Bundle Trust Board Public 6 June 2019

1	Opening Business
1	09:00 - Patient Story
1.1	09:20 - Welcome and Apologies
	Apologies from Christine Blanshard and Jane Reid
1.2	Declaration of Interests
1.3	Minutes of the previous meeting
	Nick Marsden *For approval*
	1.4 DRAFT Public Board mins 23 May 19.docx
1.4	Register of Attendance
	Nick Marsden *For approval*
	Register of Attendance - Public Board 2019-20.docx
1.5	Matters Arising and Action Log
	1.5 Action Log Trust Board Part 1 (public meeting).xlsx
1.6	09:25 - Chairman's Business
	Nick Marsden *For information*
1.7	09:30 - Chief Executive Report
	Cara Charles-Barks *For information*
	1.7 CE Trust Board Report - June 2019.docx
2	Assurance and Comittee Reports
2.1	09:40 - Corporate Governance Statement Self Certification FT4
	Fiona McNeight *Assurance*
	2.1 Corporate Governance Statement Self Certification FT4.pdf
2.2	09:50 - Integrated Performance Report
	Andy Hyett *Assurance*
	2.2 Integrated Performance Report.pdf
2.3	Finance & Performance Committee Report - 3 June 2019
	Verbal update from Paul Miller *Assurance*
3	Quality and Risk
3.1	10:20 - Learning from Deaths Report Q4/Annual Report
	Christine Blanshard *Assurance*
	3.1 Learning from death report Q4.pdf
3.2	10:30 - DIPC Annual Report
	Lorna Wilkinson *Assurance*
	3.2 DIPC Annual Report.pdf
4	Strategy and Development
4.2	10:40 - Corporate Communications Strategy
	Paul Hargreaves *report to follow*
	4.2 Corporate Communications Strategy.pdf
5	Closing Business
5.1	Agreement of Principle Actions and Items for Escalation
5.2	Any Other Business
5.3	10:50 - Public Questions

5.4 Date next meeting

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)

DRAFT

Minutes of the Public Trust Board meeting held at 09:00am on Thursday 23rd May 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
Mrs C Charles-Barks	Chief Executive
Dr C Blanshard	Medical Director and Deputy Chief Executive
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
Glennis Toms	Deputy Director of Organisational Development and People
Kylie Nye	Corporate Governance Manager (minutes)
Sir R Jack	Lead Governor (observer)

ACTION

OPENING BUSINESS

TB1 – 23/05/01 **Apologies**

Apologies were received from:

- Andy Hyett – Chief Operating Officer
- Paul Hargreaves – Director of Organisational Development and People.
- Jane Reid – Non-Executive Director
- Michael von Bertele – Non-Executive Director

N Marsden noted that G Toms was attending on behalf of P Hargreaves.

TB1 – 23/05/02 **Declarations of Interest**

Members of the Board were reminded that they have a duty to declare any impairment to being Fit and Proper and of good character as well as to avoid any conflict of interest and to declare any interests arising from the discussion.

No member present declared any such interest or impairment.

TB1 – 23/05/03 **Minutes of the Public Trust Board meeting held on 4th April 2019**

The minutes of the Trust Board meeting held in public were approved as a correct record.

TB1 – 23/05/04 **Matters Arising and Action Log**

N Marsden presented the item and the following was noted:

- **TB1 - 06/12/23 Clinical Strategy**; C Blanshard noted that help from the communications department is required to develop a patient facing draft of the strategy. C Charles-Barks advised that she would pick this up with J McGuiness. **ACTION: JMc.** **JMc**
- **TB1 - 07/02/23 Nurse Skill Mix Review**; L Wilkinson reviewed how often the third nurse on Odstock Ward is moved and explained that the nurse if flexibly utilised if required elsewhere. Item closed.
- **TB1 - 04/04/15 Safer Staffing**; A Board Seminar to be arranged for Non-Executive Directors on interpreting the 'hours of car per patient' data. F McNeight to review Board schedule for an appropriate date. **ACTION: FMc/LW** **FMc/LW**
- **TB1- 07/02/15 Learning from Deaths;** C Blanshard noted that this piece of work had been completed. Item closed.
- **TB1 – 04/04/04 Mortality Rates;** P Miller queried that whilst further analysis and work is underway to review weekend mortality rates, is there anything further that needs to be done considering the upward trend. C Blanshard noted that work is ongoing to look into the upward trend, however, clarified that the mortality rate isn't higher at the weekend; the indicator refers to the higher mortality rate of those admitted over the weekend.

N Marsden noted that the other items on the action log were either included in the agenda or scheduled to come back to a future meeting.

There were no further matters arising.

TB1 – 23/05/05

Chairman's Business

N Marsden reported that workforce is a national ongoing priority and Julian Hartley, NHS Long Term Plan workforce lead and Dido Harding, Chairman of NHS Improvement (NHSI) have been reviewing what the strategy should be going forward. At the forefront of workforce priorities is the need to increase nursing and junior doctor placements. However, N Marsden reported the work to address key workforce issues would be delayed to November when the budget is set by the government.

Discussion:
C Charles-Barks noted that during a recent meeting with Dido Harding, several key themes had been discussed in relation to improving workforce related issues in the NHS. These included, the intention for the NHS to be the best place to work; enhancing and strengthening a compassionate leadership culture; a focus on recruitment and in particular nursing shortages, looking at how we utilise staff instead of increasing numbers; the recognition that changes to workforce are not all initiated at the centre and there has to be some local responsibility. Additionally, there was a discussion that Trust's require investment in organisational development to drive forward the above changes.

C Blanshard queried if there had been any recognition of moving towards localised junior doctor training and reported that from next year Salisbury Foundation Trust will have more non-deanery doctors than deanery posts.

There is a current debate with the deanery as these non-deanery junior doctors find it difficult to progress to senior posts and this could be rectified if in-hospital training was recognised. N Marsden and C Charles-Barks advised that they would raise this at the appropriate forum.

N Marsden further reported that there were concerns regarding central scrutiny to NHS Trust's capital plans. L Thomas noted that the Trust had been asked to resubmit its capital plan and further conversations were expected.

TB1 – 23/05/06 **Chief Executive's Report**

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

- C Charles-Barks made reference to the 2018/19 year-end position and stated that she was pleased and proud of all of the improvements in the last 12 months.
- On 28 to 30 June Salisbury is hosting Armed Forces Weekend. The hospital is playing its part in the celebrations and is also preparing for the increased number of visitors to Salisbury that weekend.
- The Service Improvement Awards took place on 16th April and C Charles-Barks congratulated the End of Life Care Team, Emergency Department and Cataracts service for being this year's award winners. The Striving for Excellence Awards take place on 13 June. Nominations are now open and entries close of 31 May. C Charles-Barks gave thanks to the Salisbury Hospital League of Friends for their sponsorship of the event. During May the Trust also celebrated International Nurses Day and International Midwives day with staff actively participating in both celebrations.
- There have been changes to the Trust's internal communications process following feedback from staff and the NHSmail migration. Included in these changes was the launch of a new weekly newsletter 'Pulse' which provides staff with news and updates. Over 4,000 staff read the first edition and it is a better, more comprehensive way of communicating messages to staff.

Discussion:

- N Marsden requested a brief schedule of the events over Armed Forces Weekend to be pulled together and distributed. **ACTION: JMc** **JMc**
- P Miller congratulated the team and wider Trust on the 2018/19 financial outturn. However, P Miller noted that whilst the additional PSF funding was unexpected, the underlying financial challenge is still there. PM asked how this message was being disseminated to staff across the Trust. C Charles-Barks noted that there were clear messages to staff regarding CIP delivery and that the additional PSF money does not solve the Trust's recurrent deficit but means that less money is borrowed.

Assurance and Reports of Committees

TB1 – **Urgent Escalation reports from Committees**

23/05/07

There were no urgent escalation reports from the Board committees.

TB1 – 23/05/08 **Integrated Performance Report**

L Thomas presented the Integrated Performance Report for Month 12 and highlighted the following key points:

- The Trust had a really positive year achieving the Referral to Treatment (RTT) 92% standard, diagnostic targets, an improved financial position, whilst also providing care to more patients in 2018/19.
- There have been quality issues during the year with more Serious Incidents reported than the previous year. However, infection rates have remained low.

Discussion:

- C Blanshard noted that within the report the word 'fit' in relation to BCSP FIT testing should be in capitals. C Blanshard explained that FIT (Faecal Immunochemical Test) is a screening test for colon cancer and tests for hidden blood in the stool. Using this form of testing should produce better screening results.
- P Miller looked forward to the coming year and noted that the focus needs to be achieving the 4 hour ED target or a potential new target if this is changed during the year. P Miller further noted his concern that the Trust was doing more activity year on year, whereas the goal for NHS Trust's is to have less activity and ensure patients are being seen and treated in the correct setting. P Miller explained that if the Trust's activity continues to grow this will continue to incur pressure. L Thomas argued that from a clinical point of view the Trust strives to do less work of the wrong type, however, the Trust is under increased pressure due to the demographics of the area. PM discussed the percentages of people who argue they're either worse off or their life has not improved once they have had their procedures. C Blanshard argued that the Trust's patient reported outcome measures are better than the national average.
- N Marsden argued that an increase in demand is a fact unless the system is part of a solution to manage growth. There is currently no more capital or readily available staff and if the way the Trust works doesn't change this will result in future problems.
- T Baker referred to Primary Care Networks (PCN) and queried the speed at which they are emerging and effectively working. C Charles-Barks explained that with regards to pace the PCN's are all emerging at different speeds. They have all been funded for a clinical director, pharmacist and a social prescribing navigator post. There is a risk that as these networks emerge they could start to ring-fence catchment areas and the Trust needs to facilitate bringing these together to work as system partners.
- N Marsden summarised that 2018/19 had been a positive year and that the ongoing challenges reflect the national position. The solutions to these challenges are not short term and whilst structures are put in place to mitigate, the focus for the Trust is to

continue to treat patients are achieve our statutory targets.

CLOSING BUSINESS

TB1 – 23/05/09 **Agreement of Principle Actions and Items for Escalation**

N Marsden noted that there were no items for escalation.

TB1 – 23/05/10 **Any Other Business**

There were no other items of business.

TB1 – 23/05/11 **Public Questions**

There were no questions raised by the public.

TB1 – 23/05/12 **Date of Next Meeting**

Thursday 6th June 2019, 10:00 am, The Board Room, Salisbury District Hospital

TB1 – 23/05/13 **ITEMS FOR INFORMATION**

There were no further items for information.

TB1 – 23/05/14 **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).

Register of Attendance – Public Board 2019/20

	4 April	23 May	6 June	4 July	1 August	5 September	3 October	7 November	5 December	January	February	March	% attendance rate
Nick Marsden	✓	✓											100%
Tania Baker	✓	✓											100%
Michael von Bertele	✓	X											50%
Paul Kemp	✓	✓											100%
Jane Reid	X	X											0%
Rachel Credidio	✓	✓											100%
Paul Miller	✓	✓											100%
Cara Charles-Barks	✓	✓											100%
Christine Blanshard	✓	✓											100%
Lisa Thomas	✓	✓											100%
Andy Hyett	✓	X											50%
Lorna Wilkinson	✓	✓											100%
Paul Hargreaves	✓	X											50%

Attended - ✓

Apologies - X

Trust Board Part 1 (Public) Action log

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

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
04 October 2018						
2374/07 - NHSI Quality Governance Framework Self-Assessment	increase publicity of the ways concerns can be raised and escalated if individuals feel they are not being heard	CCB	~~28/02/2019~~ ~~4/4/2019~~ 02/05/2019	New Head of Communications is building this into the internal/external communication strategy Communications Strategy to Private Board in April Update - will be discussed at May's Board Seminar	N	2
06 December 2018						
TB1-06/12/23 - Clinical Strategy TB1 – 23/05/04	Patient facing version of the document to be produced which also details the patient engagement and participation approach	CB	~~31/03/2019~~ 04/07/2019	Met with JM on 28/12/18 to discuss comms and engagement approach. No comments received. Comms team to undertake stakeholder mapping and developing an engagement strategy No update re patient engagement - meetings happening with GPs and CCGs CB noted that help from the comms team is required. CCB ill pick this up with JMc	N	2
07 February 2019						

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
0702/12 - Nurse Skill Mix Review	C Blanshard, the clinical director for medicine and head of medical workforce will consider the new doctor safe staffing toolkit and will look to bring a future report to Board via the Workforce Committee	CB	06/06/19	Workforce agenda - 23rd May Trust Board - June	N	2
7th March 2019						
TB1 - 0703/06 - NHS Long Term Plan/ Legislation update	A series of papers would come to the Board on the long term plan and the potential implications on legislation. In April / May a timeline with with indicative milestones and a map of expected key papers will be coming to Board.	LT	13/06/19	First session planned for June Board.	N	4
TB1 - 0703/15 - Estates Strategy	1. L Arnold to meet with J McGuiness to ensure the strategy describes the ambition for the organisation. 2. The language in the strategy to be reviewed as the term “backlog maintenance and high risk” required context. L Arnold will provide context and bring back to the Board once changes have been made	LA/JM	04/07/19		N	4
4-Apr-19						
TB1 - 04/04/04 - mortality rates	A paper will come to a future Board meeting following a detailed piece of work into weekend mortality rates.	CB	Future Board meeting TBC	C Blanshard noted that work is ongoing to look into the upward trend, however, clarified that the mortality rate isn’t higher at the weekend; the indicator refers to the higher mortality rate of those admitted over the weekend	N	4
TB1 - 04/04/15 - IPR	1) A revised IPR report will be coming to the Board in June. 2) AH to clarify data in relation to time to first assessment and time to triage figures and include in future IPR reports.	AH/KH	6/6/2019	The revised IPR will now come to July's Board	N	4
TB1 - 04/04/15 - Exit Interviews	PH to write to all staff who have left in a 6 month period to investigate reasons for leaving. This will feed back to Workforce Committee	PH	9/26/2019		N	4
TB1 - 04/04/15 - safer staffing	LW to arrange a session with NEDs on interpeting the 'hours of care per patient' data.	LW/FMc	5/23/2019	A Board Seminar to be arranged on 'interpreting hours of care per patient' FMc to review Board Schedule for an appropriate date.	N	4

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
23-May-19						
TB- 23/05/06	N Marsden requested a brief schedule of the events over Armed Forces Weekend to be pulled together and distributed.	JMc	6/6/2019		N	**4**

Report to:	Trust Board (Public)	**Agenda item:**	**1.7**
Date of Meeting:	06 June 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: • **Performance –** update on current performance • **Finance –** update on our financial recovery plan • **Workforce –** update on workforce situation • **Inspection by the Health and Safety Executive** • **Walk for Wards** • **Celebrating our staff and volunteers**

Performance

We have started the financial year meeting the referral to treatment standard. While we did not meet the Emergency Department waiting time standard, reporting 92.5%, this was above our planned trajectory. We also narrowly failed to deliver the diagnostic standard by 0.3%.

It is essential that we continue to provide good quality safe care and we have had no MRSA or C.difficile cases in the first month of the year and no hospital acquired grade three or four pressure ulcers. We did have one fall resulting in major harm and one resulting in moderate harm and we will continue to ask staff to follow the falls interventions list to ensure that measures are in place to reduce the risk of falls in their areas. Further

details of this and our performance across all targets will be covered later in the Trust Board.

Finance

The Trust met its 2018/19 NHS Improvement control total deficit (subject to audit). This means that we have been awarded the full £2.6m financial element of the Provider Sustainability Funding (PSF) available to us plus a further £2.7m PSF 'bonus'. These cash allocations have directly reduced our cash borrowing requirements, helping in our journey towards financial sustainability.

2018/19 saw a total CIP delivery of £10.2m, significantly greater than that delivered in recent years and I would like to personally thank the hard work and support of all our staff in achieving this. We will face a similar level of financial challenge in 2019/20, and need to deliver £10m in savings.

Workforce

Recruitment remains our major challenge and we continue to use overseas pipelines for qualified nurses and we are in the process of trialling assessment centre approaches for nursing assistants. A recruitment and retention strategy has been drafted and is currently being consulted on internally, and we are committed to the fourth wave of the NHSi nursing retention programme where good progress is being made.

The Trust's overall sickness absence rate is 3.45%, above the 3% target, however compared to last month's figure of 3.38%, both short and long term sickness have increased slightly. We continue to focus on specific areas to proactively manage sickness absence with the aim of reducing it back below target to a sustainable level.

Inspection by the Health and Safety Executive

We are planning for an inspection by the Health and Safety Executive in July. Health & Safety inspectors will be visiting the Trust on 3/4 July to look at our systems and processes around 'manual handling' and 'violence and aggression' and 'control and management of asbestos'. Whilst there will be planned visits to specific areas, we are preparing all staff for the inspection. To ensure all staff are fully supported during this process, we will be running a number of drop in sessions during June so staff can access information and understand what the inspection means for them.

