# Bundle Trust Board Public 3 October 2019

1 Opening Business

1.1 10:00 - Patient Story

1.2 10:20 - Welcome and Apologies

*Apologies from Paul Miller*

1.3 Declaration of Interests

1.4 10:25 - Minutes of the previous meeting

*Minutes of the Trust Board meeting held on 5 September 2019*

TB 1.4 DRAFT Public Board mins 5 Sept.docx

1.5 10:30 - Matters Arising and Action Log

TB 1.5 Action Log Public.docx

1.6 10:35 - Chairman's Business

*Presented by Nick Marsden*

1.7 10:40 - Chief Executive Report

*Presented by Cara Charles-Barks*

TB 1.7 2019 09 25 CEO Board Report Oct 2019_V3.docx

2 Assurance and Reports of Comittees

2.1 10:50 - Finance and Performance Committee Report - 24 September

*Presented by Paul Miller*
*Assurance*

TB 2.1 Finance and Performance Committee escalation paper 24th September 2019.docx

2.2 10:55 - Clinical Governance Committe Report - 24 September

*Presented by Paul Miller*
*Assurance*

TB 2.2 Clinical Governance Committee escalation paper 24th September 2019.docx

2.3 11:00 - Audit Committee Report - 19 September

*Presented by Paul Kemp*
*Assurance*

TB 2.3 Escalation report from Committee to Board - Audit Committee 19th September 2019.docx

2.4 Charitable Funds Committee - 19 September

*Presented by Nick Marsden*
*Assurance*

TB 2.4 Escalation report - Charitable Funds Committee.docx

2.5 11:05 - Workforce Committee Report - 26 September

*Presented by Michael von Bertele*
*Assurance*

TB 2.5 Escalation report Workforce Committee.docx

2.6 11:10 - Integrated Performance Report - August

*Presented by Lisa Thomas*
*Assurance*

TB 2.6a IPR cover sheet 191003 IPR.docx

TB 2.6b IPR October 2019 FINAL.pdf

3 Performance and Finance

3.1 11:30 - Winter Plan

*Presented by Andy Hyett*
*Assurance*

TB 3.1a cover sheet (24.09.19).docx

TB 3.1b winter 201920 (2).pptx

TB 3.1c Winter Plan 2019-2020 master v2.1.docx

4 Quality and Risk

4.1 11:35 - Patient Experience Report Q1

*Presented by Kat Glaister*
*Assurance*

TB 4.1 Q1 19_20 final Sept 2019.docx

4.2 11:40 - Learning from Deaths Report Q1

*Presented by Christine Blanshard*
*Assurance*

TB 4.2 Learning from death report Q1 19 20 Sept 19.docx

4.3 11:45 - Quality Improvement Progress Update

*Presented by Esther Provins*
*Assurance*

TB 4.3 Quality Improvement update Sept 2019.docx

5 Workforce

5.1 11:55 - National Staff Survey

*Presented by Glennis Toms*
*Assurance*

TB 5.1a Staff survey Sept 2019.docx

TB 5.1b National Staff Survey.pdf

5.2 12:00 - Fredom to Speak Up Guardian - Update

*Presented by Elizabeth Swift*
*Information*

TB 5.2 FTSUG Committee cover sheet Sept 2019.docx

TB 5.2b - FTSU Action Plan for NHSI 2019 (v4).docx

6 Governance

6.1 12:05 - Delegated authority to sign bank doumentation on behalf of the hospital charity

*Verbal update from Nick Marsden, Lisa Thomas and Cara Charles-Barks*

6.2 12:10 - Register of Seals

*Presented by Fiona McNeight*
*Approval*

TB 6.2 Register of Seals.docx

7 Closing Business

7.1 12:15 - Agreement of Principle Actions and Items for Escalation

*Nick Marsden*

7.2 Any Other Business

7.3 12:20 - Public Questions

7.4 Date next meeting

*Date of next public meeting - 7 November 2019*

8 12:25 - Resolution

*Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted)*

Salisbury NHS Foundation Trust

# Draft
# Minutes of the Public Trust Board meeting held at 09:00am on Thursday 5 September 2019 in The Board Room, Salisbury NHS Foundation Trust

**Present:**

| | |
|---|---|
| Dr N Marsden | Chairman |
| Ms T Baker | Non-Executive Director |
| Mr P Kemp | Non-Executive Director |
| Mr P Miller | Non-Executive Director |
| Ms R Credidio | Non-Executive Director |
| Mr M Von Bertele | Non-Executive Director |
| Mrs J Reid | Non-Executive Director |
| Mrs C Charles-Barks | Chief Executive |
| Dr C Blanshard | Medical Director and Deputy Chief Executive |
| Mr A Hyett | Chief Operating Officer |
| Mr P Hargreaves | Director of Organisational Development and People |
| Mrs L Thomas | Director of Finance |
| Ms L Wilkinson | Director of Nursing |

**In Attendance:**

| | |
|---|---|
| Esther Provins | Director of Transformation |
| Fiona McNeight | Director of Corporate Governance |
| Justine McGuinness | Head of Communications |
| Kieran Humphrey | Associate Director of Strategy |
| Paul Knight | Health and Safety Manager |
| Karen Crane | Nursing Assistant Orthopaedics (for minute TB1 05/09/1.1) |
| Lucie Patrick | Sister Orthopaedics (for minute TB1 05/09/1.1) |
| Alison Hemming | Outpatient Nursing Manager (for minute TB1 05/09/1.1) |
| Kylie Nye | Corporate Governance Manager (minutes) |
| John Mangan | Lead Governor (observer) |

**ACTION**

**TB1 05/09/01** **OPENING BUSINESS**

**TB1 05/09/1.1** **Staff Story**

P Hargreaves presented the story and explained that K Crane, L Patrick and A Hemming were attending the Board to talk about their experience of the managing attendance process and how support was provided and adjustments were made during the process to enable a successful return to work. PH explained that a lot of work had been done on the manager's toolkit to update management processes and feedback has been largely positive. The team spoke about their experience and the positive outcome from the managing attendance process.

**Discussion:**

- C Charles-Barks asked K Crane if there was anything further that could have been put in place from a prevention perspective. K Crane noted that she had been provided the appropriate support and her reason for being off was not

work-related. She noted that she had Occupational Health support prior to her absence too.

- P Miller asked K Crane if she had not fully supported in the way that had been described would she have returned to work as soon as she did. K Crane noted that she probably wouldn't have returned as soon as she had. She explained that her line managers had been very supportive and had never pressured her into returning to work.
- T Baker asked A Hemming if she had been trained in attendance management processes. A Hemming explained that she had received no formal training other than the attendance management sessions run by the Trust. However, she explained that she had been exposed to a number of attendance management situations in her career and as a manager you would always treat people as you would like to be treated. A Hemming did note that Occupational Health processes could be more efficient as the wait for appointments can sometimes be quite long.
- C Charles-Barks asked P Hargreaves if we get feedback from other members of staff off sick. P Hargreaves noted that feedback is not received in a structured way but noted that it would be useful to receive and review subjective feedback from staff.
- M Von-Bertele asked if external providers, for example GPs, were supportive and noted the importance of the relationship between the GP and Occupational Health. A Hemming explained that OH receive a medical report from the GP promptly, which ensures the process runs smoothly.
- A Hyett thanked the team for presenting their experience of the attending management experience. A Hyett noted that the discussion had made him reflect that HR policies are meant to result in a positive outcome and it would be worth reinforcing this when the policies are presented at the relevant committees.
- N Marsden thanked the team for sharing their story and noted that workforce is fundamental to what is discussed at the Trust Board meetings.

**TB1 05/09/1.2** **Welcome and Apologies**

There were no apologies.

**TB1 05/09/1.3** **Declarations of Interest**

There were no declarations of interest pertaining to the agenda.

**TB1 05/09/1.4** **Minutes of the part 1 (public) Trust Board meeting held on 1 August 2019**

The minutes were agreed as a correct record of the meeting held on Thursday 1 August 2019.

**TB1 05/09/1.5** **Matters Arising and Action Log**

**Delayed Transfers of Care (DTOC) –** A Hyett noted that the DTOC data had been discussed at F&P. Item Closed.

N Marsden noted that all other actions were closed or related to a future agenda item.

**TB1 05/09/1.6** **Register of Attendance**

N Marsden presented the Trust Board register of attendance.

L Wilkinson asked if the term 'authorised absence' could be changed as it's not clear what this includes.

**TB1 05/09/1.7** **Chairman's Business**

N Marsden reported that the new Terms of Reference had been published from the newly joined NHS England and NHS Improvement in relation to how performance will be assessed. N Marsden noted that the way in which the regulators assess performance will become apparent over the next few months. The first NHS Oversight meeting in over a year is scheduled for Monday 9 September and N Marsden noted this may provide the Trust with more of an indication of how the national profile is tested against the organisation.

**Discussion:**

- PK queried if the rust will be reporting on any new measures. It was confirmed that the Trust does not have to report any further information to NHSE/NHSI than already reported.

**TB1 05/09/1.8** **Chief Executive's Report**

C Charles-Barks presented her report and highlighted the following key points:

- July was a busy month with 29 out of 31 days exceeding 130 ED attendances. The Trust achieved 90.5% against the 95% four hour target. There have been concerns regarding July's financial performance as the Trust fell short of the control total, reporting a deficit of £0.4m when a modest surplus had been planned. This has resulted in the Trust not being able to recognise £0.5m PSF and Financial Recovery Funding. Efforts are being made to improve the financial position, both in the short and longer term, with particular focus on the booking of theatre lists, patient flow through the hospital (Ready-Steady-Go), and the outpatient transformation project.
- Whilst recruitment remains a challenge there were 46 starters in July, with 17 of these being international nurses. These newly appointed nurses are settling in well and are being well supported to ensure they are introduced to the Trust and community in a sustainable way. C Charles-Barks noted that this time of year is a busy period for the organisation with a

new rotation of registrars, FY1s and FY2s. Good feedback has already been received from the junior doctors and they are already settling into the Trust.

- The Trust is moving forward with its transformation agenda to ensure a service can be provided that is fit for the future. The Trust is changing its approach to improvement, which means a cultural shift away from top-down hierarchy to an environment where leaders set direction and empower staff to take action.
- The Annual General Meeting is to be held on 30 September for our members and the local community. It starts at 5pm at the Arts Centre, Salisbury.
- The pharmacy's new purpose built dispensing robot, Rowa Vmax robot automatically stores and locates over 25,000 medicines and can dispense up to three items within 12 seconds. The pharmacy team have named the robot Kryten, after the android from the television sitcom, Red Dwarf.

**Discussion:**

- T Baker noted the positive impact of the newly appointed overseas nurses but asked what the Trust are doing practically to manage the risks around retention of these members of staff. L Wilkinson noted that the new members of staff are receiving a lot of support via the Education team. P Hargreaves noted that he and Rex Webb, the Equality and Diversity Lead, had been discussing further ways to support these members of staff and integrate them into the Trust and wider community.
- L Wilkinson asked which specialties were presenting at the Annual General Meeting. J McGuinness explained that the End of Life Care Team were presenting, there would also be a military focused presentation and a recent patient story presented at the Board regarding a paediatric burns victim is also scheduled to be presented.

**TB1 05/09/2** **ASSURANCE AND REPORTS OF COMMITTEES**

**TB1 05/09/2.1** **Finance and Performance Committee Report – 3 September**

P Miller provided a verbal update from the F&P meeting held on Tuesday 3rd September. The following key points were noted:

- In July the Trust reported a £394k deficit against an expectation of £684k surplus. The committee discussed the mitigating actions for the rest of the year based on key scenarios. P Miller noted that the initial £4m risk against achieving the 2019/20 control total is now at approximately £4.5m.
- There were two business cases recommended for approval, including Cath Lab Replacement and PACS Contract Extension. It was noted that these business cases were to be discussed in the part 2 Private Trust Board.
- The committee discussed operational performance versus

strategic issues and it was noted that a wider discussion would take place as part of the strategy session later in the day.

**TB1 05/09/2.2** **Integrated Performance Report**

P Hargreaves presented the report and highlighted the following key performance issues at Month 4:

- Overall in July activity levels were higher than the same period last year, however were below planned levels for 2019/20. This has had a negative impact on the Trust's financial position as discussed earlier in the meeting.
- The Trust achieved 90.5% against the target trajectory of 89.5%. The metrics across performance and quality reflect the capacity within the Trust as DTOCs increased in month. However, bed occupancy remained fairly consistent and escalation bed days were comparably low.
- Whilst C Difficile rates show an increase, this reflects the change in national reporting, rather than deterioration in underlying performance.
- The key risks to the Trust performance metrics at the moment are issues surrounding the Diagnostic standard (DM01) with particular problems in Endoscopy. The ongoing issues are being mitigated but still remain a focus for the Executive Team. Weekend HSMR has increased based on a 12 month rolling average for the 7th month in a row. A detailed piece of work is underway to investigate and a paper is going to September's Clinical Governance Committee (CGC) with the outcome of this work and recommendations. The third key risk to Trust performance is the achievement of the Financial Plan for 2019/20. The lower than planned productivity levels in elective and day case activity, alongside lower levels of non-elective activity are concerning and recovery plans are in place, with ongoing monitoring.

**Discussion:**

- L Thomas explained that whilst July's activity was much lower than planned, the Trust had already planned low activity for August and it is therefore hoped that this may help to recover the financial position. L Thomas further noted that the Trust is in discussions with commissioners, particularly in relation to DTOC patients, who are unable to be discharged into the community due to external factors. However, L Thomas noted the issue is not all externally driven and hospital processes also needed to be reviewed.
- P Miller noted that with the exception of elective outpatients, the Trust is busier than it was in 2018/19. PM noted that the issue is not related to the Trust doing less work but it's about working differently.
- C Blanshard noted that activity last year included the additional activity undertaken by consultants, which has now been affected by the change to pension tax rules. The consultant body is reluctant to do any additional activity which

has affected performance this year. P Kemp noted that the issue is capacity, not demand. C Charles Barks noted that capacity needs to be utilised more efficiently and further work, particularly in theatres, is underway to look at this.

- R Credidio made reference to the variance in annual leave during the month and how this affects income and asked if the Executive Team were comfortable with the annual leave process. LT noted that the annual leave planning process required further work and this was being picked up by Workforce Committee.
- P Kemp thanked L Wilkinson on enhancing the data included on care hours per patient, per day. However, he questioned the table providing the % fill of registered nurses and Health Care Assistants as in the day it suggest the Trust was 3,000 hours short of plan. L Wilkinson assured P Kemp and the Board that this equated to a 92% fill rate and the wards were safely staffed. L Wilkinson noted that F Hyett was doing a piece of work to break down these figures even further to provide a more detailed analysis of nursing staff.
- P Hargreaves noted that non-medical staff appraisals had reduced. It was noted that there are plans to recover this position prior to winter and each performance metric is discussed with Directorate Management Teams to provide a focus for improvement.
- T Baker queried if the Trust measures readmission rates for stranded patients. A Hyett explained that readmission rates are reviewed in relation to super stranded patients; the next priority is to look at readmission rates for the stranded patients. T Baker asked for this information to be included in future reports. **ACTION: AH**
- P Miller asked if the Board would be getting assurance in October that the Trust is on track to achieve its control total at year end. N Marsden explained that an important piece of work to focus on is reviewing the root causes of how the Trust's financial performance declined in month 4 and what the next steps will be to recover this position. C Charles-Barks noted that further conversations were also required with commissioners and external partners going into a busy winter period. P Miller noted his understanding of the uncertainties but explained that the Trust will need to work on a revised forecast during October and therefore information will be required at the next F&P and Board as to how the Trust is planning on recovering its financial position. The Board agreed that a paper on the 2019/20 forecast will come back to September's F&P. **ACTION: LT**
- C Charles-Barks noted that the Trust is taking the rise in weekend HSMR very seriously and a paper is coming to CGC in September, following a detailed piece of work to investigate this increase.

**AH**

**LT**

**TB1 05/09/3** **QUALITY AND RISK**

**TB1 05/09/3.1** **Well Led Action Plan**

F McNeight presented the CQC Well-Led action plan update and the following key points were noted:

- The Trust commissioned an external review of the Well-Led Framework by Deloitte and 32 recommendations were identified in the report provided in May 2018.
- An action plan was subsequently implemented and a number of actions were progressed over the following 8 months, with regular oversight by the Executive Team through reports to the weekly Executive meeting.
- The CQC undertook a well-led inspection in December 2018 which provided further focus on improvement actions required. This led to a new action plan which was set to progress over 12 months. The progress has been reported back at regular Well Led Steering Group meetings, based around the key lines of enquiry (KLOE) to provide updates and assurance on progress.
- Board Committees will be picking up the oversight of this work going forward, with an ongoing focus in Directorate Governance Meetings and Executive Performance Reviews.
- There has also been a particular focus on horizon scanning and looking at a number of areas of focus going forward.

**Discussion:**

- P Miller noted that in terms of process and governance arrangements, some work was required on escalation and how reports feed into meetings and committees. L Wilkinson noted that looking into committee oversight in relation to strategies and work programmes is a priority.

**TB1 05/09/4** **WORKFORCE**

**TB1 05/09/4.1** **Health and Safety Annual Report**

P Knight joined the meeting to present the Health and Safety Annual Report which had been presented at the last Workforce Committee. The following key points were highlighted:

- Regarding injuries to staff, statistically the Trust is showing an improvement of 20% in handling injuries. Whilst violent and aggressive behaviour has shown an increase, staff injuries have not. P Knight noted that incidents in general have not peaked in any specific categories.
- The Corporate Self-Audit Results for medical records and specifically spinal, reflect the working conditions of these areas. The audit is framed around the workplace regulations and that is for medical records, space and the utilisation of such and for the spinal unit, the fabric and the fit for a modern work environment being the pressure points.
- In relation to HSE Research Report on the effect of ‘safe sharp’ legislation, the Trust has reasonable assurance of

compliance against this.

**TB1 05/09/5** **CLOSING BUSINESS**

**TB1 05/09/5.1** **Agreement of Principle Actions and Items for Escalation**

N Marsden noted that the key items of escalation were:

- The Trust's financial positon and the update that is planned for September's F&P Committee meeting on the 2019/20 forecast and financial recovery.
- The paper on weekend HSMR that is going to be presented at September's CGC meeting and will be reported back via the escalation report to the Board in October.

**TB1 05/09/5.2** **Any Other Business**

There were no other items of business.

**TB1 05/09/5.3** **Public Questions**

There were no questions raised by the public.

**TB1 05/09/5.4** **Date of Next Meeting**

Thursday 3rd October, 2019, Board Room, Salisbury NHS Foundation Trust

**TB1 05/09/6** **RESOLUTION**

Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

3 October 2019

List of action items Trust Board Public – 3 October

| Agenda item | | Assigned to | Deadline | Status |
|---|---|---|---|---|
| 1.5 Matters Arising and Action Log | | | | |
| 58. | Medical Workforce Incl. Weekend HSMR, Hospital at Night Team and GoSW | Blanshard, Christine | 24/09/2019 | Completed |
| | *Explanation action item*<br>A paper will come to September's CGC meeting in relation to the review of weekend HSMR.<br><br>A further, broader paper will also come to September's CGC meeting providing assurance that the organisation is safely staffed, particularly at weekends and out of hours.<br><br>A potential staffing gap has been recognised against Royal College of Physicians guidance. A paper outlining options to fill this gap will be coming to September's Workforce Committee. | | | |
| 59. | Guardian of Safe Working Report | Blanshard, Christine | 03/10/2019 | Completed |
| | *Explanation action item*<br>The Guardian of Safe Working report cover sheet to provide a wider context to support the content of the report. | | | |
| 2.2 Integrated Performance Report | | | | |
| 56. | Readmission Rates - Stranded Patients | Hyett, Andy | 26/09/2019 | Pending |
| | *Explanation action item*<br>TB requested data on readmission rates of stranded patients to be included in the next IPR | | | |
| 57. | 2019/20 Forecast | Thomas, Lisa | 03/10/2019 | Completed |
| | *Explanation action item*<br>The Board agreed that a paper on the 2019/20 forecast will come back to September's F&P | | | |

| Report to: | Trust Board (Public) | Agenda item: | 1.7 |
|---|---|---|---|
| Date of Meeting: | 3 October 2019 | | |

| Report Title: | Chief Executive's Report | | | |
|---|---|---|---|---|
| Status: | Information | Discussion | Assurance | Approval |
| | Yes | | | |
| 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:<br><br>• **Performance –** update on current performance<br>• **Finance –** update on our financial recovery plan<br>• **Workforce –** update on workforce situation<br>• **Annual General Meeting**<br>• **Improving our staff awards**<br>• **NHS South West Military Challenge**<br>• **STP Update** |

**Performance**

The Trust met the 4 hour emergency department standard in August; 95.6% of patients who attended A&E in August were admitted, transferred or discharged within four hours. This is the first time the hospital has achieved this demanding national standard since April 2018 - a refection of the hard work and dedication of our staff.

The Trust continued to provide good quality, safe care and again had no cases of MRSA. There were four case of C.difficile in August, bringing our total for the year to 13 which exceeds our annual target of nine. This increase was anticipated due to the inclusion of community onset healthcare associated cases in our figures. We are in regular contact with NHSI and the CCG and we will be conducting an internal 'deep dive' review in September to ensure any learning is acted upon.

**Finance**

We reduced our shortfall against our financial control total in August, reporting results £0.4m better than planned. We will need to out-perform our plan by a further £0.6m in September to recover the quarter's shortfall and earn a further £1.4m in incentive payments for financial performance. Delivery through the rest of the year continues to look stretching. There are pressures on the emergency care bed base, planned care productivity is proving challenging, and there are increasing outsourcing costs to support areas with key capacity constraints. We are reviewing all internal actions available to address these risks.

We are also working closely with our BSW system partners to agree plans to identify and mitigate system operational and financial risks as we move into the winter period.

**Workforce**

We continue to organise recruitment events and campaigns, both domestically and overseas, and in addition have attended a Jobs Fair and organised an event for Nursing Assistants this month. Internationally we have developed a healthy pipeline of registered nursing appointments, with good numbers arriving monthly - for example 10 arrived this month and we are expecting a further 25 in October. We continue to undertake Skype interviews with international nurses who have already passed the International English Language Testing System (IELTS). The Trust's overall sickness absence rate has decreased in the last month to 3.53%, above the 3% target, with long-term absence increasing and short-term absence decreasing. We are managing cases proactively in conjunction with the Head of Occupational Health, with the aim of reducing it back below target to a sustainable level. Mandatory training and medical appraisals are above target, whilst non-medical appraisals are amber at 84.15%. Individual plans should bring these back to green for September.

**Annual General Meeting**

As mentioned in my last report, on Monday 30 September, the Trust will hold the Annual General Meeting for our membership and the local community. The AGM will cover the Trust's performance in 2018/19, our plans for 2019/20, and what we aim to achieve in the future.

Ahead of the Annual General Meeting we have released a digital, user-friendly summary of our annual report. The hospital is proud of the work its staff do to support the local community to live longer, healthier lives. The annual report showcases achievements for 2018/19, our plans for the future as well as the Trust's financial position and the challenges we currently face. To make this information accessible and digestible for the community, a bitesize digital summary document has been created and released to the public. The digital summary can be viewed here.

**Improving our staff awards**

To better recognise staff for the outstanding work they do, which reflect our core values, there are some exciting changes taking place to the Trust's staff awards. Our 'Striving for Excellence' annual awards are changing to become 'Outstanding' awards, in line with our vision of delivering an 'outstanding experience every time'. Outstanding staff will be recognised on a monthly basis so that our values are celebrated regularly throughout the year.

Every month we will be giving two awards.  One award will focus on one of the Trust's four core values. This will be launched in October with the value 'responsive'.

We will also be recognising one staff member every month who has been nominated through our 'SOX – Sharing Outstanding Excellence' staff and public recognition program with a 'SOX of the month'.

There will continue to be an annual 'Outstanding' awards ceremony, a stand-out event that celebrates the fantastic work that takes place across our Trust undertaken by staff, volunteers and our charities. The long service awards will now also take place every six months and the Trust will continue to have an annual event to celebrate innovation.

**NHS South West Military Challenge**

A team from our hospital competed against 19 other teams from across the NHS in the recent NHS South West Military Challenge. Congratulations and well done to the team who came fourth overall. Our team of seven was made up of clinical, scientific and finance staff who performed a number of physical and mental tests. I'm so proud of the team, how they worked together and how they represented our organisation.

**STP Update**

**BSW Clinical Commissioning Group**

An application was recently submitted to apply to merge BaNES Swindon and Wiltshire CCGs into a single Clinical Commissioning Group. This application was approved at a meeting of the BSW Governing Bodies on 25 September and this will now go forward to NHS England for final approval.

Once approval has been granted by NHS England, a mobilisation programme will be put in place to formally become one CCG, known as NHS BaNES, Swindon and Wiltshire Clinical Commissioning Group, on 1 April 2020.

**Response to the Long Term Plan**

As an STP we are required to submit an operational delivery plan detailing how we as an STP will meet all of the requirements outlined in the NHS long term plan

Expectation is that financially the system will need to meet 5 tests:

1. Financial Recovery
2. Clarity on efficiencies to enable financial sustainability
3. How demand will be moderated
4. Approach to reducing unwarranted variation and deliver tangible improvements in health outcomes and patient experience
5. Capital investment priorities

Next steps in the development of the plan as identified by BSW include:

- Move forward on the development of a **systemwide financial recovery plan**; taking into account:
    - Impact of implementing national programmes to improve productivity: making best use of clinical time, procurement, pathology and diagnostic imaging, meds management, reducing admin costs
    - best use of estates and capital, evidenced-based programme
- Local schemes aimed at:
    - reducing pressure on emergency services, such as HIUs
    - transforming out of hospital community and primary care services

  - impact of shared care decision making tools
  - out of hours crisis support for mental health
- **Use of digital technologies** to improve interoperability, online access to appointments, digital scanning and outpatients
- Review programmes aimed at reducing unwarranted variation - Provider Alliance GIRFT, NHSE/I latest Right Care pack, national CVD and Respiratory Programmes
- Transformational Programmes including QI and use of population health analytics to shape services at a locality level
- Clarify **Capital Investment Priorities** - systemwide workshop being rescheduled and in the meantime work being undertaken to consolidate current and future programmes
- Impact of **Workforce –** triangulation with finance and activity and new care models

Delivery timetable:

- First draft by **27 September**
- Plans to be agreed by **15 November**
- Approval by organisational Boards by **Wednesday 13 November** prior to submission

**Interim Director of People STP**

The STP has appointed an Interim Director of People for six months to support the development of the system workforce plan and also the merger between the three CCG's.

The post is a job share between Alison Kingscott and Sheridan Flavin.

**System Risk Summit**

On 11 October 2019 there will be a system risk summit which the CEO, Director of Finance and the Chief Operating Officer will attend.

The purpose of the risk summit is to collectively review risks regarding winter demand and capacity, elective demand and capacity and forecast financial outturn for all provider organisations.

**Cara Charles-Barks**
**Chief Executive**

**CLASSIFICATION:**

Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Trust Board (Public) | **Agenda item:** | 2.1 |
| **Date of Meeting:** | 3rd October 2019 | | |

| | | | | |
|---|---|---|---|---|
| **Committee Name:** | Finance and Performance | | **Committee Meeting Date:** | 24th September 2019 |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | | | X | |
| **Prepared by:** | Paul Miller, Non Executive Director | | | |
| **Board Sponsor (presenting):** | Paul Miller, Non Executive Director | | | |

| **Recommendation** |
|---|
| To note key aspects of the Finance and Performance Committee meeting of the 24th September 2019. |

| **Items for Escalation to Board** |
|---|
| **Operational Performance 2019/20 (including Winter Plan)** – August was a good month operationally our Emergency Department performance was 95.6%, our best since April 2018, our referral to treatment (RTT) performance stands at 92.7% despite increasing referrals, our diagnostic performance in month stands at 99.6% and our cancer waiting times continue to perform consistently in line with previous months.<br><br>However despite this the second half of the year is forecast to be very challenging, with significant numbers of delayed transfers of care, uncertainty about winter flu and clinical staffing constraints. The Winter Plan was presented, which included four scenarios, with scenario 1 (two months of planned inpatient escalation) currently built into our financial budget. If the more challenging scenarios actually occur then the Trust will face difficult prioritisation choices about (a) "protecting" elective capacity, (b) funding even more urgent care escalation capacity and (c) flexing our currently very good operational performance.<br><br>The conclusion of these discussions were that the issues were complex, still emerging and still moving, therefore it was impossible for the Committee to make a hard and fast decision at this meeting on what to do next. Rather the Committee recognised that operational choices would need to be made quickly, based on events as they happened, but at this stage there was no appetite to increase the financial budget and commission more inpatient escalation beds at this stage. |

**Diagnostic Services** – The Committee was briefed on the background to our "diagnostic services hot spots" and the current constraints that hamper simple solutions in the short and medium term. The conclusion was the safety of services was the highest priority, alongside the welfare of our staff, but a balance may have to be struck around (a) how much the Trust can afford to spend on further out-sourcing diagnostic services (given our financial challenges) and (b) protecting our currently very good operational performance. Finally, there was also a key inter-dependency, which is diagnostic capacity is essential to support elective flow in the hospital and elective activity is key to us hitting our financial targets in 2019/20. All of which re-enforces the importance of making the best possible operational prioritisation decisions going forward.

**Financial Performance 2019/20 (including outturn forecast)** – As at the 31st August 2019 (M5) the Trust was cumulatively overspent by £5.5m against a NHS Control Total target of £4.9m. This was despite a surplus of £381k in August itself, all of which means that the Trust is cumulatively £635k behind its NHS Control Total plan as at the 31st August 2019.

Of further very significant concern was the updated 2019/20 financial outturn forecast, which identifies £3.6m of financial risk that the Trust will need to successfully address if we are to achieve our agreed NHS Control Total deficit of £8.854m. Key to addressing these risks will be (a) our Cost Improvement Plans, (b) discussions with Commissioners and other NHS organisations around new forms of system contracting in 2019/20 and (c) which of the various Winter scenarios actually materialises.

Finally the Trust Board will need to consider its position at the next Board meeting on the 3rd October 2019 with regard to our current £8.8m deficit forecast to be declared at Q2 and my personal view is to hold to our current agreed forecast deficit of £8.8m, until the 31st December 2019 (Q3), when we will be clearer as to how the various risks and opportunities have landed.

**Information update, current challenges and future plans** – The Committee received a detailed presentation on the background and current position of various parts of our Information and Information Technology services. The Committee noted progress but requested a fuller formal report on future plans at its November meeting on the 26th November 2019.

**Tender evaluation report for MRI Scanner** – This Tender evaluation report was received and the Committee supported the recommended option to award the tender. However given the value of the contract the formal decision would need to be made by the Trust Board at its meeting on the 3rd October 2019.

**Board Assurance Framework (BAF) and Corporate Risk Register** – Finally following the discussions at the Committee meeting the BAF and corporate risks were updated as necessary.

**CLASSIFICATION:**

Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Trust Board (Public) | **Agenda item:** | 2.2 |
| **Date of Meeting:** | 3rd October 2019 | | |

| | | | | |
|---|---|---|---|---|
| **Committee Name:** | Clinical Governance Committee | | **Committee Meeting Date:** | 24th September 2019 |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | | | X | |
| **Prepared by:** | Paul Miller, Non Executive Director | | | |
| **Board Sponsor (presenting):** | Paul Miller, Non Executive Director | | | |

| **Recommendation** |
|---|
| To note key aspects of the Clinical Governance Committee meeting of the 24th September 2019. |

| **Items for Escalation to Board** |
|---|
| **Quoracy of the Committee** – Unfortunately as there was only one non executive present at the meeting (despite the attendance of the Chairman) the meeting was not quorate and therefore no decisions could be made. However on a more positive note interviews for a new non executive with a clinical interest started on the 25th September 2019 and the appointed person would be a member of the Committee.<br><br>**Safeguarding, Internal Audit Report** – This report covered safeguarding for both children and adult services and the overall rating was a medium risk i.e. 3rd level out of 5. The report made 5 recommendations (3 medium risk and 2 low risk) and all recommendations had been accepted by management and all were being satisfactorily progressed within the agreed timescales<br><br>**Weekend HMSR and wider weekend working assurance** – there were a number of items on the agenda which facilitated a comprehensive triangulated discussion about the "risks "patients face being admitted or cared for in the hospital on the weekend, as opposed to a week day. These included the following reports;<br><br>(a) Weekend HSMR review, noting our May 2019 weekend HSMR has risen to 127<br>(b) Safety and effectiveness of services on the weekend<br>(c) Q1 Freedom to Speak Up: Raising Concerns Report |

(d) Q1 Learning from deaths report

(e) Diagnostics update

The conclusion of the lengthy discussion was there was still no simple explanation for the increasing weekend HSMR figure, therefore the answer was likely to be made up of number of separate multi-factorial issues. Unfortunately despite the wealth of information available there was no critical evaluation as to the likely key issues. Though it was agreed by the Committee that this was an area of increasingly significant concern for both (a) the safety of patients, though at this stage there was no clear evidence that patient safety was currently being compromised and (b) reputation, as the Trust is becoming flagged up as a statistical outlier on a number of external clinical and outcome indicators.

Therefore the recommendation of the Committee was that the Chief Executive work with her colleagues to get a clear action plan, based on a critical evaluation, back to the Committee at its next meeting on the 22nd October 2019 covering (a) clinical and operational actions that needed to be put in place to manage the "risks" and (b) any further investigations deemed necessary to assist the Trust in getting to the bottom of this important issue (note this could include asking 3rd parties for support).

**Q1 Freedom to Speak Up, Raising Concerns report** – The Committee received this report and the key outcome was following significant work on this area, the Trust now had effective systems and process in place to facilitate our staff to "Speak Up". Therefore the key imperative going forward was to ensure we continued to comply with these systems and processes.

**Diagnostic update** – This report both facilitate the discussion on weekend working (above) and it also facilitated a separate but related discussion about the importance of a range of diagnostic services to the safe and effective running of the hospital 24/7. The outcome of the discussion was despite performing well against the NHS Performance Indicators in this area (higher than 99%) there are areas of significant staff shortages that require considerable operational management to ensure service continuity. Furthermore the Committee accepted that going forward some elements of service prioritisation were inevitable in the short to medium term, with protecting patient safety as the clear priority.

**Board Assurance Framework (BAF) and Risk Register** – Finally in light of the discussions at the meeting the Committee reviewed the BAF and corporate risks and made changes as necessary.

Salisbury NHS Foundation Trust

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| **Report to:** | Trust Board (Public) | **Agenda item:** | 2.3 |
| **Date of Meeting:** | 3rd October 2019 | | |

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|---|---|---|---|---|
| **Report from: (Committee Name)** | Audit Committee | | **Committee Meeting Date:** | 19th September |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | | | X | |
| **Prepared by:** | Paul Kemp (Audit Committee Chair) | | | |
| **Board Sponsor (presenting):** | Paul Kemp | | | |

## Recommendation

The Trust Board are asked to note the items escalated from the Audit Committee meeting held on 19th September 2019

The Board is asked to consider the potential benefit of arranging discussions with the Audit Committees of other STP participants, with a view to potentially

- Discuss governance and assurance issues of mutual interest that do not fall entirely within the scope of any one organisation, but are of importance to the local health system
- Share examples of good practice

If the Board agrees that this should be progressed, guidance is sought on Terms of Reference and governance of such discussions.

## Key Items for Escalation

**Deep Dive Review of Agency Process**

The committee received a presentation from the Head of Resourcing and Director of OD and People regarding processes and controls associated with the hiring of temporary staff. This topic had been subject to audits in 2018 which had shown some control issues.

The presentation clearly outlined how the earlier issues had been addressed and the committee were assured that appropriate control and process was in place for this function.

**Annual Review of Committee Effectiveness**

Following discussion in committee and having received feedback from key stakeholders, the Committee concluded that the only significant potential improvement in its functioning would be to seek to discuss broader system wide governance and assurance issues that are within the local health system but beyond the scope of the Trust on its own. See Recommendation section

**Bi-annual Review of Board Assurance Framework**

The Committee reviewed the Trust's process in managing risk and the Board Assurance Framework (BAF). The committee noted recent changes made to process as agreed in Board, in particular the "horizon scanning" addition to process, and the additional risks that had been added to the BAF as a consequence.

Some specific questions and actions were discussed and passed for action to the Executive, but generally the Committee agreed that the process was effective and was evolving in a positive fashion.

Salisbury NHS Foundation Trust

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| **Report to:** | Trust Board (Public) | **Agenda item:** | 2.4 |
| **Date of Meeting:** | 3rd October | | |

| | | | | |
|---|---|---|---|---|
| **Report from: (Committee Name)** | Charitable Funds committee | | **Committee Meeting Date:** | 19/09/19 |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | | | X | |
| **Prepared by:** | Lisa Thomas- Director of Finance | | | |
| **Board Sponsor (presenting):** | Nick Marsden- Chair | | | |

## Recommendation

The Trust Board are asked to note the items escalated from the Charities Committee meeting held on 19th September 2019

The Committee considered a number of items including a presentation from HSBC as the holders of charity investment portfolio, with an update to the portfolio's results and a refreshed look at the committees risk appetite. Overall the investment has done well in the context of the wider market performance.

The Committee considered the work of the fundraising manager and wider team who presented a report highlighting ongoing success.

The committee also started to undertake a strategic review of its governance and role with a discussion confirming work needed to commence to refresh the strategy. The committee would consider the resource plan at the next committee.

## Key Items for Escalation

The board approved a number of charitable fund bids including

- Blood pressure machine for outpatients
- Point of care scanning for neonatal
- An anti-gravity treadmill for wessex rehab services

Salisbury NHS Foundation Trust

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| **Report to:** | Trust Board (Public) | **Agenda item:** | 2.5 |
| **Date of Meeting:** | 3 October 2019 | | |

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|---|---|---|---|---|
| **Report from: (Committee Name)** | Workforce Committee | | **Committee Meeting Date:** | 26/09/2019 |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | | | X | |
| **Prepared by:** | Michael Von Bertele | | | |
| **Board Sponsor (presenting):** | Michael Von Bertele | | | |

| **Recommendation** |
|---|
| The Trust Board are asked to note the items escalated from the Executive Workforce Committee meeting held on Thursday 26 September 2019: |

**Key Items for Escalation**

- The committee noted that the Annual Staff Survey is due and felt it would be valuable to review progress in addressing issues raised in last year's report.
- The Committee noted that there is a continuing issue with levels of junior doctor staffing in relation to demand and that locum and agency fees are running ahead of target as a result. The wider question of safer staffing including Hospital at Night is to be addressed in a subsequent paper.
- The Committee noted that HEE is starting to focus on a workforce plan for the whole of BSW but it does not seem to yet take account of predicted changes in medical practice and pathways.
- Some additional risks were identified for incorporation on the Corporate Risk Register (CRR).

Salisbury NHS Foundation Trust

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| **Report to:** | Trust Board (Public) | **Agenda item:** | 2.6 |
| **Date of Meeting:** | 03 October 2019 | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Integrated Performance Report | | | |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | ✓ | | ✓ | |
| **Prepared by:** | Kieran Humphrey, Associate Director of Strategy<br>Felicity Anscombe, Information Services Manager | | | |
| **Executive Sponsor (presenting):** | Lisa Thomas, Director of Finance | | | |
| **Appendices (list if applicable):** | | | | |

| **Recommendation:** |
|---|
| The Board is requested to note the report and highlight any areas of performance where further information or assurance is required. |

| **Executive Summary:** |
|---|
| The Integrated Performance Report consolidates the latest performance information and improvement actions across the Trust's strategic priorities.<br><br>The structure of the report is aligned with the Trust's key strategic priorities and their related (CQC based) assessment frameworks.<br><br>The progress made this month in the development of the report includes more detail on the use of Care Hours per Patient Day as a measure of staffing. Teams are focussed on the roll out of the Integrated Performance Report format to the reporting to Board Committees and other meetings of the Trust where performance is considered.<br><br>The Trust is performing positively against a number of indicators, achieving the Emergency Access 4hr target in August and continuing to meet the Referral to Treatment standard and the majority of Cancer diagnosis and treatment standards. Where specific action is required or risks have been identified that may affect future performance, these are set out in the commentary and analysis in the report.<br><br>Effective patient flow and discharge remains a challenge for the Trust and wider system to address – and patients delayed in hospital has increased in August. |

| |
|---|
| While the Trust has made some recovery of its financial position in month (August), it remains under plan against agreed control total. |

| **Board Assurance Framework – Strategic Priorities** | Select as applicable |
|---|---|
| **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 | ☒ |

NHS
Salisbury
NHS Foundation Trust

# Integrated Performance Report

**October 2019**

(data for August 2019)

An outstanding experience for every patient

# Summary

Salisbury NHS Foundation Trust

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: performance, quality, workforce and finance reports and seeks to set out the interlinking issues and plans to move forward the challenges faced.

This report for October 2019 Board is now in an agreed format using data and commentary available for performance in August 2019 across the Trust's services to produce a summary report.

The Structure of the Report is being designed to align with the Trust's key strategic priorities and their related (CQC based) assessment frameworks. This month's report includes further analysis of care hours per patient day (CHPPD) and data quality indicators have been updated following assessment of the Trust's data maturity index.

**Performance**

The Trust achieved some positive results against our key performance targets in August. 95% performance was delivered against the emergency access standard (4 hour); this was first time that the standard has been achieved since April 2018. The Trust also recovered the Diagnostic waiting time standard in month, the first time since March 2019.

However these headlines should not mask the challenges that are starting to emerge. Whilst RTT performance is positive the size of the waiting list has grown 7% since March 2019, indicating a misalignment between demand and capacity. Whilst the Delayed Transfers of Care remain above trajectory, particularly as we approach the winter, there are other measures that indicate our challenge is capacity rather than demand – underlining the importance of the Ready, Steady, Go programme achieving reduced length of stay and improved timely discharge. Our activity levels have not been at planned levels year to date, resulting in the Trust under delivering on its financial plan. This reinforces the need to ensure the transformation programmes deliver the change expected.

Weekend HSMR is significantly higher than expected an initial analysis has been undertaken to identify the root cause. This is being triangulated to staffing and bed occupancy rates at weekends. Overall the Trust continues to show very positive workforce metrics overall with a significant reduction in nursing vacancies, sickness levels have decreased and training has increased.

# Structure of Report

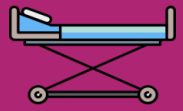
## Performance against our Strategic and Enabling Objectives

| Our Priorities | How We Measure | |
|---|---|---|
| Local Services | Are We Effective? | Are We Responsive? |
| Specialist Services | | |
| Innovation | | |
| Care | Are We Safe? | Are We Caring? |
| People | Are We Well Led? | Use of Resources |
| Resources | | |

# Summary Performance – August 2019

Salisbury NHS Foundation Trust

There were **2,712** Non-Elective Admissions to the Trust



We provided care for a population of approximately **270,000**

**17% of discharges** were completed before 12:00

We delivered **19,300** outpatient attendances


RTT 18 Week Performance: **92.7%**

Total Waiting List: **18,193** ↑

Emergency (4hr) Performance **95.0%** ↑

(Target trajectory: 90.6%)


We met **5 out of 8** Cancer treatment standards

**99.6%** of patients received a diagnostic test within **6 weeks**

**1,135** Patients arrived by Ambulance

We carried out **409** Elective Procedures & **1,937** Daycases

Our clinical income was **£19,301k** (£398k over plan)

Our overall vacancy rate was **3.98%** ↓

# Reading a Statistical Process Control (SPC) Chart

The two dotted grey lines represent the boundaries of "normal"

There should always be a minimum of 24 months worth of data

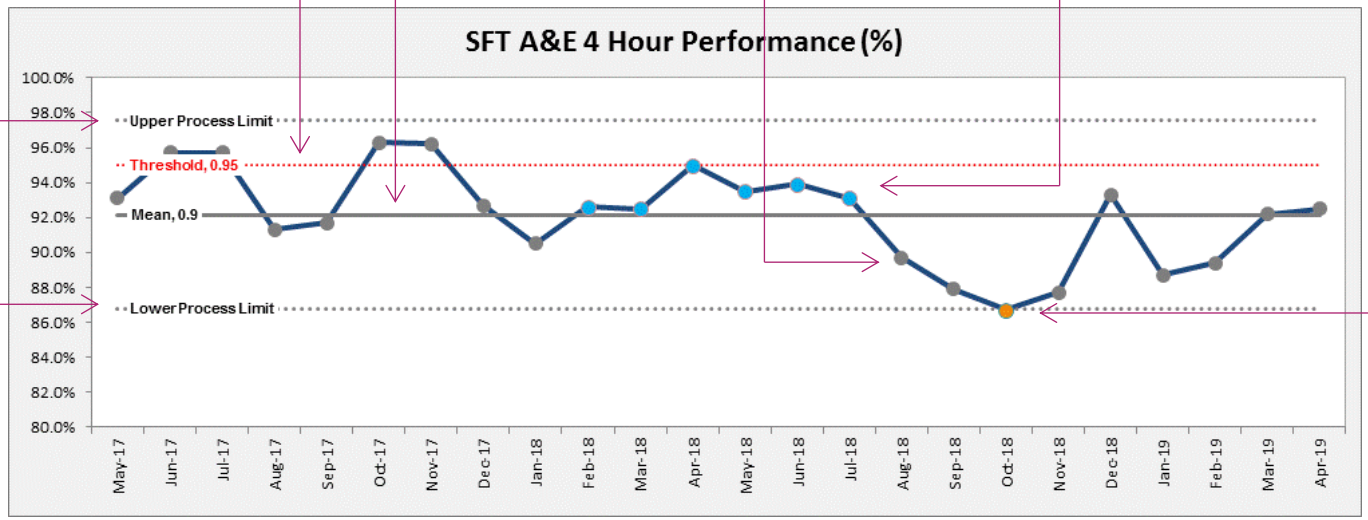
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

Blue markers indicate that there has been a marked improvement in performance, showing 6 or more points above the Mean or one point greater than the upper limit

Orange markers indicate that there has been a marked decline in performance, showing 6 or more points below the Mean or one point less than the lower limit




Statistical Process Control Chart Key:

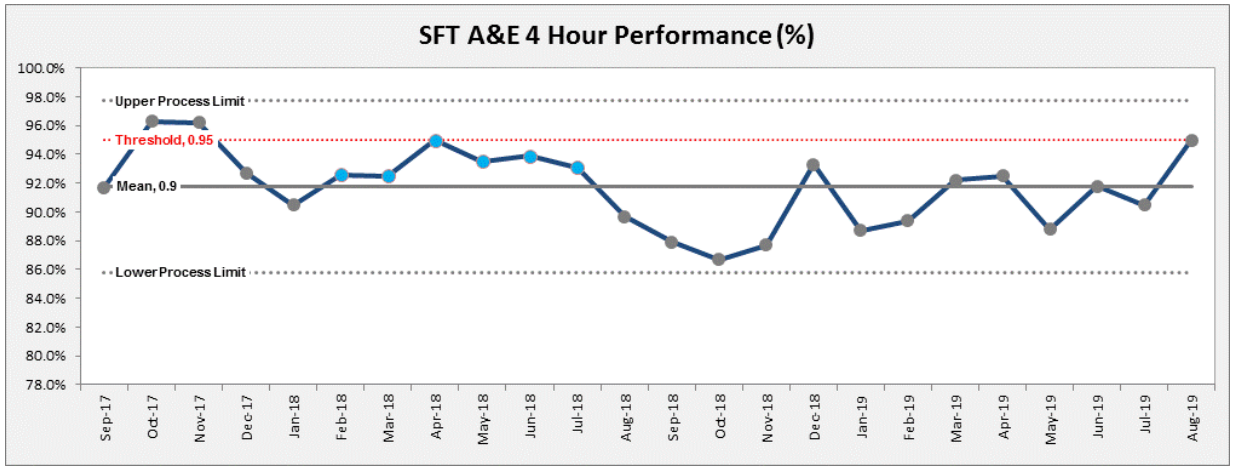
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (7 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (7 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

# Part 1: Operational Performance

| Our Priorities | How We Measure | |
|---|---|---|
| Local Services | Are We Effective? | Are We Responsive? |
| Specialist Services | | |
| Innovation | | |
| Care | Are We Safe? | Are We Caring? |
| People | Are We Well Led? | Use of Resources |
| Resources | | |

# Emergency Access (4hr) Standard Target 95% / Trajectory 90.6%

National Key Performance Indicators




| | |
|---|---|
| Data Quality Rating: | |
| Performance Latest Month: | 95.6% |
| Attendances: | 6233 |
| 12 Hour Breaches: | 0 |
| ED Conversion Rate: | 27.9% |

## Background, what the data is telling us, and underlying issues

95.6% of patients spent less than 4 hours in ED during August (against a trajectory target of 90.6%).

