Trust Board Meeting in Public
Monday 5 February 2018
1.30 pm – 4.45 pm
Board Room, Salisbury Foundation Trust

Timings	Agenda		SFT ref	Presenter	Page
	Opening Business				
1.30	**1.**	Patient/Staff Story		LW/Pres	
1.50	**2.**	Apologies and Declarations of Interest: / Fit & Proper/ Good Character (Apologies: Michael von Bertele)		NM	verbal
1.55	**3.**	Minutes of the Trust Board meeting held on 4 December 2017		NM/Enc	3
2:00	**4.**	Action Log and Matters Arising		NM/Enc	16
2.05	**5.**	Chairman's Business		NM	verbal
2:15	**6.**	Chief Executive's Report	SFT3983	CC-B/Enc	18
	Assurance and Reports of Committees				
2:30	**7.**	Workforce Committee Report –22 January 2018	SFT3984	PH/Enc	23
2:35	**8.**	Clinical Governance Committee Report – 25 January 2018	SFT3985	JR/MM/Enc	25
2:40	**9.**	Finance & Performance Committee Report – 18 December 2017	SFT3986	NM/Enc	To follow
2:45	**10.**	Standing Financial Instructions	SFT3987	LT	28
	Quality and Risk				
2:55	**11.**	Integrated Performance Report (Month 9) • Operational Performance • Winter pressures • Quality Indicators • Workforce Report • Finance Report • Safer Staffing • Wiltshire Health & Care	SFT3988	ALL/Enc	94

Timings	Agenda		SFT ref	Presenter	Page
	Quality and Risk				
3:30	**12.**	Skill Mix Review	SFT3989	LW	150
3:40	**13.**	Customer Care Report Quarter 2	SFT3990	LW	190
3:50	**14.**	Quarterly Learning from Deaths report Q1-2 2017/18	SFT3991	CB	204
4:00	**15.**	Board Assurance Framework & Corporate Risk Register	SFT3992	LW	211
4:10	**16.**	2016 Children and Young People's Survey	SFT3993	LW	254
	Strategy and Development				
4:20	**17.**	Capital Development Report	SFT3994	LA/LT	279
	Closing Business				
4.30	**18.**	Any Other Business		NM	
	19.	Public Questions		NM	
	20.	**Date of Next Meeting** Thursday 12 April 2018			

DRAFT

Minutes of the Public Board meeting held on 4 December 2017 in the Board Room at Salisbury Hospital

Present:

Dr N Marsden	Chairman
Ms T Baker	Non-Executive Director
Dr M von Bertele	Non-Executive Director
Dr C Blanshard	Medical Director
Mrs C Charles-Barks	Chief Executive
Mr P Hargreaves	Director of Organisational Development and People
Dr M Marsh	Non-Executive Director
Mrs K Matthews	Non-Executive Director
Prof J Reid	Non-Executive Director
Mrs L Thomas	Director of Finance
Ms L Wilkinson	Director of Nursing

Corporate Directors Present:

Mr L Arnold	Director of Corporate Development

In Attendance:

Sir R Jack	Lead Governor
Mr N Alward	Public Governor
Dr B Robertson	Public Governor
Mrs J Lisle	Public Governor
Mr J Mangan	Public Governor
Mr P Butler	Head of Communications
Mr D Seabrooke	Secretary to the Board
Miss A Prime	Deputy Head of Corporate Governance
Mrs B Dunn	Directorate Senior Nurse, Surgery (for item 2336/00)
Mrs C Dallimore	Sister, Eye Clinic (for item 2336/00)
Ms K Glaister	Patient Safety Programme Manager (for item 2336/00)
Ms F McCarthy	Senior Nurse, Infection Control (for item 2344/04)
Mr J Hemming	Microbiology Consultant (for item 2344/04)

2336/00 PATIENT / STAFF STORY

Lorna Wilkinson introduced the patient story, the purpose of which is to connect the Board, from the start of the meeting, with its agenda, purpose and patients. The audio recording featured a patient sharing her story about various attendances at the Trust. The patient suffers from Hemipligic Basilor migraines and locked-in syndrome and talks specifically about experiences with the Acute Medical Unit (AMU) and the new eye unit.

Central to the patient's story is the importance of communication and what has worked well in terms of clinical communication. As well as highlighting the importance of listening and valuing the patient as an individual and a human being, the patient also shared feedback on the helpful use of lighting and colour for navigating the eye clinic, the need for a darkened corner or anti-room for those who find light difficult and the enhancement a coffee machine/snack facility would make to the clinic area for those attending for the day.

The Board reflected on the story:

- Jane Reid reflected on the communication dynamic with the doctor and considered that if the patient had not been able to engage she may have had a negative experience. Nick Marsden considered the Trust prides itself on its personal approach and it is important to consider language issues in communication. Lorna Wilkinson considered the story provides some powerful vignettes around communication which, with the patient's permission, would be good to share with staff to help the understanding of what's good and what it feels like to be the patient
- Michael Marsh complimented the caring professional referred to in the story who cared for the patient in her state of temporary paralysis. He queried the efficiency of the ophthalmology clinic given the patient refers to attending for almost a day. Carol Dallimore informed the Board that when a patient has a complex eye condition and requires a variety of tests it is the aim to undertake these at the same visit which can mean a patient is attending for some time in a day. However staff usually are aware of this and offer drinks and apologised this had not happened this time
- Cara Charles-Barks reflected how the story demonstrates that getting the simple things right can make all the difference to achieving a great experience for the patient
- Andy Hyett reflected on the power of hearing the patient's story direct from a patient and has involved patients in the recent site reconfiguration groups. Despite this involvement it is not until an area starts being used that you get to know how an area looks and feels. Carol Dallimore informed the Board that the majority of patients in the eye clinic want a bright well-lit space, with feedback on the previous clinic area being that it was dark. There is not the space in the new clinic area for a dedicated darkened room for those who might be photophobic. Andy Hyett will look at tea/coffee machine facilities for the clinic
- Andy Hyett thanked Carol Dallimore and the Eye Clinic Team for all their hard work and effort in ensuring a successful move into the new clinic environment

2337/00 APOLOGIES AND DECLARATIONS OF INTEREST

Apologies were received from Mr P Kemp, Non-Executive Director.

Declaration of Interest:
The Committee noted Kirsty Matthew's new role as Managing Director of Virgin Care in which she will be managing a community contract in Bath and North East Somerset (BANES). Ms Matthews will be leaving her position as Non-Executive Director at SFT on 31 December 2017.

2338/00 CHAIRMAN'S BUSINESS

Nick Marsden informed that there has not yet been further information to clarify the impact of the funding announced in the Budget. Ian Dalton has been appointed as the new Chief Executive of NHSI.

2339/00 MINUTES OF THE TRUST BOARD MEETING HELD ON 2 OCTOBER 2017

A number of minor amendments were made to the minutes:

Pg 4, 2328/00 – reword 'in the local system of health and Social Care' to 'across acute, community and social care'

Pg 8 – ecoli – it's about the reporting nationally rather than 'handling'
Pg10, 2330/03 – final paragraph to be moved to section 2330/04

The minutes were otherwise agreed as a correct record.

It was requested when using acronyms to put the meaning in full when first used in a document.

2340/00 ACTION LOG AND MATTERS ARISING

The Board received and noted the Board action log.

2341/00 CHIEF EXECUTIVE'S REPORT – SFT3952 – PRESENTED BY CCB

The Board received the Chief Executive's Report.

Cara Charles-Barks highlighted the following:

- The continuing improvement of performance against core performance standards and quality indicators. The team have been working hard to ensure sustainable improvement against these standards. The Trust is now starting to see the number of delayed transfers of care reduce, which highlights the benefits of some of the system work with partners
- The continued financial challenge. A lot of work has been carried out to identify and respond to in-year challenges and develop a longer term financial recovery plan. Because of the change in the Trust's financial position NHSI have been carrying out an investigation and we await their determination of the position
- Workforce recruitment and retention is a challenge and we are looking at our offer to staff and the approach to retention. A new HR strategy will be presented to Board in Quarter 4 (Q4)
- The site reconfiguration is underway. This week the new Acute Medical Unit (AMU) will open. Early January the new Short Stay Surgical Unit and Breamore Ward will move to the old AMU site
- Andy Hyett and team have carried out a lot of work to review all of the Trust's escalation plans as part of preparing for winter pressures and year-round pressures
- The Trust has been an active participant in Fab Change week, with staff across the organisation making pledges. The Executive Team used this opportunity to launch the new Captain's Round approach
- The Trust's own service improvement awards have taken place. Cara Charles-Barks reported that these awards give an opportunity to hear about the fantastic work that is taking place across the hospital to improve services for patients through a number of presentations, recognising and rewarding the best of these on the day. Cara Charles-Barks congratulated the winners
- The Trust has launched a major new campaign to raise £1.5m for a second MRI scanner
- The BANES, Swindon and Wiltshire Sustainable Transformation Partnership (STP) has appointed Chris Bown as the new STP Chair
- Good progress is being made against the actions identified in the national inpatient survey which was published earlier in the year
- The Trust's Breast Unit has been highly commended in the national Building Better Healthcare awards

Lorna Wilkinson informed the Board that the Trust's Scan For Safety Team has been

shortlisted in the HSJ awards.

2342/00 ASSURANCE AND REPORTS OF COMMITTEES

The Board received the following reports of recent meetings of Board Committees:

- Workforce Committee Report - 27 November 2017 – SFT3953
- Clinical Governance Committee Report - 26 October 2017, 23 November 2017 – SFT3954
- Clinical Governance Committee Annual Effectiveness Review – SFT 3954
- Finance & Performance Committee Report – 6 November 2017, 27 November 2017 – SFT3955

The Chairman invited the Chairs of the Committees to comment on the reports and the following principal points were made:

2342/01 Workforce Committee (SFT3953) – Kirsty Matthews reported:

- There is steady improvement across the three key areas of agency spend, sickness and recruitment with a reduction in agency spend of £18,000 in month. The Committee had a good debate about recruitment and agreed in future to report on overseas recruitment separately given the need to be cautious on recruitment achieved until individuals have passed all their necessary tests and are in post. The sickness rate has improved for both long and short term sickness
- The Committee had a robust discussion on the draft People Strategy 2018 – 2022. This draft will be further developed and brought for Board discussion
- Three of the Trust's Freedom to Speak Up Guardians attended to present a progress report. Kirsty Matthews highlighted the importance of these roles and considered the Trust is fortunate to have this confident and vocal team

2342/02 Clinical Governance Committee 26 October 2017 (SFT3954) – Michael Marsh reported:

- The need to ensure staff awareness and training in relation to the General Data Protection Regulations (GDPR). GDPR to be included in a Board seminar session
- Positive assurance in relation to HSMR which has reduced over successive months. This decrease is linked to more detailed coding information being captured around palliative care and presence of co-morbidities
- Significant improvements in child and adolescent mental health service (CAMHS) provision but there is some risk as new arrangements come into place during transition

Clinical Governance Committee 23 November 2017 (SFT3954) – Jane Reid reported:

- Although electronic prescribing is in place for chemotherapy, electronic prescribing is not generally available across the Trust. This was part of the Lorenzo business case however there is a delay in this module being available nationally. The Committee were concerned that this delay has implications for the Trust and its patient safety aspirations
- Despite historical work on Entinox levels in maternity there is an ongoing concern of high levels recorded in some rooms on the labour ward which presents a risk to midwives who might themselves be pregnant. A risk assessment is in place for every shift. A capital bid has been submitted

Clinical Governance Committee Annual Effectiveness Review (SFT3954) – Michael Marsh reported:

- The Committee has a busy agenda and it can be difficult to cover all the topics in the time allocated
- The Committee has reviewed its Terms of Reference and is complying with duties
- Items escalated to the Board throughout the year have included the clinical leadership model for the Spinal Unit, Research Strategy 2017-22 and the most appropriate Committee for consideration of this strategy, persistent issue with leaks into the patient waiting area in Rheumatology and CQC preparation
- Jane Reid informed the Board that the Committee will be reviewing the papers that come to Committee to ensure they are appropriate Committee business

2342/03

Finance & Performance Committee (SFT3955) – Nick Marsden reported:

- The Committee reviews the financial and performance position of the Trust in depth. Financial issues have been focused on in-year financial recovery and longer term financial recovery
- The Committee has introduced a review at each of its meetings of the contracting position
- At its meeting on 27 November the Committee recommended approval of the IT infrastructure business case which has now proceeded to private Board. The Committee also approved the Trust moving out of Electronic Patient Record (EPR) stabilisation phase
- The Committee has approved a commercial strategy which will enable assessment of the various commercial ventures under the umbrella of SFT. The first venture review will be considered at the Committee's January meeting

2342/04 Integrated Performance Report Month 7 – SFT3956

The Board received the Integrated Performance Report for Month 7 covering a performance summary, operational performance, quality indicators, workforce, safer staffing, finance and Wiltshire Health & Care.

Andy Hyett reported on local services:

- The Trust has a positive position against national performance standards. The Trust achieved the RTT standard at 92% waiting 18 weeks or under. The number of cancellations of elective procedures has reduced greatly. Demand and capacity modelling is being carried out across RTT services to identify areas for further improvement. The Trust has achieved the diagnostic standard of 98% of patients waiting less than 6 weeks. A challenging area is patients waiting for an MRI as the Trust is currently reliant on third party providers to maintain performance against the standard
- Changes to patient pathways are being worked through to maximise opportunities from the hospital reconfiguration work
- The ED standard was delivered in October at over 96% for whole Trust performance, with type 1 and 2 standards met at 95%. Currently the position for November looks to be the same level of achievement with whole Trust performance at 96% for November, and 95% for type 1 and 2
- The number of elective operations cancelled are much lower than the previous year. Four operations were cancelled due to intensive care unit (ICU) capacity, with ICU being full with appropriate patients. Jane Reid seeks to triangulate information received between Finance & Performance Committee and Clinical Governance Committee and has been assured on winter planning that if a patient is not in the desired place of care this has to be approved by an Executive Director
- All cancer waiting targets have been achieved for Q2. Cancer metrics are monitored by the Trust monthly but the national targets are for each quarter. The Trust did not deliver the 62 day screening targets for October with 10.5 breaches, all of which were a result of patient choice and availability. All eleven patients have

now been treated. Andy Hyett highlighted his concern at the ability to access MRI but is optimistic performance will recover during Q3. All breaches are monitored carefully and the national cancer team has been invited in to review the Trust's systems

- The MRI scanner charitable appeal has gone live. Christine Blanshard reported that the staffing position in radiology has improved with two new consultant radiologists starting in December and a doctor to be recruited shortly

Andy Hyett reported on Specialist Services:

- The Trust is currently in the process of recruiting a new clinical lead for the spinal service. A more tailored approach is being developed to spinal rehabilitation services
- There was a need to deliver some activity to surrounding hospitals when both of the Trust's Cardiac catheter labs failed for different reasons. Both labs have been repaired and are operational
- Work is underway to develop the plastics service and strengthening its links to surrounding hospitals in particular Portsmouth. The service now has alignment of admission with treatment

Christine Blanshard reported on Innovation:

- Responsibility for this section of the report has transferred to Christine Blanshard to increase the focus on clinical innovation
- Sterile service response times have improved. Andy Hyett has a follow-up meeting with the company to ensure performance is back on track following previous concerns about holes in wraps
- The Trust is still waiting to hear whether its laundry tender has been successful

Christine Blanshard reported on Care:

- The HSMR reduced in October. There has been improved performance in stroke metrics although this area remains challenging particularly if there are a large number of stroke patients admitted in one day. There has been a performance issue in high risk TIA (transient ischemic attack) patients when commissioners moved to electronic referrals. This issue has now been resolved and expect to see improvement
- The Trust did well in the Royal College of Emergency Medicine (RCEM) audit of sepsis in terms of ED performance but further improvements are needed in sepsis management across the Trust. A new sepsis lead has been appointed. Last year the Trust didn't do as well as usual in the NICOR (National Institute for Cardiovascular Outcomes Research) heart failure audit but in the latest audit metrics have picked up again with all better than national average. The national neonatal audit shows the Trust has outstanding rates of babies being discharged on breast milk. The Trust has had good results in the national dementia audit and showed communications with carers and patients with delirium or dementia as an area for improvement
- Christine Blanshard expressed concerned about the results of the RCEM asthma audit. Nationally performance against the asthma standards are not as good as would be expected and nationally asthma is a leading cause of premature death. This has been identified as a priority improvement for ED and the team have been asked to appoint an asthma champion and bring an audit to the Clinical Management Board in six months. Within the STP network commissioners are keen to carry out a number of common audits across providers and Christine Blanshard has suggested asthma is looked at across the pathway. Michael Marsh highlighted the need to link to a local severe asthma centre. Christine Blanshard informed the Board that the Trust is in an informal network arrangement with

Southampton

- For stroke seven day standards the Trust has struggled to meet the twice daily consultant review at weekends, standards are met during the week with 14 hr consultant review met seven days a week. The daily consultant review standard is met six out of seven days a week. The Trust is looking at a networked approach through the smaller stroke units working together to review patients which will meet the seven day standards

Lorna Wilkinson reported on Care and Safer Staffing:

- The Trust has achieved no mixed sex breaches for eight consecutive months
- There has been a good reduction in the number of falls resulting in harm. Comparing the number of falls between May to October in 2016 and 2017 the Trust has reduced from 24 moderate/major falls to 13 resulting in moderate/major harm
- Safer staffing covers the time of year when newly qualified nurses come into the Trust which is why some ward areas look overstaffed as the newly qualified staff are supernumery at that point in the year
- NHSI has been carrying out a deep dive on the Trust's rostering practices and want to feature the Trust in a case study of excellence on how to work with e-rostering

Paul Hargreaves reported on the People section:

- There is improvement across a range of metrics. Although the drivers for the KPI performance have not been addressed yet, we have become better at managing the key areas (sickness, agency spend)
- Agency and bank spend have both reduced, driven by the new Workforce Pay Controls Group which has strong Executive level support. There is increased transparency on controlling use of agency staff and we will be using the NHSI agency self-assessment toolkit to assess our current infrastructure and processes. Boston will be supporting the Trust to do a deep dive into agency usage. As the contract with Total Assist expires in six months there is an opportunity to review the approach for the Social partnership forum across the STP
- 85 staff have been recruited in-month, which is a small net gain in total workforce as turnover has reduced slightly. 51 overseas staff have been recruited but the total number is being treated with caution until individuals are actually in post. The Trust is currently 93 short of fill rate for nursing. Work has been taking place to review the Trust's approach to recruitment campaigns and will shortly be using the Park and Ride buses as part of the Trust's generic recruitment approach and is looking at approaches to targeted nurse recruitment and use of social media. Jane Reid highlighted the need to ensure comparable standards of care when recruiting overseas
- There has been reduction in both short and long term sickness. Drivers continue to be stress and musculo-skeletal (MSK) issues. A targeted piece of work is underway in theatres, and each division is being requested to have a sickness lead and a rolling programme to support staff back to work. The Trust has completed a collaboration with Loughborough University which will help to inform the support network we want to build to support staff
- Staff survey return rate is currently 44% which is an improvement on last year
- 64% of front line staff have been vaccinated against flu, with the aim of achieving 70%. There have been staff communications to help dispel flu vaccination myths and encourage uptake. It is intended to have a staff engagement group to improve communications and engagement going forward and this will be an issue for communication that group will consider. Jane Reid suggested that it would be powerful to share stories from those staff who have opted to get vaccinated

- Improvement is needed on the level of non-medical appraisals. Areas are being informed on the number of appraisals they need to complete each month with accompanying trajectory

Lisa Thomas reported on the finance section:

- Still reporting a significant financial deficit position. There is a slight improvement in the in-month position but there is a balance between identifying opportunities for next year and our in year recovery. Progress has been made in developing a savings programme for the next two years, however actions we are able to take to reduce expenditure in-year are more limited. The Trust is stopping, for example, expenditure on courses, conferences and stationery purchases whilst continuing to discuss the financial position with the Trust's regulators and commissioners
- Savings plans are looking positive for the next two years with a good level of directorate engagement in the development of those plans. Moving into the next financial year there will be a plan to deliver the Trust back into a sustainable position
- Lisa Thomas is working with commissioners to put in place a realistic contract for 2018/19
- Lisa Thomas clarified that outsourced activity costs are charged to commissioners but there is a question of value for money. As part of financial recovery planning the Trust will be testing the cost of outsourcing against the return on investment.

Michael Marsh asked for clarification of the classification of delay transfers of care (DTOC) and 'green to go' numbers given the steady decrease shown. Andy Hyett confirmed that there is no reclassification, with the DTOC figures reflecting all those patients who are delayed transfers of care. There has been significant improvements in reducing DTOC levels to better than the Trust's national target. DTOC and the 'green to go' position is reviewed at Andy Hyett's weekly gold meeting as part of winter planning. Whilst this is a positive position it is too early in the winter period to be confident on the sustainability of this position. Cara Charles-Barks informed the Board that the team have done a lot of work internally to improve 'green to go' times and it is critical to keep this number as low as possible. Andy Hyett informed that given the complexity of patients' needs, those patients at 'green to go' today are likely to experience delayed transfers of care tomorrow. Cara Charles-Barks identified the need to keep under review the DTOC position in Wiltshire Health & Care as an increase could impact on SFT.

Jane Reid sought assurance of staffing capacity for the winter period. Andy Hyett informed the Board the he has weekly winter resilience meetings and all key on call posts are mapped out with only two gaps at present. There will be challenges but there is proactive work to align workforce challenges and capacity requirements, shutting down capacity to balance staffing needs when possible. Lorna Wilkinson expressed confidence in staffing at Christmas, with January to March being the difficult quarter. Work is underway looking at rostering efficiency, escalation and how, as an executive team, the necessary decisions are taken at the appropriate times. The Workforce Pay Control Group is looking at a bank incentive scheme for Q4 which previously has resulted in an uptake of bank shifts.

Jane Reid highlighted the value in a communications piece with the general public as part of managing winter pressures. Lorna Wilkinson will raise this at a weekly winter resilience meeting.

Michael Marsh questioned the position of the Trust with regard to delegated reporting of x-rays given last week's high profile case of failures in Portsmouth. Christine

Blanshard informed the Board that the situation is different at SFT as trainees at SFT are under direct supervision until deemed competent so x-rays are double reported by a consultant. The Trust does outsource routine x-rays out of hours so the Trust's own radiologists can focus on activity during the day – these x-rays are also double reported. In the orthopaedic fracture and plastics clinics routine follow-up and post-operative radiology is delegated. For lung cancer a benign nodule MDT has been set up. X-ray turnaround times, currently 48 hours, are monitored and outsourced if delays look to be building up. All inpatient radiology is reported.

2343/00 QUALITY AND RISK

2343/01 Board Assurance Framework – SFT3957 – Presented by LW

The Board received revised Board Assurance Framework (BAF).

Lorna Wilkson explained that this new format BAF is work in progress. The new format is intended to provide greater transparency on assurance and risk. Work is underway to review the corporate risk register to ensure the risks are updated and that the right mitigations are in place. At the front of the BAF there will be a summary sheet to provide an overview of the movement of risk levels within the BAF.

Lorna Wilkinson asked the Board to approve the new template going forward and recommended it is brought to every public Board meeting until the revised format is finalised and embedded.

- Michael Marsh asked for the presentation of the risk likelihood consequence matrix to be reviewed
- Kirsty Matthews requested the BAF includes the date the risk has been added and reviewed/updated
- Paul Hargreaves informed the Board of a change to the risk wording on page 114 of the first risk under the 'People' section.

The Board approved the new BAF template and agreed the frequency of reports to each public Board meeting whilst the new format is being finalised and embedded.

2343/02 JBD Minutes Evidencing Presentation of Assurance Framework and Risk Register – SFT3958 – Presented by LW

The Board received and noted the quarterly review of the allocated aspects of the BAF by the Joint Board of Directors

2343/03 Risk Strategy 2018/19 – SFT3959 – Presented by LW

The Board received the revised Risk Management Strategy for approval.

Lorna Wilkinson reported that the revised strategy has been reviewed in light of previous Board comments that the strategy was clinically focused and needed to make more explicit links to areas such as the workforce strategy and finance recovery plan. The document has now been adjusted to reflect this wider perspective.

The Board approved the strategy with an amendment to the front cover to clarify that this is a two year strategy. The front cover will read 'Risk Strategy 2018 – 2020'.

2344/04 Report of Director of Infection Prevention and Control – SFT3960 – Presented by LW

The Chairman welcomed Fiona McCarthy and Julian Hemming who attended to present the Director of Infection Prevention and Control (DIPC) six monthly update report 2017/18.

A key challenge in this period has included improving mandatory training compliance. Hand hygiene compliance has improved from 70% to 76% with the aim of achieving above 85%. There is focused work with directorates to ensure further improvement.

Work is ongoing with relevant teams to ensure water safety management. Positive counts have been identified during this six month period and there are robust monitoring and mitigation activities in place.

Jane Reid considered the report demonstrates encouraging progress. Gram-negative is likely to be a focus for NHSI in the future. Julian Hemming considered this will be a challenge, with a key area of improvement focused around catheter related care. Most ecoli infections come in to the hospital setting from the community. There will need to be joined up working to support learning in the community from information recorded in the hospital setting. Lorna Wilkinson emphasised the importance of links with community teams. Gram-negative is measured now and discussed at the Trust's working group and at quality review meetings with the Clinical Commissioning Group (CCG).

Andy Hyett considered a number of Trusts are experiencing challenges with CPE (Carbapenemase Producing Enterobacteriaceae) and asked how the Trust would know if it had cases. Julian Hemming confirmed the Trust has very few patients. There is a CPE policy in place and the team work to ensure staff in hospital are aware of patients who need to be screened. The main risk is transfers from other hospitals. Lorna Wilkinson considered the need to ensure those managing and organising repatriations are considering this and Fiona McCarthy is discussing with those areas who receive transfers. Julian Hemming will keep focusing on all clinical staff knowing about CPE and when to screen.

Julian Hemming reported that the team want to implement point of care flu testing on the Medical Assessment Unit (MAU) and White Parish. This would give diagnosis within an hour and support efficient triage into side rooms for appropriate treatment. Plans are in place to get this approach up and running in December.

Michael Marsh informed the Board that Legionella has been discussed by the Clinical Governance Committee. The right actions are being taken but there continues to be a need to continue to monitor the position.

Michael Marsh informed the Board that there is a need to be aware of emerging infections such as candida auris.

Michael Marsh asked how the Trust will be limiting the impacts if flu is bad this winter. Julian Hemming informed the Board that the Trust has a pandemic flu plan which has been reviewed recently. Lorna Wilkinson informed the Board that flu is discussed at weekly winter resilience meetings. If there is an outbreak it would be necessary to manage the situation in real time because it is situation specific. Cara Charles-Barks informed the Board that support given for the point of care testing for flu is crucial in

supporting patient flow. Julian Hemming informed the PCR can test for flu and RSV (Respiratory Syncytial Virus).

Jane Reid asked about the collection of Surgical Site Infection (SSI) data. Fiona McCarthy confirmed that surgical teams do collect SSI data as part of their WHO check list but enhanced surveillance outside of nationally mandated requirements is not carried out. Jane Reid informed the Board of the evidence base for procurement of chlorhexidine 2%. Christine Blanshard informed the Board that she has declined to participate in a wider SSI audit as it requires a large number of junior doctors to collect data prospectively from large number of internal and external areas.

Lorna Wilkinson informed the Board that the Trust's decontamination lead has been seconded into a national role with NHSI. In the interim Fiona McCarthy will be taking on the role of decontamination lead as well as infection control lead, with backfill support.

The Board thanked Fiona McCarthy and Julian Hemming for all their hard work. The report was received.

2344/05 National Emergency Department Survey 2016 – SFT3961 – Presented by LW

The Board received the National Emergency Department Survey 2016 with analysis of the Care Quality Commission (CQC) benchmark report and local action plan.

Lorna Wilkinson presented the report on the survey of patients attending the Trust's Emergency Department (ED) between October 2016 and March 2017. The survey placed the Trust as one of highest performing EDs in country based on patient feedback. Lorna Wilkinson congratulated the team on this achievement. An action plan has been put in place on those areas where improvements can be made.

Lorna Wilkinson reported that staff are positive about the survey outcomes but there are pockets of staff who have not yet heard about it. It was agreed there is a need to bring this to the attention of all staff who work in ED including trainees who may also be unlikely to know about the national inpatient survey.

2344/06 Emergency Planning And Resilience (EPRR) Annual Statement – SFT3962 – Presented by AH

The Board received a report on the Trust's Emergency Preparedness Resilience and Response (EPRR), seeking endorsement of the annual EPRR assurance report as part of the NHS England assurance process.

Andy Hyett reported that he is required to provide an annual statement of preparedness. The Trust has received a full assurance through the self-assessment that has gone up through the CCG to NHS England.

The Board noted and endorsed the annual EPRR assurance report as part of the NHS England assurance process.

2345/00 STRATEGY AND DEVELOPMENT

2345/01 Approval Of Trust Strategy – SFT3963 – Presented by LA

Laurence Arnold presented the final draft of the Trust's Strategy and thanked all those who have contributed to its development. The Strategy will form the basis for the Trust's future decision making and sets out the priorities for how the Trust will progress. The document has been developed within the context of local demographics, forecasts and military population growth.

Laurence Arnold informed the Board that there is a typographical error to correct on page 220 with military populations overstated. It was noted that impact figures contained within the document are correct.

The document reflects the challenges the Trust faces in terms of workforce, finance and demographics. It sets out how the Trust will collaborate with others within the healthcare setting, social care and housing and the need to collaborate and join up services effectively.

The document captures the Trust's vision, values and the six priorities. The appendix includes a list of all the priorities and how progress against these will be monitored. An Executive lead and a lead Board Committee has been identified for each. A few action plans are yet to be finalised. The document includes draft patient stories reflective of the six priorities which need to be finalised. It was noted a summary document will sit alongside the full document.

The Trust's workforce strategy, estates strategy, digital strategy, commercial strategy and clinical strategies all contribute to this overarching Trust Strategy.

In response to a comment from Michael Marsh, Laurence Arnold will review the sexual health statistic in the infographic on page 219 to incorporate a different sexual health message.

The Board approved the Trust Strategy.

2346/00 CLOSING BUSINESS

2346/01 Public Questions

John Mangan asked whether the Board would make it obligatory to be immunised against flu if working with immune compromised patients. The Board responded that this would not be appropriate at individual Board level and would need to be an action taken nationally by Government. The Board actively encourages staff vaccination as part of their safe practice and is aiming to achieve the 70% target set by commissioners. Going forward the Trust will have a small staff group to look at how to improve communications with staff and can help to better understand why some staff decide not to take up the vaccine.

2346/02 Any Other Business

There was no other business.

On behalf of Board Nick Marsden thanked Kirsty Matthews for all her support and contributions as Non-Executive Director and Vice-Chairman and wished Kirsty every success in her future role.

2346/03 Date Of Next Meeting

The next meeting will be held on Monday 5 February 2018 at 1:30 pm in the Board Room at Salisbury Hospital

Trust Board Part 1 Action log

Deadline passed. Completed Status = N	1
Deadline in future. Current progress made is updated. Completed status = 'N'	2
Completed status = 'Y'	3
Deadline in future. Current progress made is not updated	4

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
02 October 2017						
10/02/01	Genetics seminar	DS/CB/IA	05/03/18	Noted that draft tender specification now issued. March for seminar session in line with tendering timeframe	N	2
04 December 2017						
Minute ref 2336/00 (04/12/17)	**Patient Story** - consider tea/coffee machine facilities for the Eye Clinic	AH	28/02/18	Facilities are exploring solutions with suppliers	N	2
Minute ref 2342/00 (04/12/17)	**Assurance reports of Clinical Governance Committee -** GDPR to be a Board seminar topic	CB	15/01/18		Y	3
Minute ref 2343/00 (04/12/17)	**Integrated Performance Report M7** - value in a communications piece with the general public as part of managing winter pressures. Lorna Wilkinson will raise this at a weekly winter resilience meeting.	LW	22/12/17	Letter sent to Journal	Y	3
Minute ref 2344/00 (04/12/17)	**Board Assurance Framework** - presentation of the risk likelihood consequence matrix to be reviewed. Inclusion of the date the risk has been added and reviewed/updated	LW	12/04/18	Matrix change will be made to version for April Board	N	2
Minute ref 2346/00 (04/12/17)	**Risk Management Strategy** - front cover to be amended to read 'Risk Strategy 2018-2020'	LW	31/12/17		Y	3

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
Minute ref 2348/00 (04/12/17)	**National Emergency Department Survey 2016** - need to bring the ED survey to the attention of all staff who work in ED including trainees who may also be unlikely to know about the national inpatient survey results	LW	31/12/17	Survey shared with ED staff	Y	3
Minute ref 2350/00 (04/12/17)	**Trust Strategy** - select a different sexual health message for the infographic	LA	31/12/17		Y	3

Report to:	Trust Board	Agenda item:	SFT3983
Date of Meeting:	5 February 2018		

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

Recommendation:
None

Executive Summary:

This report provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers:

- **Performance –** update on current performance
- **Financial Recovery –** update on our plans
- **Outstanding Every Time –** update on programme and staff engagement exercise
- **Workforce –** update on workforce situation
- **Site changes –** update on plans for the site changes we are making to improve the management of emergency and non-emergency patients next winter
- **Cyber-attack training** - staff workshops raise awareness of cyber attacks
- **Parents, Children and Young People's Survey** – Details of positive survey results and summary of actions
- **Carers Memorandum of Understanding** – Trust signs up to MoU and principles around support and involvement of carers in decisions
- **Health Service Journal Awards (HSJ)** – Scan4Safety team do well in HSJ Patient Safety Awards
- **Ophthalmology Honours Awards** – Ophthalmology nurse highly commended in national awards
- **Striving for Excellence** – Good luck to staff shortlisted for awards

Performance

We have maintained good performance across a number of areas, including the main referral to treatment, diagnostic and cancer waiting times. We did see a drop in our key A&E target, reflecting the considerable pressure we have been under over the Christmas period and throughout January. However, we still remain in the top 25% of best performing trusts in the country on this target, reflecting the efforts of staff throughout the hospital who have worked hard to maintain the flow of patients. We are working closely with our partners in health and social care to improve the experience for patients and the number of delayed transfers of care (DTOCs) has remained steady after a reduction in December last year and we will continue to work with our partners on measures to keep DTOCs to a minimum. It is essential that we continue to provide good quality safe care and we are performing well against our main infection control targets. More detailed information on our performance will be covered in the Trust Board.

Financial recovery

Like many NHS organisations we have been facing financial challenges and working hard to improve our financial performance. However, we are now forecasting a £12.5 million deficit at the end of the financial year against a planned deficit of £7 million. Following an investigation by NHS Improvement, they have found the Trust is in breach of its licence. We have accepted their findings and, in response, we have proposed a series of actions that will return us to compliance with our licence conditions which NHSI have accepted. We are putting together a financial recovery plan designed to put us on a stable footing within the next two to three years. This plan has two parts. Firstly, it involves short-term rapid action to tackle some of its most pressing issues. Secondly, it involves medium-term action designed to transform the way in which services are delivered to improve efficiency and continue to deliver good quality of care for patients. Working with NHSI will help us to deliver this at pace and continue to take the necessary steps to guarantee the safety and quality of our services while continuing to reduce our forecast deficit. I have briefed our staff on the outcome of the investigation though my weekly message and Q&A session in the hospital. We have also briefed Governors and our stakeholders. Our completed financial recovery plan must be submitted to NHSI in June and we will continue to keep people informed through our normal communication channels.

Outstanding Every Time Programme

Last year we started to develop our Outstanding Every Time programme with the aim of continually improving patient care and saving money which will help in the future direction and success of the Trust. This “transformation programme”, recognises that if we are outstanding every time we can be both more efficient and more patient-centred. In Salisbury we have a local and national reputation for embracing innovation and a tradition of saving to invest in better services for our patients. This can be seen in some of the many projects we have taken forward and the way in which we have attracted national money where we have specific knowledge and skills which could benefit the NHS. We are now ready to launch a major staff engagement exercise on our outstanding every time programme. Every member of staff has a role to play in order to address the challenges we face. To

achieve financial sustainability and continue to improve patient care we need every member of staff to be fully involved. We need to work more closely with our partners in health and social care, make better use of our estate and embrace new technology and treatment, especially technology that helps patients manage their own conditions. We also need to continually use staff ideas about how we can make improvements that matter to our patients. We will shortly be setting up a comprehensive engagement programme, which will be led by the executive directors. The executive directors will be inviting senior members of staff to outstanding every time events which will give them an opportunity to outline the programme and gather feedback and views. They will also be looking to join department and ward meetings to talk to staff directly about the programme and how they can help.

Workforce

As I've mentioned before we are experiencing difficulties in recruiting the staff that we need to deliver our services, which has created an over reliance on agency staff and a workforce overspend on temporary staff. However, we did see a reduction in agency spend in December in some directorates. We have run a recruitment event for nursing assistants with around 100 people attending. At the time of writing we have made over 30 job offers with 50 interviews still to take place. We will have a similar event in February for registered nurses. I would just like to thank all the clinical and support staff that give up their time to make these events a success. In the meantime, we are working on a short term retention plan for nursing to reduce turnover levels. The Trust's overall sickness absence rate has reduced and time lost to short term sickness absence has decreased. However, long term sickness absence has increased so we are continuing to support areas to proactively manage this with the aim of further reducing sickness absence to below target. Our final staff survey response rate was 46% which is slightly above average for acute hospital trusts and I want to thank all staff who completed their survey questionnaire this year. The staff survey is an important way for us to receive feedback and gives us an opportunity to work with staff to improve their experience of working here at the Trust.

Site changes update

Following on from my last report on the site changes that are taking place to improve the way we manage emergency and non-emergency patients in hospital we have made good progress on our plans and phase 1 of the project is now complete. We have relocated our Acute Medical Unit (AMU) to level 2 in the former Farley template. The new AMU is an expanded single-site medical and elderly care admission unit, which has been designed by clinical staff so that it meets increasing demand. The move of AMU has enabled the endocrine service which was on Breamore Ward to move to Whiteparish. Breamore Ward will keep its name, but will be a short stay surgical ward, which will be mainly for patients who need planned surgery and expect to come in for short periods. The aim is that this will lead to less disruption for patients having surgery. Work on the new Pembroke Ward and Suite, which will lead to an increase in medical beds is ongoing and scheduled to be completed at the end of March.

Staff workshops raise awareness of cyber attacks

It is important that we have policies and procedures in place to deal with a wide range of incidents and that these are tested regularly to ensure that staff know how to respond. Following the cyber-attack that took place last year which had an impact on some NHS organisations, staff have carried out several workshops to raise awareness of the issues that can face any big organisation and give staff the skills to manage the hospital if a cyber-attack were to take place. In the latest workshop, staff in key parts of the hospital were involved in a table top exercise, which enabled them to test their knowledge and think flexibly about how they would manage the hospital if an incident were to take place. This is part of an ongoing programme that we are carrying out to test our response to a number of potential incidents that could have an impact on local health services.

Parents, children and young people rate hospital highly

I'm pleased to report that in the latest national children and young people's survey. Parents and carers of children and young people have rated their overall experience of care in our hospital highly. The survey national survey looked at inpatient and day case care and treatment from admission to discharge for 0 to 15 year olds and captured the views of parents, carers, children and young people. We were better than most other Trusts in 34 of the 63 questions asked. I think it's essential that children and young people, their parents and carers are well looked after by kind and caring staff and it was great to see that they felt that they had had a very good experience here at Salisbury. I was also pleased to see that the needs of children and young people are met and that parents, carers, children and young people have enough information about their care and treatment. We will use the survey to make improvements and we are reviewing theatre lists to ensure that children and adults are better separated within the day surgery environment, as this was an area that we felt needed to be improved following the survey.

Carers memorandum of understanding

In Salisbury we recognise the challenges that all carers face and as part of our commitment to work with carers we have signed a memorandum of understanding (MoU). This sets out a number of principles which will ensure that our staff are aware of the needs of carers and referral routes for them to access local support. It also includes a commitment from us that carers are recognised as expert care partners, that they are involved in decisions about the patient and the planning of their care and we have the right procedures in place so that carers have the support that they need. I would like to place on record my thanks to all carers for the contribution that they make to our society and the support that they give to family, friends or people that need their help.

Scan4Safety team recognised in Health Service Journal Awards

I want to say well done to our Scan4Safety team who did well in the Health Service Journal (HSJ) Patient Safety Awards, where they were shortlisted from over 1,500

entries. The HSJ is the leading healthcare journal for NHS managers and this is a considerable achievement that reflects the success of the programme at Salisbury District Hospital. Since the start of the programme the team has introduced point of use scanning of all implants and consumables in cardiology and orthopaedics, making it easier to trace products in the event of a recall. They have introduced scanning to identify patients when staff are taking observations and tracking blood products. They have also brought in location numbers or “barcodes” that help us track patients and products to places.

Ophthalmology nurse highly commended in national awards

I want to say well done to Carole Dallimore who was highly commended in the Ophthalmology Nurse or Allied Health Professional category of the Ophthalmology Honours Awards 2017. The awards recognise and celebrate the outstanding work being carried out by multi-disciplinary teams in ophthalmology throughout the UK and identify exceptional initiatives that demonstrate clinical excellence and innovation in ophthalmology. This award reflects the professionalism and commitment that I see and hear about throughout so many parts of our hospital and I want to congratulate Carole on her excellent achievement.

Striving for Excellence Awards

Our Striving for Excellence Awards take place on Friday, February 2. At the time of writing this report the ceremony will not have been completed and I will be providing an oral update at the board meeting on February 5. At this stage we do know that this year we saw a record number of nominations, reflecting the enormous appreciation that the local community has for our staff and the recognition that our own staff feel their colleagues deserve. It also represents just a small sample of the fantastic contributions our staff make across the hospital throughout the year. These awards would not have been possible without support from the Salisbury Hospital League of Friends and I want to use this opportunity to again publicly thank them for their sponsorship and their loyalty and commitment to us over so many years. I also want to acknowledge the enormous contribution our staff make to the hospital, our patients and our local community and thank them for all their efforts throughout the year.

Cara Charles-Barks
Chief Executive

Report to:	Trust Board	**Agenda item:**	SFT3984
Date of Meeting:	5 February 2018		

Report Title:	Executive Workforce Committee Board Report	**Date:**	25 January 2018
Prepared by:	Michael von Bertele, Non-Executive Director Paul Hargreaves, Director of OD and People		
Board Sponsor (presenting):	Michael von Bertele, Non-Executive Director		
Appendices (list if applicable):			

Recommendation of items for escalation :

The Executive Workforce Committee focussed on a deep dive into Nursing recruitment and retention and received an update on three key areas of concern for the Trust, reviewing the current position for each using the Workforce KPI report and receiving assurance on current actions to improve the position:

Agency Spend
There has been a reduction in agency spend of £35,416 in month, with all clinical directorates reducing their agency spend compared to last month.

Recruitment
There has been an increase in recruitment this month; with 88 starters (and 59 leavers). We have an on-going overseas recruitment campaign and are offering a guaranteed "values based" interview to all our current third year nurses. The recent recruitment events in Australia have seen 37 offers made with 6 accepted to date and a number of planned interviews booked. Whilst this is positive news, there was an understanding that increasing our offer, reducing absence, retaining and developing our nurses and understanding leavers was an important overview. Long term plan of "grow our own" is in place with recruitment events in January.

Sickness Absence
The sickness rate has reduced for both long and short term sickness this month (3.34%). Long term sickness has fallen whilst short term has risen. The work on supporting areas is specifically focused on short term absence across the Trust, short and long term absence in theatres, coupled with work to renew the policy (due February) and develop manager training.

Progress against the key performance indicators will continue to be managed through Directorate Performance Reviews.

The situation remains challenging, however it is clear that the focus of activity on the three key areas of pressure; agency spend, recruitment and sickness absence are starting to impact and we have seen early improvements in all of these areas this month. This is through tighter grip and control whilst we develop infrastructure and long term plans to improve the KPI.

The Committee was updated with the restructure to deliver the People Strategy 2018-2022. The consultation period is from 15 January to the 9 February 2018. Two staff engagement sessions have been run and the Managers of teams who, in time, will join the People directorate (bank, e-roster and Communications) have been met with on a 1:1 and team basis.

The Freedom To Speak Up Guardians presented a progress report which demonstrated that these roles are a valuable access point for staff to raise concerns. The reporting structure is now in place; a pre-meet with the Director of OD & People ahead of the meeting with the Chief Executive. Further work is now underway on the role specification and requirements for backfill.

Report to:	Trust Board	**Agenda item:**	SFT3985
Date of Meeting:	5 February 2018		

Report Title:	Clinical Governance Committee		**Date:**	25 January 2018	
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness				
Sponsor (presenting):	Dr Michael Marsh Non-Executive Director				
Appendices (list if applicable):	None				

Recommendation of items for escalation :
Following the CGC meeting in January the following items were agreed for escalation: • Guidance on the National Quality Board Learning from Deaths published in March 2017. Annex A – Board leadership, Annex B – Non-Executive Directors. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf. In accordance with the guidance the Medical Director is presenting a progress report and dashboard at the public Trust board meeting on 5 February 18.

1. Business Undertaken

1.1 Negative behaviours in the workplace – clear message from the CEO that poor behaviour is unacceptable. Staff are supported through various avenues including resilience training.

1.2 Nursing documentation – new nursing documentation piloted and will be launched on 1/2/18 supported by two learning events.

1.3 The Trust received letters from two tertiary laboratories about the quality assurance of some samples. All the samples have been re-examined and found to be the same as the original samples. No harm has been identified and all patients will be followed up.

1.4 Critical care/CCOT core service presentation – positive assurance on progress of the CQC action plan, reduction in transfers out after 10 pm (CCOT follow up these cases) and reduction in re-admissions. Mortality rate higher than previously but within control limits. Assurance provided by a robust M&M process with no obvious themes. The CGC congratulated the team on an effective service.

1.5 Spinal unit leadership update –a new clinical lead has been appointed and a consultant physician with respiratory medicine expertise. A physician associate also appointed who starts in September 18.

1.6 Theatre team presentation on theatre safety and WHO checklist - supported by staff education, monthly audits and internal audit actions completed. Improvement needed in the team brief as some members are not always present, mitigated by ongoing audit and theatre etiquette SOP being considered.

1.7 Assurance framework – care category – workforce is highest risk mitigated by recruitment strategy. New risk – potential bleep failure mitigated by new bleep system being introduced in February 18. Corporate risk register – under review, agreed it reflected current risks.

1.8 Risk report Q3 card – highest incidents are falls resulting in harm. Reduced on last year with refreshed falls reduction strategy.

1.9 Q3 Serious Incident Inquiries report - follow up of some recommendation actions required delegated to DMCs at the Clinical Management Board.

1.10 CQC preparation and progress on our 'must dos' – weekly meeting triangulated with visits to departments. Core service preparation workshops. Well-led review currently under way. Learning from other inspection reports. Review of CQC 'Insight' monthly metrics report.

1.11 Customer care report Q2 – 80 complaints, main themes are clinical treatment, staff attitude and communication. 3 requests for independent review by PHSO. Further workshops planned on key conversations and ensuring a system based on best practice.

1.12 Complaints management internal audit report – focus is on improving the complaints process to ensure learning and improvement. Mitigated by workshops as above.

1.13 National Children and Young People's survey 2016 report – excellent performance apart from children in day surgery being treated in an adult area. Mitigated by a SOP for the day to day management. Long term plan is for children only lists and improvement of the environment.

1.14 Quality indicators – positive indicators reflect an improvement in hip fracture patients being operated on within 36 hours. Improvement in high risk TIA and stroke care performance. Continued focus on reducing falls that result in harm through the falls reduction strategy.

1.15 Mortality and morbidity internal audit report - the review showed areas of good practice and areas for improvement in the recording of learning points, actions and follow up to completion. Two learning events for M&M leads planned for 18/19.

2 Items for escalation

2.1 Guidance on NQB Learning from Deaths published in March 2017. Annex A – Board leadership, Annex B – Non-Executive Directors. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf. Medical Director presenting a progress report and dashboard at the public Trust board meeting on 5 February 18.

3 Key Risks Identified and Impact

3.1 Adult safeguarding – DBS policy revision work in progress to ensure all staff groups are captured.

3.2 CAMHS – the legal and operational framework to detain children under the Mental Health Act – a service level agreement is in draft and close to completion.

4 Key Decisions

4.1 None.

5 Exceptions and challenges

5.1 None.

6 Governance and Other Business

6.1 The CGC were asked to make recommendations on topics for TIAA to audit for discussion at the February 18 meeting.

Future Business

6.2 Meeting in February 2018 with items agreed at the pre-meet.

Report to:	Trust Board	**Agenda item:**	SFT3987
Date of Meeting:	5th February 2018		

Report Title:	Standing Financial Instructions and Scheme of Delegation			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Andy James, Financial Controller			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):	1. Standing Financial Instructions 2. Scheme of Delegation			

Recommendation:
The Trust Board is recommended to adopt the revised Standing Financial Instructions (SFIs) and the accompanying Scheme of Delegation.

Executive Summary:
The Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures adopted by the Trust. They are issued to regulate the conduct of the Trust's members and officers in relation to all financial matters with which they are concerned. Adoption of the SFI's will ensure staff have clear guidance to follow when involved with financial matters on behalf of the Trust ensuring strong financial governance is in place at all times. The Audit Committee reviewed the revised SFI's on 11 December 2017.

1. Purpose

1.1. To review the Trust's Standing Financial Instructions and the accompanying Scheme of Delegation.

2. Background

2.1. The Trust's Standing Financial Instructions (SFI's) form part of Standing Orders, which are a legal requirement. These translate the statutory powers into a series of practical rules. The SFI's cover responsibilities, policies and procedures with regard to the financial matters of the Trust. Some financial responsibilities need to remain with the Trust Board and these are covered in a separate document entitled the Scheme of Delegation. As the Trust comes under greater financial scrutiny it is important the SFI's are fit for purpose. The SFI's were last reviewed and approved by the Trust Board in 2013 and so these were due for consideration and amendment, where deemed necessary.

3. Key Changes

3.1. The proposed revised SFI's and Scheme of Delegation are attached.

3.2. The revised version of the SFI's is based on examples provided by Healthcare Financial Management Association (HFMA), other local Trusts and current SFI's.

3.3. The major change from the previous version of the SFI's is within section 7 Tendering and Contracting Procedures. These have simplified when more than one quotation is required for goods and services and when staff are required to contact the Procurement Department to seek advice. They clarify the value of the contract needs to be based on the whole life cost e.g. include maintenance of the medical equipment, annual cost of any associated consumables as well as the cost of the equipment. The Authorisation limits for approval of these contracts are also included within this section.

3.4. The level when a Single Tender Action Form requires completion has also been raised to £10k from its current £5k limit. The costs of having the lower limit were considered to outweigh the benefits and staff time would be better spent on adding value to the procurement process.

3.5. Other changes involve reducing some of the detail e.g. removing each bank account held by the Trust but retaining the requirement for the Trust Board to approve the opening of any new accounts.

3.6. A number of presentations have been held to ensure budget holders are aware of their responsibilities within the context of Corporate and Financial Governance, advising them of the proposed changes to the SFI's and to remind them of other relevant matters, even if no changes are proposed in these areas. Staff were made aware at the presentations that the SFI's were in draft form and subject to review and approval by both the Audit Committee and Trust Board.

4. Summary

4.1. Staff should know their responsibilities in respect of financial matters. The revised SFI's provide clarity on what is expected of them, especially with regard to when budget holders are required to obtain quotations for goods and services.

5. Recommendations

5.1. The Trust Board is recommended to adopt the revised SFI's and Scheme of Delegation.

Lisa Thomas – Director of Finance

Standing Financial Instructions

Version:	**Final 2017-18 Version**
Authorisation Committee:	**Trust Board**
Date of Authorisation:	
Signature of authorising Committee:	
Ratification Committee (Category 1 documents):	
Date of Ratification (Category 1 documents):	
Signature of ratifying Committee Group/Chair(Category 1 documents):	
Lead Job Title of originator/author:	**Director of Finance**
Name of responsible committee/individual:	**Lisa Thomas**
Date issued:	**1 December 2017**
Review date:	**1 April 2019**
Target audience:	**All Directorates**
Key words:	**Trust powers; Trust Board; Chairman; Directors; appointment; meetings; committees; delegation; declarations; interests; contracts; tenders; business conduct; signature; documents; approval. (See also contents to the document.)**
Main areas affected:	**All Directorates**
Consultation:	**Audit Committee** **Executive Directors**
Equality Impact Assessments completed and policy promotes Equity	
Number of pages:	**55**
Type of document:	

Standing Financial Instructions

STANDING FINANCIAL INSTRUCTIONS ("SFIs")

1. INTRODUCTION

1.1 General

1.1.1 Salisbury NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on 1st June 2006, following authorisation by "NHS Improvement", the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act").

1.1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS Improvement, which this document represents).

1.1.3 The *Single Oversight Framework* details how NHS Improvement oversees and supports all NHS Trusts. Additional financial guidance is included in *The Audit Code for NHS Foundation Trusts,* and the *Department of Health Group Accounting Manual (DH GAM)*, all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

1.1.4 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Delegation").

1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors.

1.1.7 Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances be regarded as a disciplinary matter that could result in an employee's dismissal.

1.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Audit Committee for referring action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these SFIs to the Director of Finance, as soon as possible.

1.2 Responsibilities and delegation

Foundation Trust Board of Directors

1.2.1 The Trust Board of Directors exercises financial supervision and control by:

a) Formulating the financial strategy;

b) Requiring the submission and approval of budgets within specified limits;

c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

d) Defining specific delegated responsibilities placed on members of the Board of Directors and employees as indicated in the "Scheme of Delegation."

1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "'Schedule of Decisions Reserved to the Board" document, which is part of the Scheme of Delegation document. All other powers have been delegated to such executive directors in the Scheme of Delegation or, committees of the Board, as the Trust has established. The Board must approve the terms of reference of all committees reporting directly to the Board.

1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with its Constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

The Chief Executive and Director of Finance (DOF)

1.2.4 The Chief Executive and DOF will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.

1.2.5 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.6 It is a duty of the Chief Executive to ensure that Members of the Trust Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

The Director of Finance

1.2.7 The DOF is responsible for:

a) These SFIs and for keeping them appropriate and up to date;

b) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

c) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

d) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

e) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the DOF include:

i) Provision of financial advice to other members of the Trust Board and employees;

ii) Design, implementation and supervision of systems of internal financial control;

iii) Preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

Board of Directors and Employees

1.2.8 All members of the Board of Directors and employees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy and efficiency in the use of resources;

d) Conforming to the requirements of NHS Improvement, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

1.2.9 Any contractor or, employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or, who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.2.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the DOF.

2. AUDIT

2.1 Director of Finance

2.1.1 The DOF is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. An internal audit function is required by NHS Improvement's "NHS Foundation Trust Accounting Officer Memorandum" (August 2015);

b) Ensuring that the Internal Audit service to the Trust is adequate and meets NHS Improvement's mandatory internal audit standards;

c) Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of SFI 2.4 in relation to fraud and corruption);

d) Ensuring that an annual internal audit report is prepared (with interim progress reports) for the consideration of the Audit Committee. The report(s) must cover:

i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DH, including for example compliance with control criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Annual Governance Statement" and also provides assurances to the Audit Committee;

ii) Any major internal financial control weaknesses discovered;

iii) Progress on the implementation of internal audit recommendations;

iv) Progress against plan over the previous year;

v) A detailed work-plan for the coming year.

2.1.2 The DOF and designated auditors are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access during normal working hours to any land, premises or members of the Board or employee of the Trust;

c) The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

d) Explanations concerning any matter under investigation.

2.2 Role of Internal Audit

2.2.1 Internal Audit provides an independent and objective opinion to the Chief Executive, the Audit Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

2.2.2 Internal Audit will review, appraise and report upon:

a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) The adequacy and application of financial and other related management controls;

c) The suitability of financial and other related management data including internal and external reporting and accountability processes;

d) The efficient and effective use of resources;

e) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the Local Counter Fraud Specialist)

ii) Waste, extravagance, inefficient administration;

iii) Poor value for money or other causes;

iv) Any form of risk, especially business and financial risk but not exclusively so.

f) The adequacy of follow-up actions by the Trust to internal audit reports;

g) Any investigations / project work agreed with and under terms of reference laid down by the DOF;

h) The Trust's "Assurance Framework Statements" in accordance with guidance from the DH;

i) The Trust's compliance with the Care Quality Commission Essential Standards of Quality and Safety.

2.2.3 Whenever any matter arises (in the course of work undertaken by internal audit) which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the DOF must be notified immediately and, in the case of alleged or suspected fraud, the Local Counter Fraud Service (LCFS) must be notified.

2.2.4 The Head of Internal Audit or equivalent title, will normally attend Audit Committee meetings and has a right of access to Audit Committee members, the Chairman and Chief Executive.

2.2.5 The reporting system for internal audit shall be agreed between the DOF, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the "Audit Code," the "DH Group Accounting Manual" and the "NHS FT Accounting Officer memorandum."

2.3 External Audit

2.3.1 The External Auditor is appointed by the Council of Governors with advice from the Audit Committee.

2.3.2 The Audit Committee must ensure a cost-effective service is provided and agree audit work-plans, except statutory requirements.

2.3.3 The External Auditor must ensure that this service fulfils the functions and audit access and information requirements, as specified in Schedule 10 of the NHS Act 2006.

2.3.4 The Trust shall comply with the Audit Code and shall require the External Auditor to comply with the Audit Code.

2.3.5 If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Audit Code.

2.3.6 Prior approval must be sought from the Audit Committee (the Council of Governors may also be notified) for each discrete piece of additional external audit work (i.e., work over and above the audit plan, approved at the start of the year) awarded to the external auditors. Competitive tendering is not required and the DOF is required to authorise expenditure.

2.3.7 The External Auditor shall be routinely invited to attend and report to meetings of the Audit Committee, and shall be entitled to meet the Audit Committee in the absence of Trust employees, if they so desire.

2.4 Fraud, Corruption and Bribery

2.4.1 In line with their responsibilities, the Chief Executive and DOF shall monitor and ensure compliance with the NHS Standard contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to NHS Protect's standards.

2.4.2 The DOF is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.4.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the trust as specified in the NHS Protect anti-crime Standards.

2.4.4 The LCFS shall report to the DOF and shall work with staff in NHS Protect, in accordance with the NHS Protect anti-crime Standards, the anti-fraud manual and NHS Protect's Investigation Case File Toolkit.

2.4.5 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the DOF to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHS Protect.

2.4.6 The Local Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit Committee.

2.4.7 The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the DOF and outcomes fed back to the Audit Committee.

2.4.8 In accordance with the Freedom to Speak Up (Raising Concerns Policy), the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by NHS Protect.

2.4.9 The Trust will report annually on how it has met the standards set by NHS Protect in relation to anti-fraud, bribery and corruption work and the DOF shall sign-off the annual self-review and authorise its submission to NHS Protect. The DOF shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit it to the relevant authority.

2.5 Security Management

2.5.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with the NHS Standard Service Condition 24 to put in place and maintain appropriate security management arrangements, having regards to NHS Protect's standards.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist ("LSMS") as specified in the NHS Protect anti-crime standards.

2.5.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management

2.5.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD). who is the Chief Operating Officer and also to the appointed LSMS.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of the Trust Business Plan and Budgets

3.1.1 In accordance with the annual planning cycle, the Chief Executive will compile and submit to the Trust Board of Directors and to the Council of Governors the annual "Trust Business Plan" which takes into account financial targets and forecast limits of available resources. The Trust Business Plan will contain:

a) A statement of the significant assumptions on which the plan is based;

b) Details of major changes in patient care activity, delivery of services or resources required to achieve the plan;

c) The Financial Plan for the year;

d) Such other contents as may be determined by NHS Improvement (NHSI).

3.1.2 The annual plan must be approved by the Trust Board and submitted to NHSI in accordance with their requirements.

3.1.3 All executive directors, directorate management teams and corporate service managers shall be responsible for contributing to the integrated planning process, which shall incorporate plans for workforce, service delivery and quality, service capacity and activity, and efficiency planning.

3.1.4 The DOF will, on behalf of the Chief Executive, prepare and submit an annual budget for approval by the Trust Board of Directors. Such a budget will:

a) Be in accordance with the aims and objectives set out in the Trust Business Plan;

b) Accord with patient care activity and manpower plans;

c) Be produced following discussion with appropriate budget holders;

d) Be prepared within the limits of available funds;

e) Identify potential risks and mitigating actions;

f) Be based on reasonable and realistic assumptions; and

g) Enable the Trust to comply with the whole regulatory framework for Foundation Trusts.

3.1.5 The Trust Business Plan, which will include the annual budget, will be submitted to the Council of Governors in a general meeting.

3.1.6 The DOF shall monitor financial performance against budget, and report to the Finance and Performance Committee and Trust Board of Directors.

3.1.7 All budget holders must provide information as required by the DOF to enable budgets to be compiled.

3.1.8 Planned 'in year' businesses cases will be identified as much as is reasonably possible via the annual planning process. Only approved business cases will be included in the Annual Plan and budget setting. An adjustment to plans will be made in year for those that are subsequently approved. Business cases above £25k annual revenue implication are to be approved by the Joint Board of Directors (JBD) and subject to a business case recommended by the Trust Investment Group (TIG). Business cases less than £25k are subject to review and approval at the monthly Directorate performance review meetings.

3.1.9 The DOF has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive, through the DOF, may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) The amount of the budget;

b) The purpose(s) of each budget heading;

c) Individual and group responsibilities;

e) Achievement of planned levels of service;

f) Authority to exercise virements.

g) The provision of regular reports.

3.2.2 Except where otherwise approved by the Chief Executive, taking account of advice from the DOF, budgets shall only be used for the purpose for which they were provided.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the DOF, subject to guidance on budgetary control in the Trust.

3.2.4 Non-recurring budgets shall be agreed by the Chief Executive or the DOF and should not be used to finance recurring expenditure without their authority in writing.

3.2.5 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

3.2.6 Clinical Directors or Service Leads, who are responsible for 'trading activities' must ensure the integrity and supply of information to other users. Price increases in such departments should be monitored by the DOF to ensure overall efficiency and value for money is maintained.

3.3 Budgetary Control and Reporting

3.3.1 The DOF will devise and maintain systems of budgetary control. These will include:

a) Monthly financial reports to the Finance & Performance Committee and Trust Board of Directors in a form approved by the Trust Board of Directors containing sufficient information to allow the Fiannce & Performance and the Trust Board of Directors to ascertain the financial

performance of the Trust. This may include the following:

i) Income and expenditure to date, showing trends and the forecast year-end position;

ii) Workforce spend and WTEs;

iii) NHS commissioner's contractual performance to date;

iv) Movements in working capital (including cash);

v) Capital project spend and projected outturn against plan;

vi) Explanations of any material variances from budget;

vii) Details of any corrective action where necessary and the Chief Executive's and/or DOF's view of whether such actions are sufficient to correct the situation;

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) Investigation and reporting of variances from financial, workload and manpower budgets;

d) Monitoring of management action to correct variances; and

e) Arrangements for the authorisation of budget transfers and virements.

3.3.2 No budget-holder is authorised to overspend their budget. Where overspending is occurring, the budget-holder must account to their Directorate Management Team or line manager for the overspending and identify the means of addressing it. It is accepted that a budget may be exceeded for a short period in the year due to the phasing of expenditure.

3.3.3 Each Budget Holder is responsible for ensuring that no permanent employees are appointed without the approval of the Trust's Vacancy Control Panel, other than medical and nursing staff provided for within the budgeted workforce establishment.

3.3.4 The Chief Executive will delegate to budget holders responsibility for identifying and implementing cost improvement programmes ("CIPs") and income generation initiatives in order to deliver a budget that will enable compliance with NHS Improvement's Single Oversight Framework, finance and use of resources metrics.

3.4 Capital Expenditure

3.4.1 General rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the NHS Foundation Trust Annual Reporting Manual. The specific instructions relating to capital are contained in section 12 of these SFIs.

3.5 Performance Monitoring Forms and Returns

3.5.1 The DOF on behalf of the Chief Executive, will ensure that the appropriate monitoring forms and returns are submitted to NHSI in accordance with the national annual timetable. The performance figures to the Trust Board of Directors should reflect the same figures, though not necessarily presented in the same format.

4. ANNUAL REPORT AND ACCOUNTS AND QUALITY REPORT

4.1 The DOF, on behalf of the Trust, will:

a) Prepare annual financial accounts and corresponding financial returns in such form as NHS Improvement and HM Treasury prescribe;

b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by NHS Improvement as to their technical accounting content and information/data shown therein, before submission to NHS Improvement.

4.2 The Chief Executive will prepare the Annual Report in accordance with the guidance in the DH Group Accounting Manual.

4.3 The Director of Nursing will prepare the Annual Quality Report in the format prescribed by NHS Improvement/Care Quality Commission and in accordance with the DH Group Accounting Manual. The Quality Report presents a balanced picture of the Foundation Trust's performance over the financial year and up to the agreed submission date.

4.4 The Trust's Annual Report, Annual Accounts and financial returns to NHS Improvement and Annual Quality Report must be audited by the external auditor in accordance with appropriate international auditing standard, where relevant.

4.5 The Annual Report, Accounts and Quality Report (including the auditor's report), shall be approved by the Board of Directors after review by the Audit Committee. The Clinical Governance Committee will also review the Quality Report prior to its submission to the Audit Committee.

4.6 The Annual Report, Accounts and Quality Report (including the auditor's report) is submitted to NHS Improvement (in accordance with its timetable) by the DOF and put forward to be laid before Parliament in accordance with the prescribed timetable.

4.7 The Annual Report and Accounts (including the auditor's report) must be published and presented to a general meeting of the Council of Governors by 30th September each year and made available to the public for public inspection at the Trust's headquarters and made available on the Trust's website. Any summary financial statements published are in addition to, and not instead of, the full annual accounts.

4.8 The Chief Executive, Chairman and DOF, as appropriate, will sign the various documentation relating to the Annual Report, Annual Accounts and financial returns to NHS Improvements and Annual Quality Report on behalf of the Trust Board.

4.9 Where a subsidiary is owned or partially owned by the Trust in a manner to require consolidation under the requirements of IFRS then the annual accounts of the subsidiary will be completed as a part of undertaking the consolidated accounts for the Trust. Should the Trust be involved with an Associate Company the results will be reported in line with recognised accounting requirements.

5. GOVERNMENT BANKING SERVICE BANK ACCOUNTS

5.1 General

5.1.1 The DOF is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

5.1.2 The DOF will review the banking needs of the Trust at regular intervals to ensure they reflect current business patterns and represent value for money.

5.1.3 The Trust Board will approve recommendations regarding the opening of any bank account in the name of the Trust.

5.2 Government Banking Service ("GBS") Bank Accounts

5.2.1 In line with public sector practice, the Trust's principal bankers are those commercial banks working in partnership with the GBS, referred to in 5.2.2(a) below. However, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.

5.2.2 The DOF is responsible for:

a) GBS bank accounts and any non GBS bank accounts held for banking and merchant services.

b) Establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;

c) Ensuring payments made from bank/GBS/RBS accounts do not exceed the amount credited to the account except where arrangements have been made, or there is a right of set-off with another account held with that bank;

d) Reporting to the Board of Directors any arrangements made with the Trust's bankers for accounts to be overdrawn;

f) Monitoring compliance with NHS Improvement or DH guidance on the level of cleared funds;

g) Ensuring covenants attached to bank borrowings are adhered to.

5.3 Banking Procedures

5.3.1 The DOF will prepare detailed instructions on the operation of bank accounts which must include:

a) The conditions under which each bank account is to be operated, including the overdraft limit, if applicable;

b) Those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) in accordance with the authorisation framework of these GBS bank accounts.