Walk for Wards

I am encouraging all staff and their friends and families to take part in Walk for Wards, on Sunday, 7 July at Wilton House to raise money for Stars Appeal. Walkers have the choice of a 3km, 5km or 10km route and all walkers are provided with a free lunch and free entry to the Wilton House grounds after the event. A minimum sponsorship of £20 per person is required - full details are available at www.starsappeal.org and on entry forms which can found across the hospital. The Walk for Wards really is an enjoyable and special event and I'm really looking forward to walking it again this year.

The Stars Appeal is aiming to raise £1million this year to fund projects, which offer direct, practical support to patients and their families, over and above what the NHS provides. A

recent example of the difference Star's Appeal makes to our patients and staff was the recent opening of two new gardens at the hospital. Located next to one another on Level 2 of the main hospital building, one garden will be used to provide therapy to older and stroke patients, and will be known as 'The Stars Appeal Therapy Garden'. The other, which will be known as 'Rod's Place', in tribute to Rod Lennox-Gordon, a nurse on Farley Stroke Unit who died last year, will provide a tranquil space for relatives and patients.

Celebrating our staff and volunteers

Our Striving for Excellence awards ceremony takes place on 13 June, giving us an opportunity to recognise the enormous contribution our staff make to the hospital, our patients and our local community. Over seventy nominations have been received to date. All our staff are amazing and so that more staff are able to join in with the celebrations, this year the awards ceremony will be held on site on our Tennis Courts and in Horatio's Garden, who have kindly given us permission to use their beautiful garden providing a really special setting for the ceremony.

These awards would not have been possible without support from the Salisbury Hospital League of Friends who are sponsoring this event.

The beginning of June marks volunteers' week, which provides a great opportunity for the Trust to say thank you for the fantastic contribution our volunteers make to our hospital. We will be holding a celebration event for our volunteers on 4 June where they will be presented with long service badges for 5, 10 15 and 20 years of service.

Cara Charles-Barks
Chief Executive

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	06 June 2019		

Report Title:	Corporate Governance Statement Self-Certifications FT4			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	Self-Certification - FT4			

Recommendation:
To note the Trust's declaration in relation under Licence Condition FT4

Executive Summary:
NHS Foundation Trusts are required by NHS Improvement to make declarations in relation to compliance with the provider licence. The 23 May Private Board meeting agreed the declarations for FT4, G6 and CoS7. FT4 is the corporate governance condition in the Licence and is required to be published by 30 June. The Board is asked to note the report.

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	☒

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Salisbury Hospital NHS Foundation Trust

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates 2018-19 Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	**Risks:** Significant weaknesses in internal control identified through Internal Audit Programme for 2018/19 **Mitigating actions:** Trust establishing task and finish group for targeted improvement in corporate processes and procedures. #REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	**Risks:** Guidance is not identified or implemented in a timely manner **Mitigating actions:** • The Trust ensures that regular communications from NHSI, CQC and other key bodies are reviewed and acted upon.• Internal and external audit consider application of good governance during their audit programmes #REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	**Risks:** Committee terms of reference do not clearly set out key responsibilities and delegated authority and decision making **Mitigating actions:** Annual review of Committee terms of reference, including relevant up to date guidance #REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	**Risks:** The Trust's internal control systems are not sufficiently robust to ensure compliance **Mitigating actions:** • The systems and processes are regularly tested through the internal and external audit programmes, and the robust approach to risk management • Trust establishing task and finish group for targeted improvement in corporate processes and procedures. #REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	As item 4 #REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	**Risks:** There is a risk of unforeseen changes at Board **Mitigating actions:** • Deputies in post for all Executive Directors • The Board has appointed to all Non-Executive Director roles and has Governors observors for Board and Board Committees #REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name Nick Marsden **Name** Cara Charles-Barks

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "Training of governors" | **Financial Year to which self-certification relates** | Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed — OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Nick Marsden	**Name**	Cara Charles-Barks
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:	6 June 2019		

Report Title:	Integrated Performance Report, April 2019 (Month 1)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Executive Directors			
Executive Sponsor (presenting):	Executive Directors			
Appendices (list if applicable):				

Recommendation:

To note the information contained within the Integrated Performance Report for April 2019 (month 1).

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

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	☒

Performance Summary Narrative – April Performance, plus recent context

Vision – To deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans/ Forecasts**
Local Services (COO)	RTT • Trust achieved month end target of more than 92% of patients waiting for planned treatment having waited less than 18 weeks performance was over 93% for 5 months in a row • General Surgery above Q4 target at speciality level and achieved a 3.74% increase in April.	• Particular areas of pressure in: general surgery, orthopedics, oral surgery and urology. • Dermatology continues to be a challenge with Dermatologist capacity. • PTL increased to 83 above trajectory.	• Weekly review of capacity fill is being undertaken for areas with biggest activity shortfall • Using Forward Look tool to work on recovery plans for specialties under activity. • Continued monitoring of waiting list size to ensure growth within trajectory.
Local Services (COO)	**Diagnostics** • The Trust is actively monitoring the challenges associated with delivery of the diagnostic standard, measures are in place to mitigate against risk. • JAG accreditation has been awarded on the expectation that we demonstrate a reduction in all wait times, including surveillance, over the next three months. Work continues to provide reliable and sustained data capture to support the management of	• There are continued workforce challenges in Radiology resulting in the clinical prioritisation of resources. Additional clinical sessions in April to meet the demands on the service have resulted in increased 3rd party reporting, causing some delays in reporting times. • Financial challenges continue to fact the Trust as a result of an ongoing reliance on additional capacity for Endoscopy and BSCP	• Radiology workforce review is in final draft, and phased recommendations will be presented to the Executive Performance meeting in May 2019. • Capacity offered by 3rd party Radiology Reporting provider to be increased in support of demand. STP tender for the provision of these services to be launched May 2019. • Demand and capacity modelling to be refreshed in Endoscopy to identify the shortfall, and underpin a business case

	future capacity and demand. • Insourced solution to provide Gastroenterology medical staffing live from 1st April. Weekend sessions required during April to mitigate against impact of Easter Bank Holidays on lost sessions. • Clinical teams work continues to be clinically prioritised.	• BCSP Fit Testing will be live from 1st June 2019, requiring a further 2 Endoscopy sessions per month from July 2019.	for 6/7 day service provision. A recovery plan will be required to support the reduction in waiting times requested by JAG over the next 3 months for all patient cohorts. • Intensive support is being provided to the Endoscopy Service by the Executive Team.
	Positives	**Challenges**	**Plans/ Forecasts**
Local Services (COO)	**ED** ED 4 hour performance was below the national standard but above trajectory for M1 (92.46% vs 92.3%) • ED Navigators in post 7 days per week to ensure safety of waiting room and navigation of patients to correct service • Vacancies in M12, expecting further decrease in M1. • Consultant staffing fully established. • Recruitment of part time (experienced) Registrar level doctor. • No escalation beds opened in	• Consultant morale challenging due to ongoing issue with Trust Board re. job plans/rota etc • Continued gaps in nursing and medical rotas resulting in poor skill mix and junior medical workforce. • 1.6 wte consultants will be leaving over next 3 months. • 4 Junior / middle grade doctors leaving over next 5 months; hard to recruit to posts.	Continue with recruitment of nurses to reduce vacancies • Supervision and training of junior workforce • Consultant job planning and workforce review at final stages. • Advertise Consultant and middle grade vacancies. • Review ambulatory pathways to increase access to outpatient ambulatory services (away from the inpatient areas) May 2019 • Project plan for SAFER agreed and continued implementation to all wards.

	April (with exception of occasional use of ambulatory area for male/female capacity issues). • Clarendon ward remains closed		
	Positives	**Challenges**	**Plans/ Forecasts**
	Cancer • Although not finalised Month 1 is showing achievement for 62 day standard. 2ww performance struggled due to long Easter weekend (92.38%).	• Endoscopy capacity to support Lower GI pathways in particular • Concerns regarding Dermatology capacity. • Clinical Oncology provision for Breast Services • Maintaining compliant 62 day performance following recent improvements to return to +85%. • Increasing waits to treatment at tertiary centers • Delays in histology • Patient choice breaches	• Appointment of ID Medical for Gastro service provision from Q1 • Continue discussion with UHS re clinical oncology provision (May 2019) • Cancer Lead to review all MDT meetings to ensure efficiency. (April 2019) • Maintain efficient tracking of patients on open pathways to ensure breach numbers remain low. (ongoing) • React to diagnostic delays quickly through patient tracking list meetings to expedite and reduce wait time. (ongoing) • Readiness for 28 FDS standard and implementing process to support this for SFT patients.
	Positives	**Challenges**	**Plans/ Forecasts**
	MSK • Spinal Injuries 'step down	• Increased waiting times for spinal rehabilitation	• Trust Board approval of contract required following tender May 2019.

Specialist Services (COO)	pilot complete NHS E approved funding to extend to 31.03.19 • Zero spinal patients overdue an outpatient follow up appointment. Business case now awaiting Board approval. • Ongoing good compliance with Spinal patients outpatients follow up. • Wessex Rehabilitation pathway pilot for upper limb commenced in Q2 , to improve access and outcome for Major Trauma & plastics surgery patients ; ongoing. • Review of Cleft service management in conjunction with Oxford to improve efficiency and reduce cost (complete) • Continue to monitor the positive impact of the ward reconfiguration on plastics • Plastics network chaired by SFT COO well established. • Odstock Ward expected to be fully staffed by September	• Some progress in Spinal urology surgery waits however still a challenge • Concern over VUD pathway. Short term and long term solution in place. Backlog of patients to be reviewed once Lead Practitioner in Urodynamics is in place. • Number of beds on Odstock Ward insufficient. To be reviewed. • Dip in orthopedic activity in April due to leave and under-filling lists	• Business case for step down to go to NHSE May 2019. • Following Trust Board approval to award contract following completion of tender • VUD - Short term mitigation in place and being addressed in wider Urology capacity and demand intensive support work. VUD practitioner appointed. In post July 2019. • Business case for commissioner investment in Wessex Rehabilitation being written. Draft to DMT end May. Costing & Coding notice to be issued in parallel to reflect increase in activity planned. • Ongoing focused validation on the waiting list for plastic surgery to clean the waiting list, identify patients to be seen and fast track review. Good progress, following review. UHS drafting business case to manage Ortho Plastics trauma on-site at UHS and cover a 24/7 on call. Draft case expected July 2019. • Pilot for Skin Service Rapid Assessment Clinics to begin in July 2019. • Too many beds in Orthopedic footprint. Work to move capacity from Ortho to Plastics within current PFI template.

			• Weekly list review meetings are being put in place for June with COO. Additional lists being set up to recover activity.

Salisbury NHS Foundation Trust

Performance Summary Narrative – April Performance, plus recent context

Vision – to deliver an outstanding experience for every patient

	Positives	Challenges	Plans/forecast
Innovation (MD)	• GIRFT deep dive visit for hospital dentistry	• 1558 Patients recruited to NIHR portfolio studies	• Establishing a Wessex Spinal Surgery network • GIRFT summative report to Board in September
Care (MD/DoN)	• Mortality rate remains as expected • SHMI has decreased to 100 and is as expected	• Weekend HSMR higher than expected. Detailed investigation to be completed • We continue to experience mixed sex accommodation breaches in assessment units	• Case note review commenced, outcomes/findings will be reported to CGC • Revised national guidance expected 2019/20. NHSI Quality Lead and CCG DoN working with the Trust on a walkthrough of current processes in Q1 – arranged for 14 June 2019
Care (MD/DoN)	**Positives**	**Challenges**	**Plans/forecast**
	• NICOR heart failure audit shows high levels of compliance with the audit standard • Direct to CT for stroke started in April • Sustained good performance in seeing high risk TIA referrals • SSNAP audit - B	• Provision of cardiac rehab	• Action plan developed as a result of NICOR audit. Presented to CMB May 2019. Working with community partners on specialties

Salisbury NHS Foundation Trust

Performance Summary Narrative – April Performance, plus recent context

Vision – to deliver an outstanding experience for every patient

	Positives	Challenges	Plans/forecast
People (DoOD & P)	**Recruitment:** • Improving conversion rate for overseas nurses continues. • Nursing Assistant Recruitment Event held at the Red Lion on 10 April 2019. • 20 applicants attended, 10 substantive and 9 bank offers made. **Agency Spend:** • Shift of spend from Agency to bank continuing • Locums Nest fill rate for April has fallen to 65%. Increase in requested shifts to 111, (90 in March) number of unfilled shifts was 39 compared to 20 in March. • SLA between Quality Directorate and OD & People signed. • Continuing reduction in Thornbury usage	**Recruitment:** • Lack of available domestic registered nurses • Managing fluctuating numbers of overseas nurses due to arrive. **Agency Spend:** • Centralisation of all staff banks within the Trust. • HMRC challenging DE model	**Recruitment:** • The Trust will be returning to India at the beginning of June to continue with the overseas recruitment campaign • 27 Newly Qualified Nurses have been offered posts to commence September/October 2019. • Work has started to transition medical recruitment across to the recruitment team. Transition due to be completed by 31 July 2019. **Agency Spend:** • Auto enrolment to commence on 1 June for all substantive RN's and NA's. • Revised tiering system for nursing agency to commence on 1 June 2019. • Identifying opportunities which will enable the delivery and performance of the nurse bank to increase. • Revised admin and clerical bank booking process to be developed and implemented from 1 June 2019.

- 1st SLA report to be tabled for the Staffer Staffing Group meeting on 16 May 2019.

Sickness:

- HAWB strategy completed and reviewed at workforce committee
- Sickness rate at 3.45%

Sickness:

- Employee assistance programme not approved at TMC
- Associated HAWB Benefits package not agreed at TMC
- Stress a major element of absence case mix

Sickness:

- HAWB strategy to be revisited post TMC/workforce committee
- Flu campaign 2019/20 is underway clear plans to ensure the campaign plan is confirmed in readiness to deliver for 1st October 2019.

Engagement:

- Senior Leadership Forum third meeting in May – compassionate leadership
- Work underway for HEE supported OD programme

Engagement:

- Maintaining improvement in Staff Engagement Group numbers and commitment to time for meetings and consequent work

Engagement:

- First meeting of the Organisational Development diagnostic, leading to a plan for culture change at Salisbury Hospital scheduled for 31 May.

Other:

- MaST (Mandatory and Statutory Training) compliance continues to remain complaint at 91.91%
- Medical appraisal compliant at 90.65%
- Non-medical appraisal improved and compliant at 86.70%

Other:

- Pension cap affecting Consultant take up of additional sessions

Other:

- pension cap national advice to be received

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
Resources (DoF)	• The Trust met its control total in April 2019, reporting a control total deficit of £1.9m, leading to additional payments of £513k for MRET funding, PSF, and FRF. An underperformance against the activity plan offset by an underspend in expenditure budgets. • The Trust maintained its reduced Agency spend with all Clinical Directorates delivering within their Pay budget envelopes.	• Delivery of the 2019/20 financial plan is contingent on the delivery of a £10m in cost improvement programme. Plans are in place to deliver the full £10m, but risk has been cited against Workforce (£1m) and Patient Flow (£0.8m) programmes, both programmes are being overseen within the CIP escalation process. • The financial position of the health economy remains a challenge, any reductions in funding within Wiltshire Council to adult social care could have a material risk to the delivery of the 2019/20 operating plan.	• Trust submitted its operating plan and financial plan to NHSI at the beginning of April, and re-submitted in accordance with the national request in May. Trust has agreed to the NHSI control total of an £8.9m deficit for 2019/20. • The Trust is currently forecasting delivery of both the Financial Plan, and the CIP target.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public	**Agenda item:**	2.2.1
Date of Meeting:	06 June 2019		

Report Title:	M1 Operational Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Andy Hyett, Chief Operating Officer			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):	Appendix 1: Trust Board Performance Report			

Recommendation:
The Trust Board are asked to note the Trust Performance for Month 1

Executive Summary:
The Trust delivered the RTT standard for Month 1. Although the Trust failed to deliver the ED standard reporting 92.5% this was above the submitted trajectory. The Trust failed to deliver the diagnostic standard by 0.3%. At the time of reporting, cancer performance has not been confirmed.