This represents the highest performance since April 2018.

Attendance figures, although lower than M4 were greater or equal to other months within 19/20, suggestive of similar levels of demand as previous months.

The Trust was able to reduce its alert status to OPEL 1 for 13 days in month.

## Improvement actions planned, timescales, and when improvements will be seen

ED action plan refreshed during M4 and implemented in M5 will continue with a focus on staffing, flow and leadership.

Recruitment into remaining medical vacancies continues to be challenge but also a high priority.

Ready, Steady, Go! patient flow programme with Deputy Lead for ED leading the Ready group has set its priorities for improvement (including clerking processes, SSEU function, OPAL and frailty interaction with ED, managing surgical expected patients through ED).

## Risks to delivery and mitigations

Increased demand

Lack of capacity for patients converting to admission due to lack of flow from out of the hospital (high DTOC, high acuity of patients)

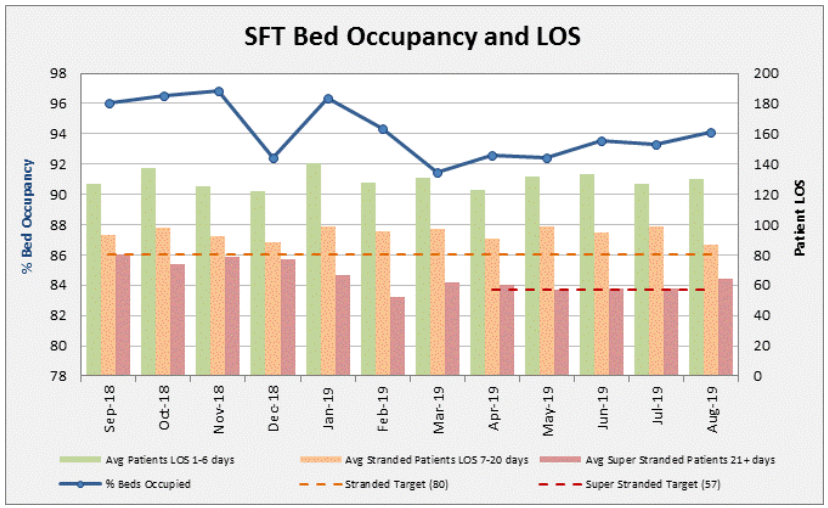
Workforce resilience and vacancies

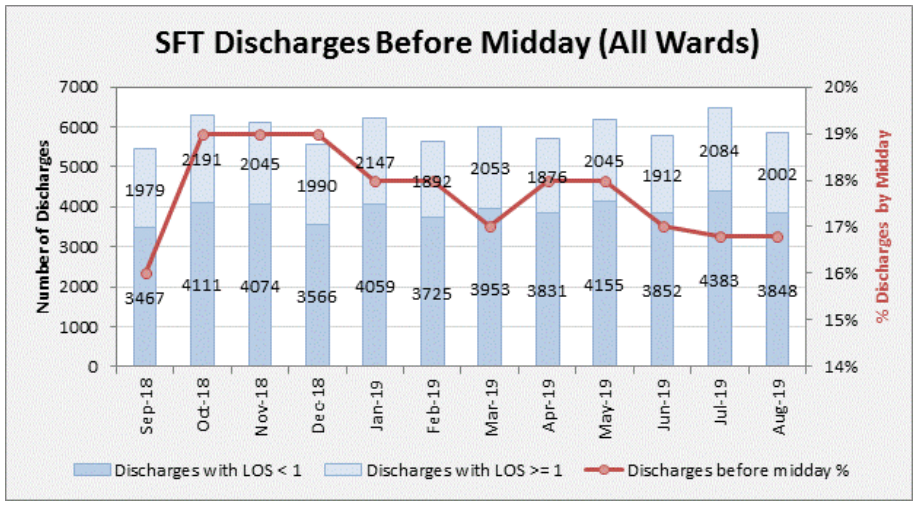
Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (7 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (7 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

# Patient Flow and Discharge

Are We Effective?




## Background, what the data is telling us, and underlying issues

Bed occupancy is beginning to climb in line with the Trust experience of increasing OPEL status through the month of August. There has been a clear decrease in the number of 14-21 LOS in addition to largely maintaining the level of 21+ LOS and 0-7 day LOS groups and we are now close to achieving both national targets for LOS set by NHSi.

Discharges before midday continue to be a challenge but performance is steady. Those with a LOS of >1 day contribute fewer numbers to the overall total indicating front door discharges are more likely to be successfully undertaken before midday.

## Improvement actions planned, timescales, and when improvements will be seen

- Expert panel now includes selected wards reporting against the 14 day + LOS and the impact of this has contributed to the positive improvement in this area. The 14 day + review will be further rolled out to wards not currently involved by November
- NHSi are feeding back the results from the analysis of national data regarding 21 day + stays on 5th November and SFT will use this to support and maintain improvements in practice here into December
- The patient flow program Ready Steady Go is now established with areas of improvement relating to flow identified and work underway. These areas are available separately to this report but include Criteria Led Discharge for example which will expand the opportunity for 7 day and pre midday discharges particularly from the back door. This is a significant piece of work and the timeline will be months

## Risks to delivery and mitigations

Winter pressures have commenced at SFT and all wards and departments will stretch to accommodate added numbers and demand on services

The lack of community capacity to discharge patients into the correct setting will impact upon the quality of care being provided by SFT.

# Delayed Transfer of Care (DToC) Bed Days

National Key Performance Indicators

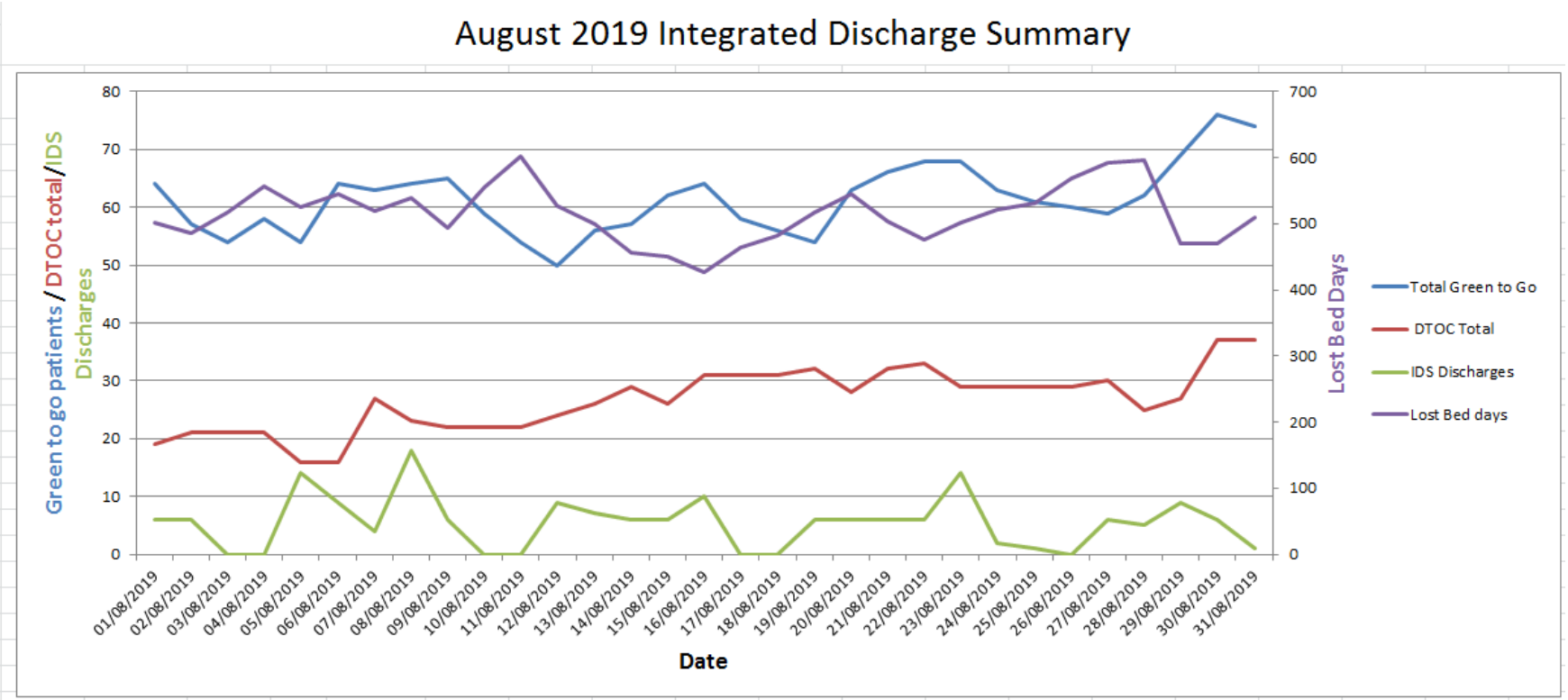
## Background, what the data is telling us, and underlying issues

There has been a jump in August regarding bed days lost to DTOC however the position is significantly better than that of the same time last year.

The data reflects particular challenges in social care in August from assessments to domiciliary care and placements.

When considered in conjunction with the LOS and bed occupancy data, the picture is of more timely internal Trust actions for all patients maintaining flow along pathway 0 but external resources being unavailable at the time required for pathways 1-3

The average DTOC number in Aug was 27. See action being taken and trend data on next slide.



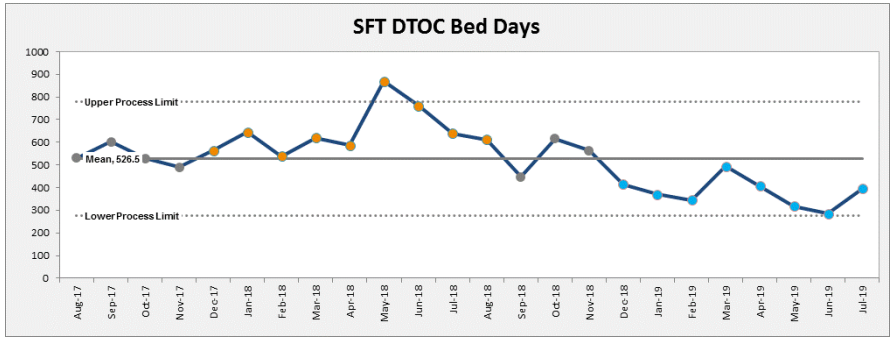
# Delayed Transfer of Care (DToC) Bed Days

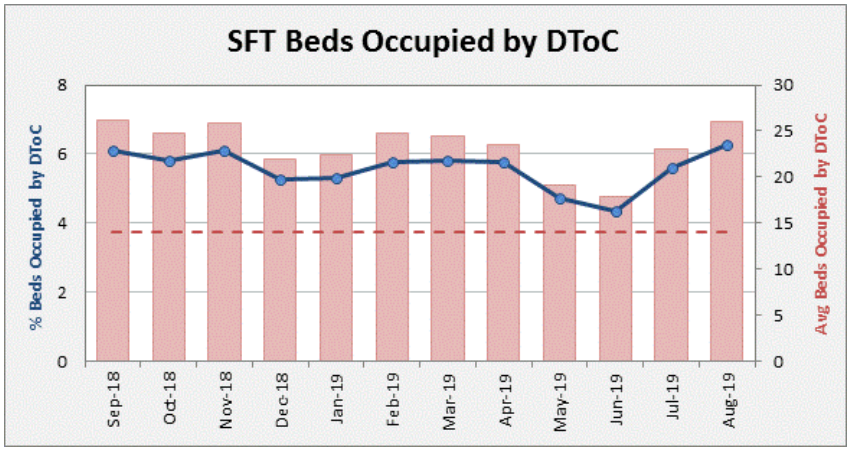
Data Quality Rating:

National Key Performance Indicators

Days Lost to DToC: NHS 122 + SS 340

DToC Patients (last Thursday of month snapshot): 26




## Improvement actions planned, timescales, and when improvements will be seen

Wiltshire Council are planning long term transformation work which will see the social care team at SFT undertake trials of new ways of working using strength based assessments. The Council are anticipating improvements in flow as a result and will begin a small trial in mid October, the results of which are likely to start to be reported on in December.

Results from the Wiltshire CCG choice audit remain outstanding and recommendations from this will be considered when this is received.

The IDB review is underway and elements of changes to roles, recording and reporting will be initiated by the beginning of November.

# Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

National Key Performance Indicators

SFT RTT PTL Volume by CCG:

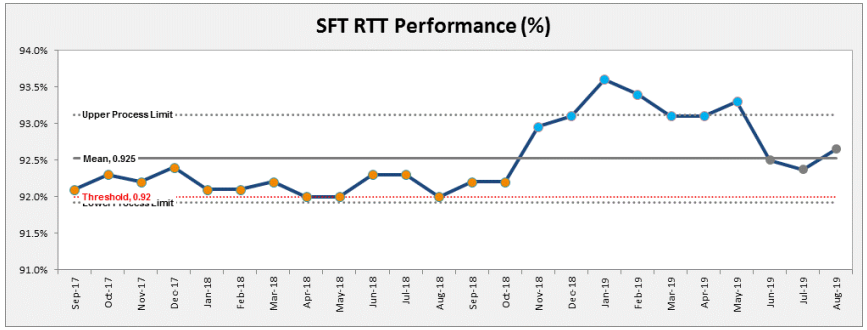
| Total WL | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dorset CCG (11J) | 2,424 | 2,459 | 2,537 | 2,588 | 2,650 | 2,762 | 2,760 | 2,771 | 2,832 | 2,845 | 2,871 | 2,889 |
| West Hampshire CCG (11A) | 1,565 | 1,620 | 1,639 | 1,666 | 1,628 | 1,696 | 1,748 | 1,638 | 1,667 | 1,690 | 1,743 | 1,695 |
| Wiltshire CCG (99N) | 10,335 | 10,343 | 10,441 | 10,192 | 10,384 | 10,500 | 10,328 | 10,540 | 10,478 | 10,718 | 10,630 | 10,809 |
| Other CCGs | 2,989 | 2,834 | 2,526 | 2,411 | 2,180 | 2,105 | 2,113 | 2,083 | 2,323 | 2,498 | 2,732 | 2,800 |
| **Trust Total** | **17,313** | **17,256** | **17,143** | **16,857** | **16,842** | **17,063** | **16,949** | **17,032** | **17,300** | **17,751** | **17,976** | **18,193** |

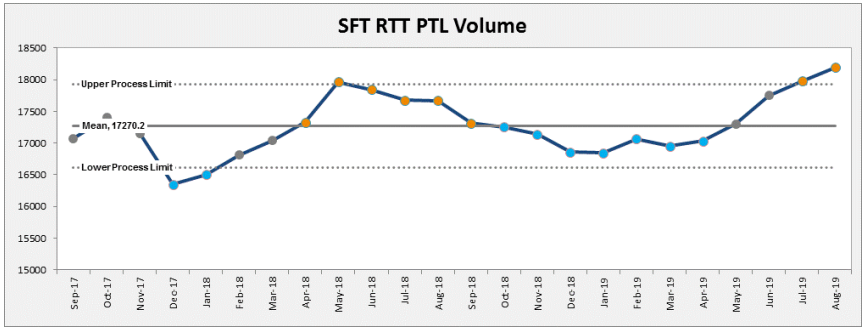
Data Quality Rating:

Performance Latest Month: 92.7%

PTL Volume: 18,193

52 Week Breaches: 0




## Background, what the data is telling us, and underlying issues

Overall RTT Performance Standard achieved with the 3 specialties of concern showing marginal improvements

**ENT** 90.68% (Up 0.78%) booking 1st appointment Jan 2020

**Urology** 84.62% (Up 2.62%) booking 1st appointment Feb 2020

**Dermatology** 62.03% (Up 0.35%) booking 1st appointment Aug 2020

The PTL continues to rise from April 18 (+1247)the most significant rise is again in the other CCG's which includes NHSE commissioned services and other CCG's which may indicate that patients are choosing SFT above their local services

## Improvement actions planned, timescales, and when improvements will be seen

The improvement actions outlined last month for the 3 specialties requiring attention continues .

**Dermatology –** A Skin Risk Summit is scheduled for October to focus attention on recovery plans and agree a clinical strategy

**PTL –** Further analysis into the rise of Other CCG's is on going and will be completed at the end of September

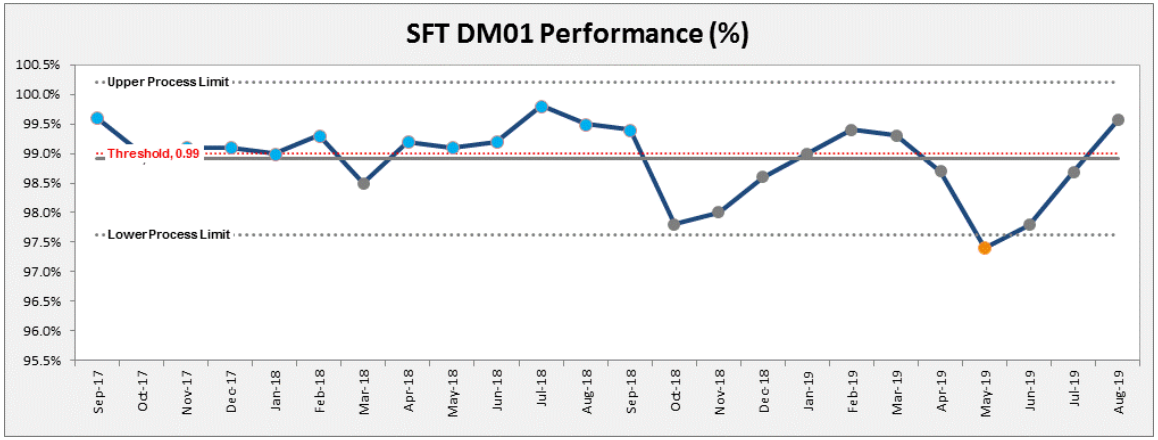
## Risks to delivery and mitigations

A greater than planned referral growth and unpredictable out of area referral creep. This will continue to be managed through monthly Planned Access and Contract Review Meetings.

No national resolution for the HMRC/Pensions issue which is restricting the ability to undertake additional activity.

# Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators




| | |
|---|---|
| Data Quality Rating: | |
| Performance Latest Month: | 99.6% |
| Waiting List Volume: | 3,632 |
| 6 Week Breaches: | 16 |
| Diagnostics Performed: | 7,451 |

## Background, actions being taken and risks and mitigations

Overall performance standard was achieved for the month this being in line with the performance recovery trajectory. A deep dive into diagnostic services will be presented at the September Finance and Performance Committee

**Endoscopy**
15 in month breaches

The procurement process is in the final stages and the contract will commence late September for 15 weekends of activity. This will ensure that performance is maintained and start to address the long waiting times which is vital to safeguard SFT's JAG status. The Lead Clinician for the service has retired and returned during August

**Radiology**
1 MRI in month breach

**Radiology Reporting** continues to be a challenge to the service, due to additional activity being undertaken to accommodate demand and due to our current provider for outsourcing reporting notifying us that they will be reducing our capacity by 70%. The being mitigation plans agreed in July and put in place during August has stabilised the situation. There are contractual and technical discussions taking place with a view to replace the lost outsourcing capacity with another provider.

# Cancer 2 Week Wait Performance Target 93%

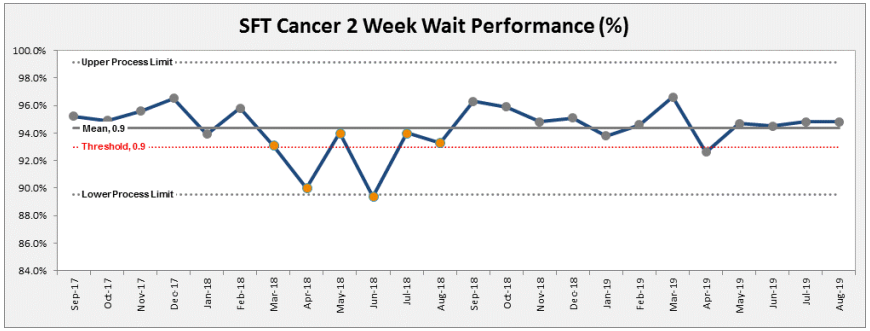
National Key Performance Indicators

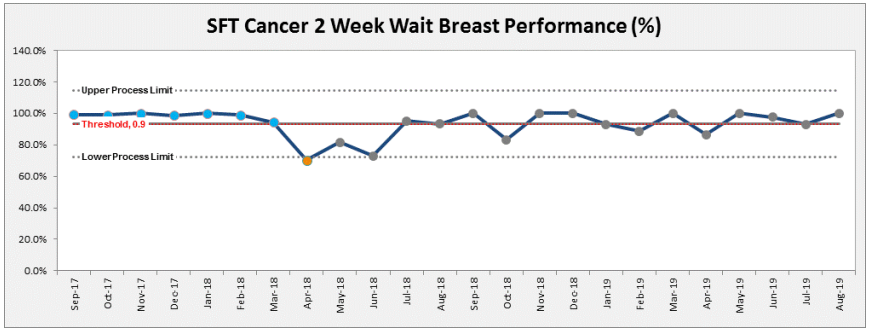
Performance Latest Month:

Two Week Wait Standard: 94.9%

Two Week Wait Breast Standard: 100%

Data Quality Rating:




## Background, what the data is telling us, and underlying issues

For both standards, there is no significant variation in performance since September 2018

## Improvement actions planned, timescales, and when improvements will be seen

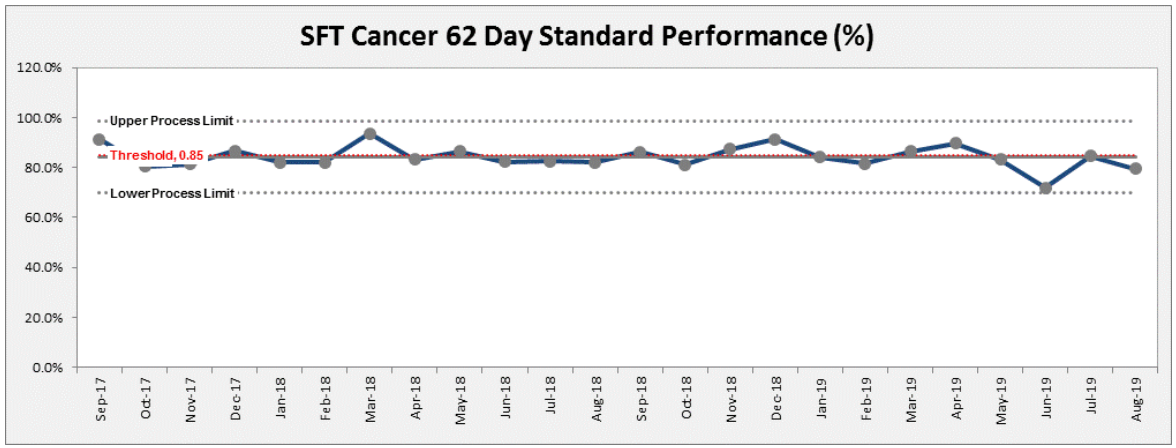
While the Trust is delivering the standard the focus will remain on looking forward to identify any risks that will potentially impact on maintaining performance in the future.

## Risks to delivery and mitigations

While the Trust continues to meet the standard, there are some concerns on the current and future consultant staffing levels in Dermatology/Plastics, however recruitment activity is underway to address this. The MSK directorate are undertaking a further demand and capacity plan.

# Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators




Data Quality Rating:

Performance Latest Month:

| | |
|---|---|
| 62 Day Standard: | 79.4% |
| 62 Day Standard (without shared care): | 76.8% |
| 62 Day Screening: | 90.0% |

## Risks to delivery and mitigations

The 62 day performance for August fell to 79.4%.

The principle risks for achieving overall cancer performance remain unchanged with agreed actions continuing:

**Dermatology**: Due to limitations within workforce there are ongoing concerns for capacity within Dermatology to meet the cancer demands on the service. Plastics are supporting with additional lists and cover where possible and, to date, there have been no breaches in compliance due to workforce or capacity issues. A multi discipline Skin Risk Summit is arranged for October to agree a strategy for recovering the position.

**Urology**: The tertiary centre delays continue to negatively impact on SFT performance more focus to ensure referrals are made before 31 days so a the breaching impact will then be solely upon the receiving trust rather than being shared

**Histology**: Capacity creating significant delays in diagnosis and treatment. Further concerns raised re delays in receipt of slides from Bioscience which is causing delays in MDT discussion. The CFSF are fully engaged and responsive to mitigating the issues where possible.

**104+ days**: See accompanying table

**Escalation Policy**: has been completed and going for ratification during September

**28 Day Faster Diagnosis Performance Standard**: Running shadow performance data for national implementation April 2020 Q1 63% Q2 76%

| Cancer Site | May | June | July |
|---|---|---|---|
| Breast | 0 | 1 | 0 |
| Colorectal | 2 | 0 | 0 |
| Haematology | 2 | 2 | 2 |
| Skin | 1 | 0 | 0 |
| Upper GI | 0 | 1 | 0 |
| Urology | 3 | 2 | 5 |
| TOTAL | 8 | 6 | 7 |

Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (7 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (7 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

# Stroke & TIA Pathways

Are We Effective?

SFT SSNAP Case Ascertainment Audit Score:

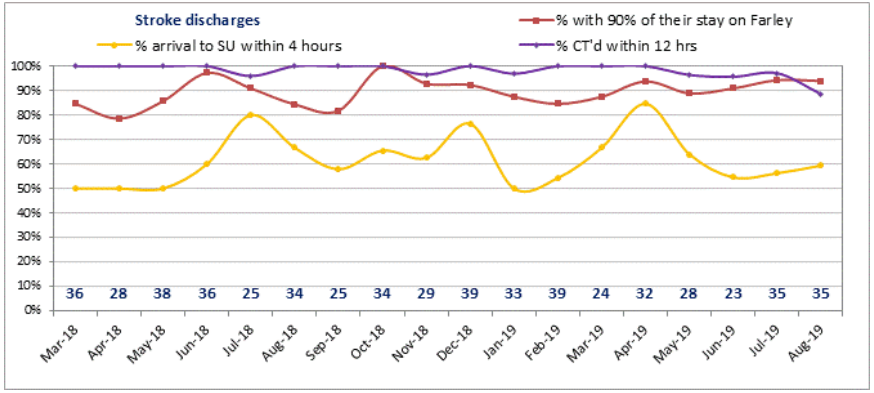
| Year | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| 2018-19 | B | C | B | B |
| 2019-20 | B | | | |

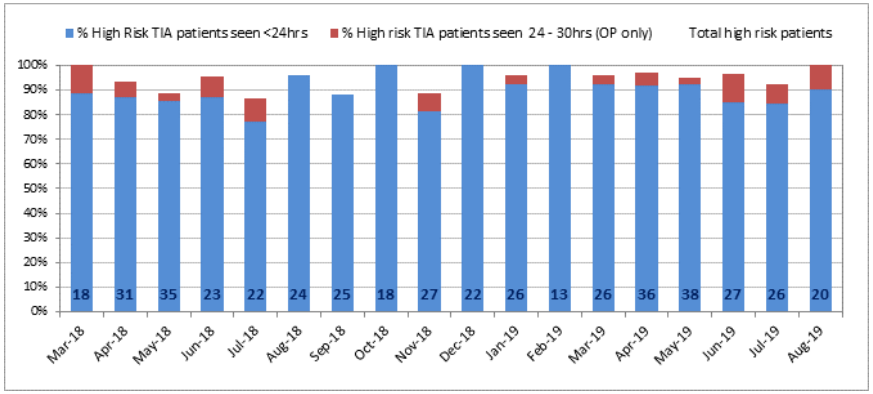
Data Quality Rating:

% Arrival on SU <4 hours: 59.4%

% CT'd < 12 hours: 88.6%

% High Risk TIA Seen < 24 hours: 90.0%




## Background, what the data is telling us, and underlying issues

In August, the proportion of patients having a CT scan within 12 hours reduced as 2 patients were admitted directly to AMU and 2 had a stroke as an inpatient.

Patients reaching the stroke unit within 4 hours slightly improved with delays mainly due to first & speciality doctor assessment in ED (8). Only FAST positive and thrombolysis-eligible patients are fast-tracked directly to CT. Performance is still relatively good compared to the national target.

Patients spending 90% of their stay in the stroke unit continued to exceed the national target.

Q1 19/20 SSNAP case ascertainment and good high risk TIA performance sustained in August.

## Improvement actions planned, timescales, and when improvements will be seen

SSNAP case ascertainment expected to improve and be sustained at 'A' once 2.0 WTE Speech and Language Therapists appointed. This will ensure patients receive the recommended input. Improvements should be seen from Q3 onwards.

Short term trial of a ANP role on Stroke Unit to assist with ensuring patients arrive from ED to the stroke unit within 4 hours is planned but has not occurred yet due to staffing issues. The team are keen to go ahead with a trial.

## Risks to delivery and mitigations

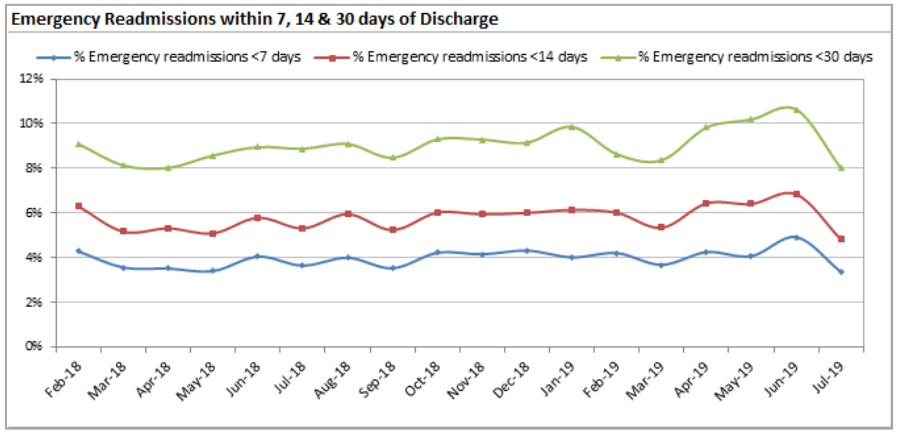
Delay in recruitment of Speech Therapist and embedding new staff in practice. Mitigated by induction and education programme.

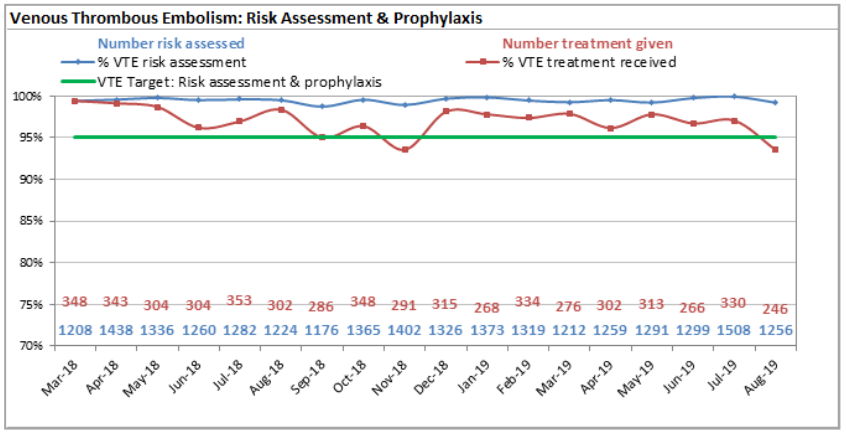
CT capacity to fast-track all patients

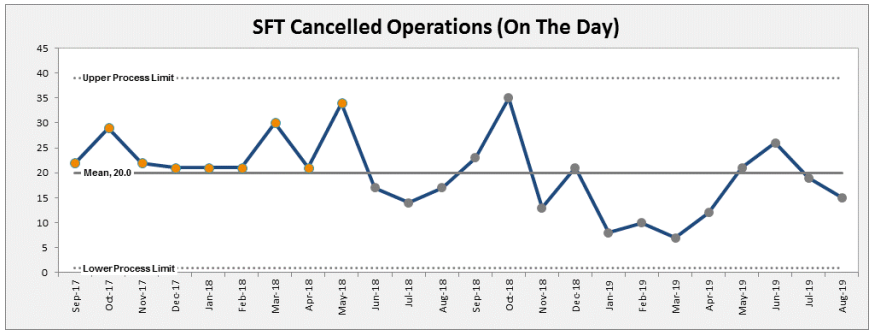
Atypical presentations resulting in delayed diagnosis

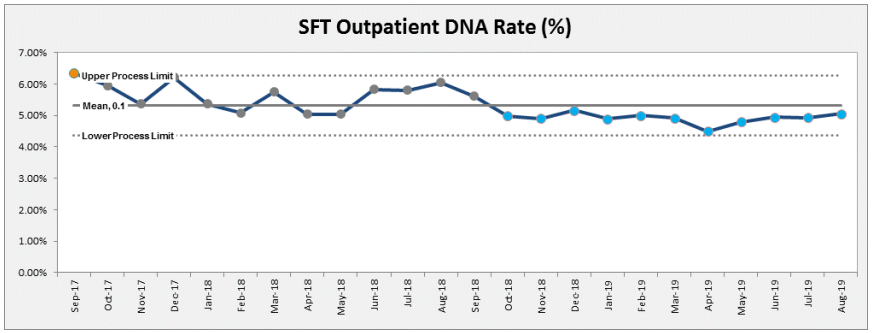
# Other Measures

Are We Effective?



Salisbury NHS Foundation Trust

# Part 2: Our Care

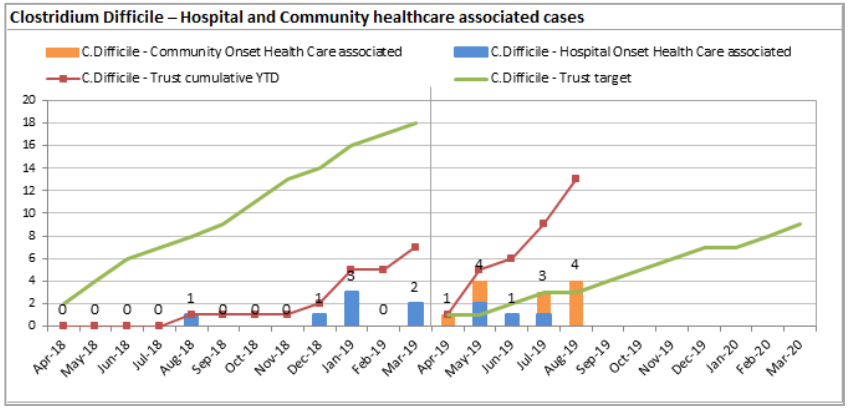
| Our Priorities | How We Measure | |
|---|---|---|
| Local Services | Are We Effective? | Are We Responsive? |
| Specialist Services | | |
| Innovation | | |
| **Care** | **Are We Safe?** | **Are We Caring?** |
| People | Are We Well Led? | Use of Resources |
| Resources | | |

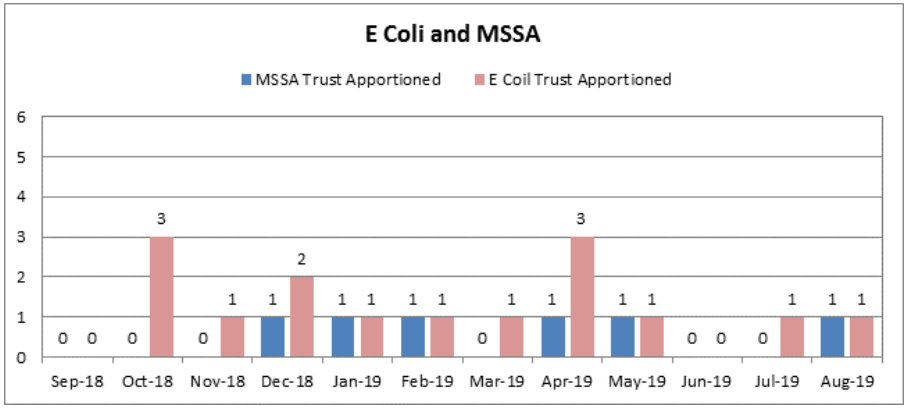
# Infection Control

Are We Safe?

| Year | 2018-19 | 2019-20 |
|---|---|---|
| MRSA (Trust Apportioned) | 3 | 0 |

Data Quality Rating:




## Summary and Action

C. difficile cases – 4 reportable cases in total in August – all 4 are community onset healthcare associated (inpatient episode in last 4 weeks) and no hospital onset healthcare associated cases.

Total YTD – 13 cases significantly exceeding the upper limit of 9 cases. In October, 5 cases will be submitted for appeal to the CCGs for no lapses in care. NHSI and the CCGs are regularly briefed on this issue with no further action currently requested. A deep dive into the YTD cases is being completed internally in September to ensure that any new learning across aggregated themes is picked up and acted upon. Q1 benchmark data available from PHE shows that the Trust is still a high performer i.e. low rates. We will continue to monitor and report on this

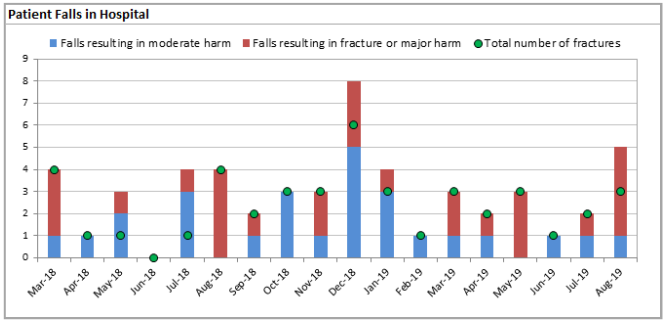
WH CCG have confirmed they have no plans to levy fines provided good lines of communication continue and effective plan are in place to address any gaps in care. Decision awaited from Wiltshire CCG.

MSSA bacteraemia – infection source uncertain, no learning identified. For MSSA we benchmark as the best performer across the South West (PHE data)

E Coli bacteraemia – hospital onset case unrelated to a catheter or device.

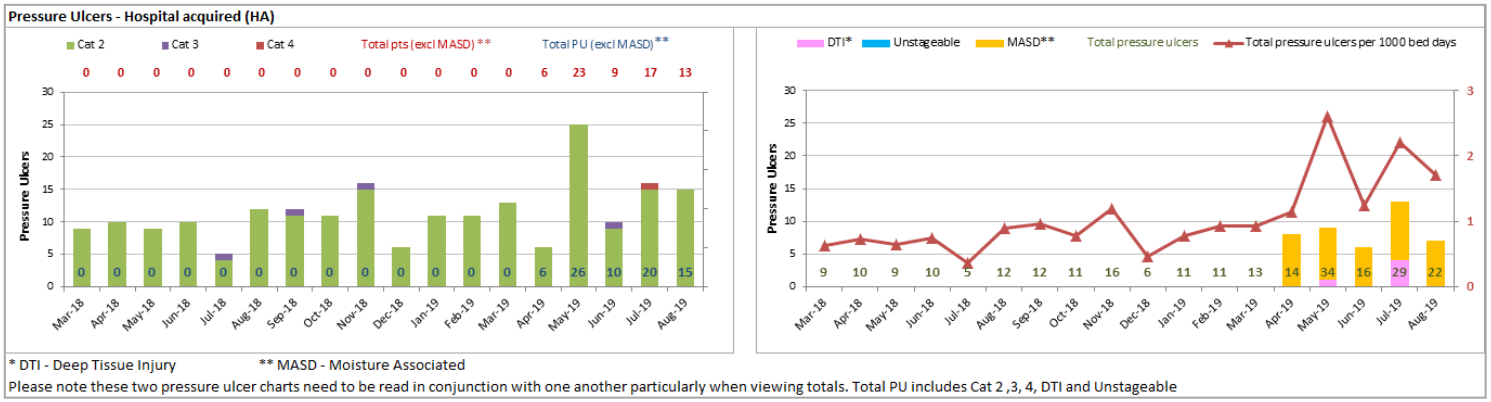
# Pressure Ulcers / Falls

Are We Safe?




Data Quality Rating:

| Per 1000 Bed Days | 2018-19 Q1 | 2018-19 Q2 | 2018-19 Q3 | 2018-19 Q4 | 2019-20 Q1 |
|---|---|---|---|---|---|
| Pressure Ulcers | 0.71 | 0.68 | 0.79 | 0.88 | 1.05 |
| Patient Falls | 0.10 | 0.25 | 0.34 | 0.20 | 0.16 |




* DTI - Deep Tissue Injury ** MASD - Moisture Associated

Please note these two pressure ulcer charts need to be read in conjunction with one another particularly when viewing totals. Total PU includes Cat 2 ,3, 4, DTI and Unstageable

## Summary and Action

**Pressure Ulcers -** *NB: the two pressure ulcer charts need to be read in conjunction with one another*.

Figures continue to fluctuate as anticipated with the new definitions and reporting requirements. It is an issue recognised across Wiltshire and Dorset and the Directors of Nursing have agreed to support the new definitions and process improvements. Work continues with the Matrons in Medicine to improve identification of tissue damage on admission to AMU, with local tissue viability teams to reduce numbers present on admission and with raising awareness of the need to report moisture associated damage. No deep tissue injury or category 3 or 4 pressure ulcers in August.

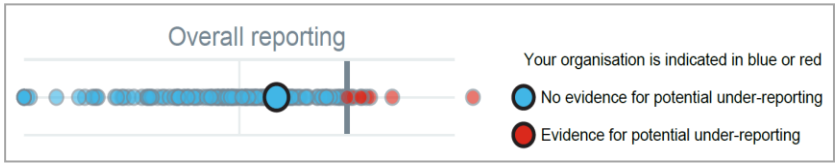
**Falls**

In August, 3 falls resulting in major harm (1 fractured hip, 1 fractured wrist and 1 surgical wound dehiscence) and 1 fall resulting in moderate harm (fractured wrist). A CQUIN of 3 high impact interventions to prevent hospital falls is in place, Q1 performance in achieving all 3 elements currently at 19%, the constraint being capture of a lying and standing blood pressure on all patients over 65 years. Q2 and Q3 data should start to show an improvement as lying and standing BP is now a mandatory field within POET. Improvement work is led by the Falls Working Group and Patient Safety Steering Group.

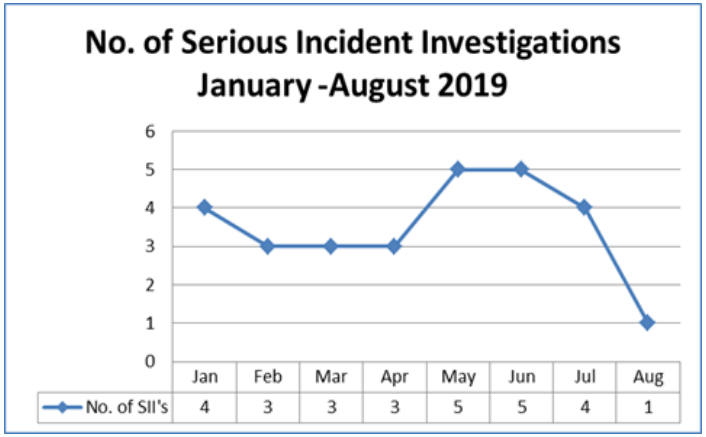
# Incidents

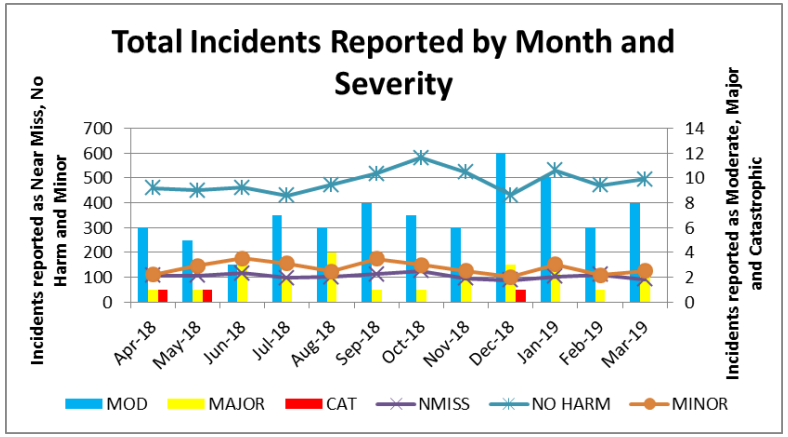
Are We Safe?

| Year | 2018-19 | 2019-20 |
|---|---|---|
| Never Events | 3 | 1 |




Information from NRLS benchmarks SFT in regard to reporting of incidents and reflects a positive reporting culture.




## Summary and Actions

The number of serious incident investigations (SII) increased in 2018/19 compared to 2017/18. Analysis has shown that the overall level of harm has increased very slightly but has not increased in line with the increased number of serious incident investigations. This is due to a number of the SII's being commissioned from a process/systems perspective which resulted in a near miss or low harm but has the potential to cause serious harm should it occur again.

Cancer Pathways have been a recognised theme:

• The Trusts Cancer Risk Summit was held in September. Further work streams have been identified as a result of the event. A plan for a follow up summit in April 2020 is planned to monitor progress and is overseen by the Cancer Board.

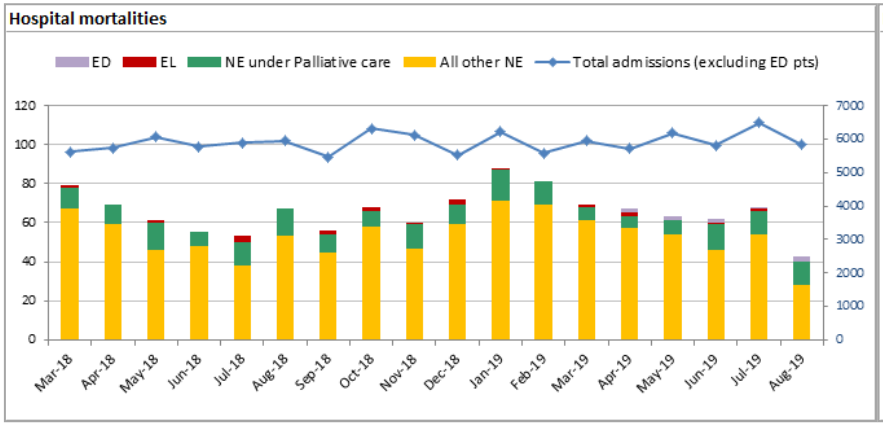
• An aggregated action plan is in place to incorporate IT and administration actions which will be worked through and will be tested and challenged by Internal Audit in Autumn 2019.