5.3.2 The DOF must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review (applicable to any non-GBS bank accounts only)

5.4.1 The DOF will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The DOF is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The DOF is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges (including for private use of Trust assets)

6.2.1 The Trust shall follow the "Payment by Results" ("PbR") financial regime determined by the DH where applicable.

6.2.2. The DOF is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Responsibility for arranging the level of property rentals, and for reviewing rental and other charges regularly shall rest upon the Director of Finance who shall take into account independent professional advice on matters of valuation. The Director of Finance shall be consulted about the pricing of goods and services offered for sale.

6.2.3 All Employees must inform the DOF promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Contracts must conform to the strategy and business plans of the Trust and shall be approved according to the limits specified at SFI Annex 3.

6.2.5 Any employee wishing to use Trust assets for private use must comply with the Trust's policies, including those on use of the telephone and the loan of equipment.

6.3 Debt Recovery

6.3.1 The DOF is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income and salary overpayments not received, after all attempts at recovery have failed should be written off in accordance with the following approvals limits;

6.3.3 The following VAT exclusive limits shall be applied to debt write offs:

Monetary Value	**Approval**
Up to £10,000	Financial Controller
£10,001 to £100,000	DOF
£100,000 plus	Audit Committee

The limits apply to individual items. A schedule of written off debt shall be presented to the Audit Committee at least annually. A schedule of debts written off in excess of £100,000 and approved by the Audit Committee should be presented to the Trust board for information.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The DOF is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery;

c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash. The Director of Finance shall be responsible for the arrangements for security and issue of bulk stocks of cheques.

6.4.3 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or loans or IOUs.

6.4.4 All cheques, postal orders, cash etc. shall be banked intact. Disbursements shall not be made from cash received, before banking, except under arrangements approved by the DOF.

6.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes, unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust shall not be liable for any loss, and written and signed “declarations of indemnity” must be obtained from the organisation or individuals fully absolving the Trust from responsibility for any loss.

6.4.6 Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses. (See Section 14 Disposals and Condemnations, Losses and Special Payments).

7. TENDERING & CONTRACTING PROCEDURES

7.1 Duty to comply with Standing Financial Instructions

The procedure for making all contracts on behalf of the Trust shall comply with these Standing Financial Instructions and Standing Orders

7.2 Thresholds Tender Guide/Placing Contracts/Waivers

The following tables outline the correct procurement process to be followed relative to value and the type of product or service being purchased.

Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract and include the whole life costs, not the annual value and should not seek to circumvent public sector procurement regulations.

For the purpose of these SFI's the definition of a Contract is a voluntary, deliberate, and legally binding agreement between two or more competent parties. Contracts are usually written but may be spoken or implied, and generally have to do with employment, sale or lease, or tenancy.

A contractual relationship is evidenced by (1) an offer, (2) acceptance of the offer, and a (3) valid (legal and valuable) consideration. Each party to a contract acquires rights and duties relative to the rights and duties of the other parties. However, while all parties may expect a fair benefit from the contract (otherwise courts may set it aside as inequitable) it does not follow that each party will benefit to an equal extent.

Table 1

Contract Value (Excl VAT)	**Quotations/Tenders**	**Min number invited to Quote/Tender where available**	**Form of Contract**
<£10,000	Single Quotation may be obtained by end user	1	Purchase Order
£10,000 - £24,999	Quotation Authorisation required from Procurement prior to obtaining quotes	2	Purchase Order
£25,000- £75,000	Quotation To be obtained by Procurement with appropriate advertising and market engagement	3	Contract and Purchase Order
£75,001 - Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order
> Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order

Where the opportunity has been advertised the Trust may shortlist suppliers, via a transparent supplier selection process, to take forward to the next stage

of the procurement process.

Threshold limits represent the contract's lifetime value (e.g. a 5 year contract of £25,000 per year requires £125,000 method and authorisation).

The cumulative amount spent with the supplier over a rolling 12 month period (e.g. 5 separate spends of £5k each will trigger the appropriate procurement process in line with the values above)

In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a waiver/ STA will not be required.

7.3 Placing Contracts

Authorisation to sign a Contract and recommendation report requirements are detailed in Table 2 below.

Under no circumstances should any member of the Trust sign and authorise a Contract from a supplier unless they are permitted under SFI's to do so as detailed in the Table 2.

Table 2

Contract Value	Recommendation Report Requirement	Authorisation To Place or sign Contract
<£10,000	No	As per purchase order system approval hierarchy approval
£10,000 – £24,999	Recommendation report required only if contract has not be awarded to the most economically advantageous offer	As per purchase order system approval hierarchy approval
£25,000 - £99,999	Yes	Head of Procurement
£100,000 – £249,999	Yes	Director of Procurement
£250,000 - £499,999	Yes	Director of Finance
£500,000 - £999,999	Yes	Finance Committee
>£1,000,000	Yes	Trust Board/Chairman

The Director of Finance, Director of Procurement, Head of Procurement and Chief Pharmacist may sign and place contracts on the Trust's behalf, providing a valid Contract Approval Document is signed by the relevant Executive Director or Chairman on behalf of Trust Board. Where appropriate this should include a supporting recommendation report.

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contract

7.4 Electronic Tendering

All invitations to tender should be on a formal competitive basis applying the principles set out below using the Trust E-Tendering Portal.

All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 7.2 – 7.12 Issue of all tender documentation should be undertaken by the Procurement Department electronically through a secure website with controlled access using secure login, authentication and viewing rules.

All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions and communication by both procurement staff and suppliers are recorded within the system audit reports.

7.5 Manual Tendering – General Exception Rules

No tenders should be conducted manually unless there is a clear valid exception that is signed off by the Director of Procurement. All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

a) A plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender);

Or

b) In a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

Every tender for goods, materials or manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 7.5.

Where appropriate tenders for building and works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC 3 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers.

Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Terms and Conditions as are applicable. Every supplier must have given a written undertaking not to engage in collusive tendering or other restrictive practice.

7.6 Receipt, Safe Custody and Record of Formal Tenders submitted manually

All tenders on the approved form shall be addressed to the appropriate officer according to the appropriate limits specified in SFI 7.2.

The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

The appropriate officer shall designate an officer or officers, not from the

originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with SFI 7.7.

7.7 Opening Formal Tenders

As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened either electronically or if manually by two officers designated by the officer as appropriate.

Every tender received shall be stamped with the date of opening and if manually opened they shall be initialed by two of those present at the opening.

A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:

a) The names of firms/individuals invited;

b) The names of and the number of firms/individuals from which tenders have been received;

c) The total price(s) tendered;

d) Closing date and time;

e) Date and time of opening; and

f) The persons present at the opening shall sign the record, where a manual process has been conducted.

Except as in the paragraph below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be logged and where a manual process has been conducted it should be initialed by two of those present at the opening.

A report shall be made in the record if, on any one tender, price alterations are considered so numerous as to render the procedure set out in the paragraph above unreasonable.

7.8 Admissibility and Acceptance of Formal Tenders (Electronically & Manually)

In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Director of Finance, Director of Procurement or nominated officer. All decisions should be recorded in line with the procurement process.

Tenders received after the due time and date may be considered only if the Director of Finance or Director of Procurement or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Director of Finance, or nominated officer, shall decide whether such tenders are admissible and whether re-tendering is desirable. Re- tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting. All decisions in relation to tenders received after the due time and date should be recorded in the procurement log.

Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the Director of Finance or nominated officer be regarded as having arrived in due time. A record supporting this decision should be recorded in the procurement log.

Materially incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the supplier upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under SFI 7.8.

Where examination of tenders reveals a need for clarification, the supplier is to be given details of such clarifications and afforded the opportunity of confirming or withdrawing his offer.

Necessary discussions with a supplier of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, will not disqualify the tender.

While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Director of Finance.

Where only one tender/quotation is received the Director of Procurement /nominated officer (within delegated limits) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

All tenders shall be evaluated on the basis of MEAT (Most Economically Advantageous Tender) and in conjunction with published Award Criteria and Weightings.

Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer (within 7.10 below).

All tenders should be treated as confidential and should be retained for inspection.

7.9 Extensions to Contract

In all cases where optional extensions to contract are outlined at the time of tendering, the authority to approve contract extensions is given to the Director of Procurement up to the value of the original contract (including formally agreed variations).

7.10 Quotation & Tendering Procedures

Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in SFI 7.2 and will involve procurement department in line with Table 1.

Tender documents will be issued by procurement on behalf of the Trust. Procurement will arrange for them to be opened in accordance with the SFIs of the Trust.

No tender shall be considered which bears any mark or name indicating the sender.

Where the total contract value exceeds £25,000 the Trust has a legal obligation to ensure that they advertise through the appropriate portal in line with Public Contracts Regulations and must subsequently ensure the respective award is also published.

Where the total contract value exceeds the Public Contracts Regulations Thresholds then the Trust is committed to conducting a legally compliant procurement process in line with the Public Contracts Regulations.

Where appropriate, pharmacy orders will be placed against National or Regionally/Divisionally agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.

The values listed also apply to disposals (SFI 14). All other Financial Limits are detailed at SFI 7.2

Tender lists for building and engineering works will be compiled in conjunction with the Director of Corporate Development from "Construction line" the Trust's approved list of Contractors.

Where there is a wide discrepancy between the estimate and / or approved funding and the final total tendered cost involving an increase in expenditure this is to be reported to the Director of Finance for further instructions.

The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in SFI 7.2.

Quotation/tenders will be completed accordance with these SFIs.

Adjudication must be made in accordance with SFI 7.8 recommendation report shall be prepared by procurement for approval or to seek authorisation, according to delegated limits.

Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2).

All contract documentation must be finalised promptly (ideally prior to the commencement of the contract) after the award of contact.

The waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee regularly.

A flow chart outlining the legally compliant competitive tendering process and contract requirements is outlined at Annex 2.

7.11 Quotation & Tendering Procedures Summary - Contracts

Competitive quotation/tenders will be obtained for all items according to the financial limits specified in SFI 7.2.

No Pre Qualifications stages should be conducted in accordance with Public Contract Regulations
Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract, not the annual value and should not seek to circumvent public sector procurement regulations. Signed Contracts will be required for all Single Tender Action waivers over £25,000.

Quotations/ tenders shall be invited for all purchases over a period of time in line with Table 1 in specified in SFI 7.2.

Quotations/ tenders will be issued in accordance with these SFI's and shall

incorporate standard NHS Terms and Conditions of Contract.

After tenders/quotations have been opened, procurement will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 7.8.

A Recommendation Report prepared by the Procurement Team should be submitted for approval or to seek authorisation as per Table 2 in SFI 7.3 according to delegated limits.

All waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee on a six monthly basis highlighting all waivers over £10,000 in line with STA's approved by the Director of Finance.

All competitive quotations/tenders should come through the e-tendering portal to ensure compliance and published in line with Public Contracts Regulations.

All Trust quotation/tenders or waivers over £25,000 in value must result in a signed contract between the supplier and the Trust under agreed terms and conditions, clear specifications and KPI's where appropriate. These will be retained through the Trust Procurement Source To Contract System. Any exceptions to this are at the discretion of the Director of Procurement.

7.12 Waiving or Variation of Competitive Tendering/Quotation Procedure

Signed Contracts will be required for all Single Tender Action waivers over £25,000.

In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a waiver/ STA will not be required.

Formal competition need not be applied (and therefore a waiver is not required) where:

a. The estimated expenditure does not, or is not reasonably expected to, exceed the Contract value out in in SFI 7.2 Table 1

b. The supply is proposed under special arrangements negotiated by the Department of Health, which the Trust is required by the Independent Regulator to comply with

c. The requirement is covered by an existing contract and the additional expenditure does not either constitute a material difference (eg/ change of scope, or increase in value of 20% of more), or result in a shift in the economic balance of the contract in favour of the contractor

d. The expenditure relates to agency pay however internal governance and authorisation will apply

e. National public sector or NHS agreements including NHS Supply Chain are in place and have been approved by the Department of Health

f. A direct award to a supplier on a national or regional framework is

permissible and recommended according to the rules of the framework. On these occasions a recommendation report will require authorisation in accordance with SFI 7.3 Table 2. The Trust will be required to demonstrate in the report, with supporting evidence, that a direct award offers value for money and is in the best interests of the Trust

g. The requirement is to attend a seminar, conference or similar unique event

h. A consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members

i. A commissioning body is market testing the whole business to ensure value for money and the Trust requires a partner or subcontractor to respond to the invitation to tender. The selection of the partner by the Trust need not be separately competed

j. The requirement is for the securing of a named individual on a temporary basis to fulfil a role and where substitution of another resource is not acceptable. In this case this does not constitute a procurement but the nominated Officer must still ensure value for money

8. CONTRACTS FOR THE PROVISION OF SERVICES

8.1 Service Contracts

8.1.1 The Trust Board shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.

8.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England/Clinical Commissioning Groups and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by the NHS England (NHSE) or NHS Improvement are mandatory for Service Contracts.

8.1.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

8.1.4 All Service Contracts and other contracts shall be legally binding, shall comply with best costing practice and shall be devised so as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income for the benefit of the Trust and its service users.

8.1.5 In discharging this responsibility, the Chief Executive should take into account:

(a) Costing and pricing (in accordance with Payment by Results) and the activity / volume of services planned;

(b) The standards of service quality expected;

(c) The relevant national service framework (if any);

(d) Payment terms and conditions;

(e) Amendments to contracts and non-contractual arrangements; and

(f) Any other matters relating to contracts of a legal or non-financial nature.

8.1.6 Prices should match national tariff, where appropriate, but the Trust can negotiate locally agreed prices, where services are not covered by the national tariff. Any local price should be at least equal to the appropriate cost of the service being provided.

8.1.7 Any local changes in the counting and coding of patient activity will need to be notified to the DOF prior to implementation

8.1.8 The DOF shall produce regular reports detailing actual and forecast income.

8.1.9 The DOF shall oversee and approve cash flow forecasts, including figures relating to the collection of all income due under the contracts.

Annex

8.1.10 The authorisation limits for signing service contracts are set out in Annex 3.

8.2 Involving Partners and Jointly Managing Risk

8.2.1 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs

and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Tendering (where SFT is a competing body)

8.3.1 Where SFT participates in a tendering exercise (whether in competition with others or not) for a health related service, approval must be sought according to the delegated authority limits.

8.3.2 Delegated authority limits associated with tendering:

	Directorate Management Team	**Joint Board of Directors**	**Finance & Performance Committee**	**Trust Board**
Decision not to bid or Bid sign-off prior to submission				
Total value range	<£50k	<£5m	<£15m	>£15m
Annual value	£20k pa	<£1m pa	>£1m<£5m pa	>£5m pa

8.3.3 No tender must be submitted without sign-off from the relevant authority. For absolute clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within the above financial limits. All tender decisions will be reported to Executive Directors for noting.

9. TERMS OF SERVICE AND PAYMENT OF BOARD DIRECTORS AND EMPLOYEES

9.1 Remuneration Committee

9.1.1 The Trust Board shall establish a Remuneration Committee, with clearly defined terms of reference specifying which posts fall within its area of responsibility, its composition and its reporting arrangements.

9.1.2 Any Trust Board post and most Senior Manager Posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by Human Resources. Human Resources are responsible for keeping the list of applicable posts up to date.

9.1.3 Appointments to senior management or Director Posts above the salary of the Prime Minister (currently circa £150k) must be referred to NHS Improvement and onward ratification by the Secretary of State.

9.2 Staff Appointments, Terminations and changes

9.2.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees, or hire agency staff subject to any approval that may be required by the Workforce Control Panel (if applicable) and provided the post is within the limit of their approved budget and affordable staffing limit. They may also regrade employees

after consultation with their Human Resources Manager and job evaluation has taken place in accordance with Trust policy.

9.2.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short term skills shortage) alternative forms of resourcing may be used including Bank and Agency. The use of bank must be in line with the Trust's procedures for booking temporary staff. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NHS and Tax regulation are complied with. Any off payroll engagements must be approved by the DOF prior to contract signature.

9.2.3 Each employee shall be issued with a contract of employment by the HR Department which shall comply with current employment legislation. A copy of the signed contract shall be submitted to the Director of Finance at the earliest opportunity.

9.2.4 All agency staff engaged should be via an approved framework agency and through the Trust's agreed supplier. Any individuals directly engaged, who sit outside of these 2 categories, should have a suitable contractual agreement in place.

9.2.5 Any appointments should follow the Trust Recruitment and Selection Policy found on the intranet.

9.2.6 A "Notification of Termination" form and such other documents as the Director of Finance may require, shall be completed and forwarded to the payroll department immediately upon the date of; an employee's resignation, retirement, or termination, being known. Where an employee fails to report for duty in circumstances which suggest they have left without notice, the Payroll Manager shall be informed immediately.

9.2.7 Changes forms covering an Employee's Personal Details i.e. Name, Address or Job Details shall be completed and forwarded to the payroll department immediately upon the Manager becoming aware of the change.

9.2.8 The Trust Remuneration Committee will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service etc. for employees on local contracts.

9.2.9 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to redeploy staff where appropriate.

9.2.10 In the event that redundancy cannot be avoided the Trust shall follow the processes as laid out in its Managing Implications of Organisational Change Policy.

9.2.11 The Trust must seek approval from NHS Improvement before commissioning Management Consultants above a cap of £50k.

9.3 Processing Payroll

9.3.1 The Director of Finance shall be responsible for the final determination of monetary pay, (including the verification that the rate of pay and relevant conditions of service are in accordance with Trust employment contracts), the proper compilation of the payroll and for payments made. No monetary payment may be made to staff other than that paid through the payroll system without the explicit approval of the Director of Finance.

9.3.2 All pay sheets, and other pay records including travel expense claim forms supported by vouchers/receipts where appropriate, shall be in a form approved by the Director of Finance (manual or electronic) and shall be certified and submitted in accordance with his/her instructions.

9.3.3 The Director of Finance shall determine the dates on which salaries and wages shall be paid.

9.3.4 All employees shall be paid by bank credit transfer, unless in exceptional circumstances agreed otherwise by the Director of Finance.

9.3.5 Payment shall not be made in advance of the pay dates determined as in 9.3.3 above except where prior approval has been obtained from the Chief Executive, Director of Finance (or duly appointed representative) or the Director of Organisational Development and People. In such cases the payment shall be limited to the estimated net pay due at the time of payment.

9.3.6 Where the Trust HR Policies so allow, loans may be made to staff and recovered in accordance with arrangements that the Director of Finance and Director of Organisational Development and People shall determine jointly.

9.3.7 The Director of Finance shall ensure adequate internal controls and audit review procedures are in place, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.3.8 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered. The process and procedures related to pay related claims and under/ over payments is contained in the Trust's Pay policy. This policy sets out that pay claims in excess of normal contractual hours will only be paid within 3 months of the extra shift/ hours. Any claims over 3 months old will need to be approved by the DOF.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority and Service Development Business Cases

10.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Director of Finance will determine the level of delegation to budget managers.

10.1.2 Council of Governors will be consulted on significant transactions.

10.2 Requisitioning and Ordering Goods and Services

10.2.1 The Director of Finance will set out:

a) The list of managers who are authorised to place requisitions for the supply of goods and services; and

b) The maximum level of each requisition and the system for authorisation above that level. Authorisation limits are specified at Annex 1.

10.3 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.3.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust Director of Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the DOF shall be consulted.

10.3.2 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise a requisition. Only for agreed goods and services (i.e. agency staff and utilities) should a good or service be obtained without a purchase order.

10.3.3 The DOF or if delegated, the Financial Controller, shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.4 The DOF will:

a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget managers) on the obtaining of goods, works and services incorporating these thresholds;

b) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) **Authorisation:**

- a list of Directors and Employees authorised to authorise invoices and that the expenditure has been authorised by the officer responsible for the contract or budget which is to be charged

ii) **Certification:**

- Goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification of accounts may either be through a goods received note or by personal certification by authorised officers;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms and that such checks are

evidenced;

- In the case of contract for building and engineering works which require payment to be made on account during process of the works the DOF shall make payment on receipt of a certificate from the appropriate technical consultant or authorised officer. Without prejudice to the responsibility of any consultant, or authorised officer appointed to a particular building or engineering contract, a contractors account shall be subjected to such financial examination by the DOF and such general examination by the authorised officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate;

iii) **Payments and Creditors:**

- a timetable and system for submission to the DOF of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) **Financial Procedures:**

- Instructions to employees regarding the handling and payment of accounts within the Finance Department;

c) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

10.3.5 Prepayments are only permitted where the financial advantages outweigh the disadvantages in such instances:

a) The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his/her commitments;

b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;

c) There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained;

d) The DOF must approve the proposed arrangements before those arrangements are contracted; and

e) The Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director if problems are encountered.

10.3.6 Managers must ensure that they comply fully with the guidance and limits specified by the DOF and that:

a) All contracts (other than for simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the DOF in advance of any commitment being made;

b) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the DOF on behalf of the Chief Executive;

c) Changes to the list of Directors and Employees authorised to certify invoices are in accordance with the scheme approved by the Board;

d) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the DOF;

e) Petty cash records are maintained in a form as determined by the DOF;

f) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement; and

g) In certain circumstances, where regular transactions are made for items such as travel, course and accommodation bookings and one off purchases, a Trust purchasing card can be an alternative means of procurement. All purchase card holders are required to follow the Trust purchasing card procedure and will be required to sign a declaration agreeing to the terms of the procedure.

10.4 Value Added Tax

10.4.1 Payment and recovery of VAT is the responsibility of the DOF who will ensure that procedures and systems are in place to enable regulations governing VAT in the NHS to be complied with.

10.4.2 Where managers are unsure of the VAT status of any particular transaction advice will be provided from the Finance Department.

11. EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

11.1 External Borrowing

11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

11.1.2 The total amount of the Trust's borrowing must be affordable within NHS Improvement's Single Oversight Framework for Trusts.

11.1.3 Any application for a loan or overdraft facility must be approved by the Trust Board and will only be made by the DOF or a person with specific delegated powers from the DOF. Use of such loans or overdraft facilities must be approved by the DOF.

11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short term borrowing requirement in excess of one month must be authorised by the DOF.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Business Plan approved by the Board.

11.2 Public Dividend Capital ("PDC")

11.2.1 Any application for an increase in public dividend capital on behalf of the Trust shall only be made by the Director of Finance or their nominated representative and will be notified to the Trust Board or the Finance and Performance Committee on the Board's behalf.

11.2.2 The Trust will comply with the guidance on dividend payments contained in the DH Group Accounting Manual.

11.3 Investments

11.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.

11.3.2 Investment of cash on a short or long term basis shall be in accordance with the Trust's Treasury Management Policy as approved from time to time by the Finance and Performance Committee. The Director of Finance shall compile and regularly review the Trust's Treasury Management Policy and advise the Finance and Performance Committee of any necessary changes.

11.3.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Trust Board.

11.3.4 Temporary cash surpluses must be held only in investments permitted by NHS Improvement and meeting the criteria approved by the Treasury Management Policy. The Treasury Management Policy will be refreshed and approved by the Finance and Performance Committee on an annual basis.

11.3.5 The DOF is responsible for advising the Board on investments and shall periodically report the performance of all investments held, to the Finance and Performance Committee.

11.3.6 The DOF will prepare detailed procedural instructions on the operation of

investment accounts and on the records to be maintained.

11.3.7 The DOF (or a senior finance manager with specific delegated powers from the DOF) will authorise all investment transactions and ensure compliance with the Treasury Management Policy at all times, with no investment made which would be outside the laid-down parameters for investment risk management in the policy. All investments are subject to periodic review and monitoring by the Finance and Performance Committee.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital Investment

12.1.1 The Trust will establish a Capital Control Group (Cap CG) chaired by the Director of Finance to oversee its allocation of capital investment. The DOF will ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the Trust's Business Planning process.

12.1.2 The Cap CG will oversee the development and monitoring of an annual capital plan, including any changes to the plan as necessary in year. The Trust Board will approve the annual capital plan.

12.1.3 The DOF shall establish systems to ensure that approved capital schemes are progressed effectively and that budgets, phasing and cash flows are properly monitored.

12.1.4 The financial performance of the Capital Programme shall be reported to the Trust Board on a monthly basis with fuller details of the larger schemes on a quarterly basis.

12.2 Approval of Capital Business Cases

12.2.1 The Chief Executive shall require that capital expenditure proposals are reflected in business cases which meet the following criteria:

a) Reliable benefits have been evaluated and compared with known costs;
b) Demonstrates the most cost effective way of achieving the service objectives;
c) Identifies whether commissioning organisations are supportive of the development;
d) Identifies the impact on income of the proposal;
e) Highlights the risks and proposed management of the risks.

12.2.2 Approval of capital business cases will be as follows:

a) The Trust Board will approve any capital business case to be submitted to NHS Improvement.

b) The Cap CG may approve all in year schemes and virements up to £100,000. The JBD shall be informed via the minutes.

c) JBD may approve all in year schemes and virements from £100,001 to £200,000 and the Finance and Performance Committee and Trust Board notified.

d) All in year schemes over £200,000 (not included within the annual capital programme approved by the Trust Board prior to commencement of the year) will require approval by the Trust Board.

Programme allocations within Capital Plan	***Group/ individual responsible for approval***
Backlog Maintenance	The Building and Works Group
Medical Equipment	Medical Devices Committee
Information Systems	Information Systems Steering Group

12.3 Private Finance Initiative

12.3.1 Proposals for Private Finance must be submitted to the Investment Group for approval or review prior to request for approval by the Finance and Performance Committee or Trust Board if required.

12.4 Asset Registers

12.4.1 The DOF is responsible for the maintenance of registers to record capital fixed assets. Appropriate adjustments must be made to reflect actual Trust assets currently in use. All items over £5,000 must be recorded on the Fixed Asset Register.

12.4.2 The DOF shall prepare procedural instructions on the disposal of assets.

12.4.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads.

12.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.4.5 The DOF shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.4.6 The value of each asset shall generally be depreciated using appropriate methods and rates in line with accounting standards.

12.5 Security of Assets

12.5.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, including donated assets) must be approved by the DOF. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Periodic verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.5.3 The DOF shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.5.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the appropriate manager who shall inform the DOF who shall decide what further action shall be taken.

12.5.5 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported.

12.5.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Employees in accordance with the procedure for reporting losses and the requirements of insurance arrangements.

12.5.7 Whenever practicable, assets should be marked as Trust property.

12.5.8 Inventories shall also be maintained and receipts obtained for Equipment on loan.

12.6 Property (Land and Buildings)

12.6.1 Significant changes relating to the Trust's Estate must receive the prior approval of the Trust Investment Group and Trust Executive Committee.

12.6.2 The following matters related to property must be approved by the Trust Board:

a) An Estate Strategy;

b) Acquisition of freehold property over £200,000 (excluding VAT); and

c) Acquisition of property where the total value of the agreement is over £200,000 (excluding VAT) by means of a lease, whether it is deemed to be an operating or finance lease.

12.6.3 Property purchases, licences and leases up to £200,000 each (excluding VAT) may be authorised by the Chief Executive, provided that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation.

12.6.4 The complexity of any property reports to the Trust Board should be determined by the materiality of the consideration or lease payments and any contentious issues, and must contain:

a) Details of the consideration or lease payments;

b) Details of the period of the lease;

c) Details of the required accounting treatment;

d) Annual running costs of the property;

e) Funding sources within the Trust of both capital and revenue aspects of the acquisition;

f) The results of property and ground surveys;

g) Professional advice taken and the resultant cost;

h) Details of any legal agreement entered into;

i) Any restrictive covenants that exist on the property; and

j) Planning permission.

12.6.5 Any property acquisition should be in accord with, Department of Health guidance.

12.6.6 The contracts to acquire the property must be signed by two Executive Directors, one of whom should be the Chief Executive.

12.6.7 Appointment of professional advisors must be in line with the separate procedures for the appointment of advisors.

12.6.8 Trust Board approval must be obtained for the disposal of any property over £100,000 (excluding VAT) which is recorded on the balance sheet of the Trust. A business case must be presented to the Trust which must include:

a) The proceeds to be received;

b) Any warrants or guarantees being given; and

c) Independent valuations obtained.

12.6.9 The disposal must be effected in full accord with Estate code.

12.6.10 Disposals of protected assets requires the approval of NHS Improvement.

12.6.11 Major divestments as defined in the Foundation Trust Compliance Framework requires the approval of NHS Improvement.

12.6.12 The granting of property leases by the Trust must have prior Board approval where the annual value of the lease is in excess of £200,000

13. INVENTORY AND RECEIPT OF GOODS

13.1 Inventory Stores and Inventory

13.1.1 Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net reliable value. Inventory shall be controlled on a First in First out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.

13.1.2 Subject to the responsibility of the DOF for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Director of Procurement. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the DOF. The control of pharmaceutical stocks shall be the responsibility of the Chief Pharmacist; and the control of fuel oil the Head of Estates.

13.1.3 The responsibility for security arrangements and the custody of keys for all Inventory Stores and locations shall be clearly defined in writing by the Logistics Manager wherever practicable; stocks should be marked as Health Service property.

13.1.4 The DOF, in conjunction with the Associate Director of Procurement, shall set out procedures and systems to regulate the Inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification; a delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate goods received/inventory record (whether a computer or manual system) on the day of receipt:

a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer and the supplier shall be notified immediately;

b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.

13.1.5 Stocktaking arrangements shall be agreed with the DOF and shall specify:

a) The procedures of system for the control of consignment stock will be defined in the Consignment Inventory Policy;

b) That there shall be a physical check covering all items in store at least once a year;

c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;

e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the DOF.

13.1.6 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the DOF.

13.1.7 The Director of Procurement shall be responsible for a system approved by the DOF for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the DOF (see also SFI 14, Disposals, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.1.8 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods (see also SFI 14, Disposals, Condemnations, Losses and Special Payments).

13.1.9 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net reliable value. The write down shall be approved by the DOF and recorded.

13.1.10 For goods supplied via the NHS Supply Chain central warehouses, or Trust Supplies Stores, the Director of Procurement shall identify those authorised to requisition and accept goods from the store.

13.1.11 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 14.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations (see also Trust Disposals Policy)

14.1.1 The DOF shall prepare detailed procedures for the disposal of assets including capital assets and condemnations.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will:

a) Establish whether it is needed elsewhere in the Trust;

b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice or the assistance of the Procurement department where appropriate. The highest possible disposal value will be realised, taking into account potential risks and reputational impacts.

14.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the DOF;

b) Recorded by the condemning officer in a form approved by the DOF which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the DOF.

14.1.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the DOF, who will take the appropriate action.

14.1.5 Disposals of assets valued between £100,001 - £200,000k (higher of either market value or net book value) must be approved by the Chief Executive.

14.2 Losses and Special Payments Procedures

14.2.1 The DOF must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in accordance with DH Group Accounting Manual and prepare a register.

14.2.2 The DOF must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (See the Trust's Fraud, Bribery and Corruption Policy).

14.2.3 Any employee discovering or suspecting a loss of any kind must immediately act according to the Trust's Fraud, Bribery and Corruption Policy.

14.2.4 The DOF is responsible for monitoring compliance with the Directions of the Secretary of State and with any other instructions issued by NHS Protect.

14.2.5 The Directorate or Service Manager shall inform the DOF of all other losses or recoveries of previous reported losses so that they can be entered in the losses and special payments register.

14.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the DOF shall inform the Chief Executive in cases where the loss may be material or where the incident may lead to adverse publicity.

14.2.7 The DOF shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.8 For any loss, the DOF should consider whether any insurance claim can be made against insurers.

14.2.9 All losses and special payments (other than compensation payments) shall be recorded without delay in the Trust's Losses Register, to be maintained by the DOF and investigated in such a manner as the DOF may require. Write-off action shall be recorded against each entry in the register.

15. INFORMATION TECHNOLOGY

15.1 Computer Systems and Data

15.1.1 The Director of Corporate Development, supported by the Director of Informatics, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out ensure procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

15.1.2 The DOF shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.1.3 The DOF shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the DOF shall periodically seek assurances that adequate controls are in operation.

15.1.5 Where computer systems have an impact on corporate financial systems the DOF shall be satisfied that:

a) Systems acquisition, development and maintenance are in line with the Trust's Informatics Strategy;

b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Finance staff have access to such data;

d) Have adequate controls in place; and

e) Such computer audit reviews as are considered necessary are being carried out.

15.1.6 No software package for use on trust equipment (PCs, laptops, tablets) should be purchased without the knowledge of the Informatics department. Any quotes to purchase software should therefore be managed through the IT helpdesk.

No hardware equipment should be connected to the network without the approval of the Informatics department.

It will be at the discretion of the Director of Corporate Development or the Director of Informatics whether a case requires discussion at ISSG.

16. PATIENTS' PROPERTY

16.1 Patients' Property and Income

16.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. Staff have a duty of care to make every effort to take care of patients' possessions, which are **not** handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions, This includes items of daily living such as glasses, false teeth, hearing aids etc.

16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, (by notices and information booklets, hospital admission documentation and property records, and/or the oral advice of administrative and nursing staff responsible for admissions), of the Trust's policy that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, subject to the exceptions identified above, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. Patients electing not to conform to this guidance must indemnify the Trust against any loss.

16.1.3 The DOF will provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

16.1.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the DOF.

16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the patient or patient's representative as appropriate, in writing.

16.1.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Department of Social Security instructions and guidelines**.**

17. CHARITABLE FUNDS HELD ON TRUST

17.1 Introduction

17.1.1 The Trust Board is legally the 'Sole Corporate Trustee' of Salisbury District Hospital Charitable Fund Charity (registered charity number 1052284), and is responsible for the management of funds it holds on trust. For the purposes of these SFI's the Trust Board members shall be termed Trustees. Although the management processes may overlap with those of the Trust, the Trustee responsibilities must be discharged separately and full recognition given to the accountability to the Charity Commission for charitable funds held on trust.

17.1.2 This section of SFIs is intended to provide guidance to persons who have been delegated to act on behalf of the corporate Trustee. As management processes overlap, most of the sections of these SFIs will apply to the management of funds held on trust with the exception that expenditure from Charitable Funds shall be restricted to the purpose(s) of the appropriate fund and be made only with the approval of the Fund Manager appointed by the Trustees or the Trustees themselves. This section covers those instructions which are specific to the management and governance of funds held on trust.

17.1.3 The over-riding principle is that the integrity of each fund must be maintained and statutory and fund obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.4 The DOF has primary responsibility to the Trust Board for ensuring that these SFIs are applied in respect of Charitable Funds.

17.2 Administration of Charitable Funds

17.2.1 The DOF shall:

a) Maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust Board as Trustees of charitable funds. These shall be maintained in accordance with legislative requirements and any directions from the Charity Commission.

b) Ensure that each fund has a specific fund objective and that funds are spent appropriately, timely and in line with the donor wishes;

c) Produce codes of procedure covering the financial management of funds held;

d) Ensure funds are held within designated or restricted accounts in accordance with charity law;

e) Periodically review the funds, rationalise funds within statutory guidelines, and report changes to the Salisbury District Hospital Charitable Fund Committee;

f) Recommend additional funds where this is consistent with good practice for ensuring the safe and appropriate management of restricted/designated funds, in particular ensuring that the new fund could not adequately be managed as part of an existing fund;

g) Ensure that all charitable funds are banked in accordance with the Trust's SFI for banking arrangements;

h) Report income and expenditure totals to the Salisbury District Hospital Charitable Fund Committee at their quarterly meetings;

i) Ensure that charitable funds' income and expenditure is managed with due regard to taxation implications;

j) Prepare the annual accounts and Trustee's report in the required format for timely submission to the Auditors, Salisbury Hospital Charitable Funds Committee and the Charity Commission.

17.3 Fundraising and Incoming Funds

17.3.1 All gifts, donations and proceeds of fund raising activities are the responsibility of the Trustees and shall be handed immediately to the DOF to be banked in the Charitable Funds bank account.

17.3.2 All gifts accepted shall be receipted and held in the name of the Trustees and administered in accordance with the Trustees' policies, subject to the terms of specific trusts. As the Trustees can accept gifts only for all or any purposes relating to the Health Service, managers shall, in cases of doubt, or where there are material revenue expenditure implications, consult the DOF before accepting gifts.

17.3.3 The DOF shall advise the Trustees on the financial implications of any proposal for fund raising activities which may be initiated, sponsored or approved.

17.3.4 The DOF shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. All correspondence concerning legacies shall be dealt with on behalf of the Trustees by the DOF who alone shall be empowered to provide an executor a good discharge.

17.4 Investments and Investment Income

17.4.1 The Trustees shall be responsible for:

a) Appointing investments advisors to manage investments and provide relevant investment advice on these. Charitable funds shall be invested in a manner to maximize medium term value,

c) Monitor the performance of investments and seek clarification from the investment advisors on any relevant issues;

d) Report any significant concerns to the Trust Board;

17.4.2 The DOF will allocate dividends, interest, and realised and unrealised gains and losses across the funds appropriately.

17.5 Expenditure

17.5.1 Expenditure from any Charitable Fund shall be conditional upon the item being within the terms of the appropriate trust, the procedures approved by the Trustees and sufficient funds being available.

17.5.2 Day to day management of individual expenditure is delegated to Fund Managers who shall not enter into any transaction which will result in any fund under their control becoming overdrawn without first obtaining authorisation in writing from the DOF.

17.5.3 The DOF shall act on behalf of the Trustees in ensuring that all expenditure incurred is in accordance with the purposes identified by the donor.

17.5.4 The powers of delegation available to commit resources are detailed in the table below. The levels of authority relate to single orders or connected multiple orders.

17.5.5 A connected multiple orders could be for example:

a) The refurbishment of a room where several suppliers are involved

b) An ECG machine and its trolley

c) An order to cover a period of more than one year (the whole value of the order is considered rather than each annual value).

17.5.6 ***Levels of Authority***

No expenditure can take place without the approval of the following:

£	**Orders can only be processed once the following people give their authority**
Up to £10,000	The Fund Manager
Over £10,000	The Fund Manager + The Salisbury District Hospital Charitable Funds Committee (reported to the Trust Board)

17.5.7 Where charitable fund expenditure has an impact on NHS costs, the approval of the Trust shall be sought prior to contractual commitment.

17.6 Asset Management

17.6.1 Assets granted by the Charity to the ownership of or to be used by the Trust, shall be maintained along with the general estate and inventory of assets of the Trust.

17.6.2 The Charity accepts no responsibility, financially or otherwise, for any liabilities arising out of the expenditure.

17.6.3 The Charity shall not be responsible for replacement of the equipment, if it is to be replaced, when it comes to the end of its natural life.

17.7 Risk Management

17.7.1 The DOF will be responsible for updating an annual risk register for

agreement by the Salisbury District Hospital Charitable Funds Committee. This will address the following key areas of risk for the charity:

a) Governance risks – e.g. inappropriate organisational structure, conflict of interest;

b) Operational risks – e.g. Service quality or development, security of assets, fund-raising activity;

c) Financial risks – e.g. accuracy and timeliness of financial information, adequacy of reserves and cash flow, investment management, recession;

d) External risks – e.g. Public perception and adverse publicity, government policy;

e) Compliance with law and regulation – e.g. Breach of charity law, lottery regulations.

18. STANDARDS OF BUSINESS CONDUCT

18.1 The Chief Executive shall ensure that all staff, volunteers and any other person associated with the Trust are made aware of, and comply with, the Trust's Conflicts of Interest Policy. This policy details the behaviour expected of individuals with regard to:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;

b) Conduct by an individual in a position to influence purchases;

c) Employment and business which may conflict with the interests of the Trust;

d) Relationships which may conflict with the interests of the Trust;

e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made to the Head of Corporate Governance for inclusion in the Register of Interests.

18.2 The Bribery Act 2010 reforms the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors.
It introduces a corporate offence which means that organisations are exposed to criminal liability, punishable by an unlimited fine, for negligently failing to prevent bribery. In addition, the Act allows for a maximum penalty of 10 years' imprisonment for offences committed by individuals.

Under the Bribery Act 2010 it is a criminal offence to:

a) Bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so, and

b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper. It is, therefore, extremely important that staff adhere to this and other related policies (specifically, Fraud, Bribery and Corruption, Conflicts of Interest and Freedom to Speak Up: Raising Concerns policies, available via the intranet).

The action of all staff must not give rise to, or foster the suspicion that they have been, or may have been, influenced by a gift or consideration to show favour or disadvantage to any person or organisation. Staff must not allow their judgement or integrity to be compromised in fact or by reasonable implication.

Staff should not be afraid to report genuine suspicions of fraud, bribery or corruption and should report all suspicions to the Local Counter Fraud Specialist (LCFS) who is responsible for tackling any concerns. Alternatively, suspicions can be reported via the National fraud and corruption reporting line (0800 028 40 60) or via the National Fraud Reporting website www.reportnhsfraud.nhs.uk.

19. RETENTION OF RECORDS AND INFORMATION

19.1 The Chief Executive shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with NHS Improvement / DH guidelines. The delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, shall be as follows:

Document	**Held By**
Property Deeds	Director of Corporate Development
Building & Engineering Contracts	Director of Corporate Development & Director of Procurement
Estate Maintenance Contracts	Director of Corporate Development & Director of Procurement
Maintenance Contracts	Director of Procurement
Commissioner Contracts	Director of Finance
Contracts for goods and services other than the above	Director Procurement

The managers noted in the table above will also be responsible for maintaining registers of the contracts held by them. Any other contracts not covered by the above which may be held by other Managers must be reported to the Director of Procurement for a register to be maintained.

19.2 The records held in archives shall be capable of retrieval by authorised persons.

19.3 Records and information held in accordance with latest NHS Improvement / DH guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive or DOF. Proper details shall be maintained of records and information so destroyed.

20. GOVERNANCE, RISK MANAGEMENT AND INSURANCE

20.1 Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a risk management policy and procedures and sound processes for risk management which will be monitored by the Board and its delegated sub committees with responsibility for Risk Management.

20.1.2 The risk management and associated policies shall include:

a) A process for identifying and quantifying risks;

b) The authority of all managers with regard to managing the control and mitigation of risk;

c) Management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control

cost effective insurance cover, and decisions on the acceptable level of residual risk;

d) Contingency plans to offset the impact of adverse events;

e) Audit arrangements including: internal audit, external audit, clinical audit, health and safety review.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by current Department of Health /NHS Improvement guidance.

20.2 Insurance

20.2.1 On an annual basis, the DOF shall review membership of the Non-Clinical Risk Pooling Scheme plus other insurance arrangements and recommend whether or not to continue with current arrangements

20.2.2 The Financial Controller shall act as the Trust's contact on insurance matters, liaising with Insurance Brokers over queries and negotiating renewal terms.

20.2.3 The Financial Controller shall ensure timely reporting of incidents against insurance provision on the third party liability scheme.

20.2.4 The Financial Controller shall ensure timely reporting of losses and the submission of claims against insurance provision on the third party liability scheme in line with the agreed limits set in these SFIs.

20.3 Clinical Risk Management/CNST

20.3.1 The Director of Nursing shall:

a) Provide a central point of contact within the Trust for NHSLA/CNST issues;

b) Report on claims to Trust Board within the set limits and values.

21. LITIGATION PAYMENTS

21.1 Claims from Staff, Patients and the Public

21.1.1 Out of court settlement of claims from staff, patients and the public shall be made where the NHS Resolution (formerly NHS Litigation Authority)/Claims Handler considers it appropriate to do so. Occupier liability claims carry an excess of £3k and employer liability claims carry an excess of £10k. Any occupier liability cases handled in house by the trust within the excess of £3k will be notified to the Head of Litigation and Insurance Services for acknowledgement only.

21.1.2 The limits for notification of individual damages payments are as follows, given that financial responsibility for the payment of all claims is the responsibility of the NHS Resolution with the Salisbury NHS Foundation Trust as the defendant.

Up to £100k	NHSLA/Claims handler	Head of Litigation
£100k-£250k	NHSLA/Claims handler	Director of Nursing
£250k-£500k	NHSLA/Claims handler	Chief Executive
>£500k	NHSLA/Claims handler	Trust Board

The DH must be consulted before making any special payments that are novel, contentious or repercussive. Any payments made contrary to legal advice must be approved by the CEO and Trust Board.

21.2 Health and Social Care Act 2003 – NHS Charges

21.2.1 Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 makes provision for the establishment of a scheme to recover the costs of providing treatment to an injured person in all cases where that person has made a successful personal injury compensation claim against a third party.

21.2.2 Regarding any claim settled by the Trust and/or by the NHS Resolution, there is a requirement to report all such matters in advance of settlement to the Compensation Recovery Unit (DWP). In the event that any NHS charges are payable these will be met in full by the compensator i.e. any other NHS Trust. In the event the compensator is Salisbury NHS Foundation Trust the act provides that SFT is exempt from repaying their "own" costs.

22. EMPLOYMENT TRIBUNALS

22.1 All settlement agreements must be approved by the Director of HR.

22.2 Any settlement agreement in excess of contractual entitlement must be approved by the Director of HR and the DOF. In certain cases, additional approval should be sought from NHS Improvement and/ or HM Treasury.

22.3 The out of court settlement of Employment Tribunal applications shall only be made where the Director of Human Resources advises it to be prudent so to do and only after taking into account the monetary sum involved and any legal advice received. The limits are as follows:

Value of Payment	**Approval**
Up to £30,000	Director of Human Resources
£30,001 to £100,000	Chief Executive
£100,000 plus	Trust Board

22.4 NHS Improvement must be consulted before making any special payments that are novel, contentious or repercussive. The Director of HR, in the case of any compromise agreements, shall submit a business case to be approved by Treasury. Any payments made against/contrary to legal advice must be approved by the Trust Board.

23. WHOLLY OWNED SUBSIDIARIES

23.1 Subsidiary companies are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, wholly owned subsidiaries are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable. Reference to the subsidiary's documentation will need to be made.

24. RESEARCH

24.1 The undertaking of research by Trust employees within the Trust's premises shall be strictly in accordance with the Trust's policies and strategies on research and shall be subject to approval accordingly.

24.2 Proposals to undertake research shall be fully costed, in accordance with the national guidance, 'Attributing the costs of health and social care research and development' (AcoRD DH2012) using the national costing guidance/templates. Excess treatment costs should be submitted to CRN:Wessex for funding.

24.3 The undertaking of research shall not commit the Trust to future expenditure and no relationship may be entered into with a third party that could affect the impartiality of a future procurement.

24.4 The Standing Orders and other sections of the SFIs apply equally to the undertaking of research and this includes declaration of interests, security of assets, budgetary control, purchasing and contracting, charitable funds, and the section on casual gifts, hospitality and commercial sponsorship.

24.5 The submission of grant applications to support research shall be signed by the Director of Finance or designated representative.

24.6 The agreement covering any undertaking of research shall give cognisance to Trust policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the project.

24.7 The principles governing probity and public accountability shall apply equally to work undertaken through research.

Annex 1

Authorisation Levels For Electronic Requisitioning System

1.1 All staff authorised to approve the purchase of goods or services, and signing of invoices where appropriate, will be allocated an authorisation level. Each Directorate can set its own authorisation levels under Level 3 below (Levels 1 and 2 are shown as suggested levels only)

Level 1 - Up to and including £500 per total requisition (e.g. nurses, ward assistants, staff with requisitioning responsibility in smaller departments)

Level 2 - £501 - £5,000 per total requisition. The actual level of authority will depend on the work area and the following are examples**:**
- £1,000: requisitioning staff in larger departments
- £2,000: ward sisters
- £3,000: supervisory levels in departments, requisitioners in theatres, staff club manager
- £5,000: catering manager, medical physics manager, deputy head in genetics

Level 3 - £5001 - £10,000 per total requisition
- £10,000: DSNs, DMs, heads of larger departments
- £10,000: Head of Facilities

Level 4 - Up to £50,000 per total requisition: Deputy Director of Finance, Financial Controller

Level 5 - Up to £100,000 per total requisition: Chief Operating Officer, Director of HR, Director of Nursing, and Medical Director

Level 6 - Over £100,000 per total requisition (but subject to any other limits approved by the Trust Board): Chief Executive, Director of Finance

1.2 Each Directorate is responsible for compiling their own authorised signatories list, including determining which staff should be given authorisation below level 3.

Amendments to the above levels of authorisation may be approved in specific cases but will need to be approved by the Director of Finance.

1.3 The Finance Department will maintain a database of staff on each authorisation level per Directorate. Directorates will be responsible for notifying the Finance Department of any additions, deletions or other changes to their authorised signatories' lists. The Finance Department will ensure the database is amended to reflect the changes and ensure the computer security is amended accordingly**.**

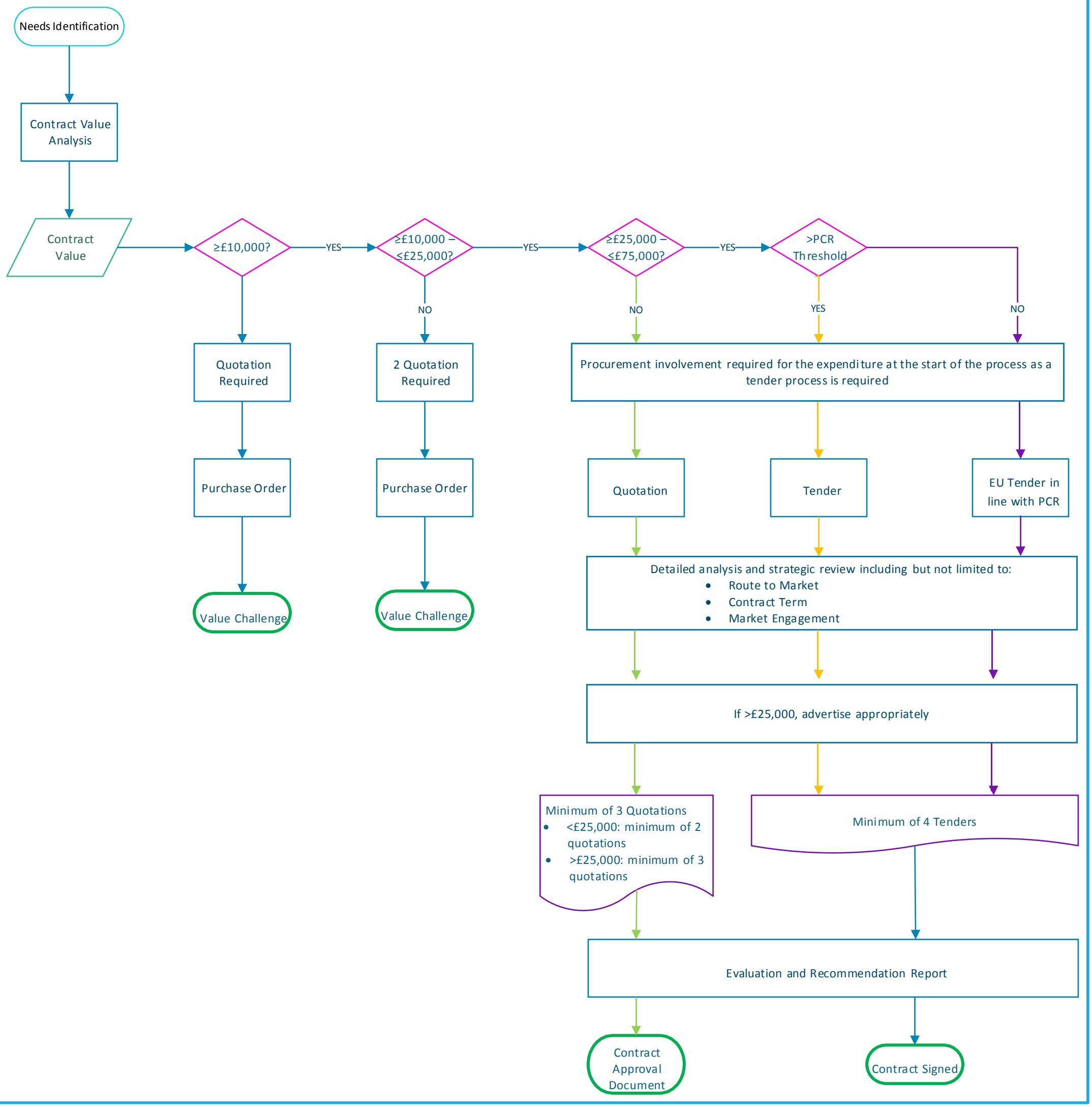
Authorisation Levels for Electronic Ordering System

2.1 All requisitions will be converted to Orders and processed within the Procurement Department where individual staff will have specific levels of authorisation below that of the Head of Procurement's £50,000 level. The electronic requisition will have already been authorised at the appropriate level within the organisation prior to receipt by Procurement.

2.2 The Associate Director of Procurement and Commercial Services will have authority to process orders up to - £250,000. Any orders beyond this amount will need to be authorised by the Chief Executive or Director of Finance.

Annex 2 Tendering & Contracting Procedures (where SFT is the procuring body)

Competitive Tendering Process Requirements



Annex 3

Contracting for Income - Financial Limits

NON NHS
All limits **exclude** Value Added Tax where applicable.

Lifetime Contract value	**Approval**
Up to £20,000	Directorate Manager
£20,001 - £300,000	DOF
£300,001 to £1.5million	Chief Executive
£1.5million plus	Trust Board

Lifetime Contract value (NHS)

Service Level Agreements	
Up to £100,000,000	Director of Finance
Over £100,000,000	Chief Executive

Salisbury
NHS Foundation Trust

Schedule of Decisions Reserved to the Board and the Scheme of Delegation

Introduction

1. The NHS Foundation Trust Code of Governance requires that there should be a formal schedule of matters specifically reserved for decision by the Board. This document sets out the powers reserved to the Board and those that the Board has delegated.
2. The Board remains accountable for all of its functions; even those delegated to the Chair, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.
3. All powers of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee of the Board shall be exercised on behalf of the Board by the Chief Executive or another executive director.
4. The Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligations. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that targets are met.
5. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. Whilst the detailed responsibility can be further delegated the Chief Executive remains accountable for that responsibility to Board. All powers delegated can be re-assumed by him/her should the need arise.
6. The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.
7. In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent powers delegated to him/her may be exercised by the Deputy Chief Executive Officer or in his/her absence by the Executive Director who is formally acting-up as Chief Executive. Formal acting-up status shall be confirmed in writing by either the Chief Executive or the Chair.
8. The Scheme of Delegation is reviewed annually.
9. As part of ensuring a sound system of corporate governance prevails, there is a requirement for staff with budgetary and/or senior managerial responsibility to sign a statement acknowledging awareness of this document and the Standing Financial Instructions, and agreeing to apply them to their everyday approach to carrying their work for the Trust. This approach promotes compliance and effectiveness.

Schedule of Decisions Reserved to the Board

SFI Ref	Decision reserved to the Board
1.2.1	• Formulate the financial strategy • Approve budgets • Define and approve essential features of important procedures and financial systems • Define delegated responsibilities.
3.1.2	Approve the Annual Business Plan
4.5	Approve Annual Report and Accounts including the auditor's report.
5.1.3	Approve the opening of new bank accounts.
7.3	Authorise contracts with Suppliers which exceed £1m.
8.1.1	Regularly review and maintain capacity and capability to provide mandatory goods and services per the terms of the licence.
9.1.1	Establish a Remuneration Committee.
10.1.1	Approve the level of non-pay expenditure.
11.1.3	Approve application for a loan/overdraft.
11.1.5	Approve all long-term borrowing.
11.3.3	Approve investments made in forming/acquiring an interest in bodies corporate.
12.1.1	Establish a Capital Control Group.
12.1.3	Approve the Annual Capital Plan.
12.2.2	Approve all capital business cases above £200,000
12.6.2	Approve Estate Strategy and acquisition of property (freehold & lease) over £200,000.
12.6.8	Approve disposal of property over £100,000.
12.6.10 & 12.6.11	Seek approval from NHS Improvement for the disposal of protected assets and major disinvestments.
12.6.12	Approve the granting of property leases where the annual value is in excess of £200,000.
16.1	Provide safe custody for money and other personal property of patients.

Decisions/Duties delegated by the Board to Committees

Committee	Duties delegated by the Board
Audit Committee	See Terms of Reference (available from Head of Corporate Governance). In addition: SFI 11.3.2 Set investment policy. Oversee all investment transactions. Approve treasury policy. SFI 11.3.4 Approve short term investment vehicle.
Remuneration Committee	See Terms of Reference (available from Head of Corporate Governance)
Salisbury District Hospital Charitable Fund Committee	See Terms of Reference (available from Head of Corporate Governance)

Scheme of Delegation of Powers from the Standing Financial Instructions (SFIs)

SFI Ref	Delegated to	Authorities / Duties Delegated
1.1.8	Audit Committee	Referring action or ratification of any non-compliance with SFIs. Also need to be disclosed to the DOF.
1.2.6 & 1.2.9	Chief Executive	Ensuring that all members of the Board and employees of the Trust understand their responsibilities within SFIs.
1.2.7	DOF	• Ensuring that SFIs are appropriate and up to date • Implementing the Trust's financial policies • Maintaining an effective system of internal financial control • Maintaining records of financial transactions • Providing financial advice to Board and employees.
1.2.8 & 1.2.9	All directors, staff and contractors	Security of Trust property, avoiding loss, exercising economy and efficiency in the use of resources, and conforming to the Constitution, Standing Orders, SFIs and the Scheme of Delegation.
2.1.1	DOF	• Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. • Ensuring that the Internal Audit service to the Trust is adequate and meets NHS Improvement's mandatory internal audit standards. • Ensuring that an annual internal audit report is prepared for the consideration of the Audit and Assurance Committee.
2.2.2	Head of Internal Audit	Reviewing, appraising and reporting upon compliance with established policies and procedures such as the Audit Code.
2.3	Chief Executive / Audit Committee	Ensure that an external auditor is appointed in compliance with the constitution and that they comply with the Audit Code. Ensure that the Council of Governors are aware as appropriate.

2.4	Chief Executive / DOF	Ensure compliance with the directions on NHS fraud and corruption. Appoint a Local Counter Fraud Specialist and consult with him/her as to the involvement of the police in cases of fraud and corruption.
2.5	Chief Executive	Control and coordinate security management. Appoint a Local Security Management Specialist.
3.1.1	Chief Executive	Submit to the Board the Annual Trust Business Plan which takes into account financial targets and forecast limits of available resources.
3.1.4	DOF	Prepare and submit an annual budget.
3.1.6	DOF	Monitor financial performance against budget and report to Board.
3.1.8	Chief Executive	Approve business cases up to £100,001-£200,000.
3.1.9	DOF	Ensure that adequate training is delivered to budget holders to help them manage successfully.
3.2.1	Budget holders	The management of a budget to permit performance of a defined range of activities.
3.3	DOF	Devise and maintain systems of budgetary control including monthly reports to Board containing sufficient information to ascertain financial performance.
3.3.4	Chief Executive	Identify and implement cost improvement programmes.
3.5.1	Chief Executive/ DOF	Appropriate monitoring forms and returns are submitted to Monitor.
4.1	DOF	Prepare annual financial accounts and returns ensuring that they comply with current guidelines.
4.2	Chief Executive	Prepare an Annual Report.
4.3	Director of Nursing	Prepare the Annual Quality Account.
4.6	DOF	Submit the annual report and accounts to NHS Improvements.
4.8	Chief Executive & Chair	Sign the Statement of Directors' Responsibilities in Respect of the Quality Report.
5.1.1 & 5.4.1	DOF	Advise on and manage the Trust's banking arrangements ensuring that these are reviewed regularly.

5.1.2	DOF	Review banking arrangements.
5.2.2	DOF	Managing the Trust's Government Banking Service (GBS) bank account, establishing non-exchequer bank accounts, ensuring funds stay in credit unless arrangements have been made,
5.3	DOF	Prepare detailed instructions of the operation of GBS accounts and advise the Trust's bankers of the conditions under which accounts will be operated.
6.1	DOF	Design and maintain income systems.
6.2.2	DOF	Approve and review the level of all fees and charges.
6.2.3	All Staff	Inform the DOF of income arising from transactions which they have initiated.
6.3.1	DOF	Take appropriate recovery action on all debts.
6.4	DOF	Provide the required documents for recording cash, cheques and negotiable instruments, and ensure adequate system and procedures for handling cash etc.
7	Chief Executive	Arrangements for tenders where SFT is the procuring body.
7.8	Director of Finance	Report the acceptance of any late tenders to the Board.
7.11	DOF	Report all waiving of variation of competitive tendering/quotation procedures to Audit Committee.
8	Chief Executive	Arrangements for contracts re provision of services.
9.2.1	Budget holder	Recruit to vacancies provided that this is within the establishment.
9.4.1	DOF	Final determination of pay.
10.1.1	DOF	Determine level of delegation of non-pay expenditure to budget managers.
10.2	DOF	Set out the list of managers and their limits for requisitioning goods and services.
10.3.3	DOF	Prompt payment of accounts and claims.

10.3.4	DOF	Recommend the thresholds for quotations or tenders and prepare procedural instructions, ensure prompt payment and maintain a system for managing all amounts payable.
11.3.5 – 11.3.7	DOF	Determine the investments required and ensure that policies and procedures are drawn up for their operation and maintenance.
12.4.1	DOF	Maintain registers of assets.
12.4.2	DOF	Prepare procedural instructions in disposal of assets.
12.4.5	DOF	Approve procedures for reconciling fixed asset accounts to fixed asset register.
12.5.1	Chief Executive	Establish procedures for the control of fixed assets.
12.5.2 & 12.5.3	DOF	Approve asset control procedures and manage process.
12.6.2	Chief Executive	Approve acquisition of property up to £200,000.
13.1.2	DOF	Systems of control for stores and stocks.
13.1.4 - 13.1.5	DOF	Establish procedures for the management of stores and stocks.
14.1	DOF	Establish processes for disposals and condemnations.
14.2	DOF	Maintain a register of condemnations, losses and special payments, prepare a fraud response plan, and take appropriate actions for any losses, condemnations and special payments.
15.1.1	Director of Corporate Development	Devise and implement procedures to safeguard the Trust's data, programs and computer hardware, have regard to the Data Protection Act 1984, ensure adequate controls over data entry, processing, storage etc.
15.1.2 – 15.1.5	DOF	Ensure that financial systems are appropriately procured and tested; ensure that there are adequate controls in operation in place.
16.1.3	DOF	Arrangements for the administration of patient property.
17	DOF	Ensure that the charitable funds are appropriately administered and managed.
17.2.1	DOF	Prepare the Charity's annual accounts for audit and authorise transactions of funds between investment vehicles.

18.1	Chief Executive	Ensure all staff are aware of the behaviour expected of all staff as set out in the Conflict of Interests Policy.
19	Chief Executive	Maintain archives for all records, information and data.
20.1	Chief Executive	Ensure that the Trust has a risk management policy and procedures and that these are monitored.
20.2.1	DOF	Review membership of the Non-Clinical Risk Pooling Scheme and other insurance arrangements.
20.2.2 – 20.2.5	DOF	Liaise with insurance brokers; ensure timely reporting of incidents, losses and submission of claims against the third party liability scheme and insurance provision.
20.3	Director of Nursing	Manage claims on NHSLA and report activity to Board.
21	Chief Executive	Managing claims from staff, patients and the public.
22	Chief Executive	Managing Employment Tribunals.
23	Wholly owned subsidiary	Manage governance process.

Other issues to be delegated

10. Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
Data Protection Act Requirements	Director of IM&T
Health & Safety Arrangements	Director of Organisational Development and People
Terms and conditions for non-AfC staff	Chief Executive provided this is in line with the AfC terms and conditions

11. This scheme of delegation covers only matters delegated by the Board to directors and certain other specific matters referred to in SFIs. Each Director is responsible for the delegation within his/her Directorate. He/she should produce a scheme of delegation for matters within his/her Directorate. In particular the scheme of delegation should include how the directorate budget and procedures for approval of expenditure are delegated.

Report to:	Trust Board	**Agenda item:**	**SFT 3988**
Date of Meeting:	5th February 2018		

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

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

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

Performance Summary Narrative – December Performance, plus recent context

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
Local Services (COO)	• Trust achieved month end target of more than 92% of patients waiting for treatment having waited less than 18 weeks.	• Pressures on referral to treatment times in some sub-specialty areas often as a result of emergency pressures. • Particular challenge in terms of gastroenterology waiting times	• Directorates produced specialty level planning to determine capacity required to achieve 18 weeks. Undertaking additional lists to move this forward between now and the middle of January • Task and finish group established to review demand and capacity – additional clinics being set up (by end of January)
	• Diagnostic waits at >99% within 6 weeks	• Diagnostic waits for MRI and audiology remain challenging	• Outsourcing to other providers to maintain waiting times for MRI. Audiology additional capacity from December
	• Within the best performing Trusts in the country for ED performance for December at 92.5% • New expanded Acute Medical Unit opened on time offering more ambulatory spaces and much improved functional unit, contributing to an increase in the number of patients discharged from AMU within 24 and 48 hours	• Emergency pressures particularly intense in December and January reflecting both changing levels of demand, including increased acuity, and internal and external capacity.	• Steering group set up to lead the internal improvement of emergency clinical pathways (meetings ongoing) • System wide session on frail elderly pathways on 1st March
Local Services	• All cancer waiting time targets achieved.	• High levels of demand in a number of cancer pathways, eg breast • Small numbers and specific pathway challenges leading to breaches • Delivery of all cancer standards will be challenging. Being monitored on an	• National Cancer Improvement Team due to visit Trust (Q4) • Additional endoscopy capacity in place to mitigate shortfall

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
(COO)		individual patient basis for 62 day pathway.	
Specialist Services (COO)	• Plastic surgery pathways being reviewed • Reviewing ward and outpatient footprint required and monitoring plastics outliers onto other wards		• Plans in place for regular meeting at COO/MD level to discuss future working between SFT and UHS
	• Short stay inpatient assessment service for non-acute spinally injured patients established • Retrieval service being trialled i	• Value of the spinal contract with commissioners • Increased numbers of delayed transfers of care	• Developing business case to specialist commissioners for spinal services to be completed following appointment of lead (Q4) • Step down facility being commissioned for spinal unit which will increase overall bed capacity – pilot being planned to commence January
Innovation (MD)	• Sterile Service performance improved over last month, especially with regard to turnaround times. Close working relationship developing – Trust to be involved in recruitment of new manager. • Drop in referrals to Odstock Medical Ltd has reduced the level of income being generated	• Still some issues with holes in drapes • Cash constraints on the Trust could place limits on the subsidiary companies ability to react to opportunities	• Plans in place to extend racking • Further contract review at executive level quarterly
Care (MD/DoN)	• Excellent performance continues in infection control – in upper quartile • Maternity survey published and is broadly positive • Audit on non-invasive ventilation published – action plan to respond been developed. • Working up the programme design for the	• Mortality rate remains above expected and reduction has stabilised • Stroke performance operationally remains challenging • Periods of intense emergency pressure at times when staffing is equally challenged	

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
Care (MD/DoN)	'requires improvement to good' initiative • Well led review by Deloitte's commissioned • Deep dive into nursing recruitment and retention presented to Executive Workforce Committee	• Staffing remains challenging in a number of ward areas • Nurse sensitive indicators (falls, pressure ulcers) seeing an increase in Q3	• Agreed further overseas nurse recruitment trip • Refresh of 'share and learn' sessions to commence in February
People (DoHR)	• Overseas nursing recruitment –cost effective and successful campaign in Australia – ongoing • Well attended open day for nursing assistants (driven by social media) • Locum's nest – successful pilot and rollout in progress on flexible contract – locum staff at reduced rate – new contract signed pending permanent solution options • Absence has fallen again, but increase in long term (fall in short term) • Agency spend has fallen for 3rd month in a row– due to tighter control • Vacancy rate fallen (change in reporting to a more accurate figure)	• Level of vacancies, especially in nursing, exacerbated by need for escalation • Month 9 control total exceeded, but improving position. NHSI control total reached – now on "comply or explain" • Flu take up rates good but refreshing communications, data evaluation to improve vaccination rate • Absence rate - high levels in theatres, causing capacity issues, a number of staff in informal stage • Long term absences have increased • Higher number of leavers than starters • Staff morale at time of intense operational pressures	• Longer term recruitment - "grow your own" plan, 10 month plan to achieve fill to 95% for ward based nursing. • On current run rate will be overspent on NHSI control total by some £2m • Workforce pay control group to review temporary pay RAG. • Workforce controls group link nursing authorisation with medical authorisation and is overseeing temporary staffing costs going forward • 30/100 surveys planned • Engagement strategy in development (due February) • Retention strategy finalising January • Staff engagement group (February) • Sub group engagement (e.g. medical secretaries) (February) • Continue trajectory approach to appraisal via performance review

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
People (DoHR)	• Staff survey rate was 46.2%. The average response rate for Acute Trusts was 45.5%. • Developing engagement strategy/events • Flu update has met CQUIN target (but CCG confirmation required)	• Appraisal challenging to hit 85% • Overspend on workforce at £807k (0.80%) WPCG to continue to manage down temporary spend whilst maintaining safer staffing	• Trust wide sickness group identified top 30 individuals to be supported back to work • Feedback for Health and wellbeing partnership with Loughborough University for study into factors causing absence to feed into HAWB
	• STP approach to joined up policies across organisations and HAWB • Leavers survey started June		• Workforce restructure consultation launched week commencing 15/1/18 to support people strategy : recruitment and retention, diversity, health and wellbeing, business partnering
Resources (DoF)	• Overall month 9 position is in line with re-forecast number. • Ongoing discussions with commissioners has reduced the level of risks. Wiltshire CCG have been very supportive.	• Trust subject to Section 106 in relation to financial deterioration, NHSI have accepted enforcement actions in response. • Trust formally re-forecast in line with NHSI protocol. Forecasting c£12.5m deficit for 2017/18. • Trust continues to borrow cash to support deficit position in year.	• Action plan being developed to address enforcement actions to be monitored through F&P Committee (Feb). • Five year capital plan being developed and will be presented to F&P Committee (Feb).