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	☒

Executive Summary of Key Operational Performance – April 2019

( ) = national targets

ED Performance (95%)	**In month (1): 92.5% (trajectory 92.3%)** **Year to date: 92.5%**	Amber
RTT Performance (92%)	**In month (1): 93.1%** **Year to date: 93.1%**	Green
Diagnostics (99%)	**In month (1): 98.7%** **Year to date: 98.7%**	Red
Cancer **2 ww (93%)** **31 day (96%)** **62 day (85%)**	**In month (1): . 2 ww = 92.3%** **31 day = 97%** **62 day = 83.3%** **All still being validated**	

Key to the delivery of operational standards, financial performance and a quality service is patient flow. A more detailed analysis is provided in Appendix 1

Emergency Pathway Performance

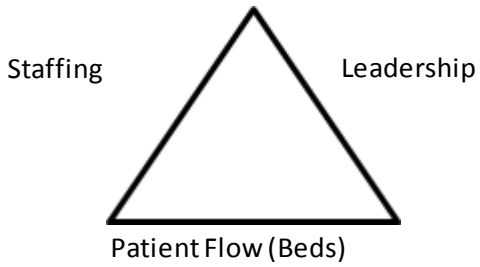
AMBER

Since June 2018 we have experienced challenge in managing our emergency pathways and performance has been below 95%. For M1, ED achieved 92.5% for the 4 hour standard against a trajectory of 92.3%. M1 performance is a similar position to M12 which is beginning to demonstrate that performance of the 4 hour target has reached some stability. The continued increase in demand, in particular, the increases in peak hours of attendances (above 10 per hour) within a day is challenging the resilience of the Department and has potential to put 4 hour performance at risk if this continues.

Whilst intensive support to ED has ceased, specific work streams in the Department continue from the Directorate and from the COO. An example of this is interrogation of time to triage and assessment performance to ensure a high standard is being achieved for these and ensure wait times are at a minimum – this will, in turn, support the anticipated national direction with regards to changes to emergency pathways standards. Timely assessment, treatment and onward flow will remain essential to the delivery of any new standards. The committee will be kept updated with any changes.

An ED action plan was written in Q3 of 18/19, recognising the challenges being faced and now, six months on, this will be refreshed with particular focus on the new and current challenges being faced. The change to the Clinical Leadership during Q3 18/9 has supported resolution of a number of key issues that the Department was facing at that time – this is allowing for a refresh of the action plan to enable focus on the 'what next'.

A more detailed analysis of M1 performance is provided in Appendix 1.



Staffing

At M1 the Consultant workforce within ED is fully established at 10 WTEs, although two resignations have been received with 1.8WTEs leaving during June/July 2019. 1.0WTEs of this 1.8WTEs will likely return to ED in 18 months' time following a period of career break – he will maintain an annualised contract with SFT which is of benefit to ED as he will be available to cover during periods of leave or during periods where resilience will be required. Both vacant positions are currently advertised but there have been no applicants so there remains a high risk that the Consultant establishment from June/July 2019 will be reduced to approximately 8.4WTEs. This will likely result in increase in Locum cover (internally and externally) at a time when there will be junior doctor change over and summer leave amongst the remaining workforce. Annual leave is already being restricted to ensure cover is maintained, particularly for the first two weeks of August when new doctors are going through induction.

The Clinical Leadership team have been able to secure the appointment of a part time registrar equivalent doctor which further supports the middle grade rota, improving senior decision making cover at all times of day and night. There remains a requirement to continue to appoint good, experienced middle grades with this workforce improving and becoming more stable although the Clinical Lead is currently in conversation with a further two Doctors who may be interested in joining SFT on a Middle Grade contract, but may not be available until later Q2 or early Q3. Gaps in the middle grade rota will be managed through locum shifts. ED are formulating their escalation plan for how they will manage their unfilled shifts and agree the steps that will be taken to mitigate the risk of having gaps in the workforce.

At the end of April 2019 nurse vacancies had reduced to circa 5WTE and staff on maternity leave will begin returning to work towards the end of Q1. Clinical Navigators have started in post ceasing the agency contract that is in place for these roles. Nursing Assistant roles are now fully recruited into with starts dates for final new starters being confirmed. Nursing cover and skill mix, although improving does remain challenging but this is managed by the Lead Nurse for ED and Head of Nursing for Medicine to ensure plans are in place to mitigate risk and improve the recruitment and retention of these roles.

Leadership

The new leadership team in ED are now established and are focused on improving the service provided. Expressions of interest have gone out to the team for replacement of the Deputy Clinical Lead role and it is expected that a member of the team with good, previous and proven leadership skills will take on this role. There remain a number of challenges in managing the morale of the Consultant workforce, although improvements are generally being made. There is work to do to improve work within the trauma and paediatric portfolios – there are good Consultant leads for these areas but there are operationally challenges that are hampering progress being made. The CD and DM for Medicine are supporting the ED Clinical Lead and the Leads for those portfolios to ensure a positive impact can be made and to assure the Leads that there is support for the work. Managing expectations of the ED workforce remains challenging but will require constant attention to ensure positive improvements are being made in the Department.

The team are very proud of the CQC report and the improvement that they have demonstrated since the last inspection. Project groups to focus on the ‘should dos’ from the CQC are being set up with a view to having agreed actions for these work streams within the next month.

Work with the Tavistock Institute regarding team working/support/facilitation continues and the team from Tavistock are due to return to SFT in mid Spring to continue with this work. This has been received positively by the ED Team and the Team await the ‘next steps’ of this piece of work.

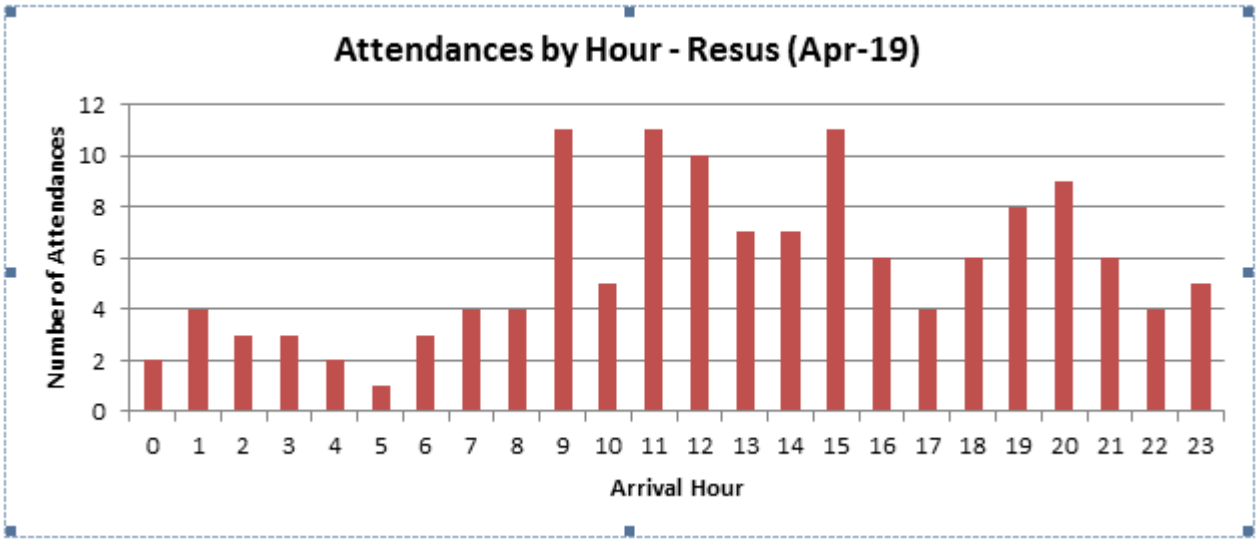
Patient Flow

The patient flow work stream is now chaired by the Clinical Director for Medicine and the COO runs a weekly patient flow delivery group to review weekly action progress. The Directorate Manager for Medicine is working closely with the PMO support lead for the Patient Flow Programme to ensure agreed actions to support the project work streams are progressing. There are a number of ‘live’ workstreams as part of the Programme – these include rollout of SAFER, enhanced recovery, AMU ambulatory (Same Day Emergency Care) service improvements etc.

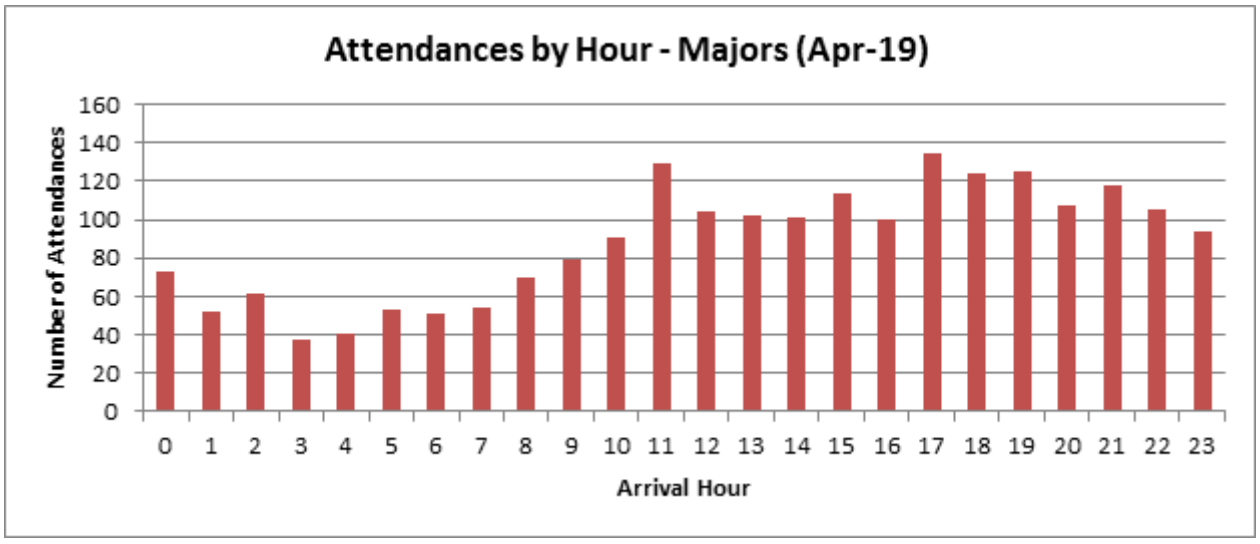
During April the Trust experienced some significant peaks in attendance. The live ED dashboard

allows early identification of peaks in activity to inform an operational response. Graphs 1, 2 and 3 show attendances by hour for April.

Graph 1



Graph 2



Graph 3

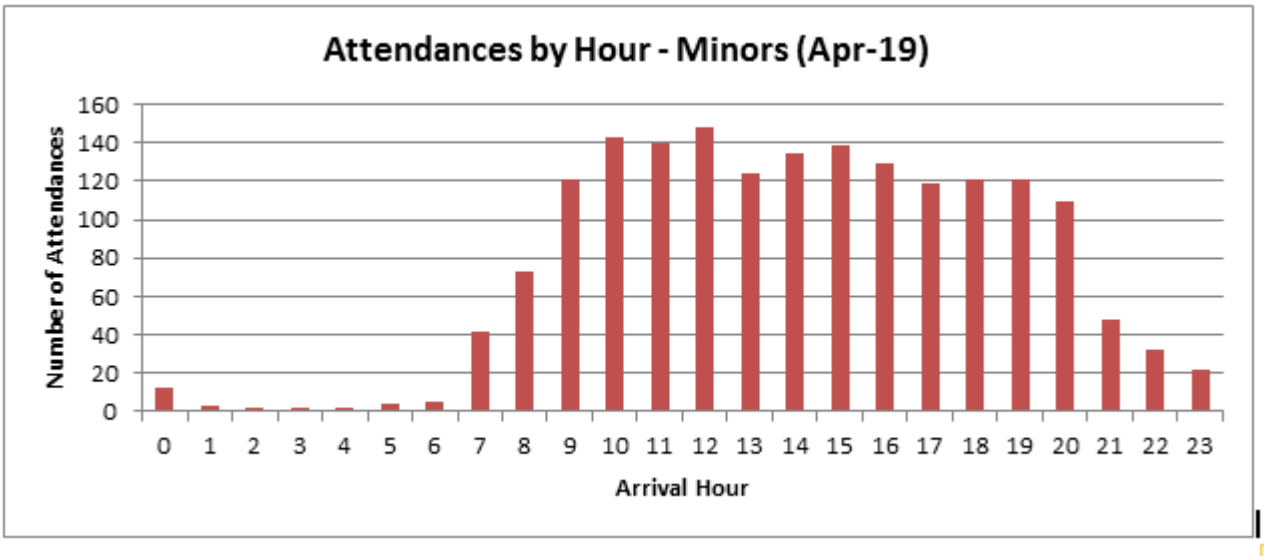


Table 1: Performance and Activity

		2018/19												
Month		1	2	3	4	5	6	7	8	9	10	11	12	1
Performance	Type 1 (%)	92.5	90.7	91.3	90.2	95	82.7	81.7	83	90.4	84	84.8	88.7	89.1
	Type 1 + 2 (%)	93.1	91.3	91.8	90.8	86	83.9	93	84	90.9	95	85.6	89.4	89.7
	Type 1,2 + 3 (%)	95	93.5	93.9	93.1	89.7	87.9	86.7	87.5	93.3	88.8	89.4	92.2	92.5
Trajectory	Type 1,2 + 3 (%)	95	93.5	93.9	93.1	89.7	87.9	85.9	88.6	89.1	89	91	91	92.3
Attendances*	Plan	3993	4258	4174	4358	4112	4077	4110	3848	3859	3718	3572	4103	5465
	Actual	4197	4640	4559	4832	4244	4338	4427	4205	4218	4331	3987	4533	5887
	Variance (%)	5.1	9.0	9.2	10.9	3.2	6.4	7.7	9.3	9.3	16.5	11.6	10.5	7.7
Average Daily Attendance	Plan	133	137	139	141	133	136	133	128	124	120	128	132	182
	Actual	140	150	152	156	137	145	143	140	136	140	142	146	196

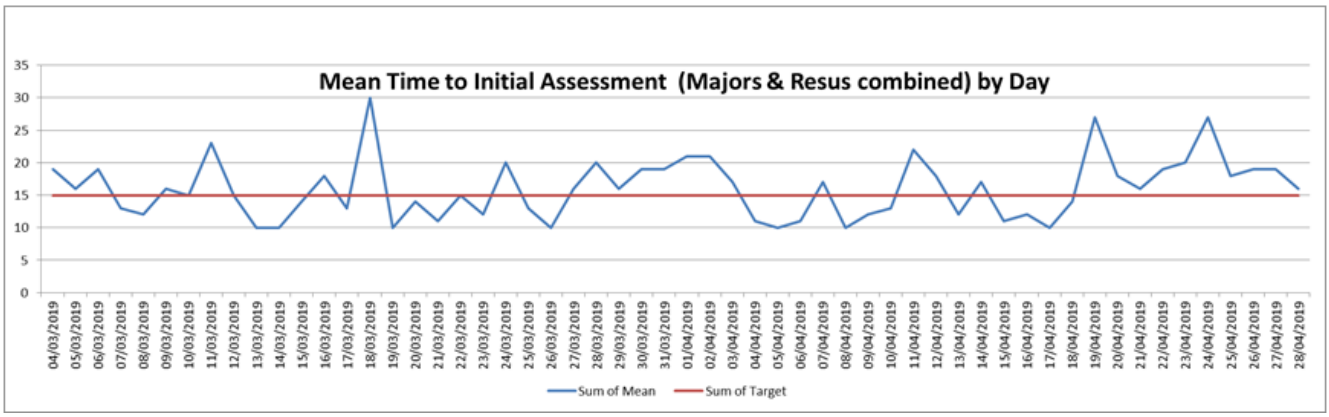
Table 2: Time to Triage

Month 12			
Performance against Trajectory	**%4hr**		
Trajectory	92.3%		
Type 1	89.72%		
Type 1, 2 & 3	92.46%		
Time to treatment	**Majors and resus (Mean)**	**Majors (Median)**	**Minors (Median)**
7/4/19	68	62.0	79.4
14/4/19	82	76.1	56.3
21/4/19	94	78.4	83.6
28/4/19	80	74.7	104.3
Time to triage	**Majors and resus (Mean)**	**Majors (Median)**	**Minors (Median)**
7/4/19	16	10.9	23.6
14/4/19	15	10.6	14.9
21/4/19	16	10.9	12.7
28/4/19	19	13.1	32.0
Ambulance Breaches	**Number**		
>1hr	0		
<1hr	16		

