk/resources/nhs-foundation-trust-annual-reporting-manual-201718/)

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

By order of the Board

Nick Marsden
Chairman
22 May 2018

Cara Charles-Barks
Chief Executive
22 May 2018

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 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

1 percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

2 percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

We refer to these national priority indicators collectively as the 'indicators'.

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 NHS Improvement.

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 and supporting guidance

- the quality report is not consistent in all material respects with the sources specified in the "Detailed requirements for external assurance for quality reports 2017/18" issued by NHS Improvement in February 2018; and

- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the "NHS foundation trust annual reporting manual" and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance on quality reports."

We read the quality report and consider whether it addresses the content requirements of the "NHS foundation trust annual reporting manual" and supporting guidance, 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 the following:

- board minutes for the period April 2017 to May 2018
- papers relating to quality reported to the board since April 2017
- feedback from Wiltshire CCG (lead commissioner), dated May 2018
- feedback from governors, dated May 2018
- Feedback from Healthwatch Wiltshire in May 2018
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
- the 2016 national inpatient survey
- the 2017 national staff survey
- Care Quality Commission inspection, dated April 2016
- the Head of Internal Audit's annual opinion over the Trust's control environment

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Salisbury NHS Foundation Trust as a body, in reporting Salisbury NHS Foundation Trust's quality agenda, performance and activities.

Use of our report

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Salisbury NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) "Assurance Engagements other than Audits or Reviews of Historical Financial Information", issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- testing key management controls
- limited testing, on a selective basis, of the data used to calculate the indicator against supporting documentation
- comparing the content requirements of the "NHS foundation trust annual reporting manual" to the categories reported in the quality report
- 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.

Limitations

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 that 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" and supporting guidance.

The scope of our assurance work has not included governance over quality or non mandated indicators, which have been determined locally by Salisbury NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

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

- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for external assurance for quality reports 2017/18; and

- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Greg Rubins
For and on behalf of BOO LLP, appointed auditor
Southampton
23 May 2018

NHS
Salisbury
NHS Foundation Trust

Annual Report and Accounts 2017 to 2018

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