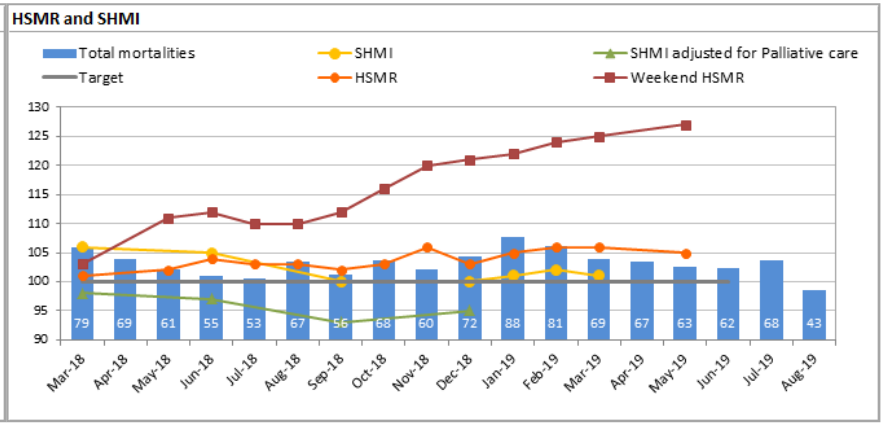
There has also been a cluster of incidents in maternity – a thematic review will be designed and undertaken with senior medical and midwifery staff.

# Mortality Indicators

Are We Safe?

Data Quality Rating:




## Summary and Action

Weekend HSMR increased for the 8th, 12 month rolling data period to 127.3 to May 19 and is significantly higher than expected range. A case notes review of 78 deaths will be presented to the Clinical Governance Committee in September 2019 with a supplementary paper reviewing the safety and effectiveness of hospital services at weekends.

Dr Foster's data shows an upward trend in the relative risk of death of patients with a fractured neck of femur but still remains within the expected range. The Mortality Surveillance Group will lead a multidisciplinary review of this group of patients.

A new relative risk of gastrointestinal haemorrhage is statistically higher than expected, particularly the weekend patient cohort. These cases will be reviewed and reported in Q2.

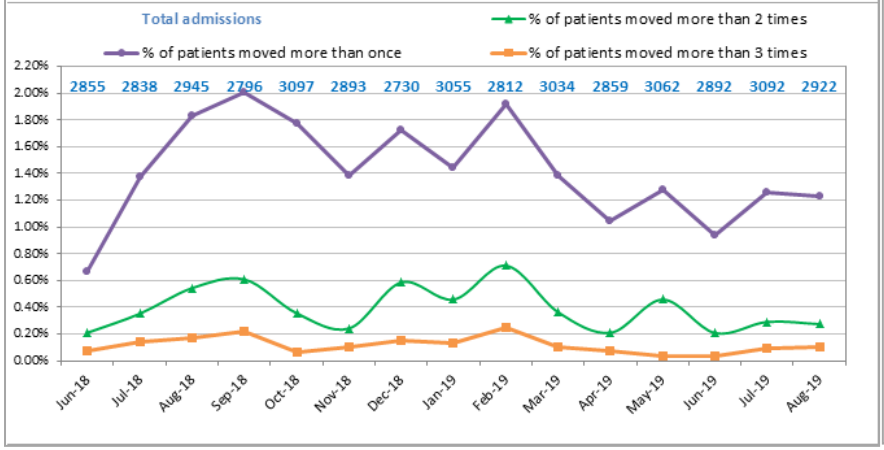
# Patient Experience

Are We Safe?

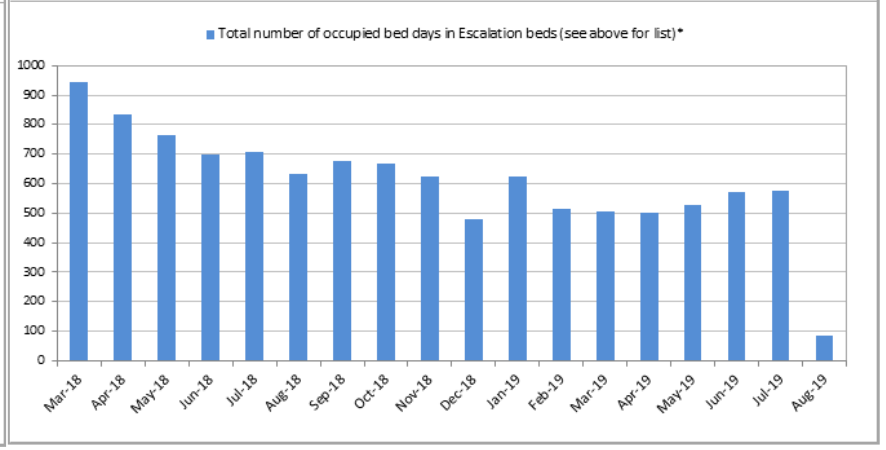
| Last 12 months | Sep 18 | Oct 18 | Nov 18 | Dec 18 | Jan 19 | Feb 19 | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bed Occupancy % | 96.0 | 96.5 | 96.8 | 92.5 | 96.3 | 94.4 | 91.4 | 92.6 | 92.5 | 93.5 | 93.3 | 94.1 |

Data Quality Rating:

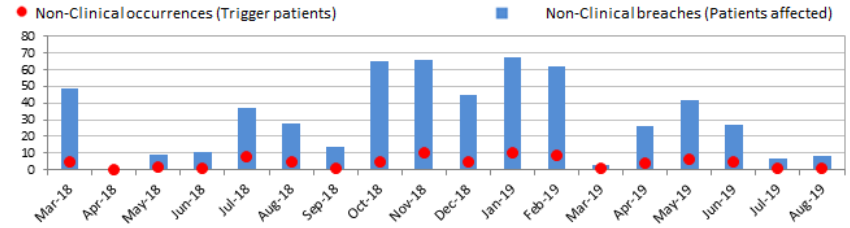
**Patients moving multiple times during their Inpatient Stay**




**Escalation Bed Days**

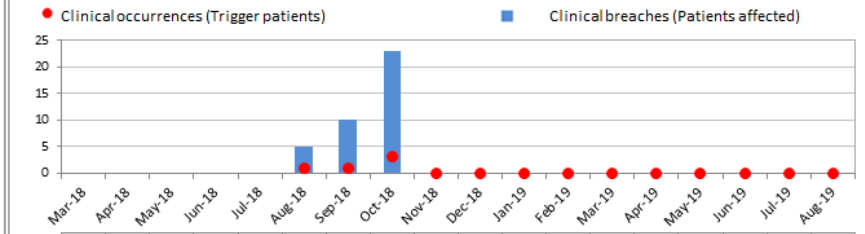



**Delivering Same Sex Accommodation - Non-clinical**




| | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ■ | 49 | 0 | 9 | 11 | 37 | 28 | 14 | 65 | 66 | 45 | 67 | 62 | 3 | 26 | 42 | 27 | 7 | 8 |
| ● | 5 | 0 | 2 | 1 | 8 | 5 | 1 | 5 | 10 | 5 | 10 | 9 | 1 | 4 | 6 | 5 | 1 | 1 |

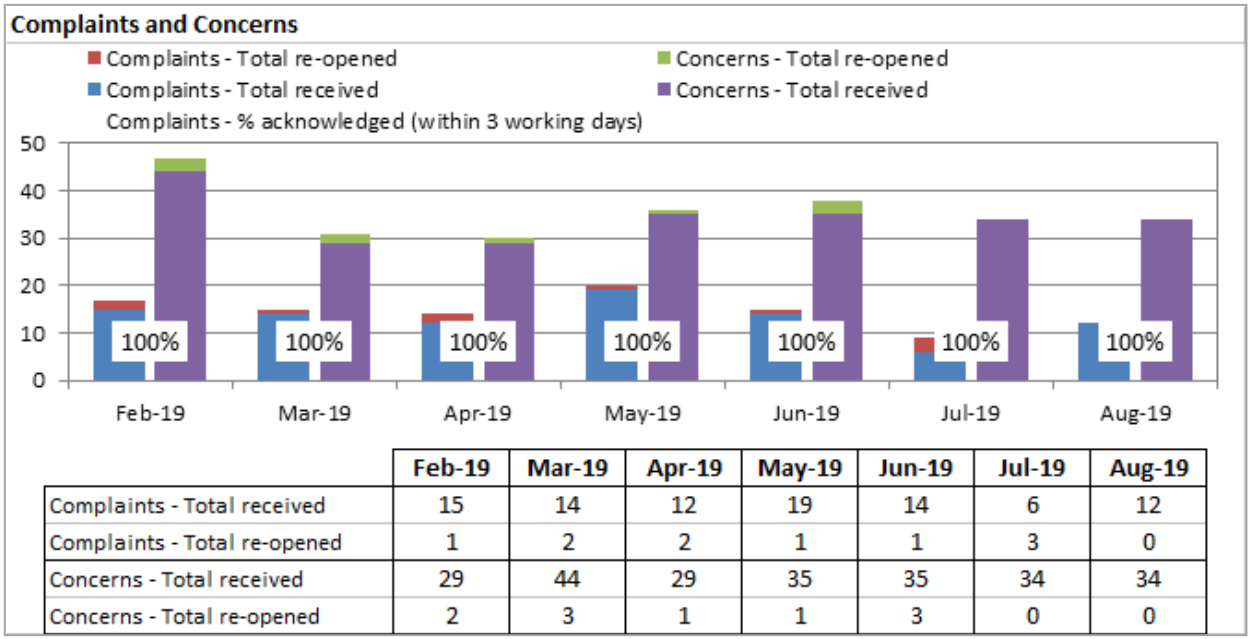
**Delivering Same Sex Accommodation - Clinical**




| | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ■ | | | | | | 5 | 10 | 23 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ● | | | | | | 1 | 1 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

# Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?




| | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 |
|---|---|---|---|---|---|---|---|
| Complaints - Total received | 15 | 14 | 12 | 19 | 14 | 6 | 12 |
| Complaints - Total re-opened | 1 | 2 | 2 | 1 | 1 | 3 | 0 |
| Concerns - Total received | 29 | 44 | 29 | 35 | 35 | 34 | 34 |
| Concerns - Total re-opened | 2 | 3 | 1 | 1 | 3 | 0 | 0 |

Data Quality Rating:

## Summary and Actions

### June- Aug 2019

4 main themes of complaints were:

- Patient Care (nutrition and hydration)
- Clinical treatment
- Values and behaviours
- Communication

### Example of actions:

Surgery - the need to consider patients' privacy and dignity was discussed with the nursing assistant and is set to feature in the next DSU staff newsletter.

ED - discussions have taken place with regards to the advice given to women with threatened miscarriage and the consistency of approach for scanning this group within ED.

ED – the team continue to work towards a RATing style model.

# Part 3: Our People

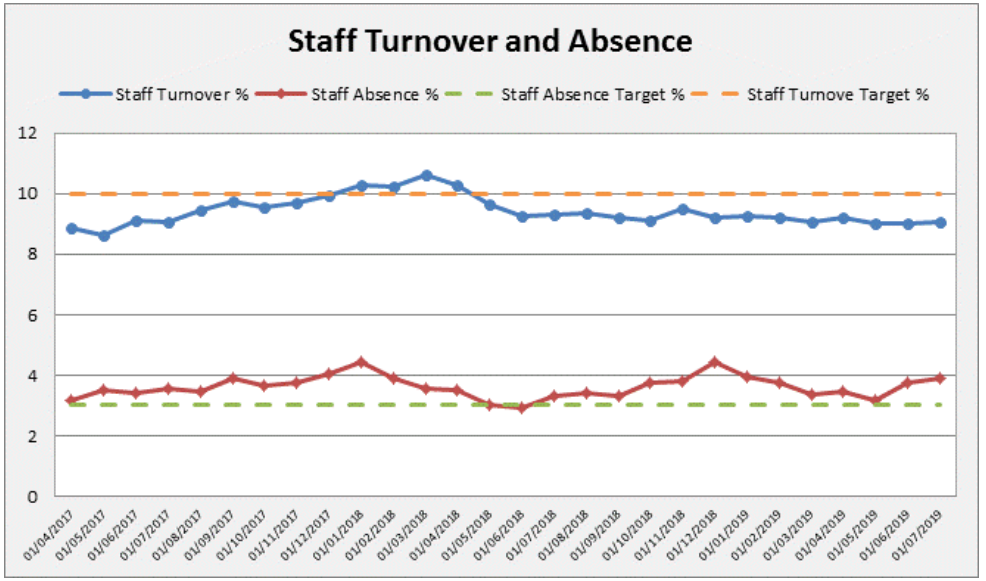
| Our Priorities | How We Measure | |
|---|---|---|
| Local Services | Are We Effective? | Are We Responsive? |
| Specialist Services | | |
| Innovation | | |
| Care | Are We Safe? | Are We Caring? |
| People | Are We Well Led? | Use of Resources |
| Resources | | |

# Workforce - Total

Use of Resources

## Total Workforce vs Budgeted Plan - WTEs

| | Aug '19 | | |
|---|---|---|---|
| | Plan WTEs | Actual WTEs | Variance WTEs |
| Medical Staff | 402.6 | 436.6 | (34.0) |
| Nursing | 939.5 | 905.4 | 34.1 |
| HCAs | 405.7 | 544.9 | (139.2) |
| Other Clinical Staff | 612.4 | 606.9 | 5.5 |
| Infrastructure Staff | 1,193.4 | 1,060.9 | 13.5 |
| **TOTAL** | **3,553.6** | **3,634.6** | **(1.1)** |




## Summary and Action

Staff turnover remained stable at 9.06%, the same as July, and there were 54 starters in the month equaling the highest intake since January 2019. Unfortunately, we also saw the highest number of leavers at 33 in the year to date. The number of exit interview questionnaire responses has not improved and remains in single figures for the third month in a row. We are attempting to gather additional information on exits by writing to all those who have left in the last three months with a request to complete a questionnaire, in addition to reviewing the process again. In terms of ward registered nursing, we are due to hit the lowest vacancy figure in YTD at 2.96 by October.

Sickness absence has decreased to 3.53% from last month's 3.9% with an increase in long term sickness and short term sickness decreasing. The principle cause appears to be anxiety/stress related. The Head of Occupational Health is working closely with People Business Partners and the DMTs to aid in management of individual cases, in particular the long term. In Surgery, for example, there are a number of cases where individuals have resigned or plan to return and these will show in later reports by October/November. The flu campaign is due to be launched on Monday 30th September.

# Workforce – Nursing and Care

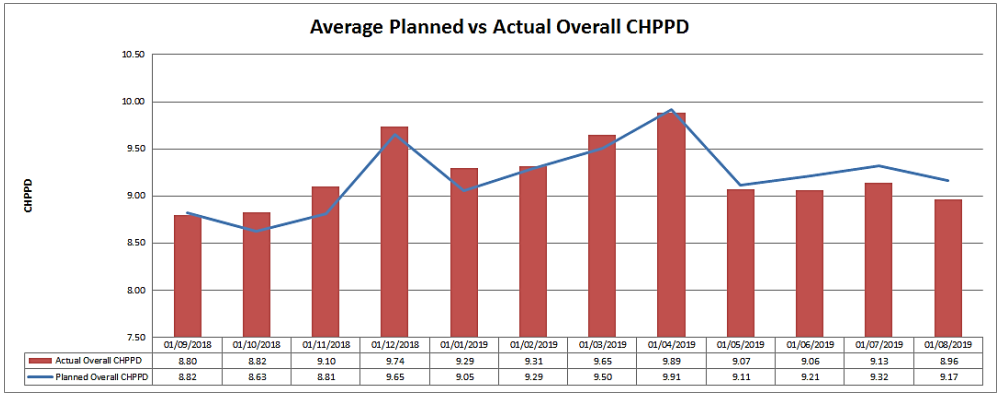
Use of Resources

## % Fill of Registered Nurse/HealthCare Assistant Shifts

| Day | RN | HCA |
|---|---|---|
| Total Planned Hours | 38065 | 20784 |
| Total Actual Hours | 34985 | 21658 |
| Fill Rate (%) | 92% | 104% |

| Night | RN | HCA |
|---|---|---|
| Total Planned Hours | 25009 | 12386 |
| Total Actual Hours | 24569 | 14127 |
| Fill Rate (%) | 98% | 114% |

## Care Hours Per Patient Day (CHPPD) - Monthly, 12 Month Trend




| | 01/09/2018 | 01/10/2018 | 01/11/2018 | 01/12/2018 | 01/01/2019 | 01/02/2019 | 01/03/2019 | 01/04/2019 | 01/05/2019 | 01/06/2019 | 01/07/2019 | 01/08/2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual Overall CHPPD | 8.80 | 8.82 | 9.10 | 9.74 | 9.29 | 9.31 | 9.65 | 9.89 | 9.07 | 9.06 | 9.13 | 8.96 |
| Planned Overall CHPPD | 8.82 | 8.63 | 8.81 | 9.65 | 9.05 | 9.29 | 9.50 | 9.91 | 9.11 | 9.21 | 9.32 | 9.17 |

## Summary and Action

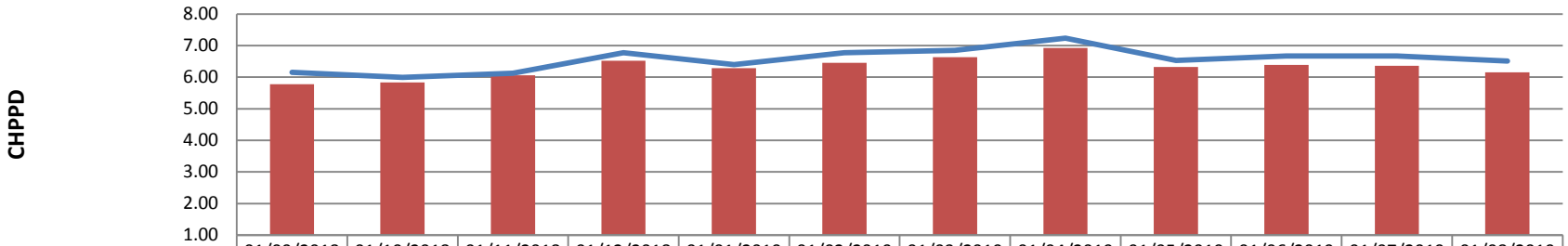
- Table 1 above shows planned vs actual hours for RNs and HCAs across the wards for August. The graph on the right shows planned vs actual Care Hours Per Patient Day at Trust level, the graphs on the following slide shows this split between RN and HCAs. (CHPPD is a simple calculation which divides the number of actual nursing/midwifery (both registered and unregistered) hours available on a ward per 24 hour period by the number of patients on the ward that day. It therefore nominally represents the average number of nursing hours that are available to each patient on that ward.)
- From aggregated Trust level data no real conclusions can be drawn other than to show that overall we are broadly meeting planned staffing levels, that there is a shortfall for RNs and slightly for HCAs – also demonstrated in Table 1. Further detail on this will be explored at Board Seminar day in November which will determine what information will be presented through the IPR going forward. The annual skill mix is a critical feature of determining that the baseline planned staffing levels are set correctly.
- 2 wards flagged red this month for actual unfilled hours (based on internal rag ratings) – Breamore and Pembroke wards for HCA day and night shifts. Breamore is due to ward relocation and staff were redeployed to other areas due to reduced bed numbers.
- The skill mix of RN:HCA remains stable for the 4th reporting month RN 62% : HCA 38%.
- Nurse agency expenditure YTD is circa £820k (£1m lower than same time period 2018 – reflecting improved vacancy position).
- Nurse sensitive indicators remain stable – anomalies with changes in national reporting requirements for clostridium difficile and pressure ulcers. On-going work continues with falls.

# Workforce – Nursing and Care

Use of Resources

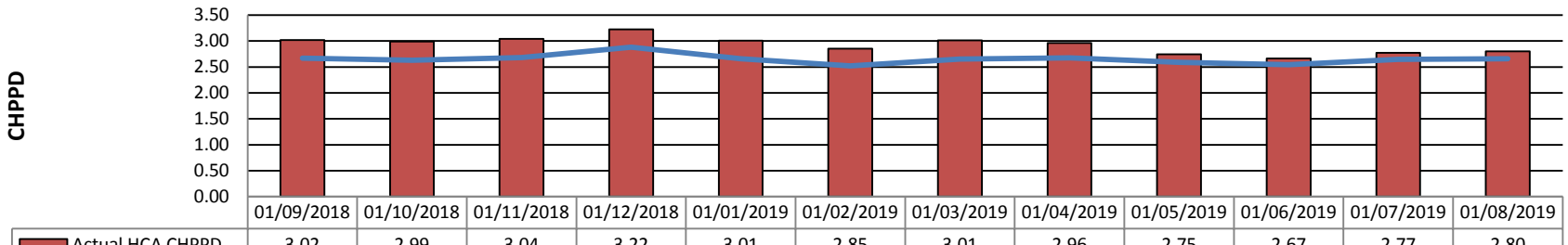
## Care Hours Per Patient Day (CHPPD) - Monthly, 12 Month Trend

### Average Planned vs Average Actual RN CHPPD




| | 01/09/2018 | 01/10/2018 | 01/11/2018 | 01/12/2018 | 01/01/2019 | 01/02/2019 | 01/03/2019 | 01/04/2019 | 01/05/2019 | 01/06/2019 | 01/07/2019 | 01/08/2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual RN CHPPD | 5.78 | 5.83 | 6.06 | 6.52 | 6.28 | 6.46 | 6.64 | 6.92 | 6.32 | 6.39 | 6.36 | 6.16 |
| Planned RN CHPPD | 6.16 | 6.00 | 6.13 | 6.78 | 6.40 | 6.77 | 6.85 | 7.24 | 6.53 | 6.67 | 6.67 | 6.51 |

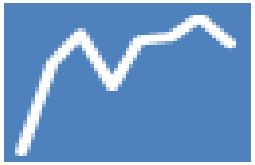
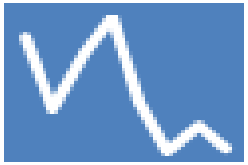
### Average Planned vs Average Actual HCA CHPPD




| | 01/09/2018 | 01/10/2018 | 01/11/2018 | 01/12/2018 | 01/01/2019 | 01/02/2019 | 01/03/2019 | 01/04/2019 | 01/05/2019 | 01/06/2019 | 01/07/2019 | 01/08/2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual HCA CHPPD | 3.02 | 2.99 | 3.04 | 3.22 | 3.01 | 2.85 | 3.01 | 2.96 | 2.75 | 2.67 | 2.77 | 2.80 |
| Planned HCA CHPPD | 2.67 | 2.63 | 2.68 | 2.88 | 2.66 | 2.52 | 2.65 | 2.67 | 2.59 | 2.54 | 2.65 | 2.66 |

# Workforce – Staff Training and Appraisals

Use of Resources

| | Training | Appraisal | |
|---|---|---|---|
| | Mandatory Training | % Complete Medical Staff | % Complete non-medical staff |
| YTD Trend |  |  |  |
| Month Trend | ↑ | ↓ | ↓ |
| Target | 85.00% | 90.00% | 85.00% |
| Jan-19 | 91.32% | 88.16% | 86.30% |
| Feb-19 | 92.03% | 91.46% | 84.90% |
| Mar-19 | 92.09% | 92.62% | 86.00% |
| Apr-19 | 92.19% | 90.65% | 86.70% |
| May-19 | 91.99% | 92.31% | 85.05% |
| Jun-19 | 91.60% | 92.42% | 84.08% |
| Jul-19 | 90.20% | 93.25% | 84.59% |
| Aug-19 | 90.22% | 92.19% | 84.15% |
| totals | 91.46% | 91.63% | 85.22% |

**Summary and Action**

**Training**

All Directorates are currently compliant with MaST. The recent HSE visit has highlighted a need to review the MaST matrix, to ensure that training requirements are appropriately identified for different staff groups, and that all staff are aware of their specific obligations for training.

**Non Medical Appraisals**

Currently below target for the third month in a row, although three Directorates and Estates & Facilities are compliant. Where services are below target, the lists of individuals non-compliant have been shared with service heads so that targeted action can be taken. Plans are in place to return this KPI to green by the end of September.

There appears to be an ongoing issue with individuals not "signing off" in the SPIDA system, which will also affect the numbers and compliance reported.

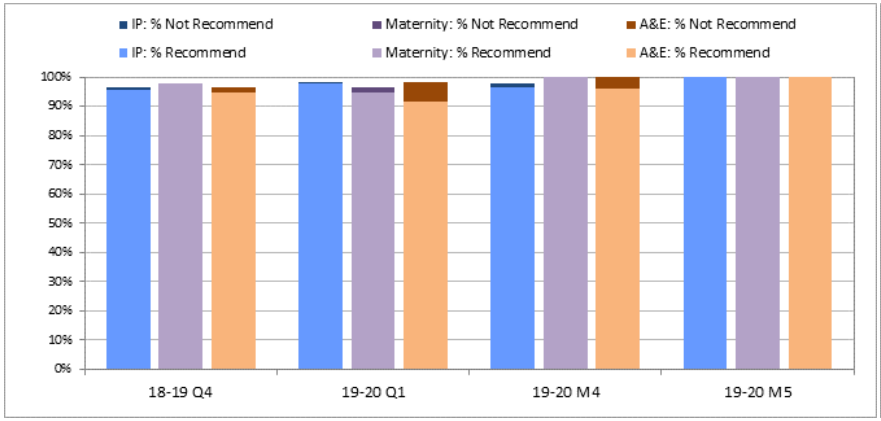
**Medical Appraisals**

Medical compliance is above target, although has seen a slight dip since last month. People Business Partners are being asked to engage with CDs to ensure that compliance is maintained.

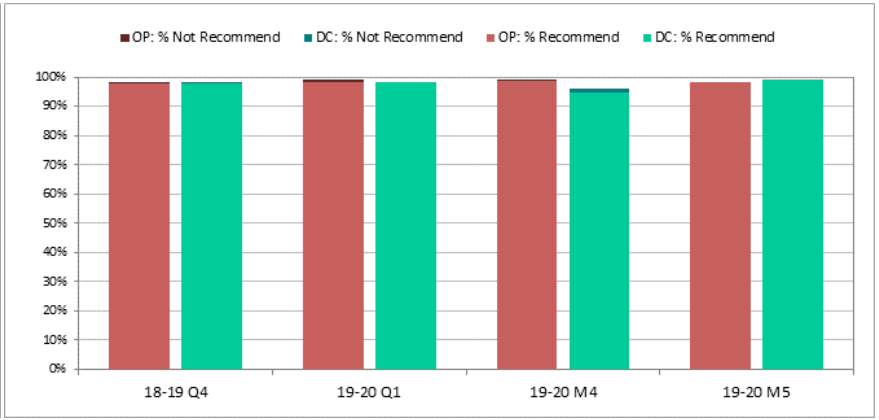
# Friends and Family Test – Patients and Staff

Use of Resources

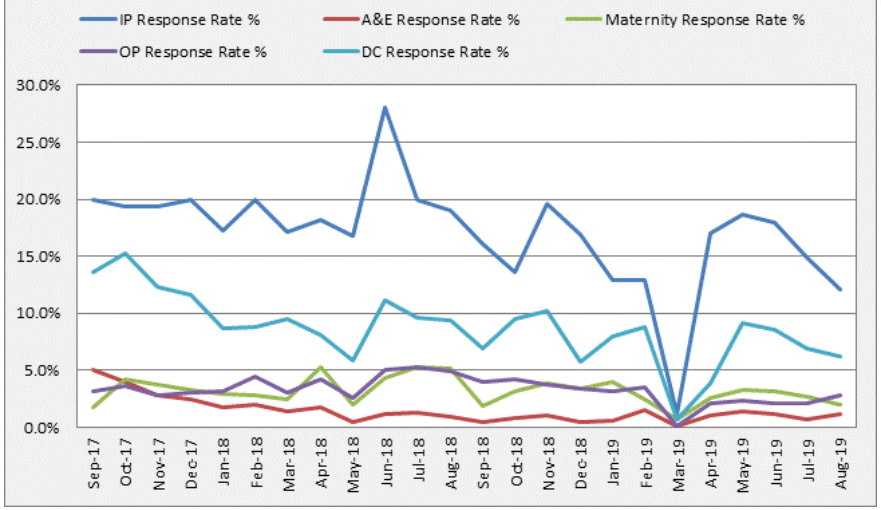
## Patient Responses: Inpatient, Maternity and A&E



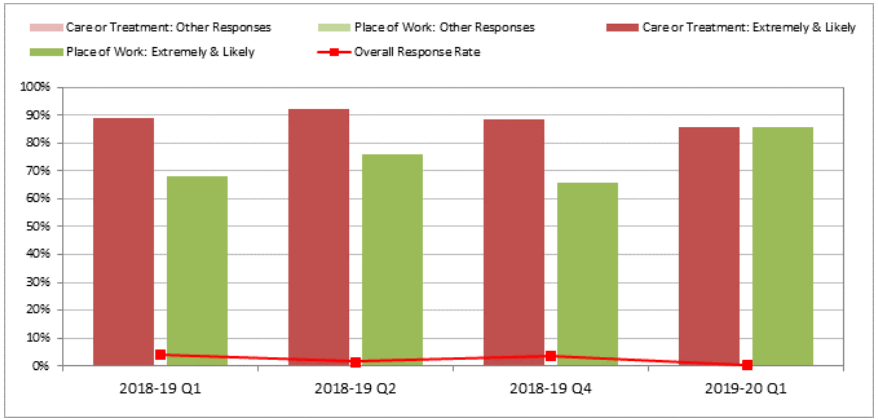

## Patient Responses: Outpatient and Daycase




## SFT Friends & Family Response Rates %




## Staff Responses: Place of Work and Place of Care




There was an issue in March 2019 whereby responses were input into the wrong FFT website and were unable to be retrieved, hence the low response rate for one month.

# Part 4: Use of Resources

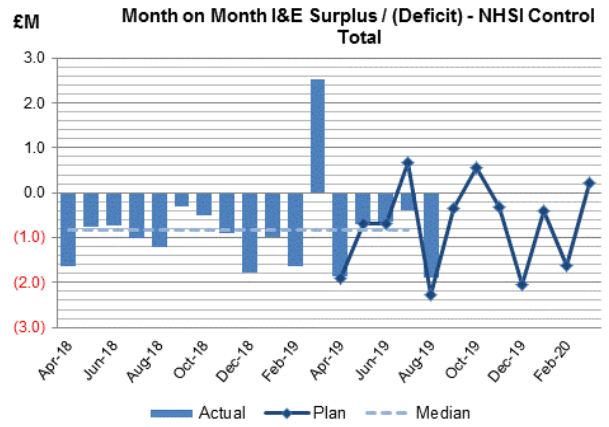
| Our Priorities | How We Measure | |
|---|---|---|
| Local Services | Are We Effective? | Are We Responsive? |
| Specialist Services | | |
| Innovation | | |
| Care | Are We Safe? | Are We Caring? |
| People | | |
| Resources | Are We Well Led? | Use of Resources |

# Income and Expenditure

Income & Expenditure:

Use of Resources

| Position | Aug '19 In Mth | | | Aug '19 YTD | | | 2019/20 |
|---|---|---|---|---|---|---|---|
| | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Actual £000s | Variance £000s | Plan £000s |
| **Operating Income** | | | | | | | |
| NHS Clinical Income | 15,774 | 15,989 | 215 | 85,432 | 83,580 | (1,852) | 196,036 |
| Other Clinical Income | 779 | 1,006 | 227 | 3,864 | 4,171 | 307 | 21,449 |
| Other Income (excl Donations) | 2,350 | 2,306 | (44) | 11,688 | 11,766 | 78 | 28,307 |
| **Total income** | **18,903** | **19,301** | **398** | **100,984** | **99,517** | **(1,467)** | **245,792** |
| **Operating Expenditure** | | | | | | | |
| Pay | (13,049) | (13,245) | (196) | (65,707) | (65,961) | (254) | (157,326) |
| Non Pay | (6,702) | (6,857) | (155) | (33,004) | (32,399) | 605 | (80,163) |
| **Total Expenditure** | **(19,751)** | **(20,102)** | **(351)** | **(98,711)** | **(98,360)** | **351** | **(237,489)** |
| | | | | | | | |
| **EBITDA** | **(848)** | **(801)** | **47** | **2,273** | **1,157** | **(1,116)** | **8,303** |
| Financing Costs (incl Depreciation) | (1,430) | (1,096) | 334 | (7,149) | (6,668) | 481 | (17,157) |
| **NHSI Control Total** | **(2,278)** | **(1,897)** | **381** | **(4,876)** | **(5,511)** | **(635)** | **(8,854)** |
| *Add: impact of donated assets* | *105* | *17* | *(88)* | *525* | *(164)* | *(689)* | *1,260* |
| *Add: Impairments* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
| *Add: Central MRET* | *174* | *174* | *(0)* | *869* | *868* | *(1)* | *2,082* |
| *Add: PSF & FRF* | *451* | *0* | *(451)* | *1,918* | *1,190* | *(728)* | *6,772* |
| ***Surplus/(Deficit)*** | ***(1,548)*** | ***(1,706)*** | ***(158)*** | ***(1,564)*** | ***(3,617)*** | ***(2,053)*** | ***1,260*** |




## Variation and Action

Although better than plan, the Trust's financial performance remains below that required by the NHSI Control Total in August, reporting a £1,897k deficit against an expectation of a £2,278k deficit. The reduction in clinical income had been planned due to the impact of the summer period, but emerging medical workforce and outsourcing cost pressures remain.

NHS clinical income continues to be affected by reductions in productivity, most materially in Orthopaedics and Cardiology, the former constrained by both the availability of additional sessions and complex operational challenges throughout the planned care pathway. The Trust also continues to observe a marked reduction in specialist Burns activity, also reflected in the national picture.

Capacity constraints are leading to sustained costs associated with outsourced healthcare, driven by both increased demand (Endoscopy), and shortfall in capacity due to key hard to fill vacancies (Pathology, Radiology).

The Trust is in the process of recruiting intakes of overseas nurses, an exercise with upfront costs but a payback period of approximately 6 months per nurse. This strategy has led to a 75% reduction in monthly nursing agency costs.

# Income & Activity Delivered by Point of Delivery

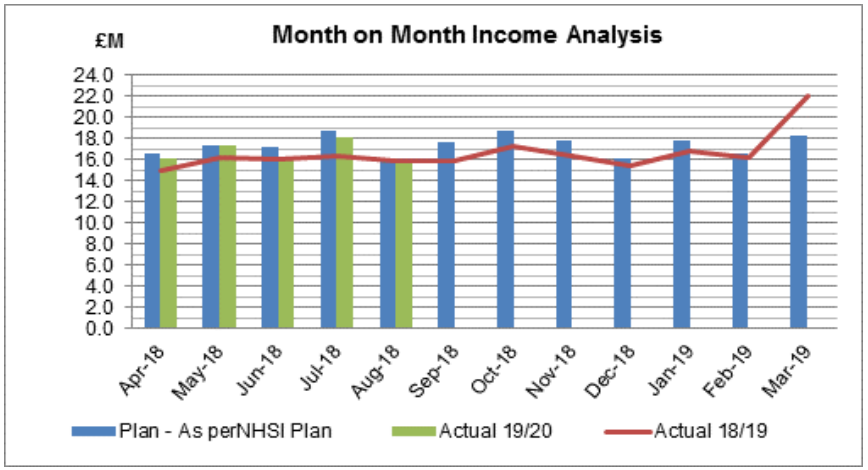
Clinical Income:

Use of Resources

| Position | | | |
|---|---|---|---|
| Income by Point of Delivery (PoD) for all commissioners | Aug '19 YTD | | |
| | Plan (YTD) | Actual (YTD) | Variance (YTD) |
| | £000s | £000s | £000s |
| A&E | 3,788 | 3,701 | (87) |
| Elective inpatients | 7,707 | 7,431 | (276) |
| Day Case | 7,183 | 7,014 | (169) |
| Non Elective inpatients | 23,695 | 22,892 | (803) |
| Obstetrics | 2,606 | 2,455 | (151) |
| Outpatients | 13,543 | 13,252 | (291) |
| Excluded Drugs & Devices (inc Lucentis) | 7,213 | 7,315 | 102 |
| Other | 19,697 | 19,520 | (177) |
| **TOTAL** | **85,432** | **83,580** | **(1,852)** |

| SLA Income Performance of Trusts main NHS commissioners | Contract Plan (YTD) £000s | Actual (YTD) £000s | Variance (YTD) £000s |
|---|---|---|---|
| Wiltshire CCG | 46,186 | 45,954 | (232) |
| Dorset CCG | 9,793 | 9,779 | (14) |
| West Hampshire CCG | 6,830 | 7,075 | 245 |
| Specialist Services | 13,227 | 12,715 | (512) |
| Other | 9,396 | 8,057 | (1,339) |
| **TOTAL** | **85,432** | **83,580** | **(1,852)** |

| Position | | | | | | |
|---|---|---|---|---|---|---|
| Activity levels by Point of Delivery (POD) | YTD | YTD | YTD | | Last Year | Variance against |
| | Plan | Actuals | Variance | | Actuals | last year |
| Elective | 2,174 | 2,049 | (125) | | 2,136 | (87) |
| Day case | 9,108 | 9,360 | 252 | | 8,900 | 460 |
| Non Elective | 11,749 | 10,922 | (827) | | 10,809 | 113 |
| Outpatients | 107,633 | 105,232 | (2,401) | | 104,398 | 834 |
| A&E | 29,720 | 29,563 | (157) | | 28,697 | 866 |




## Variation and Action

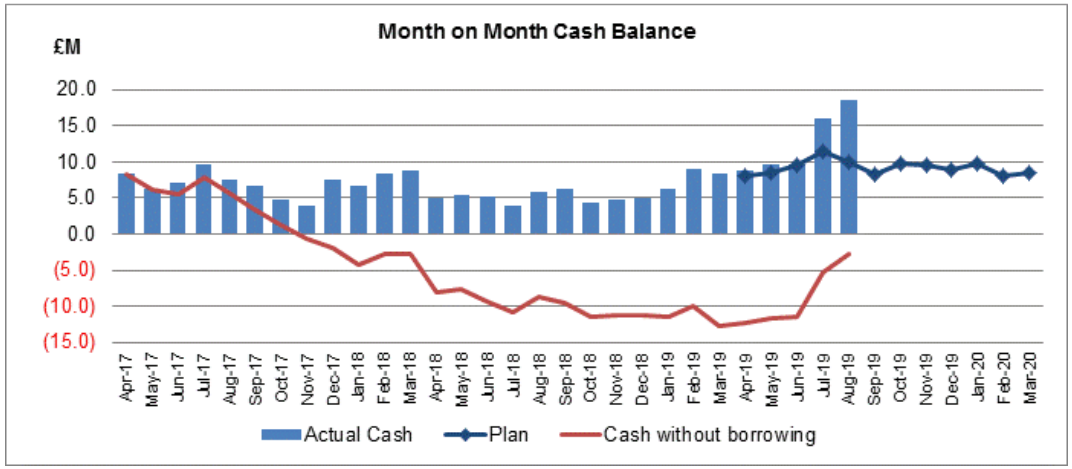
Income to date is £83,580k, £1,852k below plan and an over performance of £85k in August. Income has under performed on all points of delivery year to date with the exception of Excluded drugs and devices, Maternity and Other. Cardiology Day cases are 105 cases and £168k below plan year to date resulting from a reluctance to undertake additional lists due to the impact on Pensions with a further deterioration in month. Elective Orthopaedics are now 59 spells below the year to date plan of 587 which is an improvement in month as the August plan is 31 spells lower than the April - July average plan of 124 spells. The Non Elective position is driven by a combination of under performance on spells and excess bed days activity mainly within Trauma and Orthopaedics and Cardiology. The Outpatients position is driven by underperformance across a range of specialties most notably in Dermatology due to Consultant vacancies with cover being provided by other specialties.

An adjustment of +£1,046k is included to reflect the blended approach, +£963k for Wiltshire CCG and +£83k for West Hampshire CCG, due to under performance on the non elective element of the contract. An adjustment of +£65k is included to increase income to reflect the under performance on the Dorset managed contract at Month 5. The total impact is +£1,111k.

# Cash Position & Capital Programme

Capital Spend: Cash & Working:

Use of Resources

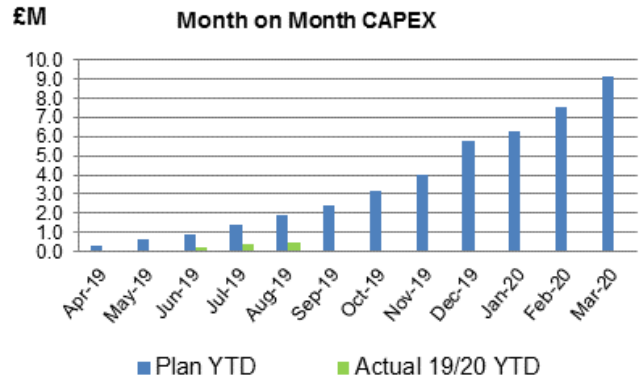



The Trust's working capital position is reasonably in line with the plan, although the Trust is benefiting from slippage in capital expenditure. The cash position has also improved partly as a result of Health Education England now paying the Trust a quarter in advance and also due to limited expenditure on the capital programme to date.

The cash flow will continue to be closely monitored during 2019-20 to ensure funds are available when required. Although the Trust is not planning for additional borrowing in 2019-20 this will be constantly reviewed in line with the financial performance and forecast for the remainder of the year.

**Capital Expenditure Position**

| Schemes | Annual Plan £000s | Aug '19 Plan £000s | Aug '19 Actual £000s | Aug '19 Variance £000s |
|---|---|---|---|---|
| Building schemes | 700 | 0 | 0 | 0 |
| Building projects | 1,814 | 525 | 57 | 468 |
| IM&T | 3,540 | 950 | 112 | 838 |
| Medical Equipment | 2,650 | 250 | 93 | 157 |
| Other | 420 | 175 | 175 | 0 |
| **TOTAL** | **9,124** | **1,900** | **437** | **1,463** |




## Summary and Action

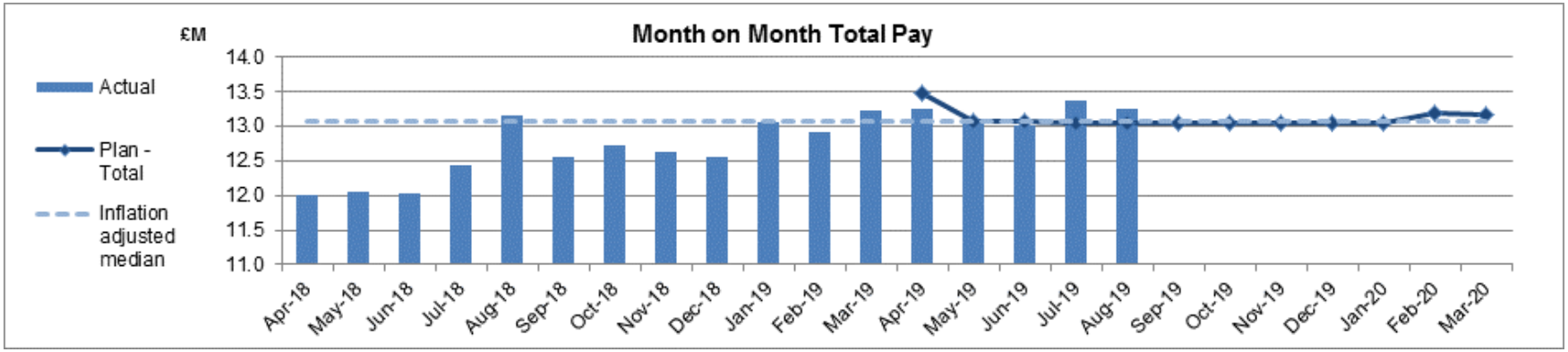
The Trust is financing its capital spend in 2019-20 through depreciation.

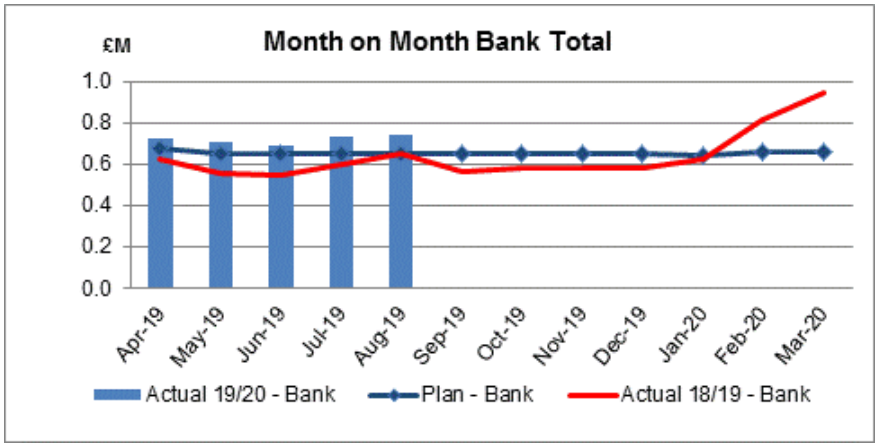
Although the Trust was anticipating to be behind plan for the first half of the year following a revision to the phasing of schemes within the capital programme, slippage into 2020-21 has been identified on a few larger schemes e.g. low risk birthing rooms, PACS and MRI infrastructure costs. Work is currently underway to identify schemes originally scheduled for next year which can be brought forward into the current year to ensure the total expenditure included in the plan is met. This work is being undertaken by the operational Capital Control Group which reports into a Strategic projects group chaired by the Director of Finance.

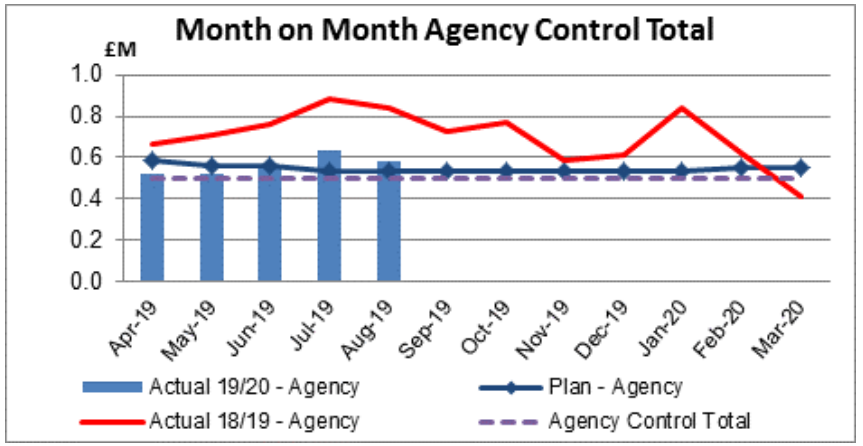
# Workforce and Agency Spend

Pay:

Use of Resources




**Summary and Action**

Pay expenditure of £13,245k in July is £196k (1.5%) greater than planned for. This is inclusive of the sustained £90k increase in run rate relating to the medical pay award, an announcement about associated funding is expected imminently although this is unlikely to exceed £20k per month (£100k YTD).

Agency costs continue to exceed plan at £586k, with the month on month increase relating primarily to the consultant workforce . The specialties being forced to cover consultant vacancies through agency are: Histopathology, General Medicine, Gastroenterology, Stroke, Emergency Medicine, and Dermatology. Planned success in reducing nursing agency has been sustained with a £1.3m year on year reduction.

Contracted medical WTEs roles in the period due to the August Deanery intakes.

The Surgery and Medicine Directorates continue to mitigate nursing vacancies with the usage of Nursing Assistants, often those in the process of obtaining full registration, as demonstrated by the WTE and financial variance swings between the staff groups.

Agency premium for the period is estimated at c£100k, roughly two thirds of which relates to medical staffing groups due to difficulties filling vacancies and rota gaps. The Head of Resourcing and Business Partners are working together closely with DMTs to identify appropriate actions to fill hard to fill vacancies, including consideration of viable alternatives in the event that the Trust accepts a complete inability to fill.