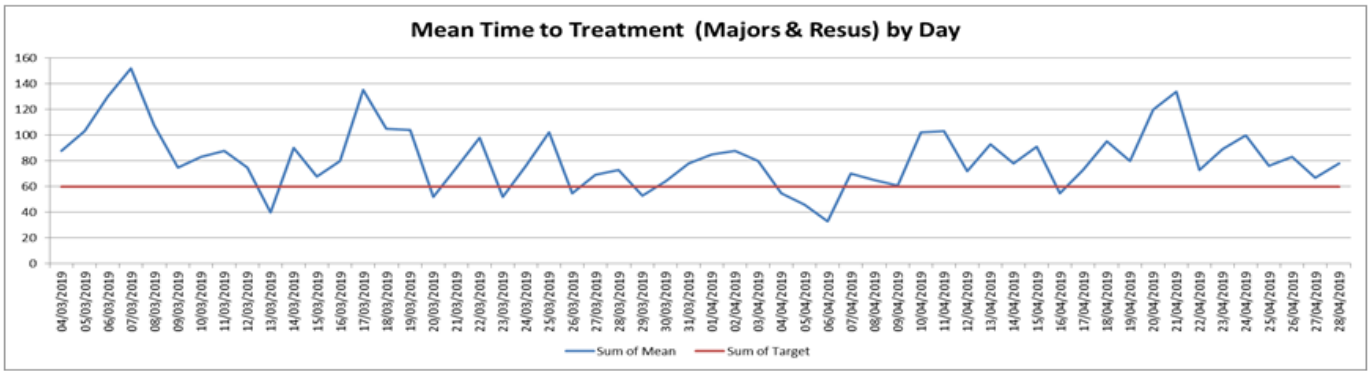
Table 3: Ambulance Conveyance

Total Reported:	21
Total Breaches:	16
Breaches > 1hr:	0
Breaches < 1hr:	16
Breaches >15 mins < 30 mins (for info)	105
Total number of patients arriving by Ambulance:	**1188**
% of patients met the target:	98.65%

Graph 4 – Mean Time for Triage



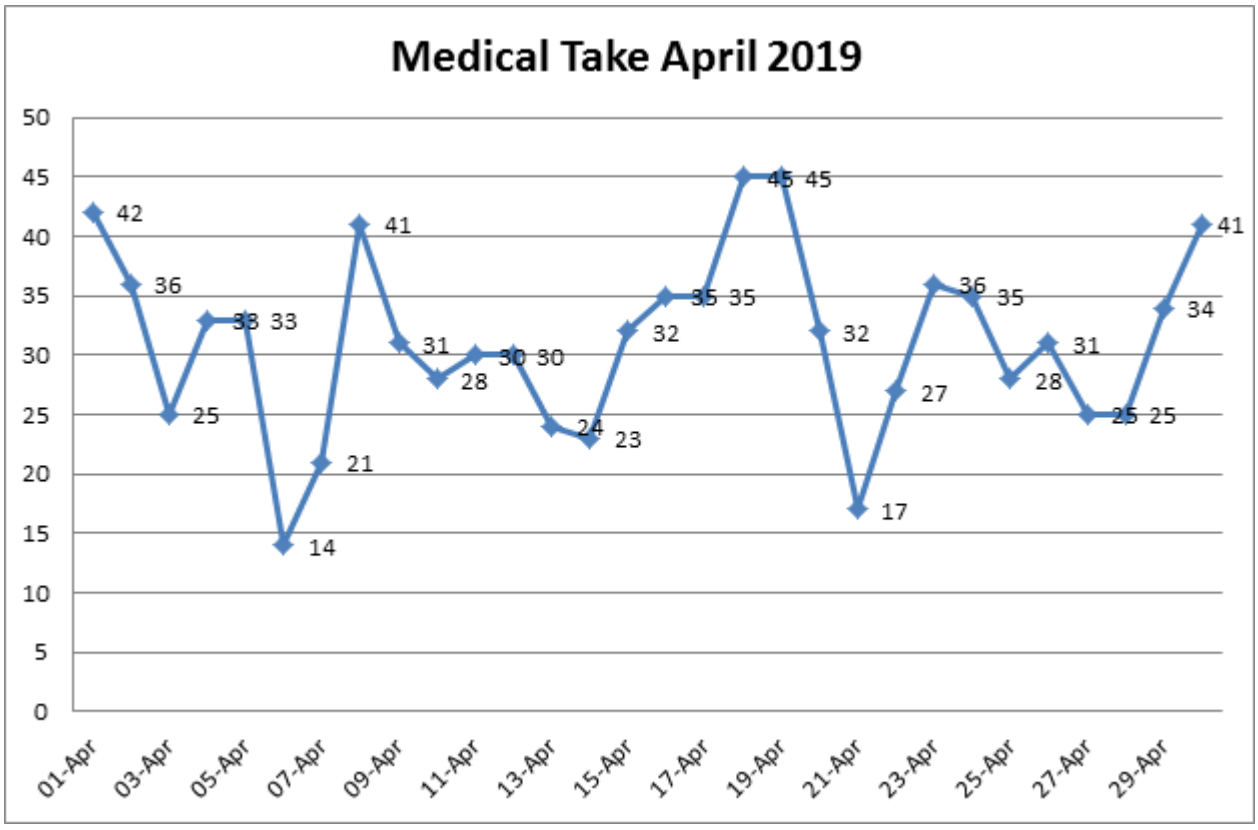
Graph 5 – Mean Time to Treatment



The medical takes continued to be high in April with peaks in activity being at the same time as

peaks in ED attendances.

Graph 6 – Medical Take



CANCER

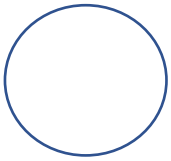


Table 5: Cancer Performance

A report to show the monthly and quarterly Cancer Target Performance figures for the current quarter. CUP patients are excluded from this report.

Description	Standard	April		
	%	In target	Total	%
All cancer Two Week wait	93	861.0	933.0	92.28
Symptomatic Breast Two Week wait	93	38.0	44.0	86.36
31 Day Standard	96	99.0	102.0	97.06
31 Day Subsequent: Drug	98	8.0	8.0	100.00
31 Day Subsequent: Surgery	94	20.0	20.0	100.00
62 Day Standard	85	57.5	64.5	89.15
62 Day Standard (without shared care logic)	85	57.0	66.0	86.36
62 Day Screening Patients	90	8.5	10.0	85.00

M1 has struggled for 2WW capacity not helped by the long Easter weekend. There were a lot of patient choice breaches but we were offering day 14 appointments which left very little room for manoeuvre. Endoscopy capacity is an ongoing challenge. Breast symptom breaches are as a result of our move to ePR which has resulted in the majority of breast referrals going through as breast 2WW which has skewed our figures for the symptomatic standard. All other standards achieved except 62 day screening with a 1.5 breach.

The ongoing challenge to maintaining 62 day performance will be the following:

- Urology: delays at the tertiary centre and late referrals by us. Appointment of CNS as cancer lead (in process) will improve the pathway.
- Dermatology capacity – service is extremely lean.
- Endoscopy capacity issues, 2WW endoscopy investigations and mid pathway patients often waiting 14-21 days for tests rather than the desired 7 days.
- Histology delays due to outsourcing of histology analysis and reporting (including 2WWs).

Referral to Treatment

The Trust reported 93.1% performance for Month 1.

***General Surgery* – (Q1 target 90.3%) - 89.7% M1**

- Continued long term consultant sickness – consultant due to return middle of May
- Organise additional lists where possible including the conversion of OP General Surgery OP clinics to theatre lists being continued (current wait for new appointment only 7w or 3w for one stop clinic) to allow increased theatre capacity for 18w+ patients
- Validation of General Surgery PTL continuing
- .Additional activity booked for new consultant throughout May and June

Urology – (Q1 target 89%) – 86.4% M1

- Continuing additional lists where possible
- Increased nurse led clinics being set up for prostate, stone and LUTS patients to alleviate capacity pressure on consultant clinics now in place
- New Cancer Lead appointed – Jonathan Borwell
- 7pa consultant post to start from 12th June, first month rota agreed and being booked.
- GIFT review meeting taken place, agreed plans at meeting for reviewing FU back log at meeting

***ENT – (Q1 target 92%)* Month 1 89.70%**

- Organise additional lists where possible including the conversion of ENT OP clinics to theatre lists.
- Validation of ENT PTL to take place
- Agreement to move long waiters between consultants where appropriate to reduce wait times, CD to discuss with ENT Team

Trauma &Orthopaedics (T&O) : (Q1 target 90%) – 89.0% M1

- Dip in activity in April due to Annual leave gaps in Rota and underfilled lists. Additional activity undertaken where ever possible using Trust appointed locums, LLP and additional payments
- Additional Limited Liability Partnership lists booked each weekend in May, June & July to maintain flow and recover lost activity.

Oral and Maxillo Facial surgery (OMFS) : (Q1 target 89%) – 91.7% M1

- Lost capacity due to under booked lists in April
- Facilitated Medical & Dental session planned for 15th May 2019

Dermatology – (Q1 target 85%) Reduced from Q4 18/19 – 77.2% M1

- Performance challenges due to medical and surgical dermatologist shortages
- High volume locum secured for additional capacity and maternity cover - Commenced April 2019 &

extended until September - to be reviewed July 19 for further extension.

- Additional 2WW plastic lists continued in April

Plastic & Reconstructive Surgery – (Q1 target 92%) – 89.28% M1

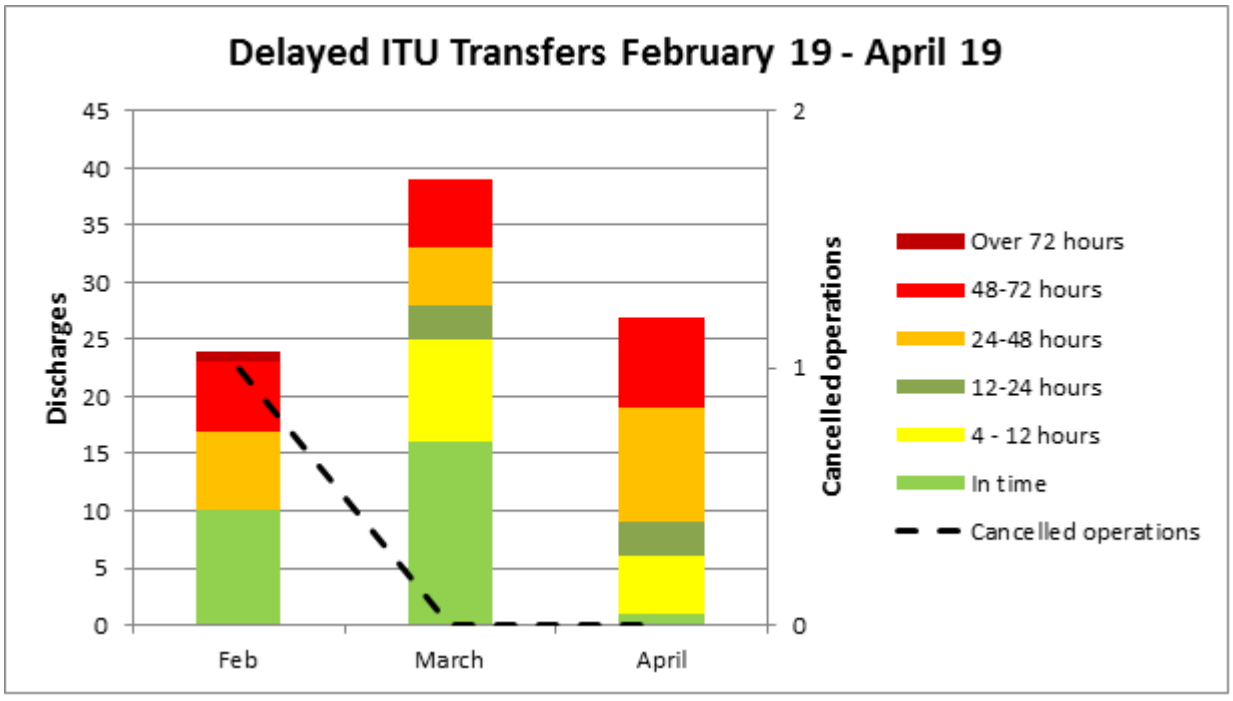
- Annual leave that took place in April would have affected activity, together with lost cases for holes in wraps and challenges experienced with theatre staffing.

Table 6: Waiting list split by CCG

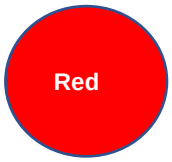
Total WL	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Dorset CCG	2,537	2,495	2,564	2,505	2,480	2,460	2,424	2,459	2,537	2,588	2,650	2,762	2,760	2,771
West Hampshire CCG	1,582	1,572	1,621	1,626	1,583	1,574	1,565	1,620	1,639	1,666	1,628	1,696	1,748	1,638
Wiltshire CCG	10,080	10,361	10,752	10,577	10,481	10,616	10,335	10,343	10,441	10,192	10,384	10,500	10,328	10,540
Other CCGs	2,839	2,886	3,024	3,138	3,135	3,016	2,989	2,834	2,526	2,411	2,180	2,105	2,113	2,083
Trust Total	**17,038**	**17,314**	**17,961**	**17,846**	**17,679**	**17,666**	**17,313**	**17,256**	**17,143**	**16,857**	**16,842**	**17,063**	**16,949**	**17,032**

ICU

Graph 7



Diagnostic (DM01)



The Trust marginally missed the diagnostic standard in April reporting 98.66%.

Endoscopy

The tender awarded to an external supplier for the provision of Gastroenterology services went live on 1st April 2019 and addresses the previously reported lack of cover from regular Endoscopists.

Concerns raised in relation to capacity for April were mitigated against by ensuring all Monday to Friday capacity was fully utilised. External supplier support was also sought for 8 additional weekend sessions.

Concerns have been raised in relation to capacity for May. These are being addressed by fully utilising Monday to Friday capacity and exploring further additional capacity for weekend working. However, there has been an abrupt stop in clinicians willing to do additional sessions.

Further activity is necessary to address the surveillance backlog, a requirement for JAG accreditation. A demand and capacity review is underway to inform the requirements, and this will be underpinned by a business case to outline 7-day working nursing staff requirements to support delivery.

Owing the multiple challenges within the Endoscopy service at the current time, SFT Executive Intensive Support is being provided. An Endoscopy Service Manager has also been appointed for a 6-month period.

Radiology

There was 1 Ultrasound Breach in April.

Despite downtime from CT1, there are no expected breaches for May. This will be achieved by a combination of additional weekend lists and evening working.

The MRI waiting list is currently at 373 with the majority of patients waiting less than 5 weeks. The demand remains constant so we are therefore continuing with the use of the mobile scanner for 3/4 days per week on a regular basis.

Whilst this is a significant cost, the demand and complexity of patient cohorts require additional capacity to the standard scanner which could not be met as efficiently with ad hoc arrangements.

Local health care providers have been notified of the available capacity on the MRI van but they have not taken advantage of this opportunity. The COO has highlighted our position to both the

CCG and NHSi.

Staffing continues to be challenging and measures continue to be investigated to improve recruitment and retention of staff.

Links to Assurance Framework/ Strategic Plan:

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

Appendix 1 Patient Flow

The four key objectives of the patient flow programme are:

1) To increase the number of discharges across all wards by midday from a baseline of 15% to 30%.
2) To ensure all patients have an accurate estimated date of discharge (EDD) recorded
3) Directorates to ensure a weekly review all patients with a LoS > 7 days who are not medically fit to ensure actions are taken to support prompt discharge.
4) Realignment of ED and ambulatory pathways.

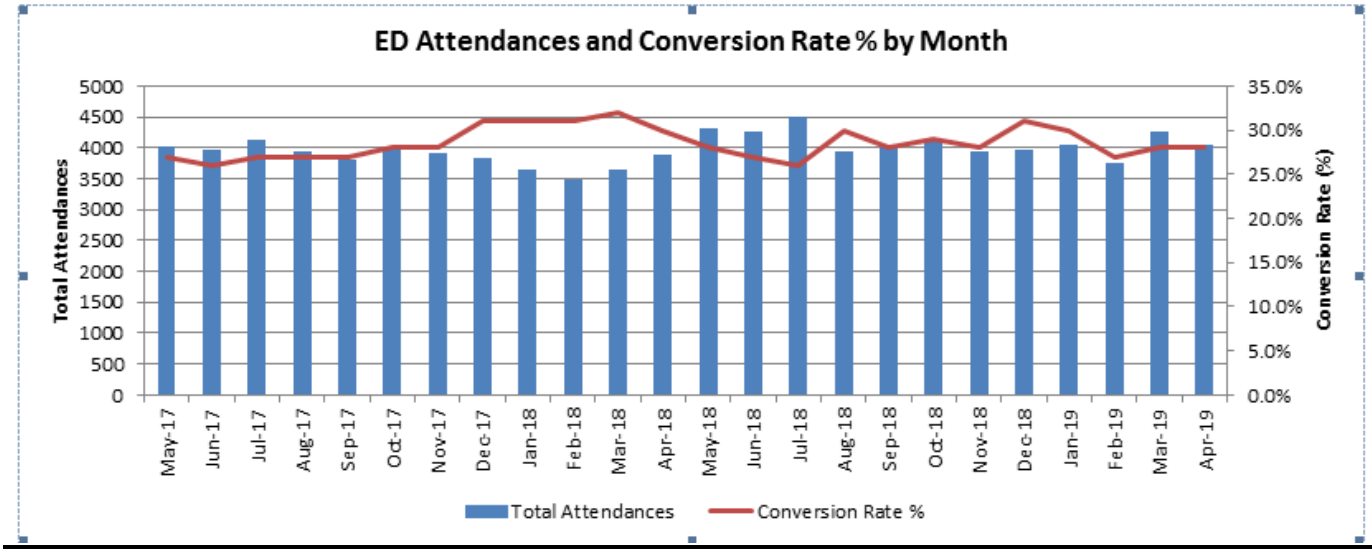
The information below outlines the performance against key KPIs aligned to the above priorities and next steps

The Trust did deliver its trajectory of 92.3% reporting 92.5% however this was against an increase in attendances against plan of 5% (Table 6). Conversion rates have stayed static when compared to the previous month (graph 8).