Integrated Performance Summary Report

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	Metric Name	Target	Last 3 Months: Oct-17	Nov-17	Dec-17	Pts affected in Dec-17	YTD
LOCAL	A&E - 4 Hour wait from Arrival	95.0%	96.3% ↑	96.2% ↓	92.5% ↓	477	94.2%
	RTT - 18 Weeks from Referral to Treatment	92.0%	92.3% ↑	92.2% ↓	92.4% ↑	1,249	91.1%
	Cancer - 62 Day Wait for First Treatment from GP Referral	85.0%	80.5% ↓	81.3% ↑	86.7% ↑	5.5	85.9%
	Cancer - 62 Day Wait for First Treatment from Screening Referral	90.0%	0.0% ↓	63.6% ↑	100.0% ↑	0.0	79.2%
	Diagnostic - 6 Week Wait	99.0%	99.0% ↓	99.1% ↑	99.1% ↑	27	98.6%
	Diagnostic - 6 Week Wait - Compliance	10 out of 10	8 out of 10	7 out of 10	7 out of 10		

	Metric Name	Target	2016-17 Q3	2016-17 Q4	2017-18 Q2	Pts affected in 2017-18 Q2	Benchmark
SPECIALIST Burns Centre**	% of adult resuscitation burns assessed by a consultant burns surgeon < 12 hours of admission	75.0%	100.0% →	100.0% →	No data	0	97.0%
	% of adult inpatients receiving daily pain assessment	80.0%	81% ↓	63.0% ↓	90.9% ↑	2	32.4%
	% patients screened for psychosocial morbidity prior to discharge from burns ward	75.0%	88% ↓	100.0% ↑	100.0% →	0	66.5%
	% of patients screened for functional morbidity < 2 working days of admission	80.0%	100% →	100.0% →	95.5% ↓	1	56.6%
	Number of adult inpatients admitted to an inappropriate level of care according to National Burn Care Referral Guidance (2012)	0	0 →	0 →	0 →	0	
	% IBID minimum dataset completed for adult inpatients		80.8% ↑	81.5% ↑	100.0% ↑	0	56.2%

*** Please note - BRN02-A; BRN05-A; BRN06-A have not shown data over the last 3 consecutive quarters. Therefore these rows have been hidden.*

	Metric Name	Target	2016-17 Q3	2016-17 Q4	2017-18 Q2	Pts affected in 2017-18 Q2	Benchmark
SPECIALIST Spinal Injuries Centre	Mean time from injury to referral (newly injured patients)		17.0 ↑	19.3 ↓	20.0 ↓		20.6
	Mean time from referral to admission into SCIC		51.2 ↑	41.8 ↑	33.0 ↓		34.7
	Mean LOS in acute phase for level of injury C1-C4		40.5 ↑	16.4 ↑	25.8 ↑		16.2
	Mean LOS in acute phase for level of injury C5-C8		18.2 ↑	19.2 ↓	14.7 ↓		18.5
	Mean LOS in rehab phase for level of injury C1-C5		106.0 ↑	113.5 ↓	112.8 ↓		94.4
	Mean LOS in rehab phase for level of injury C5-C9		114.3 ↑	109.7 ↑	86.0 ↓		101.2
	% of new injured patients receiving a face to face outreach visit from the SCIC outreach team <5 days of referral		78.1% ↓	85.3% ↑	66.7% ↓	11	87.2%
	% of newly injured patients who acquired a grade 3 or 4 pressure sore after admission to SCIC		0.0% ↓	0.0% →	3.6% ↑	<=5*	1.2%

	Metric Name	Target	Oct-17	Nov-17	Dec-17	Pts affected in Dec-17	YTD
CARE	Never Events	0	0 ↓	0 →	0 →		1
	Serious Incidents		1 ↓	1 →	0 ↓		12
	Clostridium Difficile - notifications	-	1 →	2 ↑	1 ↓		6
	MRSA Bacteraemias - notifications	0	0 →	0 →	0 →		0
	% of births as emergency caesarean sections		8.1% ↓	9.6% ↑	10.3% ↑	20	11.5%
	% of harm-free care		91.9% ↑	90.2% ↓	92.2% ↑	44	92.1%
	% of new harm-free care	95%	96.3% ↓	95.1% ↓	96.7% ↑	22	96.3%
	Venous thromboembolism (VTE) Risk Assessment	95%	99.1% ↓	99.5% ↑	99.6% ↑	6	99.4%
	Emergency re-admissions within 30 days following an emergency spell at the Provider	TBC	3.1%	2.1%	6.6%		5.9%
	Emergency re-admissions within 30 days following an elective spell at the Provider	TBC	1.2%	0.9%	0.5%		1.3%
	Complaints - Total received	TBC	16 ↓	30 ↑	15 ↓		201
	Mixed Sex Accommodation breaches	0	0 →	0 →	0 →		0
	Inpatient Scores from Friends & Family Test - % Positive		96.9% ↓	96.3% ↓	97.5% ↑	244	96.9%
	A&E Scores from Friends & Family Test - % Positive		100.0% ↑	97.7% ↓	101.6% ↑	86	98.6%
	Maternity Scores from Friends & Family Test - % Positive		82.1% ↓	100.0% ↑	100.0% →	25	96.6%

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

	Metric Name	Target	Jul-17	Aug-17	Sep-17		
CARE	Medication Errors - % Harmful Events						
	Patient Safety Incidents - % Harmful						
	Potential Under-reporting of Patient Safety Incidents						
	Central Alerting System Alerts Outstanding						
	Hospital Standardised Mortality Ratio	100	110	110	110		
	Hospital Standardised Mortality Ratio - Weekend	100	116	118	114		
	Summary Hospital Mortality Indicator	100					

Integrated Performance Summary Report

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	Metric Name (000s)	Target	Last 3 Months: Oct-17	Nov-17	Dec-17		YTD
STAFF	Total Staff Costs		£ 11,186,214	£ 11,507,641	£ 11,339,239		
	Temporary agency staff costs (£)	£ 513,000	£ 786,207	£ 750,791	£ 586,255		
	Temporary agency staff WTE		3.5% ↓	3.6% ↑	2.8% ↓		
	Temporary bank staff costs (£)		£ 523,734	£ 555,334	£ 536,208		
	Temporary bank staff WTE		6.4% ↓	5.8% ↓	6.0% ↑		
	Staff Absence	3.00%	3.63% ↓	3.75% ↑	4.02% ↑		
	Appraisals - Medical	85.0%	92.0% ↓	91.0% ↓	92.0% ↑		
	Appraisals - Non-medical	85.0%	81.3% ↓	84.6% ↑	83.9% ↓		
	Mandatory training (MLE)	85.0%	85.9% ↓	86.2% ↑	87.5% ↑		

	Metric Name		2016-17 Q4	2017-18 Q1	2017-18 Q2		YTD
STAFF	Staff Turnover (Q)		3.6% ↓	3.0% ↓	4.3% ↑		
		Target		2014-15 YTD	2015-16 YTD		
	NHS Staff Survey	43%		31% ▪	35% ↑		

	Metric Name (000s)	Target	Oct-17	Nov-17	Dec-17	YTD plan	Variance
EFFECTIVE	Income & Expenditure - Surplus (+) / Deficit (-)	-£ 7,000	-£ 8,119 ↓	-£ 9,019 ↓	-£ 10,568 ↓	-£ 5,771	-£ 4,797
	Cost Improvement Plan	£ 7,500	£ 2,821 ↑	£ 3,416 ↑	£ 3,974 ↑	£ 4,533	-£ 559
	Cash Position	£ 2,009	£ 4,642 ↓	£ 3,739 ↓	£ 7,456 ↑	£ 2,161	£ 5,295
	Risk Rating	3	4 →	4 →	4 →		

	Metric Name	Target	Oct-17	Nov-17	Dec-17		YTD
PARTNERSHIP	Emergency admissions - Medicine & Elderly care (Over 65 years)		679 ↑	684 ↑	804 ↑		5,879
	Delayed Transfers of Care (DToC) - NHS	5	19 ↓	18 ↓	8 ↓		144
	Delayed Transfers of Care (DToC) - Social Services	11	9 ↓	5 ↓	10 ↑		102
	Bed days consumed by DToC each month		528 ↓	490 ↓	563 ↑		5694

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

** Number of patients affected will not be shown as there were less than 5.*

Acronyms

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

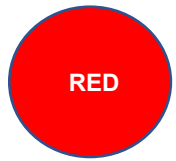
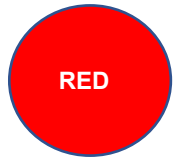
Report to:	Trust Board	**Agenda item:**	SFT3988
Date of Meeting:	5 February 2018		

Report Title:	Month 9 Operational Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Andy Hyett, Chief Operating Officer			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):	Appendix : 1 Performance & Score Card			

Recommendation:
The Trust Board are asked to note the Trust Performance for Month 9.

Executive Summary:
For Month 9 the Trust successfully delivered the Referral to Treatment standard, the Diagnostic standard, Cancer 62 day and Cancer 2 week wait standards. Unfortunately the Trust did not deliver the ED standard, reporting 92.5%.

Executive Summary of Key Operational Performance – December 2017

Area of Review	Key Highlights	Status
ED Performance	**In month (9):** National standard was not delivered in month with performance at **92.5%** **Year to date**: Improved ED performance through 2017/18. YTD performance **94.9%**	
RTT Performance	**In month (9):** National standard delivered in month with performance at **92.4%** **Year to date:** The standard has been delivered for six consecutive months	
Diagnostics	**In month (9):** National standard was delivered reporting **99.1%**. There were 31 breaches of which 26 were awaiting MRI **Year to date:** The standard has been delivered for five consecutive months. YTD **98.6%.**	
Cancer	**In month (9**): Standard delivered for 2 week wait at **96.5%** 62 day with performance at **86.7%** **Reporting Quarter 3:** 62 day standard performance improved in December however this was not sufficient to deliver Q3 performance	
DTOCs	**In month (8):** **563 bed days lost** due to patients awaiting discharge coded as a delayed transfer of care. This was above the escalation target of 20 DTOCs per day **Year to date:** **5694 bed days lost** due to patients awaiting discharge coded as a delayed transfer of care	

Emergency Pathway

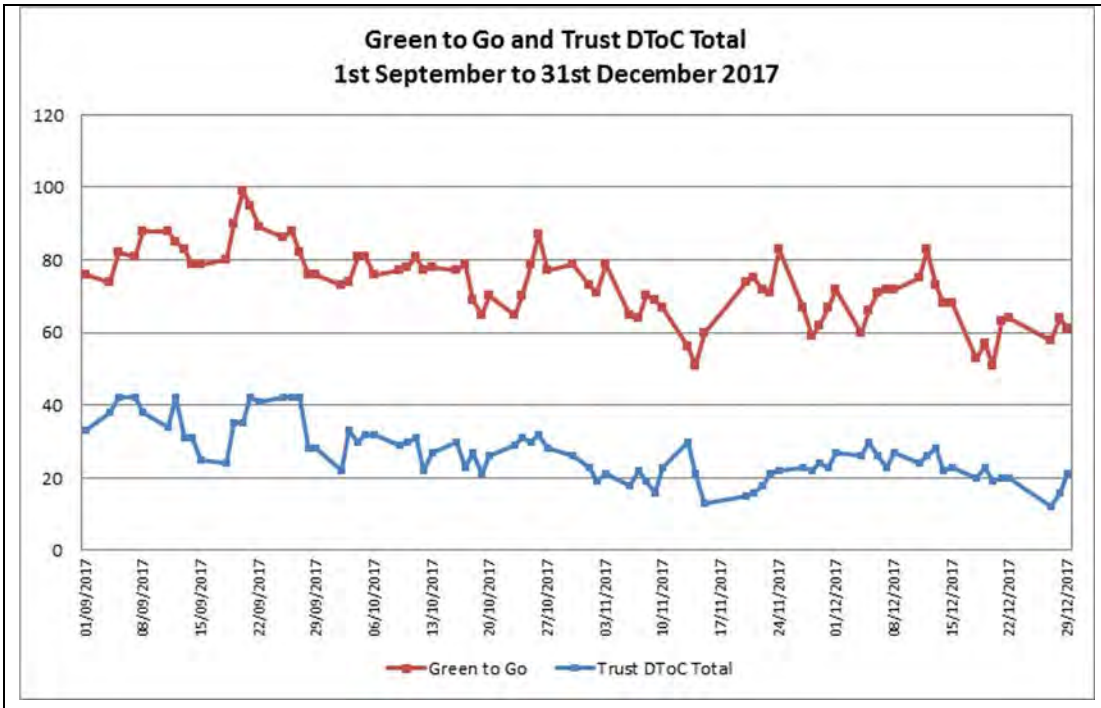
4 hour performance for December was delivered at 92.5% (Type 1,2,&3)
Ambulances Breaches: Total =29
Breaches > 1hr = 24
Breaches < 1hr = 5

No 12 hour trolley waits in December

	Time to triage -Dec	
	All	**Ambulance**
Longest (minutes)	195	184
Median (Minutes)	**11**	**8**

	Time to Treatment	
	November	**December**
Longest (minutes)	330	379
Median (Minutes)	62	55

Week	Total Attendances (T1+2+3)	Total Breaches (T1+2+3)	Total Performance (T1+2+3)
27/11/2017 - 03/12/2017	1268	31	97.56%
04/12/2017 - 10/12/2017	1425	64	95.51%
11/12/2017 - 17/12/2017	1463	120	91.80%
18/12/2017 - 24/12/2017	1370	94	93.14%
25/12/2017 - 31/12/2017	1487	185	87.56%



RTT

For December the Trust reported RTT performance of 92.4%.

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

- General Surgery
- Trauma and Orthopaedics
- Oral Surgery
- Plastic Surgery

Diagnostic

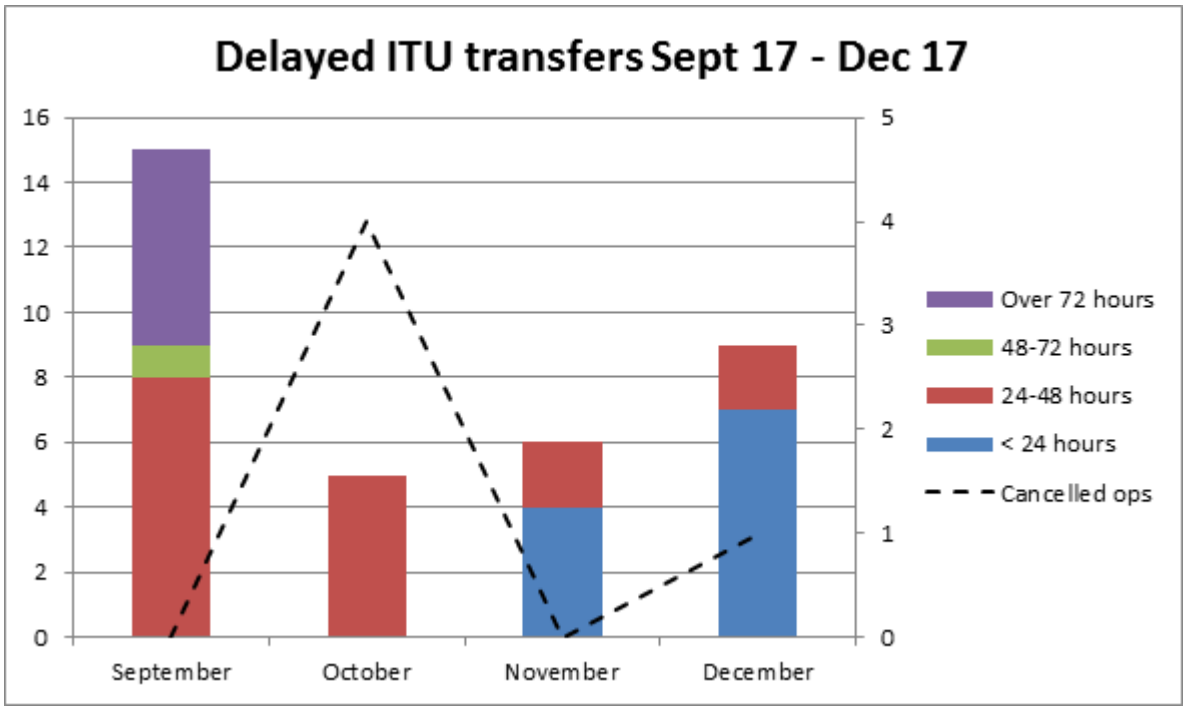
In December 99.1% of patients were seen within 6 weeks. There were 27 breaches(13 MRI,3 Audiology, 1 Cardiology 4 Endoscopy and 6 other Radiology). Current wait times are 6 weeks in Radiology and 5 weeks in Endoscopy (with the exception of a small number of patients requiring a general anaesthetic).

The position continues to be maintained by outsourcing MRI and Endoscopy tests, however outsourcing of Endoscopy tests is being reduced.

Cancer

All Cancer standards except the 31 day standard were delivered for December. There were 4 patients who breached the standard 3 on skin pathway (capacity) and 1 on a lung pathway (complex).

ICU

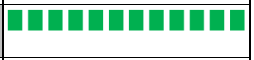
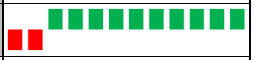
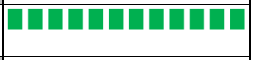
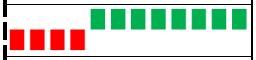
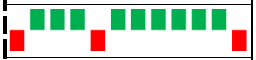


Links to Assurance Framework/ Strategic Plan:

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

Appendices: Appendix 1. Trust Board Performance Report – November 2017

Salisbury Hospital NHS Foundation Trust Board Report December 2017

			Reporting Month		Rolling 12 months
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Dec-17**	**Patients Affected in Dec-17**	**Trend Against National Standard**
Referral to Treatment Incomplete Performance	92%	STF = 92.0%	92.4%	1,249	
Referral to Treatment Incomplete Specialty Compliance	16 out of 16		12 out of 16		
Zero tolerance RTT waits > 52 weeks	0	0	0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Dec-17**	**Patients Affected in Dec-17**	**Trend Against National Standard**
A&E - 4 Hour wait from Arrival	95%	STF = 93.8%	92.5%	477	
A&E - 12 Hour Trolley Waits	0		0		
Diagnostics - Patients waiting less than 6 weeks	99%		99.1%	27	
Diagnostic Test Compliance***	10 out of 10		7 out of 10		
Urgent Ops Cancelled for 2nd time (Number)	0		0		
Mixed Sex Accommodation Breaches	0		0		
Infection control – Clostridium difficile (YTD)	YTD: 14		YTD: 6	1	
Infection control - MRSA*	0		0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Dec-17**	**Patients Affected in Dec-17**	**Trend Against National Standard**
All Cancer two week waits	93%		96.5%	21	
Symptomatic Breast Cancer - two week waits	93%		98.6%	2	
31 day wait standard	96%		94.8%	4	
31 day subsequent treatment : Surgery	94%		100.0%	0	
31 day subsequent treatment : Drug	98%		100.0%	0	
62 day wait standard	85%		86.7%	5.5	
62 day screening patients	90%		100.0%	0.0	

Cells with black dotted outlines indicate provisional data

*Please note: MRSA is no longer monitored by Monitor

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

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

Report to:	Trust Board	**Agenda item:**	SFT 3988
Date of Meeting:	5 February 2018		

Report Title:	Quality indicator report – December 2017 & Q3 17/18			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Christine Blanshard, Medical Director Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Quality indicator report – December 2017 & Q3 17/18			

Recommendation:
To note the Trust quality indicators and actions being taken to improve.

Executive Summary:
Positive indicators reflect an improvement in hip fracture patients being operated on within 36 hours and a sustained position of avoiding non-clinical mixed sex accommodation breaches. As anticipated, an improvement in high risk TIA performance. Stroke care indicators also improved. Continued focus on reducing falls that result in harm through our falls reduction strategy.

1. Purpose

1.1 To provide the Board with the Trust's quality indicators

2.0 **Background**

2.1 The Accountability Framework sets out the performance function which oversees the delivery of all elements of Trust performance throughout the year, including service performance and quality of care linked to the delivery of the Trust's transformational and financial plans.

2.2 The Performance Framework sets out the metrics that each directorate will be held accountable for. The quality indicator report provides the metrics that the Trust uses to establish the quality of care provided by the Trust.

3.0 Quality indicator report

3.1 Two serious incidents requiring investigation in Q3 (grade 3 pressure ulcer & a fractured hip).

3.2 Four Trust apportioned C difficile cases in Q3. YTD 6 cases against an upper limit of 19 cases.

3.3 Three MSSA bacteraemias in Q3.

3.4 Five E-coli bacteraemias in Q3. No links between cases or line related.

3.5 An increase in the crude mortality rate in December. HSMR decreased to 109.7 to September 17 and is higher than expected. SHMI remained at 106 to June 17 and when adjusted for palliative care increased to 104 to March 17. Screening and case reviews continue but have found no deaths with a greater than 50% chance of death due to problems in care. Mortality dashboard will be published in February 18 following the public Board meeting.

3.6 In Q3, a significant improvement in best practice tariff compliance (90%) of patients with a hip fracture.

3.7 Subtle increase in pressure ulcers and three grade 3 ulcers reported year to date. Review of how the share and learning meetings function in underway.

3.8 In December, 4 falls resulting in harm (3 fractured hips & 1 patient with both a fractured wrist and nose). In Q3, 7 patients had a fractured hip requiring surgery & 1 patient with two fractures resulted in moderate harm. Ongoing improvement work in line with the falls reduction strategy.

3.9 Slight dip in Q3 of a CT scan within 12 hours (4 inpatients). Time to reach the stroke unit within 4 hours improved at the end of Q3. Patients not transferred within the timeframe were due to waiting for a stroke bed. An improvement at the end of Q3 of patients spending 90% of their stay on Farley ward in Q3. SSNAP audit C to July 17.

3.10 As anticipated, since the introduction of twice daily clinics, an improvement in November and December of high risk TIA patients seen within 24 hours. Positive feedback received from GPs who have used the new single point of access.

3.11 Escalation bed capacity reduced. Patients experiencing multiple ward moves remained at a low level. AMU moved to its upgraded expanded unit and Breamore ward moved to level 4 in line with the reconfiguration plan.

3.12 No non-clinical mixed sex accommodation breaches for the 10th month in a row.

3.13 Real time feedback for patients rating the quality of their care sustained. The Friends and Family test of patients who would recommend all areas was sustained. Q2 staff friends and family test improved.

4.0 Summary

Positive indicators reflect an improvement in hip fracture patients being operated on within 36 hours and a sustained position of avoiding non-clinical mixed sex accommodation breaches. As anticipated, an improvement in high risk TIA performance. Stroke care indicators also improved. Continued focus on reducing falls that result in harm through our falls reduction strategy.

5.0 Recommendation

To note the Trust quality indicators and actions being taken to improve.

Claire Gorzanski, Head of Clinical Effectiveness, 29 January 2018

NHS Salisbury NHS Foundation Trust

Trust Quality Indicators - December 2017

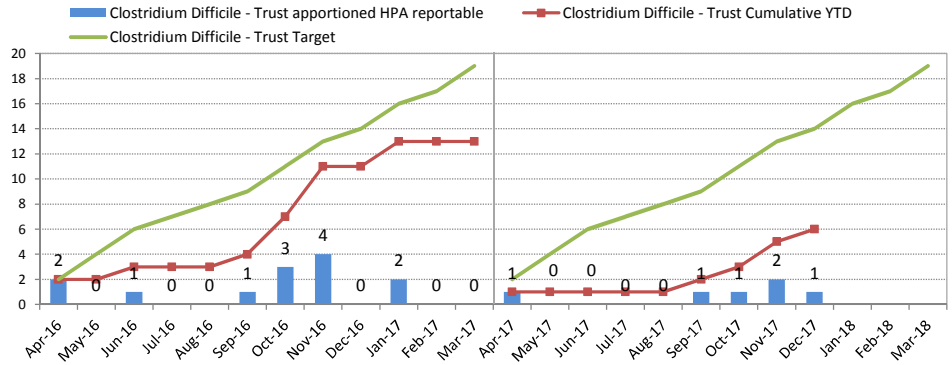
Quality Measures

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

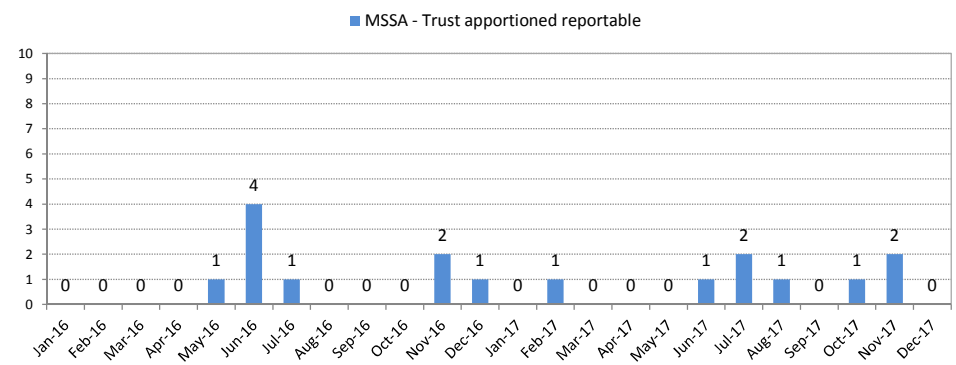
Trust Incidents	2016-17 YTD	2017-18 YTD
Never Events	2	1
Serious Incidents Requiring Investigation	47 *	12

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

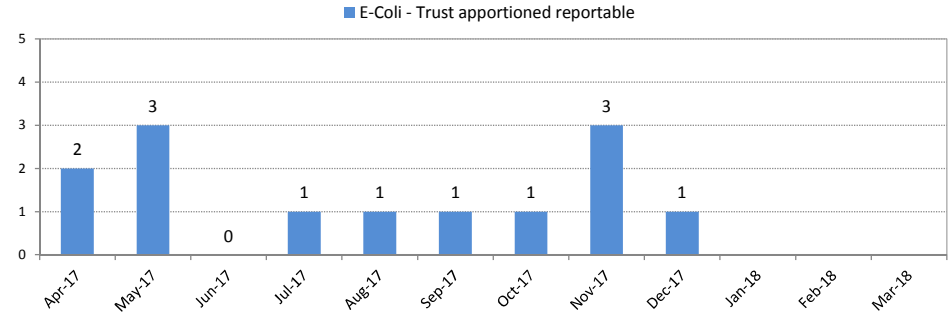
Clostridium Difficile - Trust Apportioned



MSSA - Trust Apportioned

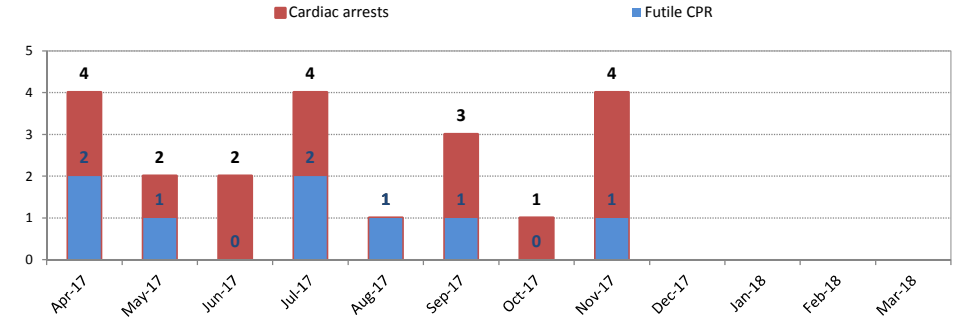


E-Coli - Trust apportioned reportable



Data from April 2017 onwards

In hospital cardiac arrests and futile CPR



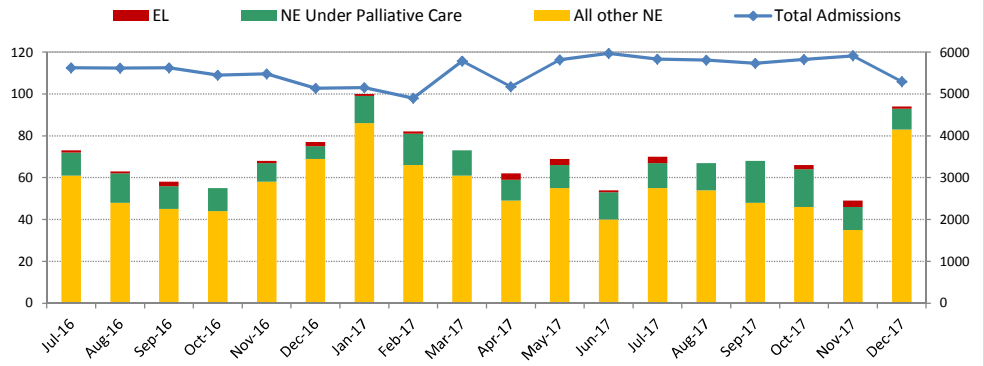
Please note cardiac arrests which occurred in ED, ITU, CCU and Paediatrics are excluded.

NHS
Salisbury
NHS Foundation Trust

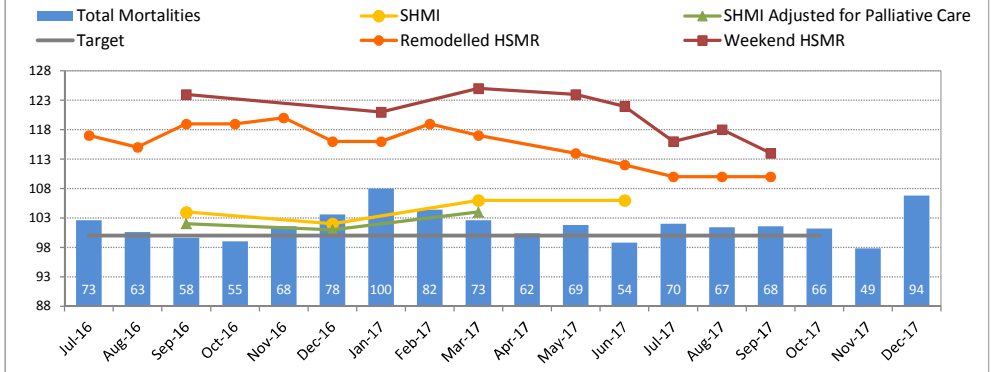
Trust Quality Indicators - December 2017

Quality Measures

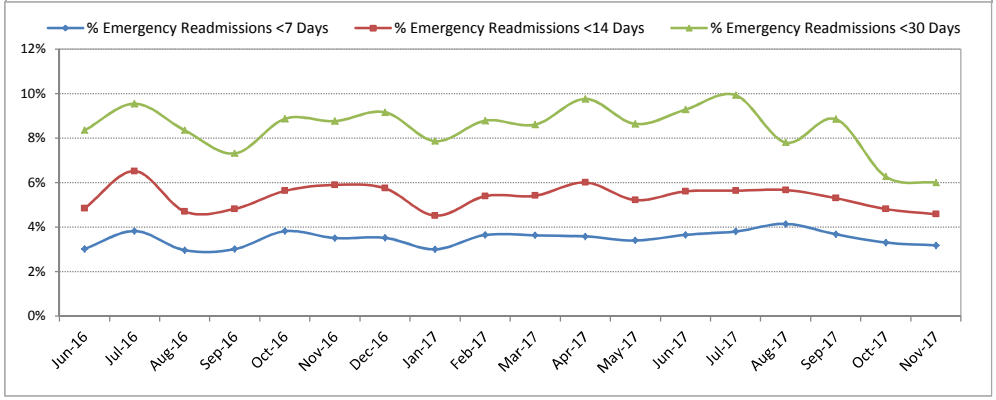
Hospital Mortalities



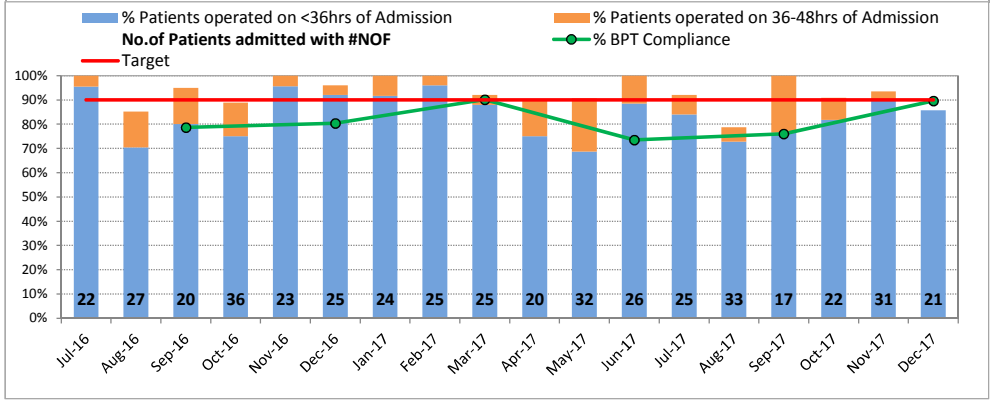
HSMR and SHMI



Emergency Readmissions within 7, 14 & 30 days of Discharge



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

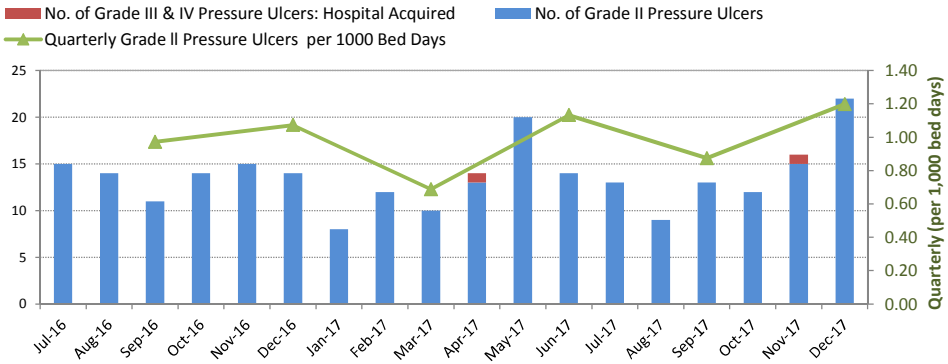


NHS Salisbury NHS Foundation Trust

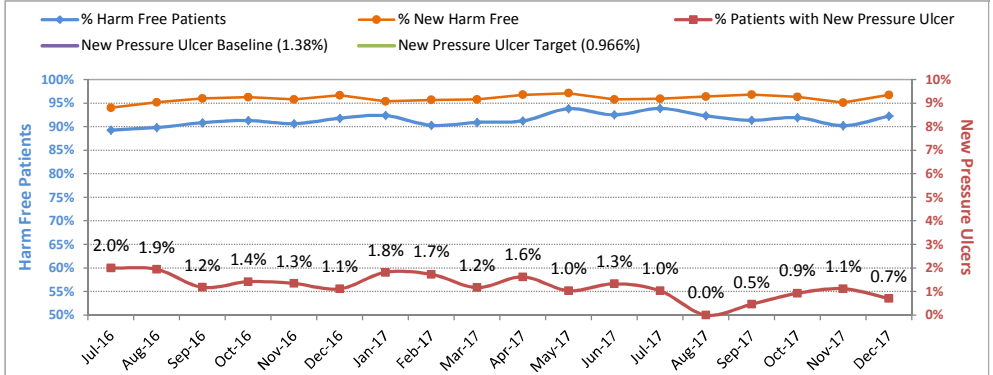
Trust Quality Indicators - December 2017

Quality Measures

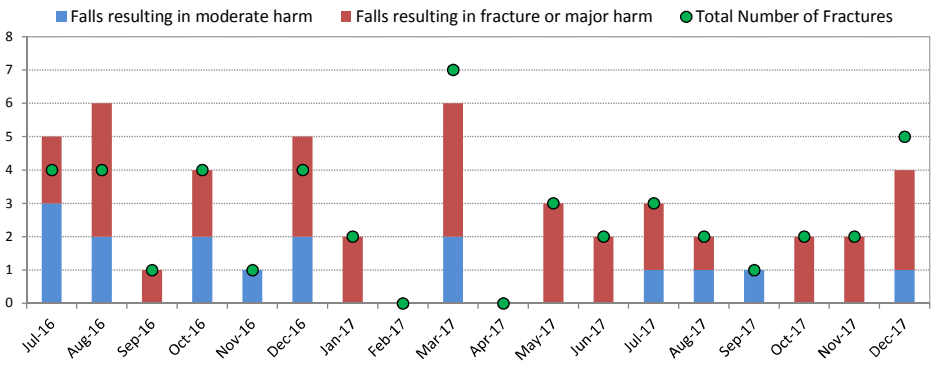
Pressure Ulcers



Safety Thermometer - One Day Snapshot per Month

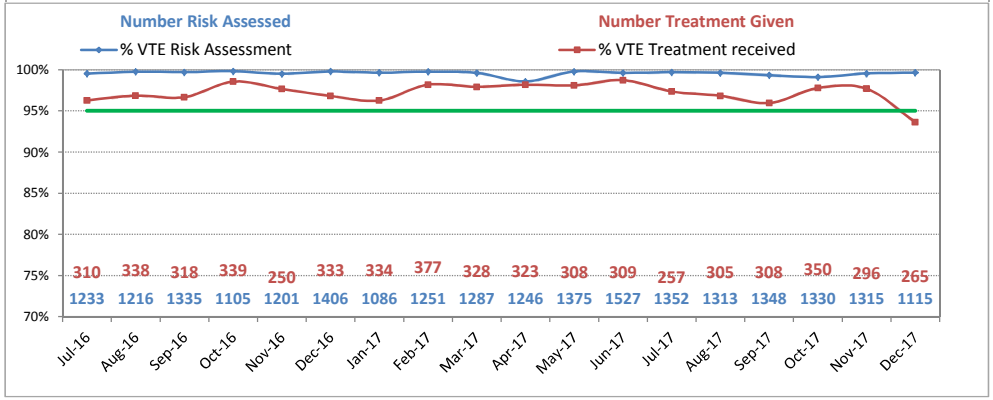


Patient Falls in Hospital



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

Venous Thrombous Embolism: Risk Assessment & Prophylaxis



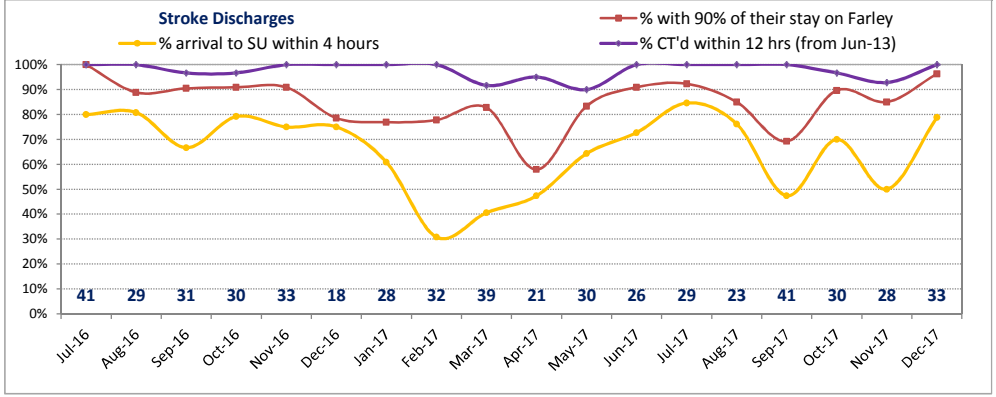
Please note, due to the time it takes to complete Clinical Coding, the current months Fracture Neck of Femur data will be subject to change over the following months.

NHS Salisbury NHS Foundation Trust

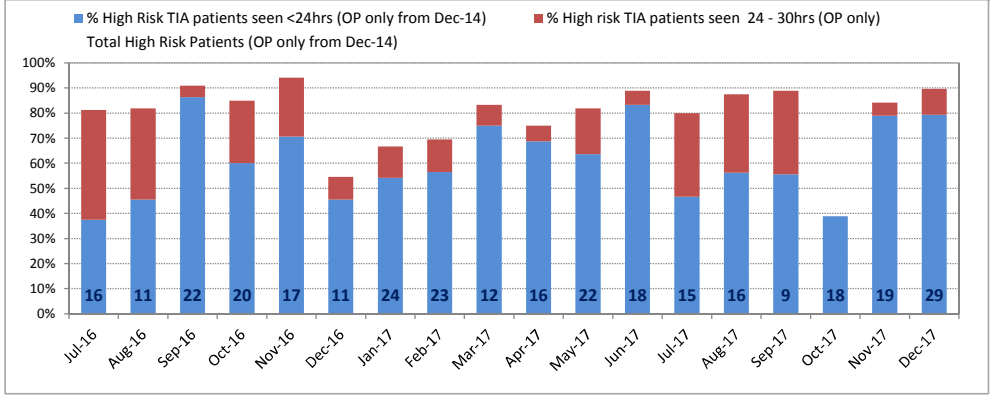
Trust Quality Indicators - December 2017

Quality Measures

Stroke Care



TIA Referrals



SSNAP Case Ascertainment Audit

Highest level = Grade A

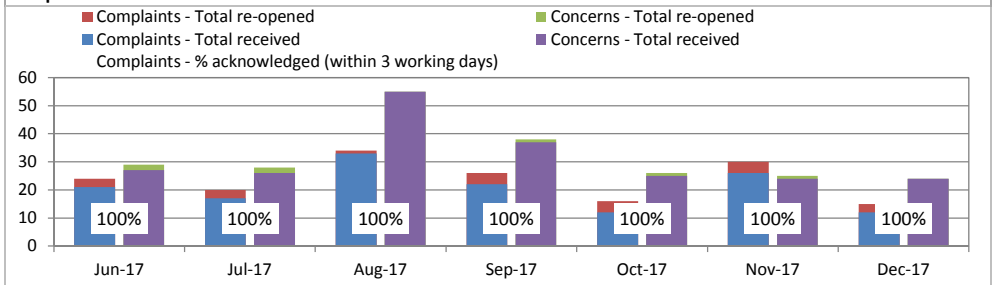
Lowest level = Grade E

Quarterly	Q1	Q2	Q3	Q4
2015-16	D	C	C	C

Tri-annually	Apr - Jul	Aug - Nov	Dec - Mar
2016-17	B	B	D
2017-18	C		

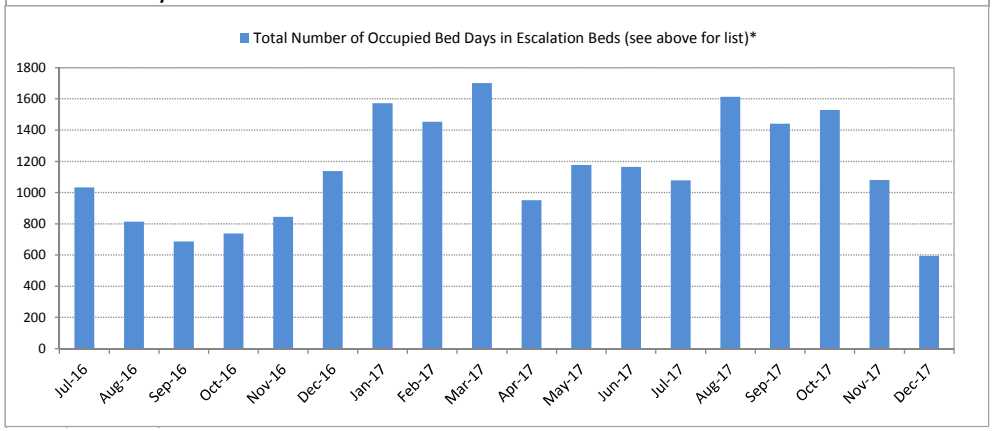
*From April 2016 escalation capacity includes beds on Breamore, DSU, Clarendon, Endoscopy, Avon, Britford SAU overnight stays, Whiteparish AMU overnight stays, Clarendon NHS, Pembroke Suite and Burns assessment room.

Complaints and Concerns

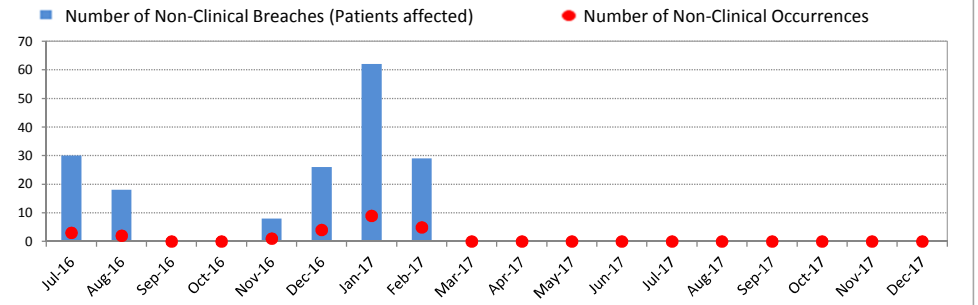


	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Complaints - Total received	21	17	33	22	12	26	12
Complaints - Total re-opened	3	3	1	4	4	4	3
Concerns - Total received	26	27	55	37	25	24	24
Concerns - Total re-opened	2	2	0	1	1	1	0

Escalation Bed Days

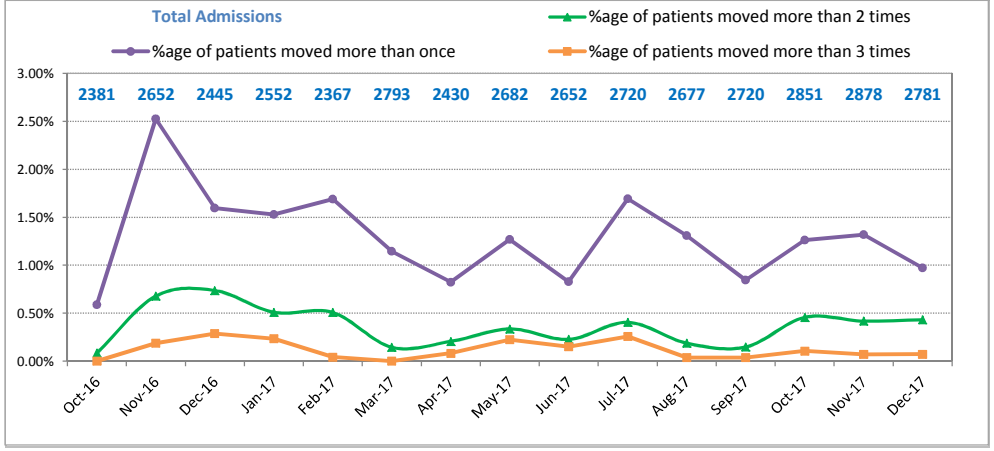


Delivering Same Sex Accommodation



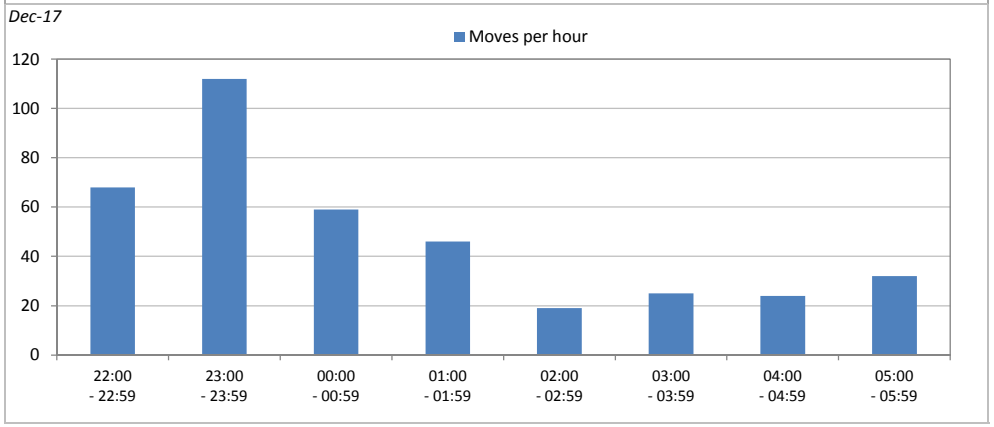
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
■	30	18	0	0	8	26	62	29	0	0	0	0	0	0	0	0	0	0
●	3	2	0	0	1	4	9	5	0	0	0	0	0	0	0	0	0	0

Patients moving multiple times during their Inpatient Stay

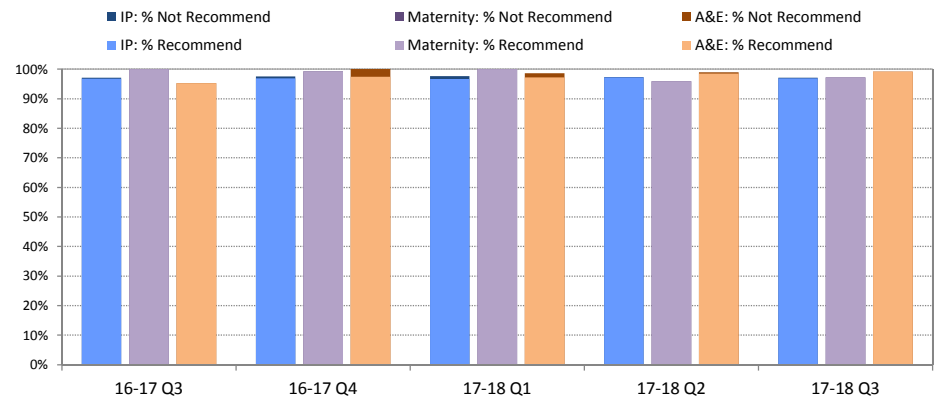


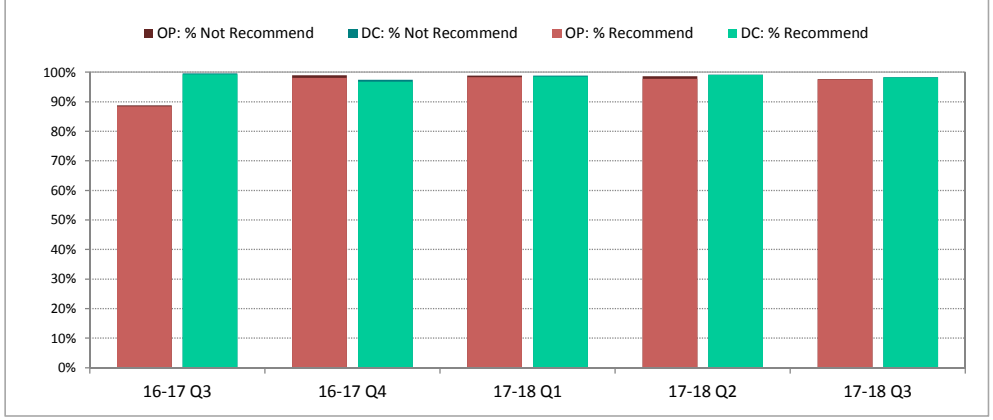
Ward moves between 22:00 and 06:00

Dec-17

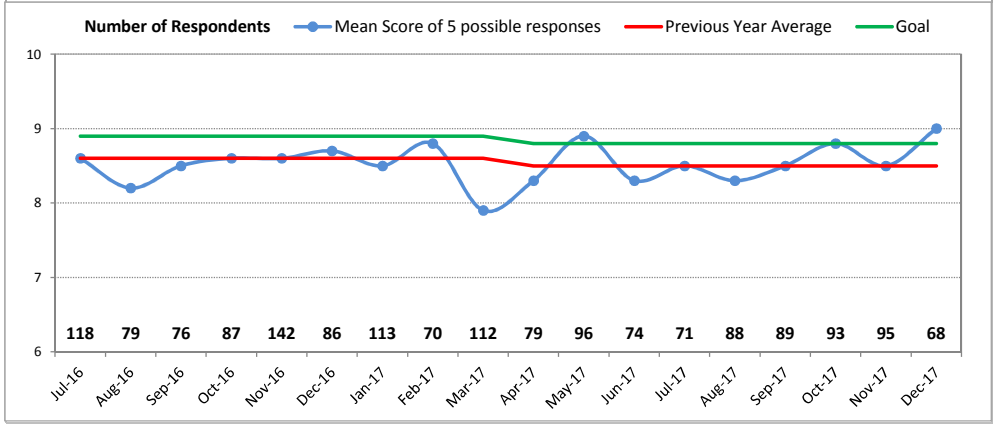


Friends & Family Test: Responses by Area

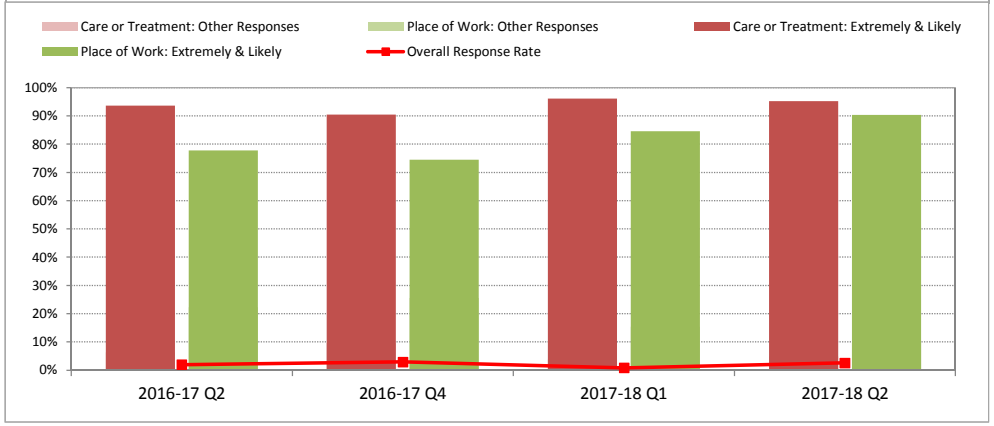




Real Time Feedback: Overall how would you rate the quality of care you received?



Friends & Family Test: Staff (% Responses)



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

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Report to:	Trust Board	**Agenda item:**	**SFT3988**
Date of Meeting:	5th February 2018		

Report Title:	Workforce Report Month 9 2017/18			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		**x**	
Prepared by:	Hilary Salisbury, Deputy Director of OD and People Mark Geraghty, Head of Workforce Information & Planning			
Executive Sponsor (presenting):	Paul Hargreaves, Director of OD and People			
Appendices (list if applicable):	Executive Summary of Key Workforce Performance Month 9 Workforce KPIs Month 9 2017/18			

Recommendation:
It is recommended that the Board note the key areas of concern and the actions underway.

Executive Summary:
The Executive Summary of Key Workforce Performance and the Month 9 Workforce Dashboard (see appendix) details the Trust's performance against the key workforce indicators: Of note this month: Agency spend has reduced for the third consecutive month. Nursing agency spend has significantly reduced and, along with decreases in other areas such as Medical Consultants, Other Medical Staff and Facilities Staff, we have seen an overall decrease of £164k. Recruitment remains challenging, particularly for nursing, however we are taking proactive measures such as holding recruitment events (the Nursing Assistant Recruitment Event on 20th January 2018 had over 100 attendees and 42 offers of employment made to date all of which have been accepted), utilising social media for vacancies and recruitment events and implementing a short term nursing retention plan which includes simplifying internal moves and offering guaranteed interviews to our 3rd year student nurses. The Trust's sickness rate has increased this month with the biggest increase relating to stress, anxiety and depression. The team continue to support areas to proactively manage sickness absence with the aim of further reducing sickness absence to below target. In addition, a health and wellbeing strategy is being developed which will include a variety of initiatives to ensure the Trust is a healthy workplace and supports improved attendance. We now have experienced Interims in the Head of Health and Wellbeing and the Medical Transformation Lead roles. We have a further interim joining us in February to cover the Head of OD and Engagement role. All the interim posts are supporting us to build on the positive work already underway and develop the respective strategies.

1. Purpose

The purpose of this report is to provide an update on performance against the month 9 workforce key performance indicators along with providing assurance on key actions which are underway or planned to achieve the targets and recover the position.

2. Background

The Month 9 data shows a £807k (0.80%) overspend on workforce year to date, which in part is due an over-reliance on agency as a result of recruitment difficulties and sickness absence levels.

Key metrics relating to agency spend and vacancies are continuing to show positive improvements this month. Nursing agency spend in month has reduced by £180k, and we have seen decreases in other areas such as Medical Consultants (£34k), Other Medical Staff (£2k) and Facilities Staff (£1k), which contributed to an overall decrease of £164k.

Sickness increased in month for all Directorates except CSFS, who have been below target all year, and Facilities.

3. Resourcing

3.1 Recruitment

We have seen a further increase in budgeted WTE this month for the fourth consecutive month. The WTE number of non-consultant medical staff has increased this month (14.99 WTE) while costs have remained fairly static. This is due to a technical adjustment and arises from a complication in changing the basis of WTE's from actual worked to contracted WTEs in month 8, and is not expected to recur. The number of contracted WTE medical staff should now settle down at the current level.

Nursing remains a challenging area; we have a 15.81% vacancy rate in Nursing currently which reflects the national picture as recently reported by NHS Digital; the number of advertised nursing and midwifery posts in England reached 34,260 in the three months up to September 2017, the highest level since records began.

Using the M9 baseline, the Trust needs to recruit 108 WTE nurses to achieve a fill rate of 95% of establishment. Over the last year the Trust has recruited an average of 6.59 WTE nurses per month, however an average of 5.69 WTE are leaving. If nurse recruitment was doubled to 13 WTE per month (on average), it would take 14 months to reach our target of 95% establishment fill.

To increase our vacancy fill rate, we are:

- Creating our own route into Nursing via apprenticeships, using a "grow your own" approach.
- Offering a guaranteed 'values based' interview to all current 3rd year Nursing students, 12 interviews have taken place to date.
- Holding recruitment events - we held a very successful recruitment event for Nursing Assistants on the 20th January which has seen 42 offers made to date, all of which have been accepted, with a further 50 people to be interviewed. We are holding a Registered Nurses recruitment event on the 24th February 2018.
- Arranging our next international nursing recruitment campaign to India for April 2018. From 4 planned days of interviews, where 110 to 120 candidates will be interviewed, we are anticipating making between 60 and 80 offers. With a conservative 25% conversion rate to starters, this could see 15 to 20 nurses starting with us.
- Improving our marketing – including a recruitment micro site (www.worklife.salisbury.nhs.uk), running Facebook campaigns for the recruitment events, advertising on one of the Salisbury Park and Ride buses, launching a hashtag

campaign #joinsalisburynhs and created a dedicated Twitter account @SDHRecruitment.

- Reintroducing the 'refer a friend scheme' during February 2018 which is intended to encourage current staff to promote Salisbury as an employer of choice to their peers and increase applications for vacancies.

3.2 Retention

Staff turnover is above target at 9.94% and is 0.65% higher than this time last year. Nursing turnover is 9.05% for the 12 months to December 2017 and, whilst it has actually decreased from the previous 12 month period (9.38%), it is deemed crucial, given recruitment difficulties, to focus on retention. Therefore, we are developing the short term nursing retention plan which will be implemented by the end of March 2018 and it is designed to reduce turnover levels by 0.5%-1% in six months (equivalent to 3.5–7 WTE). If we could reduce turnover by 1% by September, we could achieve our 95% fill rate in 13 months rather than 14 months.

The plan includes:

- Developing a two year Graduate Development Programme for newly qualified Nurses commencing employment at the Trust
- Holding a pilot career clinic drop in session for Registered Nurses to provide nurses the opportunity to discuss their career aspirations and be signposted to opportunities that currently exist.
- Implementing an internal 'Transfer Scheme' for Registered Nurses which aims to reduce the number of leavers from the Trust by simplifying the process to move to an alternative role.

3.3 Temporary Staffing

Agency spend has seen a significant reduction in month, and for the third consecutive month. M9 agency trajectories show a year end position of £2.3m overspend, a reduction of £200k in month, against our £6.2m NHSI agency control, based on average monthly year to date spend (£708k) continuing until year end.
To reduce our reliance on expensive agency staff we are:

- Using the revised medical agency request form and process (requiring Executive Director approval). Our Master Vend supplier are reporting a reduced number of requests and this data is being validated, however this information would correlate with the reduction in medical agency spend.
- Continuing to performance manage our Master Vend agency supplier. The current supplier contract is due to end mid-2018 and discussions are taking place through the Workforce Pay Control Group (WPCG) to determine appropriate future provision.
- Continuing to use Locums Nest for bank medical locums following approval at WPCG. Fill rates for medical locum shifts booked through Locums Nest have increased from 35% between August and December 2017, to 74% for January 2018. This has resulted in a reduction in requests to agency for junior medical staff and correlates with the information we are receiving from our Master Vend supplier.
- NHSI Diagnostic Tool self-assessment has been completed and rag ratings were agreed at WPCG on 26th January 2018. This has identified some areas for improvement which will now inform the development of an action plan to be approved at WPCG in February 2018.
- In the new structure we have appointed a Medical Workforce Transformation Lead starting on 29th January 2018, initially for six months to identify gaps and solutions to enable efficient well managed medical workforce. In addition, objectives will include the future options for medical bank and agency and implementation of job planning and e-rostering for medical staff.

4. Health & Wellbeing

4.1 Sickness Absence

Whilst the Trust compares favourably to neighbouring Trusts, sickness absence is above the Trust target of 3%. Our current sickness absence rate of 4.02% represents a cost of £4.7m annually, based on an annual pay bill of £116.5m.

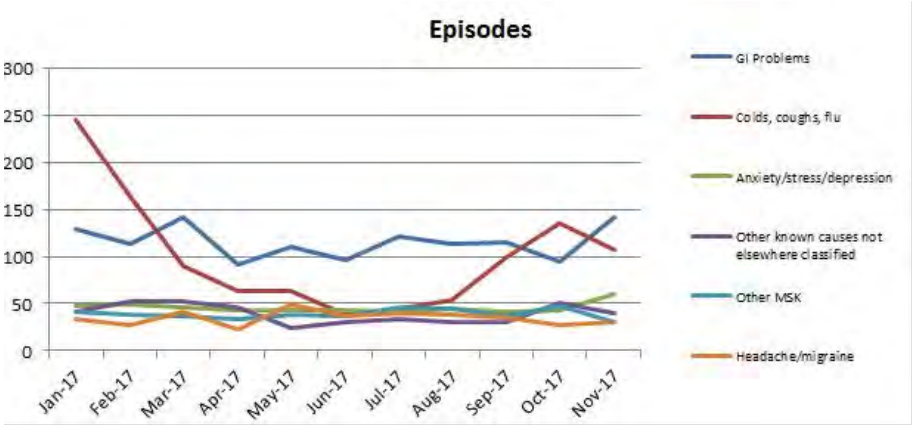
The effect of continuing 2016/17 sickness trends for the remainder of 2017/18 would place us in an out-turn position of 3.65% at year-end (March 2018).

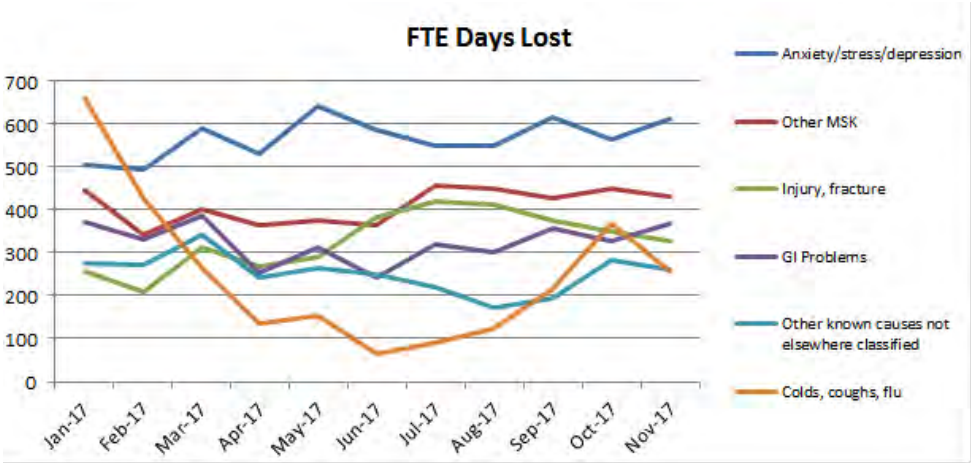
A reduction in our sickness rate of 1.02% (to reach the 3% target) would mean a reduction in sickness by 29.73 FTE (£1.2m based on an average 2016/17 salary cost).

It should be noted that the sickness absence rate has changed from last months reported figure. The reported figure can change throughout the month due to our current paper based recording processes which can result in delays in information being entered into ESR after the workforce dashboard is produced for Board. We are exploring how to resolve this issue.

To bring sickness absence back to target we are:

- Providing support to managers to ensure that individuals whose sickness absence remains problematic (both short and long term) are managed in the appropriate manner which will either support their return to work or see them being managed through the Management of Attendance Policy. This includes reviewing our Occupational Health support to ensure that staff are supported to remain at work or return as early as possible.
- Revising the Management of Attendance Policy in consultation with staff side. To accompany the new policy a toolkit for managers will be published containing templates and guidance. We are also planning in training sessions to support managers to proactively manage sickness absence whether short term or long term. Implementation is planned for March 2018 (following ratification at OMB in February 2018). This will form part of the 'Managers Toolkit'.
- We have undertaken a review of short term absence for 2017 and have identified the core areas, patterns and causes of absence. The graphs below show the number of episodes and WTE days of short term absence between January 2017 and November 2017. All reasons, except 'Colds, cough, flu', remain relatively consistent throughout the year. As a result of this review we are working to develop strategies for early Occupational Health intervention for absences between 7 and 28 days to prevent progression into long term illness.





4.2 Flu Vaccinations

The flu campaign has seen 71.5% of frontline staff vaccinated as of 25th January 2018. This means we have met the requirements for the CQUIN however the campaign continues in earnest to ensure the health and wellbeing of our staff and patients.

5. Organisational Development & Engagement

In line with the People Strategy, we have employed an Interim Head of OD & Engagement who joins the Trust on the 19th February to develop the Organisational Development & Engagement strategy and oversee the Learning & Development Department.

5.1 Learning & Development

Mandatory training

Compliance has increased again this month and remains green at 87.53%.

Appraisals

Compliance for medical staff remains above target at 91%, however compliance for non-medical staff has decreased this month to 82.09%, due to reduced capacity as a result of the significant operational pressures during December. MSK, CSFS, Surgery and Facilities have all exceeded the target.