# Efficiency – Better Care at Lower Cost

Efficiency:

Use of Resources

| Position | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Annual | Aug '19 | | | YTD | | |
| Directorate | Plan £000s | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Actual £000s | Variance £000s |
| Medicine | 2,192 | 184 | 117 | (67) | 879 | 487 | (392) |
| Musculo Skeletal | 1,385 | 119 | 88 | (31) | 514 | 389 | (124) |
| Surgery | 1,728 | 145 | 128 | (17) | 686 | 460 | (226) |
| Clinical Support & Family Services | 1,965 | 147 | 155 | 8 | 711 | 572 | (139) |
| Corporate Services | 1,730 | 138 | 163 | 25 | 671 | 808 | 137 |
| Strategic | 1,000 | 47 | 77 | 30 | 69 | 225 | 156 |
| **TOTAL** | **10,000** | **781** | **729** | **(52)** | **3,531** | **2,942** | **(589)** |

| Position | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Annual | Aug '19 | | | YTD | | |
| Scheme | Plan £000s | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Actual £000s | Variance £000s |
| Theatres | 1,068 | 89 | 16 | (73) | 445 | 16 | (429) |
| Workforce | 1,001 | 83 | 86 | 3 | 417 | 430 | 13 |
| Diagnostics | 600 | 42 | 42 | 0 | 208 | 208 | 0 |
| Patient Flow | 825 | 69 | 23 | (46) | 344 | 116 | (227) |
| Outpatients | 500 | 56 | 56 | 0 | 111 | 111 | 0 |
| Non-Pay Procurement | 1,494 | 128 | 142 | 14 | 534 | 523 | (11) |
| Medicines Optimisation - Drugs | 500 | 0 | 21 | 21 | 0 | 114 | 114 |
| Clinical Directorate Plans | 2,634 | 206 | 208 | 2 | 937 | 747 | (191) |
| Corporate Directorate Plans | 1,378 | 109 | 136 | 28 | 534 | 677 | 143 |
| **TOTAL** | **10,000** | **781** | **729** | **(52)** | **3,531** | **2,942** | **(589)** |

## Summary and Action

The Trust has reported CIP delivery of £729k (93%) in August 2019, a £176k increase on the run rate to the end of July.

The Theatres programme has benefited from the first changes to booking practices, although the Trust does not expect to gain full traction until the implementation of the scheduling tool beginning in October.

The patient flow programme has once again not met its financial target. The Trust once again managed without requiring it's escalation beds, delivering a saving of £23k but was unable to close down any of the 'core' bed base. The most notable operation KPI failure leading to this shortfall is the level of delayed transfers of care, which peaked in the final week of August following the late summer bank holiday.

Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Trust Board (Public) | **Agenda item:** | 3.1 |
| **Date of Meeting:** | 03 October 2019 | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Winter Plan | | | |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | X | | X | |
| **Prepared by:** | Andy Hyett, COO | | | |
| **Executive Sponsor (presenting):** | Andy Hyett, COO | | | |
| **Appendices (list if applicable):** | 1. Winter Plan Presentation<br>2. Operational Resilience and Capacity Plan (Winter) 2019/20 (to follow) | | | |

| **Recommendation:** |
|---|
| The attached Winter Plan provides the Committee with assurance of the plans that are in progress and in place to maintain operational delivery in 2019/2020. |

| **Executive Summary:** |
|---|
| Detailed modelling of capacity across South Wiltshire has been completed using a model commissioned by Wiltshire CCG. Four scenarios will be presented to the Committee.<br><br>In addition the Operational Resilience and Capacity Plan for SFT is included for assurance. This document will continue to be updated as winter planning continues.<br><br>The Winter Plan will be monitored through the Weekly Winter Resilience Group meeting with individual Directorates monitoring work streams included and providing update/feedback on progress in achievements at these sessions. |

| **Board Assurance Framework – Strategic Priorities** | Select as applicable |
|---|---|
| **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 | ☐ |

# SFT Winter Plan

# Wiltshire Capacity Model

Salisbury NHS
NHS Foundation Trust

Figure 1: Baseline – 2.4% growth and expected LOS reductions

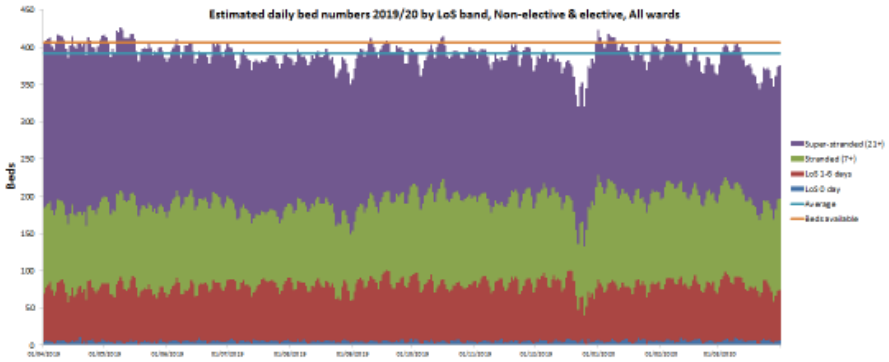



Figure 2: High Winter NEL growth (4%)

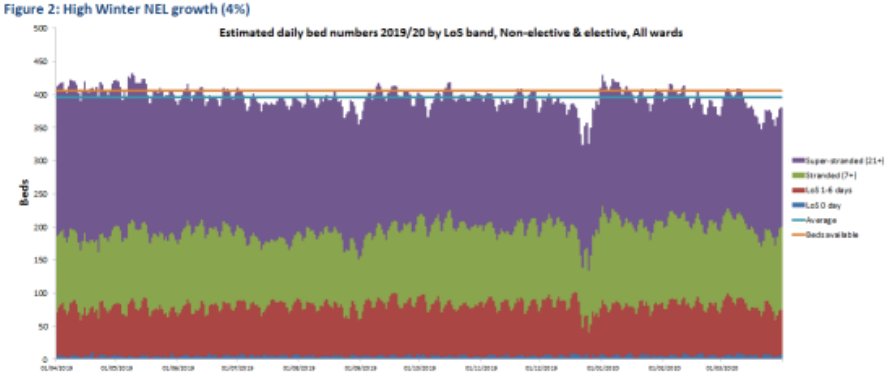



Figure 3: High Winter growth (4% NEL) and no reduction in DTOCs or LOS

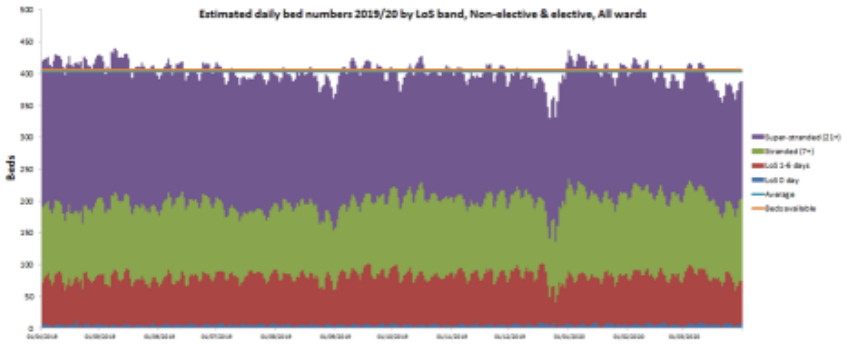
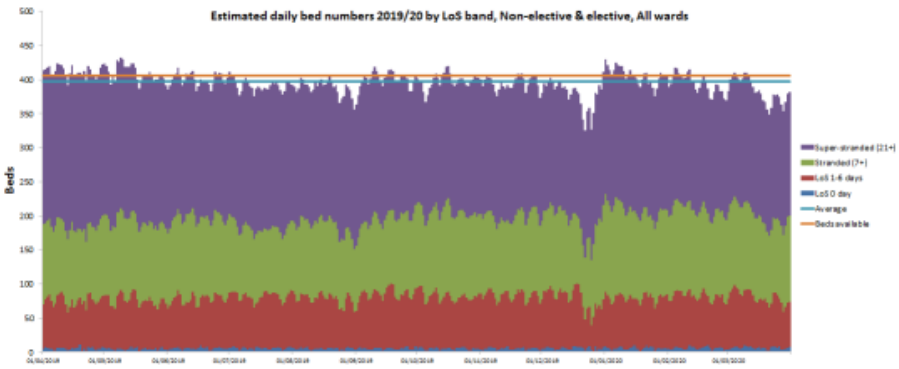



Figure 4: 2.4% growth in NEL as planned, no improvement on 7 day LOS, 1 day improvement on 21+ LOS.



# What does it tells us?

Salisbury NHS
NHS Foundation Trust

- Option 1 – DTOC 14 and normal winter
  - Laverstock for 2 months in Q4
- Option 2 – winter growth 4% (Flu)and DTOC at 14
  - Laverstock Q3 and Q4 (Q1) + 4 beds
- Option 3 – winter growth 4% (Flu) and no DTOC improvement (average)
  - Laverstock Q3 and Q4 + 10 beds
- Option 4 – No increased winter growth and no DTOC improvement (average)
  - Laverstock Q3 and Q4 + 6 beds

# Other Acute initiatives

Salisbury NHS
NHS Foundation Trust

- 7/7 Consultant ward round cover on all specialties for January (aim to extend into February)
- Additional F1/F2 ward cover Saturday and Sunday (mid December through to end of March)
- Additional Trust Grade weekend cover (0900-1400 to support wards)
- Additional x 5 SHO agency cover doctor across medicine (January to April)
- Pharmacy support to MAU at weekends (January to March)
- Additional twilight and weekend ward clerk cover on MAU
- Additional therapy support across medicine in January
- Additional B5 in AMU night shift to allow safe management of overnight patients in AMU

# Other Acute initiatives

Salisbury NHS
NHS Foundation Trust

- Continue to develop pathways to avoid GP expected patients going to ED
- Develop pathway for patients to go to Shaftsbury beds if commissioned
- Working with council on strength based model
- Alignment of physio lead services with Wiltshire Health and Care
- Development of outreach service to avoid admissions with PCNs and WH+C

# Inter dependancies

Salisbury NHS
NHS Foundation Trust

- Adverse weather – business continuity and contingency plans in place
- Flu pandemic – linking closely with Public Health
- EU exit – fully compliant with

# What next

Salisbury NHS
NHS Foundation Trust

- Working with WH+C to streamline therapy services
- All winter initiatives being implemented
- Laverstock plan to open on 1st Feb
- Weekly winter resilience meetings start 1st Oct
- Calculate impact of options on planned care
- Subsequent financial risk to SFT and wider system

- What does the model say for other providers?

Salisbury
NHS Foundation Trust

# OPERATIONAL RESILIENCE AND CAPACITY PLAN (WINTER)

# 2019/20

Version 2.2
Date 20.09.19

## 1.0 Executive Summary

1.1 Winter typically results in an increase in demand both from seasonally affected conditions and an increased risk relating to infection prevention and control outbreaks, and the potential risk of influenza. The winter plan is supported by a range of operational and escalation plans covering areas such as influenza, mortuary and major incidents. Numerous studies show that keeping patients in hospital for longer than necessary can be detrimental to their health outcomes. Further to this, keeping patients in an Emergency Department (ED) for longer than the maximum 4 hour wait will have a significant impact on their outcomes. In order to ensure patients move from ED to the appropriate service or ward, flow must be maintained throughout the hospital and into the community/home setting.

1.2 A system wide capacity demand model has been developed and the trust has used this to model scenarios. The same model should be used by other providers therefore ensuring the same assumptions and calculations are used by all.

## 2.0 Introduction

2.1 Winter pressure is a well-recognised national issue for the NHS. It is a challenge for the whole of the health and social care system and tends to be characterised by an increase in presentations and admissions to hospital which in turn impacts on capacity and flow. This requires a whole system response to effectively support admission avoidance where the needs of the patient can be met in the community, effective and optimal management of length of stay in hospital, and timely discharge to an appropriate place, ideally the patient's usual place of residence. Any 'surges' in demand materialises as over-crowding in the Emergency Department (ED) and assessment units, making the 95% urgent care standard difficult to achieve and impacts on quality and experience for patients and staff.

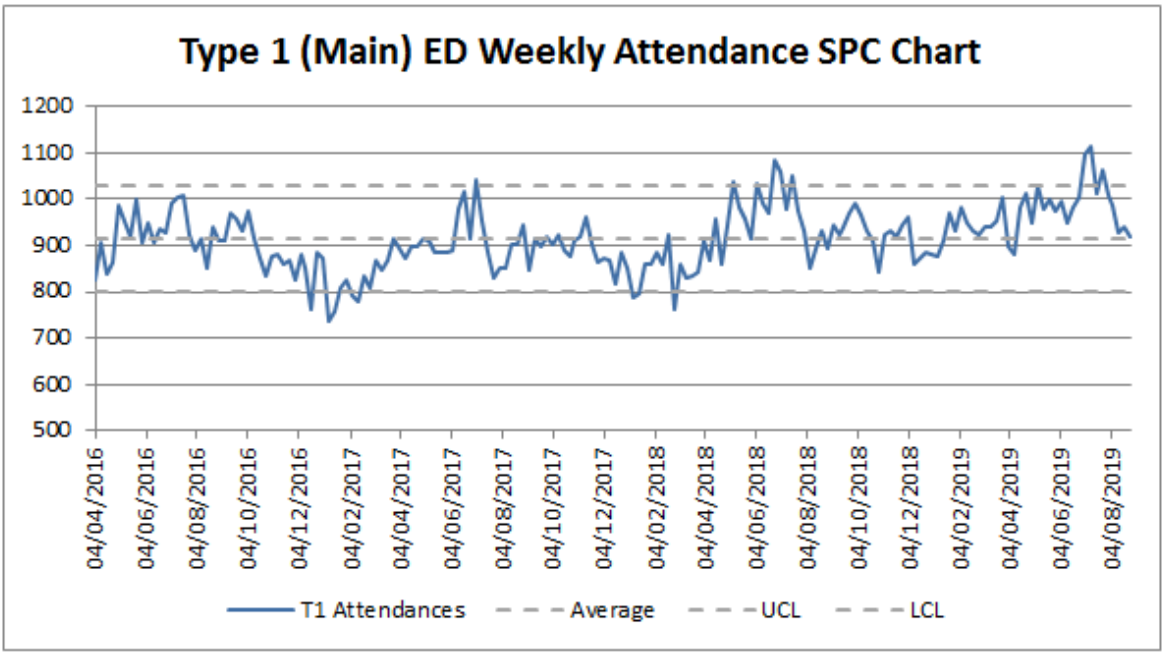
2.2 When flow across the hospital slows, ED becomes overcrowded and breaches occur. Patients end up in the wrong beds/clinical team, elongating their stay; ward rounds last longer; escalation beds are opened and ambulances queue – which in turn slows the system outside the hospital. These are symptoms of a health and social care system under pressure. Overcrowding is unsafe and impacts on both quality of care and patient experience. Therefore, ED overcrowding is a gauge of whole-system capacity and resilience and as such should be avoided.

2.3 This document gives an overview of the plans to manage increased demand on Salisbury NHS Foundation Trust (SFT) resources; this includes new ways of working internally and with partners in addition to a change in resourcing to better manage patients to avoid admissions where possible and reduce the number of prolonged admissions.

## 3.0 Local Trends and Anticipated Demand/Capacity Requirements

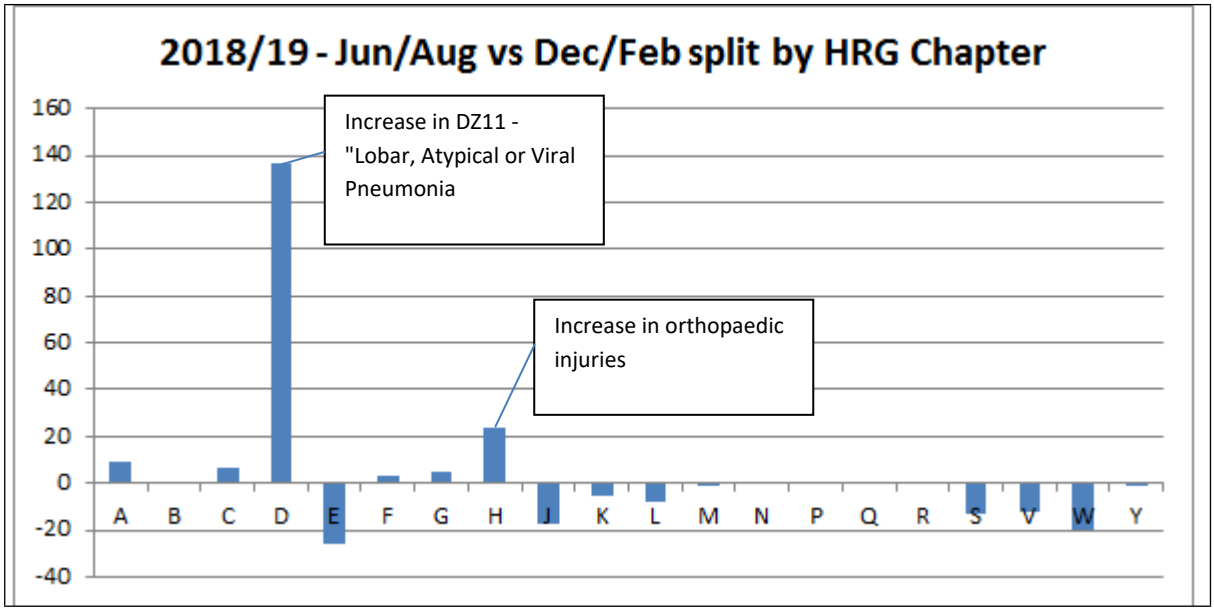
3.1 ED activity during 2018/19 and 2019/20 has seen a continued increase in attendances, averaging at 4157, over a 12 month period (Sept18-Aug19). This increase is expected to continue into winter months, alongside non-elective admissions, which also continue to see an increase across all specialities. The conversion rate from ED is around 27%, in line with national data.

**Graph 1. Type 1 Activity**



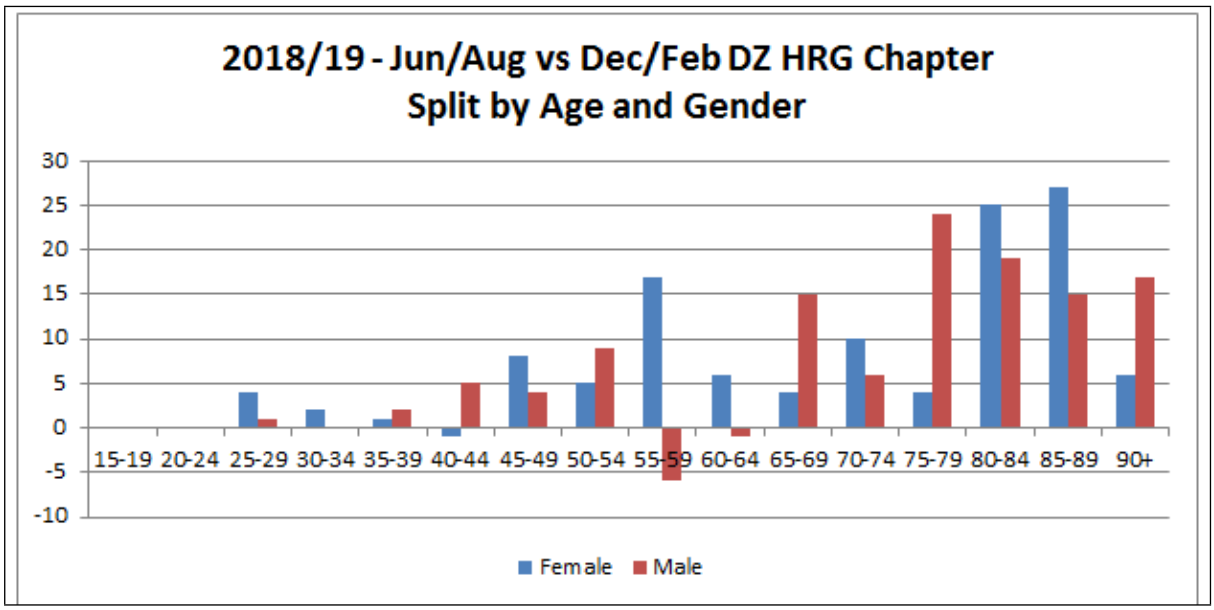

3.2 The over 75 population invariably struggles more with specific conditions, that are more prevalent over the winter period. National research highlights increased lengths of stay in elderly patients significantly reduces their function as well as increasing both onward dependency and mortality. When looking at changes in emergency admissions between summer (June to August) and winter (December to February) months, there are clear diagnosis groups which see greater change. These are respiratory disorders in both adults and children and conditions associated with viral infections.

**Graph 2. HRG Trends**




3.3 For the second year the biggest change by far is for adults in DZ HRG Chapter - "Respiratory System Procedures and Disorders". Breaking this down by age and gender, the increase is predominantly over 75 year olds. Males look to have increased admissions slightly earlier from 65 years of age.

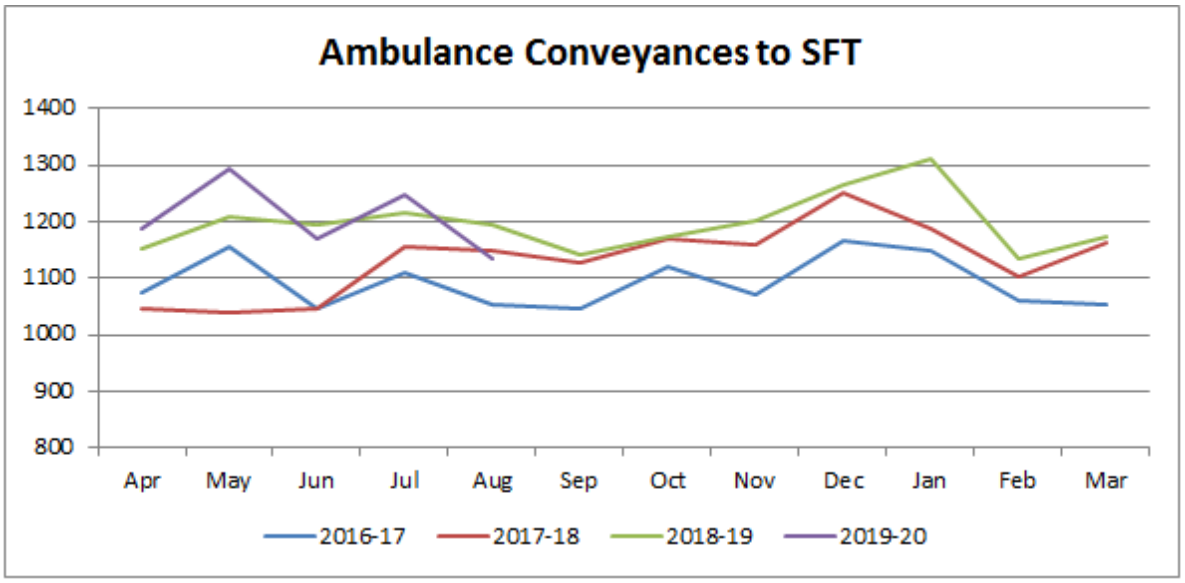
**Graph 3. Age trends**




3.4 Fractured neck of femurs are also highly prevalent in this age group all year round and did see an increase last year which has not been seen in previous years.

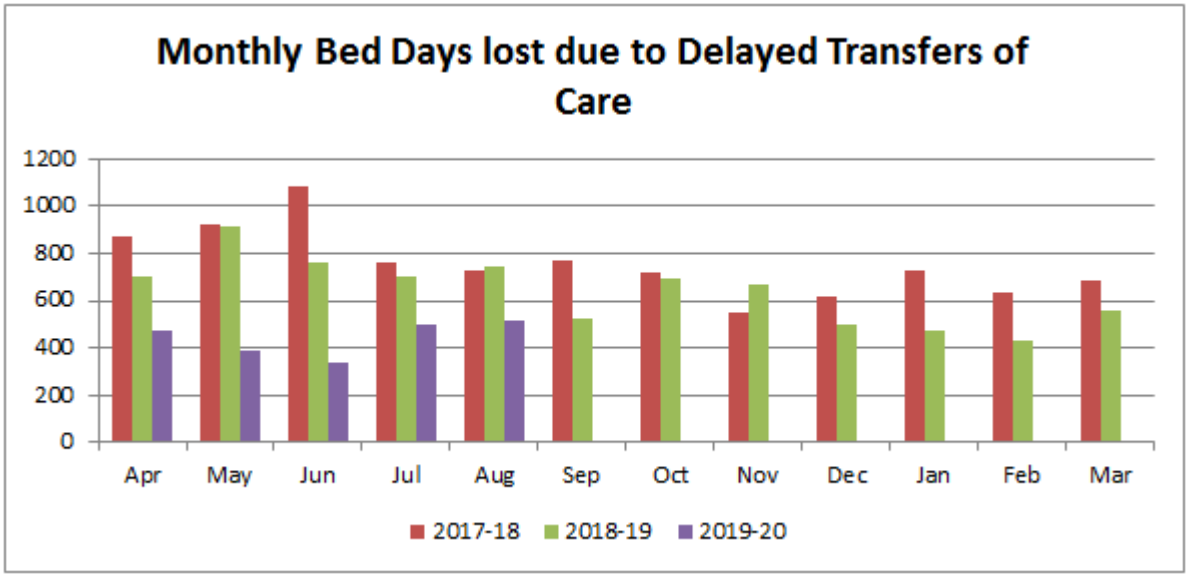
3.5 The Trust is serviced by two ambulance trusts, South Western and South Central Ambulance Services. Ambulance conveyances to the Trust have continued to grow year on year however this growth has not continued in Q2 this year.

**Graph 4. Ambulance Conveyances**



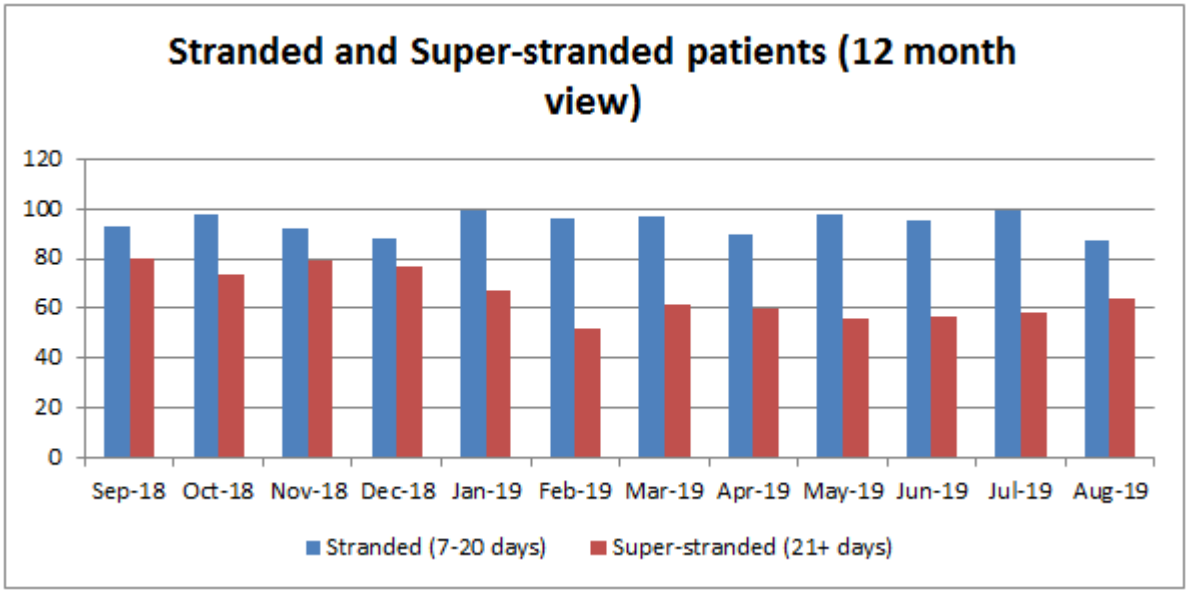

3.6 During winter 2018/19 there was an average of 30 formal delayed transfer of care (DToC) and 60 "Green to Go" patients at any given time. These numbers have not dropped sufficiently during the year, with the Trust falling within the third quartile when benchmarked nationally for bed days lost due to DToCs (Model Hospital data).

**Graph 6. Delayed Transfers**



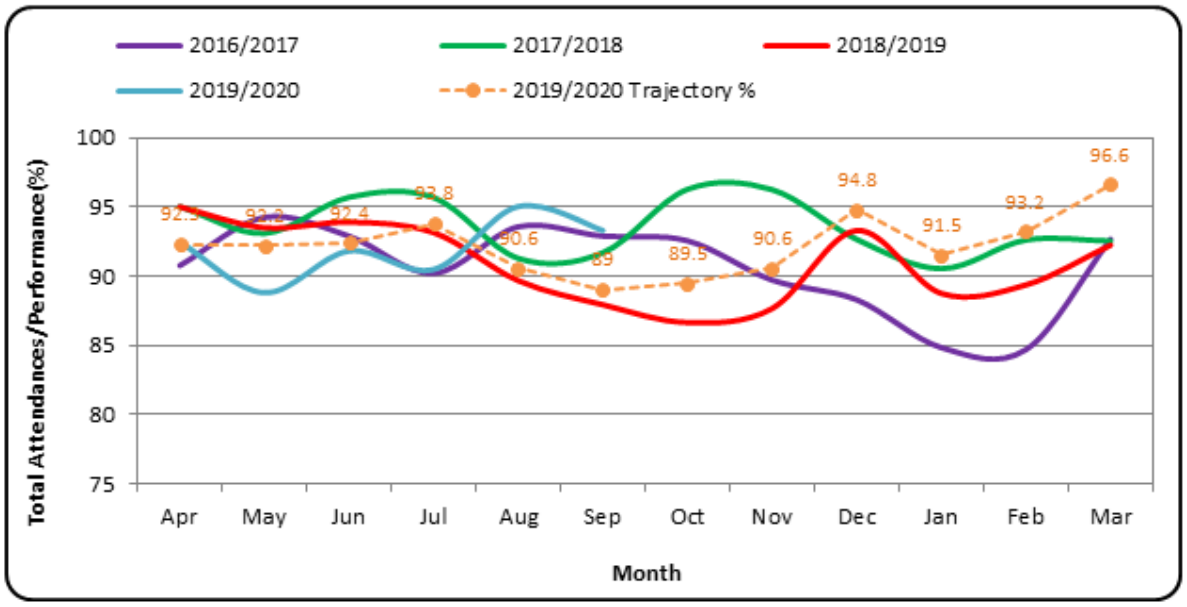
3.7 In addition to formal DToC rates, the Trust monitors current inpatients with extended lengths of stay, both stranded (7-20 days) and super stranded (21 days plus) excluding specialist care (burns, spinal and intensive care patients). The Trust has made improvements in stranded patients during the last year reducing from c.100 patients in January 2018 to 88 at the end of September but the level of super stranded has risen slightly from 72 to 84, despite increasing the number of super stranded discharges from an average of one per month to two per month since April 2018.

**Graph 7. Stranded Patients**




3.8 With the increasing demand in 2019/20, a lack of equivalent improvement in DToC patient numbers and those admitted for more than 7 days, the Trust has found it challenging to meet the urgent care trajectory.

**Graph 8. ED Performance**




## 4.0 Winter Plan

4.1 The winter plan covers the actions that the Trust will be taking above and beyond daily business as usual. Some actions started some time ago and may continue after winter however, they form an important part of the overall jigsaw to ensure the Trust is able to respond to the challenges winter might bring.

The actions within this plan will also be summarised within the South Wiltshire Local Delivery Board Winter Plan which details what each partner organisation has committed to do in the coming months above and beyond the normal escalation activities. The aim is to reduce the risk of restricting patient flow wherever possible by taking actions early. Learning from last winter has informed many of the actions in conjunction with national best practice guidance.

4.2 The principles which underpin this plan are:

- Capacity is managed as a co-ordinated system across the site, especially within the Emergency Department and Ward areas.
- The clinical priority of the patient, across all directorates is the key determinant of when and where patients are treated and cared for. This may mean some urgent elective admissions are prioritised above emergency patients.
- Managing patients at the time of increased escalation will require accepting and managing additional risks across the organisation
- We will ensure wherever possible that patients are treated in the right place, first time
- All staff are responsible and accountable for effective bed utilisation within their specialities. They must follow the relevant actions to avoid/minimise delays in admissions and discharges.
- Each ward is expected to make effective use of the discharge lounge.

4.3 It is anticipated that Laverstock ward will open from 1st February 2020 to 31st March 2020, to provide additional capacity, therefore the winter plan for 2019/20 focusses on flow and prioritisation of patients, engaging clinicians and processes to support this methodology.

4.4 **Supporting policies and documents**

This plan should be read in conjunction with the following existing documents:

- Bed Capacity Management Policy
- Business Continuity Policy
- Major Incident Policy
- Pandemic Influenza Plan
- Cold Weather Plan
- The South Wiltshire Local Delivery Board Winter Plan
- The South Wiltshire Local Delivery Board Sustainability Plan checklist
- The South Wiltshire Local Delivery Board Escalation Plan
- Internal Operational standards
- Trust Operational Pressures Escalation Framework

4.5 **Bed Modelling**

The Trust has used the whole system capacity and demand model commissioned by Wiltshire CCG. Four scenarios have been modelled and the this are shown below. In line with this modelling the trust plans to open Laverstock for 2 months in Q4 2019 / 20.

- Option 1 – DTOC 14 and normal winter
  - Laverstock for 2 months in Q4
- Option 2 – winter growth 4% (Flu)and DTOC at 14
  - Laverstock Q3 and Q4 (Q1) + 4 beds
- Option 3 – winter growth 4% (Flu) and no DTOC improvement (average)
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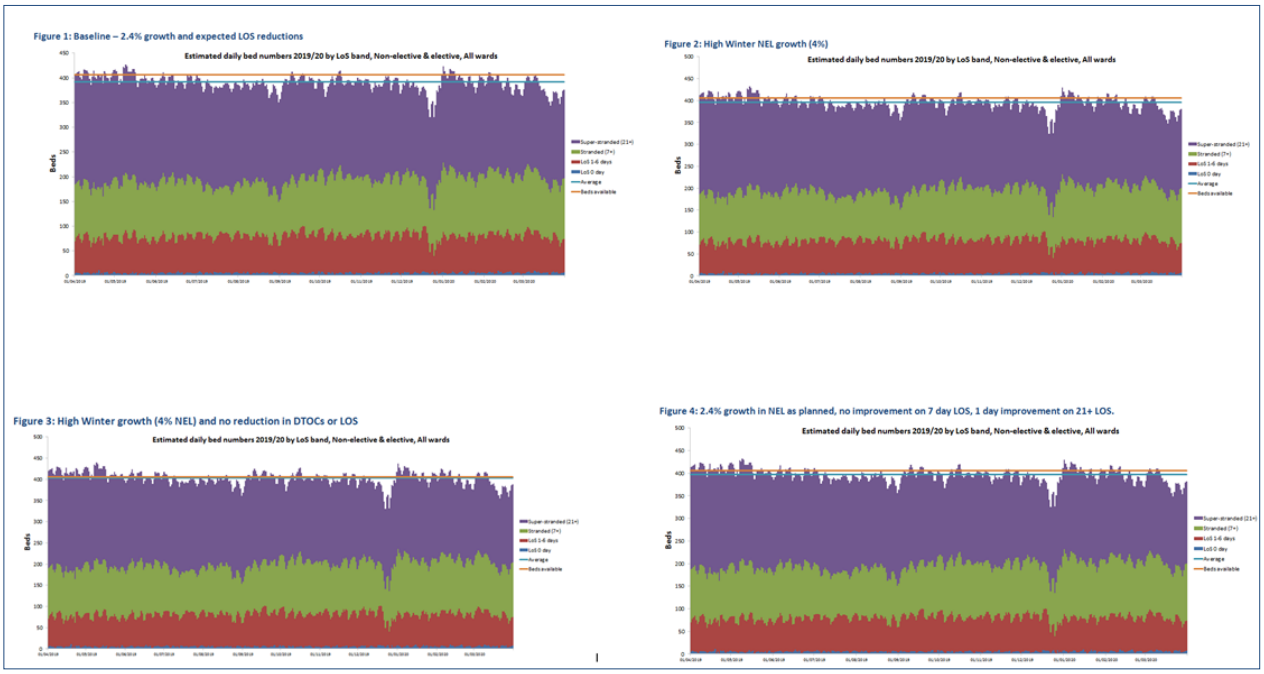



4.6 **OPAL**

The Older Person's Assessment and Liaison (OPAL) team is an evolving multi-professional team comprising of generalist trained Specialist Nurse, Occupational Therapists, Physiotherapists and Therapy Assistant Practitioners. They work in the Emergency Department (ED), Short Stay Emergency Unit (SSEU), and Acute Medical Unit (AMU) undertaking comprehensive assessment and intervention to identify frailty at the front door. This specialist input results in improved care of frail patients and timely discharges or admission avoidance. OPAL's purpose is the provision of patient-centred care that reduces avoidable admissions, minimises bed moves and length of stay and facilitates onward care planning. The OPAL team has built good working relationships with community partners which allows rapid access to community services such as step up beds, Home First/ESD support and urgent therapy follow ups. The service is available for 64 hours a week, 7 days a week.

4.7 **ESD**

The Early Supported Discharge (ESD) team is a multi-disciplinary team with a focus on supported and timely discharge for patients. The team comprises of Occupational Therapists, Physiotherapists and Therapy Assistants. The ESD team are based within the Salisbury NHS Foundation Trust, allowing them to support discharges in an efficient and expedited manner. The team works closely with ward teams, identifying pathway 1 patients and supporting their discharge home. Once the patient is home the ESD team provide ongoing support to enable the patient to return to being independent and refer to ongoing services if required. The ESD team works closely with Home First to support their capacity, work jointly on discharges and facilitate shared care plans for patients.

4.8 **Domiciliary Care**

Wiltshire County Council, Wiltshire Health and Care, Wiltshire CCG (CHC/Fast Track Teams) will work together to commission 800 hours of domiciliary care across Wiltshire and 30 beds. It is expected but not confirmed that approximately 400 hours of domiciliary care and 15 – 20 beds will be in South Wiltshire.

4.9 **Improving Discharge Processes**

There are a number of elements to support the reduction of stranded and delayed discharge patients in hospital. The SAFER Care bundle for inpatient wards (see Appendix 1) for full definition of SAFER) provides a recognised framework, but enhanced discharge processes at the point of assessment/admission with a clear focus on a plan for home is a focus for the Trust.

The Integrated Discharge Team (IDB) will continue to support and facilitate wards with those patients who have a complex discharge plan. They will continue to proactively support wards and communicate any escalate any concerns to the Head of IDB. In addition, the co-ordinators will continue to provide advice and guidance to ward teams on the discharge process, to ensure ward teams are continually aware of what is required. A revised process for those patients who require fast track referral has been implemented and is working effectively. In addition, the EOLC team have noticed an increase in timely referrals following a review of operational processes,.

The Trust continues to work with the CCG to implement Trusted Assessments, which will improve the efficiency and speed of discharge process as well as the overall relationship between the Trust and community care providers and nursing home providers etc.

A weekly 'Expert Panel', consisting of SFT, CCG and community partners is in place, with terms of reference agreed. This panel has been reviewed more recently in line with the national DPTL requirements, and the panel now discusses and reviews the plans for patients who are not medically fit for discharge but have been in hospital for more than 21 days. This panel continues to support teams in managing the discharge process for these patients discussed.

4.10 **Home First**

Home First is an initiative by Wiltshire health and Care to facilitate the discharge of patients from the acute hospitals in to the community. There are 4 discharge pathways.

In order to be eligible for Home First the patient will be assessed to be on Pathway 1 and, therefore, need to be:

- Medically stable to leave hospital and able to go home but needing additional support
- Supported by family, friends or carers
- Able to access to their normal place of residence and safe to be left between care visits
- Able to undertake assessment and rehabilitation in their own homes

Once a patient is medically fit for discharge a referral is made to access to care which is then passed to the community teams. This referral is a simple phone call involving answering 10 questions and can be made by the nursing or therapy team looking after the patient. Once the team has capacity, the patient is discharged and their care is then coordinated by the community teams. For Home First to be effective and responsive in receiving patients from hospital, they are only able to take those who are able to engage with rehabilitation and return to independence or their previous functional ability within 1-2 weeks.

Capacity within this service is not sufficient to meet demand and WH+C have expressed concern over their ability to increase capacity.

4.11 **Community/ Voluntary Sector**

Age UK and SFT are refreshing their approach to the hospital service and hope the result to be an increase in referrals with an expanded geographical offer and improved awareness of the needs of patients being discharged from hospital. Wiltshire Council have implemented a scheme with Public Health that has seen a coordinator in the South locality with a broad remit for supporting vulnerable people on discharge with a view to preventing unnecessary readmission. Additionally for Winter 2019 The Centre for Sustainable energy and Wiltshire Council are working together with SFT, providing an in hospital worker working alongside the IDB who will seek referrals for vulnerable patients who are for example at risk of fuel poverty, those with no heating in homes they are to return to on discharge or who need repairs to boilers to maintain heating at home and the worker can facilitate access to grants, heaters, and boiler repairs etc. None of this work will prevent discharge, and is designed to improve resilience in the community for people particularly at risk of readmission.

4.12 **Care Home Conveyances**

The red bag initiative is now live and the trust has been commended for its **involvement**

When a resident becomes unwell and requires hospital care, care home staff use the red bag to facilitate a smoother handover between care home, ambulance and hospital staff, as it includes the resident's standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items. This results in fewer phone calls and follow-ups looking for health information. This scheme is currently in place in Dorset for some nursing homes. Further information and timescales will be available within the Wiltshire Winter plan.

4.13 **Strengths Based approach**

The Trust is committed to working in partnership with the Local Council to pilot the Strengths based approach, within SFT. The exact area for the pilot is yet to be decided, however, work is

expected to start in October 2019 with those teams, with a working group being established and set-up.

The Strengths based approach is based on 3 conversation levels. It replaces the traditional 'assessment for services' culture with an approach that focuses on what really matters to people, in their families and their communities. People and families are the experts in their own lives, as professionals we need to listen to them and use the resources and skills we have to connect them to the right people, communities and organisations to make their lives work better. As a result:

- The satisfaction of people and families you support will increase, as they feel listened to, often for the first time, and supported to get on better with their lives
- You will have happy, motivated staff who feel liberated, trusted and useful
- You will reduce your reliance on long term, formal care and will be more able to direct the limited resources you have to where they are needed most.

**5. Ready Steady Go**

The newly revised patient flow programme, Ready Steady Go! is composed of three main working groups:

The 'Ready' working group are, in general terms, focussing on front door service improvement. They will be improving clerking processes between ED and the medical teams, reviewing the function of SSEU and its use in terms of flow and in line with the CQC recommendations, working with surgical and MSK teams to improve the process for patients that have been referred to them by their GP and are 'expected' by the teams and also working with OPAL to streamline processes for the frail elderly attending ED with the aim to reduce their length of stay or avoid onwards admission. Ready is led by the Deputy Clinical Lead for ED and is supported by Elderly Care, Acute Medicine and therapy teams.

The 'Steady' working group have four main aims. They will be reviewing and improving handover processes between nursing and medical teams, developing a business case with Pharmacy for improved downstream Pharmacy support, looking at improve access to some diagnostic teams (in particular phlebotomy) and also reviewing ward round and whiteboard practices to ensure they meet the requirements for prompt review and support early discharge. Steady is led by one the Consultant Cardiologists and a Medicine Core Medical Trainee (junior doctor). The rest of the working group is formed of site team, ward sisters and therapy staff.

The 'Go' working group's focus is improving discharge. There was already a large piece of work underway to review the IDB and this continues and will feed into 'Go'. The 'Go' group will also work with therapies to improve internal referral processes between teams and for equipment as well as look at IT requirements to improve access to IT to support prompt referral processes to external partners. Expert panel and discharge PTL continues with external partners as well, as does general pieces of work on culture relating to EDDs and choice. The Head of Integrated Discharge leads the 'Go' group but also attends 'Ready' and 'Steady' to ensure any pieces of work happening in either or their work streams that may influence discharge process are picked up. The rest of the working group is formed of representation from the site team, therapy, Geriatricians and Ward Leads.

Mortuary Winter Plan

During the winter period the mortuary and bereavement department experiences a high service demand that on average lasts from November through to March each year. During this period of time the mortuary and bereavement service may face capacity issues , delays with coronial referrals and also when dealing with non-coronial deaths and getting the paper work complete for the funeral directors to collect deceased from the mortuary.

**Mortuary Capacity**

During this period the mortuary may face capacity issues due to high volumes of death that may occur over the winter months. The Mortuary's standard overall capacity is 38 spaces. In the event the mortuary capacity becomes compromised and nearing capacity, the Mortuary coordinator will instruct the deployment of the contingency storage which consists of a refrigerated "pop up" cube which will increase the capacity by a further 12 spaces. Once these spaces are fully occupied the refrigerated bariatric bay will be utilised which can hold up to 12 further deceased.

In total this means that Trust has a maximum of 62 spaces available within the hospital.

In the event that the Trust's approaches maximum capacity, an agreement with Newman's Funeral Directors is in place to provide support for accommodation of bodies off-site on the Trust's behalf.

**Mortuary Flow**

It is important during high service demands to maintain a "good flow" within the department from bodies entering the mortuary to release, as this will have a positive effect on the overall mortuary capacity and will help mortuary staff manage capacity levels more effectively.

In order for this to happen it is important that the all deceased paper is completed as soon as possible with the aim to get the Medical Certificate of Cause of Death issues on the same day as the death.

This prevents delays in processing the deceased down the correct pathway required and allows the Mortuary and Bereavement team see families in a timely manner and release the deceased to the appropriate Funeral Director, encouraging collection as quickly as possible.

Please refer to the full mortuary escalation plan for more information.

## 5.0 Winter Bed Availability and Staffing

For winter 2019/20 there are no bed reconfiguration works planned. Laverstock is scheduled to open in Q4 (Feb-Mar20). Whilst the Trust has managed up to now, due to a mix of using escalation bed capacity, an under-utilised elective programme and actions to improve flow, the pressure on beds will only increase over the coming months.

Alongside planning for winter, the focus on ensuring the delivery of the elective programme continues with the aim to maintain elective throughput, delivering of the 92% standard and finishing the year with a waiting list size the same as the start of the year.

The Trust is committed to ensuring that no patients are held in ambulances or corridors, including areas not equipped to be bed spaces. To support this commitment, a Trust capacity escalation plan has been agreed that requires approval from the Chief Operating Officer (COO)/Deputy COO in hours and Executive Director on Call out of hours to trigger each level. There are three levels with increasing levels of impact on capacity to undertake elective work and daily diagnostic capacity. The decision to trigger each level will be taken based on the position of the Trust at that time and the wider system escalation level, considering whether partners are sufficiently supporting the Trust to mitigate the risks associated with opening additional bed capacity.

- **Level 1**
  Opens up to 12 beds in areas that are deemed low to medium risk areas for impacting on patient flow and elective work
- **Level 2**
  A further 18 beds become available, primarily in Day Surgery Unit (DSU) and through maximising all Acute Medical Unit (AMU) space for bedding patients. This has a high risk of impacting patient flow and will impede the ability to meet the elective programme
- **Level 3**
  Could see a further 65 beds being available in the most challenging times. This would see patients being bedded in areas such as endoscopy and radiology, leading to restrictions on the daily running of the hospital. The elective programme will also be significantly impacted with all DSU space and theatre recovery turned over to inpatient capacity.

Risk assessments for using escalation beds at each level has been undertaken and can be seen in Appendix 3. All patients bedded in DSU for longer than 72 hours must be reviewed by the Deputy Director of Nursing and Deputy COO. The use of Laverstock should be only considered once DSU has been reviewed, the opening standing operating procedure (SOP) must be adhered to. To initiate level 3 capacity escalation, two approvals are required with the second being one of Medical Director, Director of Nursing or COO.