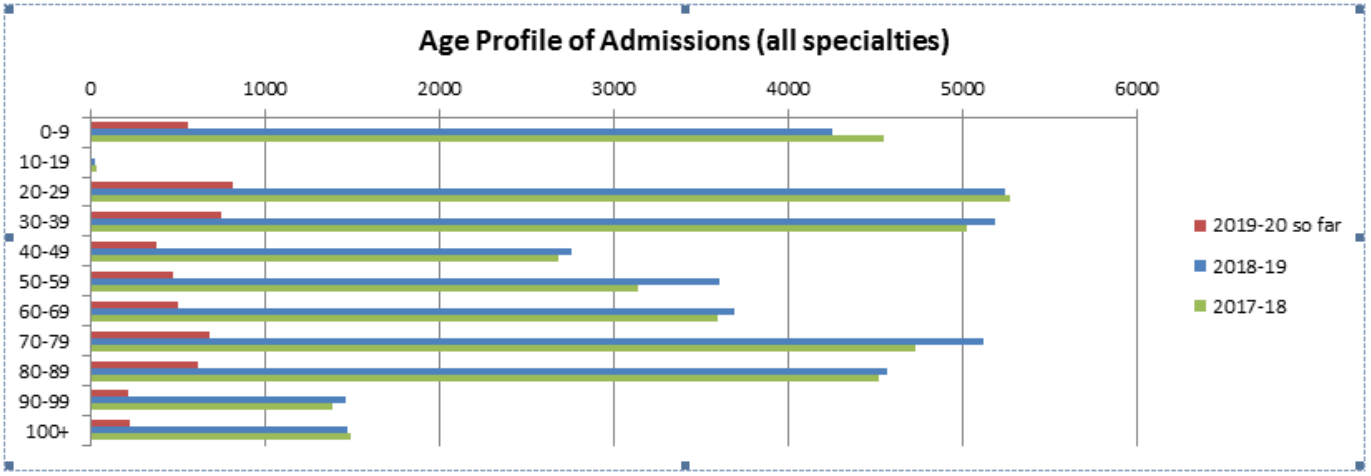
Table 6 Performance and Activity

		2018/19												
Month		1	2	3	4	5	6	7	8	9	10	11	12	1
Performance	Type 1 (%)	92.5	90.7	91.3	90.2	95	82.7	81.7	83	90.4	84	84.8	88.7	89.1
	Type 1 + 2 (%)	93.1	91.3	91.8	90.8	86	83.9	93	84	90.9	95	85.6	89.4	89.7
	Type 1,2 + 3 (%)	95	93.5	93.9	93.1	89.7	87.9	86.7	87.5	93.3	88.8	89.4	92.2	92.5
Trajectory	Type 1,2 + 3 (%)	95	93.5	93.9	93.1	89.7	87.9	85.9	88.6	89.1	89	91	91	92.3
Attendances*	Plan	3993	4258	4174	4358	4112	4077	4110	3848	3859	3718	3572	4103	5465
	Actual	4197	4640	4559	4832	4244	4338	4427	4205	4218	4331	3987	4533	5887
	Variance (%)	5.1	9.0	9.2	10.9	3.2	6.4	7.7	9.3	9.3	16.5	11.6	10.5	7.7
Average Daily Attendance	Plan	133	137	139	141	133	136	133	128	124	120	128	132	182
	Actual	140	150	152	156	137	145	143	140	136	140	142	146	196

Graph 8 : ED type 1 attendances and conversion rates



Graph 9 – Age profile of admissions

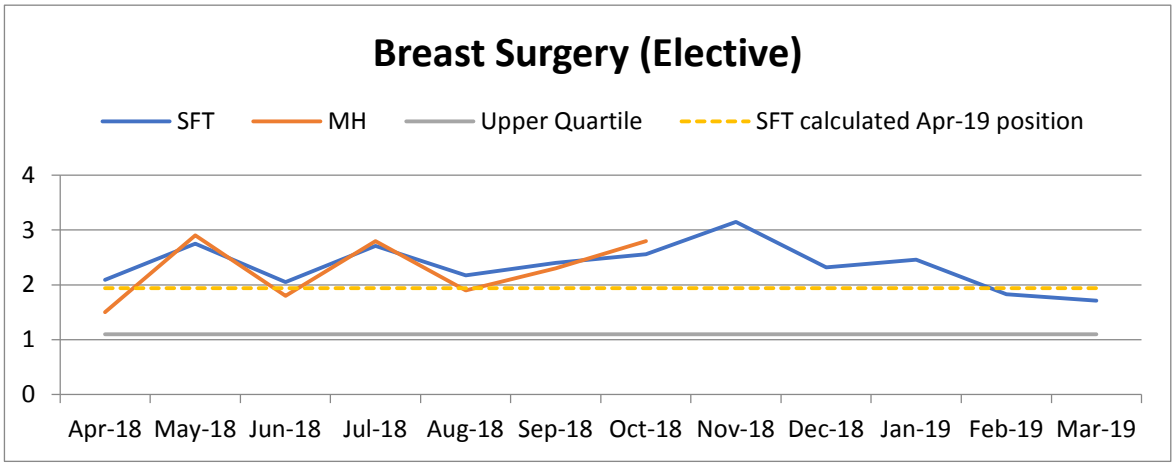


Length of Stay

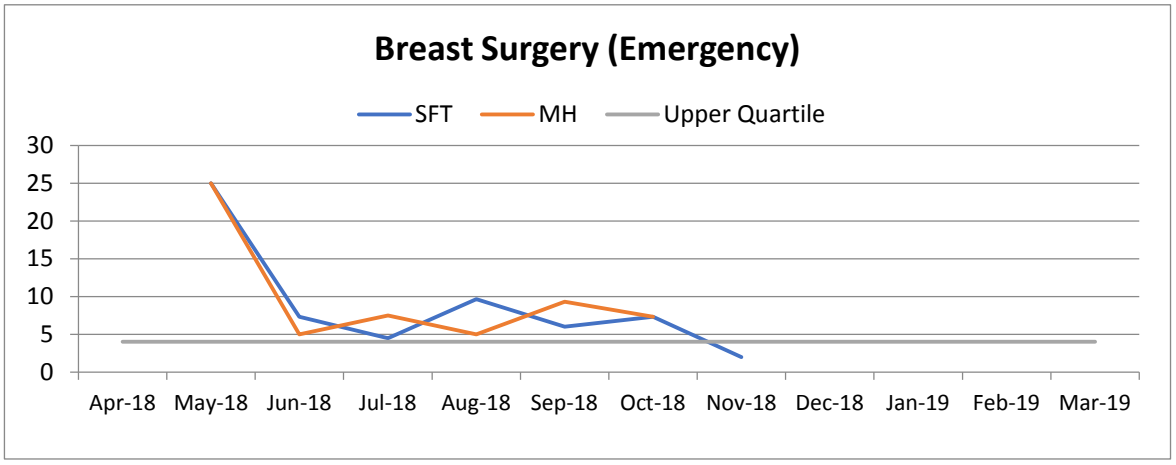
Information Services and PMO have successfully been able to produce a Length of Stay comparison at speciality level, against model hospital, this has been completed for the surgical Directorate (see graphs 10 – 12), elective breast surgery pathways appear to fall outside of Model Hospital upper quartile LOS and therefore suggest that a review of this pathway should be undertaken. Emergency pathways for breast surgery and urology, have improved and these will continue to be monitored. It is anticipated that all Speciality LoS comparison, will have been completed by June and a further update will be provided at the June F&P meeting. PMO will work with Directorates to identify specialities to review patient pathways.

The specialities where the April-19 calculated LOS was within the upper quartile shown on Model Hospital are General Surgery, Urology, Cardiology, Diabetes & Endocrinology, Elderly Medicine, ENT, Gynaecology, Orthopaedic Surgery, Paediatric (Elective Pathways). General Surgery, Elderly Patients, General Medicine, ENT, Gastroenterology, Geriatric Medicine, Respiratory, Orthopaedic Surgery, Plastic Surgery & Burns (Emergency Pathways).

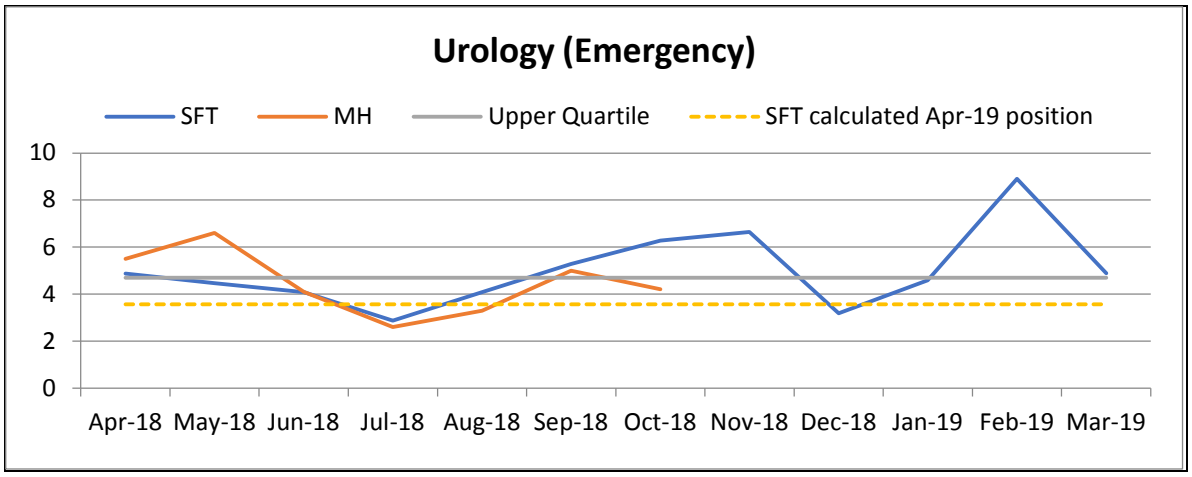
Graph 10



Graph 11

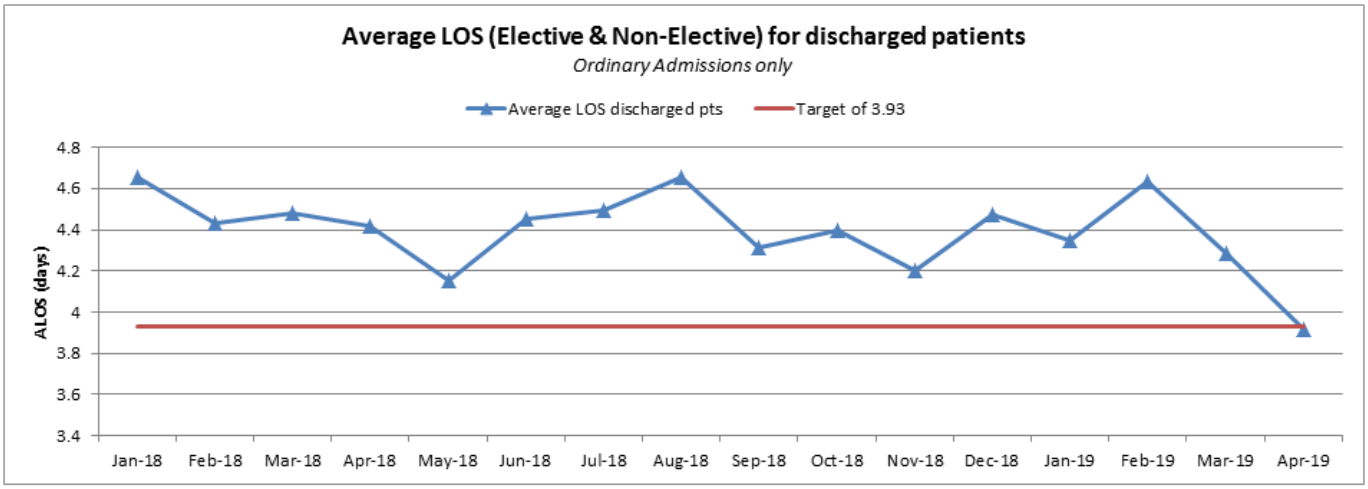


Graph 12



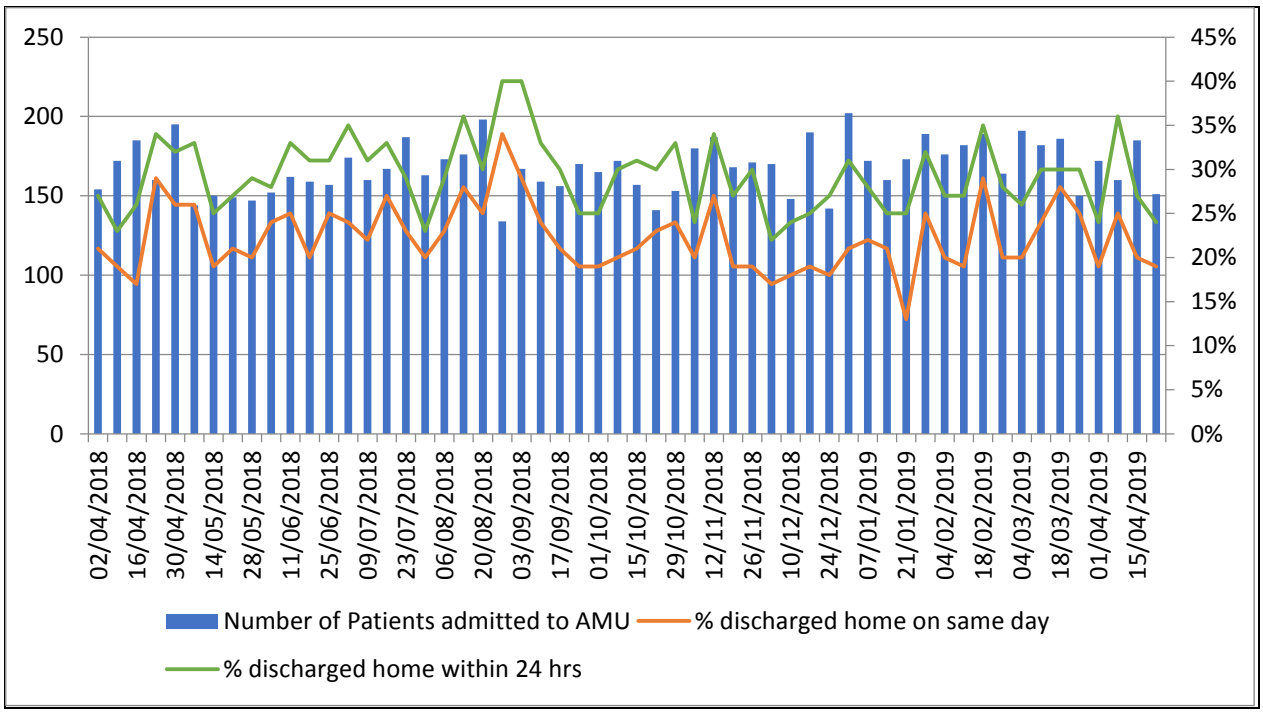
The 19/20 Trust target, for reducing LoS for elective and non-elective admissions, is set for 3.93 by the end of the financial year, this target has been based on reducing the number of patients with a LoS > 7 days and increasing the number of patients discharged by midday across all inpatient wards to 33%, as described in SAFER care bundles.