5.2 Engagement

Staff Engagement

There will be a presentation at March Board meeting on the proposed Engagement Framework which will include:

- Feedback on why staff stay at the Trust with a variety of staff stories.
- The creation of regular staff engagement forums to listen to views and feedback on how we can improve staff experience and creation of feedback mechanisms to ensure staff have a voice.
- Benchmarking ourselves against what other organisations do to improve staff engagement to learn from best practice.

Staff Survey

The survey closed on Friday 1st December 2017. The final response rate was 46.2% which is just above national average for acute Trusts (45.5%). The response rate was 35% in 2016 and 31% in 2015.

The final report will be provided to us week commencing 19th February 2018 with the results embargoed until 6th March 2018.

5.3 Equality, Diversity and Inclusion

A draft Gender Pay Gap Report for the Trust is currently out for consultation with the Diversity and Inclusion Committee and will be submitted to the Workforce Committee in March. We are required to publish our report by 31 March 2018.

We are reviewing our Mindful Employers Charter membership for the forthcoming 3 year term. The Mindful Employer Charter supports mental wellbeing at work and a requirement of membership is to undertake periodic reviews.

6. Exceptions

6.1 Nursing

The tables below highlight the key exception areas in Nursing for turnover, vacancies and sickness absence.

Turnover (year to date)	
Nursing and Midwifery Registered	9.05%
Top 3 areas of turnover (year to date)	
Downton Ward	32%
Chilmark Ward	23%
Pitton Ward	22%

Vacancies	
Nursing and Midwifery Registered	15.81%
Top 3 areas of Vacancies (WTE)	
Laverstock / Winterslow Ward	20.10 WTE
Farley Ward	12.34 WTE
Durrington Ward	7.72 WTE

Sickness Absence	
Nursing and Midwifery Registered	4.04%
Top 3 areas of sickness absence	
Theatres	7.45%
Maternity	6.33%
Emergency Department	4.92%

7. Conclusion

The situation remains challenging; however it is clear that the focus of activity, particularly on recruitment, retention and agency, is improving the position. Agency spend has reduced significantly in month and has reduced our projected overspend in year by £200k in comparison to last month.

Whilst we have seen a small increase in our recruitment overall again there are significant challenges, particularly relating to nursing. We continue to promote and grow our position in the domestic market through our social media campaigns and recruitment events It is clear from the national picture that the domestic market for nurses is very difficult and we have a longer term plan to 'grow our own' nurses through our apprenticeship programmes. In order to address our immediate need we continue to pursue international recruitment opportunities.

Sickness absence has increased in month, particularly for the reason of anxiety, stress and depression. Whilst continued focus on managing sickness absence is required and will continue, it is clear that a more preventative approach is needed and, through our Interim Head of Health and Wellbeing we are exploring strategies which will enable staff to feel supported to remain at work.

We are in consultation on the new OD & People structure to ensure we can continue the positive work underway and build our capacity and capability to be able to deliver the people element of the Trust strategy and a sustainable workforce for the future. It is anticipated that the revised structure will be implemented from 1st March 2018.

Paul Hargreaves
Director of Organisational Development & People

Executive Summary of Key Workforce Performance

Area of Review	Key Highlights	Status	Trend	Target
Turnover/ Retention	**In Month:** In month there were 56 leavers and 46 starters (headcount) compared to 59 leavers and 88 starters in the month before. This figure includes bank and locum staff. **Year to Date:** For the rolling year to date, the turnover rate was above target at 9.94%, this compares to last months position which was 9.69%. For the rolling year to M9 2016/17, the Trust's turnover rate was 9.3%.	GREEN		8.50%
Vacancies	**In Month:** There was a decrease in the vacancy rate this month, 5.36%, compared to 6.62% last month. **Year to Date:** The year to date vacancy rate is 7.80%, this compares to last months YTD position which was 8.11%. The Trust's vacancy rate for the same period last year was 6.66%.	AMBER		5.00%
Temporary Spend	**In Month:** There has been a decrease in agency spend this month at £586,255, compared to last month's position which was £750,791. This remains above the Trusts' NHSI control total target for the year to date. **Year to Date:** The financial year to date total agency spend is £6,373,925, compared to the spend for the same period in the previous year which was £5,517,690.	RED		£513,333
Sickness	**In Month:** There has been an increase in the sickness rate this month at 4.02%, this compares to last months position of 3.75%. **Year to Date:** The year to date average sickness rate is at 3.60%, which compares to last months position of 3.43%. The sickness rate for same period last year was 3.44%.	RED		3.00%
Training	**In Month:** Mandatory training compliance levels have improved this month to 87.53%, this compares to last months position of 86.22%. Compliance for the same period in 2016 stood at 82%. **Year to Date:** The year to date average compliance level is 85.46%, this compares to last months position of 85.21%.	GREEN		85.00%
Non-Medical Appraisals	**In Month:** Non-Medical Appraisal compliance has decreased this month to 83.90%, from last months position of 84.60%. Non-medical appraisal compliance for the same period last year stood at 82%. **Year to Date:** The year to date average compliance is 82.06%, this compares to last months position of 81.83%.	AMBER		85.00%

Salisbury NHS Foundation Trust Workforce Dashboard

	Strs/Lvrs		Turnover (FTE)			Vacancies				Temporary Spend					Sickness						Training	Appraisal	
	Starters *(head count in month)*	Leavers *(head count in month)*	Average Heads *(in year)*	Number of Leavers *(in year)*	Turnover *(rolling year)*	Budget Wte (Ledger)	Staff In Post Wte *(Ledger - month end)*	Vacant Wte	Vacancy Rate	spend on Agency	% Temp Spend on Agency *(in month)*	spend on Bank	Total Temp Spend	Agency Budget	Long Term Sick WTE lost *(in month)*	%	Short Term Sick WTE lost *(in month)*	%	Total WTE lost to Sickness *(in month)*	Sickness Rate	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
YTD Trend	*Data excludes: Docs in Training & Tupe Transfers. Data includes: Bank Staff*																						
Month Trend																							
Target		29		240	8.50%			154.06	5.00%	£ 513,333	40.00%								84.70	3.00%	85.00%	85.00%	85.00%
Apr-17	71	43	2,827	250	8.85%	3,081.27	2,823.20	214.76	6.97%	£ 513,765	41.61%	£ 720,840	£ 1,234,605	Over	52.11	59%	36.92	41%	89.03	3.18%	84.12%	91.00%	80.40%
May-17	59	54	2,824	243	8.61%	3,078.73	2,777.53	268.47	8.72%	£ 692,515	53.84%	£ 593,693	£ 1,286,208	Over	56.60	58%	40.26	42%	96.86	3.51%	84.76%	93.00%	81.00%
Jun-17	52	56	2,822	257	9.09%	3,078.14	2,786.46	261.33	8.49%	£ 746,142	58.41%	£ 531,232	£ 1,277,374	Over	56.51	62%	35.28	38%	91.79	3.39%	85.14%	93.00%	81.40%
Jul-17	67	46	2,820	256	9.07%	3,052.55	2,782.64	269.91	8.84%	£ 731,460	57.20%	£ 547,400	£ 1,278,860	Over	60.94	62%	36.85	38%	97.79	3.55%	86.63%	95.00%	81.90%
Aug-17	54	55	2,816	266	9.45%	3,075.03	2,778.67	296.36	9.64%	£ 762,217	56.70%	£ 582,156	£ 1,344,373	Over	60.84	61%	38.49	39%	99.34	3.45%	85.79%	95.00%	81.90%
Sep-17	62	49	2,814	274	9.73%	3,045.93	2,807.27	238.66	7.84%	£ 804,575	57.36%	£ 598,145	£ 1,402,720	Over	73.43	65%	39.67	35%	113.10	3.90%	83.07%	94.00%	82.10%
Oct-17	85	44	2,816	268	9.53%	3,113.36	2,872.77	240.59	7.73%	£ 786,207	60.02%	£ 523,734	£ 1,309,941	Over	67.67	73%	25.65	27%	93.32	3.63%	85.91%	93.00%	81.30%
Nov-17	88	59	2,825	274	9.69%	3,121.15	2,914.48	206.67	6.62%	£ 750,791	57.48%	£ 555,334	£ 1,306,125	Over	45.33	46%	53.02	54%	98.35	3.75%	86.22%	91.00%	84.60%
Dec-17	46	56	2,835	282	9.94%	3,117.45	2,950.43	167.02	5.36%	£ 586,255	52.23%	£ 536,208	£ 1,122,463	Over	69.34	58%	49.45	42%	118.78	4.02%	87.53%	92.00%	83.90%
Jan-18																							
Feb-18																							
Mar-18																							
totals	584	462		Average	9.33%			Average	7.80%	£ 708,214									Average	3.60%	85.46%		

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

Month 9 position shows an overspend on workforce of £807k (0.80%). Recruitment difficulties in some areas have lead to the Trust's agency spend trajectory exceeding its NHSI agency control total target. Overall vacancy levels have decreased this month but remain high in some areas. Staff sickness is red rated at 4.02%, which is average for the surrounding Local Acute hospital Trusts. Staff Turnover is above target at 9.94%, the second lowest (best) rate among surrounding hospitals. Mandatory training compliance levels have improved this month and are above target (green). Appraisal compliance has decreased and remains amber at 83.90%.

Exception Reporting for Board

The area with the highest sickness rate is Medicine Directorate at 5.05%

The area with the highest vacancy rate is Musculo-Skeletal at 14.02%

The area with the highest agency spend is Medicine Directorate at £273,536

Report to:	Trust Board	Agenda item:	SFT3988
Date of Meeting:	5th February 2018		

Report Title:	Finance Report Month 9			
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Mark Collis, Deputy Director of Finance			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):	None			

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

Executive Summary:
The purpose of this report is to set out the Trust's financial performance for the period to 31st December 2017. The Trust is subject to a section 106 regulatory enforcement action due to the deteriorating financial position. The Trust has formally submitted a re-forecast to NHSI in line with the regulators protocol. This shows the Trust is likely to report a £12.5m deficit at year end. The month 9 reported position is overall in line with this re-forecast deficit, however income was higher than anticipated and costs were also higher, particularly in pay. This combined with activity levels in early January; pose a risk to the overall forecast position. In mitigation the Trust remains focused on ensuring a robust set of controls are enforced in managing agency spend, and the Trust is working with commissioners to mitigate the risk of January activity flow and subsequent escalation costs.

Executive Summary of Key Financial Performance - December 2017

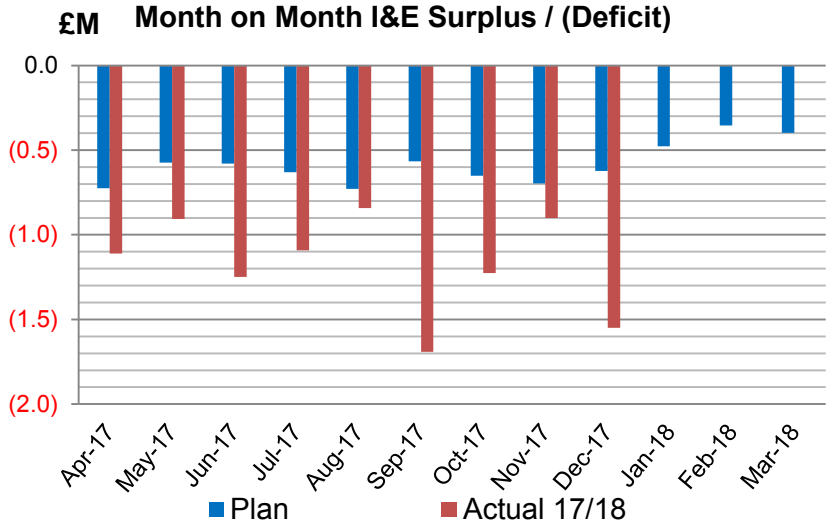
Page	Area of Review	Key Highlights	Status
1	Income & Expenditure	**In Month:** The deficit was £1,549k which was an adverse variance against the plan of £926k but in line with the re-forecast figure agreed at month 8. The attributable factors were NHS income continuing to be behind plan and non pay costs above plan mainly associated with the additional cost of outsourcing. **Year to Date:** The main cause of the YTD deficit relates to under delivery of NHS clinical income (£3,022k behind the plan). Also not all savings are being fully delivered and 42% were non-recurring to date.	RED
2	NHS Clinical Income	**In Month:** NHS clinical income was behind plan but overall income was in line with the re-forecast agreed at month 8. **Year to Date:** The most significant areas of underperformance relate to outpatients and elective work. Excluded drugs and devices were behind plan but offset by lower expenditure.	RED
3	Workforce	**In Month:** The pay was lower than previous month but higher than forecasted due increased ITU nursing costs due to higher than anticipated activity and increased acting allowances . **Year to Date:** Pay costs have exceeded plan and the adverse variance against the agency control total remains a concern. Laundry pay spend was £525k more than plan but was matched by additional income.	AMBER
4	Non Pay	**In Month:** Non pay was overspent across most areas most notable on healthcare provided by other providers as we continue to outsource activity to achieve waiting times. **Year to Date:** Non Pay spend overall was greater than plan, particularly on purchase of healthcare from non-NHS bodies, consultancy expenses and supplies and services - general.	AMBER
5	Efficiency - Better Care at Lower Cost	**In Month:** Actual savings were slightly behind plan and this was due to non delivery of income generation schemes. **Year to Date:** Savings were behind plan, mainly due to income generation schemes not delivering in line with plan.	RED
6	Use of Resources rating	The Trust's overall risk rating score remains unchanged at 4 under the new single oversight framework. A score of 4 will mean that a provider is subject to financial special measures. NHSI have completed their investigation and provided feedback to the Trust. The Trust is in the process of reviewing the feedback and developing a recovery plan.	RED
7	Cash Management	**In Month:** The Trust has made a further drawdown of cash from the DoH to support its deficit position. Cash is ahead of the planned figure, partly due to a significant annual EPR payment not being made in the month as expected, additional income being received and slippage on the capital programme. **Year to Date:** The Cash position is being carefully monitored. However the Trust has now borrowed £9.375m to support its working capital position, all of which is repayable and will impact on future years investment plans.	AMBER
8	Capital Expenditure	**In Month:** Spend was behind plan, mainly due to slippage, which has been revised for the year and the plan revised accordingly. In addition the Trust has decided not to proceed with the scanning element of the EPR project, which formed part of the plan. **Year to Date:** The capital programme will be closely monitored to ensure the Trust remains on target to achieve the current revised plan.	AMBER
9	Performance against Forecast	There was an adverse variance of £59k between the actual and forecast Month 9 position. This comprised a favourable income variance of £185k and an adverse variance on expenditure of £271k mainly on pay costs.	GREEN

Page 1 - Income & Expenditure

Status	Position	Trend

Income & Expenditure

	YTD (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s
Operating Income			
NHS Clinical Income	141,189	138,167	(3,022)
Other income	22,531	22,512	(19)
Total income	**163,720**	**160,679**	**(3,041)**
Operating Expenditure			
Pay	103,759	104,585	(826)
Non Pay	54,948	55,615	(667)
Total Expenditure	**158,707**	**160,200**	**(1,493)**
EBITDA	**5,013**	**479**	**(4,534)**
Financing Costs	10,784	11,047	(263)
Surplus/(Deficit)	**(5,771)**	**(10,568)**	**(4,797)**



Variation & Action

In Month: The in-month deficit was £1,549k which was an adverse variance against the plan of £926k but in line with the re-forecast figure agreed at month 8. The under-performance was attributable NHS income being behind plan and non pay costs above plan mainly associated with the additional cost of outsourcing and consultancy spend.

Year to Date: The main cause of the YTD deficit was NHS clinical revenue being behind the plan and pay overspend. The key areas of focus are workforce controls and maximising our resources to recover our income position.

Action: There continues to be on-going dialogue with the relevant commissioners and NHSI to resolve contractual issues. Directorates are focusing on delivering their forecast outturn positions agreed at month 8 and ensuring workforce controls are embedded to reduce the reliance on agency spend, and that CIP plans are being developed to mitigate any shortfall.

Page 2 - NHS Commissioner Income

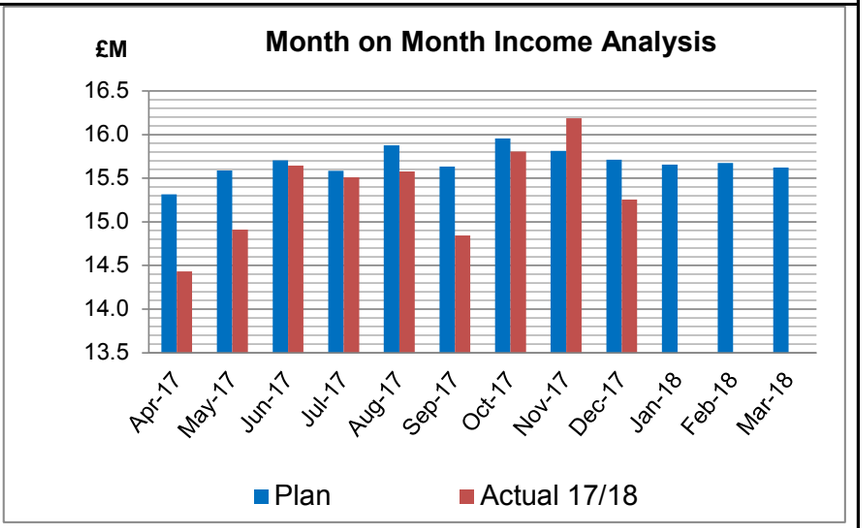
Status	Position	Trend

NHS Clinical Income

By Point of Delivery	YTD (Cumulative) Plan £000s	Actual £000s	Variance £000s
Day Case	13,326	12,582	(744)
Elective inpatients	12,272	12,101	(171)
Non Elective inpatients	46,714	47,283	569
Outpatients	20,598	18,719	(1,879)
Excluded Drugs & Devices	13,325	12,407	(918)
Other	34,954	35,075	121
TOTAL	**141,189**	**138,167**	**(3,022)**

SLA performance			
Wiltshire CCG	70,921	71,700	779
Dorset CCG	15,109	16,112	1,003
Hants CCG	11,626	11,577	(49)
Other CCGs	21,301	14,640	(6,661)
Specialist Services	22,232	24,138	1,906
TOTAL	**141,189**	**138,167**	**(3,022)**

By Point of Delivery - Actual Activity	YTD (Cumulative) Last Year	This Year	Variance
Elective - EL	3,910	3,806	(104)
Day case - DC	16,168	16,026	(142)
Non Elective - NEL	20,277	21,169	892
Outpatients	153,505	164,581	11,076
A&E	35,664	35,434	(230)



The activity variance for outpatients is subject to further investigation. Attendances this year have materially increased when compared to last year attendances post Lorenzo implementation for the following specialities; physiotherapy, orthopaedics, plastics and respiratory services.

Variation & Action

In Month: Overall income was behind of plan this month, but in line with our expected forecast. Outpatient income was lower than anticipated over the Christmas period but it is expected that the position will recover in future months.

Year to Date: Income continues to be significantly behind plan and the overall, planned inpatient activity was lower when compared to the same period last year. The over performance Dorset has been adjusted for the risk share agreement and Specialist Services includes in addition to over-performance, funding of aseptic unit and cancer MDTs.

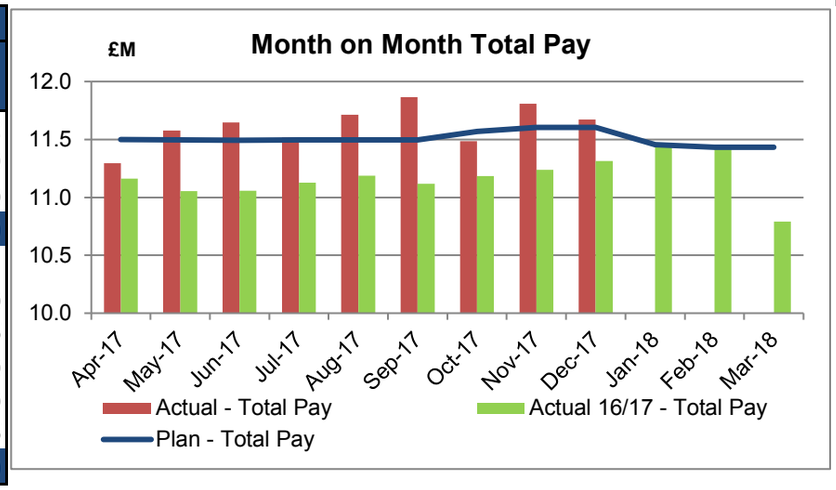
Action: There continues to be on-going dialogue with the relevant commissioners to resolve funding issues and this has formed the basis of our

Page 3 - Workforce

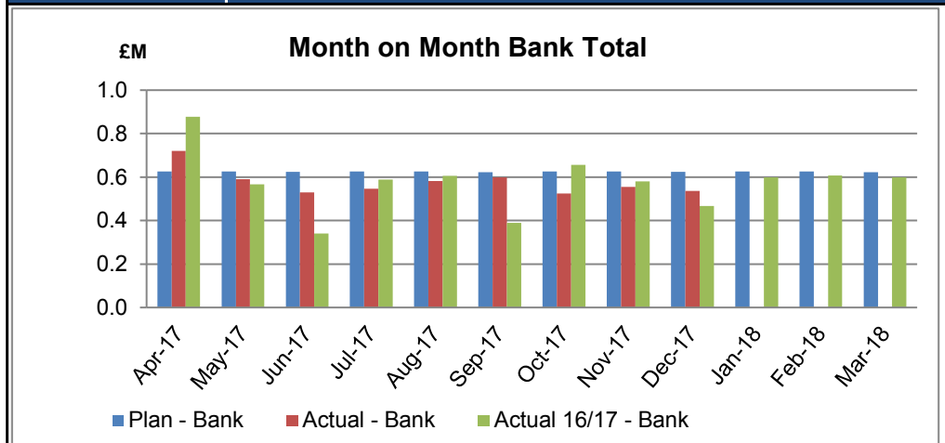
Status	Position	Trend

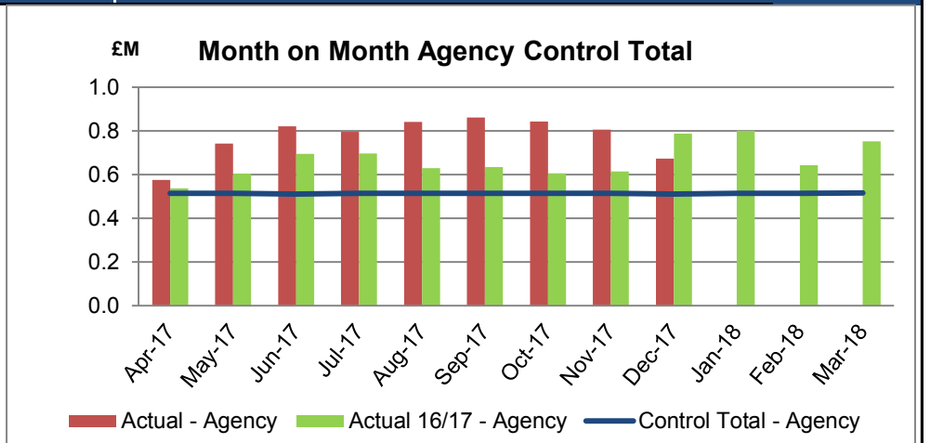
PAY

	YTD (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	93,519	92,447	1,072
Pay - Bank	5,623	5,183	440
Pay - Agency	4,617	6,955	(2,338)
TOTAL	**103,759**	**104,585**	**(826)**
Medical Staff	28,600	29,710	(1,110)
Nursing	28,726	27,381	1,345
HCAs	10,925	11,769	(844)
Other Clinical Staff	13,633	13,944	(311)
Infrastructure staff	21,875	21,780	95
TOTAL	**103,759**	**104,584**	**(825)**



Trend	Trend





Variation & Action

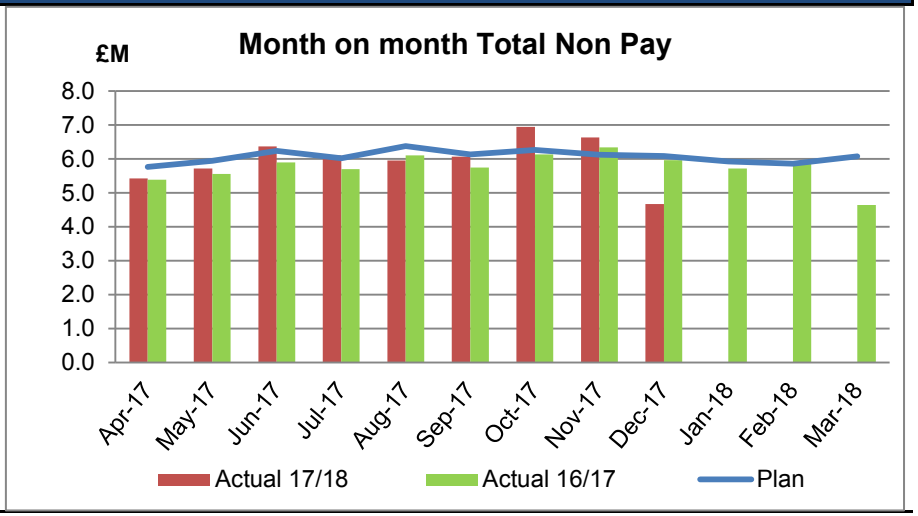
In Month: Pay has gone down when compared to last month most notably on agency spend for qualified nurses. However, the monthly total cost was above the expected forecast due to higher costs in ITU as a result of increased activity and additional acting down payments to consultant staff.

Year to Date: Pay costs are exceeding plan and the adverse variance against the agency control total remains a concern. The Trust has two key issues to address: one of volume of agency shifts, although this must be weighed against quality risks, and the price of agency shifts in terms of capped rates.

Action: The Trust has instigated an additional workforce controls group, to ensure all aspects of pay expenditure are reviewed. This group is reviewing agency spend, recruitment trajectories, sickness levels and additional payments, to ensure oversight and standardisation across all of the workforce.

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

Status	Position				Trend
		YTD (Cumulative)			
		Plan £000s	Actual £000s	Variance £000s	
NON-PAY	Drugs	15,387	15,521	(134)	
	Clinical Supplies	16,234	15,837	397	
	General Supplies	3,871	3,890	(19)	
	Outsourced healthcare	3,282	3,853	(571)	
	Other Non Pay expenses	16,173	16,514	(341)	
	TOTAL	**54,948**	**55,615**	**(667)**	



Variation & Action

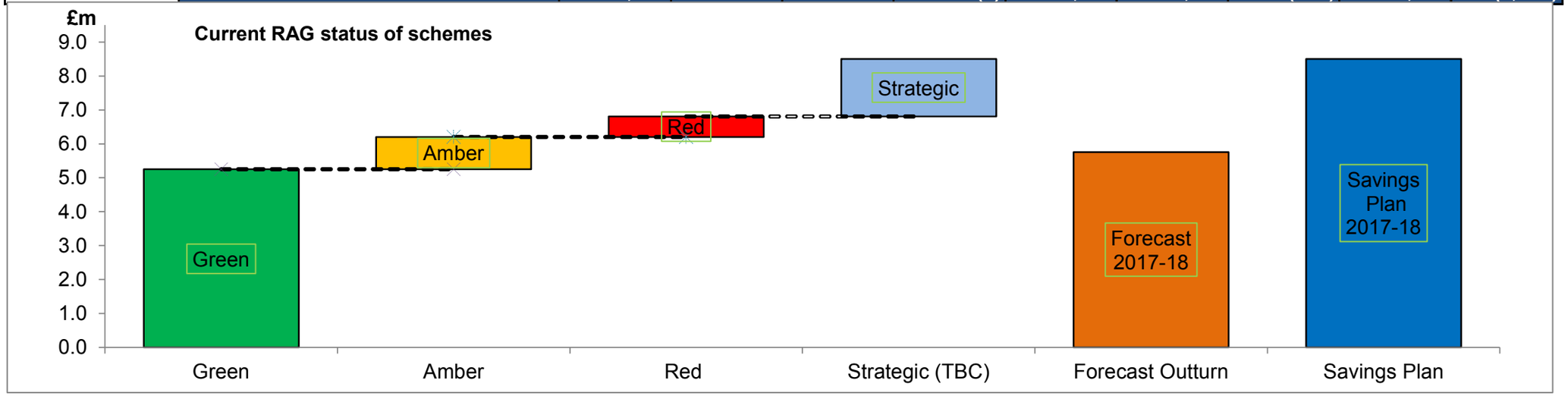
In Month: Overall non pay costs have decreased when compared to the previous month as result of less clinical activity taking place due to fewer working days in the month. There continues to be significant emergency pressures on beds, and as a result outsource activity was higher than planned to achieve the waiting time targets.

Year to Date: Overall non pay spend was overspent against plan and this was due to the on-going use of outsourced healthcare providers to achieve waiting targets, mainly endoscopy and orthopaedics activity.

Action: Procurement have identified a number of additional initiatives and are working closely with Directorates.

Page 5 - Efficiency - Better Care at Lower Cost

Status	Position									
	Directorate	Annual Plan £000s	In Month			Year to Date			Forecast	
			Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Outturn £000s	Variance £000s
Efficiency	Medicine	1,089	101	99	(2)	790	370	(420)	436	(653)
	Musculo Skeletal	933	99	75	(24)	642	655	13	988	55
	Surgery	1,425	131	52	(79)	1,010	448	(562)	730	(695)
	Clinical Support & Family Services	1,823	157	159	2	1,322	1,210	(112)	1,798	(25)
	Corporate Services	1,230	120	155	35	870	1,165	295	1,661	431
	Strategic Schemes	2,000	-50	16	66	-101	126	227	311	(1,689)
	TOTAL	**8,500**	**558**	**556**	**(2)**	**4,533**	**3,974**	**(559)**	**5,924**	**(2,576)**



Variation & Action

In Month: Actual savings were slightly behind plan this month mainly in Medicine and Surgery and relate to the non-delivery of income generation schemes.

Year to Date: Overall savings were behind plan due to income generation schemes not being delivered. Of the YTD savings delivered 42% were reported as non-recurring.

Forecast: There has been a reduction in the forecast CIP achievement of £62k. This is due to MSK reducing their forecast achievement by £79k due to a reduction in surgical over-performance income following the national decision to suspend elective surgical activity in the early part of 2018.

Action: The Directorates and BCG are looking at schemes identified for next financial year, and how these schemes might be brought forward to deliver in this financial year.

Page 6 - Use of Resources

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

Variation & Action

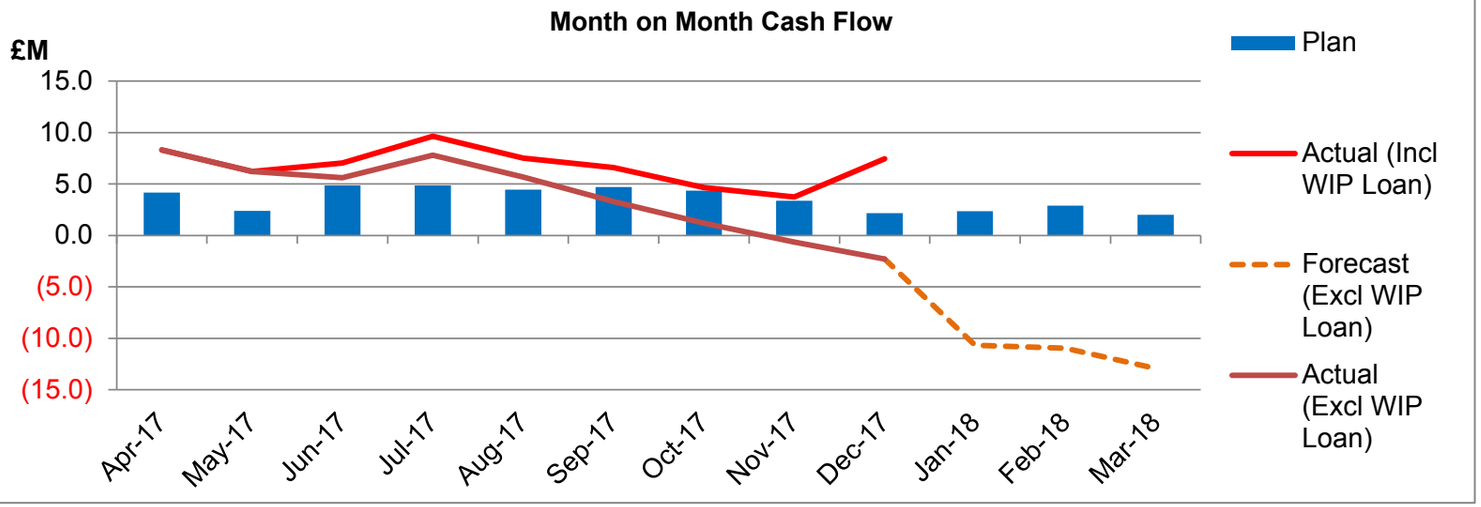
The Trust's overall risk rating score is a 4 under the new single oversight framework, 1 being the highest score with maximum autonomy. A score of 4 will mean that a provider will require support from NHSI. The level and type of support is predicated on a number of items, including what the associated circumstances are, whether the Trust understands the issue and ultimately the plan to address the issue.

NHSI have completed their investigation and provided feedback to the Trust, and draft enforcement undertaking are now being discussed.

Page 7 - Cash & Working Capital

Status	Position						Variation & Action
Cash and working		Opening Balance April 2017 £000s	Plan £000s	Current Month Balance £000s	Variance £000s	Actual In Year Movement £000s	**In Month:** The Trust's cash position was assisted by the drawdown of a further £4,983k revenue support loan in the month. The cash position is higher than expected as additional funds were received in December and a large annual payment relating to the EPR system did not go out in the month, as originally expected.
	Inventories (Stock)	4,950	2,950	6,059	3,109	1,109	**Year to Date:** Monthly cash flows are being submitted to the NHSI highlighting cash flow requirements for a three month period moving forward. Close scrutiny is being undertaken on the cash position to ensure sufficient funds are available to meet the Trust's requirements. Revenue support loans of £9,375k have been received to date with further borrowings required
	Debtors	14,968	14,219	14,968	749	0	
	Cash	7,660	2,161	7,456	5,295	(204)	
	TOTAL CURRENT ASSETS	**27,578**	**19,330**	**28,483**	**9,153**	**905**	
	Creditors	(20,515)	(17,648)	(20,730)	(3,082)	(215)	
	Borrowings	(1,140)	(1,159)	(1,140)	19	0	
	Provisions	(344)	(214)	(298)	(84)	46	
	TOTAL CURRENT LIABILITIES	**(21,999)**	**(19,021)**	**(22,168)**	**(3,147)**	**(169)**	
	TOTAL WORKING CAPITAL	**5,579**	**309**	**6,315**	**6,006**	**736**	

Trend

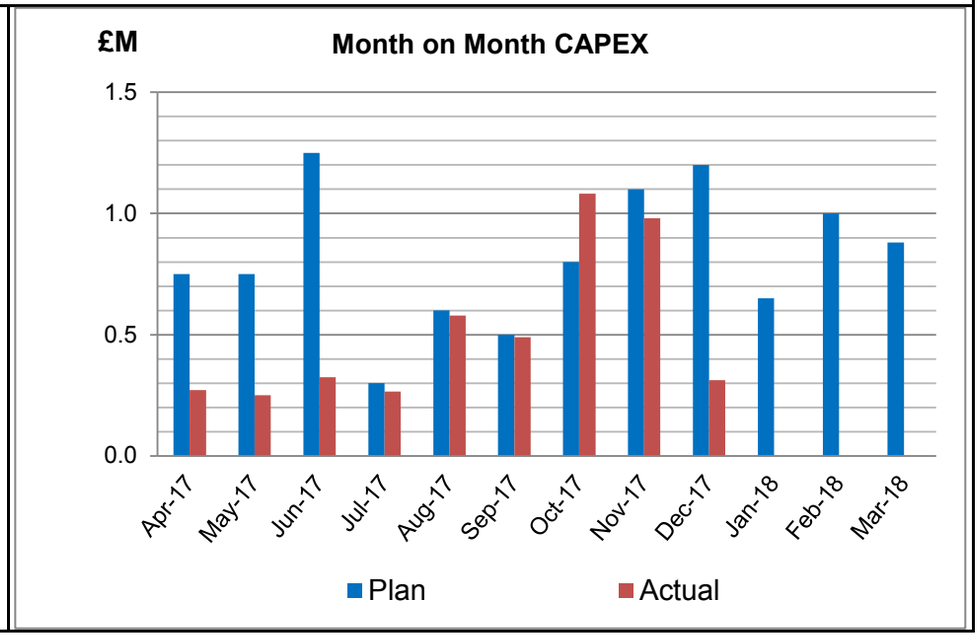


Other Indicators

BPPC % of bills paid in target	Current Month	Previous Month	Movement
- By number	82.1%	81.6%	0.5%
- By value	85.4%	85.3%	0.1%
Creditor days	104	102	2
Debtor days	24	22	2

Page 8 - Capital Expenditure

Status	Position				
	Schemes	Annual Plan £000s	YTD (Cumulative) Plan £000s	Actual £000s	Variance £000s
Capital Expenditure	Breast Unit	89	88	88	0
	Other	110	79	110	(31)
	Donated: TOTAL	**199**	**167**	**198**	**(31)**
	Estates - Ward Relocation Project	2,364	1,891	1,626	265
	Other Estates Projects	1,328	895	443	452
	Estates: TOTAL	**3,692**	**2,787**	**2,069**	**718**
	IM&T - EPR / Data Warehouse	2,356	2,356	924	1,432
	IM&T - Other	1,496	1,017	451	566
	IM&T: TOTAL	**3,852**	**3,373**	**1,375**	**1,998**
	Medical Equipment: TOTAL	**1,353**	**652**	**448**	**204**
	Other: TOTAL	**561**	**271**	**466**	**(195)**
	Contingency	**124**	**0**		**0**
	TOTAL	**9,781**	**7,250**	**4,556**	**2,694**



Variation & Action

In Month: Capital expenditure increased by £313k in the month.

Year to Date: At the November Capital Control Group all Managers responsible for capital schemes were asked to revisit their schemes and identify the level of slippage likely to take place, as there were concerns this was significantly understated. This exercise has resulted in slippage increasing to £3.950k, leaving a revised plan of £6,197k. The reasons for this change will be discussed at the forthcoming Capital Control Group meeting.

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

Page 9 - Performance against Forecast

Status	Position

Forecast

	In- Month (Dec 2017)		
	Forecast £000s	Actual £000s	Variance £000s
Operating Income			
NHS Clinical Income	15,194	15,257	63
Other income	2,388	2,510	122
Total income	**17,582**	**17,767**	**185**
Operating Expenditure			
Pay	11,502	11,672	(170)
Non Pay	6,287	6,388	(101)
Total Expenditure	**17,789**	**18,060**	**(271)**
EBITDA	**(207)**	**(293)**	**(86)**
Financing Costs	1,283	1,256	27
Surplus/(Deficit)	**(1,490)**	**(1,549)**	**(59)**

	In- Month		
	Forecast £000s	Actual £000s	Variance £000s
CSFS	3,399	3,482	83
Medicine	3,880	3,834	(46)
MSK	2,398	2,375	(23)
Surgery	3,273	3,381	108
Corporate Services	2,202	2,210	8

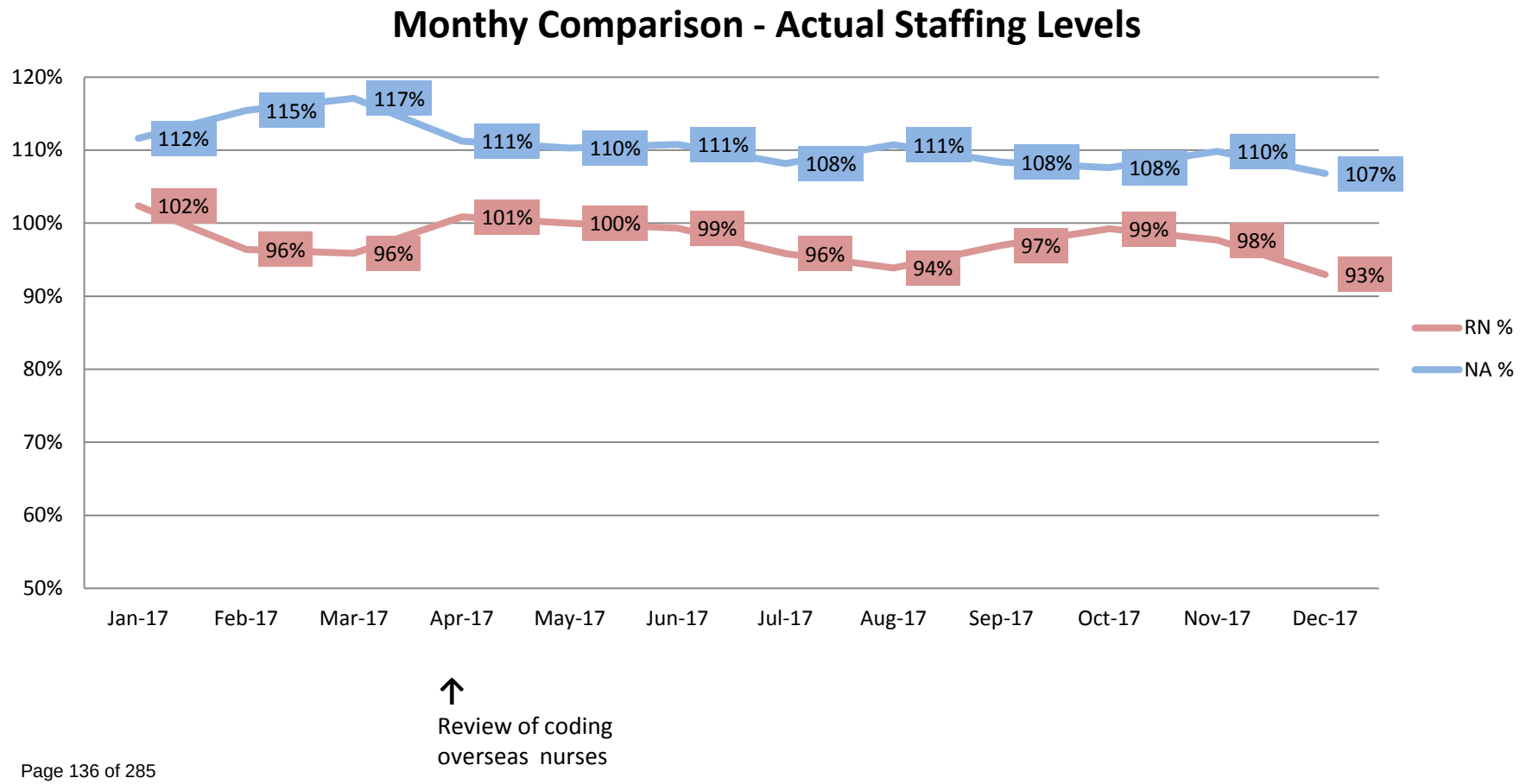
Variation & Action

There were some differences between directorate forecasts and actual positions in month 9 in the areas of pay, purchase of healthcare from NHS bodies and energy costs. A significant part of the variance in Surgery was due to use of drugs excluded from tariff in Ophthalmology and a further element was due to pay costs on ITU, where the costs of increased activity will have been offset by an increase in income. The CSFS variance from forecast was due to increased costs of flu and norovirus testing kits, an unforeseen increase in subcontracted pathology tests, and additional payments for consultants acting down.

Safe Staffing NQB Report – December 2017

Monthly Comparisons – Actual Staffing Levels

	Registered Nurses			Nursing Assistants			Combined			Skill Mix	
Month	Planned hours	Actual Hours	%	Planned Hours	Actual Hours	%	Planned Hours	Actual Hours	%	RN	NA
Dec-17	56919.5	52918.6	93%	30477.5	32545.7	107%	87397	85464.3	98%	62%	38%



Overview of Nurse Staffing Hours – December 2017

Day	RN	NA
Total Planned Hours	37626	21406
Total Actual Hours	33617	23295
Fill Rate (%)	89%	109%

Night	RN	NA
Total Planned Hours	24790	12198
Total Actual Hours	24498	12995
Fill Rate (%)	99%	107%

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

Nursing Hours by Day Shifts

Row Labels	Day RN Planned	Day RN Actual	Day RN Fill Rate	Day NA Planned	Day NA Actual	Day NA Fill Rate
Medicine	**16010**	**13458**	**85%**	**10511**	**12124.**	**114%**
AMU	1947.50	1969.00	100%	1069.00	1273.00	118%
Durrington	1221.00	957.50	78%	880.00	1172.50	133%
Farley	2274.25	1650.25	73%	1538.50	1847.50	120%
Hospice	1038.50	905.50	87%	693.00	684.50	99%
Pembroke	912.00	928.75	102%	806.25	762.58	95%
Pitton	1928.50	1576.25	82%	1174.00	1144.50	98%
Redlynch	1637.47	1372.13	84%	1144.00	1229.30	108%
Tisbury	2153.50	1864.25	87%	713.00	615.25	86%
Whiteparish	1305.75	1014.00	80%	988.00	1362.50	145%
Winterslow	1591.00	1219.67	78%	1505.50	2032.50	135%
Surgery	**7648.13**	**7672.63**	**99%**	**2752.17**	**2907.67**	**104%**
Britford	2060.30	1953.55	95%	1152.50	1158.00	101%
Downton	1269.00	1224.00	97%	912.25	1076.75	118%
Radnor	3553.00	3747.75	106%	358.50	334.50	93%
DSU Inpatient Ward	765.83	747.33	98%	328.92	338.42	103%
MSK	**8091.92**	**7180.58**	**89%**	**6752.05**	**7008.55**	**108%**
Amesbury	1666.25	1588.50	95%	1402.75	1350.50	96%
Avon	1667.08	1407.67	84%	1989.50	1836.92	92%
Burns	1606.58	1400.50	87%	741.55	948.30	128%
Chilmark	1737.75	1510.25	87%	1105.75	1335.25	121%
Tamar	1414.25	1273.67	90%	1512.50	1537.58	102%
CSFS	**5876.23**	**5306.23**	**92%**	**1390.50**	**1254.33**	**96%**
Maternity	3264.93	2877.93	88%	1045.50	896.58	86%
NICU	1192.30	1152.05	97%	0.00	4.25	100%
Sarum	1419.00	1276.25	90%	345.00	353.50	103%
Grand Total	**37626**	**33617**	**89%**	**21406**	**23295**	**108%**

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

Nursing Hours by Night Shifts

Row Labels	Night RN Planned	Night RN Actual	Night RN Fill Rate	Night NA Planned	Night NA Actual	Night NA Fill Rate
Medicine	**9900**	**9956**	**101%**	**5799**	**6615**	**112%**
AMU	1530.33	1534.17	100%	356.50	373.17	102%
Durrington	713.00	724.50	102%	713.00	814.50	114%
Farley	1069.50	1089.00	102%	713.00	943.00	132%
Hospice	589.00	594.00	101%	462.50	477.50	103%
Pembroke	713.00	705.50	99%	356.50	352.50	99%
Pitton	1058.00	1323.50	125%	713.00	805.00	113%
Redlynch	1069.50	1035.00	97%	701.50	724.50	103%
Tisbury	1414.50	1311.00	93%	356.50	345.00	97%
Whiteparish	713.00	678.50	96%	713.00	735.00	105%
Winterslow	1030.00	961.00	93%	713.00	1045.00	147%
Surgery	**5566.50**	**5677.42**	**108%**	**1782.50**	**1862.50**	**101%**
Britford	1057.50	1060.00	100%	713.00	769.50	108%
Downton	690.00	699.00	101%	713.00	793.00	111%
Radnor	3197.00	3097.50	97%	356.50	300.00	84%
DSU Inpatient Ward	622.00	820.92	132%	0.00	0.00	100%
MSK	**4222.00**	**3930.08**	**94%**	**3547.50**	**3540.75**	**100%**
Amesbury	1046.50	1047.33	100%	713.00	657.50	92%
Avon	920.00	841.00	91%	930.00	955.75	103%
Burns	1046.50	837.25	80%	705.00	718.00	102%
Chilmark	589.00	581.50	99%	579.50	579.50	100%
Tamar	620.00	623.00	101%	620.00	630.00	102%
CSFS	**5102.00**	**4933.83**	**98%**	**1069.50**	**976.25**	**97%**
Maternity	2848.00	2693.00	95%	1069.50	964.75	90%
NICU	1069.50	1069.50	100%	0.00	0.00	100%
Sarum	1184.50	1171.33	99%	0.00	11.50	100%
Grand Total	**24790**	**24498**	**100%**	**12198**	**12995**	**105%**

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

Reporting Amendments

The following amendments have been made to this months submission:

Following relocation the following name changes are permanent

Breamore is now re-named as Whiteparish
Whiteparish acute medical unit is now re-named AMU

Plastics & Burns is recorded as *Burns*

Overview of Areas with Red

(Internal Rating Below 80%)

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	Durrington	78%	√		Day	Shifts were supported by an increase in NA staff
Red	Farley	73%	√		Day	High vacancy factor Day shifts mitigated by Ward leader supporting from supervisory role and student nurses on shift plus overstaffing of NA
Red	Winterslow	78%	√		Day	Overstaffing by 35% of NA day shifts demonstrate alternative grade staff were used to bolster shift numbers lifting to ensure shift cover . Skill sets were supported from within the Ward Leader supervisory role.

- Using the SafeCare system, patient acuity and dependency is assessed at least three times a day on a shift by shift basis
- All Unfilled shifts are reviewed and risk assessed at twice daily operational staffing meetings in conjunction with patient acuity and demand.
- Shifts are reassessed if the patient acuity and demand alters.

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

Overview of Areas with Amber

(Internal Rating 80-90%)

Flag	Ward	%	RN	NA	Shift	Mitigation
Amber	Whiteparish	80%	√		Day	Skilled Band 4 staff used to cover RN shifts. 20% of the over staffing of NA shifts accounts for this. Ward Leader offering ad-hoc support. Some shifts remained uncovered but risk assessed for safety.
Amber	Hospice	87%	√		Day	Due to sickness, shifts covered by clinical manager who are not part of the general roster and therefore cover will not shown
Amber	Pitton	82%	√		Day	High vacancy factor and maternity leave Night shifts were fully covered. Some shifts remained uncovered subject to daily risk assessments with Ward leader support on day shifts as required.
Amber	Redlynch	84%	√		Day	Some shifts remained uncovered with shifts subject to daily risk assessment for safety
Amber	Tisbury	87%	√		Day	Vacancies plus sickness and maternity leave. Some shifts remained uncovered and Ward Leader support was provided from within the supervisory shifts, subject to daily risk assessment for safety .
Amber	Tisbury	86%		√	Day	
Amber	Burns	87%	√		Day	Shift cover was aided by utilising available ward senior sister or Burns CNS, along with option of redeploying Tissue Viability Nurse to ward to assist with drug rounds and specific RN tasks. Extra NA staff.
Amber	Burns	80%	√		Night	Third night nurse was not always required and is dependant on acuity/post ops. Ward and patient safety unaffected.
Amber	Radnor	84%		√	Night	Small numbers of staff involve exaggerate this percentage . NA x1 shift outstanding which went to agency and was unfilled. Patient t safety was not compromised

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

Overview of Areas with Amber

(Internal Rating 80-90%)

Flag	Ward	%	RN	NA	Shift	Mitigation
Amber	Maternity	88%	√		Day	49/56 shifts per week filled. To ensure safety ,acuity was recorded 4 hourly. Managers and other non- clinical staff were available in the day time to support any incidents of high acuity ensuring safety was maintained. A reduced birthrate in December resulted in safe staffing levels despite some unfilled shifts
Amber	Maternity	86%		√	Day	The small numbers of staff involved exaggerates the amount of unfilled shift percentage. The few shifts affected were safely covered
Amber	Avon	84%	√		Day	Any unfilled shifts were escalated to the DSN. Patient acuity and demand was risk assessed at each shift and staffing fluctuated according to patient need.
Amber	Chilmark	87%	√		Day	Alternative grade cover used. EU qualified Band 4 staff (awaiting IELTS) covered unfilled RN shifts . This is evidenced by overstaffing % of NA shifts

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

Overview of Overstaffed Areas >115%

Ward	%	RN	NA	Shift	Comments
AMU	118%		√	Day	The overstaffing was due to Band 3 overseas nurses being recorded as unqualified
Durrington	133%		√	Day	Extra NA staff were used to bolster unfilled RN day shifts and to provide 1:1 enhanced care
Farley	120%		√	Day	Over filled shifts were to support unfilled RN day shifts and to provide 1:1 enhanced care for patients at risk of falls or with mental health issues
Farley	132%		√	Night	
Winterslow	135%		√	Day	As per Farley ward
Winterslow	147%		√	Night	
Burns	128%		√	Day	Increased NA as a result of unfilled RN and providing relevant cover and back fill for B3 role when free flap undertaken.
Chilmark	121%		√	Day	Increase in NA demand as extra grade cover using Band 4 IELTS to support unfilled RN shifts. A new starter impacted on higher NA rates.
Whiteparish	145%		√	Day	NA support was used to cover unfilled RN shifts through strengthening numbers
Downton	118%		√	Day	Extra NA were required due to the increased number of medial patients on the ward some of which required a special. The correct assessments were completed to support this.
Pitton	125%	√		Night	Extra RN shifts were raised for high patient acuity needs
DSU Inpatients	132%		√	Night	This unit remained in escalation over two floors times resulting in the need for extra NA staff.

Mitigation of Risk for Red/Amber

The report evidences a downward trend in both RN & NA fill rates with a 5% reduction in RN cover and a corresponding 3% reduction for NA staff. The skill mix remains static at RN/NA 62/38.

The RN fill rate is evidenced at 89 % for Day shifts and 99% for Nights reflecting the high vacancy factor carried within some units. NA shifts demonstrate overstaffing (mainly on days) where Band 4 staff and extra NA staff are utilised to help bolster unfilled RN shifts.

To aid fill rates over the holiday period, annual leave for permanent clinical staff is reduced to a minimum as it is recognised that local temporary staffing can be difficult to attain.

Many day shifts are supported by Ward Leaders from within their supervisory role due to their availability in addition they provide an increased level of knowledge & skills. This support is usually on an ad-hoc basis and it is difficult to evidence any regular short term responses to a specific situation within rosters.

The flexible rostering processes employed by wards also aids safer staffing for night shifts when other means of RN cover is not so readily available and helps guarantee a higher level of locally qualified staff with good skills sets on shift.

RED

Farley, Durrington and Winterslow al l demonstrate reduced RN staffing levels of between 70-80% for day shifts. All three wards also evidence overstaffing for NA day shifts of between 20 -35% to help compensate for the RN shortfall.

AMBER

10 various clinical areas report within this parameter. 77% of these are for RN shifts with 69% relate to RN day shifts. Only 2 areas flag Amber for night shifts. (Pitton and Radnor)

The majority of NA day overstaffing is due to this cohort of staff being used to bolster an increase in shift numbers to cover unfilled RN shifts whilst also being supported by Ward Leader.

Over-staffing

NA over-staffing fill rates are 109% for Day shifts and 107% for Night shifts.

Only one area (Pitton) was overstaffed for RN shifts which were at night. This was for 1:1 support due to high patient acuity for a tracheostomy patient.

The main reasons for NA Overstaffing remain unaltered and were for either:

1. Enhanced 1:1 care for patients at risk of falls, mental health needs or confusion
2. Flexing bed stock and staffing levels to meet fluctuating patient demands and supporting RN shifts.

NA day shifts account for 67% of overstaffing with the vast majority used to bolster unfilled RN shifts

Whiteparish:- As per previous months (under the name of Breamore).

The unit had extra 4 beds within their capacity and this resulted in a need for an extra NA to support the extra patient demand. The unit moved in December to become Whiteparish and the change in bed stock is now accommodating the previous extra capacity. This should be reflected in the reporting from January 2018.

DSU Inpatients:- remained in escalation at times and was open during some weekends resulting in the appearance of overstaffing.

Actions taken to mitigate risk

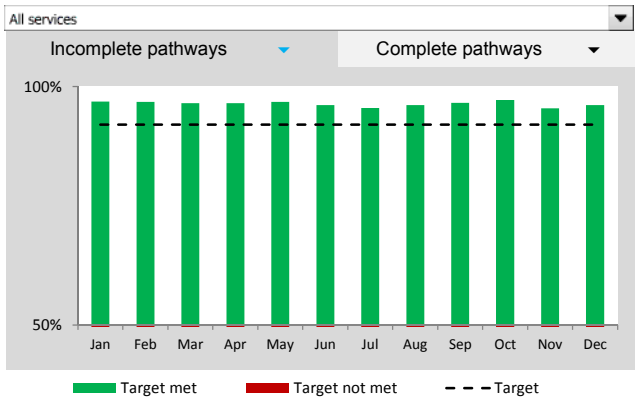
The nurse-in-charge of individual wards in discussion with the DSN/ADSN review the following on a shift by shift basis.

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

Wiltshire HEALTH AND CARE

Performance Dashboard December 2017

RTT

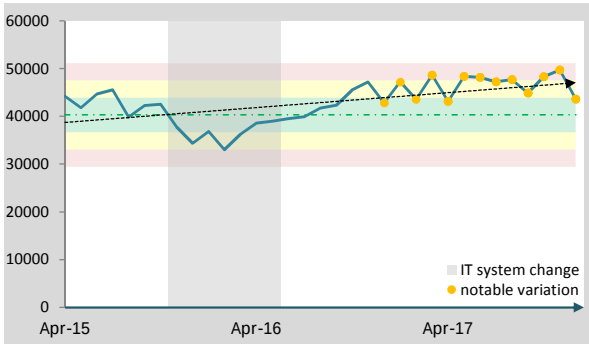


Incomplete pathways month end position

	% under 18 weeks	Breaches
Community Teams	97%	21
Continence - Adult	95%	5
LD	85%	0
Outpatient Physio	95%	112
Podiatry	99%	3
Wheelchair service	82%	13
WON	97%	11

LD service remains an area of concern - previously flagged to commissioners. There are 2 LD breaches over 52 weeks - these are Psychology referrals and are receiving care by other members of the team so are not being treated as breaches by the CCG.

Activity



Referrals ↑ 14% Contacts ↑ 8%

Notable movers

Bed Based Intermediate Care	↑ 85%
Diabetes	↑ 56%
Speech and Language Therapy	↑ 27%
MIU	↓ -11%
Dietetics	↓ -11%
Fracture Clinic	↓ -8%

LD and Wheelchair services data excluded in this view of overall activity as not comparable pre and post system migration. Old Wheelchair service system recorded each work request as a separate referral. See explanatory notes for notable variation guidance. No longer reporting Inpatient therapy contacts as agreed with commissioners.

Inpatient assessments

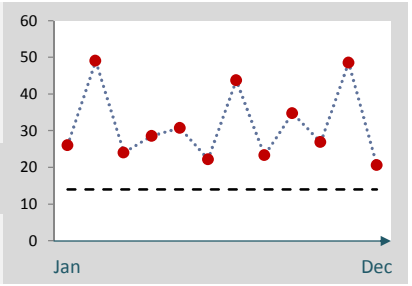
All wards

MRSA	✓ 95%
VTE	✓ 99%
VTE prophylaxis	✓ 100%
MUST	✓ 98%
PURAT	✓ 97%
Falls	✓ 98%
Dementia	✓ 100%

Overall targets met

Mean Inpatient Length of Stay

Ailesbury, Cedar, Longleat	25.6
Mulberry	52.3
Step up	20.6
Step up excluding delays	16.6



LoS heavily influenced by delayed days which routinely account for more than 20% of our ward capacity. For more detail around our LoS see the inpatient data sheet.

Discharge timings

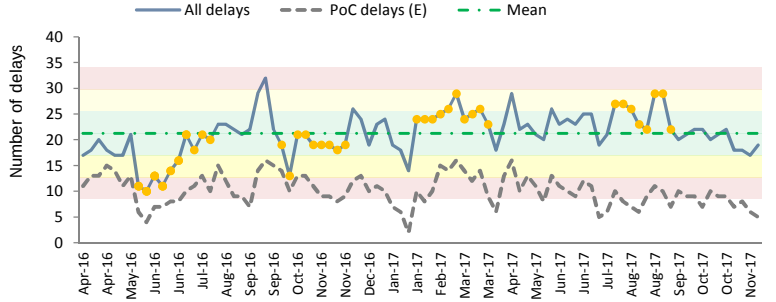
55% midday

22% weekend

excludes transfers to hospital and deaths

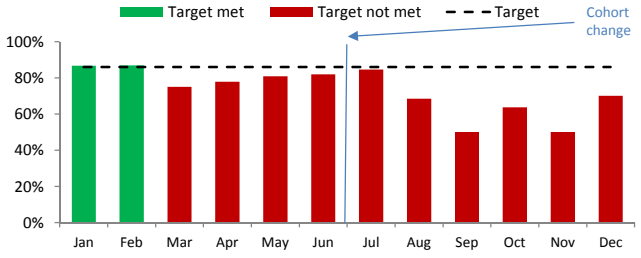
Improvement in December

Delayed Transfers of Care



Following DToC counting workshop we may see increase in POC (E) delays that would previously have counted as Housing delays. See explanatory notes Activity for notable variation guide.

Community teams 90 day reablement



In month 70% FYTD 77%

Patients still at home 90 days after referral to team

Data quality concerns

It is an ongoing challenge to identify the correct cohort for this data - now looking at Home First patients. Very low numbers since cohort change - slow to increase

End of life support

In month	FYTD
91%	93%

This month 10 of 11 patients were supported by the community teams to die in their place of choice

Strong performance year to date

Funding reviews*

	In month	FYTD
CHC 3 month		
Completed	3	75%
Due	4	
CHC Annual		
Completed	37	84%
Due	44	
FNC		
Completed	588	62%
Due	949	

CHC reporting not yet available

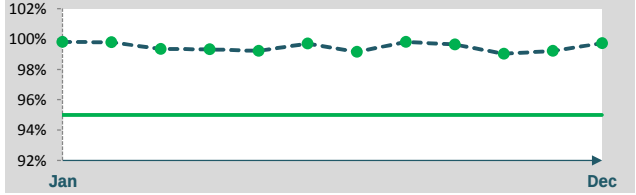
MIU waiting times

median 12 minutes

95th centile 94 minutes

MIU performance

Arrival to departure 4 hour stay	Left without being seen	Transfers to acute
100%	4%	6%

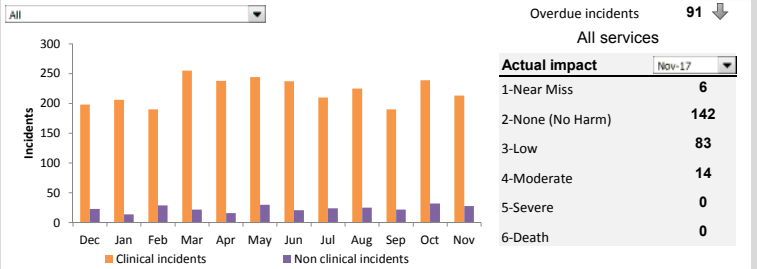


Performance on 4 hour stay and patient feedback remains strong. Data challenges remain around patients left without being seen and transfers to acute. Significant operational pressures are not reflected in the data.

Wiltshire HEALTH AND CARE

Quality Dashboard November 2017

Incidents

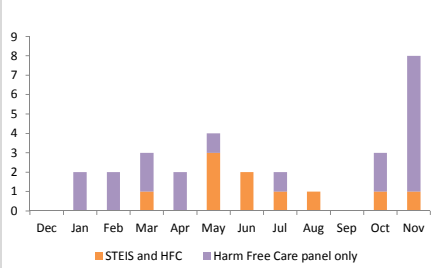


Overdue incidents 91

All services

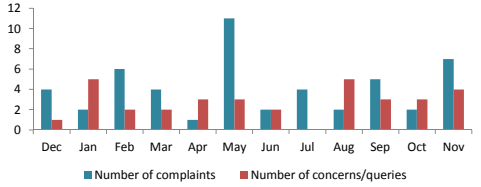
Actual impact (Nov-17)	
1-Near Miss	6
2-None (No Harm)	142
3-Low	83
4-Moderate	14
5-Severe	0
6-Death	0

Incidents Requiring Further Investigation



Complaints/Concerns

Response compliance 0% Open ombudsman cases 0



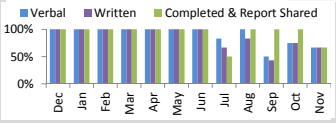
RIDDOR

Financial Year to Date

2

RIDDOR report(s)

Duty of Candour compliance

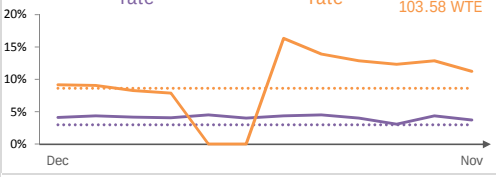


National Mandatory Audits - 1 completed in month

	Completed	Missed
Audit uploads	100%	0

Sickness/Vacancy

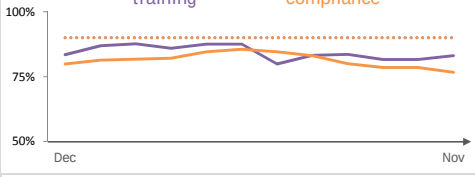
Nov-17 Sickness rate 3.74% Vacancy rate 11.23% 103.58 WTE



Sickness is 1% above same time last year. This is due to management of long term sickness.

Training/Appraisals

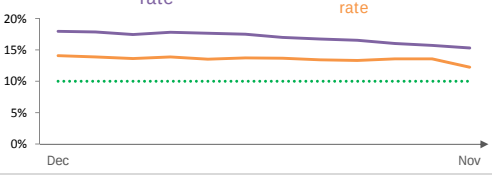
Nov-17 Mandatory training 83% Appraisals compliance 77%



The figures for both appraisals and training are below our excpectation, however plans are in place and WHC are working toward a 90% target in both areas

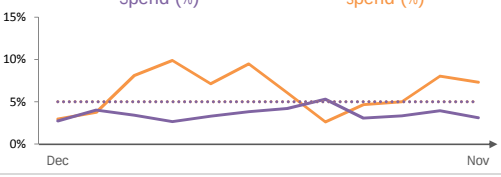
Turnover

Nov-17 Turnover rate 15.32% Voluntary turnover rate 12.23%



Bank/Agency spend %

Nov-17 Bank Staff Spend (%) 3.10% Agency staff spend (%) 7.33%



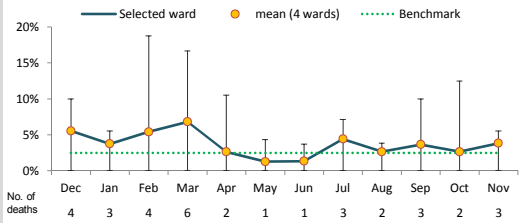
Infection Prevention & Control

All wards	In month	Prev 12 months
MRSA incidence	0	0
C diff incidence	0	1
E coli incidence	0	0
Bed days lost to norovirus	0	0

The patient was recorded as C.difficile colonisation in Aug 17 whilst in RUH, however they were asymptomatic and did not require isolation or treatment

Deaths

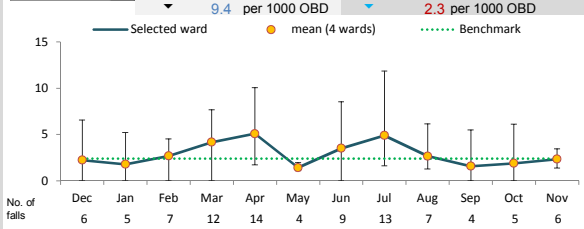
All wards — 3 death(s) in month 3.8% of discharges



Palliative care deaths are excluded from Apr 17 (in line with National benchmarking definition)

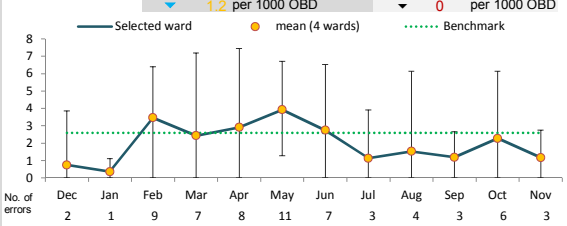
Falls

All wards — 24 fall(s) in month 9.4 per 1000 OBD — 6 Fall(s) with harm 2.3 per 1000 OBD



Medication errors

All wards — 3 error(s) in month 1.2 per 1000 OBD — 0 Harmful error(s) 0 per 1000 OBD

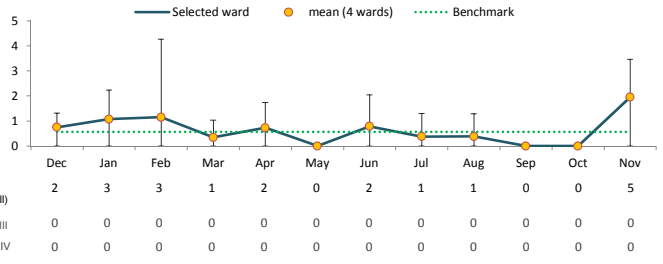


Please note: There is no benchmarking value for medication errors with harm

Medication errors now included on the community teams and specialist services sections within this dashboard.