A ward level summary of the core bed compliment and available escalation beds at each level is below:

| Ward/Area | Specialty | Original Bed Base (Excluding 56 Trollies) | Level 1 Unfunded Escalation Beds | Level 2 Unfunded Escalation Beds | Level 3 Unfunded Escalation Beds |
|---|---|---|---|---|---|
| Acute Medical Unit | General Medicine | 19 | 4 | 8 | 8 |
| Amesbury Suite | Orthopaedics | 32 | 0 | 0 | 0 |
| Avon | Spinal | 21 | 1 | 1 | 1 |
| Tamar | Spinal | 21 | 1 | 1 | 1 |
| Farley | General Medicine (Stroke) | 31 | 1 | 1 | 1 |
| Burns | Burns | 17 | 1 | 1 | 1 |
| Britford | General Surgery | 20 | 0 | 0 | 0 |
| Britford -SAU | General Surgery. | 0 | 4 | 6 | 6 |
| Chilmark Suite | Orthopaedic | 24 | 0 | 0 | 0 |
| DSU | Day Surgery Unit | 0 | 0 | 12 | 30 |
| Durrington Suite | Elderly Medicine beds | 21 | 2 | 2 | 2 |
| Laverstock | Plastic Surgery | 0 | 0 | 12 | 26 |
| Pitton | General Medicine | 27 | 0 | 0 | 0 |
| Redlynch | Elderly medicine (Gastroenterology) | 27 | 0 | 0 | 0 |
| Tisbury | General Medicine (Cardiology) | 14 | 0 | 0 | 0 |
| Tisbury CCU | General Medicine | 9 | 0 | 0 | 0 |
| Whiteparish | General Medicine | 23 | 0 | 0 | 0 |
| Spire | Elderly medicine | 30 | 0 | 0 | 0 |
| The Clarendon Suite | Private patient beds | 0 | 0 | 0 | 0 |
| Downton | Surgery | 24 | 0 | 0 | 0 |
| Breamore | Surgical Short Stay | 20 | 2 | 4 | 4 |
| Radnor | ICU | 10 | 0 | 0 | 0 |
| Sarum | Paediatrics | 16 | 0 | 0 | 0 |
| NICU | Paediatrics | 10 | 0 | 0 | 0 |
| Labour ward | Maternity | 13 | 0 | 0 | 0 |
| Ante natal | Maternity | 3 | 0 | 0 | 0 |
| Post natal | Maternity | 14 | 0 | 0 | 0 |
| Pembroke Ward | Medical Oncology | 10 | 0 | 0 | 0 |
| Pembroke suite | 5 Cl Haematology 5 Oncology | 0 | 0 | 0 | 0 |
| Short Stay Emergency Unit | Emergency Department | 8 | 0 | 0 | 0 |
| Endoscopy | Endoscopy | 0 | 0 | 0 | 10 |
| Radiology | Radiology | 0 | 0 | 0 | 4 |
| Theatre Recovery | Theatre Recovery | 0 | 0 | 0 | 1 |
| **TOTAL** | | **464** | **16** | **48** | **99** |
| **Total Minus ICU, Maternity and Paediatrics** | | **398** | **16** | **48** | **99** |

Version 2.2
Date 20.09.19

## 6.1 Ward Staffing Plan

Currently there are a total of 45 RN vacancies (173 winter 2019). Ensuring the Trust has a realistic and responsive plan to mitigate the risks of potential peaks in demand and gaps in rotas is vital. The approach for winter 2019/20 builds on the ongoing programmes of work outlined within the Trust's people strategy. The following key areas of specific focus for winter are:

a) **Forward planning of rosters:** All ward areas are required to ensure that ward rosters are signed off 6 weeks in advance, and skill mix reviewed. Block booking of lower cost agencies will be considered to ensure efficiency and effectively deployed staff to support normal bed base. This approach will then be enhanced to include escalation area needs. The additional agency booking will therefore be directed to areas for escalation (see below for details of expected maximum requirements for each capacity escalation level).

**Level 1**

| Ward/Area | Escalation Beds | RNs required | | HCAs required | |
|---|---|---|---|---|---|
| | | Day | Night | Day | Night |
| Acute Medical Unit | 4 | | 1 | | |
| Avon | 1 | | | | |
| Tamar | 1 | | | | |
| Farley | 1 | | | | |
| Burns | 1 | | | | |
| Britford -SAU | 4 | | 1 | | |
| Durrington Suite | 2 | | | 1 | |
| Breamore | 2 (up to 4) if elective capacity issues | | | | |
| **TOTAL** | **16** | | | | |

**Level 2**

| Ward/Area | Escalation Beds | RNs required | | HCAs required | |
|---|---|---|---|---|---|
| | | Day | Night | Day | Night |
| Acute Medical Unit | 8 | | 1 | | |
| Avon | 1 | | | | |
| Tamar | 1 | | | | |
| Farley | 1 | | | | |
| Burns | 1 | | | | |
| Britford -SAU | 6 | | 1 | | |
| DSU Upstairs | 12 | 2 | 2 | 1 | |
| Durrington Suite | 2 | | | 1 | |
| Laverstock | 12 | 2 | 2 | 1 | |
| Breamore | 4 | | | | |
| **TOTAL** | **48** | | | | |

**Level 3**

| Ward/Area | Escalation Beds | Nurses required | | HCAs required | |
|---|---|---|---|---|---|
| | | Day | Night | Day | Night |
| Acute Medical Unit | 10 | | 1 | | |
| Avon | 1 | | | | |
| Tamar | 1 | | | | |
| Farley | 1 | | | | |
| Burns | 1 | | | | |
| Britford -SAU | 6 | | 1 | | |
| DSU Upstairs and downstairs | 30 | 4 (2 up and 2 down – some internal cover | 4 (2 up and 2 down) | 2 | 2 |
| Durrington Suite | 2 | | | 1 | |
| Laverstock | 26 | 4 | 3 | 3 | 2 |
| Breamore | 4 | | | | |
| Endoscopy | 10 | 1-2 | 2 | 0 | |
| Radiology | 4 | 1-2 | 2 | 0 | |
| Theatre Recovery | 1 | 0 (use existing staff) | | 0 | |
| **TOTAL** | **95** | | | | |

NB of note all additional staffing above subject to daily review of acuity and dependency of patients, and thus reflects the minimum requirement.

b) Support from non-ward staff in ward tasks.
Specialist Nurses and staff volunteers from non-clinical areas will support ward teams in non-clinical tasks when demand dictates. Requests for this will be identified at the morning and afternoon staffing meetings, with the requests for support and help circulated.

c) In addition if there are other staff groups/AHP's who are able to provide additional operational support to ward teams, identification of training needs and attendance for this will be considered and managed by the respective managers.

d) The Deputy Director of Nursing will be available throughout January to support clinical areas when needed.

e) The Voluntary Services Manager will also be contacted at times of increased demand to identify additional volunteer support across the Trust. Requests will be identified at the morning and afternoon staffing meetings and the manager contacted promptly to establish what support is available.

## 6.2 Escalation process for agency staff for seasonal pressures

The Trust will optimise the utilisation of internal resources before the deployment of temporary bank/agency staff. The following flow chart summarises the prioritisation of resource:


To mitigate the need for agency usage the following has commenced:

- Nursing rosters are locked down a minimum of 6 weeks ahead of roster being worked with sign off by Matron or Head of Nursing.
- Nurse agency follows a well-established tiering process with high cost agency requiring executive approval
- Medical Staff will be asked to submit their rotas for Christmas and New Year at the beginning of November
- Medicine on-call consultant rota will be doubled for bank holiday dates
- Emergency Department staffing will be increased around known pressure points

Support of junior staff across directorates is available through Consultant presence in addition to the support provided by nursing staff.

## 6.3 Flu

Planning for the Trust's flu vaccination campaign commenced in April 2019 with a planned large scale launch for the 30th September which is the earliest opportunity to have access to the vaccine. Staff will have opportunity to be vaccinated at the launch and listen to an external speaker as well as receive information on the myth busting flu vaccination. There are a large group of peer vaccinators who will have completed additional training and will be able to also 'myth bust' on the vaccine. The process of data collection has been reviewed with the aim of more timely reporting and the use of

the jabometer (although this is not being used as part of the national campaign this year) to illustrate compliance with the aim of achieving 100% of frontline staff.

There will be a dedicated flu clinic situated in a central space within the Hospital which will be staffed from October – December and once reporting data is available, areas of low compliance will be targeted by the Occupational Health Team to understand the issues related to not up taking the vaccine.

### 6.4 Fit Testing

The number of staff FIT tested continues to vary with new starters not consistently tested on induction, however there are different approached including trialling a FIT Test day hosted by the Medical Directorate. The aim is to ensure that a range of professional staff are compliant. Clinical Directorates are prioritising the testing of clinical staff groups that are most likely to need to use a level 3 mask. Continued information and advice regarding the appropriate use of masks is ongoing with the IPC Team. Experienced Fit testers are beginning to undertake a 'train the trainer' approach and compliance monitoring will continue via the weekly winter pressures meeting.

## 7 Communication

7.1 It is important to show that winter is being taken seriously, with significant effort going into improving emergency services and highlighting the wider range of support available to patients. To this aim, each year Salisbury NHS Foundation Trust undertakes focused communications using a broad range of methods and platforms, including media relations, social media and e-marketing, targeted marketing, internal communications tools (CEO weekly message, Pulse and staff 'Cascade' briefings). This is vital to ensure our key stakeholders understand our winter plans and SFT emergency care services.

For 2019/20, the Trust intends to undertake the following additional activities:

a) To update the messaging on the main switchboard to highlight what to do if you have both norovirus and flu alongside directing patients to the website for sign posting information
b) Ensure key messages are displayed on the Trust's website home page
c) Undertake a campaign on social media with public, highlighting available services in the community available to all prior to thinking about coming to hospital
d) Proactive flu campaign media relations, including notifications to forward planning desks
e) Reactive media relations during times of escalation

7.2 Staff and stakeholders will also be engaged with to outline the key actions outlined in this plan. It is important to show that winter is being taken seriously, with significant effort going into improving emergency services and highlighting the wider range of support available to patients.

7.2 The South Wiltshire Local Delivery Board Winter Plan also highlights communication activities.

## 8 Winter Plan Key Risks

8.1 The winter plan is an iterative process, and models are in development. There remain a number of risks to service:

| Risk | Mitigation |
|---|---|
| Admission numbers continue to grow & outstrip bed capacity | Ambulatory care service & assessment beds protected going into the night – plans are in place to address this. Use of escalation beds with appropriate staffing to be utilised, in-reach into ED from Acute Medic and OPAL team (with support from therapy and social services) |
| Discharge delays remain over agreed % for the system | Focus on stranded patient reduction and DTOC numbers. The appointment of the Winter Director, Gold calls, weekly Expert panel, existing DTOC calls/meetings and IDB facilitator support to wards |
| Overcrowding in ED | Ensure ED position is prioritised as a measure of bed flow and patient safety – it is a hospital-wide gauge of quality and predicted length of stay. Streaming and AEC will assist in pulling appropriate patients through to the required environment.<br>Implementation of the 4 hour checklist is in place.<br>Successful recruitment to the ED Navigator role |
| Seasonal flu | Ensure 75% uptake of vaccine for staff. Respond to national guidance relating to pandemic arrangements (see separate guidance) Ensure all frontline staff are trained in the use of FFP3 Mask Personal Protective Equipment (PPE). Escalate to Pandemic Flu Policy as directed by PHE. Risk assessment of patients in ED remains crucial for admission avoidance. (not for inclusion Anita but last year the majority of 'flu' patients were sent home the next day after hitting an inpatient bed) |
| Norovirus | Remains the highest Infection Prevention and Control (IPCT) risk for ward closure. IPCT will re-enforce infection control practice to inform clinical staff in the lead up to winter. Daily ward rounds and monitoring for increased incidence of loose stools will continue. Direct communication from CCG/PHE and neighbouring trusts will be shared for awareness and appropriate action by SFT. |
| Severe weather | Review local business continuity plans for staff and communicate plans in line with national guidance on expected weather conditions. Include weather warnings in bed meetings where appropriate. Daily met office reports in place and live from 1 November 2018. |
| Workforce availability | HR will support operational teams with management of sudden sickness and access to temporary staffing |

## 9. Operational Delivery

Running up to and during winter the Trust turns over the weekly operational working group (OWG) to winter planning and preparedness. This group oversees the implementation of the winter plan and ensures the inevitable variations and bespoke challenges of running a hospital are responded to in a structured, tactical fashion. This ensures there is a clear bridge from the daily operational management of the Trust and a considered approach for the evolution of the

winter plan, learning from what is occurring across the hospital and wider health and social care landscape.

Having oversight of our demand and capacity is vital to ensure we understand where we are at any given time. The Trust continues to use the existing e-whiteboard system; however, this is being reviewed to identify opportunities to improve the bed management provision currently in use. The importance of keeping e-Whiteboards up to date and maintaining accurate and timely ADT (Admissions, Transfers and Discharges) on Lorenzo is understood and discussed with ward staff. Further to this, a live dashboard in ED for both staff and patients to understand the current "heat" of the department to dynamically respond to this wherever possible in order to maintain flow through the department, is now in use.

### 9.1 Escalation Plan

SFT's Operational Escalation Plan aims to provide a consistent approach in times of pressure to manage day to day variations in demand across the hospital as well as the procedures for managing surges in demand. Specifically by:

a) Enabling local systems to maintain quality and patient safety
b) Providing a consistent set of escalation levels, triggers and protocols.
c) Setting clear expectations around minimum actions for those involved in escalation in response to surge pressures
d) Setting consistent terminology

The winter plan works in conjunction with the Trust's escalation plan which has been reviewed ahead of the winter period to ensure it remains fit for purpose.

There are four levels of escalation within the escalation plan as shown in table 1 below. It is not normally expected that escalation would be a cause of a declared major incident as escalation is a result of general capacity and demand rather than pressure caused by a specific event. Whilst it is recognised that there may well be actions that are common to escalation levels 3 and 4 and major incident plans, the latter should not be confused with general escalation due to wider resilience structures and processes in place.

Table 1: Operational Pressure Escalation Levels (OPEL)

| | |
|---|---|
| OPEL 1 | **Escalation Level 1: patient flow management. Business as usual**.<br>Capacity is such that the hospital is able to maintain patient flow and is able to meet anticipated demand within available resources. |
| OPEL 2 | **Escalation Level 2: mitigation of escalation**<br>The health and social care system is starting to show signs of pressure. The hospital is required to take focused actions to mitigate the need for further escalation. Enhanced coordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. |
| OPEL 3 | **Escalation Level 3: whole system compromised**<br>The hospital is experiencing major pressures compromising patient flow and continues to increase. Actions taken in Level 2 have not succeeded in returning the hospital Level 1. Further urgent actions are now required across the local system and increased external support may be required by partners. |
| OPEL 4 | **Escalation Level 4: severe pressure and failure of actions**<br>Pressure continues to escalate leaving the hospital unable to deliver comprehensive emergency care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken to recover capacity and ensure patient safety. All available local escalation action taken, external extensive support and intervention required. Serious Incident to be reported. |

As such, the hospital may declare an internal 'critical incident' during times of great pressure or Business Continuity Incident where the level of disruption results temporarily or permanently losing ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions (e.g. internal capacity issues)

The hospital reserves the declaration of a major incident for when the formal multi-agency response is required e.g. fire or flood.

The system escalation triggers and actions, approach to escalating to a system wide black status and the actions to be taken in this event are covered in the South Wiltshire Local Delivery Board Escalation Plan link

**Major Incident, Standby or Declared**

In the event of a major incident the Major Incident Policy should be enacted which can be found on the intranet at the below link. This covers the process for escalation and de-escalation for major incidents and communication. Major incident plan action cards outline key roles and responsibilities for key individuals.

It is the expectation of all staff who might potentially be involved in a major incident to have read and understand the major incident policy and action cards relevant to them.

Major incident policy:

http://intranet/website/staff/policies/businessandprovisionofservices/major+incident+policy.asp

Major incident plan action cards:
http://intranet/website/staff/emergencyplanningdocumentation/plans/majorincidentplanv1.pdf

## 9.2 Daily Capacity Meetings

Daily capacity meetings chaired by the Head of Patient Flow will take place at 09:30 and 16:15 hrs (Mon-Fri). When in escalation extra meetings may be held. This will be kept under review to best manage timeliness of decisions throughout the winter. The capacity meetings should cover the following Issues:

- Update on Emergency Department position
- Number of admissions since midnight
- Number of breaches since midnight
- Number of Outliers
- Number of Delayed Transfers of Care (DToC)
- Contingency (extra) beds in use
- Staffing levels including that for escalation beds
- Medical Bed Status and any Issues
- Actions for Medicine
- Surgical Bed Status and any Issues in managing elective activity
- Actions for Surgery
- Site-wide Agreed RAG Status
- Infection control issues and ward closures
- Paediatric capacity
- Critical Care capacity
- Those patients requiring repatriation both into SFT and out of SFT
- Risk of mixed sex breaches in critical care
- Risk of Ambulance waits

- Send Sitrep
- Consider internal resilience to Medical staff
- Consider need for external Resilience alert
- Ambulance representative attendance when in OPEL 2 or above for indication of workload due to SFT

The 16:15 hrs meeting will ensure that the Trust has sufficient capacity to meet demand overnight and, if required, ensure there is an overnight contingency plan, which may include initiation of the Trust capacity escalation plan (Appendix 2). This level of contact will be maintained over the weekend by the on-call manager.

Proposed attendance at the site-based meetings is within the escalation plan and is outlined in the table below:

| **Monday – Friday** | **Weekend** |
|---|---|
| **OPEL 1** | |
| Head of Patient flow,<br>Clinical Site Team,<br>Directorate Managers or Deputy<br>Directorate Senior Nurses<br>Head of Therapy | Clinical Site Manager<br>On-call Manager – telephone or on site |
| **OPEL 2** | |
| As above | As above |
| **OPEL 3** | |
| As above **plus**<br>Deputy COO<br>Clinical Directors or Deputy<br><br>SWAST Bronze Commander attendance<br>Social Services | As above **plus**<br>On call Manager – on site<br>On-Call Exec – telephone contact<br><br>SWAST Bronze attendance |
| **OPEL 4** | |
| As above **plus**<br>Chief Operating Officer/Deputy Chief Operating Officer<br>Therapies representative<br>Facilities (if required)<br>Pharmacy<br>Pathology / Radiology<br>On call manager and on call Exec 12.30 meeting<br><br>SWAST Bronze/Silver Commander attendance | As above **plus**<br>On call Manager – on site<br>On call Exec – on site<br>On call Consultant(s) – as required by type of pressure<br><br>SWAST Bronze/Silver attendance |

### 9.3 Outbreak plans

The Infection Prevention and Control Team (IPCT) will continue to maintain daily ward rounds and will assess patients with known infections accordingly.

Any outbreaks will be managed by the Infection Control Team in close co-operation with the operational and clinical site management teams, and in line with national and local policy.

Patients will be RAG rated in accordance with the risk so as to allow the Clinical Site Team to have the maximum available bed spaces for use by patients with active infections. This may necessitate more frequent meetings to discuss and plan optimum bed utilisation particularly related to use of side rooms and cohort admission/ward areas, including decision making on timescales for re-opening affected areas to admissions.

## 10 Next Steps

The Board is asked to approve the outline plans, recognising winter pressures pose a significant risk to patient experience, operational, and financial performance.

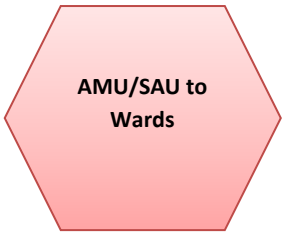
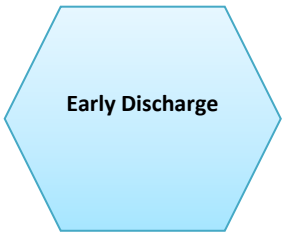
Progress against the plan will be monitored daily at bed meetings and weekly through the winter resilience meetings. This document will remain dynamic and will be updated as plans change. A first task for the winter resilience group when it commences on 2nd October will be to check all aspects of this document

## Appendix 1: SAFER

The patient flow bundle is a combined set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients.

The key interventions are described below:

| **Senior Review** | |
|---|---|
| **Board Rounds**<br>(Initial Review by 9am) | *Introduces structure to the day to day running of the ward. Helps ward team manage the patient safely and effectively*<br>• Consider sick and unstable patients first – is the patient deteriorating? What actions are required?<br>• Have new patients been given an EDD that the MDT agrees on?<br>• Are there any patients to be discharged today/tomorrow? What needs to be done to ensure they go Home for Lunch?<br>• Are there any delays that need to be expedited? |
| **Ward Rounds** | *The ward round should promote a consistent organised and disciplined approach to ensure an efficient use of time and resources, ensuring care is coordinated appropriately*<br>• The ward round should follow the board round in the morning each day<br>• Patients should be seen in a specific order<br>  ○ Sick unstable patients<br>  ○ Potential discharges<br>  ○ The remaining patients<br>• A record of the round, with clear management plans, should be recorded in the patient's notes TTO's should be prescribed and diagnostics ordered in real time<br>• Identify patients for early discharge tomorrow |
| **ALL** | |
| **Expected Date of Discharge** | *Helps the Hospital to plan and understand its available capacity at all times – it must be up to date*<br>• Has the patient's EDD been set within 24 hours of admission?<br>• Is the EDD realistic and does it reflect the actual date and time the patient is expected to go home?<br>• Has the EDD been reviewed and, if necessary, updated each day? Has a CDD been agreed?<br>• Is the patient aware of the date and time they are expected to go home? |
| **Criteria Led Discharge** | *Facilitates a smoother discharge by non-medical members of the MDT for patients that are deemed fit, provided certain defined criteria are met.*<br>• Consider a simple and timely discharge undertaken by nursing staff using agreed criteria<br>• Clinical criteria must be set by the medical team with functional and social criteria discussed by the MDT, and recorded in the patients notes<br>• The patient's TTOs and discharge letter will be completed by the MDT |

| **Flow early from Acute Medical Unit and Surgical Assessment Unit** | |
|---|---|
|  | *Wards that routinely have patients transferred to them from assessment units on a daily basis will receive a patient before 10am every day to create the require capacity for incoming patients*<br>• Inpatient wards that routinely have patients transferred to them from the assessment units need to pull the first patient to their wards before 10am everyday<br>• By creating assessment unit capacity earlier in the day, unnecessary waiting for patients awaiting admission will be significantly reduced<br>• |
| **Early Discharge from Inpatients Wards** | |
|  | *Planning and communication prevent problems for patients and staff*<br>• 33% of patients need to be discharged before midday<br>• Earlier discharge should be the norm<br>• Early discharge means beds will be available for patients and will prevent long waits |
| **Review Long Length of Stay Review** | |
|  | *We need to proactively respond to the identified delays through appropriate action planning*<br>• Do all patients have clear management plans for their medical care within the medical record?<br>• Is the patient waiting for any procedures or tests?<br>Do these need chasing?<br>• Have you considered whether the care of the patient can be provided in an alternative setting rather than an acute hospital<br>• Have all outlying patients received a daily clinical review?<br>• |

The benefits associated with the SAFER Bundle are that:

- ✓ Patients benefit from improved care co-ordination ensuring they receive their care in a timely manner
- ✓ Patients benefit from planned and timely discharge
- ✓ Staff benefit from being able to provide patients with the specialist care they need
- ✓ Staff will have access to all the information they need to provide patient care
- ✓ Staff can provide accurate, real time information to the Site Management team
- ✓ The Trust benefits from improved patient flow throughout the organisation

## Appendix 2: SFT Capacity Escalation

| Title: | **SFT Capacity Escalation Response Plan** | **Serial Number: 01.009** | |
|---|---|---|---|
| **Owner:** | Peter Holloway | | |
| **Version:** | 1.0 | **Date:Sept 2019** | **Review: Dec 2019** |

| | |
|---|---|
| **Purpose** | To provide a checklist for triggering of escalation for period October 2019 to Dec 2019 |
| **Approval** | Triggering of any escalation use requires approval of COO/Deputy COO in hours and Executive Director on Call out of hours.<br>*Holding patients in ambulances or corridors is not acceptable, including areas not equipped to be bed spaces.* |
| **Level 1** | **Level 1** - Impact on unscheduled patient flow<br>• AMU (up to 4 beds)<br>• Breamore ( up to 3 chairs)<br>• SAU (up to 3 beds)<br>• Avon (1 bed)<br>• Tamar (1 bed) |
| **Level 2** | **Level 2** - High Impact on scheduled and unscheduled patient flow (to be initiated when level 1 action has been taken)<br>• AMU ( an additional 4 beds = 8 total)<br>• SAU (an additional 2 beds = 5 total)<br>• DSU upstairs (up to 12 beds) *if the area is open for more than 72 hours DDoN and DCOO review all patients **consider Laverstock** as an alternative based on the outcome of DSU review*<br>• Laverstock (up to 12 beds) following opening SOP (governance with medicine) |
| **Level 3** | **Level 3** - High risk (order and quantity dependent on Trust wide Sitrep)<br>*In addition to COO/Exec approval – second level approval is required by Medical Director, Director of Nursing or COO (where COO, MD or DoN are Exec on call, a second is required for authorisation)*<br>• Laverstock (12 -16) (governance with medicine<br>• Laverstock (16-21) – increased staffing, (governance with medicine)<br>• Laverstock (21-26) – increased staffing, (governance with medicine)<br>• Breamore (1 Chair) – (4 chairs total)<br>• Durrington ( 2 male beds)<br>• DSU downstairs (up to18 beds) impact on theatre flow/electivity activity*<br>• DSU upstairs and downstairs (up to 30 beds) impact on theatre flow/electivity activity*<br>• Endoscopy (up to 10 beds) impact on endoscopy daily activity<br>• Radiology (up to 4 beds) impact on imaging daily activity<br>• Clarendon ( up to 4 Laverstock (12 -16 beds) (governance with medicine beds)<br>• Theatre recovery<br>***IF DSU is open for more than 72 hours DDoN and DCOO review all patients*** |

**Laverstock Escalation Staffing Requirements**

| No of beds | Early | Late | Night |
|---|---|---|---|
| 12 | 2RN and 1NA | 2RN and 1NA | 2RN and 1NA |
| 12-16 | 2RN and 2NA | 2RN and 2NA | 2RN and 1NA |
| 16-21 | 3RN and 3NA | 3RN and 2NA | 2RN and 2NA |
| 21-26 | 4RN and 3-4NA | 4RN and 3NA | 2-3RN and 2NA |

## Appendix 3: Risk Assessments of Escalation Areas

| Title: | Trust Escalation Plan OPEL 2, 3 & 4 | Serial Number: 01.009 | |
|---|---|---|---|
| Owner: | Peter Holloway | | |
| Version: | 1.0 | Date: Dec 2017 | Review: Dec 2019 |

**OPEL 2**

**PROLONGED PRESSURE REQUIRING SIGNIFICANT MANAGEMENT INPUT AND SUPPORT FROM DIRECTORATES Core team from Directorates to attend Daily Capacity Meeting, 09.30 and 16.15. To be chaired by Head of Patient flow. Request to include: DM and DSN from each Directorate, Infection Control (if appropriate)**
**TRIGGER = need to tick 3**

| A&E | Assessment Areas | Capacity | Staffing/Support Services | | Action | Who ? | Comment |
|---|---|---|---|---|---|---|---|
| 1-5 patients waiting over 4 hours | <2 beds available in MAU with additional referred patients expected | 100% bed occupancy levels | 1/3 of ward shifts are running at 1 trained staff member down | | Attend daily capacity meetings at agreed times. | Head of Patient flow Clinical Site Team, DM' DNS's | Core team to arrive at stated time |
| | | | MAU Staffing levels:1 trained shift unfilled | | DSNs to review ward/admission area bed status and to identify any further potential discharges | DSNs | Any blocks/delay to discharge to be managed and escalated for resolution |
| Capacity Full | <4 SAU trolleys, surgical take diverted to ED and no movement possible for next 2 hours | Predicted admissions are greater than expected number of discharges in the next 1 hour | | | Escalation to on call consultants/medical teams for additional ward rounds to prioritise discharges, onward care and accept outliers from any ward as appropriate. | DM's | |
| | | | External influences present that can affect patient flow (infectious illness, e.g. Norovirus, Adverse weather) | **A C T I O N** | Review and confirm prioritisation of elective TCI on hold for today and tomorrow | DM's and DSN's | Any patients requiring cancellation to be notified to admissions for cancellations and alternative date offered. All appropriate clinical teams to be informed of cancelled patients (including Theatres etc.). If OOH Patient flow/site team will do this. |
| | | | Problems reported with Clinical Support Services (IT, Pathology, Pharmacy, Facilities etc.) that can not be rectified within 30 minutes. (***Support services working to business continuity plans)*** | | Discharge team to liaise with community providers, and social services to identify capacity and support discharge to the community. Delayed discharges reviewed to identify further potential discharges | Head of Integrated Discharge Bureau | Any blocks to discharge to be escalated to DM for medicine for resolution. Silver command calls held 2 or 3 times a week. |
| | | | | | Consider opening additional escalation capacity | Deputy COO | Level 1 Capacity Opened |
| | | | | | **Pharmacy services to prioritise TTO's (to takeout) for appropriate areas and ensure that medications are delivered to the wards without delay. Consider seeking prescribing pharmacists support in writing prescriptions as needed** | **DM's** | |
| | | | | | **Utilise staff from other areas** | **DSN** | |
| | | | | | Review potential impact of above actions and de-escalate/escalate where appropriate | Head of patient flow, Deputy COO | |
| | | | | | Communicate to all Trust staffcurrent status and actions they can take to assist | Head of Patient flow | |

| Title: | Trust Escalation Plan OPEL 2, 3 & 4 | Serial Number: 01.009 | |
|---|---|---|---|
| Owner: | Peter Holloway | | |
| Version: | 1.0 | Date: Dec 2017 | Review: Dec 2019 |

**OPEL 2**

**PROLONGED PRESSURE REQUIRING SIGNIFICANT MANAGEMENT INPUT AND SUPPORT FROM DIRECTORATES Core team from Directorates to attend Daily Capacity Meeting, 09.30 and 16.15. To be chaired by Head of Patient flow.**
**Request to include: DM and DSN from each Directorate, Infection Control (if appropriate)**
**TRIGGER = need to tick 3**

| A&E | Assessment Areas | Capacity | Staffing/Support Services | ACTION | Action | Who ? | Comment |
|---|---|---|---|---|---|---|---|
| 1-5 patients waiting over 4 hours | <2 beds available in MAU with additional referred patients expected | 100% bed occupancy levels | 1/3 of ward shifts are running at 1 trained staff member down | | Attend daily capacity meetings at agreed times. | Head of Patient flow Clinical Site Team, DM' DNS's | Core team to arrive at stated time |
| | | | MAU Staffing levels:1 trained shift unfilled | | DSNs to review ward/admission area bed status and to identify any further potential discharges | DSNs | Any blocks/delay to discharge to be managed and escalated for resolution |
| Capacity Full | <4 SAU trolleys, surgical take diverted to ED and no movement possible for next 2 hours | Predicted admissions are greater than expected number of discharges in the next 1 hour | | | Escalation to on call consultants/medical teams for additional ward rounds to prioritise discharges, onward care and accept outliers from any ward as appropriate. | DM's | |
| | | | External influences present that can affect patient flow (infectious illness, e.g. Norovirus, Adverse weather) | | Review and confirm prioritisation of elective TCI on hold for today and tomorrow | DM's and DSN's | Any patients requiring cancellation to be notified to admissions for cancellations and alternative date offered. All appropriate clinical teams to be informed of cancelled patients (including Theatres etc.). If OOH Patient flow/site team will do this. |
| | | | Problems reported with Clinical Support Services (IT, Pathology, Pharmacy, Facilities etc.) that can not be rectified within 30 minutes. (***Support services working to business continuity plans)*** | | Discharge team to liaise with community providers, and social services to identify capacity and support discharge to the community. Delayed discharges reviewed to identify further potential discharges | Head of Integrated Discharge Bureau | Any blocks to discharge to be escalated to DM for medicine for resolution. Silver command calls held 2 or 3 times a week. |
| | | | | | Consider opening additional escalation capacity | Deputy COO | Level 1 Capacity Opened |
| | | | | | **Pharmacy services to prioritise TTO's (to takeout) for appropriate areas and ensure that medications are delivered to the wards without delay. Consider seeking prescribing pharmacists support in writing prescriptions as needed** | **DM's** | |
| | | | | | **Utilise staff from other areas** | **DSN** | |
| | | | | | Review potential impact of above actions and de-escalate/escalate where appropriate | Head of patient flow, Deputy COO | |
| | | | | | Communicate to all Trust staffcurrent status and actions they can take to assist | Head of Patient flow | |

| Title: | Trust Escalation Plan OPEL 2, 3 & 4 | Serial Number: 01.009 | |
|---|---|---|---|
| Owner: | Peter Holloway | | |
| Version: | 1.0 | Date: Dec 2017 | Review: Dec 2019 |

**OPEL 3**

**EXTREME PRESSURE REQUIRING IMMEDIATE AND SIGNIFICANT ACTION**

**Core team from Directorates to attend daily capacity meeting to be chaired by Patient Flow Manager with Deputy COO in attendance, at 09.30, 12.30 and 16.15 to include: DM and DSNs from each Directorate, Infection Control (If appropriate) TRIGGER = need to tick 3**

| A&E | Assessment Areas | Capacity | Staffing/Support Services | | Action | Who ? | Comment |
|---|---|---|---|---|---|---|---|
| >5 patients waiting over 4 hours | MAU bed occupancy 100% plus additional patients referred from GP's and inadequate discharges | 100+% bed occupancy with no identified capacity for referred and predicted emergency admissions | 2/3 of ward shifts are running at 1 trained staff member down | | Attend daily capacity meetings at agreed times. | Head of patient flow, Clinical Site Team, DM' DNS's, CD's or Deputy | CD to be invited to attend capacity meeting or send nominated representative - medicine and surgery need to be represented |
| 1-5 patients over capacity | | Predicted admissions are greater than number of expected discharges in the next 3 hours | MAU Staffing levels:2 trained shifts unfilled | | DSNs to review ward/admission area bed status and to identify any further potential discharges with ward sisters, nurse in charge and therapies. Consider the risk of discharging patients who are medically fit but not ready for discharge for other reasons, subject to appropriate support being available at home. | DSN | Any blocks/delay to discharge to be managed and escalated for resolution |
| | SAU full with notifications of others expected | Recovery full, 2 lists halted with no likely movement to move patients to ward beds within next 2 hours | | | Escalation to Clinical Directors to arrange for additional ward rounds and review of all potential patients for discharge identified by matrons | DM | CD to be invited to attend capacity meeting or send nominated representative - medicine and surgery need to be represented |
| | | More than 8 hours of trauma/orthopaedic emergency surgery listed | | **A** | Review and confirma prioritisation of elective TCI on hold for today and tomorrow. | DM's and DSN's | Any patients requiring cancellation to be notified to admissions for cancellations and alternative date offered. All appropriate clinical teams to be informed of cancelled patients (including Theatres etc.). If OOH Patient flow/site team will do this. |
| | | External influences present that can affect patient flow (infectious illness, e.g. Norovirus, adverse weather) | | **C** | Escalate status to Wiltshire CCGs, Community Health, Social Services and SWAST, Clinicians to contact dedicated support line to GP practices | Deputy COO/COO | Instigate Gold Acute Trust/Community Partners Call |
| | | | | **T** | **Senior clinicians to actively scrutinise all GP requests for admission** | **CD** | |
| | | | | **I** | **Review and reschedule plans for scheduled maintenance where work is likely to impact on capacity or patient flow** | **Deputy Coo/COO** | **In disussion with Facilities and Estates General Managers** |
| | | | | **O** | **Consider additional capacity to be opened** | Deputy COO/COO | Level 2 Capacity Opened |
| | | | | **N** | **Consider bringing in extra staff to radiology, pathology, pharmacy, occupational therapy etc. If appropriate deploy staff from other areas of service to relieve key pressure points** | **Deputy COO/COO/ DM** | |
| | | | | | **Facilities, porters or transfer teams to prioritise all aspects of transferring patients** | **Deputy COO/COO** | |
| | | | | | **Assign staff to care for any ambulance patients waiting for space (in ED, assessment units, and other admission areas etc.)** | **DSN** | |
| | | | | | Consider the Medical and surgical take being diverted to ED | Deputy COO,Acute Physician, ED1 | |
| | | | | | Review potential impact of above actions and de-escalate/escalate where appropriate. | Head of patient flow, Deputy COO/ CD | |
| | | | | | Communicate to all Trust staffcurrent status and actions they can take to assist | Head of Patient Flow | |

on 2.2
20.09.19

| Title: | Trust Escalation Plan OPEL 2, 3 & 4 | Serial Number: 01.009 | |
|---|---|---|---|
| Owner: | Peter Holloway | | |
| Version: | 1.0 | Date: Dec 2017 | Review: Dec 2019 |

**OPEL 3**

**EXTREME PRESSURE REQUIRING IMMEDIATE AND SIGNIFICANT ACTION**

**Core team from Directorates to attend daily capacity meeting to be chaired by Patient Flow Manager with Deputy COO in attendance, at 09.30, 12.30 and 16.15 to include: DM and DSNs from each Directorate, Infection Control (If appropriate) TRIGGER = need to tick 3**

| A&E | Assessment Areas | Capacity | Staffing/Support Services | ACTION | Who ? | Comment |
|---|---|---|---|---|---|---|
| >5 patients waiting over 4 hours | MAU bed occupancy 100% plus additional patients referred from GP's and inadequate discharges | 100+% bed occupancy with no identified capacity for referred and predicted emergency admissions | 2/3 of ward shifts are running at 1 trained staff member down | Attend daily capacity meetings at agreed times. | Head of patient flow, Clinical Site Team, DM' DNS's, CD's or Deputy | CD to be invited to attend capacity meeting or send nominated representative - medicine and surgery need to be represented |
| 1-5 patients over capacity | | Predicted admissions are greater than number of expected discharges in the next 3 hours | MAU Staffing levels:2 trained shifts unfilled | DSNs to review ward/admission area bed status and to identify any further potential discharges with ward sisters, nurse in charge and therapies. Consider the risk of discharging patients who are medically fit but not ready for discharge for other reasons, subject to appropriate support being available at home. | DSN | Any blocks/delay to discharge to be managed and escalated for resolution |
| | SAU full with notifications of others expected | Recovery full, 2 lists halted with no likely movement to move patients to ward beds within next 2 hours | | Escalation to Clinical Directors to arrange for additional ward rounds and review of all potential patients for discharge identified by matrons | DM | CD to be invited to attend capacity meeting or send nominated representative - medicine and surgery need to be represented |
| | | More than 8 hours of trauma/orthopaedic emergency surgery listed | | Review and confirma prioritisation of elective TCI on hold for today and tomorrow. | DM's and DSN's | Any patients requiring cancellation to be notified to admissions for cancellations and alternative date offered. All appropriate clinical teams to be informed of cancelled patients (including Theatres etc.). If OOH Patient flow/site team will do this. |
| | | External influences present that can affect patient flow (infectious illness, e.g. Norovirus, adverse weather) | | Escalate status to Wiltshire CCGs, Community Health, Social Services and SWAST, Clinicians to contact dedicated support line to GP practices | Deputy COO/COO | Instigate Gold Acute Trust/Community Partners Call |
| | | | | **Senior clinicians to actively scrutinise all GP requests for admission** | **CD** | |
| | | | | **Review and reschedule plans for scheduled maintenance where work is likely to impact on capacity or patient flow** | **Deputy Coo/COO** | **In disussion with Facilities and Estates General Managers** |
| | | | | **Consider additional capacity to be opened** | Deputy COO/COO | Level 2 Capacity Opened |
| | | | | **Consider bringing in extra staff to radiology, pathology, pharmacy, occupational therapy etc. If appropriate deploy staff from other areas of service to relieve key pressure points** | **Deputy COO/COO/ DM** | |
| | | | | **Facilities, porters or transfer teams to prioritise all aspects of transferring patients** | **Deputy COO/COO** | |
| | | | | **Assign staff to care for any ambulance patients waiting for space (in ED, assessment units, and other admission areas etc.)** | **DSN** | |
| | | | | Consider the Medical and surgical take being diverted to ED | Deputy COO,Acute Physician, ED1 | |
| | | | | Review potential impact of above actions and de-escalate/escalate where appropriate. | Head of patient flow, Deputy COO/ CD | |
| | | | | Communicate to all Trust staffcurrent status and actions they can take to assist | Head of Patient Flow | |

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|---|---|---|---|
| Owner: | Peter Holloway | | |
| Version: | 1.0 | Date: Dec 2017 | Review: Dec 2019 |

**OPEL 4**

**The Trust is in a critical position and ED or other departments are clinically unsafe - Executive to call to agree with CCG to call OPEL 4 Status**
**Trigger = 3 from OPEL 3 and one from OPEL 4**

| A&E | Assessment Areas | Capacity | Staffing/Support Services | ACTION | Action | Who? | Comment |
|---|---|---|---|---|---|---|---|
| Between 15-20 patients waiting more than 4 hours and/or Patient waiting over 12 hours | MAU and SAU no beds or trolleys available with 10 or more patients waiting for beds with no plan | 100+% bed occupancy with no identified capacity for referred and predicted emergency admissions | All wards are running with 1 shift short | | Attend daily capacity meetings as agreed, plus adhoc as deemed appropriate. | Head of Patient Flow/Clinical Site team, CD's | Chaired by the COO |
| 5 patients over capacity | MAU/SAU takes diverted to ED | Predicted admissions are greater than number of expected discharges in the next 5 hours | No additional staff available to staff escalation areas over Level 3. | | DSNs to review ward/admission area bed status and to identify any further potential discharges with ward sisters, nurse in charge and therapies. Consider the risk of discharging patients who are medically fit but not ready for discharge for other reasons, subject to appropriate support being available at home | DSN | Any blocks/delay to discharge to be managed and escalated to Head of Patient Flow for resolution |
| | | Routine elective patients cancelled and the likely need to cancel urgent procedures | | | Escalation to Clinical Directors to arrange for additional ward rounds and review of all potential patients for discharge identified by Ward Sisters | COO/DGM | CDs invited to attend bed meeting or send nominated representative - medicine and surgery to be represented. Cancel non urgent meetings and clinical activity to divert medical resources where appropriate e.g. clinics |
| | | Level 3 escalation beds open and full, no more capacity to open further bed. | | | Consider all additional capacity to be opened and review all patients for potential moves to other areas. | Deputy COO/COO | Level 3 capacity opened |
| | | External influences present that can affect patient flow (infectious illness, e.g. Norovirus, Adverse weather, transport) | | | Escalate status to Wiltshire CCGs, Community Health, Social Services and SWAST, Clinicians to contact dedicated support line to GP practices | Deputy COO/COO | Instigate Gold Acute Trust/Community Partners Call |
| | | Consider diverting services to other Trusts. Trust closed to plastic emergencies with the exception of life and limb with more than 8 hours of trauma/orthopaedic emergency surgery listed | | | Consider Request a divert to the surrounding Trusts | COO | Discuss with SWAS |
| | | | | | Communicate to all Trust staffcurrent status and actions they can take to assist | COO | Call on non clinical staff to support ward areas with non clinical duties, where needed. |
| | | | | | **Cancel all non-life threatening admissions** | DM/DSN | |
| | | | | | Review potential impact of above actions and de-escalate/escalate where appropriate. | Head of patient flow, Deputy COO/ CD | |

| Escalation Area | Number of Beds | Risks | Risk Score (CxL) | Controls | Mitigation | Further actions |
|---|---|---|---|---|---|---|
| Level 1 | | | | | | |
| Durrington | 2 | • Infection Prevention and control could be compromised due to close proximity of beds | 2x3 = 6 | • Formal bed spaces already configured therefore privacy and dignity/call bells in place<br>• Substantively staffed ward | • Requires Executive agreement for use<br>• High level of vigilance around IPC/PPE<br>• When in escalation daily review of patients in that area for suitability e.g. wandering/confused | |
| Ambulatory area of AMU | 4 | • Risk to maintaining flow in an ambulatory unit<br>• Mixed sex accommodation breaches<br>• Staffing – this area is not staffed for inpatients therefore risk to quality and/or staff morale | 3x3=9 | • Formal bed spaces configured<br>• Established ward and patient area | • Extra staff will need to be booked when ambulatory is used for escalation. 1 NA per shift<br>• Ambulatory escalation patients to be single sex<br>• Patients to be admitted into downstream beds asap – maximum stay of 1 night in this area<br>• Explanation/information provided to patients | |
| SAU | 4 | • Risk to maintaining flow in an ambulatory unit which is also a key component of our | 3x3=9 | • Formal bed spaces with appropriate equipment (albeit small in | • Extra staff to be booked when in planned use (1 NA)<br>• Ambulatory escalation patients to be single sex<br>• Patients to be admitted into | |

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| | | non elective surgical pathway<br>• Mixed sex accommodation breaches<br>• Trolley spaces are smaller than regular bed space<br>• Staffing – this area is not staffed for inpatients therefore risk to quality and/or staff morale | | size)<br>• Established ward area – linked to Britford | downstream beds asap – maximum stay of 1 night in this area<br>• Explanation/information provided to patients | |
| Braemore | 2 | • Disruption of flow for short stay patients post operatively<br>• Poor patient experience – these bed spaces are not the best for privacy and dignity | 3x3=9 | • Formal bed spaces present<br>• Staffed area with good skill mix and substantive staffing (low vacancies) | • Explanation/information provided to patients<br>• Review of patients daily to avoid long stays in this area | |
| Stroke take bed | 1 | • Takes the last stroke admission bed – potential impact on stroke outcome for any patient requiring urgent admission to specialist stroke care<br>• SSNAP score impact | 4x3= 12 | • Formal bed spaces present<br>• Staffed area with good skill mix and substantive staffing (low vacancies) | • Identify next available stroke bed (which may require a transfer) as soon as this is used to maintain access for those with an acute stroke<br>• De escalate at first opportunity | |
| Odstock take bed | 1 | • Takes the last admission bed for a | 3x3=9 | • Staffed inpatient area | • Identify next available burns/plastics access bed which | |

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| | | regional burns/plastics referral/admission<br>• If using the assessment room this is not optimal therapeutic space and can only be utilised for a short period of time | | | may require a transfer out<br>• De-escalate at first opportunity<br>• Patients to spend maximum 1 night if using the assessment room | |
| Avon | 1 | • Distance from main acute wards could compromise safety and specialist response times<br>• Staff work in a specialist area and therefore may not have the skills to care for a broad range of patients | 2x3=6 | • Formal bed spaces configured<br>• Established ward and patient area | • Patient selection is key to use of these escalation beds for outliers. Attempt to use from within MSK footprint | |
| Tamar | 1 | • Distance from main acute wards could compromise safety and specialist response times<br>• Staff work in a specialist area and therefore may not have the skills to care for a broad range of patients | 2x3=6 | • Formal bed spaces configured<br>• Established ward and patient area | • Patient selection is key to use of these escalation beds for outliers. Attempt to use from within MSK footprint | |
| Level 2 | | | | | | |