GRAPH 13

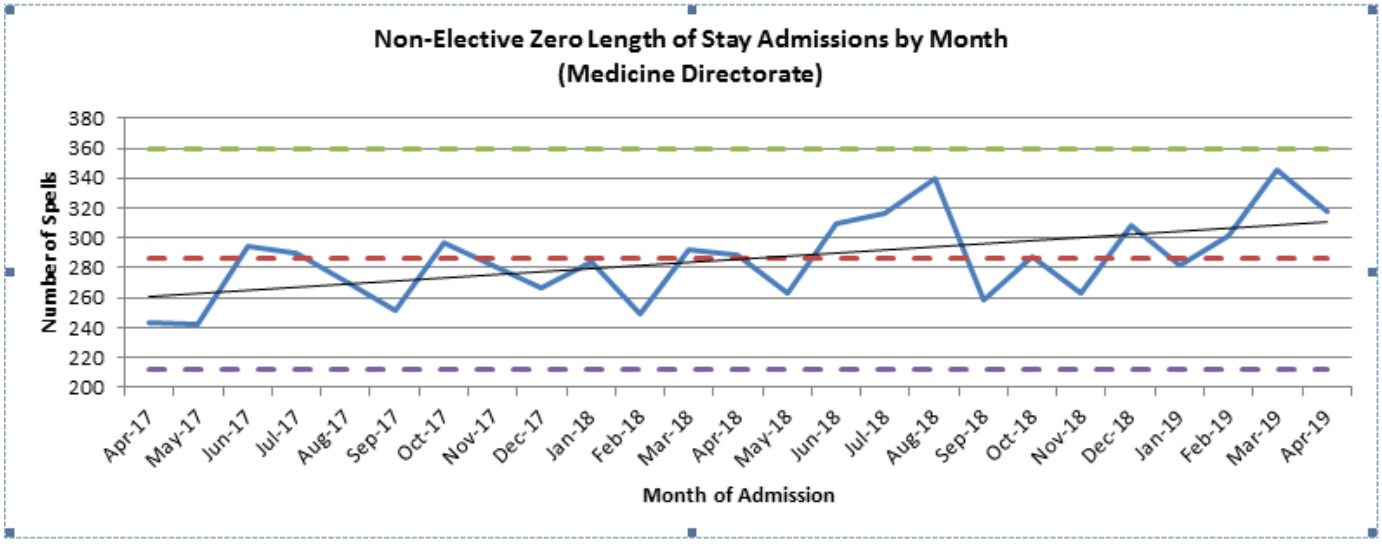


In addition we will continue to identify suitable pathways to increase 0-24 hour discharges from AMU to achieve the target set of 50%. Following discussions with AMU to pilot throughout June and July, the management of ambulatory patients (Monday – Friday) outside of AMU and within the Nunton unit, the % of discharged patients within 0-24 hours will be monitored (Graph 14). The pilot aims to see patients in a more timely manner, will focus on the 3 new CQUIN's which have recently been published (linked to same day emergency care) improve the experience for the patient and reduce time waiting in AMU. This pilot is being driven by Dr Nicola Finneran and Sister Michelle Heafey. Further updates will be provided in the F&P reports in June and July

Graph 14 – AMU Activity



Graph 15

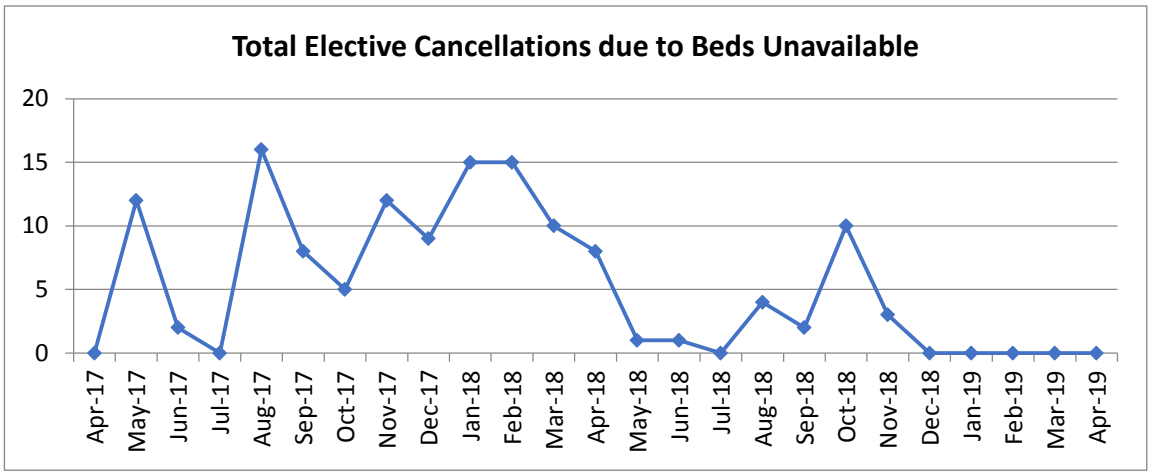


Attendance at a recent Same Day Emergency Care Conference by PMO and Medicine Directorate colleagues highlighted requirements for achievement of targets set nationally across all specialities. This will require further discussion within the patient flow PMB on what is required and timescales.

The patient flow metrics and targets have been reviewed with the scorecards being revised by Information Services. This refresh will provide a consistent and daily, weekly, monthly position against the programme metrics moving forward this financial year. The Patient Flow dashboards reporting daily, weekly and monthly level metrics continue to be circulated and used in meetings with teams/wards to provide up to date data and provide the opportunity to engage in conversation and identify areas for development
The financial figures for the patient flow scheme have been validated by finance. Elective cancellations due

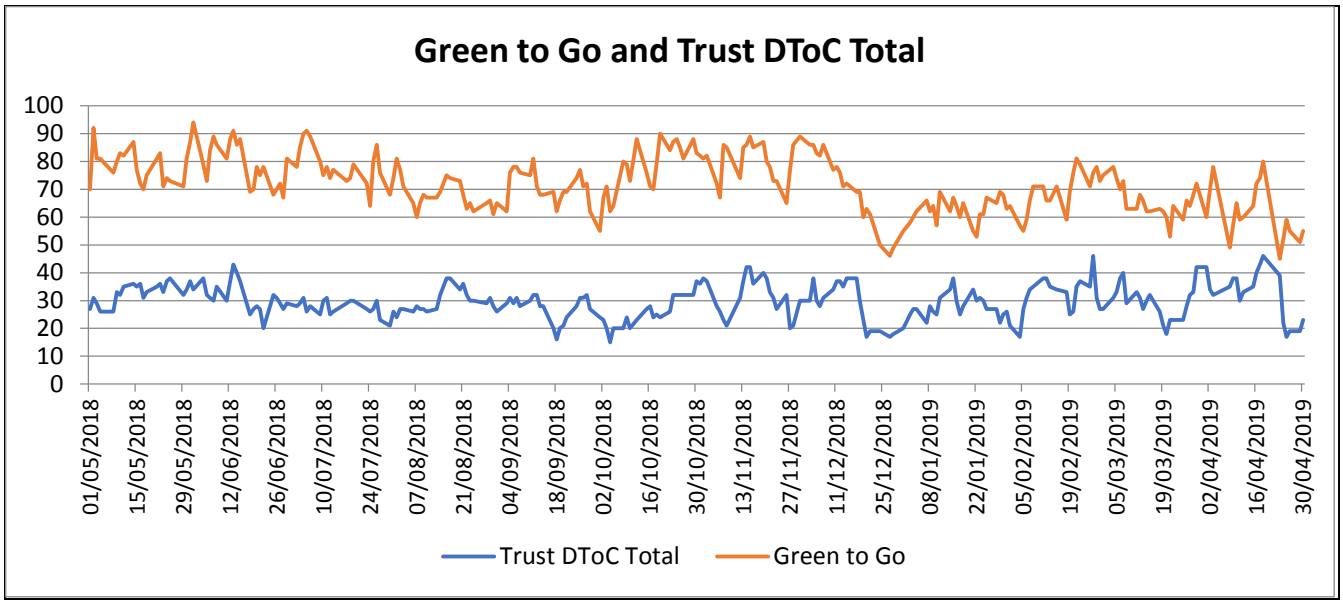
to beds being unavailable continue to remain at an all-time low (Graph 16).

Graph 16

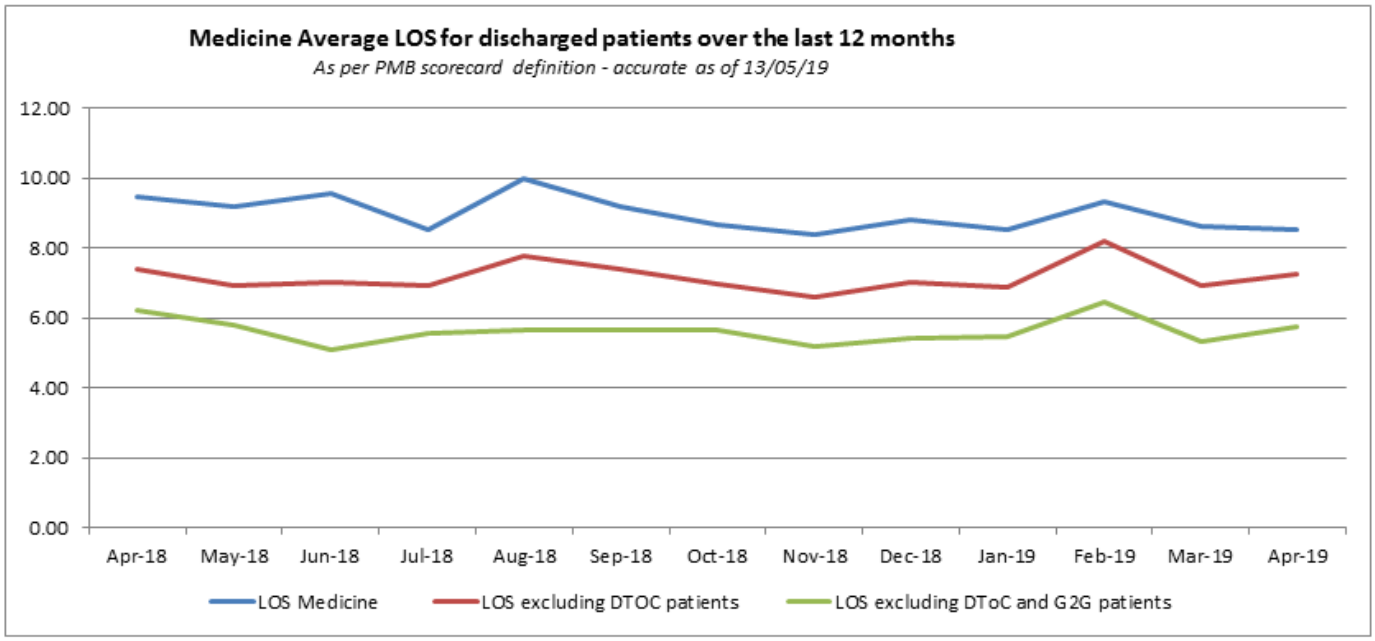


The number of patients who are coded as DTOC remains above the target of 14 (Graph 17). The system (A&E LDB, SFT, Wiltshire Health and Care and Wilshire Council) have agreed a revised target for April of no more than 14 DToC patients delayed per day (excluding Spinal Unit) and no more than 14 patients per day (including Spinal unit) for May 2019.

Graph 17



Graph 18

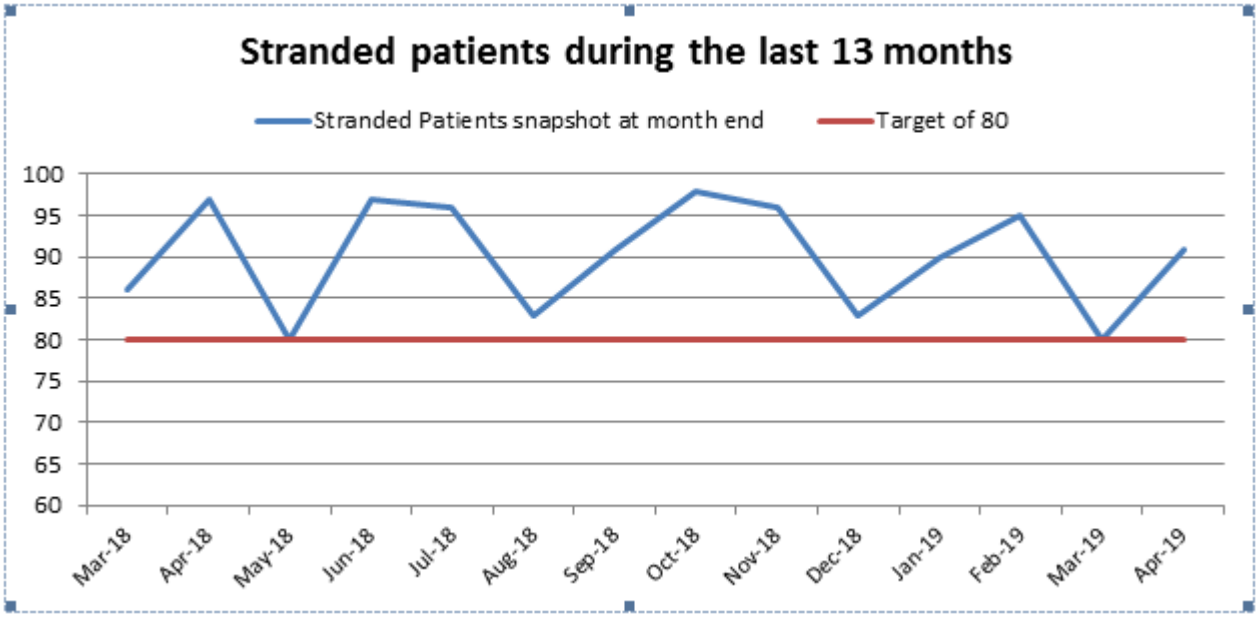


The number of stranded and super stranded patients are shown in Graph 19 and 20. All patients with a LoS > 7 days and who are not medically fit for discharge are reviewed by the Clinical Directors for individual Directorates, the Trust is reviewing our internal process for managing this and recommendations on how to continue to provide this and embed further within clinical teams will be presented to the patient flow PMB for approval.

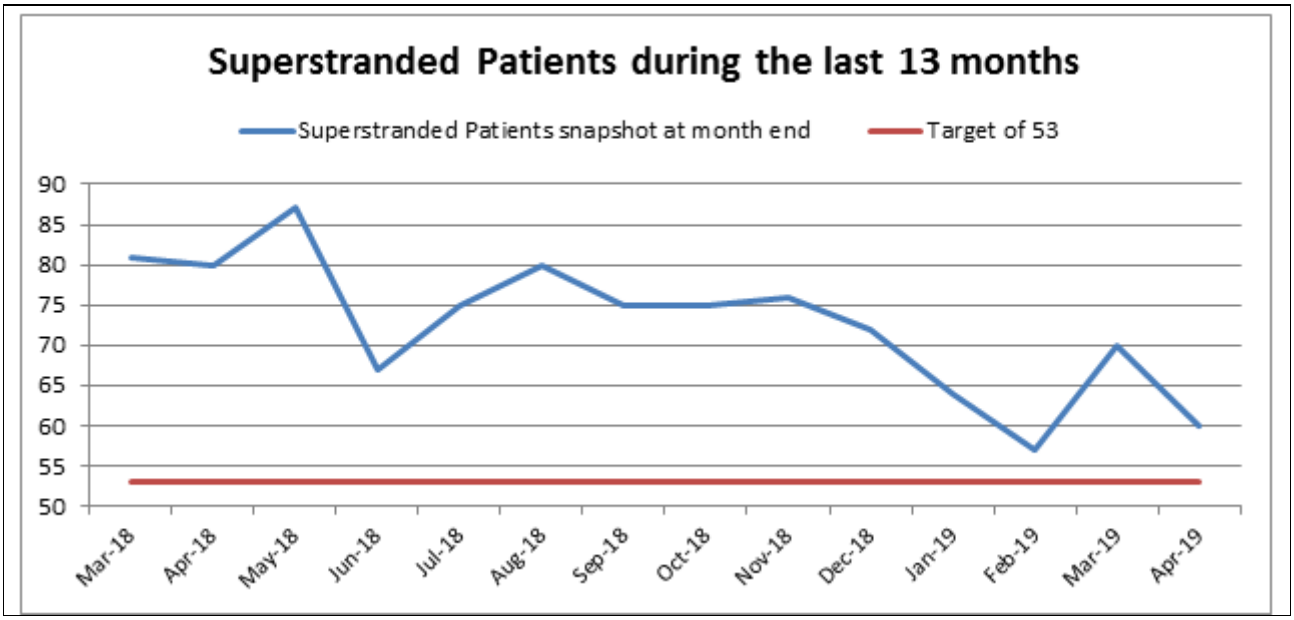
The weekly Expert panel continues to meet, with the format of these meetings having been reviewed in the previous 6-8 weeks. In addition to the patients who are medically fit for discharge, wards are now being asked to discuss their longest two waiting, not medically fit patients, so that discharge planning can commence earlier. The CCG are currently not attending these meetings however, attendance from other partners is in place. It is anticipated that from the 13 June the meeting will be moved to a Thursday afternoon, to allow the Deputy Director of Nursing to attend, SFT will manage this meeting with internal partners in attendance.