Avoidable Pressure Ulcers

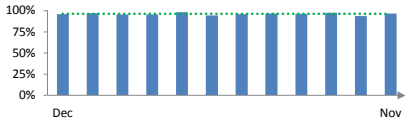
All wards — 5 avoidable pressure ulcers acquired in month 1.95 per 1000 OBD



This graph shows the total verified Category III and IV avoidable pressure ulcers.

Safety Thermometer

Percentage of Harm Free Care (new harms)

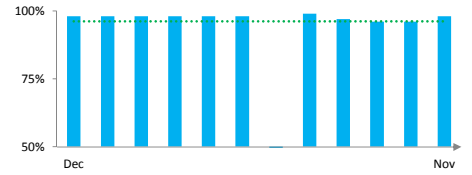


Community Wards	98.78%
Community Teams	95.83%
Wards and Teams combined	**96.72%**

Improvement in return for November see community teams and inpatients tabs. The quality team continue to work with teams to improve compliance.

Friends and Family Test

Show response numbers



98%

recommend score

There has been an increase in both the number of responses and the recommended score in November. The quality team are scoping new ways of collating feedback to improve the response rate, i.e. mobile working. There has been no resolution to the reporting error in June;

Inpatient assessments

All wards	Oct-17	Nov-17
Early Warning Score	98%	99%
VTE assessment	100%	100%
VTE prophylaxis	100%	100%
Hospital Acquired Thrombosis	0	0
Falls assessment	99%	97%
MUST assessment	96%	99%

Report to:	Trust Board	**Agenda item:**	SFT3989
Date of Meeting:	5 February 2018		

Report Title:	Skill Mix Review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		X		**X**
Prepared by:	Fiona Hyett, Deputy Director of Nursing Fiona Coker, Head of Maternity Services			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Appendix 1: National Quality Board Expectations for Safe Staffing Appendix 2: Compliance against NQB Guidance Appendix 3: Self-assessment against Safe, Sustainable and Productive Staffing Improvement Resource Appendix 4: NICE Staffing Guidance for Adult Nursing in Acute Hospitals Appendix 5: Skill Mix Directorate Summaries Appendix 6: Midwives to Birth Ratio Appendix 7: Midwifery Care in Labour Audit Appendix 8: Midwifery Acuity Audit Report			

Recommendation:

This paper is presented to Trust Board:

- To provide transparency and assurance on nurse and midwifery staffing levels
- To recommend the request for investment of £301,821 is put forward as part of the financial planning process 2018/19 in order to maintain recommended quality standards and reduce unplanned agency spend

Executive Summary:

Purpose:

- The report details the methodology, findings, risk assessment and recommendations arising from the 6 monthly ward nurse staffing review undertaken during 2017. An appendix dedicated to midwifery staffing is also included.
- The report outlines SFT's progress in meeting the recommendations from various national publications.
- The report is presented in full as an expectation of the National Quality Board guidance on staffing which requires presentation and discussion at open board of all aspects of the 6-monthly staffing reviews

Background:

- A 6-monthly staffing review has been published to JBD and Trust Board since it became a requirement in 2014. The review findings have been reviewed at the Nursing and Midwifery Forum.
- In November 2013 as part of the response to the Francis Enquiry, the National Quality Board published a guide to nursing, midwifery and care staffing capacity and capability (2013) 'How to ensure the right people, with the right skills, are in the right place, at the right time'. This guidance was refreshed and broadened and re-issued in July 2016 to cover all staff and to include the need to focus on safe, sustainable and productive staffing.
- SFT has developed a sustainable model for systematically reviewing staffing levels across all in-patient wards which has been strengthened year on year and that uses nationally recognized methodologies.

Key Findings

- The latest review for 2017 has shown that overall areas broadly meet the recommendations with staffing levels set to achieve an average of 1:5 to 1:8 registered nurse to patient ratio in the majority of areas during the day, with the exception of Amesbury which is 1:10 on a late shift following implementation of band 4 role as an outcome from a previous skill mix review.
- Overall wards are staffed at 60:40 registered/unregistered ratio in the majority of general in-patient areas. Exceptions are where there has been active implementation of a trained band 4 role where appropriate.
- Recruitment and retention remains the biggest risk to sustaining safe staffing levels, despite lots of focused efforts particularly in recruitment. This also impacts on a continued dependence on temporary and agency staffing.
- Good performance across nurse sensitive quality indicators has been sustained

National Publications:

- Progress continues with achieving compliance with the NICE guidance on staffing in acute inpatient wards published in July 2013. Of the 38 recommendations, SFT is compliant in 36 with 2 requiring further action.
- The guidance on the safe staffing issued by the National Quality Board in 2013 was refreshed and reissued in 2016. Progress continues with this and the newly issued toolkit to support adult inpatient care.
- The recommendations in this report link to the statutory responsibilities arising from the National Quality Board expectations (2013: 2016) on ensuring staffing capacity and capability.

1. Purpose

1.1 The purpose of this paper is to report the outcomes of the 6 monthly review of ward staffing nursing establishments. This 6 monthly review forms part of the Trust's approach to the systematic review of staffing resources to ensure safe staffing levels meet patient care needs.

1.2 The paper focuses specifically on a review of in-patient ward areas, intensive care, and Emergency Department (ED). Children's services, theatres and Out-patients have been subject to separate reviews. These other areas are also subject to separate emergent guidance either from NICE or NHS Improvement in relation to safe staffing levels. An evaluation of the impact of the Children's services review is included within directorate themes.

1.3 A specific report focussing on midwifery is also presented as part of this paper.

1.4 The report fulfils expectation 1 and 2 of the NQB requirements for trusts in relation to safe nurse staffing.

1.5 The report also includes an update on NICE Clinical Guidelines 1 – Safe staffing for nursing in adult inpatient wards in acute hospitals, issued in July 2014 and details SFT's compliance with 36 of 38 recommendations.

2. Specific Detail

2.1 Ward staffing review methodology

2.1.1 In 2012 SFT established a systematic, evidence-based and triangulated methodological approach to reviewing ward staffing levels on a 6-monthly basis and taking proposals for changes to establishment to Board to be approved and implemented via budget setting process. The aim of this process is to provide safe, competent and fit for purpose staffing to ensure delivery of efficient, effective and high quality care and has resulted in year on year changes to the nursing workforce matched by increased investment where required.

2.1.2 Following agreement at Board summer 2017 there will be a full annual skill mix presented to Board in December, followed up by an update review 6months later to ensure plans are still appropriate and to review the impact of any investment.

2.1.3 The approach taken for the full skill mix review utilises the following methodologies:

- Shelford Safer Nursing Care Tool Acuity/Dependency staffing multiplier (a nationally validated tool). This is now incorporated into the Safecare module of Allocate Healthroster, is assessed three times per day on the ward and used as part of the twice daily staffing meetings.
- Care Hours per Patient Day
- Professional judgement
- Peer group validation
- Benchmarking and review of national guidance
- Review of e-rostering data
- Review of ward nurse sensitive indicator data
- Review of HR indicators and finance metrics
- INSIGHTs data (from Allocate E-Roster data)

2.2 National Guidance

2.2.1 In 2013 as part of the response to the Francis Enquiry the National Quality Board (NQB) published a guide to nursing, midwifery and care staffing capacity and capability (2013) 'How to ensure the right people, with the right skills, are in the right place, at the right time'. This guidance was refreshed, broadened to include all staff groups and re-issued in July 2016 to include the need to focus on safe, sustainable and productive staffing. The expectations outlined in this guide are presented in Appendix 1.

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability -- report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

2.2.2 These expectations are fulfilled in part by this review and the detailed action plan (Appendix 2) which shows assessment and progress against the 37 recommendations that make up the 3 over-arching recommendations. This assessment shows SFT to be fully compliant with 27 recommendations, with on-going action required against 10.

This is the first time a full analysis has been completed against each recommendation and the actions against each will be reviewed within the Safe Staffing group to work towards full compliance.

2.2.3 In December 2016 a draft improvement resource for adult inpatient wards in acute hospitals was published. This is the first of a suite of improvement resources being developed designed to support the approved NQB guidance on safe, sustainable and productive staffing.

The resource is aimed at wards that provide overnight care for adult in-patients and excludes intensive care, high dependency, acute admissions and assessment units.

Whilst the resource remains draft an initial assessment of SFT's position has been completed (appendix 3) which identifies some key actions to meet the guidance including:

- Further work required on considering impact of wider team on ward staffing. Looking to pilot band 1 role on elderly care wards, introduction of band 4 role – this could be extended further to include AHP roles, exploring pharmacy technician.
- Robust recruitment strategy for nursing in place however further work is required in developing focused retention strategies
- 19% headroom applied across all wards (excluding parental leave). Actual ward uplift levels reviewed via Healthroster in skill mix reviews and averages at 23%

2.2.4 In July 2014 NICE published clinical guideline 1: Safe Staffing for nursing in adult in-patient wards in acute hospitals. This guideline is made up of 38 recommendations. A detailed action plan was developed and is reviewed every 6months to ensure still compliant with guidance and ensure progress to compliance with all 38 recommendations. The outstanding recommendations relate to headroom, which is set at 19% across the wards (excluding parental leave). Initial actions included embedding e-rostering and then analysing data on headroom – this demonstrates on average it is 23% (also excluding parental leave). A full analysis of compliance can be found in appendix 4.

2.2.5 During 2017 we have participated in a NHS Improvement Collaborative which involved deep dives of nursing rotas across the inpatient wards. This has demonstrated that despite significant vacancies there is good grip and control on the efficient deployment of the nursing workforce

2.3 6 monthly Ward Staffing Review

2.3.1 The 6 monthly review was carried out with each ward during the summer, reviewing the data from September 2016 – August 2017. The reviews were attended by the ward sister, Directorate Senior Nurse and Deputy Director of Nursing. The same triangulated methodology was used as in previous reviews – review of nurse sensitive indicators, HR and finance metrics, headroom data, nurse-patient ratios, Safecare data and professional judgement.

2.3.2 The detailed spreadsheets with ward by ward findings are included in Appendix 5. This provides detailed information on the current establishment levels for each ward and vacancies at time of ward reviews; registered to unregistered ratios; nurse to patient ratios by registered and total nurse staffing by shift; nurse sensitive quality and HR outcome data and detailing acuity and dependency information from the Safer Nursing Care Tool reviewed by ward.

2.3.3 <u>Nurse to patient ratios by registered and total nursing</u>

- The ward establishments allow for registered nurse to adult patient ratios during the day across SFT to range from 1:4 to 1:10 depending on specialty and overall staffing model. Amesbury (elective orthopaedics) is the only ward at a ratio of 1:10 where the late shift has 3 RNs and 1 Assistant Practitioner (Band 4), this was introduced in March 2016 which increased the ratio of RNs on the night shift. In some areas where there has been active implementation of the band 4 role these ratios can vary on specific shifts, although the underlying establishment ratio has not been altered. These ratios are set against establishment and can regularly increase when wards are not fully established.

- Planned staffing ratios at night require constant oversight to ensure the model is sufficient to provide the required support for patients out of hours. Ratios range from 1:5 to 1:12; all areas with lower ratios have been reviewed to ensure the registered nurse ratio is appropriate for the acuity of the ward and is offset by higher total staff to patient ratios.

2.3.4 <u>Registered to unregistered ratios</u>

- The wards have been reviewed against the benchmark of 60:40 registered to unregistered ratios as the planned model of care.

- Overall the Trusts registered to unregistered workforce meets the planned 60:40 ratio and the majority of wards are broadly at this level.

- Several wards have actively implemented the use of Band 4's (elderly care and orthopaedics) and the ratios have been reviewed as registered: band 4: unregistered. The support of band 4 roles continues to be developed as part of a model of care and this continues to be a theme for review for each skill mix review to identify further opportunities, particularly linked to the development of apprenticeships nationally and providing a career development route for unregistered staff. The Trust is part of the national pilot for the nursing associate role and this approach provides a blueprint for development in the Trust. There are ward areas where the acuity and intensity of patients has increased and treatment and medication regimes are complex and so an overall reduction in registered to unregistered ratios would not be appropriate to maintain safe staffing levels. Focus will continue on reviewing the overall registered to unregistered ratios to ensure reductions are linked to planned model of care changes.

- A few wards are significantly above the 60:40 ratios and this tends to be where the intensity of patient needs requires a higher ratio of registered staff (intensive care, cancer care, cardiology, Acute Medical Unit).

2.3.5 Assessment against safer Nursing Care Tool

- The Safer Nursing Care tool (acuity/dependency model) has been used to model required staffing based on the national recommended nurse to patient ratios for each category of patient in all the adult areas. This is integrated into the Healthcare roster system via the Safercare tool and provides information on the acuity/dependency levels and corresponding staffing levels on a real-time basis. When predicted levels differ from established numbers, professional judgement has been used to assure that the levels set are appropriate for the specialty and number of beds. The data is reviewed at each skill mix review as well as being used to review staffing levels on a daily basis.
- Analysis of SafeCare data was included within the review presented to the Trust Board in the summer and will be refreshed and included in the next full skill mix review

2.3.6 Allowance for additional headroom requirements and supervisory ward leader

- All areas have 19% funding allocated to allow for additional headroom requirements arising from non-direct care time ie annual leave, study leave, sick leave (parental leave is excluded). Review of the actual headroom for each ward continues to demonstrate that 19% is insufficient and the Trust is an outlier compared to its peers. Data from the e-rostering system overall would indicate 23% excluding parental leave is generally required (and is comparable to peers).
- The June 2015 skill mix review recommended that this be reviewed with a pilot in 3 clinical areas of increasing the headroom to evaluate impact on the ability to better manage the demands on a staffing establishment. This was not agreed at Board at that time.
- With greater clarity through the electronic rostering system it continues to be evident that the 19% headroom is not manageable nor efficient, this is once again a recommendation within this paper.

- Previous skill mix reviews saw investment into ward establishments to implement a supervisory ward leader model. The 2016 skill mix review saw this reduced to 80% to fund changes to skill mix, and reflecting that despite the introduction of the supervisory model ward leaders were often required to be in the staffing numbers due to high levels of vacancy and reflective of the low headroom. In this review the average

supervisory time achieved across the wards is 50%. Full benefits of the supervisory model will not be realised until substantive staffing levels improve but where implemented the model continues to demonstrate benefits to the patient experience and safety outcomes at ward level, as well as reducing temporary staffing usage, supporting patient flow as well as supporting the high volume of staff requiring supervision appointed by the international recruitment campaigns.

2.3.7 Specific Directorate Themes

Medicine Directorate: Overall staffing establishments for registered nurses are thought to be appropriate for the level of acuity and dependency but it is difficult to fully assess as the wards have a high level of vacancies and are reliant on temporary staffing, thus impacting on the ability to achieve the set ratios on a shift by shift basis. The exception is:

- Acute Medical Unit (AMU) – consideration to be given to increasing the numbers of Band 6's by 2.33wte on the ward to ensure a sister is available on every shift both day and night. The increase would provide leadership to support the increase in activity, patient flow, new ways of working within the new unit and is the model seen across Wessex. In addition this also provides benefits to nurse retention as increases career development opportunities.
- Breamore – additional Band 5 on the early shift to support increase in bed numbers and change in ward template when ward relocated to level 4 (and is comparable to current staffing levels when in escalation which is currently funded via escalation).

Several wards within medicine identified requirement for additional nursing assistants to support increasing dependency of patients:

- Pembroke – additional Band 2 on night shift based on professional judgement of Ward Leader, it has not been possible to link this to SafeCare data as this has been affected by the use of escalation beds and staff on the ward. In addition this will be an issue when the ward is relocated to level 3 and will be isolated on night shifts.
- Redlynch – additional Band 2 on late shift, to reduce requirement for 1:1 nursing for patients with enhanced care needs, ward currently reliant on temporary staffing and so the costs would be offset by reduction in specials expenditure – expenditure year to date on specials £19k (comparable to same period last year) and extrapolated to full year effect will be £40k. The need is also supported by SafeCare data which has shown an increasing trend of required CHPPD being higher than actual.
- Farley – additional Band 2 on late shift to support ensuring and RN and NA in each bay for caseload of patients. Again this would be used to reduce requirement for 1:1 nursing for patients with enhanced care needs, ward reliant on temporary staffing and so costs would be offset by reduction in specials expenditure – expenditure year to date on specials £39k (higher than same period last year) and extrapolated to full year effect would be £80k. The need is supported by SafeCare data which shows required CHPPD as sitting slightly higher than actual.
- Durrington – additional Band 2 on the long day, minimum of late shift, to reduce the requirement for 1:1 nursing for patients with enhanced care needs, ward currently reliant on temporary staffing and so costs would be offset by reduction in specials expenditure. Year to date expenditure on specials is £31k (lower than last year) and extrapolated to full year effect would be £60k. SafeCare data is variable but there can be seen periods with higher required CHPPD than actual, extrapolated to full year effect would be £60k. SafeCare data is variable but there can be seen periods with higher required CHPPD than actual.

- Whiteparish- additional Band 2 on late shift to support increase in bed numbers and change in ward template when ward relocated to level 4 (and is comparable to current staffing levels when in escalation).

The Directorate continue to expand the implementation of the band 4 role across the directorate and are using this to support the high numbers of vacancies by having a highly trained support worker.

There are high numbers of EU nurses within some of the wards who are currently Band 4 nurses whilst continuing to undertake International English Language Test (IELTs) to gain NMC registration, this has an impact on the staffing levels within the wards.

It is anticipated that elderly medicine and the stroke ward will pilot the use of band 1 housekeeper role as part of winter resilience funding – the aim of this work is to release band 2's to focus on clinical care and reduce reliance on temporary staffing.

ED department was reviewed and there has been work to extend the roles of nursing staff, introduce use of paramedics at the front door. A key requirement from the review was to implement a senior healthcare support worker role (band 3) which is to increase flexibility within the department, support patient flow and help offloading of ambulances in periods of high demand, initiate rapid assessment and treatment, support the navigator role. This would also provide a career development opportunity within the non-registered workforce. It is anticipated that this could be funded through Winter Resilience funding which could act as pilot to evaluate impact of the role. There remains an on-going requirement to review the staffing skill mix of the total workforce to fully explore potential opportunities.

Musculo-Skeletal Directorate: Overall established staffing levels are appropriate for the level of acuity and dependency of the patients.

The Directorate has undergone a reduction in its bed template as part of the site reconfiguration and as a result of this there have been changes to the ward establishments. The revised establishments have been reviewed as part of the skill mix reviews and are considered to be appropriate but will need to be reviewed in 6 months once embedded.

Orthopaedics have implemented the Band 4 role and has resulted in these areas having lower registered to unregistered workforce, however this model is working well and there has been no impact on key quality indicators or reported experience measures, although it can be challenging on busy post-operative days.

There are high numbers of EU nurses particularly within orthopaedics who are currently Band 4 nurses whilst continuing to undertake IELTs to gain NMC registration, this has an impact on the staffing levels within the wards.

Burns and plastics continue to have higher numbers of patients with mental health needs requiring 1:1 nursing for enhanced mental health needs, and fulfilled via RMNs. Options have been looked at to work with Avon and Wiltshire Partnership Trust (AWP) to provide bank staff but they are unable to support due to their own vacancies. Further exploration needed on potential to recruit dual registered nurse, although this would not support full 24hour requirement.

Surgical Directorate: Overall established staffing levels are appropriate for the level of acuity and dependency of the patients.

Surgical Assessment Unit continues to be staffed for day time model only but is frequently opened overnight for capacity which is reliant on temporary staffing and impacts on flow next day. In addition there is an increase in the numbers of patients flowing through the department. Britford Ward are to review numbers and assess whether an additional nurse is required or whether additional administrative support would free nurses to focus on clinical care.

Wards across surgery have experienced on-going vacancies this year, which is unusual as historically vacancies have been easily filled. A bespoke targeted recruitment campaign focusing on the opportunities and benefits of working within the surgical directorate is to be run.

Ward manager assistant role has been implemented between Britford and Downton, which has been demonstrated to have benefits in enhancing the support at ward level and enabling ward sisters to work alongside staff in supervisory capacity.

Limited use of band 4 role in the Directorate, to be further considered for any opportunities particularly as a career progression approach.

The new Short Stay Surgical Unit (23hr stay unit) is due to open in January located in the current Breamore ward. Proposed staffing levels have been reviewed, and considered to be appropriate to planned workload, these will need to be reviewed in 6months. The proposed model assumes a 6-day approach; the number of times the ward is escalated will need to be monitored as additional staffing may require increasing to a 7-day model.

Radnor (ICU) continue to maintain staffing ratios appropriate to level 2 and level 3 patients. An escalation policy on beds and staffing levels has been developed locally. Focus needs to be kept on recruitment and retention.

Clinical Support and Family Services – Paediatrics Update
In December 2015 Sarum ward increased the number of registered nurses on shift from 2 RNs on a day and night shift, to 3 RSCNs per shift. Following this move, a wider review was undertaken looking at escalation triggers and pathways, use of Safecare CHPPD and a wider review of Registered Sick Children's Nurses provision across the SFT site where children present.

Reviewing the RCN guidance regarding nurse to patient ratios and Sarum ward's historical and seasonal case load, led to the adoption of a revised ward capacity of 12 (from a historical 16). This then created the foundations of a 'normal' operating capacity of 12, and how increasing demand and/or acuity was then subsequently managed and accommodated, which is reflected in the revised escalation pathway.

Establishing the normal working capacity of 12 beds for Sarum also enabled CHPPD calculations to be more reflective and representative of actual patient demands and nursing resource available. This template change to Allocate and Safecare was made in 02/2017, which in turns successfully corroborates and evidences the ward's escalation status and potential nursing need. Whilst advances have been made in confirming the ward footprint,

and establishing an escalation process, ongoing focus is required regarding the professional judgement to record discussions and outcomes, regarding staffing resource.

In conjunction with these developments, a wider staffing review was undertaken in 2016 regarding available children's nurses on site. As a result of this work, an additional 4.0wte (x1 Band 6, x3 Band 5) funding was made available to the Sarum budget, to support a Paediatric Outreach Support Team (POST). This initiative commenced in October with the premise of enhancing the experience of children wherever they attend on site at SFT. The team offers specific children nurse intervention, training and support for adult nurses within those areas, acting as advocate and providing continuity of care. Although the team are based on Sarum ward, they move flexibly across ED, Day Surgery Unit, theatres in response to seasonal variation, acuity and demand. Calls and interventions are logged and will be next reviewed March 2018.

2.4 Trust wide risks and issues considered in the review

2.4.1 Increasing patient acuity/dependency

The development of services and changing demographic of the population continues to result in an evidenced increase in the complexity, acuity and dependency of the patients admitted into the general wards.
Information on the acuity and dependency of patients, including enhanced care needs is available to be reviewed via the SafeCare functionality in Healthroster and is used in real time as part of the daily staffing meetings. This information is also used in the 6 monthly reviews as part of the professional judgement assessment.

2.4.2 Increasing enhanced care needs

The Trust continues to incur expenditure for patients requiring additional nursing care support due to their enhanced care needs – this is mainly in medicine and MSK although is becoming an increasing requirement in surgery also. Year to date expenditure circa £300k.

Following on from work undertaken at University Hospitals Southampton it is now possible to capture additional enhanced care needs within SafeCare. This is going to be rolled out and will enable the Trust to have a better overview of the enhanced care requirements across the Trust.
A small task and finish group are also undertaking a project to establish an Enhanced Care Support team to improve the care of these vulnerable patients and impact financially through reduction of associated temporary staffing costs. The Trust has been chosen to be involved in an NHSi collaborative for enhanced care.

2.4.3 Vacancies and temporary staffing

At the time of the review RN vacancies across the wards were seen to be increasing across the in-patient areas and running at approximately 100wte (15%). Information on vacancies, temporary staffing usage and actions to reduce have been included in the monthly PMO report and are reviewed via the Safe Staffing group and will be included in the new Temporary Workforce Controls Group.

A focused recruitment campaign has been undertaken for NAs to increase the numbers of substantive staff with the intention of implementing an NA agency ban from January. The aim of this project is to improve the support tier of staff on wards to help reduce temporary staffing and the associated agency premium.

Detailed work continues on recruitment initiatives in all Directorates in close partnership with HR. Further work is required in developing retention initiatives to ensure that staff recruited into the organisation are retained and develop their careers within the organisation.

3. Conclusions

Recruitment and retention remain the biggest area of challenge in the provision of safe staffing levels across the ward areas, and thus a focus needs to be maintained on recruitment and retention initiatives as priority areas.

Nursing continues to demonstrate effectiveness in deploying our workforce efficiently as seen in both INSIGHTs data and feedback from the NHSi Collaborative which stated “good grip and control of workforce despite significant vacancies”.

Good progress has been made against the national publications on nurse staffing

SafeCare CHPPD data has shown some areas to require additional investment which is supported when triangulated with professional judgement and these are identified as recommendations within this paper.

Quality of care continues to be maintained according to reportable nurse sensitive indicators despite the challenging environment of vacancies, temporary staffing and increasing acuity and dependency.

4. Recommendations

- To note the findings of the 6 monthly ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically:
    - SFT nursing establishments are set to achieve an average of 1:5 – 1:7 registered to patients across the majority of wards during the day; areas not achieving have been reviewed.
    - Wards are staffed on average 60:40 registered/unregistered ratio, with exceptions linked to the implementation of the band 4 role.
- To note the on-going progress with compliance with the refreshed guidance from the National Quality Board on safe, sustainable and productive staffing and the self-assessment against the draft toolkit of acute adult inpatient care.
- To note the sustained compliance with the NICE guideline on safe staffing for nursing in adult inpatient wards.
- To continue momentum of actions to fill vacancies and reduce the reliance on high cost agency against the backdrop of agency control from NHS Improvement.
- To discuss the report at both JBD and open Trust Board as an ongoing requirement of the National Quality Board expectations around safe staffing assurance.
- To undertake a pilot with 4 wards into impact of increasing headroom
- To agree the additional investment into staffing as outlined below:

Proposed Investment for 2018/19	£ amount	Comments
AMU: Uplift of B5 to B6 (based on 2.33wte)	 **£10,338**	New expenditure
Whiteparish: Additional RN (1.54wte) Additional NA (1.33wte)	 **£53,489** **£33,052**	Currently paid for via escalation, proposal to move into budget
Pembroke: Additional NA (2.55wte)	**£63,370**	New expenditure
Redlynch: Additional NA (1.33wte)	**£33,052**	To be reviewed post NHSi enhanced care collaborative
Farley: Additional NA (1.33wte)	**£33,052**	To be reviewed post NHSi enhanced care collaborative
Durrington: Additional NA – Long day (2.55wte) or Late shift	**£63,370** **£33,052**	To be reviewed post NHSi enhanced care collaborative
Emergency Department Band 3 role	**£141,572**	Q4 this year funded by non-recurrent funding
Total	**£301,821**	Includes AMU, Breamore (Whiteparish) and ED

Midwifery staffing Establishment report
Report from: Fiona Coker- Head of Maternity and Neonatal Service

1. Purpose

The review has been undertaken utilising National published responses to maternity staffing:

- Safer Childbirth: Minimum standards for the organisation and the delivery of care in labour (RCOG, RCM 2007).
- Birth rate Plus (Salisbury assessment 2015).
- National Quality Board (2016). Supporting NHS providers to deliver the right staff with the right skills, in the right place at the right time- Safe, sustainable and productive staffing.
- Safe Midwifery staffing for maternity settings (NICE 2015).
- National Maternity Review: - 'Better Births' (2016) – A five year forward view for maternity care.
- Salisbury CQC report following inspection (2016)

The maternity management team reviews the service and workforce in line with the recommendations and standards outlined in the above documents on a monthly basis.

2. Maternity Services staffing review methodology

2.1 The Salisbury maternity services are currently funded to a Midwife to Birth ratio of 1:30. The Safer Childbirth (2007) ratio recommendation is 1:28 for a DGH service. The ratios are analysed monthly and is affected by fluctuating birth numbers (Appendix 6). This staffing establishment funding was set following the Birth rate plus assessment in 2015 and the board supported an investment of 10 WTE registered midwives.

2.2 Every opportunity to skill mix within the service has been taken. The service has evolved, utilising more maternity assistant hours (for example opening the Day Assessment during the weekend to relieve pressure on labour ward) and the establishment of unregistered staff now needs to be reviewed.

2.3 The NICE clinical standard (55) dictates that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a trainee midwife under direct supervision. This is audited monthly (appendix 7) and demonstrates good compliance as the care of labouring women is always the priority and escalation is utilised when needed to ensure this.

2.4 2015 NICE Safe midwifery staffing for maternity settings. The service was assessed when this guidance was published, and they were found to be in alignment with that guideline's recommendations. However, nationally maternity services are not reporting using this methodology.

2.5 National Quality Board (2016). Supporting NHS providers to deliver the right staff with the right skills, in the right place at the right time- Safe, sustainable and productive staffing. Benchmarking against this guidance suggests alignment but this is not a national expectation according to CQC.

2.6 The service received a significant investment in 2016 but continued to experience recruitment issues. This has improved in the last 6 months and now the focus is on reducing sickness and managing turnover. In June 2017 the vacancy rate was standing at over 11 WTE out of an establishment of 85.86 WTE. This was mitigated by a lower birth rate and the use of bank staff ensuring safety and adequate 1:1 care in labour provision. By October the vacancy rate had dropped to 6.26 WTE and quality indicators have remained stable in the last 6 months despite turnover. As an acute service, activity is difficult to predict so a robust escalation policy is in place within maternity which is heavily reliant on the community workforce.

2.7 The population health changes have impacted on the maternity service. There has been an evidenced increase in women with raised BMI, pre-existing medical conditions, age at birthing and mental health difficulties over the last 8 years. In addition the antenatal surveillance arising from the 'GAP' programme has identified an increase in the number of 'small for gestational age babies. ' This has led to a significant rise in the acuity within the service which has led to challenges. The activity, acuity and dependency are regularly analysed as the staffing need is not just about birth numbers. Maternity utilises an evidence based acuity tool (Birth rate plus) and this is measured within the labour ward on every shift.

2.8 The department is working towards triangulating activity, acuity and the use of escalation so that there is better understanding of the impact of acuity. In June 2017, when vacancy rates were high, births were slightly lower than normal. However the department escalated on 20% of shifts and this was due to the impact of acuity rather than just numbers of women. Appendix 8 demonstrates a retrospective audit suggesting that the acuity was higher than appreciated and the impact this had on staffing in this month.

2.9 The department has been well supported by HR and turnover and morale have significantly improved. The staff numbers, activity and dependency will continue to be analysed on a monthly basis. The Trust also commissioned a team coaching programme for clinical and non-clinical midwifery leaders in the dept

3. Challenges:

3.1 In the 2016 National Maternity Review 'Better Births' (NHS England 2016) was published outlining expectations for a five year forward vision for maternity services. Within the vision document a model of case loading midwifery is recommended across all services with the aim of providing continuity of care throughout pregnancy, intrapartum and postnatal period, delivered within midwifery teams of 4-6. Considerable additional midwifery resource of approximately 10 WTE will be required if the service does adopt a fully case loading team model of midwifery as recommended within 'Better Births'. Currently, Salisbury offers a traditional model of inpatient staffing and community teams.

3.2 The maternity service continues to be an area where there is high numbers of staff on maternity leave. This is predicted to be an issue going into 2018 with up to 8WTE likely to be on maternity leave in the New Year.

3.3 The maternity bank staff numbers have reduced despite regular advertising to recruit to the designated bank. The bank contingent is now mostly contracted staff who will when possible work additional hours. Caution has been exercised not to utilise too much from this section of the workforce as tiredness and sickness has been a result in the past.

4. Strategies considered for improving recruitment and retention of all staff

4.1 The following strategies are being utilised to improve the recruitment and retention across the maternity workforce:

- Early advert to capture newly qualified 'home grown' staff- This resulted in successful recruitment of 6 newly qualified staff in October 2017
- Social media campaign
- Plan to over recruit to vacancies and to cover maternity leave to reduce the need to resort to agency staff
- Rolling advert and interview as soon as application is filed.

5.0 Recommendations

1. To note the improvements and the on going progress in recruitment.
2. To note and support the plan to over-recruit to cover maternity leave.
3. To support a Work force review in 2018 of unregistered staff
4. Note the current maternity staffing and challenges with increased acuity
5. For the board to support the department with a review of staffing to meet the 'Better Births' expectations.

National Quality Board Expectations for Safe Staffing
Safe, Sustainable and Productive Staffing (July 2016)

Expectation 1: Right Staff	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (ie the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the Board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified. Safe staffing is a fundamental part of good quality care, and the CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.
Expectation 2: Right Skills	Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services and there is a staffing resource that reflects a multi-professional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.
Expectation 3: Right Place and Time	Boards should ensures staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at Board, if concerns arise. Directors of Nursing, Medical Directors, Directors of Finance and Directors of Workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

	Descriptor	No	Recommendation	Current measures in place	Assessed SFT rating C-compliant A-actions required	Identified actions required	Timescale	Lead
Expectation 1: Right Staff	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (ie the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the Board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified. Safe staffing is a fundamental part of good quality care, and the CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.	**1.1 Evidence-based Workforce Planning**						
		1.1.1	The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource	Triangulated approach to skill mix reviews well embedded. Shelford SNCT used and embedded in SafeCare as part of e-rostering. NICE guidance systematically reviewed	C	Continue with current approach and further develop use fof CHPPD and SafeCare	Complete	DDoN
		1.1.2	The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and enable benchmarking with peers	All tools used as recommended	C	Continue to monitor use of SafeCare to ensure no local modification	Complete	DDoN/E-roster lead
		1.1.3	Workforce plans contain sufficient provision for planned and unplanned leave eg sickness, parental leave, annual leave, training and supervisions	Headroom 19%. Uplift reviewed at each skill mix review	A	Skill mix reviews to continue to demonstrate actual uplift required	Apr-18	DoN/DDoN/ E-roster lead
		1.2 Professional Judgement						
		1.2.1	Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.	6-monthly staffing reviews which are face to face meetings with Ward Lead, DSN and Deputy DoN. Range of indicators including quality, HR, finance and ratios are reviewed alongside professional judgement	C	Continue with current approach and further develop use fof CHPPD and SafeCare	Complete	DDoN/DSNs/ Ward Leads
		1.2.2	Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing to reflect changesin case mix, acuity/dependency and activity.	Professional judgement used as part of twice daily staffing meetings.	C	Continue with current approach and further develop use fof CHPPD and SafeCare	Complete	DDoN/DSNs
		1.3 Compare Staffing with Peers						
		1.3.1	The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.	Benchmarking with peers via INSIGHTs. Data being entered into Model Hospital	A	Review opportunities for more formalised benchmarking with peers	Apr-18	DDoN
		1.3.2	The organisation reviews comparative data on actual staffing alongside data that provides the context for differences in staffing mix (eg length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design and patient acuity and dependency	All considered as part of systematic staffing reviews	C	Continue with current approach and horizon scan for further opportunities	Complete	DDoN
		1.3.3	The organisation has an agreed local quality dashboard that triangulates comparitive data on staffing and skill mix with other efficiency and quality metrics eg for acute inpatients, the model hospital dashboard will include CHPPD	Quality/HR/finance indicators reviewed at Skill Mix reviews. Data entered into Model Hospital but needs further focus on analysing data	A	Continue to work with Allocate and NHSi on Heatmap work looking at CHPPD metrics	Jan-18	DDoN/E-roster lead
	Boards should ensure clinical leaders and managers are appropriately dveloped and supported to deliver high quality efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive serv ices. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an idenified need or skill gap.	**2.1 Mandatory training, development and education**						
		2.1.1	Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated appoach outlined in the document.	All frontline leaders skilled to manage staffing agenda, roster masterclasses, and training for new ward leaders. Recent NHSi work on heatmaps shows good roster management	C	Continue to maintain competence, skill and knowledge through on-going masterclasses and staffing reviews	Complete	DDoN/E-roster lead/DSN
		2.1.2	Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.	19% headroom allowance (excluding maternity leave). Rosters show average of around 23% needed (excluding maternity leave). Ward leads get 4/5 days supervisory allocated but only taking approx 50% due to staffing pressures	A	Continue through skill mix reviews to demonstrate need for additional headroom. Continue to review supervisory time. Continue roll out of CLIP model to support students	Apr-18	DDoN/E-roster lead/DSNs/Education team

Expectation 2: Right Skills		2.1.3	Those with line mangement responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals and support to revalidate and maintain professional registration.	JDs articulate management responsibilities, compliance with appraisals and training monitored. All staff successfully revalidated so far	C	Continue to keep oversight of JDs and continue to monitor compliance through HR metrics and skill mix reviews	Complete	DDoN/DSNs/HR
		2.1.4	The organisation analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisations training and development strategy, which also aligns with Health Education England's quality framework.	Training needs analysis completed at ward level, further work required to bring this into comprehensive trust approach	A	Work with HR and L&D to agree approach	Apr-18	DDoN/HRD/Head of L&D
		2.1.5	The organisation develops its staff skills, underpinned by knowledge and understanding of public health and prevention, and supports behaviour change work with patients, including self-care, well-being and an ethos of patients as partners in care	Implementing MECC and Health Coaching with nurse specialists	A	Continue to implement	Apr-18	DDON/Patient safety lead
		2.1.6	The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary education and training to support changes in models of care.	QI approach throughout the organisation being established. Working across boundaries much more developed within Thearpy working	A	Identify areas where this should be prioritised and piloted such as OPAL	Apr-18	OPAL team
		2.1.7	The organisation recognises that delivery of high quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.	Ward sisters have 80% allocated supervisory time. Ward sister development sessions run quarterly. Intensive support programmes run where concerns regarding leadership of clinical area	C	Continue to monitor % of time given to supervisory as linked to on-going vacancy challenges	Complete	DDoN/DSNs
		2.2 Working as a multiprofesssional team						
		2.2.1	The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clincial duties and decisions about patient care	Involved in national pilot of Nursing Associate roles, utilising APs, reviewing options such as pharmacy techs delivering medicines, ward administrator in place in surgery and looking to implement ward housekeeper role	C	Continue to review all opportunities for delivering workforce differently	Complete	DDoN/DSNs/Education
		2.2.2	The organisation recognises the unique contributution of nurses, midwives and care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high quality care to patients. This stronger multiprofessional approach avoids placing demands solely on any one profession and supports improvements in quality and productivity as shown in the literature	Strong evidence for staff pursuing extended roles as part of skill and service reviews	C	Continue to expose opportunities for new ways of working within the MDT	Complete	
		2.2.3	The organsiation works collaboratively with others in the local health and social care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries	Evidence through introduction of models such as OPEL and ESD	C	Continue to seek out opportunities to work collaboratively with other professions and sectors	Complete	
		2.3 Recruitment and retention						
		2.2.1	The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap42 demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.	Strong equality and diversity lead in the organisation, with compliance monitored through separate subgroup. Deputy DoN sits on this group	C	Separate Equality & Diversity plan, reported through to Board	Complete	E&D lead/Director of HR
		2.3.2	The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid the over reliance on temporary workforce	Full recruitment strategy for nursing in place. Safe Staffing Group established - review all associated data and agrees actions	A	Further work required on retention of staff	Apr-18	Deputy DdoN/Deputy DHR

		2.3.3	In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention and career development	This is an area where we could improve knowledge on the issue. Approaches to retention and development tend to be localised	A	Further work required on understanding generational needs to inform recruitment and retention. This could be achieved through the retention workshops and careers clinics	Apr-18	DDoHR
Expectation 3: Right place and time	Boards shoule ensure staff are deployed in ways that ensure patients receive the right care, firsts time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at Board, if concerns arise. Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the orgnaisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.	**3.1 Productive working and eliminating waste**						
		3.1.1	The organisation uses 'lean' working principles such as the productive ward, as a way of eliminating waste	Transformation/PMO incorporates lean techniques	C	Continue to ensure lean techniues are used as part of system transformation	Complete	PMO
		3.1.2	The organisation uses pathways to optimise patient flow and improve outcomes and efficiency eg by reducing queuing	Incorporated into service redesign eg reprovision of AMU, RACE etc	C		Complete	PMO
		3.1.3	Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources	Staff are employed to be fully flexible (skills and competence allowing), skills being incorporated into rostering system, daily staffing reviews ensure staffing allocated to acuity and dependency	C	Continue to review as part of daily staffing meetings	Complete	DDoN/DSNs
		3.1.4	The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff	Staff are employed to be fully flexible (skills and competence allowing), skills being incorporated into rostering system, daily staffing reviews ensure staffing allocated to acuity and dependency	C	Continue to review as part of daily staffing meetings	Complete	DDoN/DSNs
		3.1.5	The organsiation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing wasted time is a key priority.	Included in the methodology for skill mix reviews eg looking at how other roles can be incorporated into ward based nursing	C	Continue with current approach	Complete	DDoN/DSNs
		3.1.6	Systems for manageing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed	Clear escalation process for managing staffing risks. Red flag reporting in place. Monthly staffing report to Board inlcuding mitigation	C	Contnue with current processes and monitor trends with staffing risks	Complete	DDoN/DSNs/Risk
		3.2 Efficient deployment and flexibility						
		3.2.1	Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.	All ward/dept leaders involved in 6-monthly skill mix rievews and the setting of establishment levels and reviewing rostering templates. Six monthly check and challenge meetings	C	Continue with current approach, ensure all new ward leaders are given training as part of induction	Complete	DDoN/E-roster/DSNs
		3.2.2	Clinical capacity and skill mix aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow	Clinical specialty, acuity and dependency via SafeCare and pathways included as part of systematic skill mix reviews	C	Continue with current approach and ensure staffing requirements feed into site reconfiguration	Complete	DDoN/DSNs
		3.2.3	Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs	Twice daily staffing meetings that use SafeCare which compares actual and required, and linked to site requirements	C	Continue with current approach	Complete	DDoN/DSNs
		3.2.4	Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are award of the steps to tkiae where capacity problems cannot be resolved	Twice daily staffing meetings, escalation policy for unresolved staffing issues. Temporary staffing escalation policy sits alongside	C	Continue with current approach and review escalation procedures to ensure remain fit for purpose	Complete	DDoN/DSNs/Site

		3.2.5	Meaningful application of effective e-rostering polices is evident, and the organisation uses available best practice from NHSi Employers and the Carter Review Rostering Good Practice Guidance (2016)	Best practice guidance used and included in rostering policy. Twice yearly check and challenge meetings for all wards. INSIGHTs measures effectivenss via KPIs. NHSi heatmap work complete - showing best in class rosters	C	Continue with current approach and remain aware of future guidance	Complete	DDoN/E-roster lead
		3.3 Efficient employment, minimising agency use						
		3.3.1	The annual strategic staffing assessment gives boards a clear medium term view of the likely temporary staffing requirements. It also ensures discussion takes place with service leaders and temporary workforce suppliers to give best value for money in deploying this option. This includes assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency) as reflected by NHSi Improvement Guide.	Twice yearly staffing review, includes review of vacancies and HR metrics to focus on substantive fill. Effective in-house bank. Robust relationship with procurement and agencies. Weekly and monthly reporting on temp spend. Clear links to recruitment strategy	C	Continue to maximise all opportunities to reduce agency spend	Complete	DDoN/DSNs/E-rostering/HR
		3.3.2	The organisation is effectively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplemenetary guidance and timescales	Continued focus on agency spend, tiering system to apply caps, process for break glass	C	Continue with all actions to reduce temporary staffing spend, increase bank use and ensure safe staffing	Complete	DDoN/DSNs
		3.3.3	The organisations work plan is based on the local Sustainability and Transformation Plan (STP), the place-based, multi-year plan built around the needs of the local population	Good engagement with STP workforce group led by Director of OD and People	A	Continue to work with the STP as well as Wessex workforce groups to ensure plans are built around a population base		DOD&P
		3.3.4	The organisation works closely with commissioners and with Health Education England and submit the workforce plans they develop as part of the STP, using th defined process to inform supply and demand modelling	as above	A	a/a		a/a
		3.3.5	The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving them wherever possible in developing safe, sustainable services.	Annual review of all clinical placements, utilising hub and spoke model, new initiatives with specialist nurses as hub. Quality reviews with University. Introducing CLIP model.	C	Continue to review all options for clinical placements	Complete	DDoN/Education

Safe, Sustainable and Productive Staffing – An Improvement Resource for adult inpatient wards in acute hospitals

Recommendations	Self-Assessment – September 2017
In determining nurse staffing requirements for adult inpatient settings:	
A systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers.	Compliant Skill mix reviews utilise triangulated approach
A strategic staffing review must be undertaken annually or sooner if changes to services are planned.	Compliant Currently under take ward based staffing reviews 6 monthly – will be replaced by annual review to fit in with budget cycle and followed up with light touch review at midpoint
Staffing decisions should be taken in the context of the wider registered multi-professional team.	Action required Further work required on considering impact of wider team on ward staffing. Looking to pilot band 1 role on elderly care wards, introduction of band 4 role – this could be extended further to include AHP roles, exploring pharmacy technician.
Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning process.	Compliant Twice daily staffing meetings ahead of bed meetings and which incorporate use of SafeCare.
Action plans to address local recruitment and retention priorities should be in place and subject to regular review.	Partially Compliant Recruitment strategy for nursing in place. Further work required on retention strategies
Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit temporary staff.	Compliant Flexible working policy established with annual review of individuals through IPR process. Trust in-house Bank.
A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision making.	Compliant Dashboard used in skill mix reviews including both quality and HR metrics alongside staffing ratios.
Organisations should ensure they have an appropriate escalation process in case staffing is not delivering the outcomes identified.	Compliant Systematic staffing reviews include review of all metrics and escalation process via skill mix reviews
All organisations should include a process to determine the additional uplift requirements based on the needs of patients and staff	Partially Compliant 19% headroom applied across all wards. Actual ward uplift levels reviewed via Healthroster in skill mix reviews
All organisations should investigate staffing related incidents, their outcomes on staff and patients and ensure action and feedback	Compliant Robust incident reporting process and red flag incidents reviewed at skill mix reviews.

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1	**SG1: Safe staff guideline for nursing in adult inpatient wards in acute hospitals**								High priority	Yes	COMPLIANT	Yes*
2										Partially	NON-COMPLIANT (low risk)	
3	**Overall assessment * of compliance:**	**NON-COMPLIANT (low risk)**							Low priority	No	NON-COMPLIANT (medium risk)	No
4											NON-COMPLIANT (hiah risk)	
5	**Who was involved in this baseline assessment:**	Lorna Wilkinson, Fiona Hyett, Colette Martindale, Denise Major, Louise Dennington, Ian Harvey									NON-COMPLIANT extreme risk)	
6	**Date baseline assessment completed:**	30/09/2014. Reassessment Nov 2015. Re-assessed May 2016			*** Please carry out a risk assessment**							
7												
8	**Recommendations**	**Data that can help determine if we meet the Recommendation**	**Description of current activity against Recommendation** **(to create a new line within this merged cell, press Alt + Return)**	**Do we meet this Recommendation?** **Yes/Partially/No**	**If we don't meet * the Recommendation, state actions needed to implement it** **(to create a new line within this merged cell, press Alt + Return)**	**Action deadline**	**Action by whom**	**Progress update - Nov 2015 by Lorna Wilkinson & Claire Gorzanski**	**Progress update - May 2016 by Fiona Hyett**	**Progress update - Nov 2016 by Fiona Hyett**		
9	**1.1 Organisational strategy** **These recommendations are for hospital boards, senior management and commissioners.** **They should be read alongside the National Quality Board's guide to nursing, midwifery and care staffing capacity and capability .**											
10	1.1 Organisational strategy Focus on patient care	1.1.1 Ensure patients receive the nursing care they need, including specialist nursing, regardless of the ward to which they are allocated, the time of the day or the day of the week. This includes planning to locate patients where their clinical needs can best be met.	This is considered continuously by the site team. Direct access to specialist areas such as CCU/Tisbury for cardiac, Farley for stroke. Outlie appropriate patients to mitigate against risk - this is discussed at bed meetings. CNS would see patients on their case load wherever they may be. Outreach critical care team available and accessed 24/7 for acutely unwell and deteriorating patients	Yes								
11	1.1 Organisational strategy Accountability for ward nursing staff establishments	1.1.2 Develop procedures to ensure that ward nursing staff establishments (the number of registered nurse and healthcare assistant posts that are funded to work in particular wards) are sufficient to provide safe nursing care to each patient at all times.	6 monthly skill mix review conducted with senior nurses, triangulating establishments and quality data. This is presented to the Trust Board. Evidence of investment into areas where this has highlighted gaps. Daily reorganisation of staff depending on acuity through the bed meetings	Yes					In addition Trust has been involved in productivity and efficiency work with Lord Carter programme. SFT also working closely with Allocate in piloting Insights programme and Embed information from which will be used in future skill mix reviews.			
12		1.1.3 Ensure that the final ward nursing staff establishments are developed with the registered nurses who are responsible for determining nursing staff requirements at a ward level and approved by the chief nurse (or delegated accountable staff). The board should retain organisational responsibility. (See section 1.3 for recommendations on setting ward nursing staff establishments.) This includes when the ward establishment and budget are set.	Compliant	Yes								
13		1.1.4 Ensure senior nursing managers are accountable for the nursing staff roster that is developed from the ward nursing staff establishment.	Rosters signed off by ward leader and DSNs	Yes					Information from Insights data shows SFT to be hig performer in relation to roster sign off and approval			
14		1.1.5 When agreeing the ward nursing staff establishment, ensure it is sufficient to provide planned nursing staff requirements at all times. This should include capacity to deal with planned and predictable variations in nursing staff available, such as annual, maternity, paternity and study leave (commonly known as uplift). Consider adjusting the uplift for individual wards where there is evidence of variation in planned or unplanned absence at a ward level.	Audit of the appropriate use of a diagnostic test – Medicine, Surgery, MSK and CSFS Directorate	Partially	To be reviewed as next stage of allocate implementation. April 15 update - headroom figures now being reported from Allocate and will inform future skill mix reviews. Included in skill mix review - going to Board in June 2015	31.07.15	LW/DDoN	Increase in headroom included in June 2015 skill mix review but not supported by the Board. SFT very involved in Lord Carter work - waiting for outcome of the model hospital. **Reassess: 31.1.16**	Headroom remains at 19%. Insights data starting to be used and showing headroom requirement of approx 30% against national average of 21%. To continue to be explored in detail through embedding of Insights tool.	Summer 2016 skill mix review looked at headroom - targeting work in 1-2 wards to see if investing in headroom is an efficient way - stay as partial - review Nov 2017		
15		1.1.6 When agreeing the ward nursing staff establishment, ensure capacity to deal with fluctuations in patients' nursing needs (such as seasonal variations indicated by historical records of nursing staff requirements) and staff unplanned leave or absences.	Seasonal variation in terms of escalation is funded but not through a planned establishment. Staff unplanned absences included in headroom (details of head room given above)	Yes	a/a	31.07.15	LW/DDoN	a/a	Trust does plan for winter escalation ward but relies on use of temporary staff across the organisation to support.	The approach has changed - due to the unprecedented demand over the summer, all wards are now staffed		
16		1.1.7 When agreeing the skill mix of the ward nursing staff establishment, this should be appropriate to patient needs and take into account evidence that shows improved patient outcomes are associated with care delivered by registered nurses (see recommendation 1.3.6).	Skill mix review takes into account of quality metrics for each ward, RN:NA ratio, and RN:patient ratio	Yes								
17	1.1 Organisational strategy Responsiveness to unplanned changes	1.1.8 Ensure that there are procedures to identify differences between on-the-day nursing staff requirements and the nursing staff available on a ward.	on the day differences picked up by DSN rounds and fed into Bed Meeting where decisions made to make best use of staff and ensure safe staffing levels. At weekends there is Directorate cover provided by band 6/7. Red flag events not formally embedded into this process	Yes	Ward sisters reminded of the need to update the staffing establishment proforma. DSNs to check completed	31.07.15	DSNs	Completed action.	Safe Care been implemented across Trust but furhter work required in embedding into every day practice			
18		1.1.9 Hospitals need to have a system in place for nursing red flag events (see section 1.4) to be reported by any member of the nursing team, patients, relatives or carers to the registered nurse in charge of the ward or shift.	DSN walkround picks up staffing related issues not currently specifically linked to NICE red flag events or staff used to the language	Yes	Red Flag events system formalised and rolled out. DSNs now informed of Red Flags in their areas but need to audit	31.07.15	DSNs	On Datix and completed.				
19		1.1.10 Ensure there are procedures for effective responses to unplanned variations in predicted patients' nursing needs or the availability of nursing staff at any time during the day and night. These procedures should include prompt action to enable an increase or decrease in nursing staff.	DSNs walk round pick up issues. OOH site team. The bed meeting then brings this information together. Specials booked as and when requirement assessed - enhanced risk assessment tool in place. Allocation on arrival staff booked in advance to give this flexibility however it still remains a challenge to fill these shifts. Optimum recruitment to maintain establishment levels should be the aim to maintain as much flexibility in the system as possible	Yes	Safer Care module roll out to identify changes in acuity shift by shift. Recruitment work continues	31.08.15	DD & DSNs	Completed action. Safer care module rolled out - data collection commenced Oct 2015. Recruitment work ongoing.	SafeCare been implemented across the Trust but further work required in embedding into everyday practice and ensuring used to meet variations in ward demands and staffing levels			
20		1.1.11 Action to respond to nursing staff deficits on a ward should not compromise staff nursing on other wards.	Risk based decision made on a case by case, day to day basis. Senior nurses balance the risks by considering staff cover and patient acuity across all areas. Bank and agency are booked where there are gaps in staffing known in advance. This can often lead to difficult decisions to make when considering all wards and mitigating the risk in the most effective way	Yes								
21		1.1.12 Ensure there is a separate organisational contingency plan and response for patients who require the continuous presence of a member of the nursing team (often referred to as 'specialing' care).	Enhanced risk assessment in place. Specials booked via bank/agency but all sanctioned by a senior nurse.	Yes	link enhanced risk assessment policy into staffing policy, safeguarding etc.				Remains under constant review and new tools being trialled to assess patient requirements. Good progress in staff understanding use of DOLS and MCA to support patient needs			
22		1.1.13 Consider implementing approaches to support flexibility, such as adapting nursing shifts, nursing skill mix, assigned location and employment contract arrangements.	Nursing shifts flexed to clinical need/activity in some areas such as ED, AMU (twilights), paeds to flex to need, Plastics have arranged roster to cover specials for post op flap patients. Staff contracts include need to move nursing staff to where they are needed. Allocation on arrival staff booked through Bank to give flexibility. All considered through skill mix review	Yes								

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8	**Recommendations**	**Data that can help determine if we meet the Recommendation**	**Description of current activity against Recommendation** **(to create a new line within this merged cell, press Alt + Return)**	**Do we meet this Recommendation?** **Yes/Partially/No**	**If we don't meet * the Recommendation, state actions needed to implement it** **(to create a new line within this merged cell, press Alt + Return)**	**Action deadline**	**Action by whom**	**Progress update - Nov 2015 by Lorna Wilkinson & Claire Gorzanski**	**Progress update - May 2016 by Fiona Hyett**	**Progress update - Nov 2016 by Fiona Hyett**		
23	1.1 Organisational strategy Monitor adequacy of ward nursing staff establishments	1.1.14 Ensure that there are procedures for systematic ongoing monitoring of safe nursing indicators (see section 1.5) and formal review of nursing staff establishments of individual wards at a board level at least twice a year (and more often if there are significant changes such as ward patient characteristics). These procedures should include periodic analysis of reported nursing red flag events and the safe nursing indicators (see section 1.5).	This is incorporated into the skill mix review where quality indicators are reviewed for each ward as part of this process. Safer care module in allocate will enhance this further	Yes	Red flag events to be formalised, safer care module implementation							
24		1.1.15 Make appropriate changes to the ward nursing staff establishment in response to the outcome of the review.	Compliant - as evidenced in skill mix reviews and resulting changes to resource and investment over 2014	Yes					Twice yearly skill mix reviews embedded in practice			
25	1.1 Organisational strategy Promote staff training and education	1.1.16 Enable nursing staff to have the appropriate training for the care they are required to provide.	Preceptorship programme, mandatory training, IPRs, mentorship days, local training such as ED.	Yes								
26		1.1.17 Ensure that there are sufficient designated registered nurses who are experienced and trained to determine on-the-day nursing staff requirements over a 24-hour period.	Skill mix review led to 800k investment in April 2014 to ensure all wards had one band 7 and 2 band 6s in order to ensure 7 day week senior nurse cover on wards. These nurses are able to make decisions re nursing requirements on any given day. Site team are senior nurses, H@NT senior nurses - these are in addition to ward based nurses and give 24/7 coverage	Yes					Skill mix reviews have seen over £1m invested into nursing and midwifery			
27		1.1.18 The organisation should encourage and enable nursing staff to take part in programmes that assure the quality of nursing care and nursing standards to maximise the effectiveness of the nursing care provided and the productivity of the nursing team.	**Band 7 ward leaders supervisory following investment in April 2014. Good nursing involvemnet in Quarterly updates, NMF, Matrons, (covers all relevant policies). Directorate forums, ALGs, Safety programme involvement, link nurse programmes, CGC representation of a junior nurse, Committee representation of senior nurses**	Yes								
28		1.1.19 Involve nursing staff in developing and maintaining hospital policies and governance about nursing staff requirements, such as escalation policies and contingency plans.										

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1	**SG1: Safe staff guideline for nursing in adult inpatient wards in acute hospitals**								High priority	Yes	COMPLIANT	Yes*
2										Partially	NON-COMPLIANT (low risk)	
3	**Who was involved in this baseline assessment:**									No	NON-COMPLIANT (medium risk)	
4	**Date baseline assessment completed:**		*** Please carry out a risk assessment**								NON-COMPLIANT (high risk)	
5												
6	**Recommendations**	**Data that can help determine if we meet the Recommendation**	**Description of current activity against Recommendation** **(to create a new line within this merged cell, press Alt + Return)**	**Do we meet this Recommendation?** **Yes/Partially/No**	**If we don't meet * the Recommendation, state actions needed to implement it** **(to create a new line within this merged cell, press Alt + Return)**	**Action deadline**	**Action by whom**	**Progress update - Nov 2015 by Lorna Wilkinson & Claire Gorzanski**				
7	**1.2 Principles of determining nursing staff requirements** **These recommendations are for registered nurses in charge of individual wards or shifts who should be responsible for assessing the various factors used to determine nursing staff requirements.**											
8	1.2 Principles for determining nursing staff requirements	1.2.1 Use a systematic approach that takes into account the patient, ward and staffing factors in box 1 to determine nursing staff requirements both when setting the ward nursing staff establishment and when making on-the-day assessments.	senior nurses do this every day and shift however currently not through a systematic approach. This information is taken into account during the skill mix review meetings with each ward leader/DSN/DDoN	Yes	Safer care module implementation to further inform this approach	31.08.15	DD & DSNs	Completed. October 2015.				
9		1.2.2 Use a decision support toolkit endorsed by NICE to facilitate the systematic approach to determining the nursing staff requirements (see the NICE endorsement programme webpages for full details).	Use of the Shelford model in role out of Safer Care	Yes	Safer care module implementation to further inform this approach	31.08.15	DD & DSNs	Rolled out October 2015. Completed.				
10		1.2.3 Use informed professional judgement to make a final assessment of nursing staff requirements. This should take account of the local circumstances, variability of patients' nursing needs, and previously reported nursing red flag events (see section 1.4).	Final decision based on prof judgement. Compliant	Yes	Red flag system to be formalised and incorporated							
11		1.2.4 Consider using the nursing care activities summarised in tables 1 and 2 as a prompt to help inform professional judgement of the nursing staff requirements.	The Safer Care Module will underpin our assessments of nursing activities and time required	Yes	Safer care module implementation to further inform this approach	31.08.15	DD & DSNs	Rolled out October 2015. Completed.				

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1	**SG1: Safe staff guideline for nursing in adult inpatient wards in acute hospitals**								High priority	Yes	COMPLIANT	Yes*
2										Partially	NON-COMPLIANT (low risk)	
3	**Who was involved in this baseline assessment:**									No	NON-COMPLIANT (medium risk)	
4	**Date baseline assessment completed:**				*** Please carry out a risk assessment**						NON-COMPLIANT (high risk)	
5												
6	**Recommendations**	**Data that can help determine if we meet the Recommendation**	**Description of current activity against Recommendation** **(to create a new line within this merged cell, press Alt + Return)**	**Do we meet this Recommendation?** **Yes/Partially/No**	**If we don't meet * the Recommendation, state actions needed to implement it** **(to create a new line within this merged cell, press Alt + Return)**	**Action deadline**	**Action by whom**	**Progress update - Nov 2015 by Lorna Wilkinson & Claire Gorzanski**	**Progress Update - May 2016 by Fiona Hyett, Deputy Director of Nursing**	**Progress update - Nov 2016 by Fiona Hyett**		
7	**1.3 Setting the ward nursing staff establishment** **These recommendations are for senior registered nurses who are responsible for determining nursing staff requirements or those involved in setting the nursing staff establishment of a particular ward.**											
8	1.3 Setting the ward nursing staff establishment	1.3.1 Set ward nursing staff establishments using the stages outlined in recommendations 1.3.2–1.3.8. This should involve the designated senior registered nurses at a ward level who are experienced and trained in determining nursing staff requirements. This process could be facilitated by the use of a NICE-endorsed decision support toolkit.	most of the requirements are incorporated into current skill mix review methodology. This will be further enhanced with implementation of the safer care module	Yes	safer care module implementation	31.08.15	DD & DSNs	Action completed - Oct 2015.				
10	1.3 Setting the ward nursing staff establishment Stage 1: Calculate the average nursing staff requirement throughout a 24-hour period	1.3.2 Routinely measure the average amount of nursing time required throughout a 24-hour period for each of the ward's patients. The measurement should take into account the patient factors and nursing care activities outlined in section 1.2. It could be expressed as nursing hours per patient to ensure ward nursing staff establishments are derived from individual patient's needs. (A measurement of nursing hours per patient enables the nursing needs of individual patients and different shift durations of the nursing staff to be more easily taken into account than with a nurse-to-patient ratio. See the glossary for more information.)	This will be covered through safer care module as the methodology we have chosen	Yes	safer care module implementation	31.08.15	DD & DSNs	Action completed - Oct 2015.				
11		1.3.3 Formally analyse the average nursing hours required per patient at least twice a year when reviewing the ward nursing staff establishment.		Yes	safer care module implementation	31.08.15	DD & DSNs	Action completed - Oct 2015.				
12		1.3.4 Multiply the average number of nursing hours per patient by the average daily bed utilisation (the number of patients that a ward nursing team is responsible for during each 24-hour period). Using bed utilisation rather than bed occupancy will ensure that the nursing care needs of patients who are discharged or transferred to another ward during a 24-hour period are also accounted for.		Yes	a/a	31.08.15	DD & DSNs	Safer care and NUPPD work with Dept of health. Close.				
13		1.3.5 Add an allowance for additional nursing workload based on the relevant ward factors such as average patient turnover, layout and size, and staff factors such as nursing activities and responsibilities other than direct patient care (see recommendations section 1.2, box 1).	Already factored into skill mix review conversations and judgements	Yes								
14	1.3 Setting the ward nursing staff establishment Stage 2: Determine required nursing skill mix and shift allocation	1.3.6 Identify the appropriate knowledge and nursing skill mix required in the team to meet the nursing needs of the ward's patients, with registered nurses remaining accountable for the overall care of patients. Base the nursing staff requirements on registered nurse hours, and consider which activities can safely be delegated to trained and competent healthcare assistants. Take into account: - the level of knowledge, skill and competence of the healthcare assistants in relation to the care that needs to be given - the requirement for registered nurses to support and supervise healthcare assistants - that improved patient outcomes are associated with a higher proportion of registered nurses in the ward nursing staff establishment.	Covered through current skill mix review methodology when considering skill mix ratios and RN to patient ratios against the demands of a particular ward and patient group	Yes								
15		1.3.7 Use average patients' nursing needs and the estimated time of day or night when care will be required to:	Implementation of Safer Care tool	Yes	Implementation of Safer care model	31.08.15	DD & DSNs	Safer care and NUPPD work with Dept of health. Close.				
16		1.3.8 Take account of the following factors (commonly known as 'uplift' and likely to be set at an organisational level, see recommendation 1.1.5): planned absence (for example, for professional development, mandatory training, entitlement for annual, maternity or paternity leave) unplanned absence (such as sickness absence).	Headroom 19% in inpatient wards. This has been queried as benchmarks as low when compared regionally and nationally.	Partially	Information now available from the Allocate system. To be reviewed as part of the skill mix review	31.07.15	LW & DDoN	Increase in headroom included in June 2015 skill mix review but not supported by the Board. SFT involved in Lord Carter's work - await outcome of model hospital. **Reassess: 31.1.16**	Headroom remains at 19%. Insights data starting to be used and showing headroom requirement of approx 30% against national average of 21%. To continue to be explored in detail through embedding of Insights tool.	Summer 2016 skill mix review looked at headroom - targeting work in 1-2 wards to see if investing in headroom is an efficient way - stay as partial - review Nov 2017.			

	A	B	C	D	E	F	G	H	M	N	O	P
1	**SG1: Safe staff guideline for nursing in adult inpatient wards in acute hospitals**								High priority	Yes	COMPLIANT	Yes*
2										Partially	NON-COMPLIANT (low risk)	
3	**Who was involved in this baseline assessment:**									No	NON-COMPLIANT (medium risk)	
4	**Date baseline assessment completed:**				*** Please carry out a risk assessment**						NON-COMPLIANT (high risk)	
5												
6	**Recommendations**	**Data that can help determine if we meet the Recommendation**	**Description of current activity against Recommendation** **(to create a new line within this merged cell, press Alt + Return)**	**Do we meet this Recommendation?** **Yes/Partially/No**	**If we don't meet * the Recommendation, state actions needed to implement it** **(to create a new line within this merged cell, press Alt + Return)**	**Action deadline**	**Action by whom**	**Progress update - Nov 2015 by Lorna Wilkinson & Claire Gorzanski**	**Progress Update - May 2016 by Fiona Hyett Deputy Director of Nursing**	**Progress update - Nov 2016 by Fiona Hyett**		
7	**1.4 Assessing if nursing staff available on the day meet patients' nursing needs** **These recommendations are for the registered nurses on wards who are in charge of shifts.**											
8	1.4 Assessing if nursing staff available on the day meet patients' nursing needs	1.4.1 Systematically assess that the available nursing staff for each shift or at least each 24-hour period is adequate to meet the actual nursing needs of patients currently on the ward. The nurse in charge on individual shifts should make the on-the-day assessments of nursing staff requirements, which could be facilitated by using a NICE-endorsed decision support toolkit. Also take into account the patient factors outlined in section 1.2, box 1 and tables 1 and 2. Safe staffing for nursing in adult inpatient wards in acute hospitals	Nurse in charge responsible for this and information collated at DSN walk rounds and concluded at bed meeting	Yes								
9		1.4.2 Monitor the occurrence of the nursing red flag events shown in box 2 throughout each 24-hour period. Monitoring of other events may be agreed locally.	Some of these events are routinely picked up and communicated/escalated to the DSN/site immediately such as less than 2 RNs on a shift. The red flags in the guidance are not systematically used across the Trust	Yes	Review and implementation of a restructured and commonly understood red flag process	01/12/2014	DSNs	Completed. Now incorporated into Datix and reviewed by part of skill mix review.				
10		1.4.3 If a nursing red flag event occurs, it should prompt an immediate escalation response by the registered nurse in charge. An appropriate response may be to allocate additional nursing staff to the ward.	Compliant with current agreed 'red flags' such as inadequate RNs on per shift	Yes	see above							
11		1.4.4 Keep records of the on-the-day assessments of actual nursing staff requirements and reported red flag events so that they can be used to inform future planning of ward nursing staff establishments or other appropriate action.		Yes	need to improve ward level and the bed meeting documentation on this so that information can be reviewed retrospectively and inform skill mix reviews	31/03/2015	DSNs	Ongoing. **Reassess in May 2016.**	DSNs now have i-pads to enable use of SafeCare tool - further work required to embed this into practice. Review again	Safer care tool now embedded into wards.		