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| AMU | 8 | • Non elective medical flow severely compromised leaving only 2 trollies to operate from<br>• Risk of transferring medical take into ED with subsequent risk to ED safety and flow<br>• Mixed sex accommodation breaches<br>• Staffing – this area is not staffed for inpatients therefore risk to quality and/or staff morale | 3x4 = 12 | • Formal bed spaces configured<br>• Established ward and patient area with associated infrastructure such as therapies, physicians, pharmacy | • Extra staff will need to be booked when ambulatory is used for escalation. At this level - 1 RN per shift<br>• Ambulatory escalation patients to be single sex<br>• Patients to be admitted into downstream beds asap – maximum stay of 1 night in this area<br>• Explanation/information provided to patients | |
| SAU | 6 | • This option completely blocks any non-elective surgical flow through this area resulting in surgical take reverting to ED<br>• Mixed sex accommodation breaches<br>• Trolley spaces are smaller than regular bed space – poor patient experience with risk to maintaining adequate privacy and dignity as | 4x4 = 16 | • Formal bed spaces with appropriate equipment (albeit small in size)<br>• Established ward area – linked to Britford with associated infrastructure | • Extra staff to be booked when in planned use (1 RN)<br>• Ambulatory escalation patients to be single sex<br>• Patients to be admitted into downstream beds asap – maximum stay of 1 night in this area<br>• Explanation/information provided to patients<br>• Surgical take diverted to ED<br>• Review of elective lists | |

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| | | well as IPC<br>• Staffing – this area is not staffed for inpatients therefore risk to quality and/or staff morale | | | | |
| Braemore | 4 | • Complete disruption of flow for short stay patients post operatively out of Main theatres with resulting impact on recovery and theatre flow/efficiency<br>• Poor patient experience – where these bed spaces are located compromises privacy and dignity as well as single sex provision | 3x4 = 12 | • Formal bed spaces present<br>• Staffed area with good skill mix and substantive staffing (low vacancies) | • Explanation/information provided to patients<br>• Review of patients daily to avoid long stays in this area<br>• Review of elective lists | |
| DSU upstairs | 12 | • Poor patient experience – lack of facilities such as showers, hoisting etc.<br>• Lack of continuity of staff especially out of hours and weekends<br>• This area is not staffed as an inpatient area with subsequent risks to quality of care and | 4x4 = 16 | • Formal bed spaces and patient area<br>• Some substantive staffing during the day who are experienced in surgical specialities<br>• SOP in place to guide opening and patient | • Strict adherence to SOP and patient selection<br>• Review of elective lists through DSU to consider what should be cancelled<br>• Patients to be limited to short stay only. Directorate review at 48 hours and escalated to exec at 72 for patient review (included in SOP) | |

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| | | morale of current DSU staff who are also juggling DSU lists<br>• High agency costs associated with conversion into inpatient areas and backfill from surgical wards which depletes them further – compromising care in other areas<br>• Compromises elective activity through DSU and therefore RTT/cancellations<br>• Lack of infrastructure support into this as an inpatient area e.g. pharmacy, medical ownership, therapies<br>• DSU is a distance from the main acute areas which can compromise response times of specialist teams | | selection | | |
| Level 3 | | | | | | |
| Laverstock | 12 | • This area is not staffed so lack of continuity of staff as temporary workers or | 4x3=12 | • Formal inpatient facility so has all associated environmental | • Establish SOP for running this area<br>• Workforce plan required for this area<br>• In the meantime use only as short | • Establish SOP for running this area<br>• Workforce plan required for this area |

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| | | back fill from main wards would be used. This is a risk to patient experience and safety and efficiency.<br>• Resulting risk to safety and quality if we are diluting skill mix elsewhere to backfill here<br>• High cost of agency usage<br>• Lack of infrastructure support into this as an inpatient area e.g. pharmacy, medical ownership, therapies has not been established | | infrastructure | stay surge management with review at 48 hours and daily review then on to assure quality and safety | |
| DSU downstairs | 18 | • Poor patient experience – lack of facilities such as showers, hoisting etc.<br>• Lack of continuity of staff especially out of hours and weekends<br>• This area is not staffed as an inpatient area with subsequent risks to | 4x4=16 | • Formal bed spaces and patient area<br>• Some substantive staffing during the day who are experienced in surgical specialities<br>• SOP in place to guide opening | • Strict adherence to SOP and patient selection<br>• Review of elective lists through DSU to consider what should be cancelled<br>• Patients to be limited to short stay only. Directorate review at 48 hours and escalated to exec at 72 for patient review (included in SOP) | |

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| | | quality of care and morale of current DSU staff who are also juggling DSU lists<br>• High agency costs associated with conversion into inpatient areas and backfill from surgical wards which depletes them further – compromising care in other areas<br>• Compromises elective activity through DSU and therefore RTT/cancellations<br>• Lack of infrastructure support into this as an inpatient area e.g. pharmacy, medical ownership, therapies<br>• DSU is a distance from the main acute areas which can compromise response times of specialist teams | | and patient selection | | |
| DSU upstairs and downstairs | 30 | • This option Compromises elective activity through DSU and therefore | 4x5 = 20 | • Formal bed spaces and patient area<br>• Some substantive | • Cancellation of operating activity in DSU<br>• Patients to be limited to short stay only. Directorate review at 48 hours | |

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| | | RTT/cancellations<br>• Poor patient experience – lack of facilities such as showers, hoisting etc.<br>• Lack of continuity of staff especially out of hours and weekends<br>• This area is not staffed as an inpatient area with subsequent risks to quality of care and morale of current DSU staff who are also juggling DSU lists<br>• High agency costs associated with conversion into inpatient areas and backfill from surgical wards which depletes them further – compromising care in other areas<br>• Lack of infrastructure support into this as an inpatient area e.g. pharmacy, medical ownership, therapies<br>• DSU is a distance from the main acute areas which can | | staffing during the day who are experienced in surgical specialities<br>• SOP in place to guide opening and patient selection | and escalated to exec at 72 for patient review (included in SOP)<br>• Strict adherence to SOP and patient selection | |

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| | | compromise response times of specialist teams<br>• It is unlikely when using this number of beds that it will be possible to enforce strict adherence to patient criteria and selection therefore risks are increased | | | | |
| Laverstock | 26 | • This area is not staffed so lack of continuity of staff as temporary workers or back fill from main wards would be used. This is a risk to patient experience and safety and efficiency.<br>• Resulting risk to safety and quality if we are diluting skill mix elsewhere to backfill here<br>• High cost of agency usage<br>• Lack of infrastructure support into this as an inpatient area e.g. pharmacy, medical | 4x4=16 | • Formal inpatient facility so has all associated environmental infrastructure | • Establish SOP for running this area<br>• Workforce plan required for this area<br>• In the meantime use only as short stay surge management with review at 48 hours and daily review then on to assure quality and safety with aim constantly of reducing bed numbers | • Establish SOP for running this area<br>• Workforce plan required for this area |

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| | | ownership, therapies has not been established | | | | |
| Downton becomes medical | 24 | • This is a surgical ward whose staff have invested in surgical skills so impact on morale and retention would be a risk<br>• Ward establishment is based on short stay surgery not a medical ward which would require an uplift<br>• Potential for skills gap<br>• Lack of associated infrastructure such as medical input<br>• Impact on surgical throughput, RTT, cancelled ops | 4x4=16 | • Formal inpatient facility so has all associated environmental infrastructure<br>• Substantively staffed – although also see risks | • Staffing would need to be reviewed if this was to be actioned<br>• Identify physician input into ward and any associated support services<br>• Plan for surgical elective activity would be required | |
| Endoscopy recovery | 10 | • Risks to RTT for diagnostics and ultimately JAG accreditation<br>• This is not an inpatient area and is not staffed out of hours – resulting in risk to continuity of care and high cost of | 4x5=20 | • Bed spacing and allowance within build to single sex<br>• Sited within main hospital | • SOP would need to be established to run this area – including patient selection and staffing requirements<br>• Review every 24 hours of patients to ensure they are not staying more than one night<br>• Explanation/information to any patients involved | |

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| | | temporary workforce<br>• Risk to endoscopy staff morale trying to combine a diagnostics area with inpatients<br>• Lack of appropriate facilities such as showers<br>• Lack of infrastructure support into this as an inpatient area e.g. pharmacy, medical ownership, therapies | | | | |
| Radiology Recovery | 4 | • This is not an inpatient area so risk to patient experience in that there are no facilities associated with a ward area such as showers and ability to single sex<br>• Area is not staffed<br>• Risk to patient safety as no agreement as to who these patients would be under the care of etc<br>• Impact on diagnostics access times for interventional radiology and other services using this | 4x5 = 20 | • Sited close to ED for acute footprint input | • Is this the last resort for overnight stay only of bedded patients in ED<br>• Requires a staffing plan<br>• Would require SOP and infrastructure plan<br>• Explanation/information to any patients involved | |

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| | | area<br>• Staff morale in radiology when trying to juggle an outpatient based service with inpatient escalation<br>• Lack of infrastructure support into this as an inpatient area e.g. pharmacy, medical ownership, therapies | | | | |
| Clarendon | 4 | • Area no longer staffed therefore risk to patient safety and experience due to no continuity<br>• High agency costs associated with conversion into inpatient areas and backfill from surgical wards which depletes them further – compromising care in other areas<br>• Lack of infrastructure support into this as an inpatient area e.g. pharmacy, medical ownership, therapies<br>• Distance from main | 4x4 = 16 | • Inpatient area with associated environmental infrastructure | • SOP and patient selection must be adhered to<br>• Staffing plan must be adhered to | |

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| | | hospital site and size (1 RN) means that patient selection criteria is key – risk to patient safety<br>• Considering all of the above this area only gives 4 extra beds | | | | |
| Theatre Recovery | 1-2 | • Poor patient experience of holding in recovery associated with lack of infrastructure of inpatient area<br>• MSA risk if used over and above early post-operative requirement<br>• Potential impact of emergency theatre capacity due to impact on staffing | 4x3=12 Based on one night of appropriate post op patients who require this level of observation | • Staffed area with trained staff for post operative care<br>• Area within acute template that can respond to surgical emergencies | • Can only be used for overnight maximum post op due to such a poor patient experience<br>• Strict patient selection with executive approval on case by case basis<br>• Consideration should already have been taken on cancellation of electives<br>• Explanation/information to any patients involved | |

**Appendix 5**

Key Schemes of the Winter Plan 2019/20

- 7/7 Consultant ward round cover on all specialties for January (aim to extend into February)
- Additional F1/F2 ward cover Saturday and Sunday (mid December through to end of March)
- Additional Trust Grade weekend cover (0900-1400 to support wards)
- Additional x 5 SHO agency cover doctor across medicine (January to April)
- Pharmacy support to MAU at weekends (January to March)
- Additional twilight and weekend ward clerk cover on MAU
- Additional therapy support across medicine in January
- Additional B5 in AMU night shift to allow safe management of overnight patients in AMU
- Continue to develop pathways to avoid GP expected patients going to ED
- Develop pathway for patients to go to  Shaftesbury beds if commissioned
- Working with council on strength based approach
- Alignment of physio lead services with Wiltshire Health and Care
- Development of outreach service to avoid admissions with PCNs and WH+C

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| **Report to:** | Trust Board (Public) | **Agenda item:** | 4.1 |
| **Date of Meeting:** | 03 October 2018 | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Q1 Patient Experience Report | | | |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | | | | |
| **Prepared by:** | Katrina Glaister, Head of Patient Experience | | | |
| **Executive Sponsor (presenting):** | Lorna Wilkinson, Director of Nursing | | | |
| **Appendices (list if applicable):** | Patient experience headlines | | | |

| Recommendation: |
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| The Board is asked to note this report. |

**Executive Summary:**

This report provides a report of activity for Q1 2019/20 in relation to patient experience, complaints, public engagement, and the opportunities for learning and service change. Some key changes are highlighted below:

- A Complaints/Risk newsletter has been produced and shared with the teams. This will go out every quarter so that learning can be shared trust-wide.
- The variable response time as set out in the Complaint Handling Policy went live on 01 Aug 2019 but any changes in compliance with agreed timeframe will not be seen until Q2
- The PALS complaint coordinators have initiated weekly ward rounds with the aim of facilitating real-time and prompt resolution to concerns patients may disclose. It is hoped that this will prevent concerns escalating in to more formal complaints. The initial feedback from the ward staff has been positive.
- The mid-year report (attached appendix) shows the mid-year progress against our patient and public priorities

This report provides assurance that the Trust is responding and acting appropriately to patient feedback.

| Board Assurance Framework – Strategic Priorities | Select as applicable |
|---|---|
| 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 | ☐ |

**Patient Experience Report - Quarter 1**

**1 April – 31 June 2019**

**Purpose of paper**

To provide assurance that the Trust is responding appropriately to complaints from patients and demonstrate that learning and actions are taken to improve services in response to feedback.

To provide assurance of patient and public involvement in service co-design and improvement.

**Background**

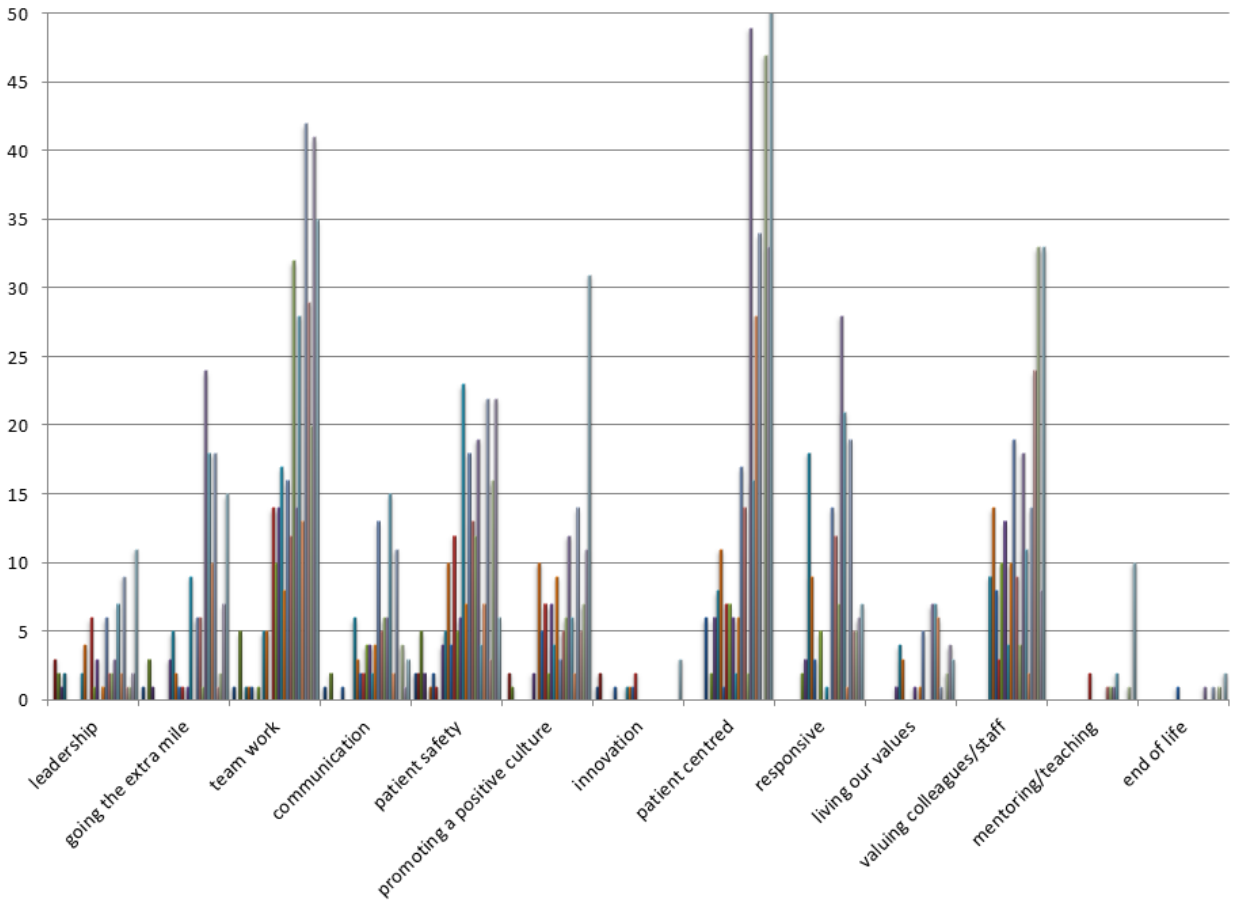
Patient experience is defined as "the sum of all interactions, shaped by an organisation's culture that influence patient perceptions across the continuum of care".[1] Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative, including learning from feedback, transparency and honesty when healthcare goes wrong. This report provides some evidence of the patient experience feedback and activities in relation to self-improvement based on that feedback.

## 1. Sharing Outstanding Excellence (SOX)

There is growing awareness nationwide that since complaints are a small minority compared to other PALS feedback, learning from what goes well in a Trust is as important as learning from complaints. In this Trust, a positive report is known as a SOX.

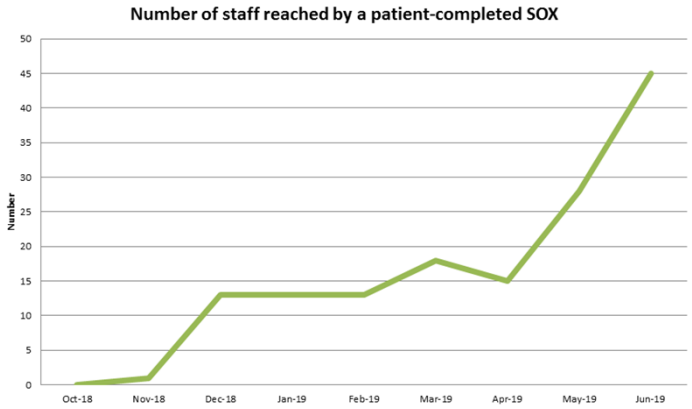
As can be seen from the graph below, 'Team Work' and 'Patient Centred' are the most frequently occurring themes:

**Graph to show SOX themes (from October 2016 to present day)**



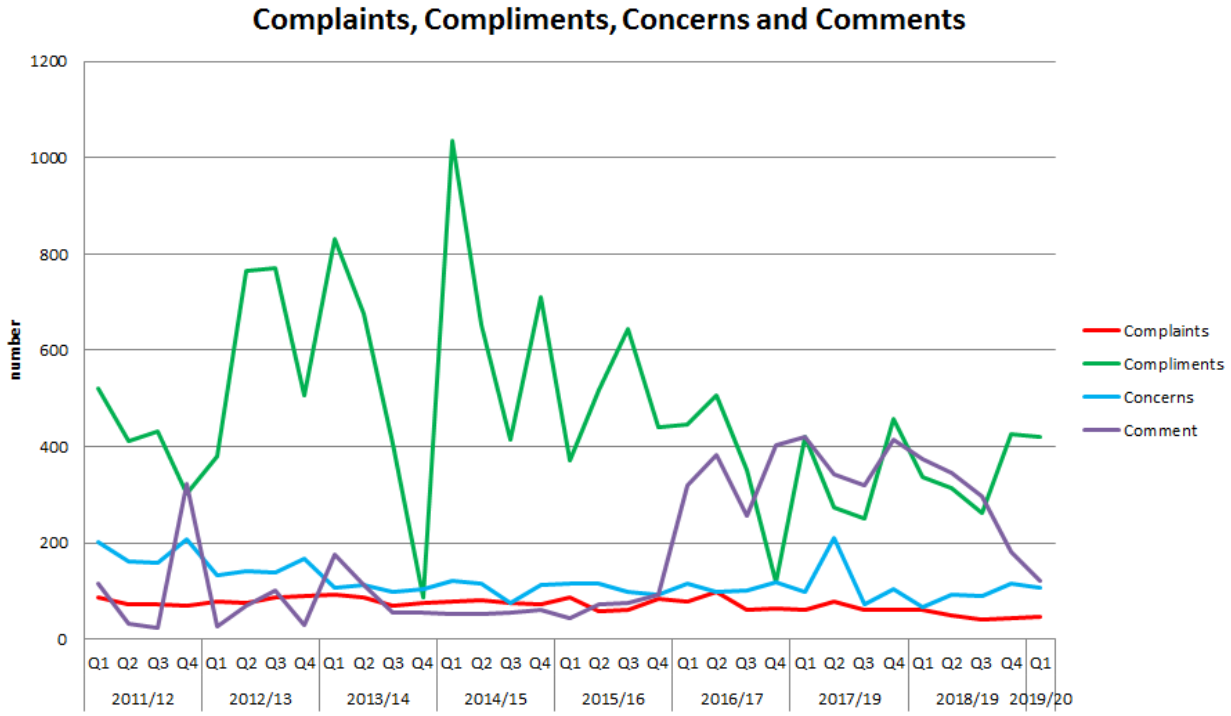

Each month we are seeing an increasing number of SOX forms completed by patients/visitors. The link to the SOX form was added to our patient-facing website last quarter and patients are now accessing the SOX email and giving their feedback. A recent example surrounding end of life care is *'The care and compassion Ann showed my father-in-law went way beyond the scope of her role. Our family will forever be grateful'*

[1] The Beryl Institute. Available at https://www.theberylinstitute.org/page/DefiningPatientExp




## 2. Complaints

The graph below shows the numbers of complaints, compliments, concerns and comments over time. Complaints show a slight reduction over time. There is more variation in concerns and comments and the PALS team have met to clarify what constitutes a comment vs what constitutes a concern, as whilst concerns can be themed, comments cannot be and it is important that key themes are not missed. The result of this work shows as an increase in concerns and a corresponding decrease in comments this quarter.

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**Actions taken since last report**

- The Complaints handling policy has been ratified and the new variable response times brought into use.
- The quarterly complaints compliance report has been pulled together and sent to the directorates. Going forward these reports will be shared with all the directorates at a quarterly PALS/Risk/PPI meeting.
- A complaints/risk learning newsletter has been compiled and sent to the directorates.
- The PALS complaint coordinators have initiated weekly ward rounds with the aim of facilitating real-time and prompt resolution to concerns patients may disclose. It is hoped that this will prevent concerns escalating to formal complaints. The initial feedback from the ward staff has been positive.

**Complaint themes**

The K041 categories are used to theme complaints. The main theme this quarter is:

- Patient Care including nutrition / hydration (n =23); CSFS n=7, Medicine n = 4, Surgery n =7, MSK n = 5.

48 complaints were received in Q1. A breakdown of numbers and themes from complaints according to the K041 subject code is listed below by directorate:

| | CSFS | Informatics | Medicine | MSK | Surgery | Total |
|---|---|---|---|---|---|---|
| Appointment postponed | 0 | 0 | 0 | 1 | 0 | 1 |
| Assistance not given | 0 | 0 | 1 | 0 | 0 | 1 |
| Clinical Treatment - Surgical Group | 0 | 0 | 0 | 2 | 2 | 4 |
| Clinical Treatment - Accident and Emergency | 0 | 0 | 3 | 0 | 0 | 3 |
| Clinical Treatment - Obstetrics & Gynaecology | 2 | 0 | 0 | 0 | 0 | 2 |
| Correct diagnosis not made | 0 | 0 | 1 | 2 | 1 | 4 |
| Delay in receiving appointment | 1 | 0 | 0 | 0 | 0 | 1 |
| Delay in receiving treatment | 0 | 0 | 0 | 0 | 1 | 1 |
| Further complications | 0 | 0 | 1 | 0 | 2 | 3 |
| Harm | 0 | 0 | 0 | 1 | 0 | 1 |
| Inappropriate treatment | 2 | 0 | 0 | 0 | 0 | 2 |
| Information not given to family | 0 | 0 | 0 | 0 | 1 | 1 |
| Information required | 1 | 0 | 0 | 0 | 0 | 1 |
| Insensitive communication | 0 | 0 | 1 | 0 | 0 | 1 |
| Neglect | 1 | 0 | 0 | 0 | 0 | 1 |
| Nursing Care | 0 | 0 | 0 | 1 | 1 | 2 |
| Operation delayed | 0 | 0 | 0 | 0 | 1 | 1 |
| Patient Confidentiality | 0 | 1 | 0 | 0 | 0 | 1 |
| Treatment unavailable | 0 | 0 | 0 | 1 | 0 | 1 |
| Unsatisfactory treatment | 4 | 0 | 3 | 1 | 2 | 10 |
| Wrong information | 0 | 0 | 1 | 0 | 0 | 1 |
| Attitude of nursing staff | 0 | 0 | 1 | 0 | 0 | 1 |
| Attitude of staff - medical | 0 | 0 | 2 | 1 | 1 | 4 |
| Total | 11 | 1 | 14 | 10 | 12 | 48 |

There were 90 concerns in Q4. The main themes within concerns are:

- Lack of communication (n = 9)
- Appointment systems and procedures (n = 8)
- Delay in receiving appointment (n = 8)

In Q1 the Trust treated 35,439 people as inpatients, day cases and regular day attendees. Another 18,170 were seen in the Emergency Department (includes the walk-in clinic) and 17,607 as outpatients. 48 complaints were received which is 0.054% of the number of patients treated.

421 compliments were received across the Trust in Q1. Those sent directly to the Chief Executive or Customer Care Department were acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment/national patient survey/RTF the PALS team complete a SOX which is sent to the individual and their line manager.

## Timeliness of response

100% of complaints were acknowledged within 3 working days.

There were 4 re-opened complaints in Quarter 1 (see directorate reports for full details)

There were 2 re-opened concerns in Quarter 1

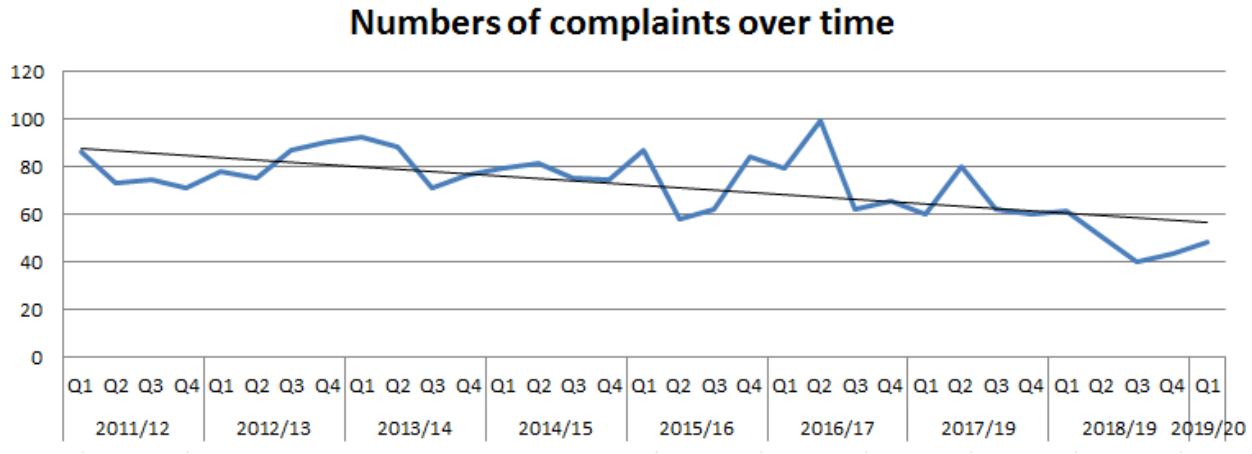
The total number of enquiries, comments, concerns and complaints received by the team in Q1 was 427. Of these 76% were dealt with within 10 days.

| 0-10 working days | | 11-24 working days | | 25+ working days | |
|---|---|---|---|---|---|
| 326 | 76% | 48 | 11% | 41 | 9% |

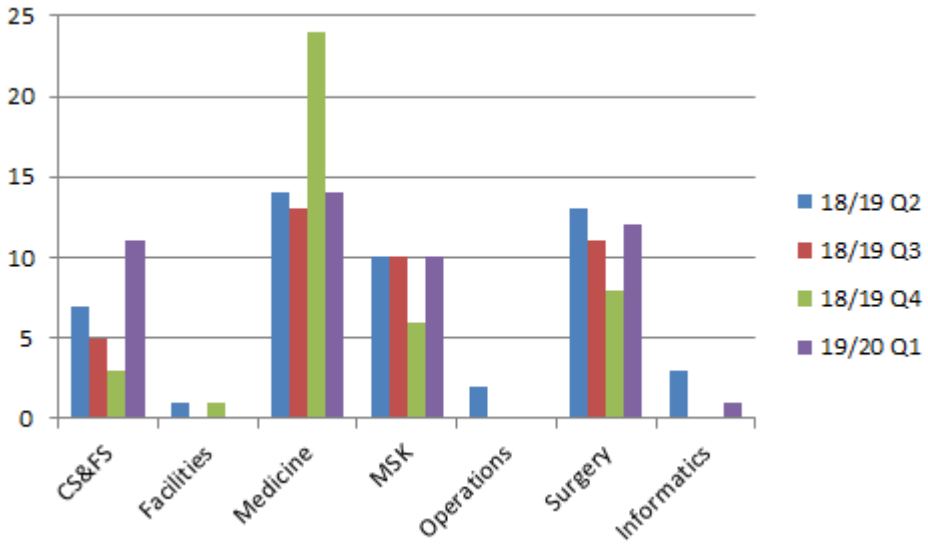
Response timescales for complaint responses going out between 11-24 days has improved this quarter however a significant percentage extend beyond 25 working days. It is hoped that the new variable response times will improve the percentage of complaint responses sent at the agreed time but this will not be seen until Q2. See individual directorate reports for the maximum length of time a complainant waited for a response this quarter.

| 0-10 working days | | 11-24 working days | | 25+ working days | |
|---|---|---|---|---|---|
| 5 | 10% | 19 | 40% | 18 | 38% |

## 3. Complaints by directorate




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



## Clinical Support and Family Services Directorate

| | Quarter 1 2018-19 | Quarter 4 2018-19 | Quarter 1 2019-20 |
|---|---|---|---|
| **Complaints** | 11 | 3 | 11 |
| **Concerns** | 8 | 16 | 15 |
| **Compliments** | 90 | 96 | 42 |
| **Re-opened complaints** | 3 | 0 | 0 |
| **% complaints responded to within agreed timescale** | 54% | 33% | 63% |

- There were 11 complaints raised in quarter 1 with Maternity receiving the most (n=4). The main theme was unsatisfactory care. The brief narrative for these are:
  - Misdiagnosis of Anorectal Malformation.
  - Care fell below expected standard for various reasons resulting in lack of confidence that her and her baby are going to receive the care needed.
  - Lack of care from midwife resulted in her having baby on her own without partner and the trauma from it all has cost her £15,000.
  - Patient not listened to regarding complications and hernia not diagnosed and problems with feeding not picked up by staff.
- 15 concerns were raised in quarter 1 with Gynaecology receiving the most (n=4). The main theme was lack of communication.
- Response compliance has increased significantly during this quarter; however one complaint is still open (should have been sent out by the end of July – the delay is due to the investigating manager going to visit the complainant at home to resolve her concerns).
- The PALS department received 53 comments and enquiries for CSFS in Quarter 1 which have been resolved by the team.
- Total activity within the directorate was 9107 and of this number 0.12% raised a complaint.
- 8 action plans are outstanding from 1st April 2019. PALS are working with the teams to check whether or not action plans are required.

**Themes and actions**

| Department/Ward | Topic | Actions |
|---|---|---|
| **Maternity Department** | Unsatisfactory care | Development of a staff and patient information sheet regarding NIPE is underway. Staff have been informed of the importance of performing NIPE in accordance with national standards.<br><br>Space management exercise to be undertaken in Antenatal clinic.<br><br>An opportunity to discuss any unresolved paediatric concerns with a paediatrician can be arranged at the complainant's request. |
| **Gynaecology** | Lack of communication | Actions reviewed by consultants and clinical lead. No further issues. |

**Compliments**

42 compliments were received in quarter 1, the breakdown is as follows:

Endoscopy = 2, GP and Spinal X-ray = 16, Gynaecology = 1, Labour ward = 2, Pathology = 1, Postnatal = 2, Radiology = 16, Sarum ward = 2.

## Medicine Directorate

| | Quarter 1 2018-19 | Quarter 4 2018-19 | Quarter 1 2019-20 |
|---|---|---|---|
| **Complaints** | 21 | 24 | 14 |
| **Concerns** | 17 | 37 | 32 |
| **Compliments** | 157 | 110 | 183 |
| **Re-opened complaints** | 3 | 0 | 1 |
| **% complaints responded to within agreed timescale** | 52% | 46% | 57% |

- The Emergency Department received the most complaints with 7 this quarter which is the same as quarter 4. The main theme of these complaints was unsatisfactory clinical treatment.
- One complaint meeting has been arranged for Q2.
- There were 32 concerns raised in Quarter 1. The Emergency Department received the most concerns (n=7) with themes of unsatisfactory treatment and the attitude of nursing staff. Pitton ward received 4 concerns (no particular theme).
- Response compliance has increased from Quarter 4.
- The PALS department received 54 comments and enquiries for the Medical Directorate in Quarter 1 which have been resolved by the team.
- Total activity within the directorate was 32721 and of this number 0.04% raised a complaint.

**Themes and actions**

| Department/Ward | Topic | Actions |
|---|---|---|
| **Emergency Department** | Unsatisfactory Clinical Treatment | ED workforce plan underway to look at senior cover in ED to support department at times of surge and to support junior doctors. |

**Compliments**

183 compliments were received in Quarter 1, the breakdown is as follows:

AMU = 5, Cardiology = 4, Discharge team = 1, Durrington = 47, Elderly Medicine = 1, Endocrinology = 1, Emergency Department = 19, Farley = 42, Gastroenterology = 1, Hospice = 50, Oncology = 2, Pembroke = 1, Pitton = 2, Redlynch = 2, Respiratory = 2, Tisbury = 2, Whiteparish = 1.

## Musculo-Skeletal Directorate

| | Quarter 1 2018-2019 | Q4 2018-2019 | Quarter 1 2019-2020 |
|---|---|---|---|
| Complaints | 12 | 6 | 10 |
| Concerns | 16 | 22 | 22 |
| Compliments | 42 | 14 | 37 |
| Re-opened complaints | 3 | 7 | 3 |
| % complaints responded to within agreed timescale | 50% | 33% | 50% |

- The total activity across the Directorate was 15,618 and of this number 0.06% raised a complaint.

- There have been 5 re-opened complaints and concerns. One complaint is now with litigation, 3 additional response letters have been sent, one meeting has been held and an additional meeting has been arranged for Aug 2019 (8111).
- The reasons the 3 complaints were re-opened are as follows:
    - The complainant felt the response was not truthful (8053)
    - The complainant would like compensation for injury (8101)
    - The complainant remains unhappy with symptoms and their management (8111). A meeting has been arranged for Q2.
- The reasons the 2 concerns were re-opened are as follows:
    - The patient had additional concerns regarding his ongoing treatment (40505)
    - The family had new queries having received the requested discharge summary (40884)
- The largest number of complaints received was for the Orthopaedics Department (n=4); Amesbury Suite and Oral Surgery also had two each. Dermatology and Plastics Department had one each.
    - The main theme for complaints was clinical treatment – surgery with two complaints and correct diagnosis not made with two complaints.
- The longest time a complaint (8124) was open for this quarter was 43 working days (the complaint remains open). The complainant has been told that there is a due to further investigations needed and a holding letter has been sent from the Clinical Director.
- The highest number of concerns received were for the Plastics Department (n=6) and Oral Surgery (n=4).
    - The main themes for concerns were the delay in receiving appointment (n=5).
- The PALS department received 42 comments and enquiries for MSK in Quarter 1 which have been resolved by the PALS team.

**Themes and actions**

| | | |
|---|---|---|
| **Orthodontics (OMFS)** | Clinician behaviour | The DMC have held a meeting with the locum consultant.<br>An action plan has been agreed and the DMC will review progress. |
| **T&O** | Clinical treatment | Whilst the DMC have reviewed all the cases for themes and identified no particular themes, anonymised complaints have been shared with staff to improve patient experience |

**Compliments**

37 compliments were received by the MSK directorate in Q1, the breakdown is as follows:

Orthopaedics = 12, Plastics Department = 8, Wessex rehab = 5, Chilmark Ward = 4, Amesbury Ward = 3, Maxillo-Facial = 2, Rheumatology = 1, SALT = 1, Spinal Unit = 1

## Surgical Directorate

| | Quarter 1 2018-19 | Quarter 4 2018-2019 | Quarter 1 2019-20 |
|---|---|---|---|
| Complaints | 19 | 8 | 12 |
| Concerns | 22 | 35 | 33 |
| Compliments | 33 | 218 | 158 |
| Re-opened complaints & concerns | 6 | 2 | 1 |
| % complaints responded to within agreed timescale | 37% | 25% | 50% |

- Total inpatient and outpatient activity within the Directorate was 13,770 and of this number 0.09% raised a complaint.
- There are three complaints still open - 8133 – open 31 working days, 8128 – open 40 working days, 8131 – open 32 working days.
- There have been two complaint meetings held for this quarter.
- The highest number of complaints were for the Ophthalmology Department and General Surgery with three complaints each and Breamore Ward with 2 complaints.
- The oldest complaint open is 8128 which was due out on 22nd July 2019 and has been open for 40 working days.
- One complaint was re-opened in this quarter, it is now closed.
- The reason the complaint was re-opened was: 8047 – disagreed with final letter stating patient was referred back to optician and no apology given from consultant. Meeting subsequently held with patient to resolve complaint 08/05/2019.
- The most common theme for complaints was for clinical treatment – surgical group (n=2), further complications (n=2 ), unsatisfactory treatment (n=2)
- The most common theme for concerns was for the appointment system – procedures (n=4).
- The highest number of concerns were for the Central Booking Department (n=8) and Britford Ward (n=5) and General Surgery (n=5).
- The PALS office have received 61 enquiries and comments for the Surgical Directorate which were resolved by the PALS team.

**Themes and actions**

| Department/Ward | Topic | Actions |
|---|---|---|
| **Ophthalmology** | Complaints | Of the 3 complaints against Ophthalmology this quarter, 2 did not have any themes and 1 is still being investigated. |
| **General Surgery** | Complaints/ Difficult Consultations | Three complaints have been investigated for General Surgery but there were no common themes identified.<br>Following a difficult consultation which could have been handled better, the Registrar will attend a “difficult interactions with patients” course. |
| **Breamore** | Patient Experience | Sister will share anonymised version of complaint with staff to improve the patient experience (ward was noisy and patient’s catheter site was not checked for leakage). |

**Compliments**

In total 158 compliments have been received across the Directorate with the breakdown as:

Britford Ward = 73, Downton Ward = 50, Radnor Ward = 15, Central Booking = 4, Urology = 3, SAL = 2, Eye clinic = 2, Breamore Ward = 2, Breast Recon Nurse Specialists Unit = 1, ENT = 1, General Surgery = 1, Ophthalmology = 1, Pre-op assessment = 1, SAU = 1, Theatres = 1

## 4. Trustwide feedback

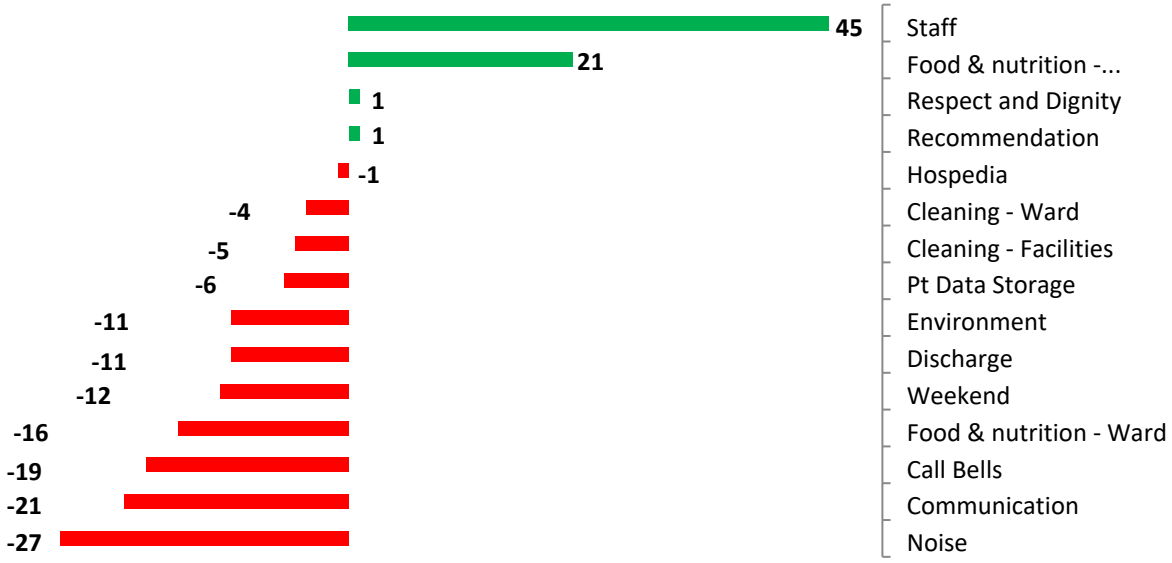
### Patients surveyed

A total of 3,052 patients provided feedback during the quarter through national patient surveys, real-time feedback (eRTF) and the Friends and Family Test (FFT). This is an improvement on the previous quarter where the numbers dropped although not back up to previous levels (2019 Q4 – 2,387; 2018 Q3 – 4,538; Q2 – 4,386.

### Real-Time Feedback

#### a) Inpatients

A total of 220 inpatients were surveyed in the quarter. They made 189 positive comments and shared 204 suggestions of areas where services could be improved. These have been categorised and the balance of positive to negative comments is shown in the graph below.




The largest area of positive comments related to staff (59 positive against 14 negative).

*"The care has been superb. The staff are friendly and helpful. Cannot commend them enough."*

The main areas of concern were noise, communication and response to call bells.

### Noise

12 positive and 39 negative comments were made regarding noise.

*"Last night it was very noisy; a man sang all night."*

'Other patients' were cited most for the cause of noise on Chilmark ward (n=6)


### Communication

6 positive and 27 negative comments were made regarding communication.

*"The staff could do more to involve me in decisions about my care and treatment."*

Care and treatment was cited most for lack of communication on Redlynch ward (n=3)

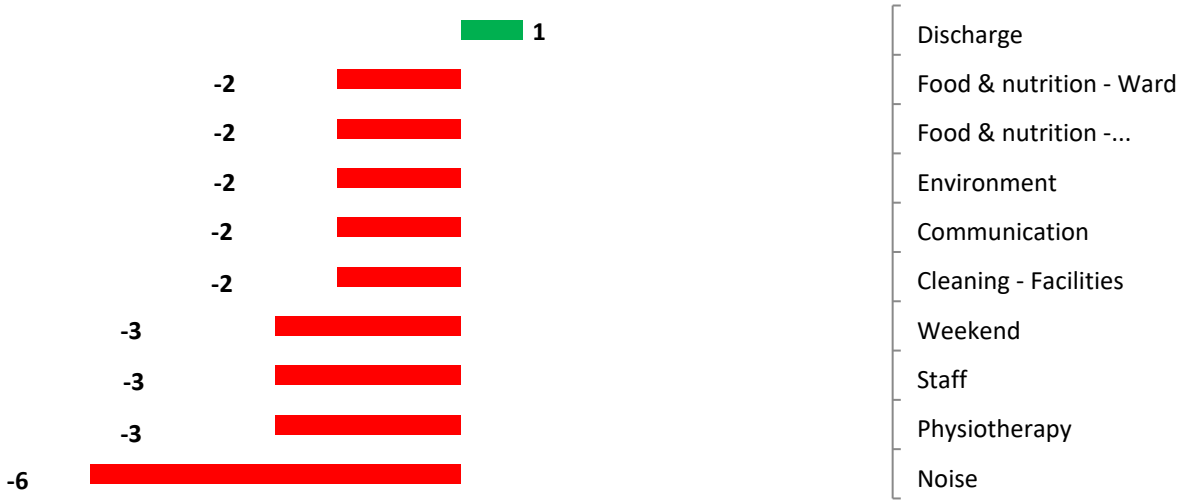

**Call bells**

19 negative comments were made regarding response to call bells. The 3 areas receiving most comments (3 each) were Chilmark, Farley and Whiteparish.

*"More nurses are needed at night to answer the call bells."*

**b) Spinal**

A total of 24 patients were surveyed in the quarter. They made 10 positive comments and shared 32 suggestions of areas where services could be improved. These have been categorised and the balance of positive to negative comments is shown in the graph below.

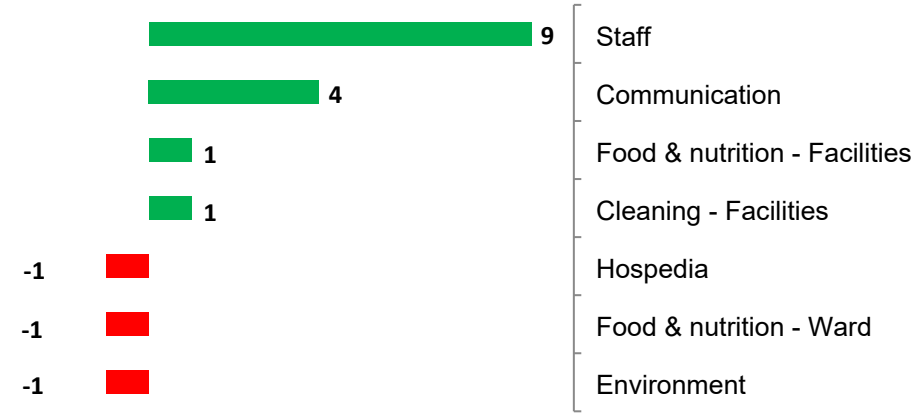



The main area of concern was noise (two positive against eight negative).

*"There is noise from lots of banging and clanging, and talking."*

**c) Maternity**

A total of 10 new mothers were surveyed in the quarter. They made 33 positive comments and shared 9 suggestions of areas where services could be improved. These have been categorised and the balance of positive to negative comments is shown in the graph below.

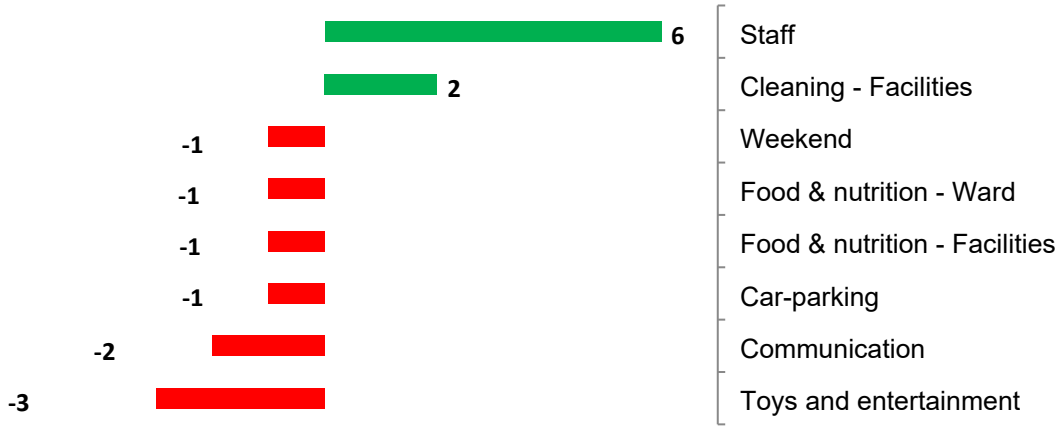



The highest number of positive comments related to staff (10 positive against one negative).

*"Although it has been a slow and difficult process, the midwives' and doctors' compassion and competence have made it much better than it otherwise would have been."*

**d) Paediatrics**

A total of 11 adults or carers and 11 children were surveyed during the period. They made 14 positive comments and shared 15 suggestions of areas where services could be improved. These have been categorised and the balance of positive to negative comments is shown in the graph below.




The highest number of positive comments related to staff (eight positive against two negative).

*"The staff are amazing."*

The main area of concern was toys and entertainment.