Graphs 19 and 20 have been updated following a review of the patient metrics and from the 1 April will now show the average month position, rather than the last day of the month snapshot, as has been the case in 18/19.

Graph 19



Graph 20



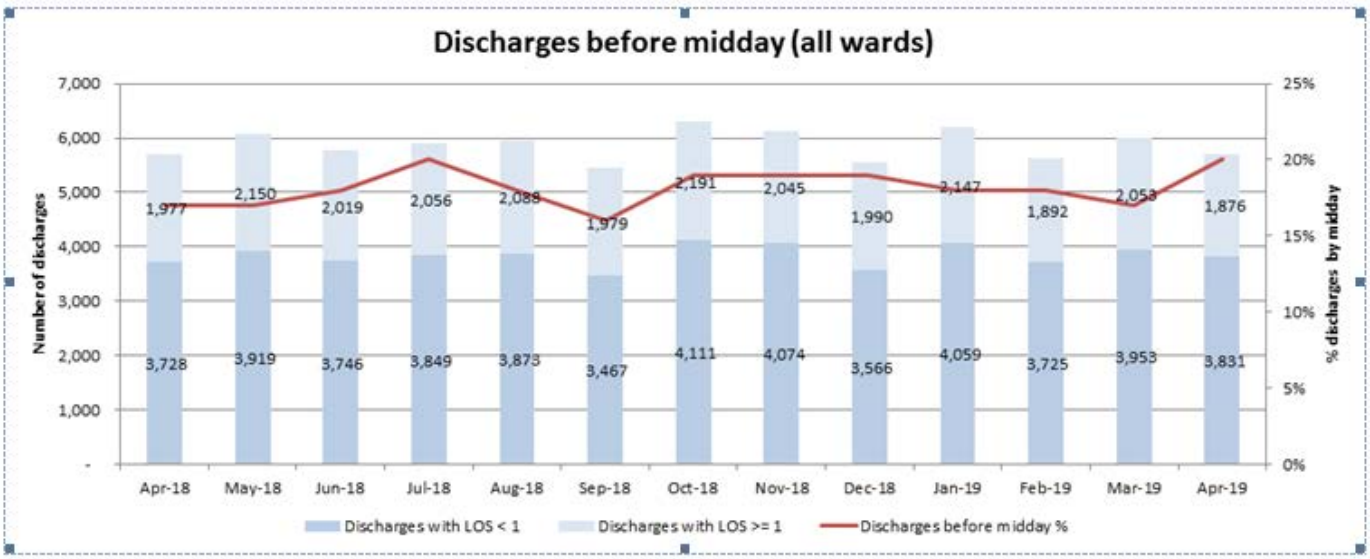
The SAFER programme of work continues to respond to the needs of the wards and teams, Senior Nursing teams are fully engaged in the programme and are developing locally owned plans and identifying opportunities they wish to pursue with support from the PMO. Examples of which include; pharmacy attendance at whiteboard meetings, reviewing discharge summary sign off parameters, PT/OT referrals, improved use of the e-whiteboard, access to SystemOne.

The programme of work has now supported teams on Whiteparish, Tisbury, Chilmark, Amesbury, Redlynch, Downton and Durrington. The ECIST workshops will help to embed and ensure that this programme of work is sustained within those teams, and it is anticipated that the information presented at

these workshops will reach those wards before the SAFER support reaches them.

The discharge of patients by midday continues to be an area of focus for ward teams and as a result of the SAFER support and ECIST workshops, opportunities to improve this have been identified and will now be discussed and worked up. The peak discharge time recorded remains between 15.00-17.00. Graph 21 shows the % of those discharged as a proportion of overall discharges in that month.

Graph 21



Further work

Three 2 hour workshop sessions on the 2 and 3 May 2019, were delivered by ECIST. In addition there was a senior management session on the Thursday morning, with the focus being on how they would support teams to continue to embed the principles of SAFER and good patient flow within their teams. There was representation from across all Directorates and from a variety of staff disciplines. The workshops provided the space for staff to discuss in table groups, the Four N's (Nuggets, Niggles, Nice If's, No No's) in relation to patient flow. This information is now being collated, themed and will be discussed at the patient flow PMB in May/June. In addition staff were asked to complete evaluation forms to establish what they were taking away and going to implement/needed help to implement on their ward/with their teams.

The ECIST team have offered further support to the Trust, including reviewing the ECIST recommendations from the report generated in November. They will also be attending the patient Flow PMB on the 15 May, to help progress the discussions held in the senior mgmt session. In addition, we are also looking to secure further workshop sessions with the ECIST team to reach further staff in the Trust across all bands.

A meeting with Wiltshire Public Health, to discuss the roll out of the Making Every Contact Count (MECC) behavioural change programme within the Trust, is now being discussed further to compliment the work that ECIST have started. Discussions with external colleagues to tailor the course to meet the needs of the patient flow programme are being pursued, which will empower staff to have conversations with patients/visitors etc. around the nationally recognised 4 questions, which will assist with discharge planning.

The patient flow project plan continues to be updated, with key areas of focus in the next month linked to:

- The intra hospital plan
- SAFER roll out and individual ward plans
- Ambulatory care pathway
- T&O Enhanced care pathway
- Action plan following ECIST workshops
- Breamore chair initiative (potential roll out in DSU)

A sub group continues to meet to develop the patient 'bed-side' literature to educate/raise awareness and empower patients across a number of areas, including 'discharge plans/arrangements'. The group has agreed a 3 sided format, with initial ideas being tested with patients and relatives, feedback has been received and revised ideas to be tested over next 2-3 weeks. The main areas of focus include eat, drink, move, 4 questions and communication.

The roll out of the national 'Eat, Drink, Move Campaign' in the Trust, continues to pick up pace on Spire ward. Training has been completed with ward staff to make them aware of the project and the importance of their role. Volunteers have been allocated to the ward, with training planned. The use of the newly refurbished day room on Spire and links with Elevate to support music/exercise is being worked through. KPIs have been identified, and include; patients sitting out of bed, reduction in hospital acquired pneumonia, dehydration and step count, with baseline data collected pre rollout. A full launch on spire ward is planned for 1 July 2019.

A review of existing processes within the IDB team continues, there is a clear understanding of where processes can be improved and the Head of IDB and PMO are jointly working together to identify new processes and a plan for implementation. As of the 13 May, the Fast track paperwork will now be completed at ward level and submitted through to CHC for approval, it is anticipated that this will increase the number of requests (patient criteria dependant) and speed up the process rom identification to approval being received, an area which has been supported by IDB facilitators up until now.

The Older People and frailty task and finish groups continue to meet to progress key areas of development (training/education, falls, implementation of the Comprehensive geriatric assessment, ReSPECT form roll out and the development of the RACE clinic model in South Wiltshire, training and awareness for all Trust staff. A further 2 GP meetings have been held in the North of the County to identify what future developments colleagues in primary care would like seen for the RACE clinic. Feedback following the workshop on the 5 will be provided in the June F&P report, alongside other areas highlighted, as a number of meetings are scheduled to continue to move this work forward. In addition a meeting is scheduled on the 11 June, as part of the STP programme of work to agree metrics across the STP for this work.

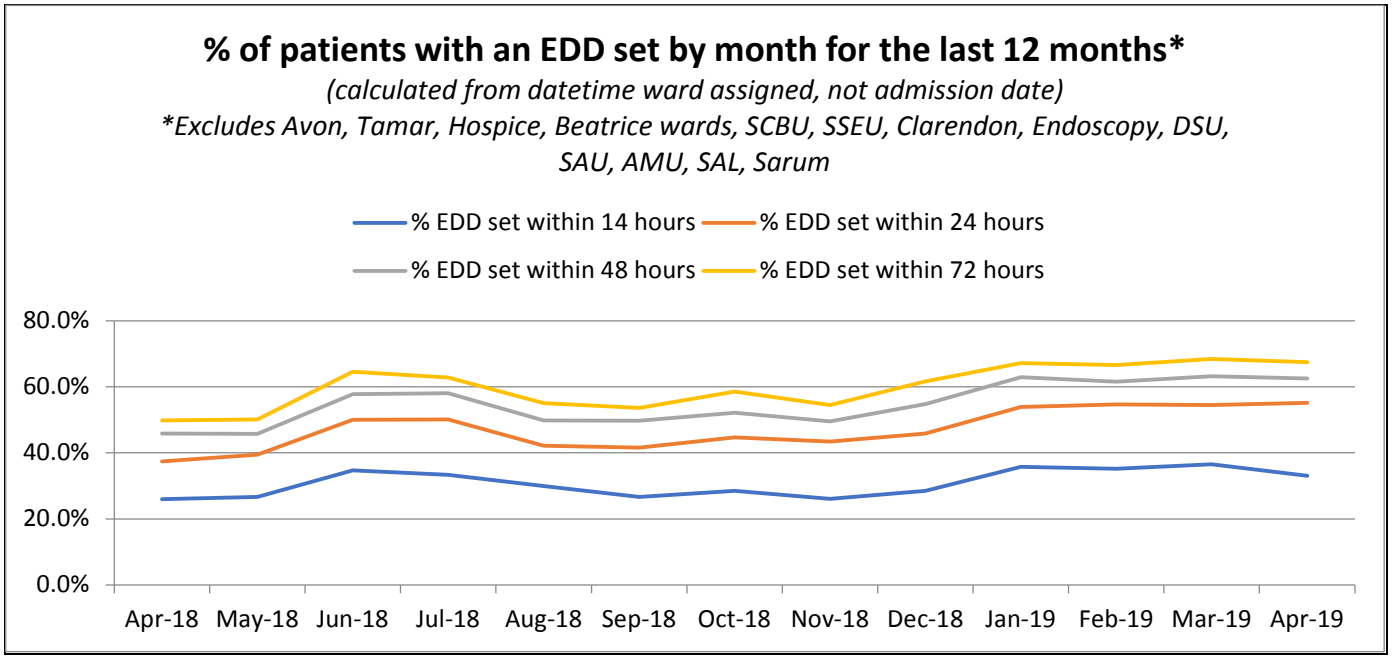
Further meetings with Salisbury Hospice colleagues have been set up and a core team are now working on mapping the current patient pathway to help with the development and defining of the future strategy. The business case for funding from the Better Care Fund for Hospice at Home Services is awaited. In addition, further discussions with Wiltshire CCG linked to CHC funding and West Hampshire CCG for potential service developments are being pursued.

The setting of EDDs continues to be monitored on a daily basis with the clinical site team printing lists of those patients with an EDD set for that date, and also those with no date set. As part of the SAFER roll out, we are supporting multi-disciplinary teams to set and review EDD's on a daily basis. This will ensure that all patients have an acurate and up to date EDD set. Further clarity is provided to wards on the definition of EDD and the setting of this via the e-whiteboard system, when the patient is medically fit or not medically fit.

The Intra hospital action plan continues to be monitored and actions progressed. One area of focus is in relation to the ordering of bariatric eqquipment for inpatients and for their onward discharge, whilst there has been progress, driven by PT/OT colleagues, further opportunities to improve this, have been identified

and will now be discussed and progressed further. The number of bariatric patients in the Trust at any time is steadily increasing and areas of development are linked to medequip processing and ordering, contract negotiation and education/awareness for ward staff. Improvements to this pathway have the potential to reduce LoS and improve the overall experience for patients.

Graph 22



Salisbury Hospital NHS Foundation Trust Board Report - April 2019

NHS Salisbury NHS Foundation Trust

			Reporting Month		Rolling 12 months
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Apr-19**	**Patients Affected in Apr-19**	**Trend Against National Standard**
Referral to Treatment Incomplete Performance	92%	STF = 92.0%	93.10%	1,175	
Referral to Treatment Incomplete Specialty Compliance	16 out of 16		9 out of 16		
Zero tolerance RTT waits > 52 weeks	0	0	0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Apr-19**	**Patients Affected in Apr-19**	**Trend Against National Standard**
A&E - 4 Hour wait from Arrival	95%	STF = 92.3%	**92.5%**	444	
A&E - 12 Hour Trolley Waits	0		0		
Diagnostics - Patients waiting less than 6 weeks	99%		98.66%	46	
Diagnostic Test Compliance*	10 out of 10		7 out of 10		
Urgent Ops Cancelled for 2nd time (Number)	0		0		
Delivering same sex accommodation	0		**26**		
Infection control – Clostridium difficile (YTD)	YTD: 1		YTD: 0	0	
Infection control - MRSA	0		0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Apr-19**	**Patients Affected in Apr-19**	**Trend Against National Standard**
All Cancer two week waits	93%		92.3%	72	
Symptomatic Breast Cancer - two week waits	93%		86.4%	6	
31 day wait standard	96%		97.1%	3	
31 day subsequent treatment : Drug	98%		100.0%	0	
31 day subsequent treatment : Surgery	94%		100.0%	0	
62 day wait standard from GP referral	85%		89.15%	7.0	
62 day wait standard from GP referral *(without shared care logic)*	85%		86.36%	9.0	
62 day screening patients	90%		85.0%	1.5	

Cells with black dotted outlines indicate provisional data

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

CLASSIFICATION
Unrestricted

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	**2.2.2**
Date of Meeting:	06 June 2019		

Report Title:	Quality indicator report – April 2019			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Christine Blanshard, Medical Director Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Quality indicator report – April 2019			

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

Executive Summary:
Positive indicators – good C difficile performance, SHMI of 100 within the expected range. Good stroke and TIA performance with a SSNAP score of B. Of concern – a rise in the weekend HSMR for the 4th 12 month rolling data point to significantly higher than expected to be investigated by a case notes review undertaken by a multidisciplinary team and reported to the Clinical Governance Committee in September 2019.

Board Assurance Framework – Strategic Priorities	
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐

1.0 Purpose

1.1 To provide the Board, Committees and Forums with the Trust's quality indicators.

2.0 Quality indicator report

2.1 No cases of hospital onset health care associated C Difficile cases. The Trust's C difficile upper limit for 19/20 is 9 cases. A new metric added of cases appealed and successful appeals for no lapses in care.

2.2 One MSSA bacteraemia - likely cannula related.

2.3 Three E Coli bacteraemias – currently under investigation of unrelated cases.

2.4 3 new serious incidents requiring investigation commissioned in April.

2.5 A decrease in crude mortality in April. Note: Deaths occurring in ED now included in the overall total. HSMR increased to 105.3 to January 19 and is within the expected range. SHMI is 100 to December 18 and when adjusted for palliative care is 94 to September 18. Both are within the expected range. Weekend HSMR increased for the 4th, 12 month rolling data period to 122.3 to January 19 and is significantly higher than expected range. A case notes review of patients admitted on a Saturday and Sunday with pneumonia, sepsis and patients with a 7 – 14 day LOS, a zero Charlson comorbidity score and aged 65 -74 will be undertaken by a multidisciplinary team to investigate the cause and improvement actions. The report will be presented to the Clinical Governance Committee in September 2019.

2.6 80% of hip fracture patients were operated on within 36 hours of admission.

2.7 Pressure ulcer are now reported in line with new national guidance. Pressure ulcers present on admission and hospital acquired are reported by category 2, 3 or 4, deep tissue injury (DTI), unstageable ulcer, moisture associated (MASD) and device related ulcers (d). SFT's Tissue Viability Team provides advice to community Tissue Viability and District Nurses on category 3 & 4 ulcers.

2.8 In April, 1 fall resulting in major harm (hip fracture treated surgically) and 1 fall resulting in moderate harm (fractured clavicle). A CQUIN with 3 high impact interventions to prevent hospital falls is underway and will be reported to the Falls Working Group and Patient Safety Steering Group.

2.9 Stroke patients receiving a CT scan within 12 hours sustained at 100%. Time to reach the stroke unit within 4 hours improved to 85% with delays due to first doctor assessment in ED (2) and waiting for a bed (2). Patients spending 90% of their stay in the stroke unit improved to 94% exceeding the national target of 80%. SSNAP case ascertainment audit – score B.

2.10 92% of high risk TIA patients seen within 24 hours of referral.

2.11 A reduction in the number of multiple ward moves in April with improvements in patient flow and ongoing work with multi-agency partners on stranded and super-stranded patients.

2.12 In April, 4 non-clinically justified mixed sex accommodation breaches in AMU affecting 26 patients. All were resolved within 12 – 24 hours. Privacy and dignity is maintained during these times with the use of quick screens and identification of separate bathroom facilities. Updated national guidance is anticipated soon.