	A	B	C	D	E	F	G	H	M	N	O	P
1	**SG1: Safe staff guideline for nursing in adult inpatient wards in acute hospitals**								High priority	Yes	COMPLIANT	Yes*
2										Partially	NON-COMPLIANT (low risk)	
3	**Who was involved in this baseline assessment:**									No	NON-COMPLIANT (medium risk)	
4	**Date baseline assessment completed:**		*** Please carry out a risk assessment**								NON-COMPLIANT (high risk)	
5												
6	**Recommendations**	**Data that can help determine if we meet the Recommendation**	**Description of current activity against Recommendation** **(to create a new line within this merged cell, press Alt + Return)**	**Do we meet this Recommendation?** **Yes/Partially/No**	**If we don't meet * the Recommendation, state actions needed to implement it** **(to create a new line within this merged cell, press Alt + Return)**	**Action deadline**	**Action by whom**	**Progress update**				
7	**1.5 Monitor and evaluate ward nursing staff establishments** **These recommendations are for senior management and nursing managers or matrons to support safe staffing for nursing at a ward level.**											
8	1.5 Monitor and evaluate ward nursing staff establishments	1.5.1 Monitor whether the ward nursing staff establishment adequately meets patients' nursing needs using the safe nursing indicators in box 3. These are indicators that evidence shows to be sensitive to the number of available nursing staff and skill mix. Consider continuous data collection of these safe nursing indicators (using data already routinely collected locally where available) and regularly analyse the results. (Appendix 2 gives further guidance on data collection for the safe nursing indicators.)	Quality indicator review incorporated into skill mix review	Yes								
9		1.5.2 Compare the results of the safe nursing indicators with previous results from the same ward at least every 6 months. The comparisons should also take into account the specific ward and patient characteristics (such as patient risk factors and ward speciality). Reported nursing red flag events (see section 1.4, box 2) should also be reviewed when undertaking this monitoring and prompt an earlier examination of the adequacy of the ward nursing staff establishment.	Completed as part of skill mix review, red flag events as previously stated need to be reviewed and implemented	Yes								
10		1.5.3 There is no single nursing staff-to-patient ratio that can be applied across all acute adult inpatient wards. However, take into account that there is evidence of increased risk of harm associated with a registered nurse caring for more than 8 patients during the day shifts. Therefore if the available registered nurses for a particular ward (excluding the nurse in charge) are caring for more than 8 patients during the day shifts, the senior management and nursing managers or matrons should: - closely monitor nursing red flag events (see section 1.4, box 2) - perform early analysis of safe nursing indicator results (see section 1.5, box 3) - take action to ensure staffing is adequate to meet the patients' nursing needs if indicated by the analysis of nursing red flag events and safe nursing indicators. In many cases, patients' nursing needs, as determined by implementing the recommendations in this guideline, will require registered nurses to care for fewer than 8 patients.		Yes								

WARD STAFFING REVIEW
September 2016 - April 2017

											Current Position																										
											Sisters/Charge Nurses		Vacancies (as at time of skill mix interview)					Total Number of staff per shift													Admin support (WTE)			Sisters/Charge Nurses	Skill mix as a proportion of total staff (RCN note national benchmark of RN 65%)		
Wards/department	Beds	Total Funded Establishment WTE	Funded Establishment B6 and 7 WTE	Funded Establishment Band 5 WTE	Funded Establishment Band 4 WTE	Funded Estabalishment Band 3 WTE	Funded Establishment Band 2 WTE		Current maternity leave WTE	Average % uplift during March 16 - August 16	No Band 7	No Band 6	Band 6 Vacancy WTE	Band 5 Vacancy WTE	Band 4 vacancy WTE	Band 3 vacancy WTE	Band 2 vacancy WTE	E- registered	E - Band 4	E - Band 3	E - Band 2	L -Registered	L -Band 4	L -Band 3	L - B2	N - Registered	N - Band 4	N - Band 3	N -Band 2	Shift patterns (ie 2 or 3 shift pattern)	Ward Clerk	Housekeeping Assist	Ward managers Assistant	Average % supervisory	Registered %	Band 3 / 4 %	Band 2 %
Whiteparish	21 + 4 amb + nunton	36.05	4	21.87	1.8	0.51	8.87		3	24%	0.8	5.92	0	5.00	0.40	0.00	3.00	5	inc in RN	0	3	5		0	3	4	0	0	1	2	1.86		0	60%	70%	7%	23%
Tisbury	23 (5 L2)	32.88	4	21.22	2		5.66		1xb6	21%	1	3	1	10.0			0.0	6	inc in RN		2	6	inc in RN		2	4	inc in RN		1	2	1			75%	76%	8%	16%
Redlynch	27	33.33	3	16.18	0.5	0.67	10.43		0	22%	0.8	1.75	0.25	4.0			3.0	4			4	4			2	3			2	4	1			40%	62%	4%	34%
Pitton	27	33.77	3	18	1.69	1.31	9.77		2xb2	26%	1	2	1	5.0	0.0	0.0	1.0	5 (4)			4	5(4)			2		3		2	2	0.92			70%	71%		29%
Breamore	20+4	24.65	3	9.77	2		11.88		0	16%	1	2		6.8			0.0	3	inc in RN		3	3	inc in RN		2	2			2	2	1			50%	51%		49%
Farley	30	38.61	4	19.5	1	0.8	15.31		1	22%	1	3	0	4.9	0.0	0.0	2.5	y to Friday)	1	0	5	5		0	3	3	0	0	2	2	1	0	0	20%	62%		38%
Durrington	21	28.49	3.59	12.13	0	0	12.77		1 x b6	19%	1	2	0.6	5.3			3.0	3			3	3			2	2			2	2	1	0		20%	55%		45%
Winterslow	30	37.68	3	19.44	0	0	18.25		1.6	16%	1	2	0	6.0	0.0	0.0	3.0	4	0	0	6	4	0	0	3	3	0	0	2	2	1	0	0	20%	59%		41%
Hospice	10	21.51	0.9	11.38	0	0	9.23		1 x b5	25%		1	0.2	0.0			3.3	2			2	2			1+twi	2			1	Mixed	0	0	0		57%		43%
Pembroke	10 +12	24.41	1.8	15.27	0	2	3.3		0.00	17.80%	0	4	0	0.7			0.4	2			1	2			1	2			0	Mixed	1	0.0%		80%	81%		19%
ED	6 SSEU	47.8	7.7	28.99	0	0.32	10.79		1 x B5 1x0.61	26.2				3.1																							

NB All these indicators are for period of September 2016 - April 2017

Trained nurse staffing relative to patients (early / day shift)		Trained nurse staffing relative to patients (late shift)		Trained nurse staffing relative to patients (night shift)		Staffing relative to population served ie nurses per occupied bed (NPOB) on a eaerly/day shift		Staffing relative to population served ie nurses per occupied bed (NPOB) on a late shift		Staff Turnover	Sickness absence (average)	Nursing Sensitive Indicators September 2016 - August 2017									
RN	No Patients	RN	No of patients	RN	No Patients	Nurses	No. beds	Nurses	No beds	%	%	No of PU Grade 2 or above	Complaints	No of Falls	No of MRSA Bactaraemia	No of MSSA Bactaraemias	No of C-diff (reportable and non-reportable)	% Compliance Appraisals	% compliance Stat and Mand training	No of Red Flag Incidents	SafeCare in Place
1	5.25	1	5.25	1	7	1	3	1	3		3.52%	3	2	47	0	5	0	63%		29	yes
1	4 (3.3)	1	4(3.3)	1	4(3.3)	1	3	1	3	high	1.90%	5	3	35	0	1	0		76%	9	Yes
1	6.75	1	6.75	1	9	1	3.4	1	3.4		2.40%	7	3	114	0	3	3	64%	75%	34	Yes
1	5.4(6.75)	1	5.40	1	9	1	3	1	4		3.83%	31	7	67	0	0	1	95%		43	Yes
1	6.6(8)		6.6(8)	1	10(12)	1	3.3(4)	1	5(6)		1.80%	7	4	119	0	0	0	62%	91%	7	Yes
1	6.00	1	6.00	1	10	1	3	1	3.8		5.19%	10	4	124	0	0	0	67%	89%	58	Yes
1	7.00	1	7.00	1	10.5	1	3.5	1	4.2	3.2%	2.70%	11	4	96	0	0	0	77%	92%	14	Yes
1	8	1	8	1	10	1	3	1	4.4		4.00%	8	6	147	0	0	0			23	yes
1	5.00	1	5.00	1	5	1	2.5	1	2.73		9.10%	6	1	25	0	0	0	96%	84%	3	Yes
1	5.00	1	5.00	1	5	1	3.33	1	3.33		2.70%	10	2	43	0	0	1			4	Yes
											6.30%		12	1	0	0	0	86%	84%		N/A

WARD STAFFING REVIEW
September 2016 - April 2017

Current Position											Sisters/Charge Nurses		Vacancies (as at time of skill mix reviews)					Total Number of staff per shift													Admin support (WTE)			Sisters/Charge Nurses	Skill mix as a proportion of total staff RCN note national benchmark of RN 65%		
Wards/department	Beds	Total Funded Establishment WTE	Funded Establishment Band 6 and 7	Funded Establishment Band 5 WTE	Funded Establishment Band 4 WTE	Funded Estabalishment Band 3 WTE	Funded Establishment Band 2 WTE		Current maternity leave WTE	Average % uplift during March 16 - August 16	No Band 7	No Band 6	Band 6 Vacancy WTE	Band 5 Vacancy WTE	Band 4 vacancy WTE	Band 3 vacancy WTE	Band 2 vacancy WTE	Early - RN	Early - Band 4	Early - Band 3	Early - Band 2	Late -RN	Late -Band 4	Late -Band 3	Late - Band 2	Night - Registered	Night - Band 4	Night - Band 3	Night -Band 2	Shift patterns (ie 2 or 3 shift pattern)	Ward Clerk	Housekeeping Assist	Ward managers Assistant	Average % supervisory	Registered %	B3 / B4 %	B2 %
Amesbury	32	36.15	3.5	14.86	2.76	1	14.33		0	22.5%	0.5	3	0.2				3.83	4	1		4	3	1		4	3			2	2	1			80%	45%	9%	45%
Chilmark	24	28.87	3.5	12.9	0.8	0	11.97		1	14.9%	0.5	3	0.25				4.5	4			3	3			2	2			2	3	0.8			80%	56%		44%
Burns	17	24.57	3	14.79	0	0	6.78		1	30.0%	1	2		3			0	4			2	3			1	2			1	2	1.2			50%	72%		38%
Laverstock	26	28.95	3	16.62	1.2	0.8	7.33			26.2%	1	2						5	inc in RN		3	3	inc in RN		2	3			1	2	1.6				59%	6%	36%
Burns + Plastics	17		3	16.33			10.22				1	2						4			2	3			3	3			2						62%		38%

NB All these indicators are for period of September 2016 - April 2017

Trained nurse staffing relative to patients (early / day shift)		Trained nurse staffing relative to patients (late shift)		Trained nurse staffing relative to patients (night shift)		Staffing relative to population served ie nurses per occupied bed (NPOB) on a eaerly/day shift		Staffing relative to population served ie nurses per occupied bed (NPOB) on a late shift		Staff Turnover	Sickness absence (average)	Nursing Sensitive Indicators September 2016 - August 2017									
RN	No Patients	RN	No of patients	RN	No Patients	Nurses	No. beds	Nurses	No beds	%	%	No of PU Grade 2 or above	Complaints	No of Falls	No of MRSA Bactaraemia	No of MSSA Bactaraemias	No of C-diff (reportable and non-reportable)	% Compliance Appraisals	% compliance Stat and Mand training	No of Red Flag Incidents	Shelford Tool Used
1	8	1	10.6	1	10.6	1	3.5	1	4		4.6%	5	8	96	0	1	0	93%	95%	10	yes
1	6	1	8	1	12	1	3.85	1	4.8		1.8%	4	3	94	0	0	0	93%	97%	3	yes
1	4.3	1	5.6	1	8.5	1	2.8	1	4.25	2.0%	3.2%	3	2	25	0	0	1	63%	80%	25	yes
1	5.2	1	8.6	1	8.6	1	3.25	1	3.25		5.6%	6	2	38	0	0	1			6	
1	4.25	1	4.25	1	5.6	1	2.8	1	2.8												

WARD STAFFING REVIEW
September 2016 - April 2017

Current Position

Wards/department	Beds	Total Funded Establishment WTE	Funded Establishment Band 6 + 7	Funded Establishment Band 5 WTE	Funded Establishment Band 4 WTE	Funded Estabalishment Band 3 WTE	Funded Establishment Band 2 WTE	Budget (financial)	Current maternity leave WTE	Average % uplift during March 16 - August 16	Sisters/Charge Nurses: No Band 7	Sisters/Charge Nurses: No Band 6	Vacancies (at time of skill mix review): Band 6 Vacancy WTE	Vacancies: Band 5 Vacancy WTE	Vacancies: Band 4 vacancy WTE	Vacancies: Band 3 vacancy WTE	Vacancies: Band 2 vacancy WTE
Britford	20	39	3	21.37	0	5.32	9.31	1	1.6	18%	1	3		5.00			2.00
SAU	6																
Downton	24	25.38	3	11.83	0	0	10.55	892,419	0.0	16%	1	2	?1	6.20			0.25
Radnor	10(6+4)	54.91	14.08	34.89	0	0	5.11	2,317,863	3.8	24%	7	8		5.91			0.61
DSU	32 trollies	58.13	1+5.31	32.78	3.28	1	10.57	1,795,891	3.7	Not known	1	2.5		9.03	0.00	0.00	0.00

Wards/department	Total Number of staff per shift: E- registered	E - Band 4	E - Band 3	E - Band 2	L -Registered	L -Band 4	L -Band 3	L - B2	N - Registered	N - Band 4	N - Band 3	N -Band 2	Shift patterns (ie 2 or 3 shift pattern)	Admin support (WTE): Ward Clerk	Admin support (WTE): Housekeeping Assist	Admin support (WTE): Ward managers Assistant	Sisters/Charge Nurses: Average % supervisory	Skill mix as a proportion of total staff RCN note national benchmark of RN 65%: Registered %	B3 / B4 %	B2 %
Britford	5		1	1	4		1	1	3			2	3	0.5		0.26	100	65%		35%
SAU	1		1		1		1													
Downton	4			3	3			2	2			2	2	0.5	0	0.26	82	58%		42%
Radnor	9			1	9			1	9			1	2	1.67			N/A	86%		14%
DSU	4			2	4			2					3				100%			
	4				4															
	1			1	1			1												

NB All these indicators are for period of September 2016 - April 2017

Trained nurse staffing relative to patients (early / day shift)		Trained nurse staffing relative to patients (late shift)		Trained nurse staffing relative to patients (night shift)		Staffing relative to population served ie nurses per occupied bed (NPOB) on a eaerly/day shift		Staffing relative to population served ie nurses per occupied bed (NPOB) on a late shift		Staff Turnover	Sickness absence (average)	Nursing Sensitive Indicators September 2016 - August 2017										
RN	No Patients	RN	No of patients	RN	No Patients	Nurses	No. beds	Nurses	No beds	%	%	No of PU Grade 2 or above	Complaints	No of Falls	No of MRSA Bactaraemia	No of MSSA Bactaraemias	No of C-diff (reportable and non-reportable)	% Compliance Appraisals	% compliance Stat and Mand training	No of Red Flag Incidents	Shelford Tool Reviewed	
1	4	1	5	1	7	1	3.2	1	3.2		2.20%	5	4	26	0	0	1	95%	88%	15	Yes	
1	6	1	8	1	12	1	3.4	1	4.8	20.8%	4.00%	4	2	39	0	0	0	90%	85%	4	Yes	I
										1.9%	4.40%	8	1	4	0	1	3	71%	78%	11	N/A	
1	7	1	7			1	5		5		5.03%	4	2	5	0	1	0		84%	10	N/A	beds
1	1		1																			recovery
1	9		9				5		5													chairs

Midwives to Births Ratio
(excluding HOM & Management time)

Month	Midwives Establishment	Reg Births (E3)	Non Reg Births (E3)	Total Births	Midwife to Birth ratio		12 Month average
Dec-15	71.21	188	3	191	1:32	32	35.2
Jan-16	71.21	220	4	224	1:38	38	34.8
Feb-16	71.21	176	1	177	1:30	30	35.0
Mar-16	71.21	204	2	206	1:35	35	35.0
Apr-16	71.21	209	5	214	1:36	36	35.2
May-16	71.21	203	1	204	1:34	34	34.8
Jun-16	71.21	185	0	185	1:31	31	34.7
Jul-16	71.21	206	1	207	1:35	35	34.7
Aug-16	71.21	199	4	203	1:34	34	35.0
Sep-16	71.21	235	1	236	1:40	40	35.2
Oct-16	71.21	174	2	176	1:30	30	34.5
Nov-16	71.21	180	4	184	1:31	31	33.8
Dec-16	71.21	161	2	163	1:27	27	33.4
Jan-17	76.21	179	2	181	1:29	29	32.7
Feb-17	76.21	157	4	161	1:25	25	32.3
Mar-17	76.21	197	7	204	1:32	32	32.0
Apr-17	76.21	190	3	193	1:30	30	31.5
May-17	76.21	190	0	190	1:30	30	31.2
Jun-17	76.21	198	2	200	1:31	31	31.2
Jul-17	76.21	186	2	188	1:30	30	30.8
Aug-17	76.21	187	2	189	1:30	30	30.4
Sep-17	76.21	202	4	206	1:32	32	29.8
Oct-17	76.21	185	1	186	1:29	29	29.7

<=1:28
>1:28-<1:35
>=1:35

Notes:
Since Jan 2017 ratio is based on midwife establishment minus non clinical percentage as recommended by Birthrate Plus
Total Births sourced from E3 reports
Ratios are rounded to nearest integer

SALISBURY NHS FOUNDATION TRUST

1:1 Midwifery Care in labour Audit
2017 Q2 report

Conducted by Alison Lambert

1.0 Introduction

This report is the result of an audit undertaken to demonstrate our 1:1 midwifery care in labour as a result of actions arisen from the CQC inspection.

2.0 Background

The RCOG Safer Births report (2007) recommends that women should not, in principle, be left alone during or just after labour. It is an expectation that women are offered 1:1 midwifery care in labour.

3.0 Aim

- To ascertain compliance with the standard that 1:1 midwifery care in labour is achieved.
- To ascertain compliance with the standard and ensure appropriate action is taken in the event that 1:1 midwifery care is not achieved consistently.

4.0 Audit standards

4.1. 1:1 midwifery care should be offered to all women during labour**.**

5.0 Methodology:

Prior to January 2016, data demonstrating our 1:1 care in labour figures were limited and somewhat unreliable. Work was undertaken to incorporate an additional field within the Maternity E3 database system. This field was entered within the delivery segment, which the delivering midwife completes to reflect whether she was able to provide 1:1 care. This data is pulled on a monthly basis. In the event that this field is left incomplete or in the cases where it was identified that 1:1 was not achieved, a manual retrospective review of the intrapartum records is undertaken to ensure accuracy of data.

Since the introduction of this method of data collection, compliance to the standards has been between 99=100%.

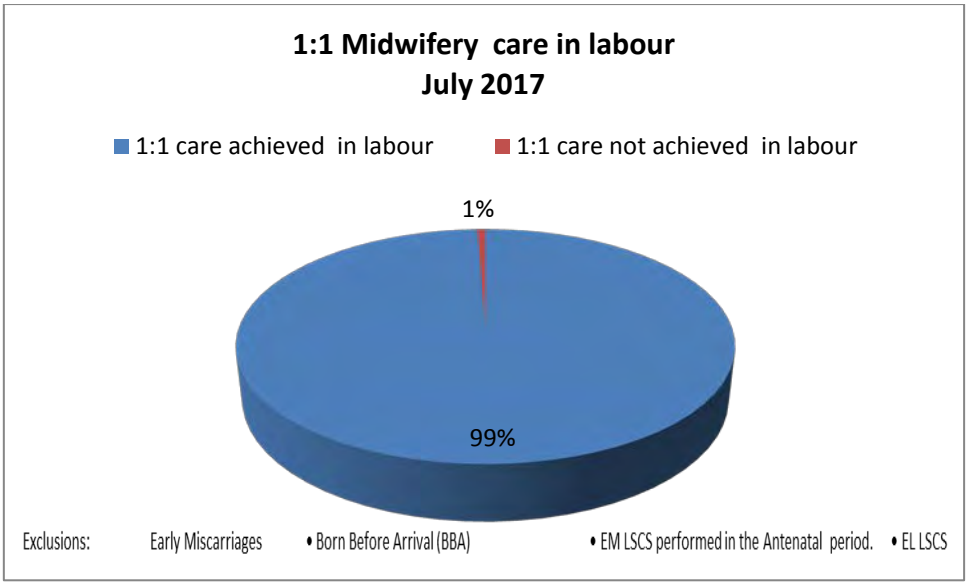
6.0 Exclusion:

Cases excluded from the audit:

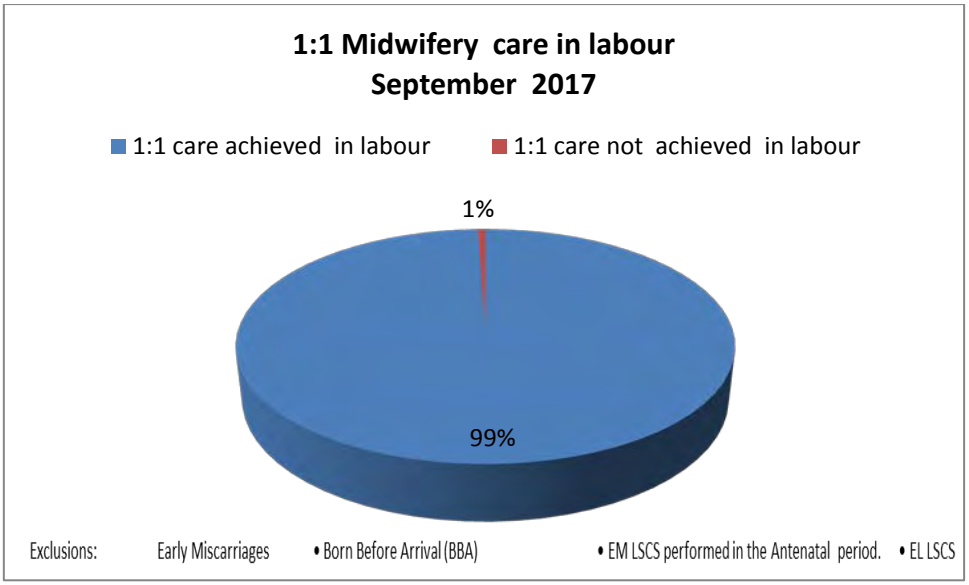
- Early miscarriages
- Born before Arrival (BBA)
- EM LSCS performed in the A/N period.
- All ELLSCS.

7.0 Audit results:

July 2017	August 2017	September 2017	**Q2**
160/161=99%	161/161= 100%	171/172= 99%	492/494= 99.5%


1:1 Midwifery care in labour
July 2017
1:1 care achieved in labour
1:1 care not achieved in labour
1%
99%
Exclusions: Early Miscarriages • Born Before Arrival (BBA) • EM LSCS performed in the Antenatal period. • EL LSCS


1:1 Midwifery care in labour
August 2017
1:1 care achieved in labour
1:1 care not achieved in labour
0%
100%
Exclusions: Early Miscarriages • Born Before Arrival (BBA) • EM LSCS performed in the Antenatal period. • EL LSCS



8.0 Discussion:

Q2's findings demonstrate exceptional compliance to the standards, at 99.5%. There were only 2 cases in this quarter, where 1:1 midwifery care was not achieved.

The cases were reviewed in order to establish a possible theme.

The maternity records confirmed that 1:1 midwifery care was not achieved in both cases. On one occasion, 1:1 care was not facilitated due to acuity of the labour ward. The escalation policy was initiated, and a community midwife was asked to support the unit during the busy period. Once the community midwife was in attendance, 1:1 midwifery care was then achieved.

1:1 midwifery care was not facilitated in the second case as the woman had a precipitant late miscarriage.

Due to a small sample size it is not possible to draw any reliable themes. However, on both occasions where 1:1 care was not achieved, the incidents occurred during the night shifts.

9.0 Actions

No	Action	By who, by when	Evidence	RAG
1	No actions required			Green

SALISBURY NHS FOUNDATION TRUST
Acuity Audit Report
July 2017

1.0 Introduction

This report is the result of a table top Birthrate plus audit for the month of June 2017.

2.0 Background

The audit was undertaken to review the level of acuity of the women using our intrapartum services.

3.0 Aim

- An understanding of the total midwifery time required to care for women based on a minimum standard of providing one-to-one midwifery care throughout established labour
- A classification for intrapartum care which uses clinical indicators to assess the level of need of the mother and baby
- Collecting real time data on the length of time a woman required care during labour and delivery and an addition of extra midwife time for those with a high level of need/ intervention or emergency
- To ensure the staffing reflects the needs of our service users, in order to provide a safe and responsive service.

4.0 Method

All deliveries from 1st – 31st June 2017 were reviewed and audited in line with the Birthrate Plus score sheet.
The 'live' acuity tool was used to reconcile the data. The Birthrate Acuity system is a standalone methodology which can be used to assess and analyse staffing needs, and to compare client needs and staffing availability whenever records are made during the working day.

Exclusions

The purpose of the audit is to establish acuity in the intrapartum period, all other areas of the service was not included within this audit.

Sample size: 192

5.0 Results

Category	Level of care/ midwife to woman ratio to meet with acuity	Result
Cat1	1:1	5.2%
Cat2	1:1	16.%
Cat3	1:1.2	20.8%
Cat4	1:1.3	26%
Cat5	1:14	32%

6.0 Discussion

The audit finding revealed that in 80% of the 192 deliveries, where found to be of high acuity. Therefore, 80% of the women using the service required more than 1:1 care in labour, to ensure that the complexity of their clinical needs where met; thus ensuring a safe

delivery of care. Reconciling these figures against the 'live' Acuity tool demonstrates that the current staffing provision on shift, did not meet the acuity 40% of the time.

These figures demonstrates a short full in staffing requirement to meet the clinical needs of the women accessing our intrapartum services.

7.0 Appendix

Birthrate Plus intrapartum Acuity tools for June 2017	

Report to:	Trust Board	**Agenda item:**	SFT3990
Date of Meeting:	5th February 2018		

Report Title:	Customer Care Report Q2 2017-18			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Hazel Hardyman, Head of Customer Care			
Executive Sponsor (presenting):	Lorna Wilkinson, Deputy Director of Nursing			
Appendices (list if applicable):	N/A			

Recommendation:
The Board is asked to note this report. It brings together the themes from patient experience feedback and where improvements can be made.

Executive Summary:
This report brings together the themes from patient experience feedback e.g. comments, concerns, complaints, compliments, Friends and Family Test (FFT), real time feedback and NHS Choices. It also provides an overview of Patient and Public Involvement (PPI) activity and outcomes across the Trust to improve our services for patients. • 80 complaints were received in Q2 where the main themes remain clinical treatment, staff attitude, communication and appointments. The main themes from concerns were clinical treatment, communication and staff attitude. • There were 3 requests for independent review by the Parliamentary and Health Service Ombudsman. • A total of 248 inpatients were surveyed in the quarter for real time feedback. They made 192 positive and 153 negative comments. • The responses to the Friends and Family Test remain overwhelmingly positive and the numbers are too low to identify any main area of concern. • There have been 9 new PPI projects, plus one National Patient Survey and 6 completed project reports. • NHS Choices received 14 comments in Q2 with 11 positive and 3 negative relating to 11 different areas. This report provides assurance that the Trust is responding and acting appropriately to patient feedback.

Customer Care Report - Quarter 2
1st July – 30th September 2017

1. PURPOSE OF PAPER

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

2. BACKGROUND

This quarterly report brings together the themes from patient experience feedback e.g. comments, concerns, complaints, compliments, Friends and Family Test (FFT), real time feedback and NHS Choices. It also provides an overview of Patient and Public Involvement (PPI) activity and outcomes across the Trust to improve our services for patients.

3. COMPLAINTS

3.1 The main issues from complaints are:

- Clinical treatment (29), 6 more than Q1 (23) - sub-themes were 9 unsatisfactory treatment across 9 different areas, 6 further complications, 4 delay in receiving treatment, 4 inappropriate treatment, 3 correct diagnosis not made, and 1 each for delay in discharge, pain management and treatment unavailable. Orthopaedics received 4 complaints about clinical treatment and 3 each for the Emergency Department and Child Health.
- Staff attitude (13), 2 more than Q1 (11) – 7 related to nursing staff and 6 medical staff across 10 different areas. The Plastics Department received 3 (2 medical and 1 nursing staff).
- Communication (12) 5 more than Q1 (7) – sub-themes were 8 related to lack of communication, 3 wrong information and 1 insensitive communication with no link to a particular area.
- Appointments (11), 2 more than Q1 (9) – sub-themes were 4 appointment cancelled, 3 appointment date required, 2 appointment delays and 2 appointment system procedures, across 9 different specialties.

The main issues from concerns were appointments (37), clinical treatment (30) - 8 related to the Bowel Screening Programme as they send their feedback in batches to be recorded, the sub-themes were bowel prep (Moviprep) and sedation, communication (21) and attitude of staff (10). The main area for concerns and complaints about appointments was the Central Booking Department and for staff attitude it was the Emergency Department and Plastic Surgery.

80 complaints were received in Q2 compared to 60 complaints in Q1 and 99 complaints for the same period in the previous year. The activity from comments, concerns and enquiries has increased from 419 in Q2 last year to 474 in Q2 this year. A breakdown of numbers and themes from complaints according to Datix is below:

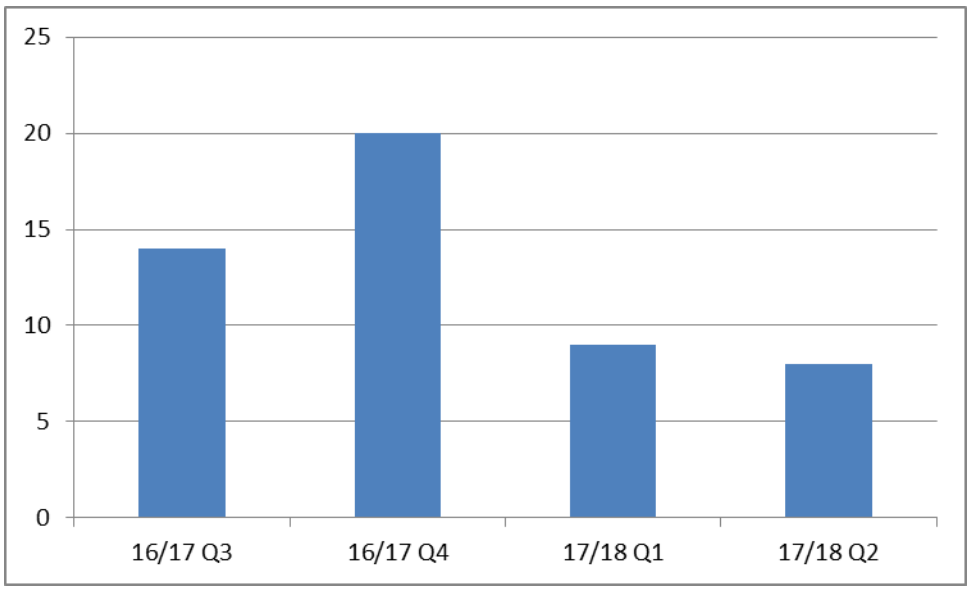
	CS&FS	Finance	Medicine	MSK	Surgery	Q2 total 2017-18	Q2 total 2016-17
Admission	0	0	1	0	1	2	8
Appointments	1	0	3	2	5	11	15
Attitude of staff	2	0	3	5	3	13	14
Clinical treatment	8	0	8	9	4	29	32
Communication	4	0	3	1	4	12	6
Confidentiality	0	0	0	0	0	0	1
Delay	0	0	0	0	1	1	2
Discharge	0	0	1	2	0	3	11
Equipment	0	0	0	0	0	0	1
Facilities on site	0	0	0	0	0	0	1
Falls	0	0	0	0	0	0	1
Food	0	0	0	0	0	0	1

Information	0	0	0	0	0	0	1
Invoicing	0	0	0	0	0	0	1
Nursing care	0	0	0	1	0	1	1
Operation	0	0	0	2	0	2	1
Trust policy	0	1	0	0	0	1	0
Hospital procedures	1	0	1	0	0	2	1
Property	0	0	0	1	0	1	0
Safeguarding	0	0	0	0	0	0	0
Waiting time	0	0	0	2	0	2	1
Totals:	**16**	**1**	**20**	**25**	**18**	**80**	**99**
Patient Activity	9,289	0	27,043	15,293	13,329		

In Q2 the Trust treated 17,152 people as inpatients, day cases and regular day attendees. Another 12,746 were seen in the Emergency Department and 35,056 as outpatients. 80 complaints were received overall which is 0.1% of the number of patients treated. There were no complaints about mental health issues this quarter. 274 compliments were received across the Trust in Q2, which represents 0.4% of the number of patients treated. Those sent directly to the Chief Executive or Customer Care Department were acknowledged and shared with the staff/teams named.

3.2 Timeliness of response

100% of complaints were acknowledged within three working days. 8 complaints were re-opened in Q2 with one Medicine complaint still awaiting a further response. The following graph shows the trend for re-opened complaints over the last four quarters.



The overall number of enquiries, comments, concerns and complaints responses falling into the 25+ working days has increased from 11.5% in Q1 to 16%:

0-10 working days		11-24 working days		25+ working days	
420	76%	44	8%	90	16%

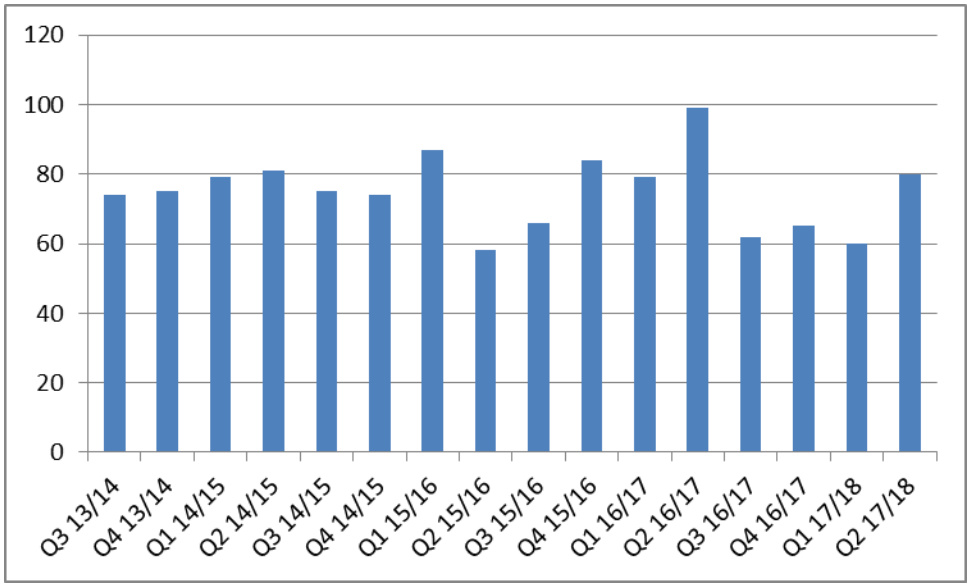
Response timescales for just complaints beyond 25 working days is unacceptably high, with an increase of 0.75% on Q1 and will be the directorates focus:

0-10 working days		11-24 working days		25+ working days	
6	7.5%	27	33.75%	47	58.75%

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

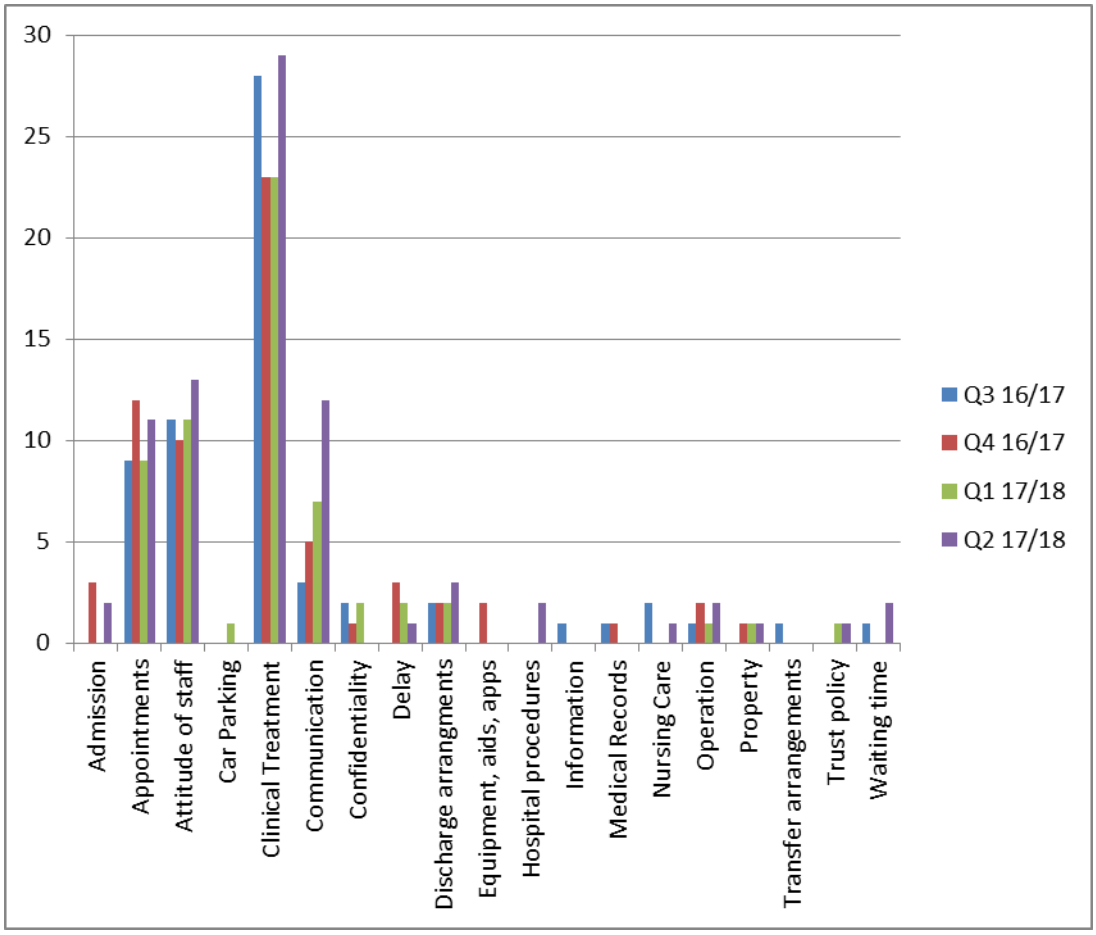
3.3 Complaints by quarter

The following graph shows the trend in complaints received by quarter. There has been an increase in complaints in Q2 compared to Q1. The specialty areas with the most complaints are Orthopaedics (12), Emergency Department (7) and Plastic Surgery (7), with 10 related to clinical treatment.



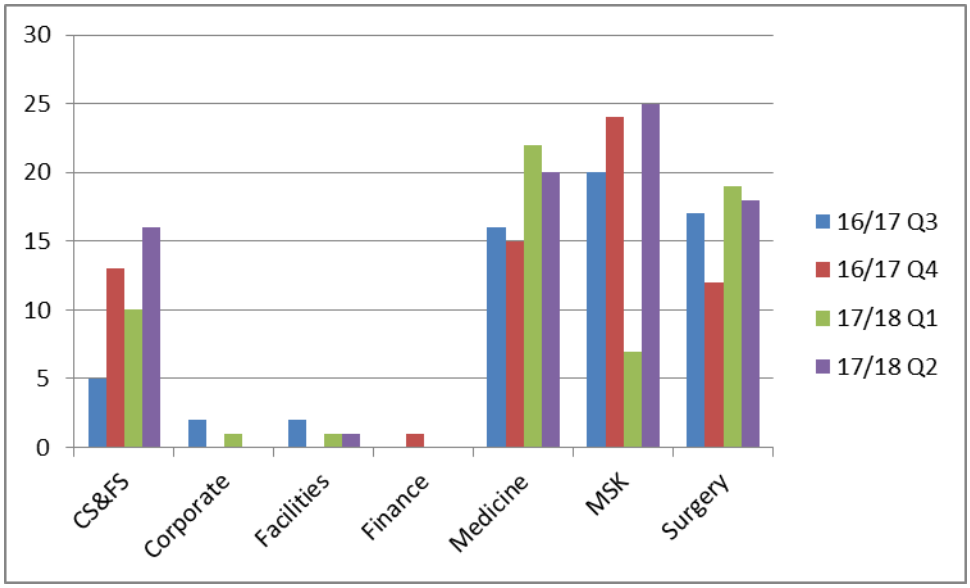
3.4 Complaints by Subject

The following graph shows the trend in complaints by subject over the last four quarters. Complaints have increased from the previous quarter by 20 with clinical treatment and communication seeing the highest increases, followed by attitude of staff, appointments and hospital procedures. The two complaints about hospital procedures related to ward moves and the second to a national policy that does not allow expectant mothers to have their other children in the room whilst being scanned. This is to allow the Sonographer to concentrate on the diagnostic test, which is in line with other Trusts.



3.5 Complaints by directorate

The following graph shows the number of complaints by directorate over the last four quarters. Clinical Support and Family Services and Musculo-Skeletal have both seen an increase in complaints in Q2 compared to Q1. 17 of the 41 complaints related to clinical treatment, followed by staff attitude (7) and communication (5).



3.6 Clinical Support and Family Services Directorate

	Quarter 2 2016-17	Quarter 1 2017-18	Quarter 2 2017-18
Complaints	15	10	16
Concerns	18	16	25
Compliments	145	70	76
Re-opened complaints	2	0	0
% complaints responded to within 25 working days	66%	40%	31%

- Complaints have increased by 6 this quarter compared to Q1.
- The Children's Outpatient Department received 4 complaints with 3 related to clinical treatment and 1 to appointments. Maternity also received 4 complaints with 2 relating to communication, 1 to hospital procedures and 1 to the attitude of a midwife.
- No complaints were re-opened in this quarter and two meetings took place.
- Concerns have increased by 9 compared to Q1, with the Bowel Screening Department receiving 14 concerns due to sedation and the screening kit not being suitable. The Bowel Screening Department send their compliments and concerns recorded on their feedback forms to Customer Care in bulk, which affects the figures from quarter to quarter. The Bowel Screening Team addresses their concerns immediately on receipt. Bowel Screening has developed a questionnaire to gain in depth feedback about their patients' experiences (see section 7).
- Reduction in response compliance was due to delays in receiving statements from consultants and members of nursing staff. This was discussed at a recent directorate team meeting and it was agreed to raise it at the next Heads of Service meeting and to make sure it is raised at individual service meetings.
- Total activity within the directorate was 9289 and of this number 0.17% raised a complaint.
- The directorate are piloting a rota system to proactively deal with concerns and complaints, whereby the individual staff members are linked to a speciality instead of a set day as in the Musculo-Skeletal model.
- Customer Care is waiting for 7 actions plans outstanding from closed complaints since 1st April 2017 for this directorate. Action plans should be returned to Customer Care with the draft response letter. The Complaint Co-ordinators provide the directorates with weekly reports of any overdue concerns, complaints and outstanding action plans.

- This will continue to be followed up by the Customer Care Team and discussed at the Executive Performance Review.

Themes and actions

Department/Ward	Topic	Actions
Children's Department	Unsatisfactory treatment and delays in receiving appointments	• Additional outpatient sessions arranged to help clear current waiting list backlog. • Additional consultant now in post to help ensure adequate cover in place to prevent late clinic cancellations.
Bowel Screening	Concerns regarding sedation offered and testing kits	• Comments fed back to Lead Consultant for Bowel Screening Service to investigate further as to how the comments can be fed back to national programme, and review comments regarding sedation - this work is still ongoing.
Maternity	Lack of information	• Develop patient information leaflets about aftercare following an emergency hysterectomy in the intrapartum or immediate postpartum period.

Compliments

In total 76 compliments have been received across the directorate with the breakdown as: Bowel Screening = 29, Postnatal = 17, Endoscopy = 10, Beatrice = 5, Gynaecology = 3, Radiology, Sarum and Pathology = 2 each, Child Health, Fertility, Maternity Admin, Pharmacy, Spinal X-ray and Therapies = 1 each.

3.7 Medicine Directorate

	Quarter 2 2016-17	Quarter 1 2017-18	Quarter 2 2017-18
Complaints	29	22	20
Concerns	27	19	18
Compliments	160	189	112
Re-opened complaints	2	2	5
% complaints responded to within 25 working days	73%	41%	55%

- Complaints have decreased by 2 from Q1.
- The Emergency Department received the most complaints with 7; 2 less than Q1. There were no particular themes.
- 5 complaints were re-opened this quarter due to complainants having further concerns or needing further clarification.
- 6 meetings were held in Q2 which is an increase from previous quarters. The directorate has identified the value of meeting with families, particularly in relation to end of life care.
- The number of concerns has decreased by 1 from Q1.
- Response compliance has increased from Q1, the reason for some delays were due to the complexities of arranging suitable times for meetings and awaiting statements from nursing and medical staff.
- Total activity within the directorate was 27043 and of this number 0.07% raised a complaint.
- The Medicine directorate has not set up the daily rota system based on the Musculo-Skeletal model due to already having a good system in place whereby the directorate managers and senior nurses are contactable whenever there is a problem.
- Customer Care is waiting for 29 actions plans outstanding from closed complaints since 1st April 2017 for this directorate. Action plans should be returned to Customer Care with the draft response letter. The Complaint Co-ordinators provide the directorates with weekly reports of any overdue concerns, complaints and outstanding action plans.
- This will continue to be followed up by the Customer Care Team and discussed at the Executive Performance Review.

Themes and actions

Department/Ward	Topic	Actions
Across the Medicine Directorate	Unsatisfactory treatment and lack of communication	• The directorate has actively been identifying complaints where it is felt that a meeting with key clinicians is the most beneficial way of resolving the complaint.
Elderly Care	End of life care	• Two new consultants have been recruited therefore relying on locum consultants now is less likely to occur.

Compliments

In total 112 compliments have been received across the directorate with the breakdown as: ED = 28, Hospice = 21, Pembroke ward = 16, Farley Ward = 12, Redlynch Ward = 8, Tisbury and Durrington wards = 6 each, Pitton and Whiteparish wards = 4 each, Breamore Ward = 2, Cardiac Care Team, Laverstock Ward, ED Majors, ED Minors and Medical wards = 1 each.

3.8 Musculo-Skeletal Directorate

	Quarter 2 2016-17	Quarter 1 2017-18	Quarter 2 2017-18
Complaints	29	7	25
Concerns	36	23	32
Compliments	89	63	41
Re-opened complaints	5	4	1
% Complaints responded to within 25 working days	31%	50%	48%

- Complaints have increased by 18 this quarter compared to Q1, which is significant but is a decrease in the number received in the same period last year.
- Concerns have also increased by 9 this quarter compared to Q1, but decreased from the same period last year.
- The total activity in the Directorate was 15,293 and of this number 0.16% raised a complaint.
- There has been one re-opened complaint.
- Orthopaedic Outpatients and the Plastics Department received the most complaints with 6 each. The main themes for the complaints were delays in receiving treatment (3), attitude of nursing staff (3), attitude of medical staff (2), further complications (2) and inappropriate treatment (2).
- The highest number of concerns received was for the Plastics Department with 6, then 3 each for Orthopaedics Rheumatology and Oral Surgery. 5 concerns related to unsatisfactory treatment, 4 appointment dates required, 3 delays in appointment system and 3 for lack of communication.
- There have been two meetings held in Q1.
- Customer Care is waiting for 1 actions plan which is outstanding from closed complaints since 1st April 2017 for this directorate. Action plans should be returned to Customer Care with the draft response letter. The Complaint Co-ordinators provide the directorates with weekly reports of any overdue concerns, complaints and outstanding action plans.
- This will continue to be followed up by the Customer Care Team and discussed at the Executive Performance Review.

General actions

- Daily telephone contact still working well and Dr Richard Smith has now joined the rota for one day per week.

Themes and actions

Department/Ward	Topic	Actions
Orthopaedic, Plastic Surgery and Oral Surgery	Concerns relating to appointments	• Continue to review long waiters. • Increase capacity in specialities through additional sessions. • Informatics support to provide accurate waiting

		list information by speciality. • Active waiting list validation by specialty to reduce waiting list times.
Orthopaedic and Plastic Surgery	Staff attitude	• No theme with individuals so managed through investigation process and 1:1s. No further action.
Orthopaedic and Plastic Surgery	Unsatisfactory treatment	• No themes of treatment or individual clinician so individual actions relating to complaint taken to resolve issues.

Compliments
In total 41 compliments have been received across the Directorate with the breakdown as: Avon Ward = 14, Orthopaedics = 8, Rheumatology = 6, Chilmark Suite = 5, Oral Surgery = 2, Amesbury Suite, Laverstock Ward, Orthopaedic Outpatients, Orthopaedic Therapy Team, Plastics Department and Plastics Trauma Team = 1 each.

3.9 Surgical Directorate

	Quarter 2 2016-17	Quarter 1 2017-18	Quarter 2 2017-18
Complaints	24	20	18
Concerns	18	36	41
Compliments	100	93	39
Re-opened complaints	0	3	2
% complaints responded to within 25 working days	87.5%	35%	44%

- Complaints decreased in Q2 from the previous quarter and response times within the 25 working day timeframe have improved by 9%.
- The activity within the Directorate was 13,329 and of this number 0.13% people raised a complaint.
- Two complaints and two concerns were re-opened in this quarter.
- There have been two complaint meetings held to reach resolution.
- The highest number of complaints was for ENT (5), with 3 complaints each for the Central Booking Department and Ophthalmology. Of the 5 ENT complaints, no particular themes were identified.
- The highest themes for complaints were the cancellation of appointments, further complications and lack of communication.
- The Ophthalmology Department received the highest number of concerns (12) and Central Booking (11). Of the 12 concerns in Ophthalmology 7 related to appointment issues.
- The Surgical Directorate will start a daily rota system in February 2018 when the Associate DSN role has been appointed to.
- Customer Care is waiting for 15 actions plans outstanding from closed complaints since 1st April 2017 for this directorate. Action plans should be returned to Customer Care with the draft response letter. The Complaint Co-ordinators provide the directorates with weekly reports of any overdue concerns, complaints and outstanding action plans. The directorate are working through the backlog.
- This will continue to be followed up by the Customer Care Team and discussed at the Executive Performance Review.

Themes and actions

Department/Ward	Topic	Actions
Central Booking	Letter not received Poor communication around appointment	• Partial booking posters being produced to be displayed in outpatient areas. • Letter project set up with patient readership panel to review processes and content of letters. • Further roll out of Electronic Referral Service enabling patients to choose their appointment

Compliments
In total 39 compliments have been received across the Directorate with the breakdown as: Britford Ward = 9, Downton Ward and Urology = 5 each, Clarendon Suite = 3, Urology Outpatients, Vascular and Diabetes, Vascular Outpatients, Breast Service and Day Surgery Unit = 2 each, Medical/Surgical Outpatients, General Surgery, Redlynch Ward and ENT = 1 each.

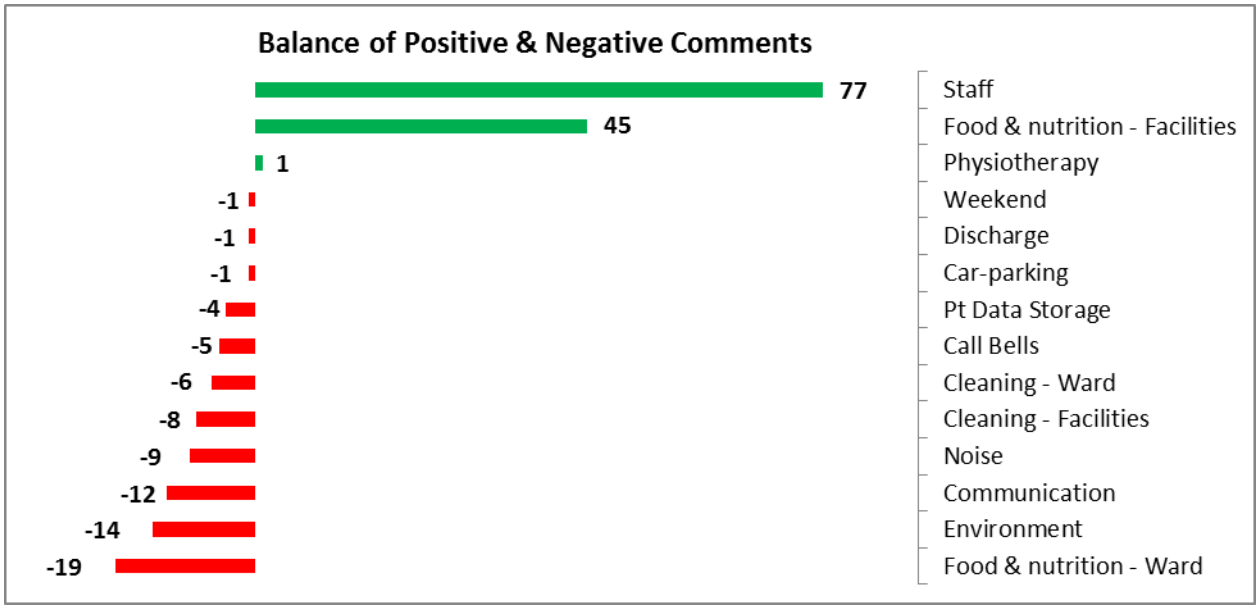
4. TRUSTWIDE FEEDBACK – INCLUDING REAL TIME FEEDBACK AND THE FRIENDS AND FAMILY TEST

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

Feedback area	Theme	Actions
Complaints	Clinical Treatment Staff Attitude/Communication Appointments	• No themes of treatment or individual clinician so individual actions relating to complaint taken to resolve issues. • Managed through investigation process and 1:1s. • Meetings with key clinicians is the most beneficial way to resolve complaints. • Additional outpatient sessions arranged to help clear current waiting list backlog. • Active waiting list validation by specialty to reduce waiting list times.
Inpatient, Maternity and Spinal RTF	Food and nutrition on the ward Communication Call bells Environment	• Wards are currently reviewing progress on their action plans.
FFT	Numbers too low	• Wards reviewed progress on their action plans.

5. INPATIENT REAL TIME FEEDBACK

A total of 248 inpatients were surveyed in the quarter. They made 192 positive and 153 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below.



The ward based action plans have been reviewed by Clinical Governance Committee. The main areas of concern were food and nutrition on the ward, environment and communication.

Food and Nutrition on the Ward

A total of 2 positive and 21 negative comments were received regarding food and nutrition on the ward. The negative comments have been categorised as set out in the table below.

REASON	WARD
Temperature (13)	Chilmark (4)
	Farley (1)
	Tisbury (3)
	Winterslow [Farley] (2)
	Britford (2)
	Day Surgery IP (1)
Help with meals (2)	Amesbury (1)
	Winterslow [Farley] (1)

REASON	WARD
Portion size (2)	Winterslow [Farley] (1)
	Pitton (1)
Quality (2)	Chilmark (1)
	Pitton (1)
Delays in surgery (1)	Amesbury (1)
Lack of protected meal-time (1)	Britford (1)

Environment

A total of 1 positive and 15 negative comments were received regarding the environment. The areas of negative comments are as follows:

REASON	WARD
Bathroom/shower (7)	Breamore (1)
	Clarendon (1)
	Tisbury (1)
	Pembroke (1)
	Pitton (1)
	Redlynch (1)
	Winterslow [Farley] (1)
Lighting (2)	Winterslow (1)
	Winterslow [Farley] (1)

REASON	WARD
Garden (1)	Pembroke (1)
Lack of newspapers (1)	Downton (1)
Lack of pillows (1)	Chilmark (1)
Patients wandering (1)	Redlynch (1)
Smoking outside (1)	Pitton (1)
Spartan (1)	Clarendon (1)

Communication

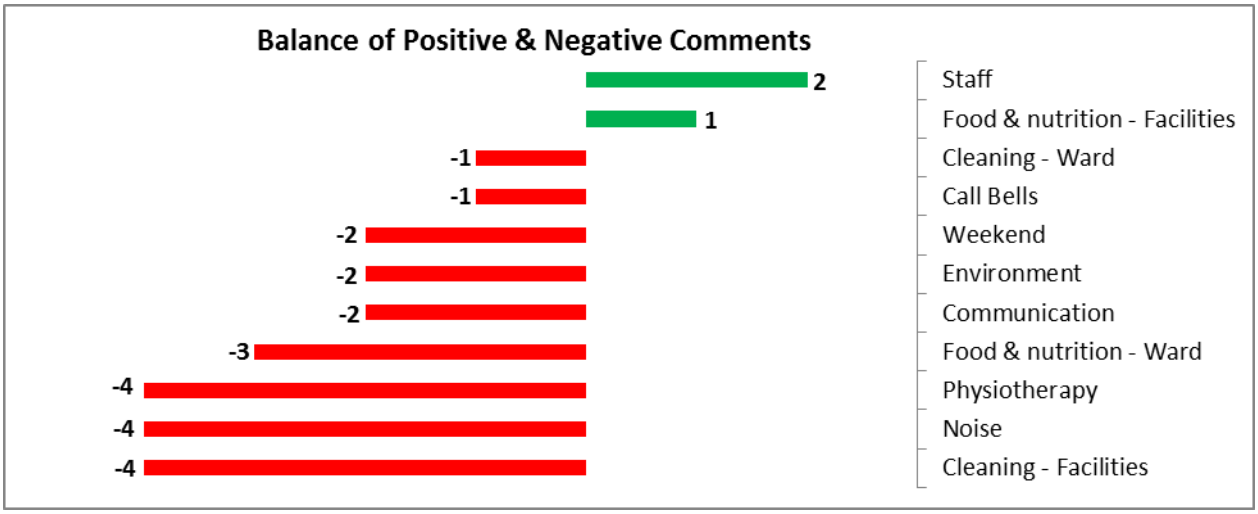
A total of 12 positive and 24 negative comments were received regarding communication. The negative comments were made in the following areas:

REASON	WARD
Doctors (6)	Amesbury (1)
	Downton (1)
	Durrington (1)
	Pitton (1)
	Tisbury (1)
	Winterslow [Farley] (1)
Staff attitude (3)	Britford (1)
	Chilmark (2)
Lack of information (3)	Day Surgery IP (1)
	Farley (1)
	Pembroke (1)

REASON	WARD
Language (3)	Winterslow [Farley] (2)
	Redlynch (1)
Discharge (2)	Amesbury (1)
	Durrington (1)
Lack of family involvement (2)	Winterslow [Farley] (2)
Medication (2)	Downton (1)
	Tisbury (1)
General (1)	Pitton (1)
Inter-hospital (1)	Redlynch (1)
Lack of knowledge about pt (1)	Britford (1)

Spinal

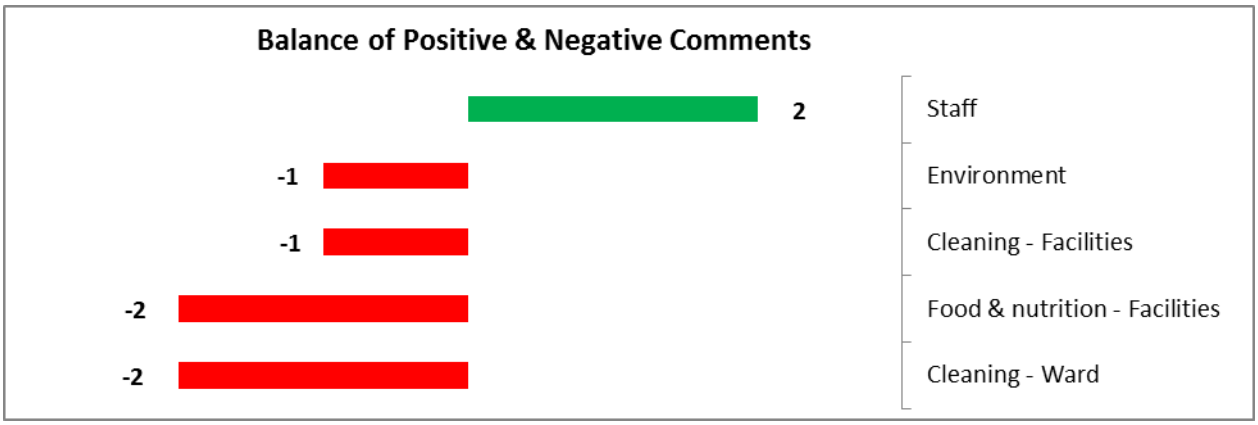
A total of 27 patients were surveyed in the quarter. They made 5 positive and 23 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below.



The main areas of concern were cleaning, noise and physiotherapy.

Maternity

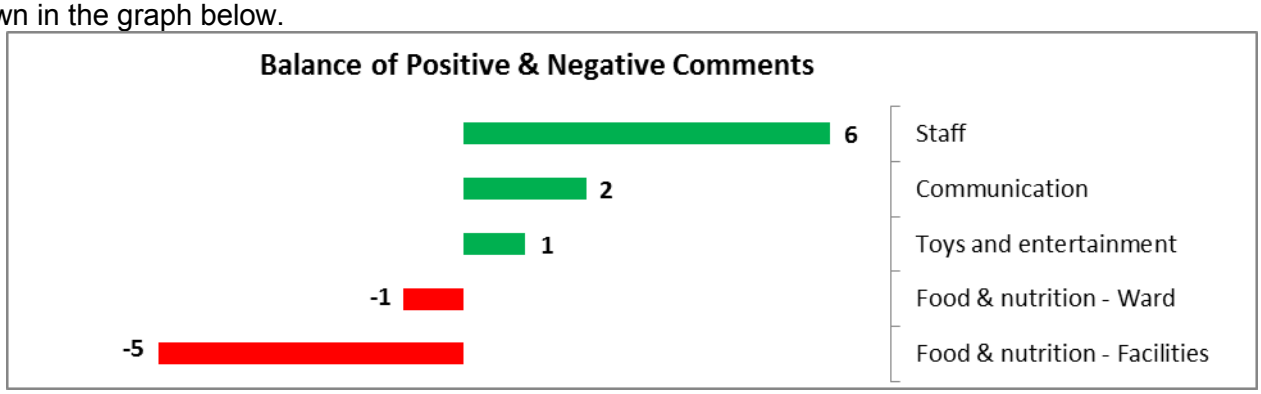
A total of 12 patients were surveyed in the quarter. They made 2 positive and 6 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below.



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

Paediatrics

A total of 12 adults or carers and 6 children were surveyed during the period. They made 10 positive and 9 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below.



The main area of concern was food and nutrition.

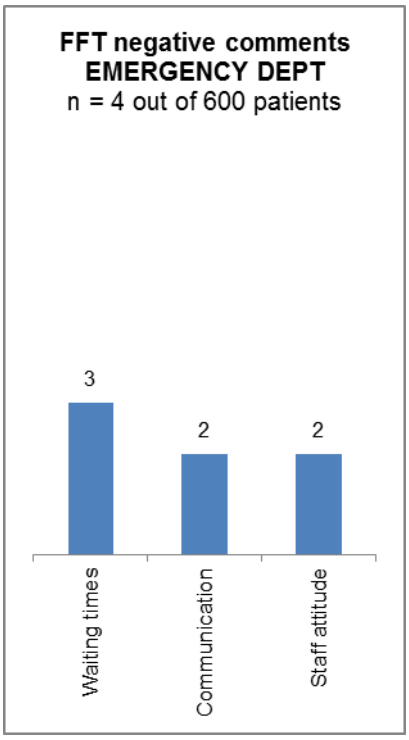
6. FRIENDS AND FAMILY TEST

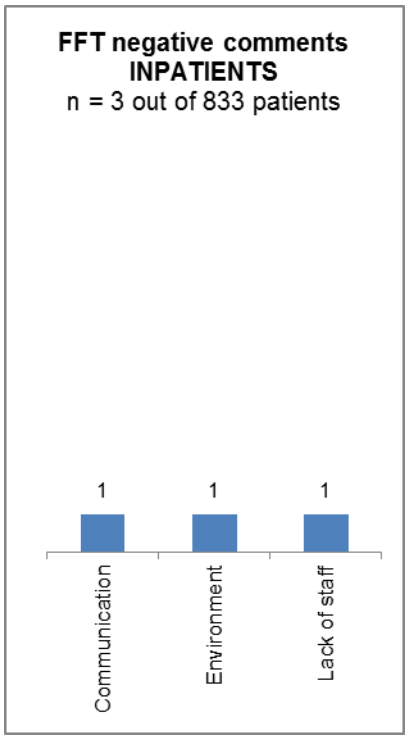
Responses for the period were as follows:

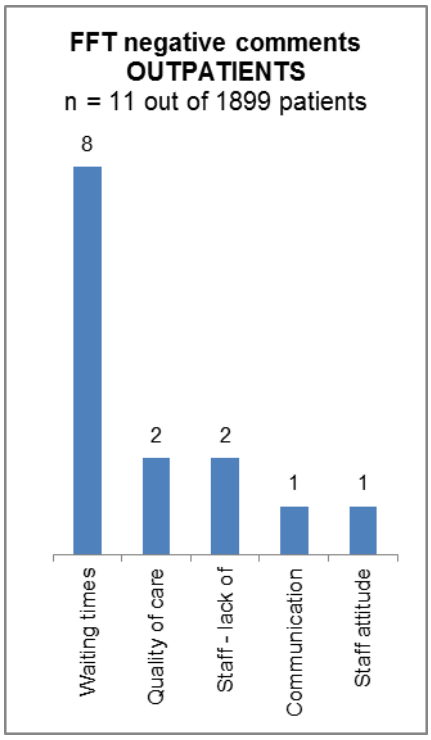
	Total Responses Received *	Rating				
		Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely Unlikely
Day Case	750	698	45	5	0	1
Emergency Dept	600	526	64	4	0	4
Inpatients	833	691	120	19	1	0
Maternity	1510	1285	190	26	1	4
Outpatients	1899	1652	205	25	4	5

* Shortfall between combined totals in rating columns and overall totals above equates to those who responded "don't know".

Comments made by those patients who stated they would be unlikely or extremely unlikely to recommend the hospital have been categorised as set out in the graphs below.







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

Action taken on areas of concern
Wards, the Emergency Department and Maternity, have action plans in place to address the main areas of concern in their location.

7. PATIENT AND PUBLIC INVOLVEMENT (PPI)

There has been 9 new projects, plus one National Patient Survey and 6 completed projects.

Clinical Support and Family Services
Two projects have been approved: Bowel Screening developed a questionnaire to gain feedback from patients attending for a colonoscopy as part of the Bowel Cancer Screening Programme to have choice and flexibility to improve their experience of taking bowel preparation.