*"There are out-dated games consoles, etc."*

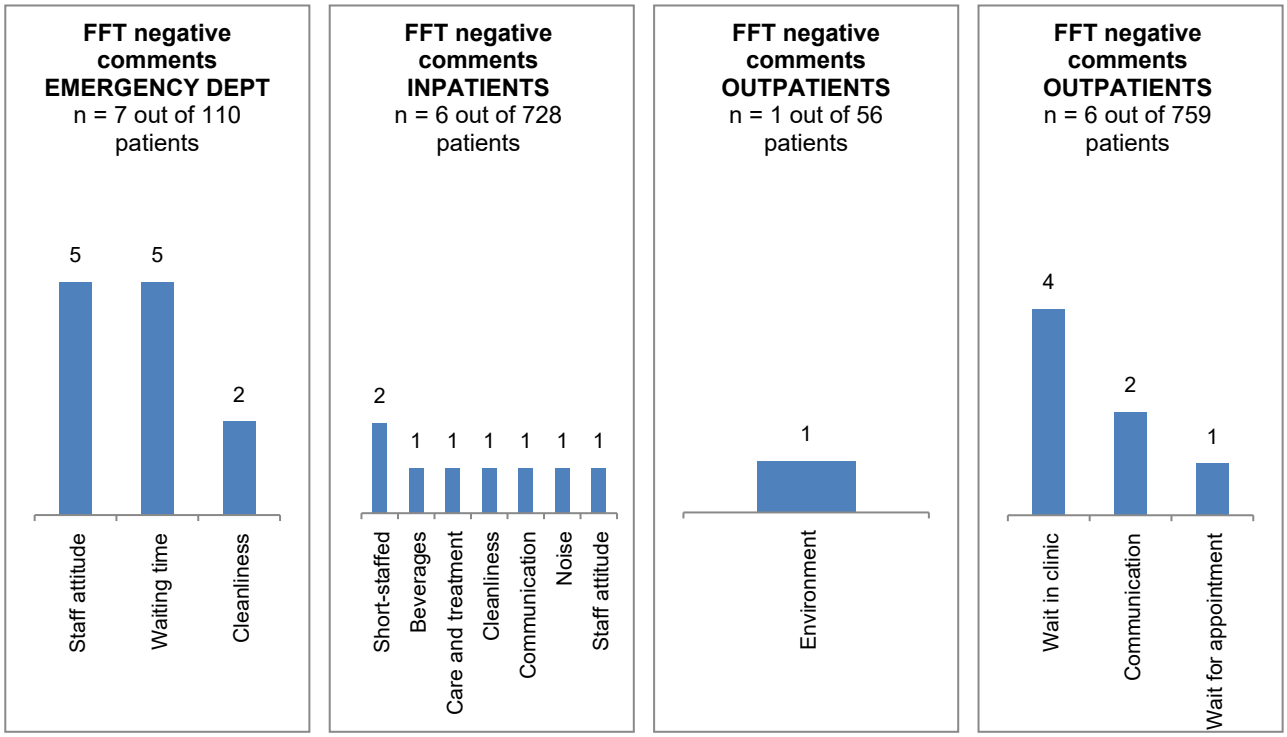
**Friends and Family Test**

Responses for the quarter are set out in the table below.

| | | Rating | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total Responses Received | Extremely Likely | | Likely | | Neither likely nor unlikely | | Unlikely | | Extremely Unlikely | |
| Day Case | 250 | 233 | 93% | 13 | 5% | 4 | 2% | 0 | | 0 | |
| Emergency Dept | 110 | 94 | 85% | 7 | 6% | 2 | 2% | 0 | | 7 | 6% |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Inpatients | 728 | 661 | 91% | 51 | 7% | 11 | 1.5% | 5 | 0.5% | 0 | |
| Maternity | 56 | 49 | 87% | 4 | 7% | 2 | 4% | 0 | | 1 | 2% |
| Outpatients | 759 | 700 | 92% | 46 | 6% | 7 | 1% | 3 | 0.5% | 3 | 0.5% |

Comments made between April and June 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.

## Patient and public involvement – National Surveys

### National Inpatient Survey 2018

The results of the national inpatient survey 2018 were published on the Care Quality Commission's website on 20 June 2019. They are available at:
https://www.cqc.org.uk/provider/RNZ/survey/3#undefined

- SFT scored 'better' than most other Trusts in one of the eleven overall sections:
    - The Emergency Department.
- SFT scored 'better' than most other Trusts in one of the 63 individual questions:
    - Hospital staff considering patients' family and home situation when planning their discharge, if this was necessary.
- Respondents made 400 comments on things they felt were good about their stay compared with 327 on areas they felt could be improved.
    - The top three areas where staff in general, doctors and nurses.
    - The three areas where there were more negative than positive comments related to communication, discharge and food & nutrition on the ward.
- When compared with neighbouring Trusts (Bath, Bournemouth, Dorchester, Poole, Southampton, Swindon, Winchester and Yeovil) Salisbury's scores were fairly evenly matched across all areas.
    - Salisbury had the highest or joint highest score in two of the 11 overall sections:
        - Doctors
        - Leaving hospital
    - and nine of the 63 individual questions:
        - Were you given enough privacy when being examined or treated in the A&E Department?
        - When you had important questions to ask a doctor, did you get answers that you could understand?

        - Did you have confidence and trust in the doctors treating you?
        - When you had important questions to ask a nurse, did you get answers that you could understand?
        - Did nurses talk in front of you as if you weren't there?
        - Did a member of staff say one thing and another say something different?
        - Were you given enough notice about when you were going to be discharged?
        - Did hospital staff take your family or home situation into account when planning your discharge?
        - Did hospital staff discuss with you whether additional equipment or adaptions were needed in your home?
    - Salisbury had the lowest or joint lowest score in seven of the 63 individual questions:
        - Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?
        - Did you get enough help from staff to eat your meals?
        - During your time in hospital, did you get enough to drink?
        - Do you think the hospital staff did everything they could to help control your pain?
        - Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?
        - While in hospital, were you ever asked to give your views on the quality of your care?
        - Did you see, or were you given, any information explaining how to complain about the care you received?

**Mental health issues**

One of the questions in the survey asks respondents if they have a mental health condition that has lasted or is expected to last for 12 months or more. 45 of the 668 respondents stated that they did.

When comparing the results of those with a mental health condition (n= 45 [7%]) with those who did not (n=623 [93%]) scores for 57 questions were lower (45 by -0.5 or less) and the remaining six were higher (1 by more than 0.5).

The results for 2017 were 50 lower (41 by -0.5 or less) and nine higher (3 by 0.5 or more). Three results were the same.

*"Overall, my stay was good. I met lots of nice folk and made friends I am still in touch with. I also put on weight because I was eating at regular times. This was amazing."*

*"Nurse could have handled my fears and mental health better!"*

There were no complaints or concerns raised about (or including) mental health issues in Q1.

**Action taken on areas of concern from surveys**

Wards, the Emergency Department and Maternity, have action plans in place to address the main areas of concern in their location. Progress is monitored via the Trust's Matrons Monitoring Group and is overseen by the Clinical Management Board.

PALS are supporting a QI methodology approach known as 'Always Events' where the trust-wide theme of '**noise at night'** will be worked on by two different ward areas, and learning shared with other wards.

A table talker has been co-produced with patients aimed at improving **discharge and communication around discharge**. It suggests questions that patients/carers/family members can ask to find out where they are in their recovery and when they could expect to be discharged. The suggestion has been made that the information offered will vary according to the patient population/ward. The initiative will initially be trialled on Spire Ward.

Action plans against the latest Inpatient Survey are currently been worked on and PALS will work with the wards/departments to improve patient experience; more information will be presented in future patient experience reports.

## 5. Patient Stories

Patient stories are presented at the public Trust Board 6 times a year. Explicit consent is obtained to share the taped stories and, as soon as the Trust's Intranet is developed, these will be uploaded along with a structured reflection guide for staff to use for revalidation and personal/team learning.

## 6. Patient and public involvement (PPI)

Please see separate mid-year report.

PPI Projects are shared on the following web page on the Intranet:
http://intranet/website/staff/quality/customercare/patientandpublicinvolvement/ppiprojects/index.asp

## 7. Interpreting and Translation

The annual spend on interpretation and translation has risen year on year. As a result of this, reminders and updates about the interpreting service will be sent out to all email users and updates in Cascade Brief/Pulse are planned.

The annual spend on interpretation and translation has risen year on year. As a result of this, reminders and updates about the interpreting service will be sent out to all email users and updates in Cascade Brief/Pulse are planned.

The PALS team continue to work hard with the clinical teams to ensure interpreters are being used appropriately, and reduce the overall cost of interpreting to the Trust. It is hoped that by increasing staff awareness of the telephone language interpreting service and clarifying when the use of face-to-face language interpreters is appropriate, costs can be reduced but an excellent service can still be provided. Requests for face-to-face language interpreters must be approved by the DMT before they are booked. A translation and interpreting solution across the STP is currently being explored by Procurement. It is hoped that a video-based solution, whilst more expensive than the telephone, would be more acceptable to the clinical teams whilst still offering a saving compared to the face-to-face solution.

This quarter's most frequently used language for face-to-face interpreting (used on 31 occasions):

Polish 19.4% = 6  Nepalese 16.1% = 5

Total spend for face-to-face interpreting this quarter = £5699.35

British Sign Language was used on 12 occasions this quarter with a total spend of £1956.95

The areas where interpretation was used most often are:

Endoscopy = 38.5% Eye Clinic = 9.7% Sarum OPD = 9.7% Med Surg OPD = 9.7%  Radiology = 9.7%

## 8. Patient Information

All information leaflets will move to a web-based app this year. In preparation for this a workshop was held with patients, families and key staff in July 2019. The app solution was overwhelmingly supported by all those present. The app developers are now working on the design which will be tested with patients/staff before going live. The option to print a leaflet will be built into the solution, but it is hoped that the app will help reduce the number of leaflets that are printed.

## 9. Parliamentary and Health Service Ombudsman (PHSO)

The PHSO received one new request for independent review in Q1.

- An investigation has been commissioned into the loss of a family heirloom (ring) during an elderly patient's admission to the emergency department.

**Update on cases shared in previous report** The PHSO C2071155/ complaint 8006 - Consent for surgery.

In accordance with the Ombudsman's recommendations, a letter of apology and the action plan has been sent to the complainant. The PHSO has requested that the action plan is shared with the Care Quality Commission (CQC). The Head of Compliance has forwarded the action plan to the CQC via email, and will discuss the case at the next engagement contact.

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

## 10. NHS Choices website


In Q1 there were 11 new comments posted on the NHS Choices website. Ten reviews were positive and one was negative.

An example of a positive one is:

*'Attended SAU following referral from GP. Seen quickly and efficiently by F1 and then registrar. Booked for surgery and taken to theatre within an hour. Back to Braemore ward, sandwiches tea and home. All the staff with whom I came into contact were friendly, caring and compassionate. Absolutely perfect service. The NHS at its very best. Thank you'.*

The negative one surrounded the care of a patient on an unnamed respiratory ward and reported that nurses were ignoring her husband's suffering. *'I'm very sad that my hubby has been treated like this'*

The NHS Choices feedback has been managed by the Communication Team in the past but was handed back to PALS in May 2019. This has allowed faster response and earlier sharing with the named teams.

All feedback is responded to and sent to the relevant team(s) although the fact that the feedback is anonymous makes it difficult for the teams to investigate.

## 11. Facebook

89 positive comments were posted on Facebook in Quarter 1. Most of these were comments on photographs and articles posted by the Comms Team. However, there were 13 comments that related to care here. For example *'Amazing hospital, amazing staff, incredible care, especially at Sarum Ward. we can't speak highly enough …',* and *'Salisbury A&E is amazing! I presented with my son (10) who was struggling to breathe, within minutes he was triaged and in majors being monitored. Utterly outstanding team at Salisbury, thank you for all that you do!'*

There were no negative comments posted on Facebook this quarter.

## 12. Summary

This report brings together the themes from patient experience feedback and where improvements can be made.

**Actions for the PALS team for Q2:**

- Work with directorate teams to improve compliance against the agreed complaint response timescales
- Item in Pulse newsletter and Cascade Brief regarding interpreting/translation.

**Actions for the PALS team going forwards:**

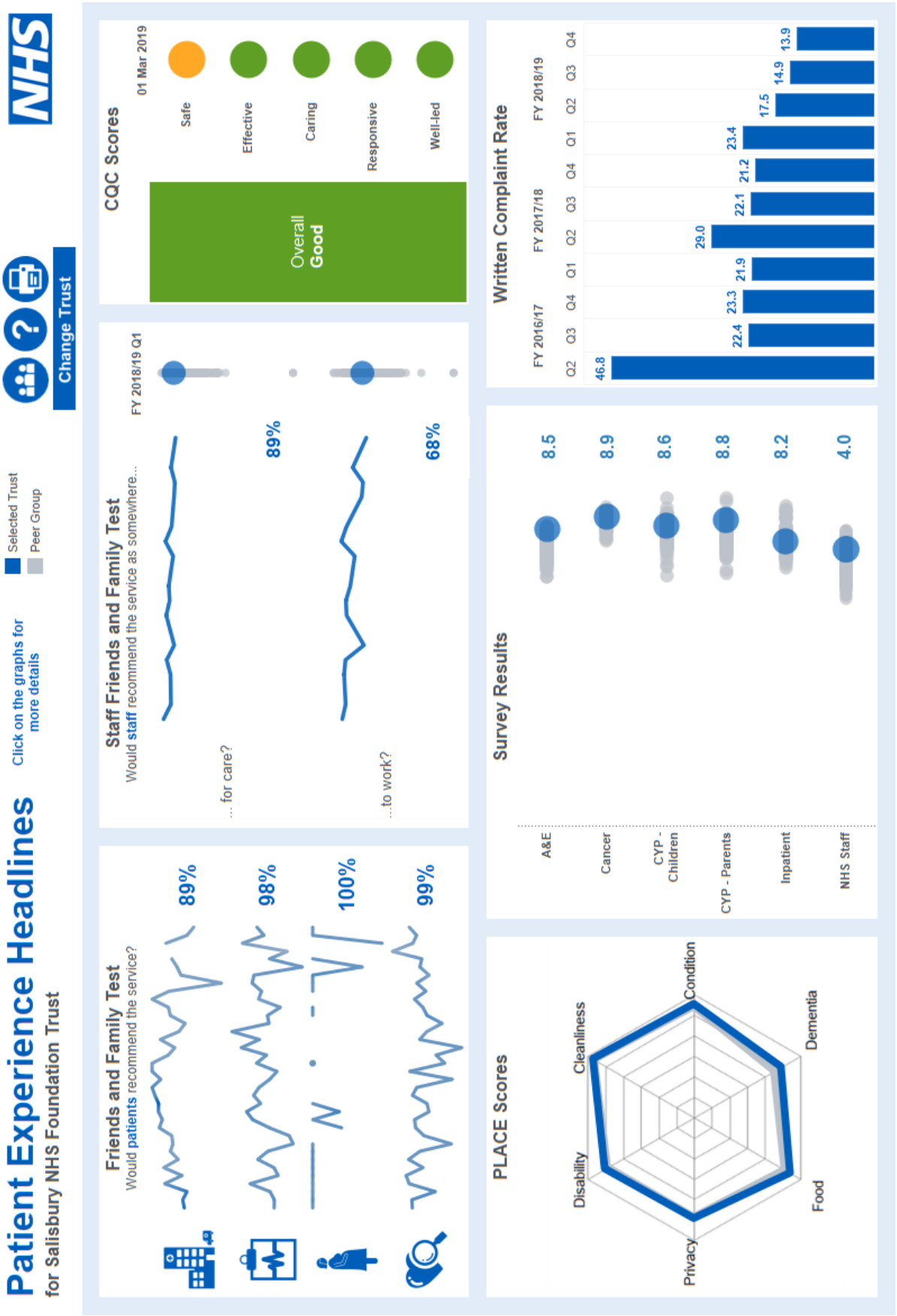
- Complete the Patient Experience Toolkit in a workshop with relevant staff
- Review the PPI toolkit
- Develop a new website to share projects/improvements/learning across the Trust
- Attend the Always Event training event and use this QI methodology to explore noise at night in more detail (planned event for June was cancelled by NHS England)
- Start to move all the patient information onto the new app-based portal.

## 13. Recommendations

The Board is asked to note this report and agree the actions going forwards.

**AUTHOR:** Katrina Glaister
**TITLE:** Head of Patient Experience

**Appendix 1**




The above infografic is one that is pulled together from data that all trusts submit to NHS Digital. This image shows how Salisbury NHS Foundation Trust currently compares to others in our region (July 2019).

Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Trust Board (Public) | **Agenda item:** | **4.2** |
| **Date of Meeting:** | 3 October 2019 | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Learning from deaths Q1 2019 - 2020 | | | |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | | | ✓ | |
| **Prepared by:** | Dr Belinda Cornforth, Consultant Anaesthetist<br>Claire Gorzanski, Head of Clinical Effectiveness | | | |
| **Executive Sponsor (presenting):** | Dr Christine Blanshard, Medical Director | | | |
| **Appendices (list if applicable):** | Appendix 1 – Mortality dashboard Q1 2019/20<br>Appendix 2 - Learning from death themes and improvement actions.<br>Appendix 3 – Mortality dashboard explanation of terms | | | |

| **Recommendation:** |
|---|
| **Recommendation** – assurance that the Trust is learning from deaths and making improvements. |

| **Executive Summary:** |
|---|
| The report highlights the planned introduction of the Medical Examiner system in January 2020 and the improvements in bereavement support. The Q1 mortality dashboard shows the number of deaths, outcome of reviews, learning themes and actions taken to improve. The majority of deaths were unavoidable and expected but one (0.52%) was provisionally probably avoidable pending a case review. 4 deaths were subject to serious incident inquiries.<br><br>A new theme emerged in Q1, of 3 acutely unwell patients who needed a medical review at a weekend who did not receive it. Escalating deteriorating patients to the appropriate level is also a theme. A new relative risk of gastrointestinal haemorrhage is statistically higher than expected, particularly the weekend patient cohort. These cases will be reviewed and reported in Q2. The relative risk of death of patients with a fractured neck of femur has risen and these cases will also be reviewed and reported in the next quarter.<br><br>HSMR remains stable but the increasing trend of weekend HSMR is of concern. A review of 78 deaths of patients admitted as an emergency on a Sunday found no direct causal link with patients being admitted as an emergency at a weekend. |

| **Board Assurance Framework – Strategic Priorities**<br>**Select which area(s) of the strategic priorities your report relates** | |
|---|---|
| **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 | ☐ |

## 1. Purpose

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.

## 2. Background

The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

A system of Medical Examiners is to be introduced in January 2020 to strengthen the support of bereaved families and drive improvements in the investigation and reporting of deaths.

## 3. Medical Examiners (ME)

A plan is now in place to provide the new Medical Examiner service to ensure excellence in care for the bereaved with a provisional start date of 1 January 2020 when the MEs have been trained. This includes:

- A 5 day (ME) roster covering adult and paediatric deaths within the Trust, including cover for all leave.
- Adequate staffing is in place to ensure that the registration of a death is not delayed by the ME process.
- A facility for Qualified Attending Physicians (junior doctor) to discuss each death and death certification in a meaningful way with the ME.
- A facility for each ME or Medical Examiners' Officer (MEO) to have a meaningful discussion with the next of kin regarding the end of life care of a loved one and an explanation of the medical certificate.
- A framework for ensuring that deaths highlighted as requiring further review by the ME are forwarded to the Trust's Mortality Surveillance Group to ensure learning is shared across the organisation.
- The ability to fast track the ME process when required.
- The facility for accurate recording of ME datasets, and for our data to be submitted to the national ME.
- A local network of MEs to share learning and provide an independent review facility if needed.

## 4. Working with bereavement families

In July 19, the local bereavement survey was restarted – to date 40 surveys have been given to relatives with 6 returned, all with extremely positive comments and no requests for contacting the team to discuss any concerns about care. The positive feedback is shared with to the individual wards and any named staff.

At the end of July 19, the wards started sending condolence cards and a leaflet on 'Support and advice following a bereavement' 3 weeks after the death. No calls have been generated from the leaflet to date.

In Q1 19/20, 4 families contacted the end of life care team. All of the patients had been supported by the end of life care team prior to death. One family was referred by a District Nurse of a patient who had been discharged to the preferred place of care but the planned overnight care did not turn up and the patient died in the early hours of the morning.

Themes:

- Seeking clarification of events, wanting to feedback to help the Trust learn for future families
- Family dynamics – someone neutral to talk to who had met other family members
- Signposting a parent for bereavement support.
- Passing on compliments, wanting to feedback the positive effect that staff compassion had on the family and patient experience.

## 5. Mortality dashboard, learning, themes and actions

In Q1 2019/20, 192 deaths occurred in the Trust. The total includes patients who died in the Emergency Department. Of these, 185 (96%) were screened to ascertain whether the death needed a full case review. 62 (32%) deaths had a full case review. One (0.52%) death was provisionally probably avoidable but still needs a full case review, 3 were possibly avoidable but not very likely, less than 50/50 chance, and 5 had slight evidence of avoidability. Key themes arising from the 20 learning points were:

1. End of life care – recognition of the dying patient, communication with patients and families, ceilings of care.
2. Three acutely unwell patients who needed a medical review at a weekend did not receive it.
3. Recognising deteriorating patients and escalating to the appropriate level.

## 6. Improvement actions in Q1 19/20

- Plan the introduction of the ReSPECT form (Treatment Escalation Plan & DNAR form) - the CCG have asked the Trust to put the introduction of ReSPECT on hold until the national version 3 is published in ?January 2020 so that it can be launched as an STP wide piece of work.
- Improve documentation of consent, risks and benefits of ward based procedures such as chest drains and ascitic taps - Chest drain insertion sticker - partially completed. Ascitic drainage requires further work with the development of a LoCSSIP.
- Undertake a review of weekend deaths – completed to be reported to the Clinical Governance Committee in September 2019.
- Improve the escalation of patients who deteriorate in accordance with the NEWS2 policy – ongoing education and quarterly escalation audits.

## 7.0 CUSUM alerts

In Q1 19/20, 4 new CUSUM alerts:

- Essential hypertension 1 death vs 0 expected with a relative risk 334. Case review showed that there were no iatrogenic events that contributed to the death and it was not caused by hypertension.

Learning points from this case:

- Poor communication between two Trusts and a failure to contact the next of kin of this patient in a timely manner.
- No next of kin details recorded on Lorenzo on admission.

- Operations on vitreous body 1 death vs 0 expected with a relative risk 539 – to be investigated and reported in Q2 19/20 report.
- Repair of umbilical hernia 2 deaths vs 0.2 expected with a relative risk 1090. 1) A 92 year old patient with an obstructed bowel received post-operative care in ITU, but had a myocardial infarction from which she succumbed. Death not avoidable and no learning points. 2) A 62 year old patient admitted with abdominal pain and renal failure. CT showed metastatic cancer. The decision to undertake surgery and the management of post-operative care is to be discussed at a joint surgical/anaesthetic M&M meeting in September 19.
- Cancer of ovary 3 vs 0.6 expected with a relative risk 478 - all these deaths occurred in the Hospice and the Mortality Surveillance Group agreed these deaths did not need to be investigated

## 8.0 Relative risk alerts

One new relative risk alert arose in Q1 19/20:

Gastrointestinal (GI) haemorrhage – 18 deaths vs 10.2 expected with a relative risk 176.5 is statistically significantly higher than expected. SFT is the only Trust in the peer review group to have this alert. There has been an upward trend in relative risk for GI haemorrhage over the last 5 data points. The weekend cohort has a statistically significantly higher than expected relative risk. These are mostly frail patients of 75 years and over. The Mortality Surveillance Group will lead a multidisciplinary review of the 18 deaths and include the 3 deaths in the gastritis and duodenitis CUSUM alert arising in Q2 19/20.

## 9. Death following a planned admission to hospital

In Q1 19/20, 3 deaths of patients following a planned admission:

- A patient admitted from clinic with painless jaundice and cellulitis. CT and ultrasound scan showed evidence of liver cirrhosis and portal vein thrombosis. The patient failed to respond to intensive care. Death was expected and not avoidable. No learning points.

- Patient repatriated from UHS with recent diagnosis of granulomatous vasculitis but deteriorated despite treatment. Not fit for further aggressive management and the patient wished to stop active treatment. Death was expected and not avoidable. No learning points.

- Patient with mesothelioma developed localised upper abdominal pain and was admitted to the Hospice for symptom control and died on the same admission. Death was expected and not avoidable. No learning points.

## 10. Unexpected deaths

In Q1, there were 4 unexpected deaths.

1) A patient who was fit to be discharged fell and fractured his femur. It was surgically treated but the patient died of a wound infection. Root cause showed an inaccurate falls and bed rails assessment such that appropriate interventions were not put in place. Improvement actions are being led by the Falls Working Group (SII311).
2) A stillbirth of an intra-uterine death at 30 weeks The case is currently being investigated as a serious incident inquiry.
3) A 70 year old man with multiple comorbidities initially diagnosed with a nephrotic syndrome, later established to be chronic pancreatitis treated with creon. The patient was only reviewed once by a consultant in the first 7 days – aggravated by the Easter weekend. During this time he developed an e-coli sepsis but the early signs of a raised c-reactive protein and white cell count were not acted upon until 48 hours later. Had he received broad spectrum antibiotics earlier it would have resulted in a greater chance of survival. Death was possibly avoidable. Actions: Deteriorating patient and sepsis working group to use this case to emphasise the importance of acting on results promptly.
4) A patient who died from hospital acquired C difficile. Missed opportunities to identify the high risk factors for acquiring C difficile when receiving repeated antibiotics for aspiration pneumonia. Actions: 1) Education to ensure it is raised on the safety brief and escalation of symptoms 2) Identify and train more infection prevention and control link nurses 3) Introduce a new stool chart 4) Directorate attendance at the Infection Prevention and Control Working Group (SII324).

## 11. Stillbirths, neonatal deaths and child death

One stillbirth in May of an intra-uterine death at 30 weeks (SII). No neonatal or child deaths in Q1.

## 12. Patients with a learning disability

In Q4 18/19 (not previously reported), three patients with a learning disability died:

- A patient with multiple comorbidities and a cancer excised in 2015 was investigated when it recurred in 2018. At MDT meetings it was considered inoperable. During a subsequent admission a treatment escalation plan was initiated and the patient was discharged to a nursing home because of increasing needs. On the final admission the patient had sepsis with a plan for supportive treatment and ward based care. She died with the family present. The death was expected and not avoidable.

]

Learning points:

- Sepsis treatment with antibiotics given at 1.5 hours but multiple discussions as to the appropriateness led to a delay.
- Medical certificate should have record all the comorbidities in part 2.

➢ A patient with multiple comorbidities admitted with increasing oxygen requirements due to Rhinovirus infection with care escalated to intensive care including intubation and ventilation. The patient recovered and was transferred to the ward but quickly deteriorated developing respiratory failure. In discussion with the family treatment was withdrawn and palliation agreed. Death was expected and not avoidable. Learning points:

- The severity of the mixed acidosis was not appreciated or the respiratory attempts to compensate.
- Palliative care could have been started earlier after failure of non-invasive ventilation.

➢ A 78 year old patient with mild dementia and some memory impairment newly diagnosed with leukaemia. Commenced chemotherapy as a day attender but did not attend on the 4th day. Police brought the patient to hospital and he was treated for neutropenic sepsis but died from overwhelming infection. Care was graded as good. Consultant consented the patient for treatment (keen to proceed) Learning point:

- Consider an IMCA in an unbefriended patient for the purposes of taking consent to ensure the patient understood the risk associated with chemotherapy toxicity.
- Review the coding of this patient as dementia is not a learning disability.

In Q1 19/20, 1 patient with a learning disability died:

➢ Patient with an out of hospital cardiac arrest with unsurvivable hypoxic brain injury – good family support provided. Death not avoidable. No learning points

All the deaths are reported to the LeDeR programme following a case notes review.

## 13. Patient with a serious mental illness

One patient with a serious mental illness died in Q4 18/19 (not previously reported):

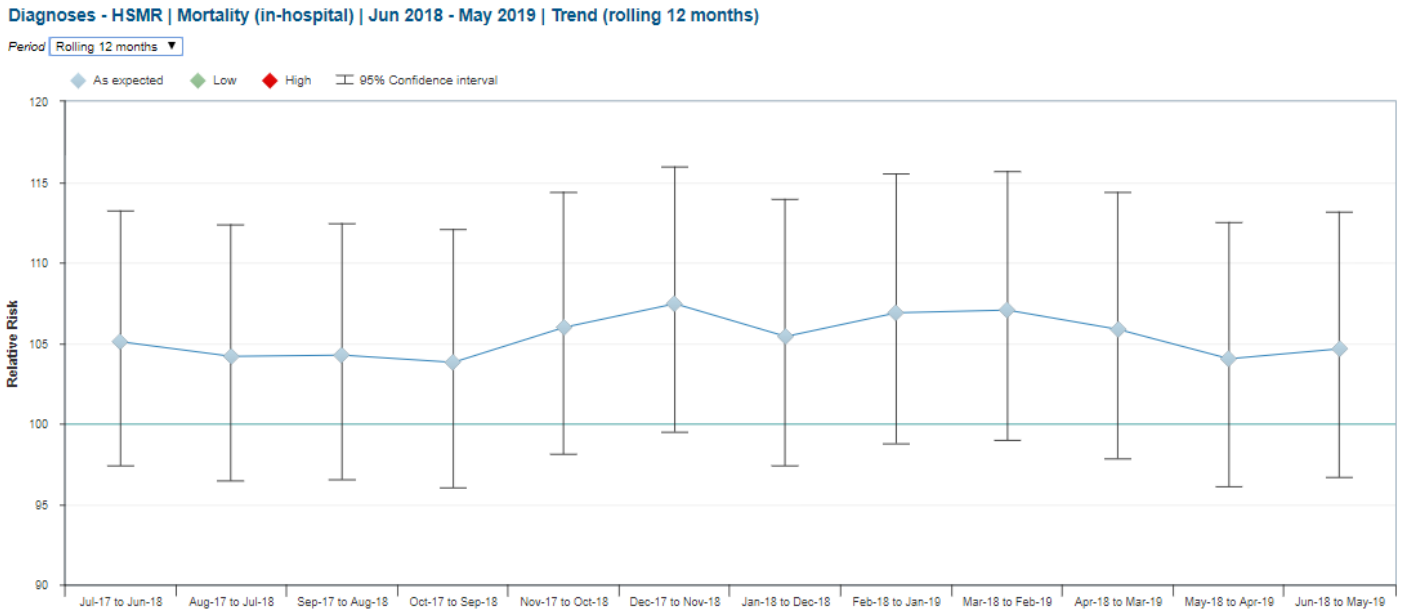
➢ A 74 year old woman admitted from Fountains Way being treated for depression, delusional disorder and self-neglect with an upper GI bleed and aspiration pneumonia. Investigated and treated for gastritis and duodenitis. Respiratory function deteriorated and full treatment given which included an ITU review. End of life care recognised and personalised care initiated. Family only contacted when the patient was close to death as contact details were unknown. Death expected and not avoidable. Learning point:

- Early communication with Fountains Way should have taken place to ascertain next of kin details.

In Q1 19/20, two patients with a serious mental illness died and these will be reported in Q2 19/20.

## 14. HSMR rolling 12 month trend to May 2019

**Table1: HSMR relative risk of all non-elective diagnoses June 2018 – May 2019**




HSMR remains stable within the expected range and shows a slight downward trend over the last 4 data points.

## 15. SHMI April 2018 – March 2019

SHMI is 101.4 within the expected range. When comparing SHMI by site Salisbury District Hospital is 96.32 and Salisbury Hospice is 222.3. SHMI adjusted for palliative care is 95 to December 2018.

## 16. Comorbidity and palliative care coding 19/20

Trends in comorbidity coding show that the Trust has a Charlson comorbidity upper quartile rate for the HSMR basket of 23.9% which is 96 as an index of national (note: 19/20 only contains 2 months of data).

**Table 2: Trend in Charlson Comorbidity upper quartile rate**

| | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|
| Upper-quartile comorbidity | 24.2% | 24.4% | 24.7% | 23.9% |
| as index of national (100) | 97 | 98 | 99 | 96 |

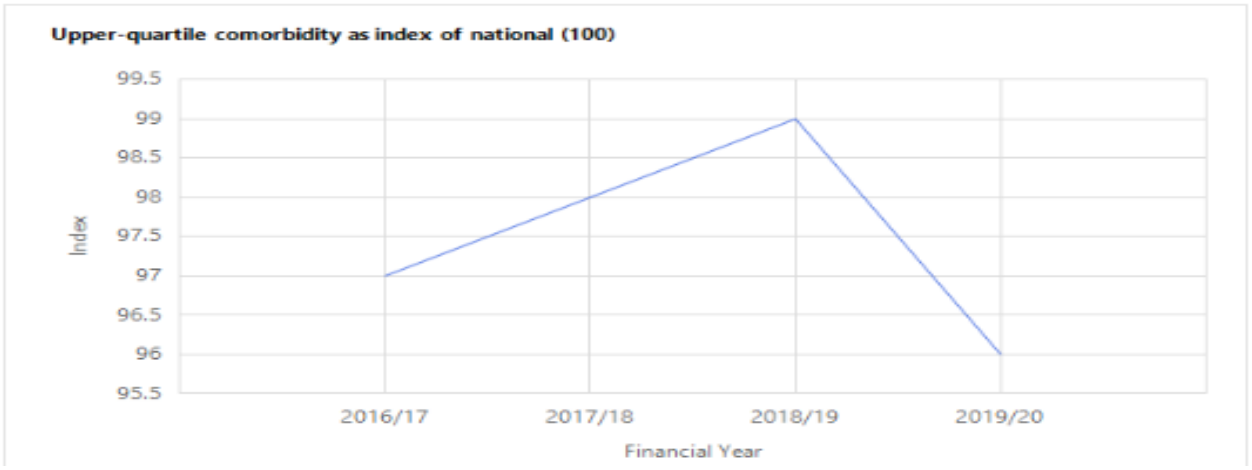
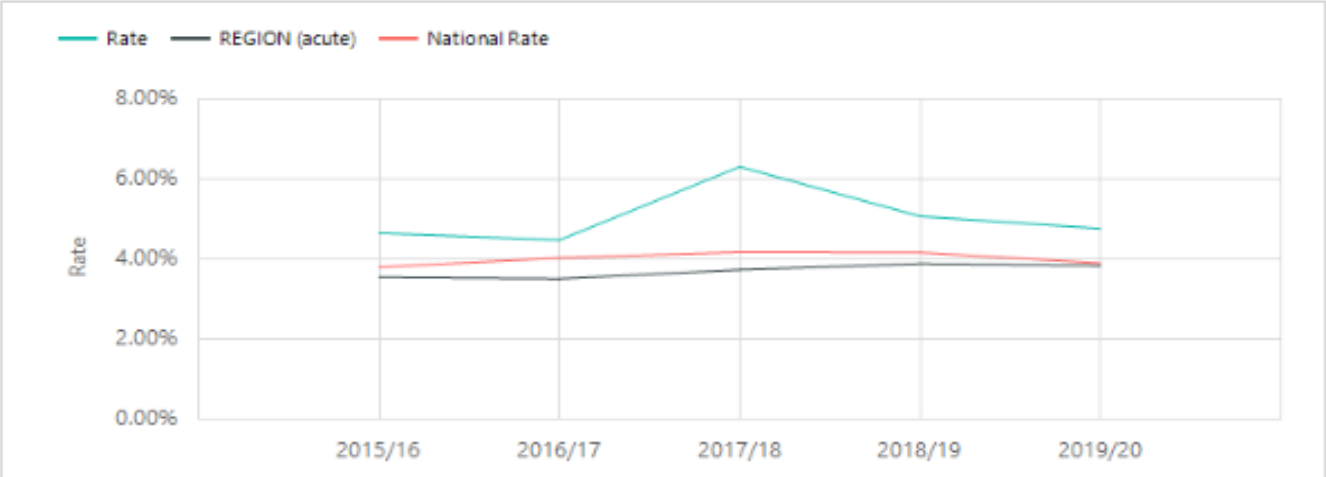


**Table 3: Trend in Palliative Care coding rate**

| Trend (Financial Year) | Non-elective spells | Palliative care | Rate | National Rate | Peer Group Rate |
|---|---|---|---|---|---|
| 2015/16 | 9,168 | 426 | 4.65% | 3.79% | 3.54% |
| 2016/17 | 9,523 | 426 | 4.47% | 4.03% | 3.51% |
| 2017/18 | 9,773 | 616 | 6.30% | 4.17% | 3.73% |
| 2018/19 | 9,971 | 505 | 5.06% | 4.16% | 3.88% |
| 2019/20 | 1,639 | 78 | 4.76% | 3.90% | 3.84% |




Trends in palliative care coding show that for 19/20 the Trust has a palliative care coding rate for non-elective spells of 4.76% which is higher than the national rate of 3.90%. The Trust's rate has decreased compared to the 18/19 financial year caution should be exercised as 19/20 only contains 2 months of data.

## 17. Weekday/weekend HSMR

Emergency weekday is within the expected range but weekend HSMR is statistically significantly higher than expected at 127.5. Sunday has a statistically significant higher than expected relative risk.

**Figure 4: Emergency weekday/weekend HSMR June 2018 – May 2019**

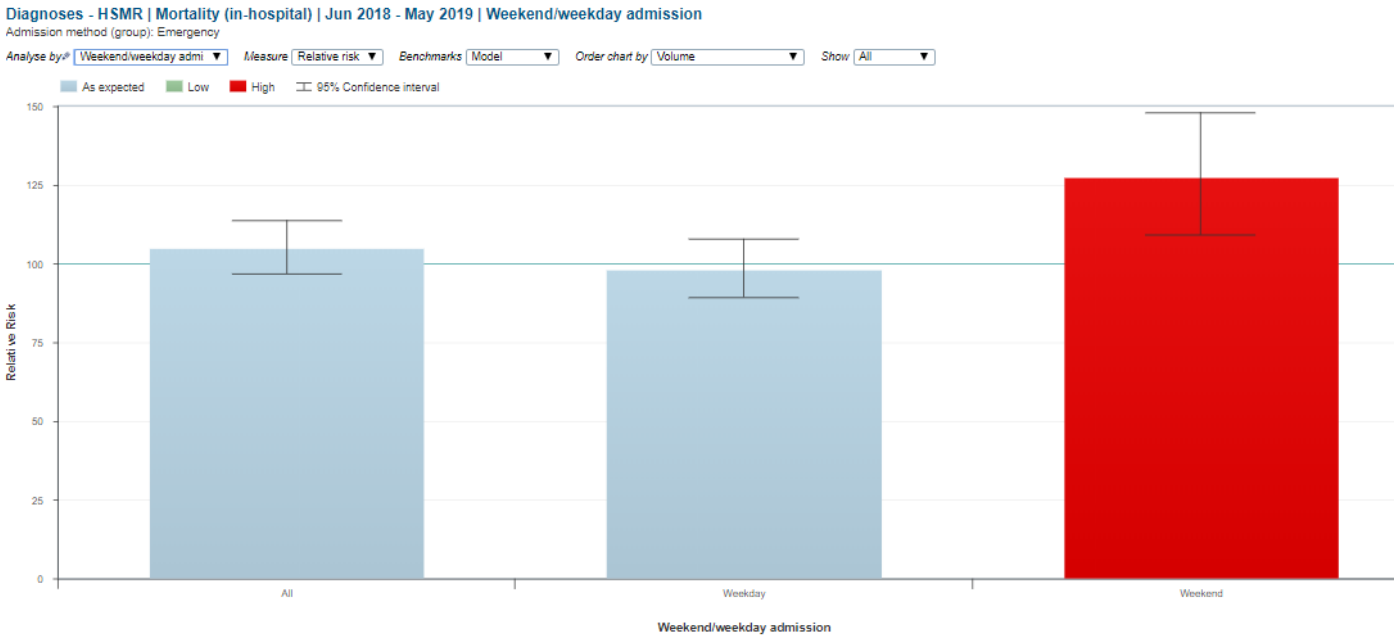
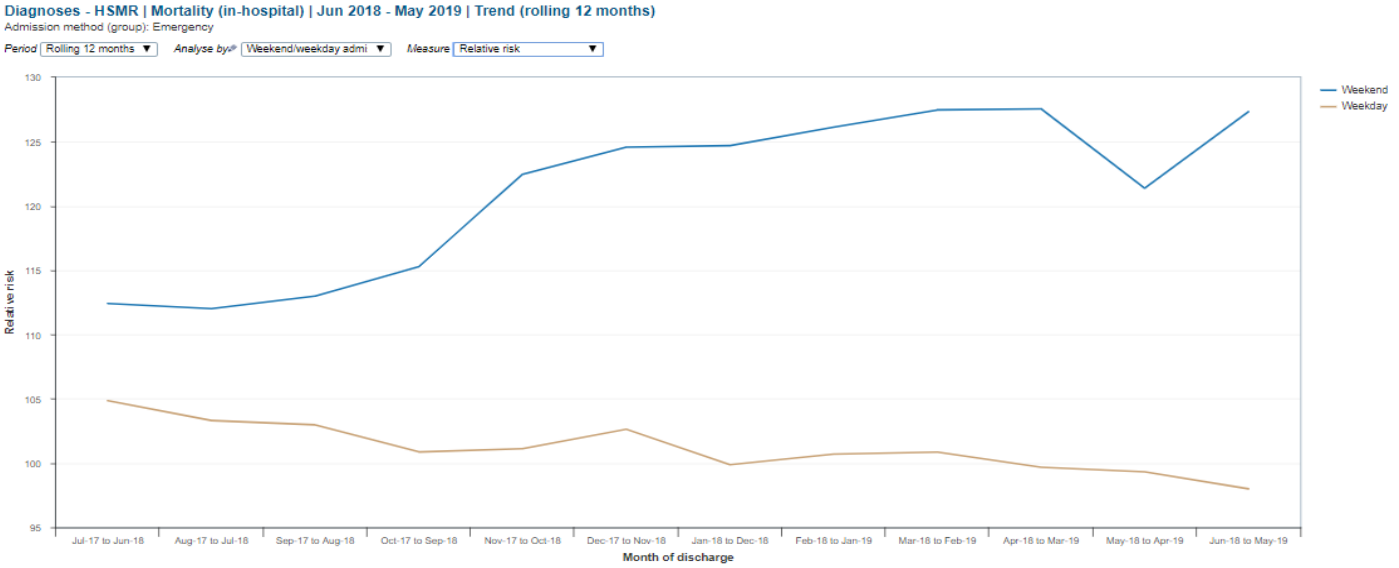


**Figure 5: Rolling 12 month trend in emergency weekend and weekday HSMR**



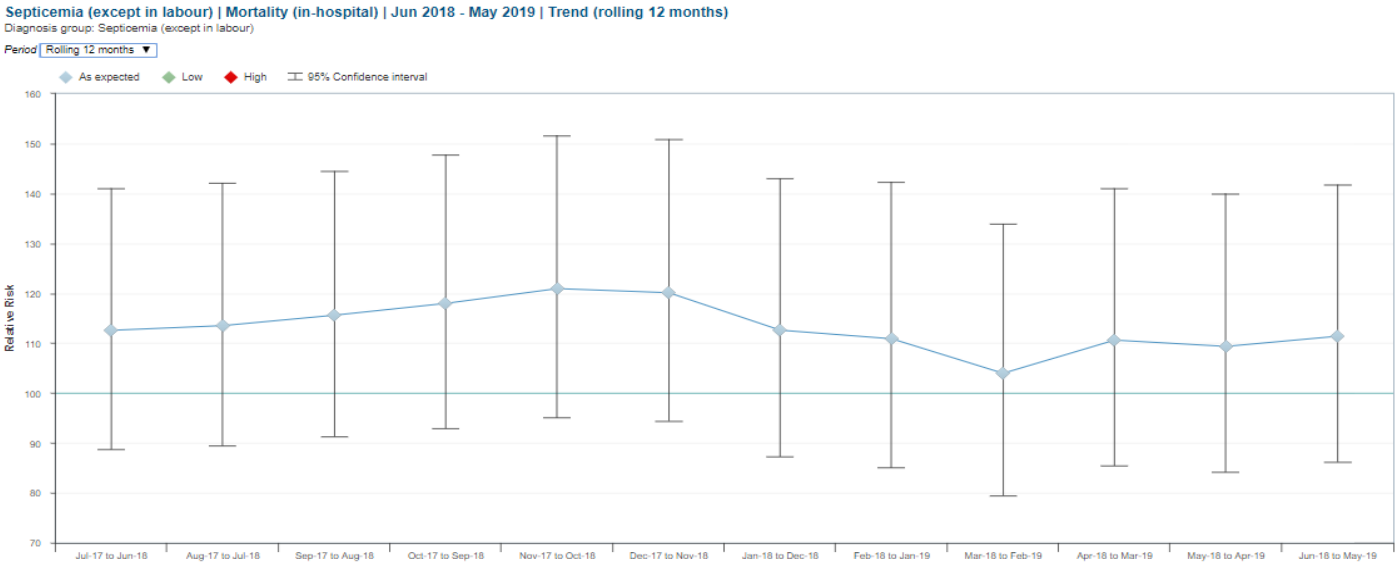

The emergency weekend HSMR has been statistically significantly higher than expected since October 2018.

In June 209, a team of experienced assessors undertook a review of 78 deaths of patients admitted as an emergency on a Sunday to determine whether there were any adverse events that may have contributed to these deaths and to ascertain the cause of a rising trend in our weekend HSMR. The review of 78 deaths found no direct causal link with patients being admitted as an emergency at a weekend. Of the 33 problems in care, 28 caused no harm, 1 resulted in major harm (fractured femur), 1 fall resulted in possible harm (head injury requiring neurosurgery), and 3 minor harms (delay in DVT treatment, complex fluid management and failure to escalate to ITU). 73 deaths were definitely not avoidable, 5 had slight evidence of avoidability. Further analysis is required to determine if there was any delay between the time of admission to the first junior doctor assessment. Learning points have been identified, but none were specifically related to weekend admission or to poorer outcomes. An action plan is provided to mitigate the problems in care.

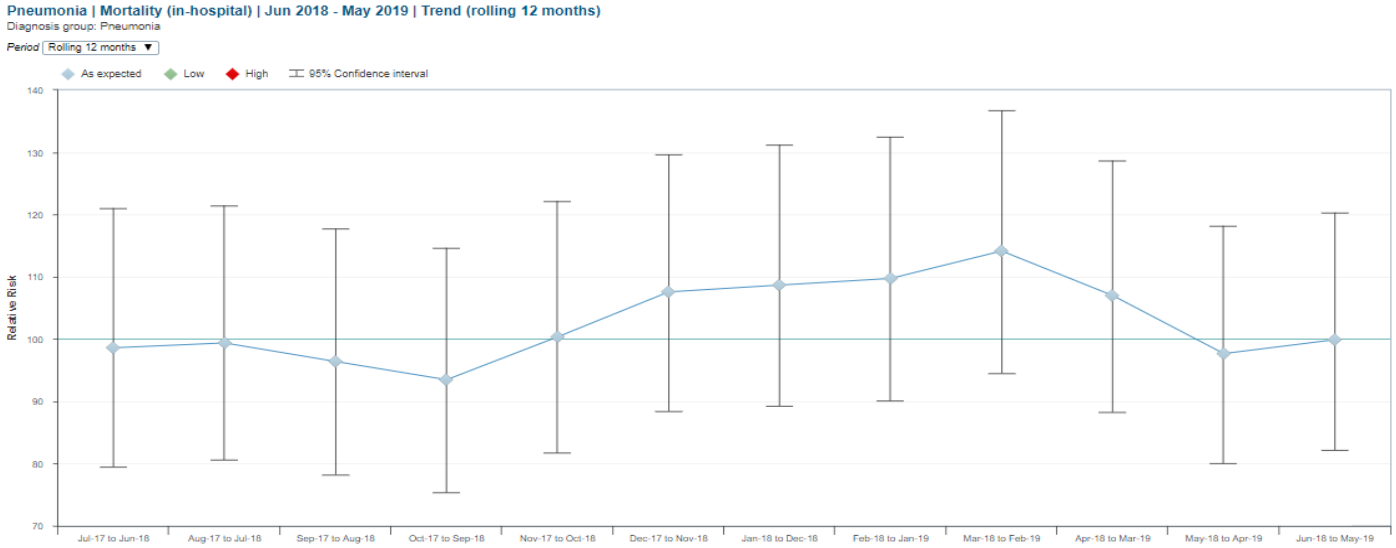
## 18. Deaths in high risk diagnosis groups (June 2018 – May 2019)

The Mortality Surveillance Group monitors a 12 month rolling trend in the relative risk for 7 high risk diagnosis groups.