Clinical Science and Engineering developed a patient satisfaction questionnaire to identify clear areas to improve the effectiveness of the patients' experience within the department.

Speech and Language Therapy completed their project on Communication Skills Training. The decision to provide this type of training was taken as it was felt that the benefits of having a workforce of staff skilled in supporting patients with Aphasia on Farley Stroke Ward would outweigh the disadvantages of the unit staff not being trained. Some of these concerns were highlighted by staff during the training e.g. the safety implications of patients not understanding physiotherapy instructions, nurses being unable to complete a comprehensive assessment due to communication difficulties, and implications for consenting patients for procedures.

The Neonatal Unit Parents questionnaire is being used and the feedback is shared with staff. From the feedback so far, the team have looked at the visiting guidelines, and mothers can choose another person to be with them and support them if the father has to go back to work. The plan is to continue to gather feedback.

Medicine
Three projects have been approved: Whiteparish Acute Medical Unit (AMU) is relocating to Level 2 and will be redesigning their ambulatory area. They are seeking comments and ideas from patients and carers to help improve the ambulatory service.

The Hospice has developed a questionnaire to improve end of life care. Whilst the questionnaire is designed to be anonymous, if the relative has concerns about the care given to the deceased during their last hospital stay, there is the option of leaving contact details so that these concerns can be explored and the appropriate action taken. This supports the recently published National Guidance on Learning from Deaths (NQB, 2017) which clearly recommends that bereaved relatives should be given the opportunity to raise concerns about the care their loved ones received prior to their death. Paying close attention to what bereaved families and carers say can offer an invaluable source of insight to improve clinical practice.

It is intended that the questionnaire is offered to bereaved relatives of everyone who dies in the hospital and hospice, whether or not the death was expected. Exceptions to this are children under the age of 18 and people who die in the Emergency Department (who will be followed up by their own departments).

The Hospice aims to feedback formally to the wards every month and have a “you said, we did” board sited in the Bereavement Suite, Hospice and on the hospital website home page, which will demonstrate actions taken in response to the public.

Elderly care will be having a carer’s focus group to find out what support carers would like from us when the person they are caring for is admitted to hospital, and also what carers would like from us when they themselves are admitted to hospital.

Musculo-Skeletal Directorate
Two projects were approved, both for Spinal. The first is a questionnaire for improving discharge processes and patient experiences, supported by a HEE Wessex Team Fellowship. The second is a urinary catheter drainage questionnaire to inform a study about the best methods for patients.

Patient feedback on Horatio’s Garden has been positive, therefore no actions need to be taken currently.

Operations Directorate
The Programme Management Office project to implement placemats on the bedside to encourage patients to ask questions was completed. The findings were mixed and long-term implementation of this should be considered with a more detailed review of questions, design and roll-out.

The second project to evaluate the value of #endPJParalysis on Amesbury and Breamore wards was completed. Although the findings were positive in getting dressed, there were mixed messages about the leaflet itself. Long-term implementation of this should be considered with a more detailed review of questions, design and roll-out.

Quality Directorate
The National Inpatient Survey 2017 commenced.

Surgery Directorate
Two projects were submitted for approval. Ophthalmology introduced a new way of working by setting up virtual clinics. Rather than the “traditional” way of working, the patient does not see a Doctor on the day but sees and Ophthalmic Assistant (OA), who takes the patient through a series of tests over a 30 minute period and then the results get reviewed virtually by a Doctor after the appointment and the patient receives a written outcome. This has helped significantly to ease the pressure in clinic and reduce waiting times, however Ophthalmology wish to understand how patients feel about this new way of working. This project has been approved.

The second project is being undertaken by ENT to survey patients who have been upgraded to a new bone-anchored hearing aid (BAHA) in the past 6 months, to find out how patients compare their new BAHA to their old one.

The Audiology patient survey was completed with the following actions:

- Changes to the outpatient department reception area to address the issue of checking in.
- Focus group to gain a better understanding of improvements that could be made to the department.

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

8. PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

In Q2 there were three new requests for independent review: two for Surgery and one for Children's Services. The complaint file and copy records have been sent for all three cases. The Trust has written a letter of apology for one of the Surgery cases that was partially upheld and has developed an action plan to address the failings identified by the PHSO. The Trust is awaiting an outcome on the other two cases.

The PHSO publishes complaints data on a quarterly basis that includes numerical information on the complaints received, assessed, and investigated and is available at:
http://www.ombudsman.org.uk/reports-and-consultations/reports/health/quarterly-reports-on-complaints-about-acute-trusts

9. NHS CHOICES WEBSITE

In Q2 there were 14 comments posted on the NHS Choices website relating to 11 different areas. Of the 11 positive comments, one person said of Tisbury Ward "It was lovely to meet such a mix of nationalities, who were very competent and their English excellent. I hope the government realise how important it is that we need them and give them the same rights as us. CQC should give Salisbury an excellent rating." Of the 3 negative comments, one person said of Gynaecology "I was seen 45 minutes late to be then given a prescription, upon collecting prescription; it was an injection to be given with no needle supplied - told to go back to Gynae and ask how to administer. The nurse was not sure - unable to contact consultant - 4 hours later still waiting for an answer!! Not a happy patient". All the feedback was shared with the departments.

10. SUMMARY

This report brings together the themes from patient experience feedback and where improvements can be made, the directorates are acting accordingly.

11. RECOMMENDATIONS

The Board is asked to note this report.

AUTHOR: Hazel Hardyman
TITLE: Head of Customer Care

Report to:	Trust Board	**Agenda item:**	SFT3991
Date of Meeting:	5 Februrary 2018		

Report Title:	Quarterly Learning from Deaths Report Q1 – Q2 2017/18			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Christine Blanshard, Medical Director			
Appendices (list if applicable):				

Recommendation:
Recommendation – assurance that the Trust is complying with the national guidance on learning from deaths. **Assurance** – the Trust has made good progress in implementing the national guidance on learning from deaths. A mortality policy and a dashboard with the number of reviews and learning themes is published for Q1 and Q2 2017/18. Most importantly, the support of bereaved families and carers has been strengthened and their views are being used to make improvements.

Executive Summary:
• In December 2016, the Care Quality Commission (CQC) published 'Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate deaths of patients in England'. The report made recommendations about how the approach to learning from deaths could be standardised across the NHS. In particular, they found that families and carers often had a poor experience of investigations. • The National Quality Board published guidance on learning from deaths in March 2017 and placed a number of new requirements on Trusts. • The report outlines our mortality policy, our dashboard with the number of reviews and learning themes published for Q1 and Q2 17/18. • Most importantly, the support for bereaved families and carers has been strengthened and their views are being used to make improvements.

1. Purpose

1.1 To comply with the national requirements of the learning from deaths framework, Trust Boards must publish information on deaths, reviews and investigations via a quarterly agenda item and present a paper to a public board meeting from Q3 2017 onwards.

2. Background

2.1 In December 2016, the Care Quality Commission (CQC) published 'Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate deaths of patients in England'. The report made recommendations about how the approach to learning from deaths could be standardised across the NHS. In particular, they found that families and carers often had a poor experience of investigations and there was no single framework for NHS Trusts that sets out what needs to be done to maximise the learning from deaths.

2.2 The National Quality Board published guidance on learning from deaths in March 2017 and placed a number of new requirements on Trusts. These are:

- From April 2017 onwards, collect new quarterly information on deaths, reviews and investigations and resulting quality improvements.
- By September 2017 publish a Trust mortality policy on how the Trust responds to and learns from the deaths of patients in its care.
- From Q3 2017 onwards publish information on deaths, reviews and investigation via a quarterly agenda item and paper to its public board meeting including information on reviews of the care provided to those with severe mental health needs and learning disabilities.
- From June 2018 publish an annual overview of this information in Quality Accounts.

2.3 The main purpose of this initiative is to promote learning and improve how Trusts support and engage with the families and carers of those who die in our care.

3 National Guidance on learning from deaths

3.1 The Trust published its mortality policy in September 17. It is available at the following link: http://www.icid.salisbury.nhs.uk/ClinicalManagement/OperationalIssues/Pages/MortalityReviewPolicy.aspx

3.2 Mortality dashboard, learning, themes and actions

A new screening process was introduced in August and by the end of September 117 (87%) deaths had been subject to a first screen. In Q1 & Q2, 146 (37%) deaths had 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 are implementation of treatment escalation plans, timely ceiling of care reviews, timely DNACPR decisions and procedural documentation regarding risks and benefits. Improvement actions are set out in appendix 2. Learning is shared via quarterly mortality bulletins and educational events. An annual overview of learning from our deaths will be published in the Quality Account 2017/18.

3.3 Patients with learning disabilities

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, 4 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.

3.4 Patients with serious mental illness

One patient with a serious mental illness died in 2017/18. This case was subject to a full case review. A best interests meeting was held about treatment. The death was not considered avoidable and there were no learning points.

3.5 Bereavement support

Bereavement support is offered to families and carers of patients who die in the Emergency 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 giving relatives a bereavement survey called 'your views matter'. So far, 15 surveys have been returned, of which 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.

4.0 Summary

The Trust has made good progress in implementing the national guidance on learning from deaths. A mortality policy and a dashboard with the number of reviews and learning themes is published for Q1 and Q2 2017/18. Most importantly, the support of bereaved families and carers has been strengthened and their views are being used to make improvements.

5.0 Recommendation

The report is provided for assurance that the Trust is complying with the national guidance on learning from deaths.

Claire Gorzanski
Head of Clinical Effectiveness
15 January 2018

SALISBURY NHS FOUNDATION TRUST
MORTALITY DASHBOARD 2017/2018

	April 17	May 17	Jun17	Jul 17	Aug 17	*Sep17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total
Deaths	62	69	54	70	67	68							390
1st screen					54	63							117/135
% 1st screen					81%	93%							87%
Case reviews	30	21	9	37	31	18							146
% case reviews	48%	30%	17%	53%	46%	26%							37%
Deaths with Hogan score 1 - 3	0	0	0	0	0	0							0
Deaths with Hogan score 4 - 5	0	1	1	3	4	3							12
Learning points	5	4	0	3	7	8							27
Family/carer concerns	0	0	0	1	3	2							6
CUSUM alerts	0	4	0	1	1	0							5
CUSUM investigated	0	3	0	1	1	0							4
Deaths investigated as an SII	0	0	0	0	0	0							0
Elective deaths	3	3	1	3	0	0							10
Unexpected	0	0	0	0	0	0							0
Stillbirths/ neonatal/child death	1	1	3	2	1	2							10
Learning disability deaths	0	1	0	1	1	1							4
Reported to LeDeR	0	1	0	1	1	1							4
Serious mental illness	0	0	0	0	1	0							1
Maternal deaths	0	0	0	0	0	0							0

*1st screen commenced of patients who died in the Hospice

Note: Appendix 3 - explanatory notes

Appendix 2

SALISBURY NHS FOUNDATION TRUST

MORTALITY DASHBOARD LEARNING THEMES AND ACTIONS 2017/2018

No	Learning points	Action point	By whom	By when	Status
1	PICC line service – Monday to Friday service and single handed practitioner	Consider options for extending the availability of the PICC line service	Anaesthetic lead	31/12/17	
2	Discussion regarding resuscitation status in a timely manner to prevent futile CPR.	Ongoing education programme Analysis and reporting of futile CPR attempts	Resuscitation Committee	Ongoing	
3	Improve the use and uptake of Treatment Escalation Plans.	Work with Wiltshire CCG on the introduction of the national Treatment Escalation Plans	Resuscitation Committee	Ongoing	
4	Initiating and documenting ceilings of care early/continuing to review the ceiling of care regularly as the patient's condition changes.	Part of end of life care ongoing training	Specialist Palliative Care and End of Life Care teams	31/03/18	
5	Improve documentation of consent, risk and benefits of ward based procedures such as chest drains, lumbar punctures and ascitic taps	Ongoing education programme on consent Implementation of local standard operating procedures (LocSIPPs)	Risk Team	31/03/18	

SALISBURY NHS FOUNDATION TRUST
MORTALITY DASHBOARD – EXPLANATION OF TERMS

1. Deaths – the number of adult, child and young people deaths in the hospital and the Hospice.

2. 1st screen - the number of deaths screened to decide whether they need a full case review.

3. Case review - the number of deaths subject to a full case review using a structured method. Case record reviews involve finely balanced judgements. Different reviewers may have different opinions about whether problems in care caused a death. This is why the data is not comparable.

4. Deaths with a Hogan score of 1 – 3. The scores are defined as: 1) Definitely avoidable 2) Strong evidence for avoidability 3) Probably avoidable, more than 50/50 but close call . NHSI guidance 'Any publication that seeks to compare organisations on the basis of the number of deaths thought likely to be due to problems in care is actively and recklessly misleading the reader'.

5. Deaths with a Hogan score of 4 – 6. The scores are defined as 4) Possible avoidable but not very likely, less than 50/50 but close call. 5) Slight evidence of avoidability 6) Definitely not avoidable.

6. Learning points – the number of issues identified from reviews and investigation (including examples of good practice). The main purpose of this initiative is to promote learning and improve how Trusts support and engage with families and carers of those who die in our care.

7. Family/carer concerns – the number of concerns raised by families and carers that have been considered when determining whether or not to review or investigate a death. All families are offered support from our bereavement service and involved in investigations where relevant.

8. CUSUM (or cumulative sum) alerts - are statistical quality control measure which alerts the Trust to when the number of deaths observed exceeds the number expected in a diagnostic or procedure group. Each death in a CUSUM alert is subject to a full case review to promote learning and improvement.

9. Deaths investigated as a SII (serious incident inquiry).

10. Elective deaths – are patients who died following a planned admission to hospital. Our reviews indicate that the majority of these patients had metastatic cancer and were admitted to hospital for symptom control or a procedure to relieve their symptoms and died from disease progression.

11. Unexpected deaths – of patients who were not expected to die during their admission to hospital are subject to a full case review.

12. Stillbirth – is a baby that is born dead after 24 completed weeks of pregnancy.

13. Neonatal death – is the death of a live born baby during the first 28 days after birth.

14. Child death – the death of a child up to the age of 18. All unexpected child deaths are reviewed by the Wiltshire and Swindon Child Death Overview Panel.

15. Learning disability deaths – all patients with learning disabilities aged 4 to 74 years. The Trust reports all these deaths to the LeDeR programme.

16. LeDeR programme – Learning Disabilities Mortality review programme hosted by the University of Bristol aims to guide improvements in the quality of health and social care services for people with learning disabilities across England. The programme reviews the deaths of people with learning disabilities.

17. Serious mental illness – all patients who die with a serious mental illness.

18. Maternal deaths – is the death of a woman while pregnant or within 42 days of the end of pregnancy from any cause related to or aggravated by the pregnancy or its management. Maternal deaths are rare events.

Reference

NHS Improvement, July 2017. Implementing the learning from deaths framework: key requirements for Trust Boards. NHS Improvement, London

Report to:	Trust Board	Agenda item:	SFT3992
Date of Meeting:	5 February 2018		

Report Title:	Board Assurance Framework and Corporate Risk Register			
Status:	Information	Discussion	Assurance	Approval
				X
Prepared by:	David Seabrooke, Head of Corporate Governance Andrea Prime, Deputy Head of Corporate Governance			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	- Revised BAF (v2.8 TB January 2018) - Corporate Risk Register Summary (January 2018) - Corporate Risk Register (January 2018)			

Recommendation:
The Board are asked to consider and approve the revised Board Assurance Framework.

Executive Summary:
Background The Board Assurance Framework provides the Trust Board with a vehicle for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being met to satisfy internal and external requirements. In turn it will inform the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. This informs the Annual Governance Statement and annual cycle of business. **Process:** The Trust Board carries out an annual review of the Board Assurance Framework (BAF) process. This new format BAF was adopted by the Trust Board at its meeting in December 2017. To ensure that this new format is embedded and a live and dynamic document, it was agreed that the BAF will be updated and presented bi-monthly to the Board to ensure that the risks described are the most valid and the document remains fit for purpose following review of assigned sections through each of the Board's Committees: • Local Services : Finance & Performance Committee • Specialist Services : Finance & Performance Committee

- Innovation: Clinical Governance Committee
- Care : Clinical Governance Committee
- People : Executive Workforce Committee
- Resources : Finance and Performance Committee

In addition the Joint Board of Directors (JBD) will also review the complete BAF and CRR as part of this bi-monthly process.

The aims of the revised BAF are to:

- Ensure there is clear alignment between the Trust's Strategy, BAF and Corporate Risk Register
- Enable the Board to be able to clearly see progress / deterioration of risks on the Corporate Risk Register and where required request further assurance / deep dive
- Support the updating of actions against gaps in one place

The BAF:

The BAF has been revised and updated. In order to assist in the easy identification of changes to the document:

- New content is highlighted in yellow
- Out-dated content to be removed is shaded grey

Supporting Documentation:

- *The Corporate Risk Register* (CRR) is presented alongside the BAF for review
- *The Corporate Risk Register Summary* supporting the CRR, tracking the risk previous months, detailing the date of addition to the risk register, Lead Executive and whether the risk is an internal or external risk. Updates can also be requested and tracked through this summary sheet

Review of Risks:

It is clear from the summary sheet that our highest risk areas are:

- Local Services: ensuring capacity to meet demand and patient flow in services – ward reconfiguration project on track
- Resources: higher than planned deficit position. Currently working with NHSI and BCG on financial recovery plan
- People: continuing challenges in recruitment, particularly Registered Nurses

Next Stages:

- The BAF will be reviewed during March for presentation to Board at its meeting in April
- Risks on the Corporate Risk Register will continue to be reviewed by the Executive Lead to ensure they are representative of the actual current risk
- Further work is needed to ensure that all gaps identified on the BAF are trackable either through relevant risks on the risk register or further development of this template
- Internal Audit to consider using the evidence within the BAF to align the audit plan with gaps identified and support the Trust where there is insufficient Level 3 Assurance currently available

Board Assurance Framework
2017/18

Date: V2.8 as at 29/01/18

Trust Vision: An Outstanding Experience for Every Patient

Delivery of our vision and the strategic objectives is underpinned by our Trust Values and Behaviours: Patient Centred and Safe, Professional, Responsive, and Friendly. A drive to be 'outstanding every time.' It is also recognised (as illustrated above) that woven throughout the delivery of the strategy is the need to successfully develop and work across partnerships and collaborations which is why the Corporate Risk Register highlights both internal and external risks to delivery of our objectives.

Strategic Priorities

Local Services – We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

Care – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm

People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

Resources – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources

Board Assurance Framework – Glossary

Strategic priority	Executive Lead and Reporting Committee	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver	Executive lead for the risk The assuring committee that has responsibility for reporting to the Board on the risk.	What management controls/systems we have in place to assist in securing delivery of our objective	Where we gain independent evidence that our controls/systems, on which we are placing reliance, are effective.	What evidence demonstrates we are reasonably managing our risks, and objectives are being delivered **Level 1 Assurance** – Internally generated report or information which describes the effectiveness of the controls to manage the risk. For example – the Integrated Performance Report, self-assessments. **Level 2 Assurance** – Semi-independent reports or information. For example – Non-Executive Director walk arounds, Internal Audits **Level 3 Assurance** – Independent reports or information which describes the effectiveness of the controls to manage the risk. For example – External Audits, regulator inspection reports/reviews.	Where do we still need to put controls/systems in place? Where do we still need to make them effective?	Where do we still need to gain evidence that our controls/systems, on which we place reliance, are effective?

Key for progress against objectives

	Completed
	On schedule and full delivery expected within timeframe
	Work ongoing with risks to full delivery within timeframe
	Not started, and/or high risk of not achieving within timeframe

Risk Score Key

Low Risk	Moderate Risk	High Risk	Extreme Risk
1-3	4-6	8-12	15-25

Strategic Priorities – Risk Overview

	Overall risk score
Local Services We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.	
Specialist Services We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.	
Innovation We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	
Care We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	
People We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	
Resources We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	

Strategic Priority:

> **Local Services –** We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

Executive Lead: Chief Operating Officer **Reporting Committee:** Finance and Performance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Frail Elderly** - Development of an integrated frail elderly service	COO	April 2018	
2. **Emergency Care** - Implement new systems to manage the flow of emergency patients	COO	April 2018	
3. **Delayed Discharge** - Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need	COO	April 2018	
4. **Access** - Improving access to core services to support prompt, responsive care	COO	April 2018	

Corporate Risk Register Principal Risks

Likelihood \ Consequence	5	4	3	2	1
5					
4				5306	
3			5305		
2					
1					

4682 - Non elective admissions, DTOCs and 'Green to go' patients and impact on elective capacity CLOSED – superceded by new risk 5305

5220 - Delay in radiology reporting CLOSED

3919 – Capacity planning – required number and range of facilities CLOSED – superceded by new risk 5305

5305 – Consitutional performance standards may not be met as result of increased demand or decreased capacity

5306 - Reduction in beds during site reconfiguration work

Key Controls	Assurance on Controls
• Established performance monitoring and accountability framework • Access policy • Accountability Framework • Ward reconfiguration governance structure • Engagement with commissioners and system (EDLDB) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wilts Health and Care	• Integrated performance report • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes • Performance reports to weekly Delivery Group

Key Headlines - Objectives

Objective	Positive Assurance	1	2	3	Gaps in Control / Assurance
1. Development of an integrated frail elderly service	• Performance against quality metrics including increased number of discharges within 48 hours • Workshop to develop pathways for older people across the health economy has been agreed • Patient ward moves reduced (Getting the patient to the right place, first time)	X X X X			• Unsuccessful recruitment of acute physicians. • Agreeing pathways from ED/AMU to frailty. • Inability to create capacity between AMU and Durrington to support the frail elderly pathway • Records of patient moves not consistently kept up to date • Locality model for elderly pathways not fully implemented • Lack of single bed base in acute footprint to ensure seamless pathway
2. Implement new systems to manage the flow of emergency patients	• Performance against national standards and internal quality metrics (improving length of stay and flow of patients) • Positive ED quality metrics • Good progress with new build, project on track - Ophthalmology, AMU and short stay surgery units open. Pembroke move on track for Q4 • Active use of escalation process over winter period	X X X X			• Unsuccessful recruitment of acute physicians - gaps in senior clinical posts effecting regular senior ward rounds • Reliance on agency staff effecting ability to embed new ways of working • Accurate data entry at ward levels. • Patient handovers (from ambulance) affected by staff shortages

3. Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need	• Clarity on the number of non DTOC delays being reported • Early triggers in place to alert other providers when numbers of delays are increasing	X X			• Community/voluntary sector funding and capacity. • Staff availability to identify and develop opportunities to improve pathways and discharge • Inability of the health system to respond to increases in demand • Community capacity not aligned to need
4. Improving access to core services to support prompt, responsive care	• Delivering national access standard • Reports indicate current performance and waiting list now delivering • RTT waiting list has stabilised • Clarity obtained as to what capacity is required to clear backlogs	X			• Consultants job plans currently do not allow accurate capacity and demand modelling • Follow up waiting list still being validated • Additional short term capacity required to clear backlogs – concern about affordability and whether deliverable delivered • Inability to increase capacity to clear backlogs in a timely way • Review of access policy (underway)

Strategic Priority:

> **Specialist Services –** We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

Executive Lead: Chief Operating Officer **Reporting Committee:** Finance and Performance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Spinal Centre –** Service improvement initiatives within Spinal Cord Injury Centre	MD	April 2018 (Phase 1)	
2. **Plastics** - Delivery capacity to separate elective and emergency care. Lead provision of plastic surgery network across Wessex	COO	April 2018	
3. **Partnership Working** - Work with our partners in networks to develop care pathways for specialist services which improve effectiveness and patient experience (eg burns, cleft lip, genomics)	MD/COO/DoCD	June 2018 (Phase 1)	

Corporate Risk Register Principal Risks

Likelihood \ Consequence	5	4	3	2	1
5					
4					
3			**5100**		
2		**3322**	**5047**		
1					

3322 - Genetics National reconfiguration

5047 - Vacant Lead Clinician Post (spinal)

5100 - Inability to provide robust activity & income performance reports

Key Controls	Assurance on Controls
• NHS England contract standards • Access Policy • Work with key network partners in Plastic Surgery - Solent Alliance/Plastics Venture Board	• Integrated Performance Report • Specialist Services dashboards

Key Headlines - Objectives

Objective	Positive Assurance	1	2	3	Gaps in Control / Assurance
1. Service improvement initiatives within Spinal Cord Injury Centre	• Reducing the delay to admission and acceptance of admissions. • Reducing LoS by introducing intense rehab and standardisation of care, whilst also introducing a step down facility for rehab. • Ensuring a sustainable outpatient model, with every patient being recorded. • Improve inpatient decision making • Ensuring appropriate and reduce unnecessary diagnostic tests • Improve therapy collaborative working across patient pathway, including inpatient and outpatient services • Recruitment of a clinical lead to support change within the teams • Implemented and embedded multi-disciplinary ward round, including support from respiratory • Improvement plan in place and maintained via Directorate Performance Reviews • Work ongoing on clinical pathways to embed best practice	x	x		• The historical and cultural national referral process restrictions. • Workforce gaps in staffing levels and conflicting priorities. • Levels of therapy engagement resulted in pilot work being stopped. New approach from lead therapist to be worked through. • multi-disciplinary ward round, including support from urology not yet implemented and embedded • Common MDT vision and strategy not yet developed
2. Plastic Surgery: Deliver capacity to separate elective and	• Theatre timetables have been redesigned to ensure that elective and emergency capacity is separated.	x			• Required changes to operational and clinical practice/behaviour associated with reconfiguration of Burns and Plastics Inpatient Ward is not yet embedded.

emergency care. Lead provision of plastic surgery network across Wessex	• Support to PHT to become sustainable out of hours • Network approach to Plastic surgery service provision				• The proposed model of 1:8 on call at UHS is being scoped and costed, this o/c would be in addition to SFT. Proposal with options being written. • Currently it's a short-term agreement between PHT and SFT, on how SFT can facilitate OOH services for PHT. SLA to be produced and formalised in January 2018 • Changes in operational practice from relocation of weekend Plastics Trauma Clinics to Burns and Plastics Inpatient dept • Workforce and skills gaps in Nursing Team
3. Work with our partners in networks to develop care pathways for specialist services which improve effectiveness and patient experience (eg burns, cleft lip, genetics/genomics)	• Cleft appointed new consultant cleft surgeon, who is also rotated on the plastic surgery O/C rota. • Work continues with Oxford and Southampton in ensuring the appropriate site is available for cleft surgery • Genetics - good progress in forming an alliance partnership with BWCH, UHB, OUH and UHS	x			• Questions re tariff for complex plastics and burns work. A review of SLR coding/funding/tariff for Burns and Plastic is being undertaken with a report due in December 2017. Preliminary report published for comment December 2017; final version due January 2018. • Access Policy not reflective of changes in national requirements • As part of the national tender process for genetics/genomics the following gaps have emerged: ✓ Financial model for the genetics service and implications for SFT ✓ Clarity on what genetics services will continue to be offered at SFT ✓ Clarity on genetics service implications for workforce, estates and infrastructure

Strategic Priority:

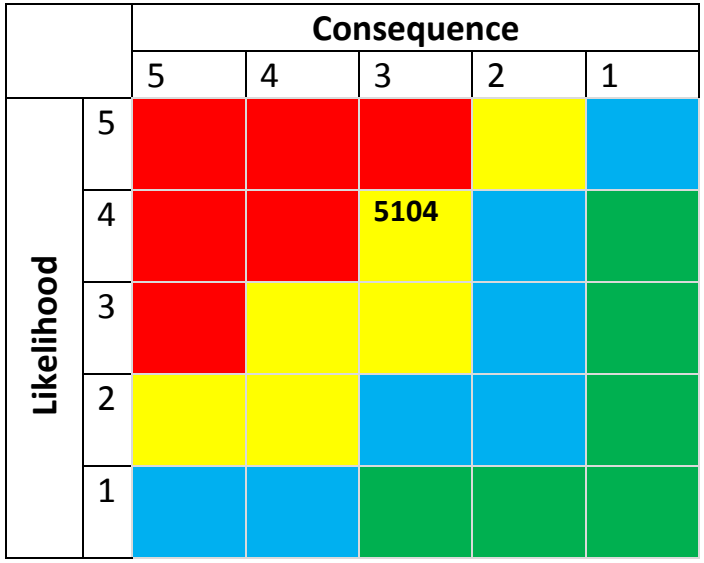
Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

Executive Lead: Medical Director **Reporting Committee:** Clinical Governance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Research -** Deliver an increased range of high quality research which directly benefits patient care and increases the level of research income earned	MD	April 2019	
2. **Improvement -** Build a culture of innovation and continuous improvement adopting a consistent QI methodology	COO/MD	Jan 18	
3. **Innovation -** Introduce innovative processes, pathways and to change how we deliver our services to improve effectiveness of our services and to bring additional benefit for our patients	MD/COO	April 2018 2019	

Corporate Risk Register Principal Risks



5104 - Potential monies at risk through non delivery of some of the CQUIN targets in 17/18

Risks to be added:

Ability to develop the QI capability and culture to transform services

Key Controls	Assurance on Controls
• Outstanding Every Time Board • QI training and coordination via PMO • Research Governance Framework	• Model Hospital benchmarking • NIHR Wessex

Key Headlines - Objectives

Objective	Positive Assurance	1	2	3	Gaps in Control / Assurance
1. Deliver an increased range of high quality research which directly benefits patient care and increases the level of research income earned	• Attaining recruitment target • Increased number of departments are research active • Good progress in recruiting to time and target • Team won national Research Excellence Award	X		X	
2. Build a culture of innovation and continuous improvement adopting a consistent QI methodology	• Business case developed setting out future QI approach	x			• Historically there has been no consistent approach to QI. Improvement on this will be dependent on business case being approved • Fragmented capture of QI work within the Trust
3. Introduce innovative processes, pathways and to change how we deliver our services to improve effectiveness of our	• Trust weighted activity unit benchmark in top 10% of country as per the Model Hospital tool. • Consistently approving introduction of new procedures • GROW programme – 78% reduction in stillbirth rate • New ambulatory gynaecology service • Introduction of virtual fracture clinic and patient initiated follow up	X		X	• Surgical pathway requires improvement to reduce pre-surgery bed days • Failure to embed standard operating procedure for Fractured neck of femur pathway • Gaps in communications with GPs due to Consultant Connect not being commissioned for SFT

services and to bring additional benefit for our patients	• Roll out of email advice service				

Strategic Priority:

> **Care –** We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm

Executive Lead: Medical Director and Director of Nursing **Reporting Committee:** Clinical Governance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **CQC** - Achieve a CQC rating of Good	DoN	March 18	
2. **Safety -** Deliver on the local and national safety priorities	DoN	March 18	
3. **Infection -** Maintain our focus on reducing rates of infection	DoN	March 18	
4. **End of Life Care -** Review process to establish learning and improvement	MD	March 18	
5. **Patient Experience -** Work with our patients to plan and improve the services we provide to ensure the care delivered meets patients' needs	DoN	March 18	

Corporate Risk Register Principal Risks

Likelihood \ Consequence	5	4	3	2	1
5		3914			
4			**5107**		
3		**5291**	**4977**	3925	
2			5078		
1					

4977 – Inpatient fall resulting in harm

5078 – Mortality (HSMR) Ratio higher than expected range

5291 – Potential for bleep failure

Linked workforce risks (see People section)
3914 – Failure to recruit adequate numbers of nursing staff
3925 - Failure of staff to maintain updated statutory /Mandatory Training
5107 - Failure to recruit to vacant posts will result in an inability to provide outstanding patient care

Key Controls	Assurance on Controls
• Quality Governance Framework • Integrated Governance Framework • Accountability Framework • Policies and procedures • Patient and user feedback mechanisms / patient stories at Board • Contract Quality Review Meeting / contractual monitoring • Annual audit programme • Safety programme • Infection Prevention and Control Governance Framework and plan • Learning from Deaths Policy	• Internal reporting processes to Committees and Board • External reporting and benchmarking mechanisms • Internal audit programme • CQC inspection regime • Patient Surveys/Friends and Family Test/Real Time Feedback • Executive Board safety Walks • Well led review commissioned for December 2017 • Internal Audit report on morbidity and mortality meetings

Key Headlines - Objectives

Objective	Positive Assurance	1	2	3	Gaps in Control / Assurance
1. Achieve a CQC rating of Good	• Positive CQC Insights report on key benchmarks • Improvement delivery on Must do/ Should do's	x		X	
2. Deliver on the sign up to safety work streams	• Quarterly reports show most workstreams on track • Positive NRLS report re reporting culture	X		x	• Falls continues to be biggest risk within the work streams • Improvement needed in local Mortality and Morbidity meetings
3. Maintain our focus on reducing rates of infection	• Trust in the upper quartile for reportable infection rates in the South West in Q1 and Q2			X	
4. Review process to establish learning and improvement	• Mortality review reports show low levels of avoidability • HSMR showing decline improvement • Internal audit report on morbidity and mortality meetings • Learning from Deaths Policy being published on Trust website • Mortality dashboard being published in February	 X X x	x	X	• HSMR still above expected • Improvement needed in local Mortality and Morbidity meetings

5. Work with our patients to plan and improve the services we provide to ensure the care delivered meets patients' needs	• Mixed sex breaches at 0 for last 6 months • ED patient survey amongst best in the country • Cancer survey benchmarks positively • High satisfaction shown in Friends and Family Test and Real Time Feedback • Positive Patient and Public involvement in ophthalmology build	X x	 x 	X x 	

Strategic Priority:

People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

Executive Lead: Director of Organisation and People **Reporting Committee:** Executive Workforce Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Resourcing and Talent Management -** Deliver a cohesive plan to attract, deploy, retain and reward a flexible workforce	DoODP	March 2019 (phase 1)	
2. **Business Partnering** - Establish effective partnerships to align business and HR strategies	DoODP	March 2019 (phase 1)	
3. **Health and Wellbeing** - Improve the health and wellbeing of staff	DoODP	March 2019 (phase 1)	
4. **OD and Engagement** - Develop a diverse and inclusive culture where staff feel engaged	DoODP	March 2019 (phase 1)	
5. **Leadership -** Develop strong leadership capability across all levels of the organisation to support an innovation culture	DoODP		

Corporate Risk Register Principal Risks

Likelihood	Consequence 5	4	3	2	1
5		3914 5340			
4		5107			
3		5261		3925	
2					
1					

5220 - Covering Radiology services and workload due to staffing shortages - CLOSED

3924 - Failure to recruit to vacant posts could result in an inability of the organisation to deliver excellence to all patients and places additional responsibility on existing staff to manage services. – CLOSED

3914 - Failure to recruit adequate numbers of substantive nursing staff
3925 - Failure of staff to maintain updated statutory /Mandatory Training
5107 – High level of vacant clinical posts incurs costs due to increasing use of agency staff
5261 – Rechecking system inadequate to maintain current DBS recheck requirement
5340 – ESR Portal Access

Key Controls	Assurance on Controls
• Executive Workforce Committee (EWC) • Health and Wellbeing Board • People Strategy Programme Group (not yet established) • HR Policies • Directorate Performance meetings • Trust values and behaviours • Workforce Pay Control group • Safer Staffing Group • Equality, Diversity and Inclusion Steering Group (under review) • Health and Safety Committee • Integrated Performance Report at Board • Monthly Workforce Dashboard • Executive Safety Walks • Freedom to Speak Up Guardians • JCC Staff Side Meeting	• Staff Survey • Staff Friends and Family Test • External Audits • Internal Audits • CQC Well Led Domain • NHSI temporary spend caps • Leavers surveys • Staff Engagement Group

Key Headlines - Objectives

Objective	Positive Assurance	1	2	3	Gaps in Control / Assurance
1. Deliver a cohesive plan to attract, deploy, retain and reward a flexible workforce	• Staff turnover remains steady (reported through EWC) • Growing medical locum bank (Locums Nest trial) • Engaged with regional streamlining work stream • Engaged with STP Agency cap and control work stream	X X X x			• Impact of Brexit not yet clear • Impact and delay of IELTS / OSCE for international recruits • Recruitment data not easily reportable • No retention strategy and associated resource • Feedback gaps (candidate/ starter/ leaver) • Potential for shortage areas to be removed from Shortage Occupation list (e.g. Nursing) • Pay constraints • Inability to triangulate hard and soft metrics on wellbeing of staff /depts. • Process not in place to gather recruitment experience • E-Roster not rolled out to wider workforce

					• Resourcing strategy does not align temporary and substantive staffing needs • Haven't got a fully developed Retention strategy • Programme of staff benefits not fully developed
2. Establish effective partnerships to align business and HR strategies	• New Workforce KPI Dashboard	X			• Lack of management training and toolkits on key people management topics • Lack of accessibility and transparency of key workforce data (workforce dashboards) • Inaccurate data captured within ESR • Current inability to triangulate hard and soft data across depts. • Immature Business partner model for service delivery • HR Directorate structure not fit for purpose to deliver revised People Strategy
3. Improve the health and wellbeing of staff	• Staff sickness benchmarks well against local Trusts at approx. 3.5% as an average. • Shape up at Salisbury offering for staff well supported. • Onsite Occupational Health and staff counselling services	X X X			• Staff sickness remains above 3% target • Sickness absence management not effective • Sickness absence reporting processes and data not robust • Current inability to triangulate hard and soft data across depts. •
4. Develop a diverse and inclusive culture where staff feel engaged	• Staff survey results in upper quartile nationally • Staff Friends and Family Test results are positive • In HSJ top 100 places to work			X X X	• Mandatory Training compliance remains below target of 85% • Appraisal rates for non-medical staff remain below target of 85% • Funding gap for education and training
5. Develop strong leadership capability across all levels of the organisation to support an innovation culture	• Leadership programmes in place • Strong relationships with local providers • Equality and diversity programme in place • Values embedded	X X X			• Lack of robust talent management and leadership development programme across the Trust. • Leadership programme not aligned to culture (in development) • Lack of comprehensive engagement and communication strategy in place.

Strategic Priority:

Resources – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources

Executive Lead: Director of Finance **Reporting Committee:** Finance and Performance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Financial Recovery Plan -** Deliver on financial recovery plan to secure financial sustainability	DoF	March 2019	
2. **Campus Scheme** - Develop a financially viable scheme to rejuvenate and improve the utilisation of the estate	DoCD	April 2021	
3. **Digital Strategy -** Develop and implement a digital strategy which will enable the delivery of more effective care through the use of technology	DoCD	April 2021	
4. **Service Reviews -** Undertake reviews of core services to ensure ongoing plans for sustainability and delivery of key objectives	MD	March 2018	

Corporate Risk Register Principal Risks

		Consequence				
		5	4	3	2	1
Likelihood	5			**5098**		
	4			**5104**	**5108**	
	3			**5100** **5102**		
	2			**5101**		
	1					

3809 - Failure of move to Data warehouse - CLOSED
5105 - Inflationary & local unavoidable cost pressures greater than plan. CLOSE
5099 - NHSI offer a control total which requires the Trust to make more cost savings which are not achievable. CLOSED. Risk accepted

5100 Inability to provide robust activity & income performance reports due to problems with data warehouse and EPR system.
5104 - Potential monies at risk through non delivery of some of the CQUIN targets in 17/18
5098 – As result of not delivering the Trust's savings programme for 2017/18 the Trust is in financial deficit and therefore experiences cash flow shortfalls
5108 – Commissioners able to successfully implement material referral management QIPP schemes which will leave the Trust with significant stranded costs
5101 – Unable to borrow funds to keep supporting the operating expenditure of the Trust meaning the Trust may run out of cash
5102 – risk Trust cannot fund full capital programme requirement

Risk to be added – risk of further enforcement action if not making sufficient progress on financial recovery plan (red risk)

Key Controls	Assurance on Controls
• Finance and Performance Committee • Accountability Framework – Directorate Performance Reviews • Contract monitoring systems • Contract performance meetings with commissioners • INNF Policy Distributed • OETB • Capital control group • Budget setting process • Internal Audit Programme • Trust Investment Committee (TIG)	• Internal Performance reports to Trust Board • Audit Committee Reports • Internal Audit Reports • External Audit Reports

Key Headlines - Objectives

Objective	Positive Assurance	1	2	3	Gaps in Control / Assurance
1. Deliver on financial recovery plan to secure financial sustainability	• Outstanding Every time Board established with CEO chairing monthly • Additional capacity procured to support the development and delivery of the recovery programme (BCG). • Initial draft plan developed with high level savings opportunities identified • Transformation Director appointed (commences March 18) • NHSI planning to cite SFT as centre of excellence for nurse rostering	X X	 X 	 X	• Engagement with STP and Commissioners on SFT recovery plan. • Capability and capacity across the organisation to deliver change at pace. • Recruitment challenges across the organisation limit delivery of the plan. • 2-year financial recovery plan yet to be finalised (deadline to be confirmed) • Action plan to be completed in response to NHSI Enforcement Letter
2. Develop a financially viable scheme to rejuvenate and improve the utilisation of the estate	• Additional management capacity with experience in delivering similar projects secured • National schemes are coming on line which offer potential frameworks for development • Support from Wiltshire Council and commissioners for proposed scheme		X		• Link into wider Trust strategic estate plans needs strengthening • Reliance on private sector investment, agendas/timescales may not align • Lack of communication expertise for a project that will have a significant PR element • Absence of detail to progress financial modelling

	• Potential private sector partner for Joint Venture agreement • Positive early clinical engagement.		X		• Signed agreement for private sector partner
3. Develop and implement a digital strategy which will enable the delivery of more effective care through the use of technology	• Early draft of document developed to begin consultation • Foundation of an integrated patient record system exists which can be linked to other systems • Strong engagement from some clinical quarters, eg nursing • Some signs of STP wide solutions which may benefit the Trust		X		• Delay in subsequent phases of EPR, delivery against business case • System supplier engagement • Because of usability issues, risk around engagement • Lack of capital funds to invest (potential national funds will be allocated by the STP) • Need to redefine the role of ISSG in taking forward the digital strategy • Difficulties from information held in both paper and digital form
Undertake reviews of core services to ensure ongoing plans for sustainability and delivery of key objectives	• Outstanding Every time Board established with CEO chairing monthly to oversee programme. • Additional capacity procured to support the development and delivery of the recovery programme (core services one element) • Use of Model hospital and GIRFT to support pathway change in place.		X		• Timeliness of publication of relevant benchmarking information to support decision making. • Capacity to undertake reviews then implement change at pace. • Structured framework to evaluate core clinical services for sustainability

Corporate Risk Register Summary – January 2018

Risk Score Key

Low Risk 1-3	Moderate Risk 4-6	High Risk 8-12	Extreme Risk 15-25

Internal (I) or External (E) Risk	Risk Detail				Score Trend				
	Risk (Datix) Ref	Risk Title	Exec Lead	Date Risk added	Initial score	Nov 17	Jan 18 current	March 18	Target
	Strategic Priority - **Local Services** – We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do								
	5220	Covering Radiology services and workload due to staffing shortages **- CLOSED**	Chief Operating Officer	Nov 2017	12	12	4		12
	3919	Capacity planning – required number and range of facilities **– CLOSED superseded by new risk 5305**	Chief Operating Officer	May 2015	12	15	15		6
	4682	Delayed transfers of care (DToC) and 'Green to go' patients - negative impact on capacity - **– CLOSED superseded by new risk 5305**	Chief Operating Officer	July 2016	20	20	20		8
	5305	Consitutional performance standards may not be met as result of increased demand or decreased capacity	Chief Operating Officer	Nov 2017	15		9		6
	5306	Reduction in beds during site reconfiguration work	Chief Operating Officer	Nov 2017	15	15	8		8

	Risk (Datix) Ref	Risk Title	Exec Lead	Date risk added	Initial score	Nov 17	Jan 18 current	Mar 18	Target
	Strategic Priority - **Specialist Services** – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population								
	3322	Genetics National Reconfiguration	Medical Director	Nov 2017	12	12	8		6
	5047	Spinal Unit Clinical Leadership – post vacant - **Closed**	Medical Director	Feb 2017	12	12	6		3
	5100	Inability to provide robust activity & income performance reports	Director of Finance	Apr 2017	15	15	9		6
	Strategic Priority - **Innovation** – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered								
	5104	Potential monies at risk through non delivery of some of the CQUIN targets in 17/18	Director of Finance	Apr 2017	16	16	12		8
	Strategic Priority - **Care** – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm								
(I)	4977	Inpatient fall resulting in harm	Director of Nursing	Jan 2017	12	12	12		8
(I)	5078	Mortality (HSMR) ratio	Medical Director	Aug 2017	9	9	6		3
(E/I)	3914	Failure to recruit adequate numbers of nursing staff	Director of Nursing	May 2015	16	20	20		9
(I)	3924	Failure to recruit to vacant posts could result in an inability of the organisation to deliver excellence to all patients - **CLOSED superseded by new risk 5107**	Director of OD & People	May 2015	12	12	12		9
(I)	3925	Failure of staff to maintain updated statutory /Mandatory Training	Director of OD & People	May 2015	12	12	6		6
	5291	Potential for bleep failure	Chief Operating Officer	Dec 2017	20		12		4

	Risk (Datix) Ref	Risk Title	Exec Lead	Date risk added	Initial score	Nov 17	Jan 18 current	Mar 18	Target
	Strategic Priority - **People** - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams								
	5220	Covering Radiology services and workload due to staffing shortages - **CLOSED**	Chief Operating Officer	Nov 2017	12	12	4		4
	3914	Failure to recruit adequate numbers of substantive nursing staff	Director of Nursing	May 2015	16	20	20		15
	3924	Failure to recruit to vacant posts could result in an inability of the organisation to deliver excellence to all patients and places additional responsibility on existing staff to manage services - **CLOSED superseded by new risk 5107**	Director of OD & People	May 2015	12	12	12		9
	3925	Failure of staff to maintain updated statutory /Mandatory Training	Director of OD & People	May 2015	12	12	6		6
	5107	Failure to recruit to vacant posts will result in an inability to provide outstanding patient care.	Director of OD & People	Apr 2017	12		16		12
	5261	Rechecking system inadequate to maintain current DBS recheck requirement	Director of OD & People	Jan 2018	15		12		9
	5340	ESR portal access - NEW	Director of OD & People	Jan 2018	20		20		1

	Risk (Datix) Ref	Risk Title	Exec Lead	Date risk added	Initial score	Nov 17	Jan 18 current	Mar 18	Target
	Strategic Priority - **Resources** – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources								
	3809	Failure of move to Data warehouse - **Closed**	Director of Corporate Development	May 2015	12	12	4		4
	5105	Inflationary & local unavoidable cost pressures greater than plan **CLOSED**	Director of Finance	Apr 2017	12	12	6		6
	5099	NHSI offer a control total which requires the Trust to make more cost savings which are not achievable **CLOSED**	Director of Finance	Apr 2017	15	15	15		6
	5100	Inability to provide robust activity & income performance reports due to problems with data warehouse and EPR system	Director of Corporate Development	Apr 2017	15	15	9		6
	5104	Potential monies at risk through non delivery of some of the CQUIN targets in 17/18	Director of Finance	Apr 2017	16	16	12		8
	5098	As result of not delivering the Trust's savings programme for 2017/18 the Trust is in financial deficit and therefore experiences cash flow shortfalls	Director of Finance	Jan 2018	12	12	15		9
	5108	Commissioners able to successfully implement material referral management QIPP schemes which will leave the Trust with significant stranded costs	Director of Finance	Apr 2017	8	8	8		8
	5101	Unable to borrow funds to support revenue expenditure programme (CHANGING DESCRIPTION) to: Unable to borrow funds to keep supporting the operating expenditure of the Trust meaning the Trust may run out of cash.	Director of Finance	Apr 2017	10	10	6		4

Corporate risk register extract
January 2018

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Done date	Action Leac	Source of Review	Review date	Rating (Target)	Assurance Framework link	Assurance Committee	Executive Lead
3914	Quality Directorate	Trustwide	20/05/2015	Other assurance not listed	16	Failure to recruit adequate numbers of substantive nursing staff with the following implications: Quality and safety concerns at ward level Poor patient experience High agency spend - financial risk to the Trust	Will undoubtedly recur, possibly frequentl	Major	20	Continue recruitment initiatives within UK	01/04/2016	29/04/2016	Wilkinson, Lorna	Executive Workforce Committee	31/01/2018	15	People	Clinical Governance Committee, Trust Board (Corporate Risk Register	Director of Nursing
										Overseas recruitment planned for 2015/16 (50 RNs)	31/03/2016	18/03/2016	Harvey, Ian						
										Participate in Workforce Productivity and Efficiency Programme (DH) - 1 of 22 participating Trusts	31/03/2016	18/03/2016	Wilkinson, Lorna						
										Participate in the implementation of the Monitor/TDA Staffing tool kit. Launch being held in June 2015	24/12/2015	15/10/2015	Wilkinson, Lorna						
										Skill mix review to be carried out twice per year	31/12/2016	28/12/2016	Wilkinson, Lorna						
										Explore strengthening of controls around use of expensive agency	31/07/2015	15/10/2015	Wilkinson, Lorna						
										Specials project - design and implement PDSA cycles linked into Lord Carter work, develop sitting service (volunteers)	30/06/2016	30/06/2016	MART						
										Robust review of roster perform metrics at monthly safer staffing meeting	31/03/2016	18/03/2016	Hyett, Fiona						
										Development of sensitive KPIs for PSG with clear outcome criteria to show how agency premia s being reduced	31/08/2016	28/12/2016	Hyett, Fiona						
										To implement the agency rules and caps this year.	29/04/2016	30/06/2016	Wilkinson, Lorna						
										Implementation of 2016/17 recruitment strategy	31/03/2017	24/05/2017	Wilkinson, Lorna						
										Continue local recruitment campaigns Develop micro site	30/01/2018		Wilkinson, Lorna						
										Overseas recruitment to continue EU, non EU	30/06/2018		Wilkinson, Lorna						
										Ensure exit interviews carried out for all leavers	31/03/2017	24/05/2017	Wilding, Henry						
										Continue controls around use of expensive agency	30/04/2016	30/04/2016	Wilkinson, Lorna						

Corporate risk register extract
January 2018

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Done date	Action Leac	Source of Review	Review date	Rating (Target)	Assurance Framework link	Assurance Committee	Executive Lead
										Ensure exit interviews carried out for all leavers	30/09/2017	29/11/2016	DENNIN						
										Ensure exit interviews carried out for all leavers	30/03/2018	24/05/2017	Harvey, Ian						
										Ensure exit interviews carried out for all leavers	31/03/2017	24/05/2017	JONJ						
										Develop apprenticeship and Nursing associate opportunities	01/03/2018		Hyett, Fiona						
										Full recruitment of NA staff	01/03/2018		Hyett, Fiona						
										Performance management of agency contrscts	01/03/2018		Hyett, Fiona						
										Focus on Retention collaborative actions (NHSI)	01/06/2018		Hyett, Fiona						
										Agreement for 2018/19 overseas recruitment programme	28/02/2018		Wilkinson, Lorna						
										Agreement for OETS support	28/02/2018		Wilkinson, Lorna						
5340	Human Resources	Trustwide	25/01/2018	Trustwide risk assessment	20	ESR access is moving to a web portal which requires updating of browsers. Patient and finance systems will not work with the updated version of the browsers.	Will undoubtedly recur, possibly frequently	Major	20	Browser to be compatible with ESR upgrade.	31/03/2018		Linda Dunham	Executive Workforce Committee	28/02/2018		People	Trust Board (Corporate Risk Register)	Director of Organisational
5098	Finance and Procurement	Trustwide	27/03/2017	Trustwide risk assessment	12	As a result of not delivering the Trust savings programme for 2017/18 the Trust is in financial deficit and therefore experience cash flow shortfalls. This in turn will impact on the reputation of the organisation, and the regulatory action the Trust is likely to face from NHSI.	Will undoubtedly recur, possibly frequentl	Moderate	15	The strengthening of PSG/PMO governance & performance management arrangements.	31/10/2017	31/10/2017	Hyett, Andy	Finance Committee	30/03/2018	9	Resources	Finance Committee, Trust Board (Corporate Risk Register	Director of Finance
										Executive review of budget management arrangements & reserves policy to strengthen budget holder accountability.	28/04/2017	02/01/2018	Collis, Mark						
										Delivery of the 'Carter' Efficiency programmes.	29/09/2017	02/01/2018	Collis, Mark						
										Actively support and deliver STP transformation programmes.	30/03/2018		Collis, Mark						
										Ensure CIPs are realistically set and delivered recurrently to avoid impacts on future years.	29/09/2017	02/01/2018	Collis, Mark						
										Trust to develop CIP plan for 2018/19 and 2019/20	30/03/2018		Collis, Mark						

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4977	Quality Directorate	Trustwide	03/01/2017	Incident reports	12	There is a recognised national risk of in-patients falling, slipping or tripping whilst in hospital care. There has been an increase in falls resulting in high harm within SFT. In addition to this, we have increasingly frail patients and high ward acuity. Bed capacity within the Trust has become challenging due to an increase in non-elective admissions and patients who are fit for discharge but awaiting care packages or placements. This results in patients being occasionally nursed in areas which are not ideal for their needs, increasing their risk of falling. Harm ranges from psychological, such as loss of confidence and fear of falling (thus reducing their rehabilitation opportunities) to physical injuries such as minor cuts, bruises or more serious injuries such as fractures or head injuries. Rarely injuries from falls can be fatal. Those for whom rehabilitation is limited, may require on-going care needs which may be a litigation risk for the organisation.	May recur occasionally	Major	12	HImP team developing stickers to use in patient notes. The stickers are designed to ensure a systematic assessment takes place and follows NICE guidance.	31/07/2017	29/06/2017	Cox, Dr Christina	Falls Group	31/07/2018	8	Care	Clinical Governance Committee, Trust Board (Corporate Risk Register	Director of Nursing
										Create a sticker to use by nursing staff to assist with triaging patients, ensuring appropriate assessments and escalation are made following a fall.	31/07/2017	29/06/2017	Mooney, Vanessa						
										National Falls Audit 2015 identified Lying and Standing Blood pressures as a key area for improvement nationally. Trust compliance with this is poor and need to agree a process we can use in key areas at SFT.	31/07/2017	31/05/2017	Benson, Rebekah						
										The National Falls Audit in 2015 identified some gaps in our current falls assessment compared to national recommendations. SFT had only recently introduced a revised assessment and agreed to embed this, then look to incorporate the additional recommendations with future revisions.	29/12/2017	31/05/2017	Hill, Fenella						
										Development of the role of falls links nurses (undertaking data collection for SU2S work stream) into falls Champions for their area.	31/07/2017	25/07/2017	ROEL						
										Need to develop consistent training programme for ward staff.	31/07/2017	31/05/2017	Hill, Fenella						
										Incorporate key falls prevention measures into daily management plans currently being revised	31/07/2017	05/07/2017	Ford, Maria						
										Ensure clear guidelines for staff regarding appropriate imaging when patients have fallen and a head injury is suspected (or can not be excluded)	17/07/2017	13/07/2017	ROEL						

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										RCA template to be adapted to support ward staff when investigating and provide assurance to the CCG in relation to the SI Framework	27/01/2017	31/05/2017	Lowe, Tarah						
										Set up 'Share and Learn' sessions for ward staff to present their RCA's and facilitate sharing of good practice	02/04/2018	14/12/2017	Lowe, Tarah						
										Double grip slipper socks to be implimented on adult inpatient wards Trust wide.	21/08/2017	01/10/2017	ROEL						
										Falls reduction strategy and action plan to be approved at CMB.	28/06/2017	08/06/2017	ROEL						
										SBAR handover of care stickers to be trialled on Whiteparish and Durrington Wards.	28/06/2017	19/06/2017	ROEL						
										Action leads for falls action plan to be identified in order to drive forward revised action plan.	31/07/2017	10/07/2017	ROEL						
										Roll out SBAR handover stickers across the Trust	28/02/2018	14/12/2017	Lowe, Tarah						
										Multifactorial falls risk assessment and interventions form to be approved with plan for roll out to be decided.	28/08/2017	13/07/2017	ROEL						
										Nursing post falls assessment to be trialled	31/01/2018	30/11/2017	Mooney, Vanessa						
										Medical post falls assessment form to be trialled.	31/01/2018	14/12/2017	Lowe, Tarah						
										New multifactorial falls risk assessment and interventions form to be trialled for 1 month. 18/10/17: Assessment trialled, currently being incorporated into new nursing assessment document as part of documentation work stream.	28/08/2017	18/10/2017	Ransby, Katie						

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										Create version 2 of nursing post falls assessment sticker for cascade out across the Trust.	31/07/2018		Lowe, Tarah						
5107	Human Resources	Trustwide	27/03/2017	Trustwide risk assessment	12	Failure to recruit to vacant posts will result in an inability to provide outstanding patient care. The impact of this effects staff morale and is unsustainable for the existing workforce if not addressed. Patient safety is at risk with gaps in substantive clinical workforce and cost of workforce increases over budgets. NHSI control total will be at risk. of the organisation to deliver excellence to all patients and places additional responsibility on existing staff to manage services. Identified specialities are not recruited to establishment and therefore there is a reliance on a temporary workforce such as bank and agency. This has an impact on reputation, quality and financial aspects of the organisation. Posts identified include specialist Medical Posts (i.e. Dermatology, Community Geriatricians, Gastroenterology, Opthalmology) where this is a national recruitment problem and nursing post (particualrly medicine) where this is a supply problem	Will probably recur, but is not a persistent issue	Moderate	16	Procurement agency staff at tier 1 rates only.	30/03/2018	23/01/2018	Wilkinson, Lorna	Finance Committee	30/03/2018	12	People	Finance Committee, Trust Board (Corporate Risk Register	Director of Organisational Development and People
										Review and consider threshold of care whilst maintaining safe patient services.	30/03/2018	23/01/2018	Wilkinson, Lorna						
										Tight control of agency and specialing.	30/03/2018	23/01/2018	Wilkinson, Lorna						
										Recruitment and retention initiatives.	30/03/2018		Hargreaves, Paul						
										Seek to pay capped rates only. Review rosters to reduce reliance on agency staff	30/03/2018		Blanshard, Dr Christine						
										Look to partnerships with other Trusts to cover hard to fill posts.	30/03/2018		Hargreaves, Paul						
										Review of loss making clinical activities predominately supported by locums as part of business planning.	30/03/2018		Blanshard, Dr Christine						
										Launch overseas recruitment and more focussed recruitment in the UK.	30/03/2018		Wilkinson, Lorna						
										Review & update (if appropriate) financial section of business case template for the appointment of medical staff.	30/03/2018		Blanshard, Dr Christine						
										Transitioning work with Army - making links with the groups moving back onto the plain - promoting careers at Salisbury with Army spouses	31/12/2017	25/01/2018	Holt, Sharon						
										Focus on retention of current staff - Developing of 'fresh eyes' approach for new staff - Reviewing Exit Interview to increase update and learning	29/09/2017	25/01/2018	Salisbury, Hilary						
										Use of head hunting agencies to secure medical locums	31/03/2017	05/04/2017	Hargreaves, Paul						

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										Monitoring agency usage via 'Reducing Agency Spend' group.	31/03/2017	05/04/2017	Wilkinson, Lorna						
										Monitoring of vacancies	31/03/2017	05/04/2017	Hargreaves, Paul						
										'Branding' of Salisbury to promote reputation.	31/03/2017	05/04/2017	Hargreaves, Paul						
										Use of other medias including social media (Facebook and Twitter) to promote Trust	31/03/2017	05/04/2017	Hargreaves, Paul						
										Liaison with University to assess and promote student experience to ensure students consider SFT a positive place to work.	31/03/2017	05/04/2017	Hargreaves, Paul						
										Working with training institutions to raise the profile of Salisbury and attendance at careers fairs such as university or national.	31/03/2017	05/04/2017	Hargreaves, Paul						
										Recruitment initiatives such as 'refer a friend', European Recruitment, job fairs	31/03/2017	05/04/2017	Hargreaves, Paul						

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5104	Finance and Procurement	Trustwide	27/03/2017	Trustwide risk assessment	16	Potential monies at risk through non delivery of some of the CQUIN targets in 17/18. Generally, some targets are difficult to achieve. 1a - improvement of health and wellbeing of NHS staff - improvement of 5% over 2 years in 2 out of 3 questions in the staff survey. Responses to all 3 questions decreased between 2015 & 2016 survey. £85K at risk. 1C - Improving uptake of flu vaccine for front line staff - no opt out for West Hampshire CQUIN (£23k at risk). Partial payment if 60 - 70% uptake achieved. 2 - Supporting discharge - 2.5% increase in discharging patients to usual place of residence. £205K at risk. 3 - Sepsis - achievement of 90% screening and treatment and reduction in 2 of the 3 antibiotic groups on 2016 baseline. £162K at risk. 4 - Reducing mental health frequent flyers in A&E - 20% reduction in attendances of selected cohort. £205K at risk. Total monies at risk of non delivery of CQUIN targets £475K - £680K	Will probably recur, but is not a persistent issue	Moderate	12	Baseline position currently being established.	30/03/2018	08/08/2017	Wilkinson, Lorna	Finance Committee	31/03/2018	8	Innovation, Resources	Finance Committee, Trust Board (Corporate Risk Register	Director of Nursing
										Exec lead, SRO and working group oversight.	30/03/2018	17/11/2017	Wilkinson, Lorna						
										CCG meeting 27th Feb to agree interpretation of scheme and evidence required.	30/03/2018	08/08/2017	Wilkinson, Lorna						
										[26/06/2017 17:28:36 Claire Gorzanski] Reduce the level of work related stress and MSK work related problems in groups of staff who have the highest rates. Target high risk groups for action through work led by DD of HR and staff & health wellbeing group.	31/03/2018		Salisbury, Hilary						
										[26/06/2017 17:31:36 Claire Gorzanski] Increase the uptake of the flu vaccine of front line staff by running a comprehensive flu campaign based on learning in 16/17 and from other Trusts.	31/03/2018		Knight, Paul						
										[26/06/2017 17:35:44 Claire Gorzanski] Increase discharges to usual place of residence through the existing programme of work related to patient flow, the LDB and multi-agency partnerships to reduce stranded patients.	31/03/2018	17/11/2017	Knight, Sarah						
										[26/06/2017 17:39:17 Claire Gorzanski] Improve the screening of inpatients by adding a sticker to the EWS escalation section 'could the patient have an infection'. Continue current ward based CCOT education programme. Provide regular feedback on timeliness of screening and IV antibiotics audit. Monitor progress through the Sepsis working group.	31/03/2018		Ford, Maria						

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										[26/06/2017 17:43:26 Claire Gorzanski] Reduce the consumption of all antibiotics, carbapenem and piperacillin/tazobactum through AMR stewardship ward rounds, education and feedback to individual clinicians and teams on practice. Take part in antibiotic awareness week. Agree protocol changes at the Infection Prevention and Control Group.	31/03/2018		Williams, Lou						
										[26/06/2017 17:46:43 Claire Gorzanski] Ensure all patients in the identified cohort of ED frequent attenders have a personalised care plan agree with them. For relevant patients agree a multi-agency plan with police, ambulance service, AWP, primary care. Monitor attendance of the cohort and target ongoing frequent attenders.	31/03/2018	23/01/2018	Davies, Dr Stephen						
										[26/06/2017 17:49:52 Claire Gorzanski] Agree and implement a plan for 35% of specialties to offer advice and guidance by Q4 17/18. Open negotiations with the CCG and agree a local tariff for A&G.	31/03/2018	08/08/2017	Barrett, Jessica						
										[26/06/2017 17:53:31 Claire Gorzanski] Map existing clinics to the Directory of Services on eRS so they are made available to GPs. Prioritise the specialties the CCG have said will not be available to GPs unless they refer using eRS. Monitor progress monthly and report to the OPD PMB.	31/03/2018	08/08/2017	Stephens, Mrs Davina						

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5291	Facilities	Trustwide	24/10/2017	Incident reports	20	There have been incidents whereby emergency bleeps have failed and bleeps have not been received. Currently a bleep can be recorded as being sent, but there is not way of tracing whether it was received, therefore the bleep could fail due to a number of issues - signal black spot, low battery or failure of unit, for example. In an emergency situation such as an emergency caesarean this could have severe consequences. Bleep system expected to be replaced Dec 17/Jan 18. 20th November - anaesthetic registrar now carrying a baton internet mobile phone. This allows for greater coverage of signal in areas affected by poor bleep signal coverage.	May recur occasionally	Major	12	Install and commission PageOne bleep system by end of January 2018.	28/02/2018		Robinson, Ian	Operational Management Board	01/03/2018	4	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer
5261	Human Resources	Trustwide	15/09/2017	Human Resources	15	Identified that a number of DBS checks have not been recorded in ESR consistently. In addition existing staff are not in a 3 year check programme, as required. The existing policy is not compliant and requires updating with additional clear guidance on posts that require a standard or enhanced DBS check	May recur occasionally	Major	12	Policy review	30/04/2018		Holt, Sharon	Executive Workforce Committee	04/05/2018	9	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People
										Consistent recording of electronic ESR.	31/07/2018		Holt, Sharon					
										Identify posts that require checking.	30/04/2018		Holt, Sharon					
5305	Operations Directorate	Trustwide	08/11/2017	Trustwide risk assessment	15	As a result of Increased demand or decreased capacity there is a risk that constitutional performance standards may not be met, which may result in a decrease in quality of patient care, longer waiting times, fines, damage to Trusts reputation and action from regulators.	May recur occasionally	Moderate	9	Assurance to Finance and Performance Committee and Trust Board	01/04/2018		Hyett, Andy	Weekly Delivery Group	01/04/2018	6	Local Services	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Capacity and demand modelling for all areas.	31/03/2018		Hyett, Andy					
										Weekly Delivery Group monitoring performance and agreeing actions	31/03/2018		Hyett, Andy					
5100	Finance and Procurement	Trustwide	27/03/2017	Trust Board, Trustwide risk assessment	15	Inability to provide robust activity & income performance reports due to problems with data warehouse and EPR system. This could result in commissioners not paying for any growth in activity or under-performance of QIPP schemes.	May recur occasionally	Moderate	9	Engage with STP commissioners to agree reasonable funding including a fair year end settlement.	30/03/2018		Arnold, Laurence	Finance Committee	01/03/2018	6	Resources	Finance Committee, Trust Board (Corporate Risk	Director of Finance
										EPR Stabilisation Programme	27/11/2017	27/11/2017	Arnold, Laurence					

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5102	Finance and Procurement	Trustwide	27/03/2017	Trustwide risk assessment	9	As a result of financial challenges and poor cash position, there is a risk that the Trust cannot fund the full capital programme requirement for the year. This may result in the Trust not having equipment or building that are optimal for use.	May recur occasionally	Moderate	9	Apply to DH for capital loan.	30/06/2017	03/01/2018	Collis, Mark	Finance Committee	31/03/2018	6	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance
										Undertake critical review of programme before start of financial year to prioritise schemes within available internal funding, and to review position every financial quarter.	31/03/2018		Collis, Mark						
										Secure more charitable support.	31/03/2018		Collis, Mark						
										Greater use of leased equipment (Issues: Availability of revenue & impact on capital spend limit).	30/03/2018		Collis, Mark						
4107	Musculo-Skeletal	Plastic Outpatients	17/09/2015	Service Delivery Plan, Specialty Risk assessment	12	Failure to adhere to clinician requested timeframes for follow-up appointments for skin cancer patients. Risk of clinical deterioration in between follow-ups which could lead to untreatable disease progression. Appointments requested for patients are not always being given in a timely manner, particularly a risk for oncology patients (follow up clinic) Failure to follow national guidelines for the management of patients with skin cancer - particularly melanoma patients not being seen at regular 3 month intervals. Significant risk of patient mis-management with long term effects - disease progression making treatment options limited. Risk of duty of candour	May recur occasionally	Moderate	9	Further recruitment of 2 plastics consultants	18/12/2015	11/10/2016	Wright, Jonathan	Directorate Management Team Meeting	31/03/2018	6	Care	Governance Committee, Joint Board of Directors, Trust Board (Corporate Risk Register)	Chief Operating Officer
										Prospective reporting of booked activity to facilitate communication and ultimately improvements in the booking of clinics.	17/01/2017	25/01/2018	Insull, Victoria						

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										review Lorenzo and Somerset data and create PTL and book all patients into an appointment by end of March 2018	17/01/2018	17/01/2018	Insull, Victoria					Clinical	
										monitor and review capacity and time to follow up	31/03/2018		Vandyken, Ali						
3322	Clinical Support and Family Services	Genetics	29/08/2013	Organisational risk assessment	12	National reconfiguration of genetic services planned. Potentially a major threat to the future of genetic lab services in Salisbury.	Do not expect it to happen again but it is possibl	Major	8	A genomics strategy group, co-chaired by Christine Blanshard (MD), has been established that involves University Hospitals Southampton and the University of Southampton. A pilot project is planned for 2015 and will formulate a regional strategy once details of the proposed reorganisation are known. This was not released until Nov 2016 These meetings have restarted with additional parties due to the updated project named "re-procurement" Genomic tender meetings occurring regularly between UHS and SFT including Trust representative. Partnership negotiations begun for a wider partnership bid.	01/04/2018	25/01/2018	Blanshard, Dr Christine	Trust Board	01/04/2018	6	Specialist Services	Clinical Governance Committee, Finance Committee, Trust Board (Corporate Ris Register)	Medical Director
										Tender document issued. Alliance formed with UHB, BWCH, OUH and UHS to respond to the tender. BWCH proposed to become the central laboratory hub and WRGL will become a local genomics laboratory.	31/03/2018		Blanshard, Dr Christine						

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5306	Operations Directorate	Trustwide	24/05/2017	Access targets, Trustwide risk assessment	15	A number of site reconfiguration schemes are taking place between July 2017 - March 2018 which when completed will realigne the trust's bed capacity more closely to specialty demand. During this period there will be a reduction in bed capacity to allow for building works to take place. The key risks arising will be: •Loss of beds in medicine ,MSK ,Surgery •Increased risk of not achieving 4 hour ED Performance •Increased delays transferring patients from assessment units •Increased numbers of outlying more patients •Reduced elective activity •Prolonged usage of escalation areas	Will probably recur, but is not a persistent issue	Minor	8	Capacity issues are part of the plan discussed at the Trusts Reconfiguration Board meeting held each week Capacity is reviewed daily at bed meetings	31/12/2017	19/12/2017	Holloway, Peter	Trust Board	28/02/2018	8	Local Services	Trust Board (Corporate Risk Register)	Chief Operating Officer
5108	Finance and Procurement	Trustwide	27/03/2017	Trustwide risk assessment	8	The commissioners are able to successfully implement material referral management QIPP schemes which will leave the Trust with significant stranded costs.	Will probably recur, but is not a persistent issue	Minor	8	Engagement in STP planned & unplanned care projects to ensure stranded costs are identified and managed appropriately across the STP footprint. This action is in place to help keep the current risk rating the same as the target whilst tolerating the risk.	30/03/2018	03/01/2018	Collis, Mark	Finance Committee	31/03/2018	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance
										Agree with commissioner transitional arrangements for stranded costs.This action is in place to help keep the current risk rating the same as the target whilst tolerating the risk.	30/03/2018	03/01/2018	Collis, Mark						
										To agree year end financial settlements with Commissioners. This action is in place to help keep the current risk rating the same as the target whilst tolerating the risk.	31/03/2018		Collis, Mark						

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5078	Quality Directorate	All clinical areas	08/03/2017	Clinical Governance	9	Due to higher than expected HSMR there is a risk to the Trusts reputation as patients, the public and regulator potentially could perceive it as a negative indicator of care.	Do not expect it to happen again but it is possibl	Moderate	6	Implement the recommendations of the Mortality and Morbidity meetings review.	30/06/2017	08/08/2017	Gorzanski, Claire	Clinical Governance Committee	29/04/2018	3	Care	Clinical Governance Committee, Trust Board (Corporate Risk Register	Medical Director
										Pilot screening of all deaths for avoidable harm by junior doctors presenting each case to a consultant.	30/06/2017	08/08/2017	Cornforth, Dr Belinda						
										Any deaths with a suboptimal pathway or adverse event to receive a second review by the speciality M&M meeting to determine and share learning points.	30/06/2017	08/08/2017	Cornforth, Dr Belinda						
										CUSUM and other alerts to be reviewed by the Mortality Surveillance Group and learning points disseminated.	30/06/2017	08/08/2017	Cornforth, Dr Belinda						
										Publish a monthly 'mortality matters' newsletter. Email to all medical staff.	30/06/2017	10/03/2017	Cornforth, Dr Belinda						
										Introduce a system for tracking implementation of lessons learned.	30/06/2017	08/08/2017	Cornforth, Dr Belinda						
										Develop a mortality dashboard for reporting to the Mortality Surveillance Group.	30/09/2017	31/10/2017	Mortimore, Martin						
										Implement the recommendations of the national mortality review using the structured judgement review.	30/09/2017	01/08/2017	Blanshard, Dr Christine						
										Use the Datix platform to record death reviews once available and in the meantime continue to use the Trust's electronic recording mortality tool.	30/09/2018		Cornforth, Dr Belinda						
										West of England AHSN to hold a local event to train the trainers in the new structure judgement review process.	30/12/2017	13/12/2017	Blanshard, Dr Christine						
										Identify deaths of patients with learning disabilities and notify the LeDeR programme of the death and input to the review of the circumstances leading to the death.	30/04/2017	08/08/2017	Cornforth, Dr Belinda						

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5101	Finance and Procurement	Trustwide	27/03/2017	Trustwide risk assessment	10	Unable to borrow funds to keep supporting the operating expenditure of the Trust meaning the Trust may run out of cash.	Do not expect it to happen again but it is possibl	Moderate	6	Apply to DH for investment loan and work with NHSI to gain their support for the cash required.	31/03/2018	23/01/2018	Collis, Mark	Finance Committee	30/03/2018	4	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance
										Work with Commissioners to review the investment of retained funds (MRET & Readmissions) to get more income into the Trust.	30/06/2017	03/01/2018	Collis, Mark						
										Work with commissioners to ensuring patient care services are affordable. Undertake deep dive review of block agreement and specialities making significant losses.	30/09/2018		Collis, Mark						
										Delivery of Trust and STP CIP & transformation programmes.	30/03/2018		Collis, Mark						
										Renegotiation of payment terms with suppliers.	30/06/2017	03/01/2018	Collis, Mark						
3925	Human Resources	Trustwide	26/05/2015	Trustwide risk assessment	12	Failure of staff to maintain updated Statutory/Mandatory Training There is a high rate of completion of statutory and mandatory training by staff on entry to the Trust. However there is a failure amongst some staff to update with regards to these modules. There is a risk that staff may be practising without having completed updates - this is identified as a low risk from a patient safety perspective as staff will have knowledge from initial completion, however it has implications for regulation activity and organisational reputation.	May recur occasionally	Minor	6	Raise staff awareness of their individual and professional responsibilities in relation to training.	31/03/2017	05/04/2017	KINGSC	Executive Workforce Committee	30/03/2018	6	People	Joint Board of Directors, Trust Board (Corporate Risk Register)	Director of Organisational Development and People
										Monitor staff training records with individuals through appraisal.	31/03/2017	05/04/2017	KINGSC						
										Appropriate sanctions to be managed with staff where evidence of non completion i.e. failure of pay progression	31/03/2017	05/04/2017	KINGSC						
										Monitoring of training records through Directorate Performance Meetings	31/03/2017	05/04/2017	KINGSC						
										Provide an exception report of all staff who are over 6 and 12 months non compliant with any statutory mandatory training and ensure line manager schedules completion within following 3 months.	28/02/2018	25/01/2018	Salisbury, Hilary						

Report to:	Trust Board	**Agenda item:**	SFT3993
Date of Meeting:	5 February 2018		

Report Title:	National Children & Young People's Survey 2016 CQC Benchmark Report and Local Action plan			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Hazel Hardyman, Head of Customer Care Gill Sheppard, Clinical Governance Administrator			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Appendix A: Care Quality Commission's (CQC) benchmark report			

Recommendation:
Board members are invited to endorse this approach and note the contents of the report.

Executive Summary:

Salisbury NHS Foundation Trust (SFT) participated in the third national children's survey between February and June 2017 for children who had attended Salisbury District Hospital during November or December 2016 either as a day case (DC) or inpatient (IP). The overall sample size was 534. The response rate was 44%
Details are available on the CQC website at:
http://www.cqc.org.uk/publications/surveys/children-young-peoples-survey-2016.
The benchmark report for SFT is attached to this report (Appendix A).

Analysis of the Benchmark Report

- SFT scored better than most other Trusts in 12 out of 18 questions asked of children and young people aged between 8 to 15 years.
- SFT scored better than most other Trusts in 6 out of 14 questions asked of parents or carers of children aged between 0 and 7 years.
- SFT scored better than most other Trusts in 16 out of 28 questions asked of parents or carers of children and young people aged between 0 and 15 years.
- SFT scored worse than most other Trusts for one question relating to children in day surgery being treated in an adult area. A standard operating procedure regarding the day-to-day management of children on the Day Surgery Unit has been established. Further work will be undertaken on reviewing DSU and elective processes in due course.

Letter from the Chief Inspector of Hospitals, Care Quality Commission

- The chief inspector has written to SFT's chief executive highlighting the very positive results for Salisbury. It had performed 'better than expected' for the 0-7 age group and 'much better than expected' for the 8-15 age group compared to other Trusts within the survey.

- He did highlight some areas for improvement which are identified within the Trust's action plan.

Comparisons with Neighbouring Trust

- Salisbury had the highest or joint highest score for 45 of the 63 questions, including highest or joint highest scores for every question in sections on facilities, pain management, discharge and overall experience.
- Salisbury had the lowest or joint lowest score for only one question regarding parents or carers being given a choice of admission date.

Action Plan

Areas where improvements could be made have been identified and an action plan developed accordingly. Progress will be monitored via the Trust's Clinical Management Board and Clinical Governance Committee.

1. PURPOSE

1.1 This report sets out Salisbury's results for the National Children and Young People's Inpatient and Day Case Survey 2016 (CYP16). It identifies areas where improvement is required and shows the work being undertaken within the Trust to address these issues.

2. BACKGROUND

2.1 Salisbury NHS Foundation Trust (SFT) participated in the third national children's survey between February and June 2017 for children who had attended Salisbury District Hospital during November or December 2016 either as a day case (DC) or inpatient (IP).

2.2 Three questionnaires were used as follows:-

0 – 7 year olds	for completion by the parent or carer of the child;
8 – 11 year olds	consisting of two sections – the first for completion by the child and the second for completion by the parent or carer;
12 – 15 year olds	consisting of two sections – the first for completion by the young person and the second for completion by the parent or carer.

Young people aged 16 or 17 years were included in the national adult inpatient survey.

2.3 The overall sample size was 534. The response rate was 44% compared with the national average of 26%.

3. ANALYSIS OF THE BENCHMARK REPORT

3.1 The benchmark report (Appendix A) was published on 28 November 2017. It is available on the CQC website at: http://www.cqc.org.uk/publications/surveys/children-young-peoples-survey-2016.

3.2 Children and young people, aged 8-15

SFT scored **better** than most other Trusts in 12 out of 18 questions:

- Did you like the hospital food?
- Was it quiet enough for you to sleep when needed in the hospital?
- Did hospital staff talk with you about how they were going to care for you?
- When the hospital staff spoke to you, did you understand what they said?
- Did the hospital staff answer your questions?
- If you felt pain while you were at the hospital, do you think staff did everything they could to help you?
- Before the operations or procedures, did hospital staff explain to you what would be done?
- Afterwards, did staff explain to you how the operations or procedures had gone?
- Did a member of staff tell you who to talk to if you were worried about anything when you got home?
- When you left hospital, did you know what was going to happen next with your care?
- Do you feel that the people looking after you were friendly?
- Overall, how well do you think you were looked after in hospital?

3.3 **Parents/carers of children, aged 0-7**

SFT scored **better** than most other Trusts in 6 out of 14 questions:
- Did new members of staff treating your child introduce themselves?
- Do you feel that the people looking after your child listened to you?
- Did a member of staff tell you who to talk to if you were worried about your child when you got home?
- Do you feel that the people looking after your child were friendly?
- Do you feel that your child was well looked after by the hospital staff?
- Were you treated with dignity and respect by the people looking after your child?

3.4 **Parents/carers of children & young people, aged 0-15**

SFT scored **better** than most other Trusts in 16 out of 28 questions:
- Did hospital staff keep you informed about what was happening whilst your child was in hospital?
- Were you able to ask staff any questions you had about your child's care?
- Did a member of staff agree a plan for your child's care with you?
- Did staff involve you in decisions about your child's care and treatment?
- Were you given enough information to be involved in decisions about your child's care and treatment?
- Were members of staff available when your child needed attention?
- Did you have confidence and trust in the members of staff treating your child?
- Were you able to prepare food in the hospital if you wanted to?
- How would you rate the facilities for parents or carers staying overnight?
- If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?
- Before the operations or procedures, did a member of staff answer your questions in a way you could understand?
- When you left hospital, did you know what was going to happen next with your child's care?
- Did a staff member give you advice about caring for your child after you went home?
- Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?
- Do you feel that you (the parent/carer) were well looked after by hospital staff?
- Overall experience.

SFT scored **worse** than most others Trusts for one question [this related to day case patients]:
- For most of their stay in hospital, what type of ward did your child stay on?

A standard operating procedure regarding the day-to-day management of children on the Day Surgery Unit has been established. Further work will be undertaken on reviewing DSU and elective processes in due course.

4. LETTER FROM THE CHIEF INSPECTOR OF HOSPITALS, CARE QUALITY COMMISSION

4.1 On 14 November 2017 the Chief Executive received a letter from Professor Ted Baker, Chief Inspector of Hospitals - CQC, highlighting the very positive results for Salisbury.

4.2 SFT was identified as performing 'better than expected' for the 0-7 age group and 'much better than expected' for the 8-15 age group compared to other Trusts within the survey. This was because a higher than average proportion of respondents answered positively about the care they had received.

4.3 The statistical method used to identify positive patient experience focused on the most positive response option a respondent could select for any scored question. Respondents within both the 0-7 and 8-15 subgroups for SFT gave the most positive answer to questions, across the whole survey, more frequently than the England average.

4.4 The chief inspector did go on to say that the England level results highlighted some areas for improvement including availability of staff and a small proportion of children being treated on adult wards (this related to day surgery).

4.5 The full report is available at:
http://www.cqc.org.uk/sites/default/files/20171128_cyp16_outliers.pdf

5. COMPARISONS WITH DEMOGRAPHIC CHARACTERISTICS

5.1 The split between male and female respondents was 56% male and 44% female, compared with 55%/45% nationally. SFT's ethnicity responses for the White group were slightly higher than nationally (89% compared with 77%); response from other ethnic groups were 11% compared with 23% nationally.

6. COMPARISONS WITH NEIGHBOURING TRUSTS

6.1 Work has been undertaken to compare this Trust's results with those of other Trusts in the area - Bath, Dorchester, Poole, Southampton, Swindon, Winchester and Yeovil.

6.2 Salisbury had the highest or joint highest score for 45 of the 63 questions, including highest or joint highest scores for every question in sections on facilities, pain management, discharge and overall experience.

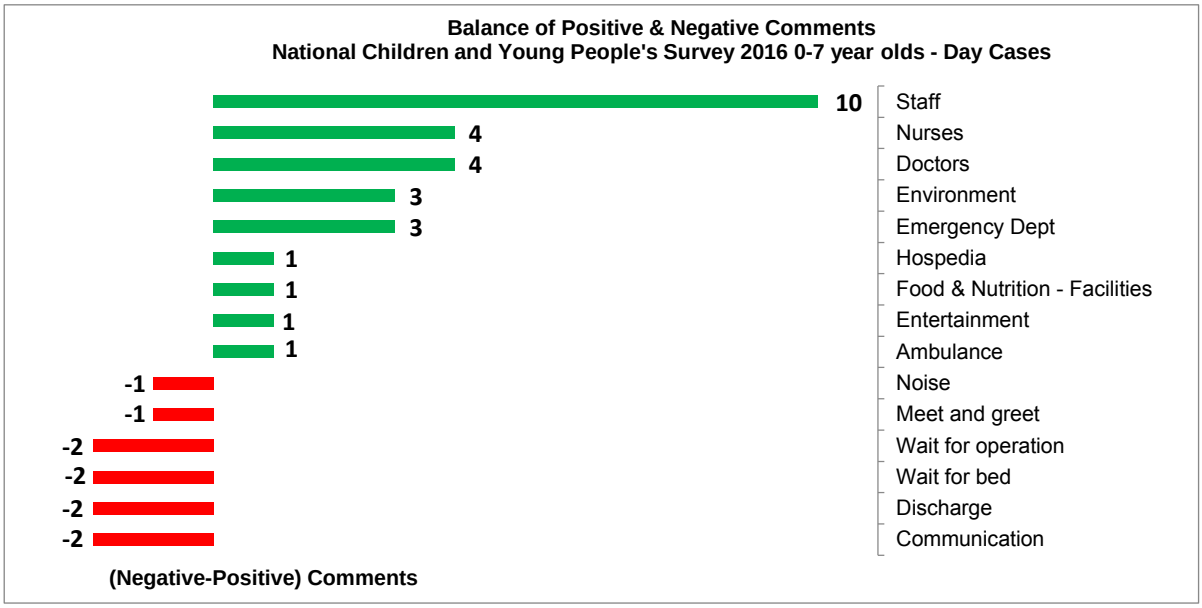
6.3 Salisbury had the lowest or joint lowest score for only one question regarding parents or carers being given a choice of admission date. This will be considered further within the Trust.

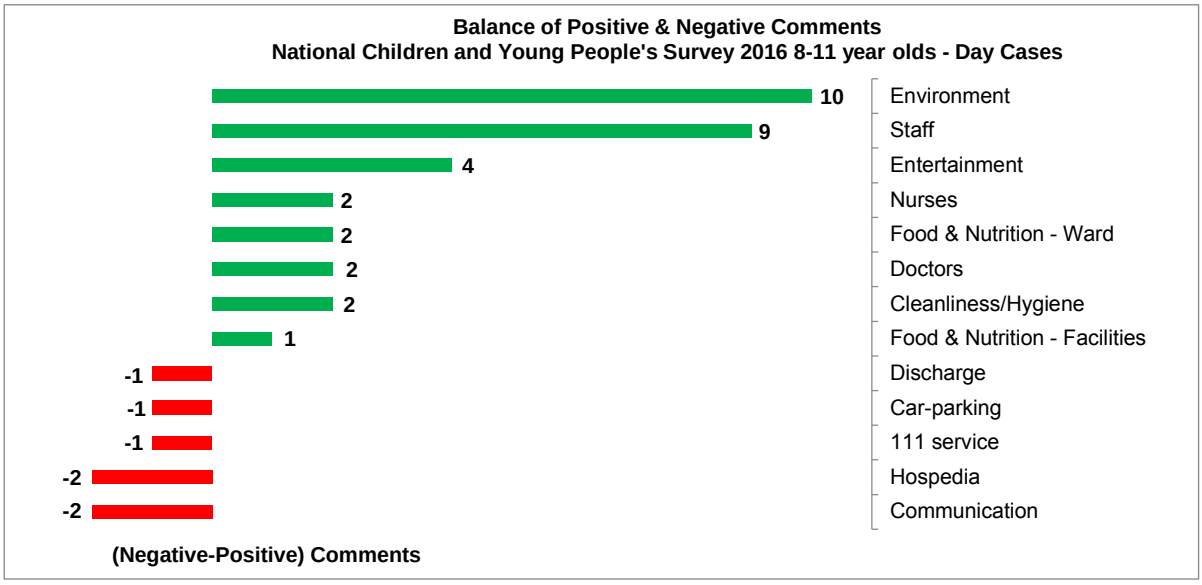
7. LOCAL RESULTS ANALYSIS AND THE NEXT STEPS

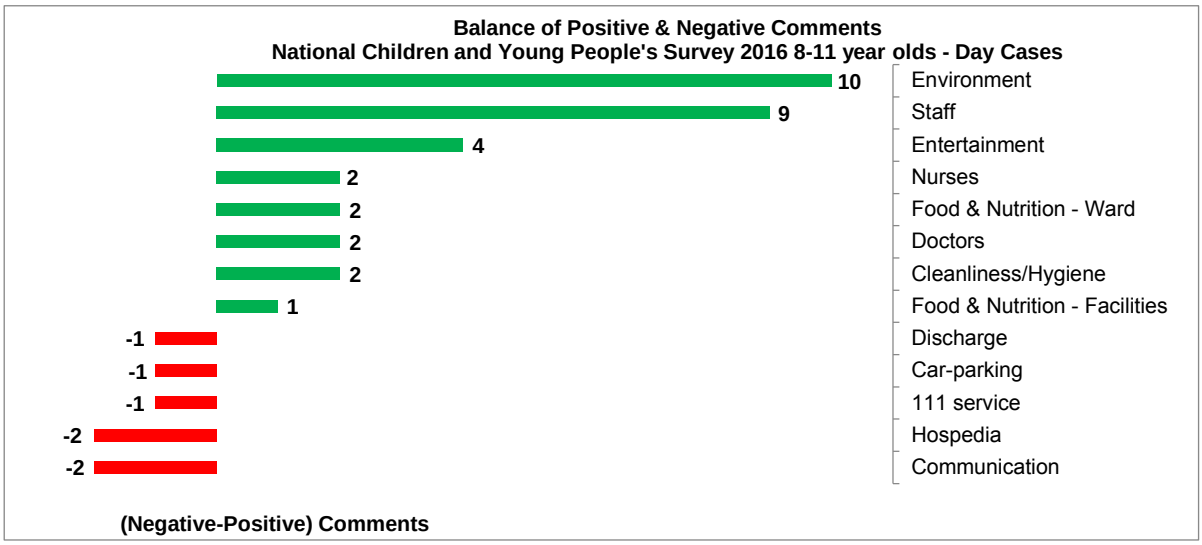
7.1 In addition to the standard questions, parents/carers, children and young people were invited to make comments about anything which they felt was particularly good about their care or things that they felt could be improved. The table below shows the number of comments received for each age group:-

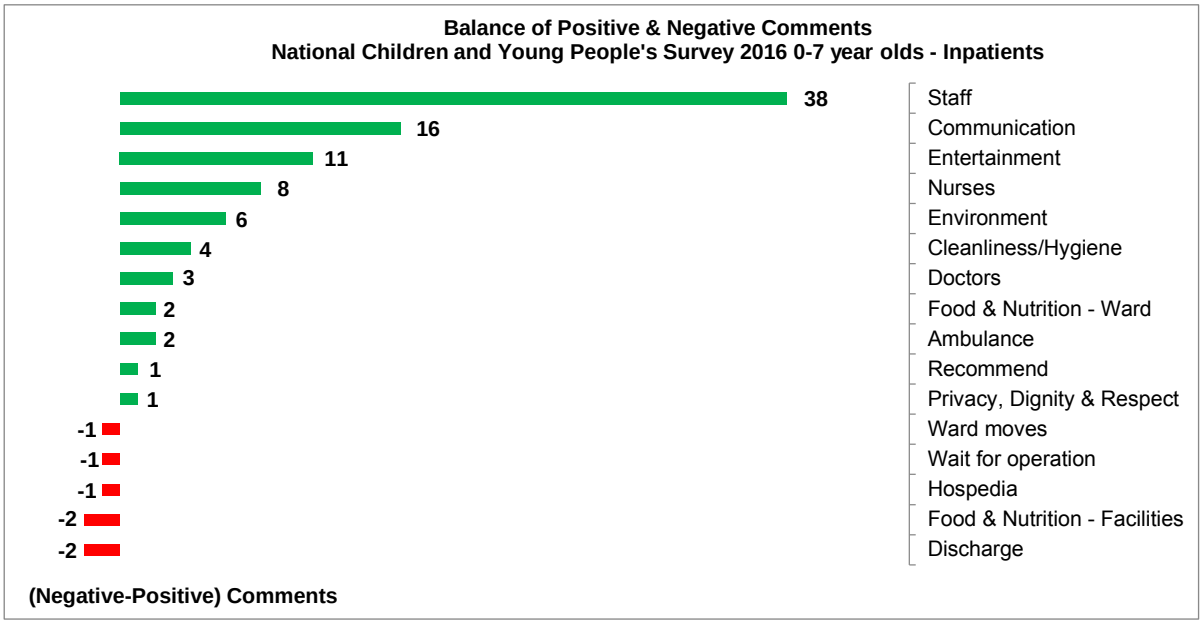
	GOOD		IMPROVE	
	DC	IP	DC	IP
0 – 7 year olds (parents/carers)	24	53	16	26
8 – 11 year olds (parents/carers & children)	6	8	5	5
12 – 15 year olds (parents/carers & young people)	8	12	2	4

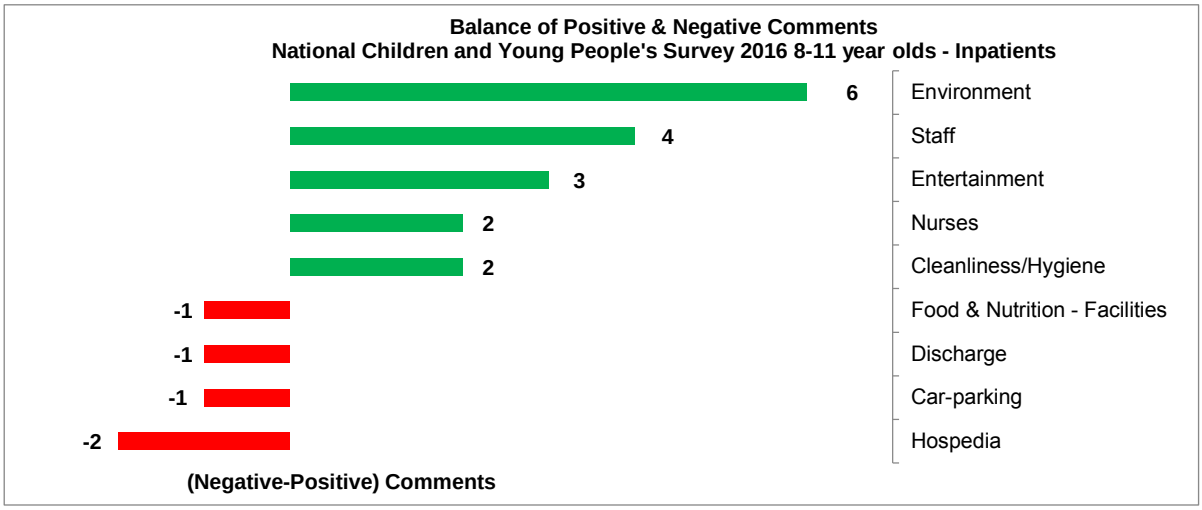
7.2 The balance of positive v negative comments is shown in the graphs below:-

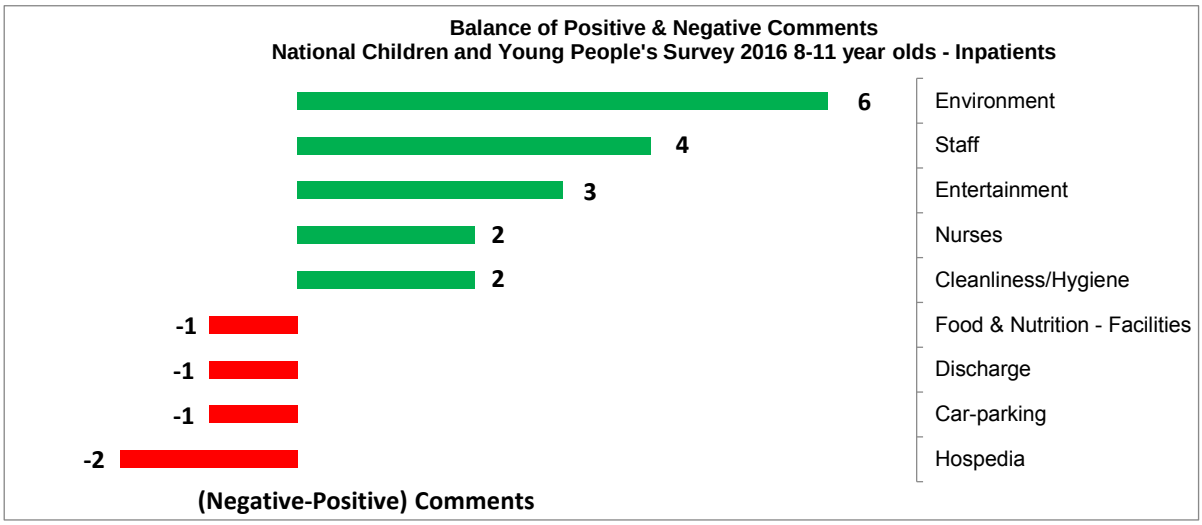

Balance of Positive & Negative Comments
National Children and Young People's Survey 2016 0-7 year olds - Day Cases
10
4
4
3
3
1
1
1
1
-1
-1
-2
-2
-2
-2
Staff
Nurses
Doctors
Environment
Emergency Dept
Hospedia
Food & Nutrition - Facilities
Entertainment
Ambulance
Noise
Meet and greet
Wait for operation
Wait for bed
Discharge
Communication
(Negative-Positive) Comments


Balance of Positive & Negative Comments
National Children and Young People's Survey 2016 8-11 year olds - Day Cases
10
9
4
2
2
2
2
1
-1
-1
-1
-2
-2
Environment
Staff
Entertainment
Nurses
Food & Nutrition - Ward
Doctors
Cleanliness/Hygiene
Food & Nutrition - Facilities
Discharge
Car-parking
111 service
Hospedia
Communication
(Negative-Positive) Comments


Balance of Positive & Negative Comments
National Children and Young People's Survey 2016 8-11 year olds - Day Cases
10
9
4
2
2
2
2
1
-1
-1
-1
-2
-2
Environment
Staff
Entertainment
Nurses
Food & Nutrition - Ward
Doctors
Cleanliness/Hygiene
Food & Nutrition - Facilities
Discharge
Car-parking
111 service
Hospedia
Communication
(Negative-Positive) Comments


Balance of Positive & Negative Comments
National Children and Young People's Survey 2016 0-7 year olds - Inpatients
38
16
11
8
6
4
3
2
2
1
1
-1
-1
-1
-2
-2
Staff
Communication
Entertainment
Nurses
Environment
Cleanliness/Hygiene
Doctors
Food & Nutrition - Ward
Ambulance
Recommend
Privacy, Dignity & Respect
Ward moves
Wait for operation
Hospedia
Food & Nutrition - Facilities
Discharge
(Negative-Positive) Comments


Balance of Positive & Negative Comments
National Children and Young People's Survey 2016 8-11 year olds - Inpatients
6
4
3
2
2
-1
-1
-1
-2
Environment
Staff
Entertainment
Nurses
Cleanliness/Hygiene
Food & Nutrition - Facilities
Discharge
Car-parking
Hospedia
(Negative-Positive) Comments


Balance of Positive & Negative Comments
National Children and Young People's Survey 2016 8-11 year olds - Inpatients
6
4
3
2
2
-1
-1
-1
-2
Environment
Staff
Entertainment
Nurses
Cleanliness/Hygiene
Food & Nutrition - Facilities
Discharge
Car-parking
Hospedia
(Negative-Positive) Comments

7.3 Staff have carefully considered the results of this survey in conjunction with feedback from real-time feedback (RFT), Friends and Family Test (FFT), complaints and concerns. They have identified some areas for improvement and have drawn up an action plan. Progress against the plan will be reported to the Clinical Governance Committee in November 2017.

8. SUMMARY

8.1 Overall, the results are very positive. Where areas for improvement have been identified, an action plan has been drawn up and progress will be monitoring through the Trust's Clinical Management Board and Clinical Governance Committee.

9. RECOMMENDATION

9.1 Board members are invited to endorse this approach and note the contents of the report.

Lorna Wilkinson
Director of Nursing

Patient survey report 2016

APPENDIX A

2016 Children and young people's inpatient and day case survey

Salisbury NHS Foundation Trust

NHS patient survey programme
2016 Children and young people's inpatient and day case survey

The Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and we encourage care services to improve. Our role is to register care providers and to monitor, inspect and rate services. If a service needs to improve, we take action to make sure this happens. We speak with an independent voice, publishing regional and national views of the major quality issues in health and social care.

2016 Children and young people's inpatient and day case survey

To improve the quality of services the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences.

The 2016 survey of children and young people involved 132 acute and specialist NHS trusts across England. We received 34,708 completed questionnaires, a response rate of 26%. Patients were eligible to participate in the survey if they were admitted to hospital as an inpatient or day case and aged between 15 days and 15 years old when discharged between the 1 November and 31 December 2016[1]. Full sampling criteria can be found in the survey instruction manual (see further information section).

The 2016 survey of children and young people used three different questionnaires, each one appropriate for a different age group:

- The 0-7 questionnaire; sent to patients aged between 15 days and 7 years old at the time of discharge.
- The 8-11 questionnaire; sent to patients aged between 8 and 11 years old at the time of discharge.
- The 12-15 questionnaire; sent to patients aged between 12 and 15 years old at the time of discharge.

Copies of the questionnaires are available here: http://www.nhssurveys.org/surveys/1009

Questionnaires sent to those aged 8-11 and 12-15 had a short section for the child or young person to complete, followed by a separate section for their parent or carer to complete. Where a child was aged 0-7, the questionnaire was completed entirely by their parent or carer.

Fieldwork for the survey (the period during which questionnaires were sent out and returned) took place between February 2017 and June 2017.

The children and young people’s inpatient and day case survey is part of a wider programme of NHS patient surveys, which covers a range of topics including adult inpatients, emergency departments, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

The Care Quality Commission will use the results from this survey in our regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of CQC Insight, which provides inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections. NHS Improvement will use the results to guide its work to improve the quality of care provided by NHS Trusts and Foundation Trusts.

[1]Five trusts sampled back to 1 October 2016 in order to achieve the minimum sample size.

Interpreting the report

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part.

It uses an analysis technique called the '**expected range**' to determine if your trust is performing 'about the same', 'better' or 'worse' compared with other trusts. For more information, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

Results presented in this report are grouped depending on i) whether parent and carers or children and young people were asked the question and ii) whether the question was common across multiple questionnaires or unique to one. As a result, there are five different benchmark groups:

- Children aged 8-11; questions which were asked of children in the 8-11 questionnaire only.
- Young people aged 12-15; questions which were asked of young people in the 12-15 questionnaire only.
- Children and young people aged 8-15; questions which were asked of both children and young people and were common across the 8-11 and 12-15 questionnaires.
- Parents and carers of children aged 0-7; questions which were asked of parents or carers in the 0-7 questionnaire only.
- Parents and carers of children and young people aged 0-15; questions which were asked of parents or carers and were common across the 0-7, 8-11 and 12-15 questionnaires.

This report shows the same data as published on the CQC website (www.cqc.org.uk/childrenssurvey). The CQC website displays the data in a simplified way, identifying whether a trust performed 'better', 'worse' or 'about the same' as the majority of other trusts for each question.

As multiple versions of the questionnaire were used, a mapping tool has been developed which provides information on:

- Full question text
- Question number within each questionnaire version
- Benchmark group which answered the question
- Whether the question was scored or not,

The mapping tool is available at: http://www.nhssurveys.org/surveys/1009

Standardisation

Trusts have differing profiles of people who use their services. For example, one trust may have more younger patients than another trust. This can potentially affect the results because parents and carers may answer questions in different ways, depending on certain characteristics of their children. For example, the parents of older children may report more positive experiences than those of younger respondents. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of people.

To account for this, we ‘standardise’ the data. Results have been standardised by age group (survey version), route of admission (emergency or elective) and length of stay (0 or 1+ overnight stays) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-admission type-length of stay profile reflects the national age-admission type-length of stay distribution (based on all of the respondents to the survey). Standardisation therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess trust performance. For example, they may be a descriptive question which asks respondents if their

child’s attendance was an emergency or planned. Alternatively they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be “During their stay in hospital, did your child have any operations or procedures?”

For full details of the scoring please see the ‘Survey Technical Document’ (see further information section).

Graphs

The graphs in this report show how the score for the trust compares to the range of scores achieved by all trusts taking part in the survey. The black diamond shows the score for your trust. The graph is divided into three sections:

- If your trust's score lies in the grey section of the graph, its result is 'about the same' as most other trusts in the survey.
- If your trust's score lies in the orange section of the graph, its result is 'worse' compared with most other trusts in the survey.
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey. If there is no text the score is 'about the same'.

These groupings are based on a rigorous statistical analysis of the data, as described in the following 'methodology' section.

Methodology

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the '**expected range**' which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust and the scores for all other trusts. If the trust's performance is outside of this range, it means that it performs significantly above/below what would be expected. If it is within this range, we say that its performance is 'about the same'. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance.

In some cases there will be no orange and/or no green area in the graph. This happens when the expected range for your trust is so broad it encompasses either the highest possible score for all trusts (no green section) or the lowest possible for all trusts score (no orange section). This could be because there were few respondents and / or a lot of variation in their answers.

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question. This is because the uncertainty around the result is too great. A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see further information section).

Tables

At the end of the report you will find tables containing the data used to create the graphs. These tables also show the response rate for your trust and background information about the people that responded.

Results for 2016 are not comparable with previous surveys owing to differences in the methodology used. Children and young people were sampled at a different time of year which may impact on any change in results.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
www.cqc.org.uk/childrenssurvey

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/953

More information on the programme of NHS patient surveys is available at:
http://www.cqc.org.uk/content/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-nhs-acute-hospitals

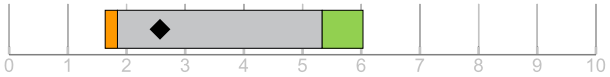
This survey used, under licence, questionnaires originally developed and owned by Picker Institute Europe.

2016 Children and young people's inpatient and day case survey
Salisbury NHS Foundation Trust

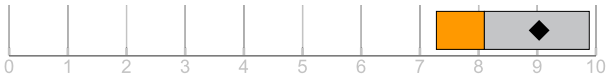
Going to hospital (answered if the patient's visit was planned or they were on a waiting list)

Parents/carers of 0 to 7 year olds were asked:

Did the hospital give you a choice of admission dates?



Did the hospital change your child's admission date at all?



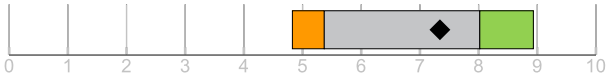
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

2016 Children and young people's inpatient and day case survey
Salisbury NHS Foundation Trust

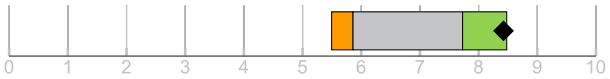
The hospital ward

Children/young people aged 8 to 15 were asked:

Were there enough things for you to do in the hospital?

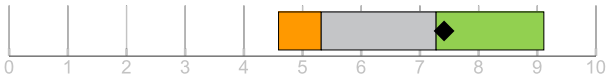


Did you like the hospital food?



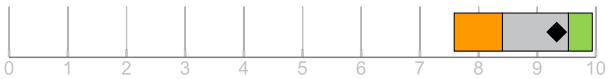
Better

Was it quiet enough for you to sleep when needed in the hospital?



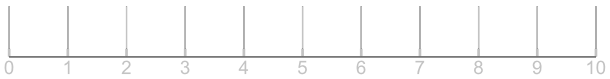
Better

Were you given enough privacy when you were receiving care and treatment?



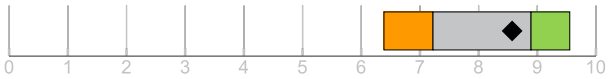
Children aged 8 to 11 were asked:

Did hospital staff play with you or do any activities with you while you were in hospital?



Young people aged 12 to 15 were asked:

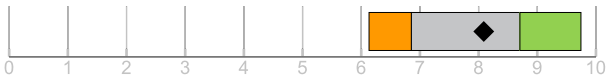
Was the ward suitable for someone of your age?



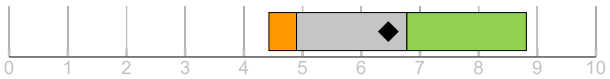
Parents/carers of 0 to 7 year olds were asked:

Did staff play with your child at all while they were in hospital?

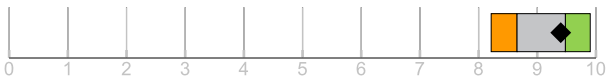
Were there enough things for your child to do in the hospital?



Did your child like the hospital food provided?

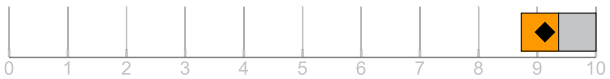


Was your child given enough privacy when receiving care and treatment?



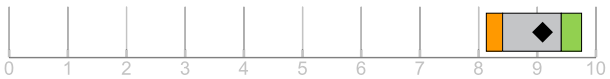
Parents/carers of 0 to 15 year olds were asked:

For most of their stay in hospital what type of ward did your child stay on?

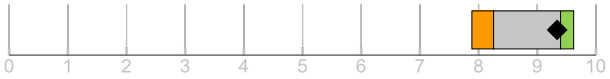


Worse

Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?



How clean do you think the hospital room or ward was that your child was in?



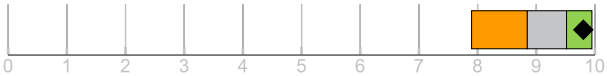
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

2016 Children and young people's inpatient and day case survey
Salisbury NHS Foundation Trust

Hospital staff

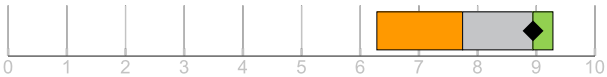
Children/young people aged 8 to 15 were asked:

Did hospital staff talk with you about how they were going to care for you?



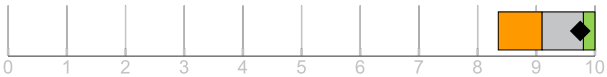
Better

When the hospital staff spoke with you, did you understand what they said?

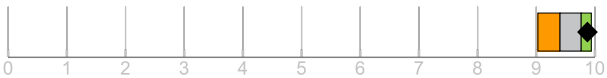


Better

Did you feel able to ask staff questions?

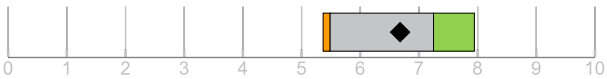


Did the hospital staff answer your questions?

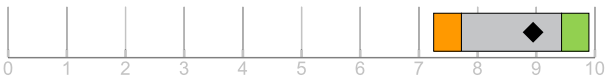


Better

Were you involved in decisions about your care and treatment?

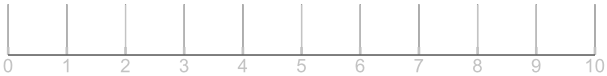


If you had any worries, did a member of staff talk with you about them?



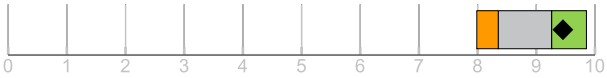
Young people aged 12 to 15 were asked:

If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?



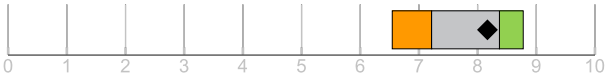
Parents/carers of 0 to 7 year olds were asked:

Did new members of staff treating your child introduce themselves?

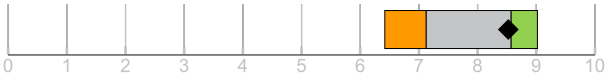


Better

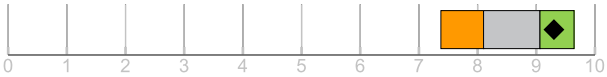
Did members of staff treating your child communicate with them in a way that your child could understand?



Did different staff give you conflicting information?



Do you feel that the people looking after your child listened to you?



Better

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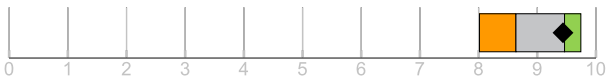
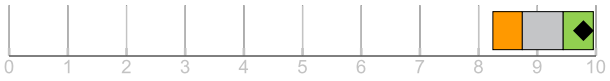
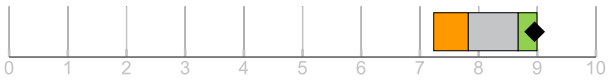
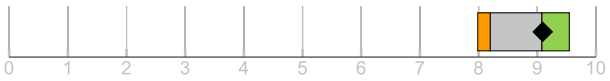
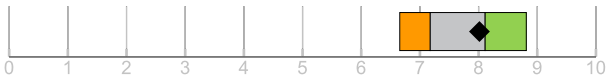
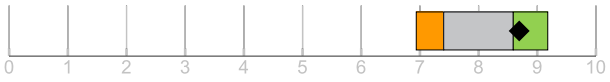
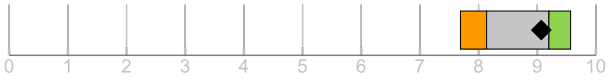
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

2016 Children and young people's inpatient and day case survey
Salisbury NHS Foundation Trust

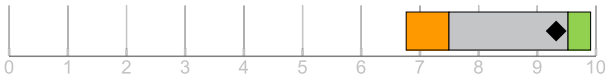
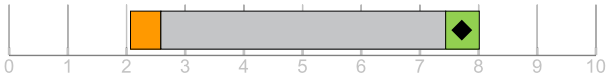
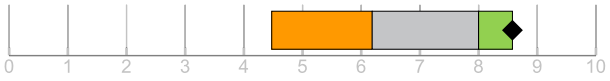
Hospital staff

Parents/carers of 0 to 15 year olds were asked:

Did members of staff treating your child give you information about their care and treatment in a way that you could understand?	
Did hospital staff keep you informed about what was happening whilst your child was in hospital?	 Better
Were you able to ask staff any questions you had about your child's care?	 Better
Did a member of staff agree a plan for your child's care with you?	 Better
Did staff involve you in decisions about your child's care and treatment?	 Better
Were you given enough information to be involved in decisions about your child's care and treatment?	 Better
Were the different members of staff caring for and treating your child aware of their medical history?	
Did you feel that staff looking after your child knew how to care for their individual or special needs?	
Were members of staff available when your child needed attention?	 Better
Did the members of staff caring for your child work well together?	
Did you have confidence and trust in the members of staff treating your child?	 Better

Facilities for Parents & Carers

Parents/carers of 0 to 15 year olds were asked:

Did you have access to hot drinks facilities in the hospital?	
Were you able to prepare food in the hospital if you wanted to?	 Better
How would you rate the facilities for parents or carers staying overnight?	 Better

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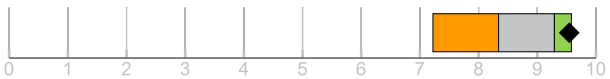
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

2016 Children and young people's inpatient and day case survey
Salisbury NHS Foundation Trust

Pain management

Children/young people aged 8 to 15 were asked:

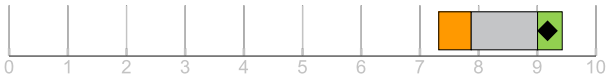
If you felt pain while you were at the hospital, do you think staff did everything they could to help you?



Better

Parents/carers of 0 to 15 year olds were asked:

If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?



Better

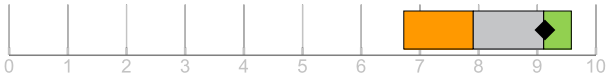
Operations and Procedures

Children/young people aged 8 to 15 were asked:

Before the operations or procedures, did hospital staff explain to you what would be done?

Better

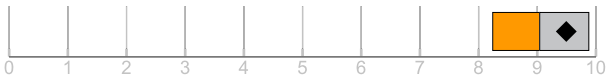
Afterwards, did staff explain to you how the operations or procedures had gone?



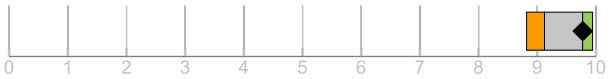
Better

Parents/carers of 0 to 15 year olds were asked:

Before your child had any operations or procedures did a member of staff explain to you what would be done?

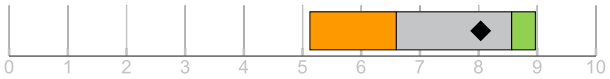


Before the operations or procedures, did a member of staff answer your questions in a way you could understand?



Better

During any operations or procedures, did staff play with your child or do anything to distract them?



Afterwards, did staff explain to you how the operations or procedures had gone?

Medicines (answered if the patient was prescribed new medicines)

Parents/carers of 0 to 15 year olds were asked:

Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?

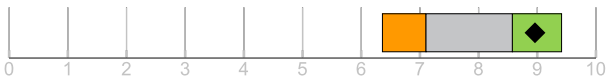
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

2016 Children and young people's inpatient and day case survey
Salisbury NHS Foundation Trust

Leaving Hospital

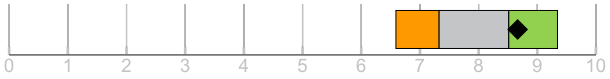
Children/young people aged 8 to 15 were asked:

Did a member of staff tell you who to talk to if you were worried about anything when you got home?



Better

When you left hospital, did you know what was going to happen next with your care?

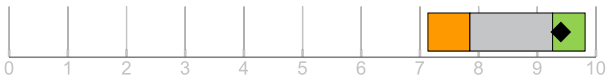


Better

Did a member of staff give you advice on how to look after yourself after you went home?

Parents/carers of 0 to 7 year olds were asked:

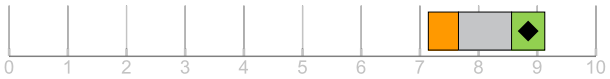
Did a member of staff tell you who to talk to if you were worried about your child when you got home?



Better

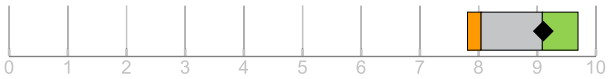
Parents/carers of 0 to 15 year olds were asked:

When you left hospital, did you know what was going to happen next with your child's care?



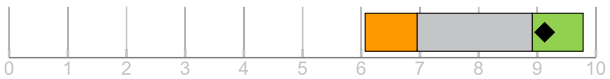
Better

Did a staff member give you advice about caring for your child after you went home?



Better

Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?



Better

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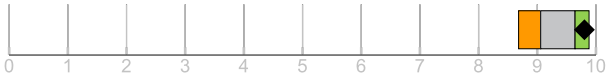
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

2016 Children and young people's inpatient and day case survey
Salisbury NHS Foundation Trust

Overall

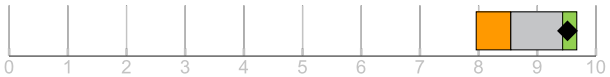
Children/young people aged 8 to 15 were asked:

Do you feel that the people looking after you were friendly?



Better

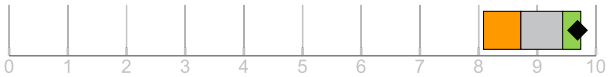
Overall, how well do you think you were looked after in hospital?



Better

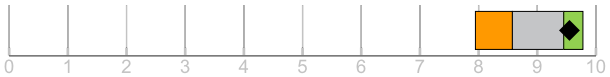
Parents/carers of 0 to 7 year olds were asked:

Do you feel that the people looking after your child were friendly?



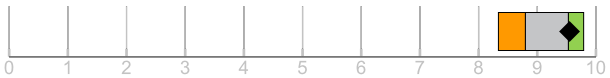
Better

Do you feel that your child was well looked after by the hospital staff?



Better

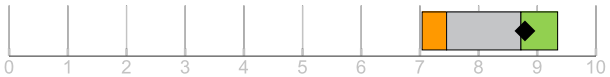
Were you treated with dignity and respect by the people looking after your child?



Better

Parents/carers of 0 to 15 year olds were asked:

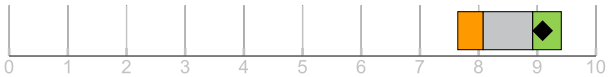
Do you feel that you (the parent/carer) were well looked after by hospital staff?



Better

Very poor experience Very good experience Better

Overall, I felt my child had a...



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

2016 Children and young people's inpatient and day case survey

Salisbury NHS Foundation Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)
Going to hospital (answered if the patient's visit was planned or they were on a waiting list)				
Parents/carers of 0 to 7 year olds were asked:				
Did the hospital give you a choice of admission dates?	2.6	1.6	6.0	57
Did the hospital change your child's admission date at all?	9.0	7.3	9.7	59
The hospital ward				
Children/young people aged 8 to 15 were asked:				
Were there enough things for you to do in the hospital?	7.3	4.8	8.9	72
Did you like the hospital food?	8.4	5.5	8.5	54
Was it quiet enough for you to sleep when needed in the hospital?	7.4	4.6	9.1	54
Were you given enough privacy when you were receiving care and treatment?	9.3	7.6	9.9	71
Children aged 8 to 11 were asked:				
Did hospital staff play with you or do any activities with you while you were in hospital?	-	2.5	6.6	
Young people aged 12 to 15 were asked:				
Was the ward suitable for someone of your age?	8.6	6.4	9.6	41
Parents/carers of 0 to 7 year olds were asked:				
Did staff play with your child at all while they were in hospital?	7.2	4.3	9.7	75
Were there enough things for your child to do in the hospital?	8.1	6.1	9.7	144
Did your child like the hospital food provided?	6.5	4.4	8.8	80
Was your child given enough privacy when receiving care and treatment?	9.4	8.2	9.9	158
Parents/carers of 0 to 15 year olds were asked:				
For most of their stay in hospital what type of ward did your child stay on?	9.1	8.7	10.0	223
Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?	9.1	8.1	9.8	179
How clean do you think the hospital room or ward was that your child was in?	9.3	7.9	9.6	226

2016 Children and young people's inpatient and day case survey

Salisbury NHS Foundation Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)
Hospital staff				
Children/young people aged 8 to 15 were asked:				
Did hospital staff talk with you about how they were going to care for you?	9.8	7.9	9.9	68
When the hospital staff spoke with you, did you understand what they said?	8.9	6.3	9.3	69
Did you feel able to ask staff questions?	9.7	8.4	10.0	55
Did the hospital staff answer your questions?	9.9	9.0	9.9	53
Were you involved in decisions about your care and treatment?	6.7	5.4	7.9	67
If you had any worries, did a member of staff talk with you about them?	8.9	7.3	9.9	52
Young people aged 12 to 15 were asked:				
If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?	-	7.1	10.0	
Parents/carers of 0 to 7 year olds were asked:				
Did new members of staff treating your child introduce themselves?	9.5	8.0	9.9	158
Did members of staff treating your child communicate with them in a way that your child could understand?	8.2	6.5	8.8	150
Did different staff give you conflicting information?	8.5	6.4	9.0	157
Do you feel that the people looking after your child listened to you?	9.3	7.4	9.6	157
Parents/carers of 0 to 15 year olds were asked:				
Did members of staff treating your child give you information about their care and treatment in a way that you could understand?	9.4	8.0	9.7	226
Did hospital staff keep you informed about what was happening whilst your child was in hospital?	8.9	7.3	9.6	226
Were you able to ask staff any questions you had about your child's care?	9.5	8.1	9.7	225
Did a member of staff agree a plan for your child's care with you?	9.8	8.2	10.0	216
Did staff involve you in decisions about your child's care and treatment?	9.0	7.2	9.0	225
Were you given enough information to be involved in decisions about your child's care and treatment?	9.1	8.0	9.5	225
Were the different members of staff caring for and treating your child aware of their medical history?	8.0	6.7	8.8	200
Did you feel that staff looking after your child knew how to care for their individual or special needs?	8.8	7.6	9.1	182
Were members of staff available when your child needed attention?	8.7	6.9	9.2	212
Did the members of staff caring for your child work well together?	9.1	7.7	9.6	224
Did you have confidence and trust in the members of staff treating your child?	9.5	8.1	9.7	226

2016 Children and young people's inpatient and day case survey

Salisbury NHS Foundation Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)
Facilities for Parents & Carers				
Parents/carers of 0 to 15 year olds were asked:				
Did you have access to hot drinks facilities in the hospital?	9.3	6.8	9.9	225
Were you able to prepare food in the hospital if you wanted to?	7.7	2.1	8.0	149
How would you rate the facilities for parents or carers staying overnight?	8.6	4.5	8.6	151
Pain management				
Children/young people aged 8 to 15 were asked:				
If you felt pain while you were at the hospital, do you think staff did everything they could to help you?	9.5	7.2	9.6	59
Parents/carers of 0 to 15 year olds were asked:				
If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?	9.2	7.3	9.4	188
Operations and Procedures				
Children/young people aged 8 to 15 were asked:				
Before the operations or procedures, did hospital staff explain to you what would be done?	9.9	8.7	10.0	46
Afterwards, did staff explain to you how the operations or procedures had gone?	9.1	6.7	9.6	46
Parents/carers of 0 to 15 year olds were asked:				
Before your child had any operations or procedures did a member of staff explain to you what would be done?	9.5	8.2	9.9	117
Before the operations or procedures, did a member of staff answer your questions in a way you could understand?	9.8	8.8	9.9	112
During any operations or procedures, did staff play with your child or do anything to distract them?	8.0	5.1	9.0	76
Afterwards, did staff explain to you how the operations or procedures had gone?	9.2	7.3	9.6	115
Medicines (answered if the patient was prescribed new medicines)				
Parents/carers of 0 to 15 year olds were asked:				
Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?	9.6	8.6	9.9	102

2016 Children and young people's inpatient and day case survey

Salisbury NHS Foundation Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)
Leaving Hospital				
Children/young people aged 8 to 15 were asked:				
Did a member of staff tell you who to talk to if you were worried about anything when you got home?	9.0	6.4	9.4	57
When you left hospital, did you know what was going to happen next with your care?	8.7	6.6	9.3	70
Did a member of staff give you advice on how to look after yourself after you went home?	9.1	6.5	9.7	66
Parents/carers of 0 to 7 year olds were asked:				
Did a member of staff tell you who to talk to if you were worried about your child when you got home?	9.4	7.1	9.8	153
Parents/carers of 0 to 15 year olds were asked:				
When you left hospital, did you know what was going to happen next with your child's care?	8.8	7.1	9.1	210
Did a staff member give you advice about caring for your child after you went home?	9.1	7.8	9.7	218
Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?	9.1	6.1	9.8	160
Overall				
Children/young people aged 8 to 15 were asked:				
Do you feel that the people looking after you were friendly?	9.8	8.7	9.9	71
Overall, how well do you think you were looked after in hospital?	9.5	8.0	9.7	71
Parents/carers of 0 to 7 year olds were asked:				
Do you feel that the people looking after your child were friendly?	9.7	8.1	9.7	157
Do you feel that your child was well looked after by the hospital staff?	9.5	7.9	9.8	157
Were you treated with dignity and respect by the people looking after your child?	9.6	8.3	9.8	157
Parents/carers of 0 to 15 year olds were asked:				
Do you feel that you (the parent/carer) were well looked after by hospital staff?	8.8	7.0	9.3	227
Overall, I felt my child had a...	9.1	7.6	9.4	225

2016 Children and young people's inpatient and day case survey
Salisbury NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	231	34708
Response Rate (percentage)	44	26

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	56	55
Female	44	45
Ethnic group (percentage)	(%)	(%)
White	89	77
Multiple ethnic group	5	5
Asian or Asian British	2	8
Black or Black British	1	3
Arab or other ethnic group	0	1
Not known	3	6

Report to:	Trust Board	**Agenda item:**	**SFT 3994**
Date of Meeting:	5th February 2018		

Report Title:	Capital Development Report, January 2018			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Prepared by:				
Executive Sponsor (presenting):	Laurence Arnold, Director of Corporate Development			
Appendices (list if applicable):	Appendix A – other building and works schemes Appendix B – other information technology schemes Appendix C – other medical equipment replacement schemes			

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

Executive Summary:
The Capital Development Report describes the improvements that have been made in the last four months to the estate, across buildings, information technology, medical equipment and infrastructure. In relation to the EPR programme, a revised business case is under development and will come to the Board in March.

1. Purpose

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

2. Building Schemes

Acute Medical Unit (AMU) Project

Following the completion of the building work in the former Farley ward template, the new Acute Medical Unit (AMU) successfully opened on the 6th Dec.

Breamore Ward then moved to the space vacated by AMU on the 11th Dec and is now known as Whiteparish Ward with a focus on acute medicine and diabetes.

The former Breamore Ward in the central corridor underwent a short period of redecoration and replacement flooring in the bathrooms, and opened as Breamore Short Stay Surgical ward on the 3rd Jan.

Ophthalmology OPD

The new Ophthalmology OPD building was completed to program and following the move, was fully operational on the 2nd Oct 2017.

There are some issues with the sizes of the consulting rooms and this is currently being investigated with the project team.

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

Building work started in the former ophthalmology template level 3 on 6th November.

Drilling into the concrete for the drainage work has been problematic due to the depth of the concrete, the noise and vibration, as expected, is also having a adverse impact to the Operating Theatres on level 4 and ENT/Audiology on level 3. This has resulted in the program being delayed by two and half weeks, with completion now expected 6th April.

The contractor is doing all he can to minimise the delay and is also working to try to facilitate the ten beds being available mid-March.

Once the building work has been completed in level 3, the following moves will take place in line with the Board approved business cases:

- Pembroke ward and suite will move to newly refurbished level 3
- Farley Ward will move to the former Pembroke ward and suite on level 2
- The elderly care ward on level 4 will move back down to level 2 and will be known as Spire ward
- Laverstock Ward on level 4 will open as additional medical beds.

3. IT Schemes

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

Electronic Whiteboards
The bi-directional interface with Lorenzo and whiteboards is still in the testing phase – expecting to be complete by the end of March.

Patient Observation and Escalation Tool (POET)
POET is now live on 13 wards with Redlynch, Pitton and Pembroke wards currently being trained. Visual Infusion Phlebitis (VIP) scores are now available for recording on POET. Clinical assistants have been trained to record cannula insertion electronically to aid the recording of VIP score. Further developments are being released into live over the coming weeks and the trialling of replacement handheld devices is on-going.

Electronic Discharge Summaries
Minor amendments and bug fixes have been released during the last quarter. A fully integrated solution has been developed within the EDS to allow pharmacists to refer patients, and order dossett boxes to a Community Pharmacy of the patients choosing. Patients identified for referral will receive a medication review appointment with their chosen pharmacy. It is anticipated that this service may reduce re-admissions.

NHSmail 2
A project initiation workshop has taken place with the supplier Accenture and work will start in February 2018 with migration of email accounts is likely to start in May 2018.

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

Infrastructure Refresh
Following Board approval in December, negotiations are almost complete with the contract and order to be completed this month. The plan remains a go live of mid 2018.

4. Recommendations

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

Laurence Arnold
Director of Corporate Development

26th January 2018

APPENDIX A

Other significant schemes in the Approved Capital Programme for 2017/18

Building and Works schemes	Completion date	Budget cost incl VAT
Efficiency schemes (7703C0) Funding available to support efficiency projects with rapid payback revenue savings. Funding ring-fenced for in-year bids.		£200K (2017-18)
Road repairs and Pedestrian crossings (7020C0) Repairs to the roads on site and upgrading the pedestrian crossings to current standards – project slipped to 2017/18 and scope of works to be reviewed, and consideration made in respect of new developments on site such as the new Sterilisation Unit.	Slipped	£214k (2017-18)
Accommodation upgrade (7011C0) Final works on this scheme nearing completion.	Complete	£150K

Rolling work programmes (multi year projects)

Building and Works schemes	Completion date	Budget cost incl VAT
Air Handling Units (7041C0) This is the fourth year of a 7 year (£2m) programme to replace the 50 specialist ventilation systems supporting SDU, Pharmacy, ED/SSEU, Pathology, Spinal X ray and all the Theatres. Funding for this financial year to be utilised for the AHU / Ventilation system for the new modular build for Ophthalmology. Work in Theatres 1 & 6 delayed due to clinical activity – date for installation being discussed.	March 2020	£250k (2017-18)
Nurse Call System upgrade (7202C0) Nurse call system in the Spinal to be replaced in October / November 2017.	2017/18	£68K (2017-18)
Lift Refurbishment Programme (7056C0)	Complete	£66k

APPENDIX B

Information Technology schemes	**Completion date**	**Budget cost incl VAT**
PACS/RIS (7943C0) Successful upgrade to the system last week. XDS is continuing to be rolled out across the domain. Due to resource issues the Obstetric ultrasound reports are still not available but are expected to be in the LIVE system by the end of March. Discussions started with regarding endoscopy images being available in PACS and XDS.	Ongoing	
Order Comms and Results Reporting (7942C0) GP T'Quest EMIS have agreed to Trust changing the delivery dates for the Review upgrade. This will take into account more testing (20 days) prior to switching to live and also the dates are close to Easter. Likely to be delivered 1st or 2nd week April (just after Easter). All background work is progressing against plan as required by EMIS and Trust (IT). Progress with rolling out electronic radiology requesting to GP practices and ability to view images – two practices now live and rolling out further.	Ongoing	
Telecoms Voice Over IP (7948CO) New system in and working. Next phase of rollout will commence once start up issues are completed	On-going roll out	£0
SpIda The latest build is being tested by HR before being deployed	Early 2018	N/A
Genomics Bioinformatics software Genomic sequencing produces very large amounts of data which must be filtered to prioritise variants and then individual sequence variant must be interpreted to classify their clinical significance. This is a complex task that requires specialised support software. This project will allow both faster analysis of existing tests and for the implementation of additional genomic tests in future. The software is already being used to help analyse several existing tests. Development and validation is underway to use the software for additional tests this will be implemented from February or March	March 2018	£50,000
Gynaecology System PHE developed software being used and set up work is underway	March 2018	£78,000
Network Maintenance To replace network hardware on the edge of the Trust's LAN, which either already have or are about to go end of support.	March 2018	£50,000
Network Security Tender awarded, project being initiated to enable better secure remote access to the SFT site. Delivery mid-2018	March 2018	£139,000

APPENDIX C

Medical Devices schemes	**Completion date**	**Budget cost**
Capital schemes		
Bed Replacement programme (7131C0) The bed replacement programme is progressing. 452 of the replacement beds have now been ordered. 20 additional beds have been ordered to address escalation needs, this funding has been taken from the 2017/18 capital allocation. A capital bid has been submitted for the 2018/19 capital round to complete the replacement programme.	Year 5 of a 5 year programme	£150k (2014/15) £204k (2015/16) £120k (2016/17) £55k (2017/18)
Review of Theatre Instruments (7122C0) The Trust commissioned an external review of instrumentation. The joint SSL and SFT stakeholder group is working well and monitors and audits the emergency requirements and plans for the future needs. As a result, the total budget allocation from 2016/17 was not used and has been slipped to form the budget allocation for this project for 2017/18	Rolling programme	£300k (2014/15) £500k (2015/16) £500k (2016/17) £122k (2017/18)
Replacement of Room 14 x-ray equipment in Radiology (7176C0) A capital bid was submitted for the replacement of this equipment owing to its age and decreasing performance which has led to safety concerns. *All safety concerns have been addressed during this interim period.* The clinical evaluation has been completed and the tender awarded. The enabling works element of the tender is being finalised between the Trust and the PFI provider. The project was planned for installation and completion by December 2017. However, this has now slipped to March 2018.	March 2018	£318k
Operating tables replacement (7172C0) A rolling replacement programme has been funded for the replacement of the operating tables in Main Theatres and DSU.	March 2018	£150k

Medical Devices schemes	Completion date	Budget cost
3 will be replaced in this financial year but a tender is being undertaken for all tables to enable a call off arrangement to be implemented. The clinical evaluation has been completed and the tender is due to be awarded.		
Donated Assets		
Tomography machine for Ophthalmology As part of the business case for the appointment of an Ophthalmology Consultant to implement a Consultant-led anterior segment service, the Charitable Trustees approved funding for an anterior segment tomographer. The Consultant is now in post and a tendering exercise is being undertaken.	March 2018	£43k
2nd MRI scanner The Stars Appeal have launched a fund raising campaign for a 2nd MRI scanner. The specification and most appropriate location are being finalised.	March 2019	£1.5m