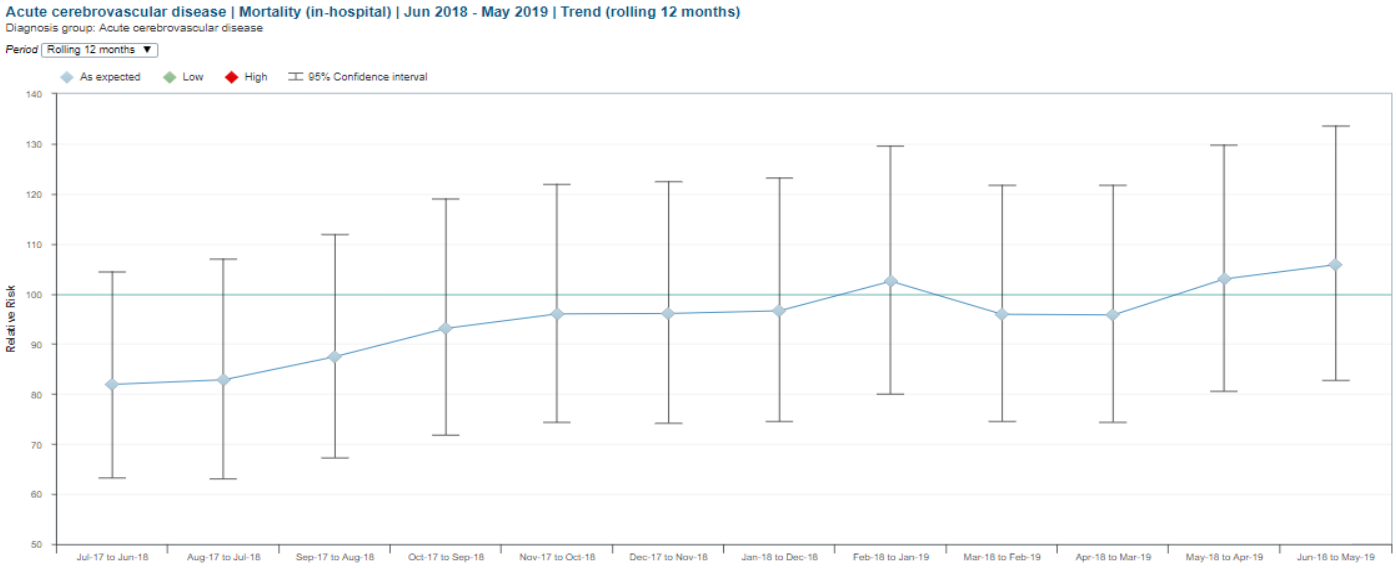
**Figure 6: Trend in relative risk for septicaemia (except in labour)**



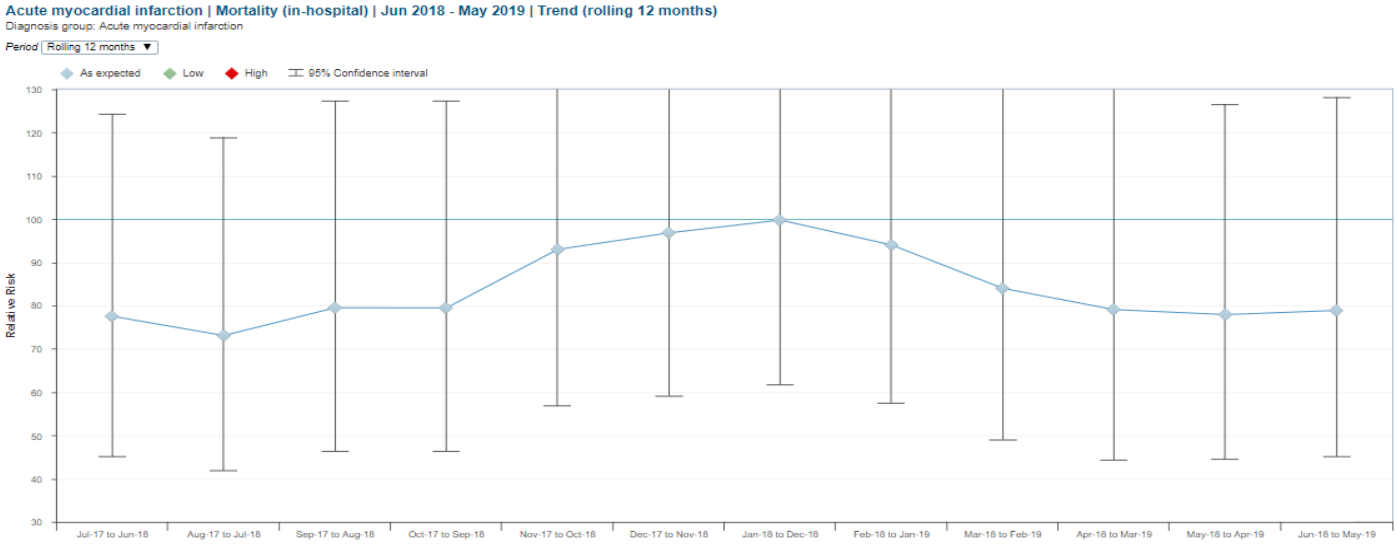
## Figure 7: Trend in relative risk for pneumonia



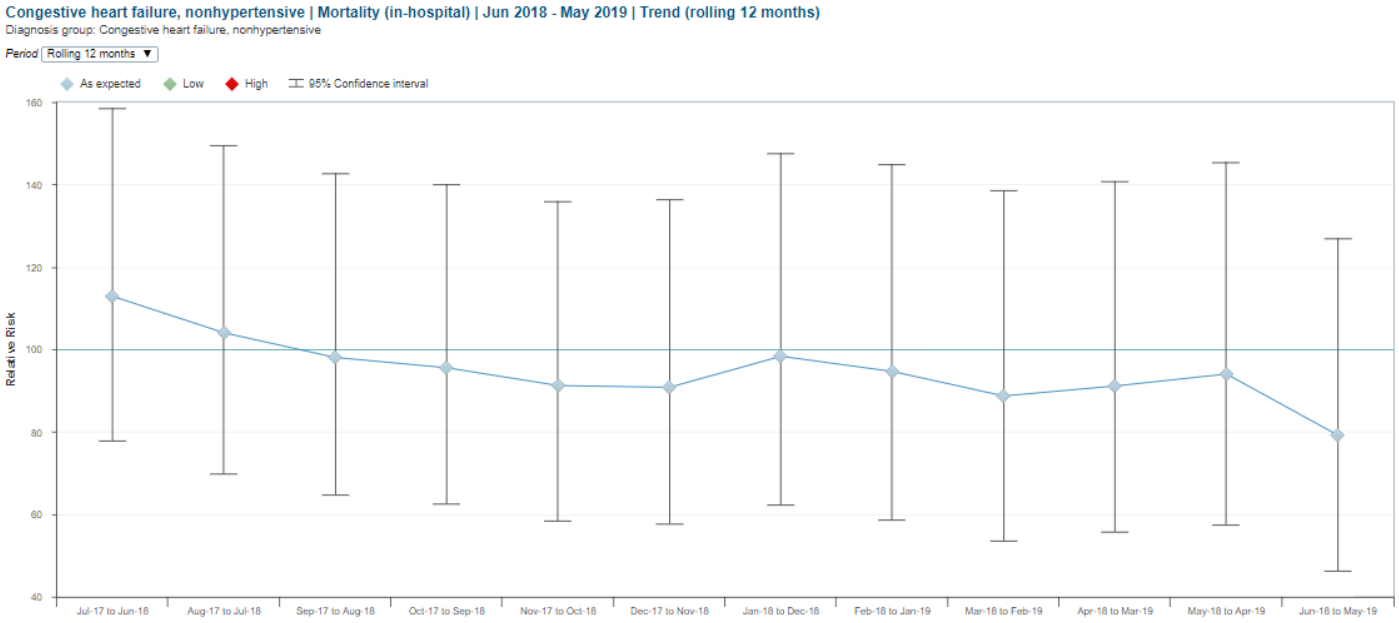

## Figure 8: Trend in relative risk for acute cerebrovascular disease



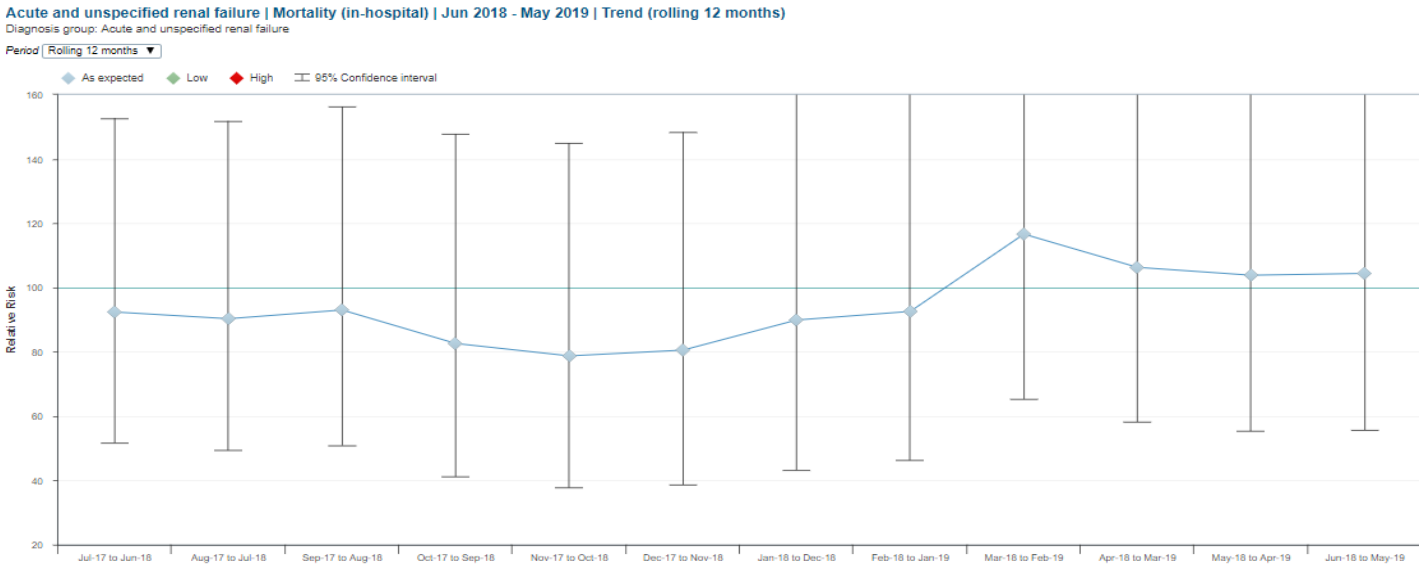

## Figure 9: Trend in relative risk for acute myocardial infarction



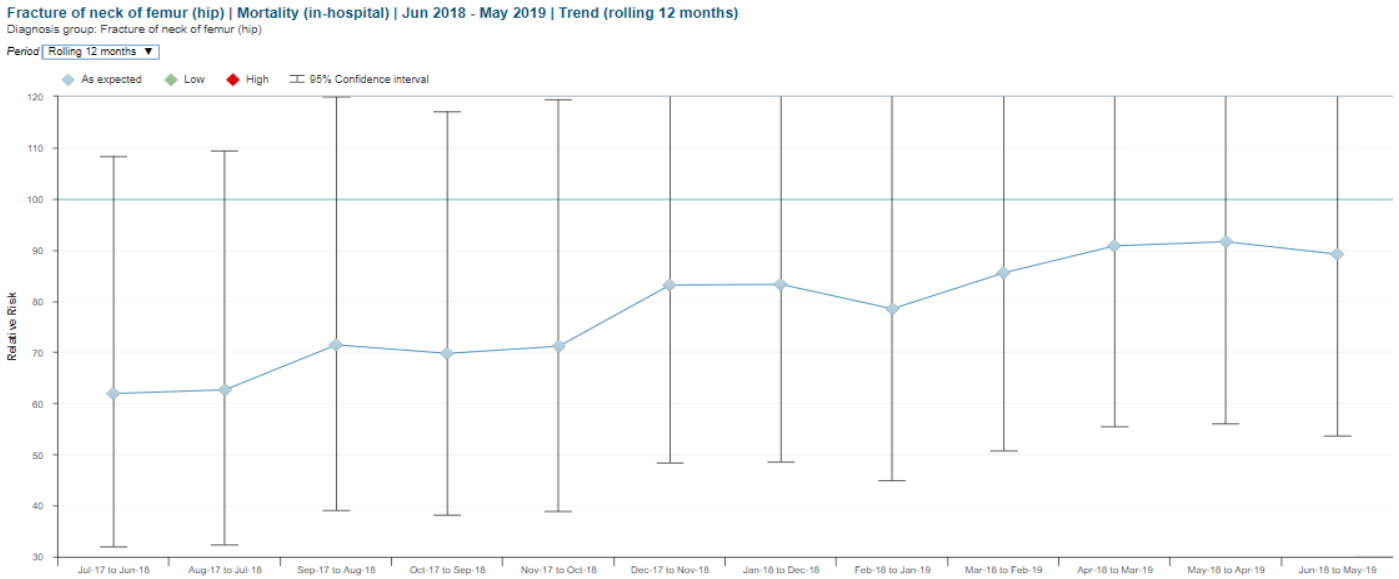
## Figure 10: Trend in relative risk for congestive cardiac failure




## Figure 11: Trend in relative risk for acute and unspecified renal failure



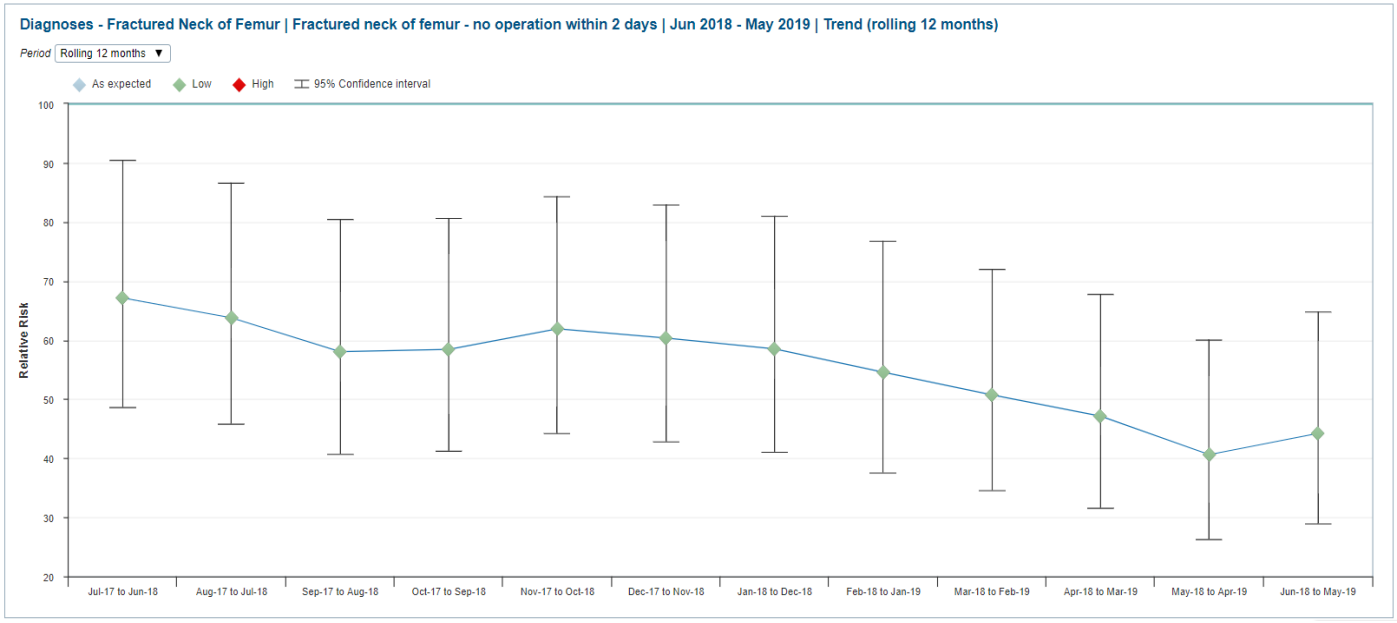

## Figure 12: Trend in relative risk for fracture of neck of femur




The Mortality Surveillance Group will lead a multidisciplinary review of patients with a fractured neck of femur arising from the alert and report it in the Q2/3 Learning from Deaths report. Figure 13 indicates that

the relative risk associated with delays in surgery is not a factor but this needs to be established at the individual patient level.

**Figure 13: Trend in relative risk for fractured neck of femur – no operation within 2 days**




Although all 7 diagnosis groups remain within the expected range acute cerebrovascular disease and fractured neck of femur have shown an upward trend over the last 3 data points.

## 19. Summary

The report highlights the planned introduction of the Medical Examiner system in January 2020 and the improvements in bereavement support. The Q1 mortality dashboard shows the number of deaths, outcome of reviews, learning themes and actions taken to improve. The majority of deaths were unavoidable and expected but one (0.52%) was provisionally probably avoidable pending a case review. 4 deaths were subject to serious incident inquiries.

A new theme emerged in Q1, of 3 acutely unwell patients who needed a medical review at a weekend who did not receive it. Escalating deteriorating patients to the appropriate level is also a theme. A new relative risk of gastrointestinal haemorrhage is statistically higher than expected, particularly the weekend patient cohort. These cases will be reviewed and reported in Q2. The relative risk of death of patients with a fractured neck of femur has risen and these cases will also be reviewed and reported in the next quarter.

HSMR remains stable but the increasing trend of weekend HSMR is of concern. A review of 78 deaths of patients admitted as an emergency on a Sunday found no direct causal link with patients being admitted as an emergency at a weekend.

## 20. Recommendation

The report is provided for assurance that the Trust is learning from deaths and making improvements.

**Dr Belinda Cornforth, Consultant Anaesthetist**
**Chair of the Mortality Surveillance Group**

**Claire Gorzanski, Head of Clinical Effectiveness,**
**17 September 2019**

**Appendix 1**

## SALISBURY NHS FOUNDATION TRUST
## MORTALITY DASHBOARD 2019/2020

| | Apr 19 | May 19 | Jun 19 | Q1 | Jul 19 | Aug 19 | Sep 19 | Q2 | Oct 19 | Nov 19 | Dec 19 | Q3 | Jan 20 | Feb 20 | Mar 20 | Q4 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deaths | 67 | 63 | 62 | **192** | | | | | | | | | | | | | **192** |
| 1st screen | 65 | 58 | 62 | **185** | | | | | | | | | | | | | **185** |
| % 1st screen | 97% | 92% | 100% | **96%** | | | | | | | | | | | | | **96%** |
| Case reviews | 23 | 19 | 20 | **62** | | | | | | | | | | | | | **62** |
| % case reviews | 34% | 30% | 32% | **32%** | | | | | | | | | | | | | **32%** |
| Deaths with Hogan score 1 | 63 | 60 | 60 | **182** | | | | | | | | | | | | | **182** |
| Deaths with Hogan score 2 - 3 | 4 | 3 | 1 | **8** | | | | | | | | | | | | | **8** |
| Deaths with Hogan score 4 - 6 | 0 | 0 | 1 | **1** | | | | | | | | | | | | | **1** |
| Learning points | 7 | 7 | 6 | **20** | | | | | | | | | | | | | **20** |
| Family/carer concerns | 1 | 1 | 2 | **4** | | | | | | | | | | | | | **4** |
| CUSUM alerts | 3 | 1 | 0 | **4** | | | | | | | | | | | | | **4** |
| CUSUM investigated | 1 | 0 | 0 | **1** | | | | | | | | | | | | | **1** |
| Deaths investigated as an SII | 0 | 2 | 2 | **4** | | | | | | | | | | | | | **4** |
| Death following an elective admission | 2 | 0 | 1 | **3** | | | | | | | | | | | | | **3** |
| Unexpected | 0 | 3 | 1 | **4** | | | | | | | | | | | | | **4** |
| Stillbirths/ neonatal/child death | 0 | 1 | 0 | **1** | | | | | | | | | | | | | **1** |
| Learning disability deaths | 0 | 1 | 0 | **1** | | | | | | | | | | | | | **1** |
| Reported to LeDeR programme LeDeR | 0 | 1 | 0 | **1** | | | | | | | | | | | | | **1** |
| Serious mental illness | 0 | 0 | 2 | **2** | | | | | | | | | | | | | **2** |
| Maternal death | 0 | 0 | 0 | **0** | | | | | | | | | | | | | **0** |

Note explanatory notes in appendix 3

**MORTALITY DASHBOARD THEMES AND ACTIONS 2019/2020** **Appendix 2**

| No | Learning points | Action point | By whom | By when | Progress update to 1/5/19 | Status |
|---|---|---|---|---|---|---|
| 1 | Plan the introduction of the ReSPECT form (Treatment Escalation Plan & DNAR form) | Work programme developed with planned implementation on 4/11/2019 | Resuscitation Committee | 31/03/20 | The CCG have asked the Trust to put the introduction of ReSPECT on hold until the national version 3 is published in January 2020 and it can be launched as an STP wide piece of work. | |
| | | | | | | |
| 2 | Improve documentation of consent, risk and benefits of ward based procedures such as chest drains and ascitic taps | Ongoing education programme on consent Implementation of LocSSip | B Cornforth Risk Team | 31/03/20 | Chest drain insertion sticker - partially completed.<br>Ascitic tap drainage requires further work. | |
| | | | | | | |
| 3 | Acutely unwell patients did not have a medical review at a weekend. | Undertake a review of weekend deaths | B Cornforth | 24/09/19 | Completed | |
| | | | | | | |
| 4 | Recognising deteriorating patients and escalate to the appropriate level. | Improve the escalation of patients in accordance with the NEWS2 policy. | N Finneran M Ford | 31/03/20 | | |
| | | | | | | |

**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 by medical staff 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 not avoidable 2) Slight evidence of avoidability 3) Possibly avoidable but not very likely less than 50/50.

5. Deaths with a Hogan score* of 4 – 6. The scores are defined as 4) Probably avoidable more than 50/50. 5) Strong evidence of avoidability 6) Definitely avoidable. 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'.

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.

**References**

*Hogan H et al, 2015 Avoidability of hospital deaths and association with hospital wide mortality ratios: retrospective case record review and regression analysis. BMJ 2015;351 https://www.bmj.com/content/351/bmj.h3239

NHS Improvement, July 2017. Implementing the learning from deaths framework: key requirements for Trust Boards. NHS Improvement, London.

| | | | |
|---|---|---|---|
| **Report to:** | Trust Board (Public) | **Agenda items:** | 4.3 |
| **Date of Meeting:** | 03 October 2019 | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Quality Improvement progress report | | | |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | x | | x | |
| **Prepared by:** | Esther Provins, | | | |
| **Executive Sponsor (presenting):** | Esther Provins, Director of Transformation, | | | |
| **Appendices (list if applicable):** | n/a | | | |

| **Recommendations:** |
|---|
| The Workforce and Clinical Governance Committees are asked to note this report. |

| **Executive Summary:** |
|---|
| This paper provides on progress on the delivery of the 'Strategy for Improvement' and Quality Improvement implementation plan approved at Trust Board in May 2019. |

| **Board Assurance Framework – Strategic Priorities** | Select |
|---|---|
| **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 | ☒ |

## 1. Introduction and Purpose

1.1 This paper provides on progress on the delivery of the 'Strategy for Improvement' and Quality Improvement implementation plan approved at Trust Board in May 2019.

1.2 The paper provides an overview of the work streams in progress, their overall position and risks/mitigations to ensure continued delivery and sustainability of the programme.

## 2. Background

2.1. Our most recent CQC inspection report noted that *"The Trust is committed to quality improvement and innovations. However, it is important that improvement principles and practices are given pace and prioritisation within the organisation."*

2.2. In response, a trust-wide approach was developed and the Board approved 'Our strategy for improvement' and Quality Improvement implementation plan in May 2019.

2.3. QI is not a quick fix but a continuous process requiring a sustained focus over time and involving a cultural shift in ways of thinking, leading and working, across the organisation.

2.4. The QI areas of focus and work streams currently underway include:

- Development of an internal talent bank*
- Development of a dragons den initiative
- Development of a ward level accreditation programme*
- Recruitment of QI coaches and associated training
- Development of QI training/workshops
- Inclusion at Trust wide induction*
- Development of a website
- Publicity/Marketing

**these items were not in the operational plan, however due to the links to QI are now being supported through the programme.*

## 3. Highlights

3.1. Great progress has been made to date. The QI steering group has quickly matured and is working well. Membership includes all Trust Q-fellows along with other key stakeholders, and the meetings are well attended and function effectively.

3.2. In September a leadership forum session was held, to support Trust leaders in reflecting on their own personal role in relation to quality improvement. Each attendee was asked to make a personal pledge as to what they would do differently, and the QI Project team received a number of expressions of interest in being more involved in the project going forwards.

3.3. A similar session is planned with line managers, and is expected to be received with a positive response.

3.4. Of note is the ongoing work regarding development a network of 'Quality Improvement Coaches'. The plan is that each department, team and ward in the Trust has a nominated 'QI Coach' that receives training on continuous improvement methodology, and then takes this learning back to their own team. Rather than a 'train the trainer' approach, this approach relies on action learning. A number of members of staff have already volunteers to be a 'QI Coach' and this network is expected to grow over the next two months. Teams that have not nominated a QI coach will be proactively approached.

3.5. Funding of £10k from Health Education England was secured via a successful bid, and this is supporting the development of the QI Coach network. This is the only additional funding the programme has received.

3.6. Development of a Dragons Den event is making good progress. Plans for these events has been approved by the QI Steering Group. This year, 'Fab Change Day' is providing a helpful setting for innovative ideas to be sought, shared and supported. A larger event is being planned for April 2020, with the aim this will run every six months from then onwards. Lessons learned from other Trusts show that interest and effectiveness of this process increases over time.

3.7. Of significance is the work that has been done around statistical process control and in particular the introduction of this 'measurement for improvement' approach in our Trust board and committee reporting. SPC templates are now available for use, and this will be one of the tools available on the virtual academy.

3.8. We are using the developing ward accreditation scheme to further embed continuous quality improvement into wards; this is being driven by the Nursing & Quality directorate.

3.9. A new QI talent management approach is planned to start in November, as a pilot. This will aim to better under the skills of our staff and their desire to use them to the full in the Trust. A parallel exercise will be undertaken to understand gaps and opportunities for using these skills, and matching appropriate members of staff to the need. The pilot phase will last for six months and will be reported in future updates.

## 4. Challenges

4.1. Challenges have been experienced in relation to setting up the virtual academy, primarily due to difficulties in securing the appropriate technology. The Trust is in the progress of upgrading our intranet, and this has meant the launch of the virtual academy has been delayed. However, we have agreed to press forward with an interim solution that can be migrated to our new platform at a later date.

4.2. The QI implementation plan for 19/20 was put in place with no additional funding; and as such some individual elements of the plan have been re-prioritised, due to resource availability and operational pressures. However, overall this has not significantly affected key deliverables.

## 5. Plans for next period

5.1. Over the next six months, we are planning significant activity in developing the QI Coaching network, including identifying and training volunteers.

5.2. The virtual academy is due to go live in November, which will be a key resource for colleagues to use. We will also be using the virtual academy to share case studies and good practice.

5.3. Development of non-clinical leadership modules in quality improvement will be introduced, along with quarterly workshops for all staff to attend.

5.4. The talent management pilot will commence.

## 6. Key risks to delivery

| Risk | Mitigation |
|---|---|
| QI coaches being released from day to day activities to attend the training courses and all sessions | Presentation given to Leadership forum on 17.9.19 to explain QI approach. Detailed communications have been sent to clinical and non-clinical managers. Workshops scheduled to explain what is required of the QI coach. Clear messages about the programme and time commitment. Staff will be required to complete an application form confirming they have sought line manager approval. |
| Staff do not have the time for continuous improvement | Focussed engagement and messaging to clarify messages.<br>Direct engagement with team leaders, managers to communicate messages, and to support them and their teams. |
| Culture shift required to one of continuous improvement | An overarching programme of organisational development work is being planned, which will support this. Continued engagement with teams to present and talk about QI in team meetings is being encouraged. |
| QI website development due to capacity issues in IT and re-prioritisation of web development requests work. | An interim solution, the use of Microguide, has been found and is currently being populated with information. |

## 7. Conclusion

7.1. The programme is still in early stages of implementation and as such, the impact to date is difficult to evidence.

7.2. Nevertheless excellent progress is being made, and there is clearly interest and engagement from staff across the organisation.

7.3. Although there have been some minor delays, overall the programme is on track and receiving much interest and support.

7.4. A detailed progress report against plan is contained in Appendix A to this report.

## 8. Recommendations

8.1. The Committee notes this progress report.

**Appendix A**

| Objective | Action | Delivery date | Update (18.9.19) |
|---|---|---|---|
| **Embed QI into trust leadership & governance** | • Set up QI task-finish steering group<br>• Secure patient & stakeholder representation<br>• Agree measures of success<br>• Ensure QI programme has Board oversight, via appropriate Board sub-committee | February 2019<br>March 2019<br>March 2019<br>March 2019 | Complete<br>In progress<br>Nearing completion, to be formally signed off in October.<br>Complete |
| **Adopt a common QI methodology** | • Review current methodology/best practice<br>• Agree common methodology at steering group/committee level | February 2019<br>March 2019 | Complete<br>Complete |
| **Provide tools and techniques to support QI initiatives** | • Set up QI Virtual Academy<br>• Agree standard project management approach<br>• Develop and provide tools to support use of statistical process control (SPC) | August 2019<br>March 2019<br>June 2019 | Nearing completion, expected in November 2019.<br>Complete<br>Complete |
| **Provide support, expertise and training in QI** | • Develop a central team/network of 'improvement agents'<br>• Develop and agree role of network/virtual team<br>• Train the virtual team<br>• Training included in clinical leadership programme<br>• Training included in general leadership programme<br>• Make training available to all staff<br>• Set up rapid improvement support | May 2019<br>May 2019<br>October 2019<br>January 2019<br>Quarter 4 19/20<br>Quarter 4 19/20<br>Quarter 4 19/20 | Nearing completion, expected by November 2019<br>Complete<br>Nearing completion, expected November 2019.<br>On track<br>On track<br>On track<br>Not yet started |
| **Embed a QI approach into day to day activities** | • Promote and encourage discussions about QI in 1:1's, team & directorate meetings<br>• Review QI activities at a team/specialty/directorate level<br>• Include QI in appraisal conversation materials | December 2019<br>December 2019<br>December 2019 | On track<br>On track<br>On track |
| **Communication & engagement** | • Prepare communications plan (to reach all staff groups, to include public facing material on website) | May 2019 | Complete |
| **Reward and share good practice and evaluate progress** | • Release regular updates on progress and successes<br>• Set up annual 'Dragons Den' to encourage innovation<br>• Reward good practice – Service Improvement Awards<br>• Review progress on 6 monthly basis<br>• Evaluate measures of success, including feedback from staff, patients and partners | From May 2019<br>Quarter 3/4 19/20<br>Quarter 1 19/20<br>From Sept 2019<br>From Sept 2019 | Complete<br>On track<br>Complete<br>Complete<br>On track |

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| **Report to:** | Trust Board (Public) | **Agenda item:** | 5.1 |
| **Date of Meeting:** | 03 October 2019 | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Launch of Staff Survey 1st October 2019 and Review of Staff Survey 2018 | | | |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | | X | X | |
| **Prepared by:** | Glennis Toms, Deputy Director of OD & People | | | |
| **Executive Sponsor (presenting):** | Glennis Toms, Deputy Director of OD & People | | | |
| **Appendices (list if applicable):** | Appendix A – Communications Plan<br>Appendix B – Staff Survey Action Plan | | | |

| **Recommendation:** |
|---|
| That the Committee are assured of actions taking place following the 2018 staff survey and can support the communications plan to raise awareness of the 2019 survey. |

| **Executive Summary:** |
|---|
| Once again this year, the Trust is contracted with Picker to complete the staff survey. Although 1st October as a launch date coincides with the launch of the flu campaign, we believe that two months is a reasonable timeframe for the survey to be "live", as the final date for the survey is Friday 29th November.<br><br>During this time, we will publish reminders as well as information about what we have done since last years' survey, in the hope of encouraging as large a response as possible.<br>As a starting point, we agreed that OD & P would present the survey results and request initial feedback from a range of groups in the Trust:<br><br>This process was completed and we created a plan, from the feedback, which was intended to contain visible and tangible actions for each of the three areas of concern. There are Trust wide and Directorate specific actions identified within the plan which are in the process of being updated so that the following communications can provide the details of progress in each area.<br><br>A communications plan is attached at Appendix A, which is designed to maintain a steady flow of communication about staff survey activity throughout the whole period that the survey is open. |

| **Board Assurance Framework – Strategic Priorities** | Select as applicable |
|---|---|
| **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 | ☒ |

Once again this year, the Trust is contracted with Picker to complete the staff survey.

We have already completed our staff list template and submitted our staff list and are now waiting for confirmation that we are able to launch this year's survey on 1st October 2019. The latest date that we can launch is Monday 7th October and the final date for the survey is Friday 29th November. Although 1st October as a launch date coincides with the launch of the flu campaign, we believe that two months is a reasonable timeframe for the survey to be "live".

During this time, we will publish reminders as well as information about what we have done since last years' survey, in the hope of encouraging as large a response as possible.
As a starting point, we agreed that OD & P would present the survey results and request initial feedback from:

- Senior leaders Forum
- Staff Engagement Group
- All Diversity Groups
- Joint Consultative Committees
- Directorate Management Teams

This process was completed and we created a plan, from the feedback, which was intended to contain visible and tangible actions for each of the three areas of concern, which were:

- Quality of Care
- Health and Wellbeing
- Violence & Aggression (bullying & harassment)

There are Trust wide and Directorate specific actions identified within the plan, attached at Appendix B, which are in the process of being updated so that the next communication can provide the details of progress in each area.

A communications plan is attached at Appendix A, which is designed to maintain a steady flow of communication about staff survey activity throughout the whole period that the survey is open.

Appendix A

Staff Survey Communications Plan

| Date | Content | Specific |
|---|---|---|
| 25/9 | Opening/introduction similar to previous page | Whole Trust |
| 2/10 | Quality of Care | Corporate |
| 9/10 | Quality of Care | Directorates |
| 16/10 | Health & Wellbeing | Corporate |
| 23/10 | Health & Wellbeing | Directorates |
| 30/10 | Violence & Aggression (bullying & harassment) | Corprate |
| 6/11 | Violence & Aggression (bullying & harassment) | Directorates |
| 13/11 | Corporate aspirations 2019 | Corporate |
| 20/11 | Directorates aspirations 2019 | Directorates |
| 27/11 | Closing/thanks and final reminder | Whole Trust |

Staff Survey
Action Plan 2019

3 areas of concern;
2 actions from each area

Clinical Directorates and Estates & Facilities detailed in addition to Trust wide actions

**Quality of Care**

| Theme | Trust wide | Directorates | Deadline | Lead |
|---|---|---|---|---|
| Vacancies | Implementing Recruitment & Retention Strategy | | 31/07/2019 | Sharon Holt |
| | | | | |
| Valuing all contributions | Regular conversations and quality of appraisals | | 31/12/2019 | Jean Scrase |
| | | | | |
| Nursing | | Restructure senior roles<br>Perfect ward inspections/Out of Hours<br>Regular Directorate Leaders Forum | 31/12/2019 | MSK, Surgery, Medicine |
| Assurance | | Area Performance Reviews/Qtly service visits<br>Processes for sharing learning & outcomes | 31/08/2019 | Surgery/ CSFS |

**Health and Wellbeing**

| Theme | Trust Wide | Directorates | Deadline | Lead |
|---|---|---|---|---|
| Strategy | Implementation of the Health and Wellbeing Strategy | | 30/06/2019 | Alison Evans |
| Investment | Gain investment and make significant progress towards implementation of the reward/recognition/EAP platform | All managers to attend attendance management training<br>Sickness Forum for sharing good practice | 30/09/2019 | Alison Evans |
| Improving wellbeing | | Engage volunteers to support staff as well as patients<br>Bi-monthly informal meetings with DMT in Springs | 31/08/2019 | MSK |
| Flexible working | | DMC to review any request that is declined during 2019/20 | 31/03/2020 | CSFS, Estates & Facilities |
| Improving environment | | Service Heads to run Better Breaks project<br>Coffee & cake sessions and listening events | 31/10/2019 | CSFS, Estates & Facilities |
| Improving communications | | Creating open forums/ Q&A sessions<br>Increase visibility of DMT via walkthroughs | 30/09/2019 | Medicine |

**Violence & Aggression: (bullying & harassment)**

| Theme | Trust wide | Directorates | Deadline | Lead |
|---|---|---|---|---|
| OD Programme | Launch of diagnostic for Organisational Development | Culture change in Theatres | | Paul Hargreaves, Surgery |
| OD & People roles | Clarity of roles EDI & FTSUG | Opportunities to raise concerns and access support | 31/07/2019 | OD&P/Medicine |
| Nursing | | Coffee mornings for student nurses | 01/09/2019 | Surgery |
| Feedback | | rate my room approach for outpatients | 31/08/2019 | MSK |
| Leadership | | DMT on tour<br>access conflict resolution & resilience training<br>risk assessments in hotspots | 31/08/2019 | MSK, CSFS |

Salisbury NHS Foundation Trust

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|---|---|---|---|
| **Report to:** | Trust Board (Public) | **Agenda item:** | 5.2 |
| **Date of Meeting:** | 03 October 2019 | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Freedom to Speak Up Guardian Report | | | |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | X | | | |
| **Prepared by:** | Elizabeth Swift, Freedom to Speak Up Guardian | | | |
| **Executive Sponsor (presenting):** | Glennis Toms ,Deputy Director of Organisational Development & People | | | |
| **Appendices (list if applicable):** | | | | |

| **Recommendation:** |
|---|
| The Board is asked to note the Freedom to Speak Up action plan in response to NHSI Recommendations |

| **Executive Summary:** |
|---|
| The report provides the Committee with agreed recommendations from NHSI.<br><br>Board Guidance has been published in July 2019, reflecting that executives and non-executives have an important role in the supporting culture around FTSUG and wider organisational culture. National guidelines on FTSU training in the health sector have also been published and this was discussed at the Workforce Committee. |

| **Board Assurance Framework – Strategic Priorities** | Select as applicable |
|---|---|
| **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 | ☐ |

**FREEDOM TO SPEAK UP ACTION PLAN IN RESPONSE TO NHSI RECOMMENDATIONS JULY 2019**

| **Recommendation 1: Increase NED understanding of FTSU, their role and the national picture** | Completed | In progress | Not started |
|---|---|---|---|
| Plan:<br>• Distribute updated Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts from the National Guardian's Office (09/09/2019)<br>• Freedom to Speak Up Guardian to meet regularly with named NED<br>• Freedom to Speak Up Guardian to meet regularly with Chairman of The Trust Board<br>• Freedom to Speak Up Guardian to meet at least once annually with all Trust Board members | √<br>√<br>√ | √ | |
| **Recommendation 2: Include FTSU and other related cultural topics in your board development session – NHSI happy to lead a session** | | | |
| Plan:<br>• FTSU has recently been included in the board development session<br>• Invite NHSI to attend a session within the next 12 months if significant progress is not made<br>• Board attending Freedom to Speak Up and Equality, Diversity and Inclusion training session "What's it got to do with me?" on 5th September 2019. Positive feedback from session – unanimously feel that all staff should attend training | √<br>√ | *TBC | |
| **Recommendation 3: Include FTSU in your staff story slot at Board and consider using story as a basis for a self-reflection case study** | | | |
| Plan:<br>• FTSUG has identified a staff story for Board meeting (FTSUG annual report scheduled for April 2020)<br>• FTSUG to write self-reflection case study for consideration, once current case is concluded (June 2020) | | √ | √ |
| **Recommendation 4: The trust completes the work it identifies as necessary to help ensure that workers, in particular those responsible for responding to speaking up matters, have the appropriate skills to handle difficult conversations** | | | |
| Plan:<br>• Business Partners have planned breakfast meetings with line managers to help them develop skills around difficult conversations and speaking up issues (first one to be held | √ | | |

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| 13/10/2019)<br>• Continue to advertise Coach to Lead training sessions – ongoing throughout the year<br>• Continue to advertise Conflict Resolution sessions – ongoing throughout the year<br>• Identify how to evaluate the effectiveness of training and how this fits in as part of the trust wide leadership development programme. FTSU is now incorporated. Clinical Leadership sessions scheduled for Autumn 2019 and middle management programme March 2020. Feedback received and evaluated from all training sessions<br>• Integrate recently published training guidance from National Guardians Office. Head of Education will deliver Trust wide FTSU training plan by January 2020 | √<br>√<br>√<br>√<br><br><br><br><br>√ | | |
| **Recommendation 5: Consider greater use of social media to highlight speaking up channels, change that has occurred and to generate debate** | | | |
| Plan:<br>FTSUG to work with Comms Team to set up social media accounts (meeting scheduled for 2nd September), this also fits in with Speaking Up Month which is October | | √ complete Oct 2019 | |
| **Recommendation 6: Establish FTSU champion role, scope out role, recruit and train.** | | | |
| Plan:<br>• Workforce Committee supports principle of protected time for Champions, format a proposal based on the "facilities agreement" to go to TMC in October 2019.<br>• FTSUG to obtain a job description from an established Champion network (meeting on 3rd September)<br>• Workforce Committee to agree recruitment process and appropriate number of champions. (meeting scheduled for 26th September)<br>• FTSUG recruit and arrange regional training for Champions | <br><br><br>√ | √<br><br><br>√ | <br><br><br>√ |
| **Recommendation 7: Develop an effective and transparent way to triangulate staff and patient experience data to identify emerging patient safety issues.** | | | |
| Plan:<br>• Identify patient safety trends by collecting data from patient complaints, patient claims, serious incidents, near misses and never events. Attending quarterly meetings with Litigation, PALS, Risk and FTSU.<br>• Use new Organisational Development & People 'Heatmaps' which identify employee experience trends by collecting data from grievance numbers and themes, tribunal claims, exit interview themes, sickness rates, retention figures, staff survey results, polls/pulse surveys, WRES and WDES data, levels of suspension and use of settlement agreements.<br>• Use this data to identify the areas that have recurring issues | √<br><br><br><br><br>√<br><br>√ | | |

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| • Identify the areas that have reduced the number of issues<br>• Identify the areas that have no issues and why – use SOX data (sharing outstanding excellence) positive reporting.<br>• Causes of unexpected spikes in issues<br>• Identify any areas that may have an overlap of patient and staff issues – meeting with PALS 12/09/2019 | <br>√<br><br>√<br>√ | √ | |
| **Recommendation 8: Consider how to manage confidentiality and information governance issues that arise having multiple people handling speaking up cases.** | | | |
| Plan:<br>• FTSUG to be clear with person raising the concern about how their information will be used.<br>• FTSUG to be clear when discussing or forwarding on details of cases about confidentiality and the use of the information disclosed.<br>• Clarity from all parties handling a case around timely feedback and to whom. | <br>√<br><br>√<br><br>√commenced and ongoing | | |
| **Recommendation 9: Take all appropriate steps to ensure that its network of cultural ambassadors reflects the diversity of the workforce that it supports.** | | | |
| Plan:<br>• Work with EDI Lead to assess which groups face particular barriers and ensure support is available to those staff groups (ie. Jnr doctors induction, overseas nurses forum)<br>• Tailor FTSU and EDI training to identified staff groups that may face additional barriers to speaking up, commenced programmed and continue to roll out during next 6-12 months<br>• FTSUG to attend network meetings to raise awareness of the Speaking Up agenda | <br>√<br><br>√<br><br>√ | | |
| **Recommendation 10: Design, issue and evaluate 30 and 100 day surveys sent to people who have spoken up to understand if they have suffered any detriment.** | | | |
| Plan:<br>• Work with Business Partners to draft the surveys and have it agreed by December 2019 and published January 2020.<br>• Agree how the data collected from these surveys should be used and stored<br>• Agree a plan of how to support staff suffering detriment from speaking up<br>• Agree a plan of how to manage staff causing the detriment to the person(s) speaking up<br>• There is a rolling programme of policy renewal established to ensure all related policies are up to date. | <br><br><br><br><br>√ | √<br><br>√<br>√<br>√ | |
| **Recommendation 11: Freedom to Speak Up Guardian to attend Patient Safety Committee** | | | |

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| Plan:<br>• FTSUG to meet with Head of Risk to discuss attending meetings | √ | | |
| **Recommendation 12: Freedom to Speak Up Guardian to understand the decline in how secure staff feel to speak up in order to assure the board of causes and solutions.** | | | |
| Plan:<br>• Triangulate data from exit interviews, Datix, speaking up data etc to identify areas within the Trust that have a decline in raising concerns.<br>• Work with DMT's to formulate plans to address the findings ie. Bespoke training, manager training – in line with the recently published training guide.<br>• Ensure that the recent NGO training guidelines are rolled out for all staff – training plan to be delivered by January 2020. | | √<br>√<br>√ | |

| Report to: | Trust Board (Public) | Agenda item: | 6.2 |
|---|---|---|---|
| Date of Meeting: | 03 October 2019 | | |

| Report Title: | Register of Seals | | | |
|---|---|---|---|---|
| Status: | Information | Discussion | Assurance | Approval |
| | | | | x |
| Prepared by: | Fiona McNeight, Director of Corporate Governance | | | |
| Executive Sponsor (presenting): | Cara Charles-Barks, Chief Executive | | | |
| Appendices (list if applicable): | | | | |

| Recommendation: |
|---|
| The Board is asked to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board. |

| Executive Summary: |
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| To report entries in the Trust's Register of Seals since the last report to Board in April 2019.<br><br>None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed. |

**Register of Seals entries**

| No. | Date signed in Register | Approval Details | Held on file with: | Signature one: | Signature Two: |
|---|---|---|---|---|---|
| 347 | 11/4/2019 | Lease between SFT (landlord) and Salisbury Trading Ltd (tenant) for Block 03A Laundry Store and extension for a term of 7 years | Laurence Arnold | Cara Charles-Barks | Nick Marsden |
| 348 | 11/4/2019 | Sublease between SFT (landlord) and Salisbury Trading Ltd (tenant) for Block 03 (PFI owned) Laundry | Laurence Arnold | Cara Charles-Barks | Nick Marsden |

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|---|---|---|---|---|---|
| | | Building for a term of 7 years | | | |
| 349 | 23/5/2019 | Lease between SFT (landlord) and Odstock Medical Ltd (tenant) for parts of the Glanville Centre and the Laing Building for a term of 3 years | Laurence Arnold | Cara Charles-Barks | Nick Marsden |
| 350 | 8/7/2019 | Lease between SFT (landlord) and Oxford Health NHS FT (tenant) for part of Block 40 for a term of 3 years | Laurence Arnold | Cara Charles-Barks | Nick Marsden |
| 351 | 12/7/19 | Deed of surrender of lease for Douglas Arter Centre from SCOPE to SFT | Laurence Arnold | Cara Charles-Barks | Nick Marsden |
| 352 | 13/8/2019 | Licence to underlet Renal Dialysis (Block 08) SFT and Renal Services Operations Ltd and Renal Services Trading Ltd | Laurence Arnold | Cara Charles-Barks | Nick Marsden |