2.13 Patients rating the quality of their care improved in April.

3.0 Summary

Positive indicators – good C difficile performance, SHMI of 100 within the expected range. Good stroke and TIA performance with a SSNAP score of B.

Of concern – a rise in the weekend HSMR for the 4th 12 month rolling data point to significantly higher than expected to be investigated by a case notes review undertaken by a multidisciplinary team and reported to the Clinical Governance Committee in September 2019.

Claire Gorzanski, Head of Clinical Effectiveness, 13 May 2019.

NHS Salisbury NHS Foundation Trust

Trust Quality Indicators - April 2019

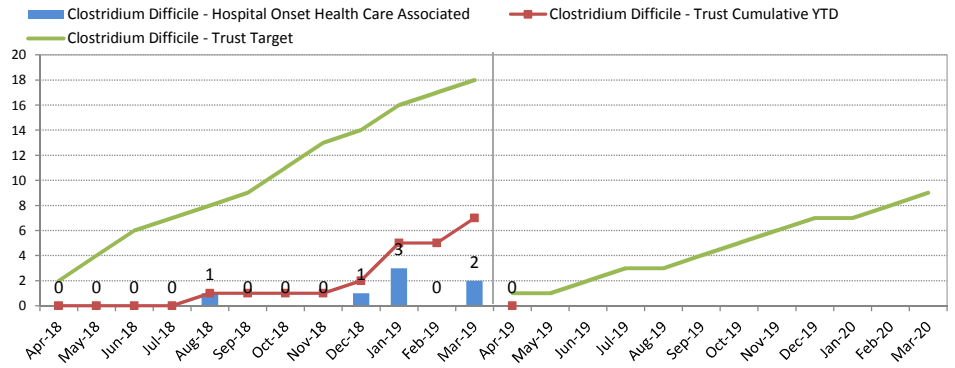
Quality Measures

Infection Control	*2018-19 YTD*	*2019-20 YTD*
MRSA (Trust Apportioned)	3	0

Trust Incidents	*2018-19 YTD*	*2019-20 YTD*
Never Events	3	0
Serious Incidents Requiring Investigation	35	3

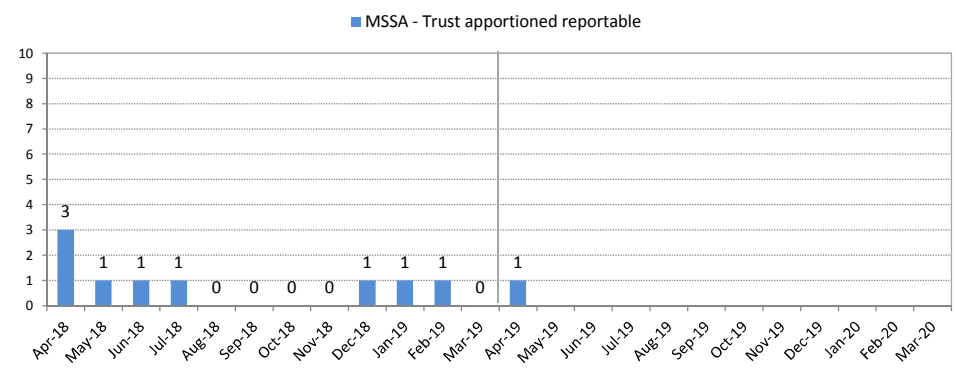
Clostridium Difficile	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Cases appealed	0											
Successful appeals	0											

Clostridium Difficile - Hospital Onset Health Care Associated

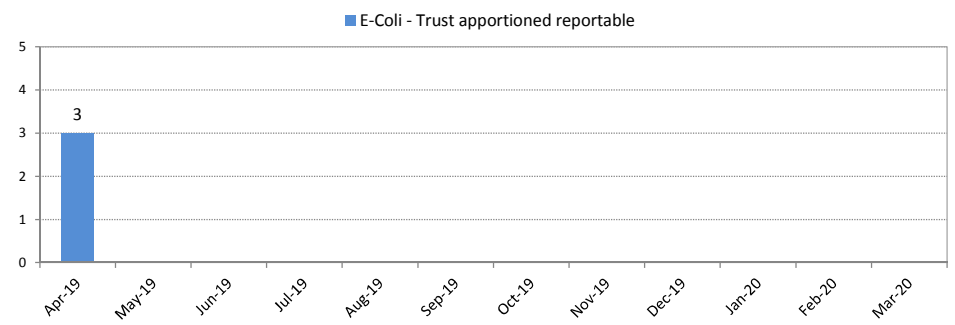


* December 2018 - Trust apportioned C difficile case – a successful appeal was made for no lapses in care to Somerset CCG and the number was removed from the Trust figures

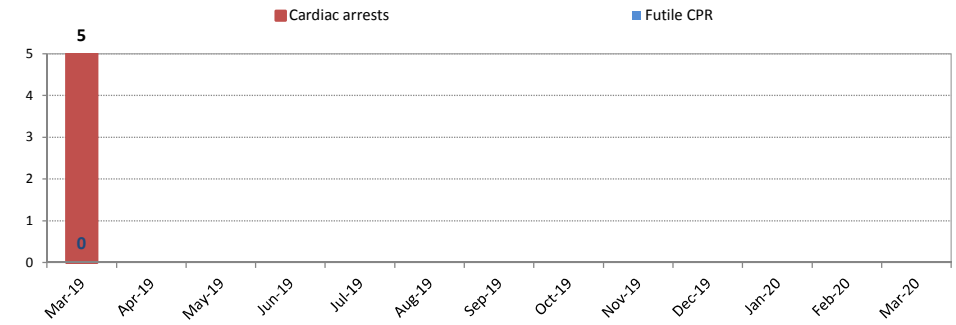
MSSA - Trust Apportioned



E-Coli - Trust apportioned reportable



In hospital cardiac arrests and futile CPR



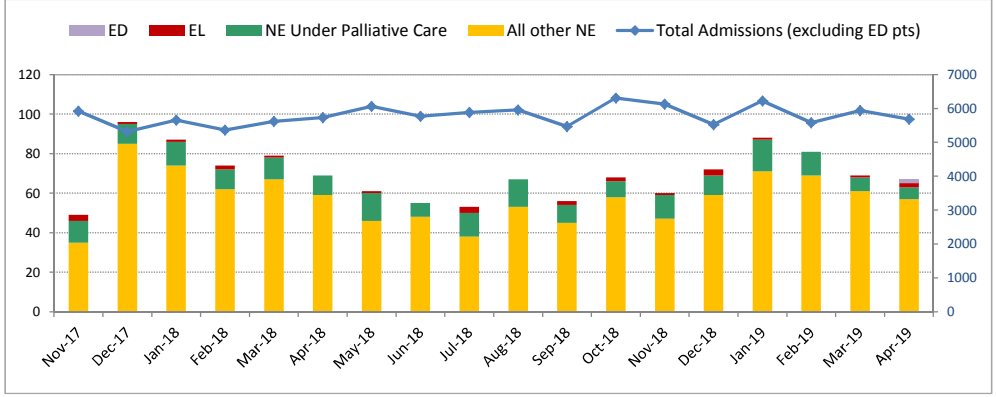
Please note cardiac arrests which occurred in ED, ITU, CCU and Paediatrics are excluded.

NHS Salisbury NHS Foundation Trust

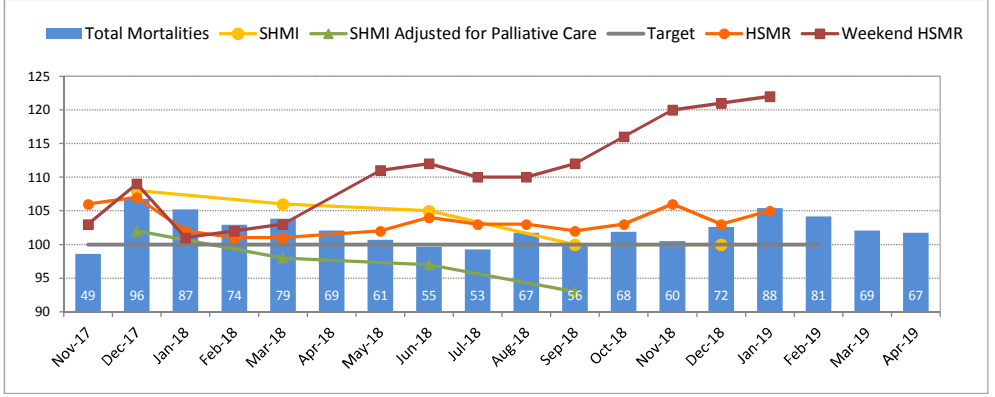
Trust Quality Indicators - April 2019

Quality Measures

Hospital Mortalities

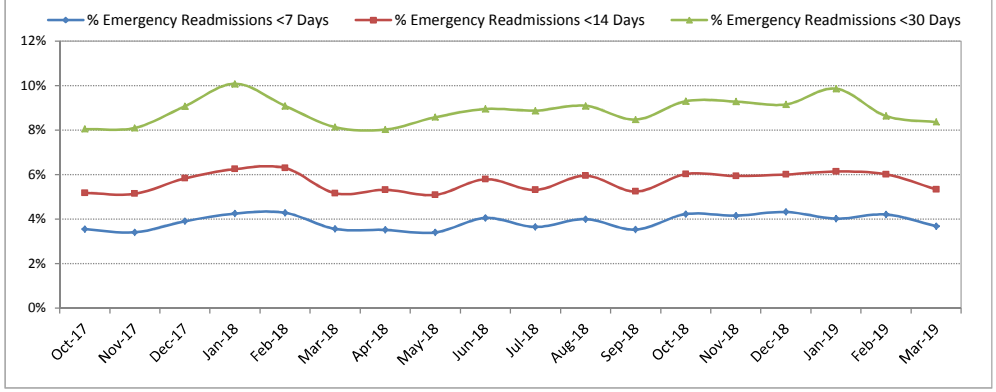


HSMR and SHMI

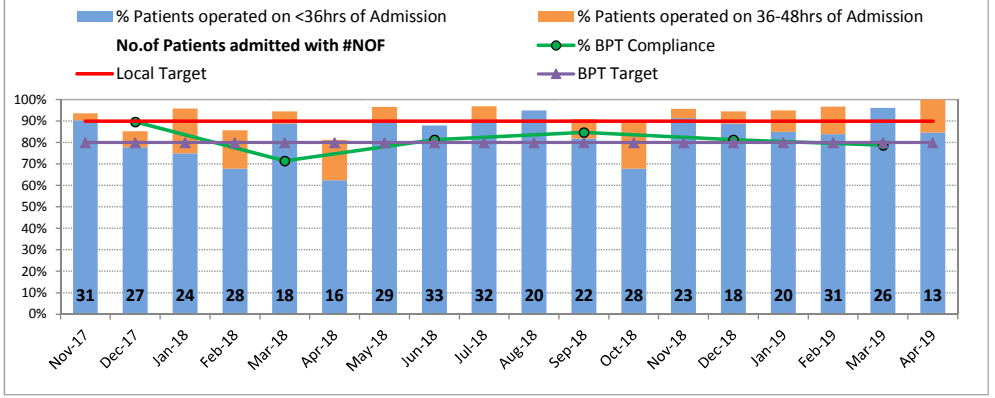


** From April 2019 Total Mortalities includes deaths in ED*

Emergency Readmissions within 7, 14 & 30 days of Discharge



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



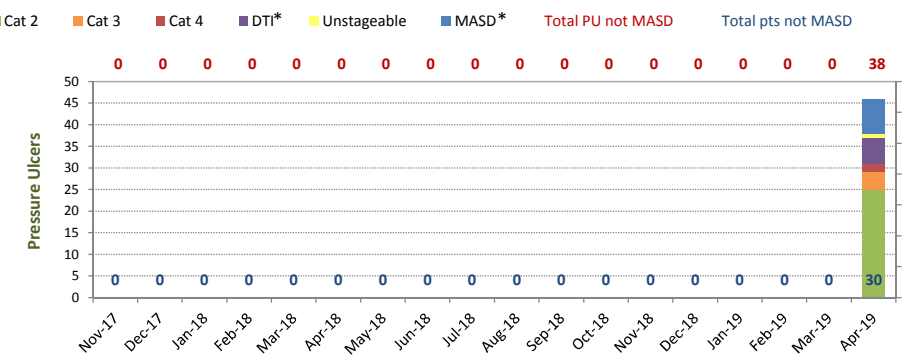
Please note, due to the time it takes to complete Clinical Coding, the current months Fracture Neck of Femur data will be subject to change over the following months.

NHS Salisbury NHS Foundation Trust

Trust Quality Indicators - April 2019

Quality Measures

Pressure Ulcers - Present on admission (POA)



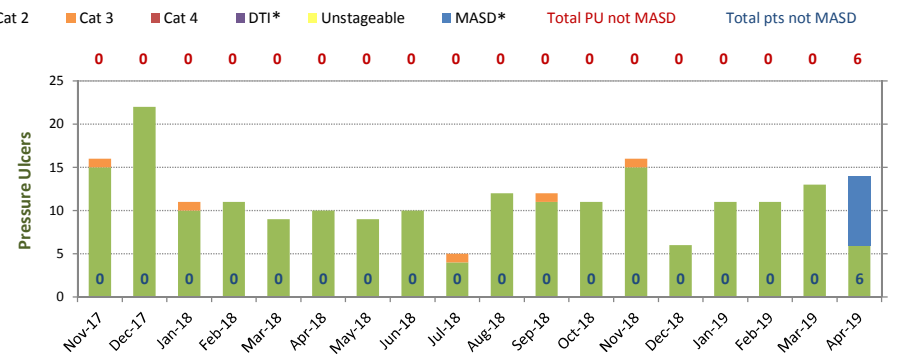
From the chart above, the following with (d) are device related

	Nov-17	Dec-17	Jan-18	Feb-18	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
Cat 2 (d)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cat 3 (d)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cat 4 (d)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DTI (d)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unstageable (d)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

* DTI - Deep Tissue Injury

* MASD - Moisture Associated

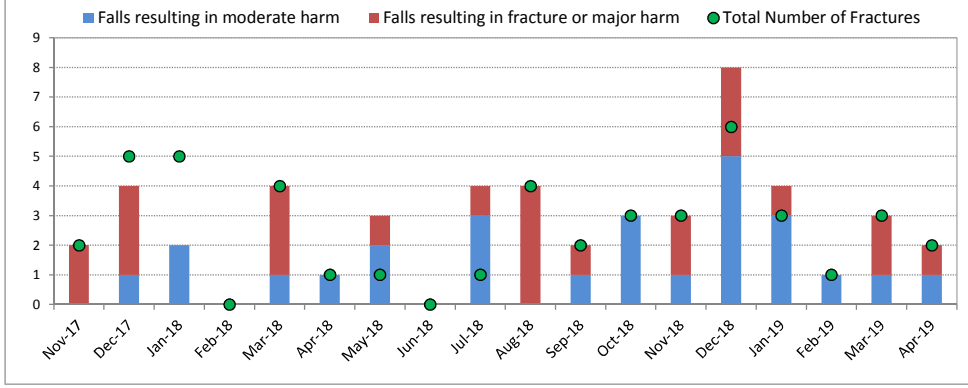
Pressure Ulcers - Hospital acquired (HA)



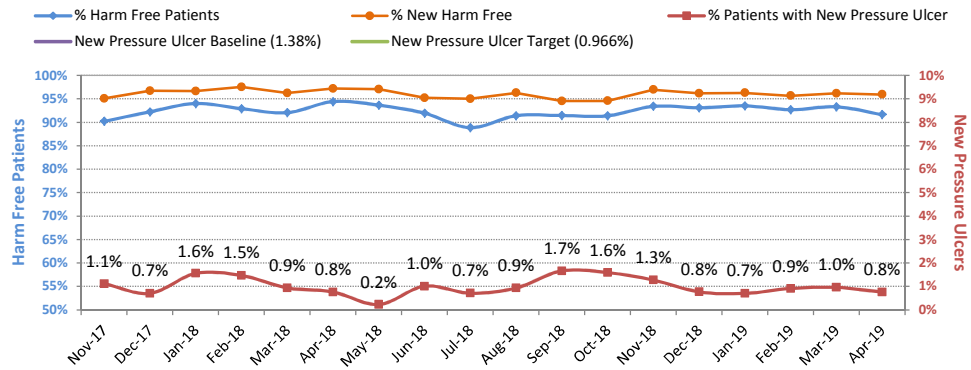
From the chart above, the following with (d) are device related

	Nov-17	Dec-17	Jan-18	Feb-18	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
Cat 2 (d)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Cat 3 (d)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cat 4 (d)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DTI (d)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unstageable (d)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Patient Falls in Hospital



Safety Thermometer - One Day Snapshot per Month

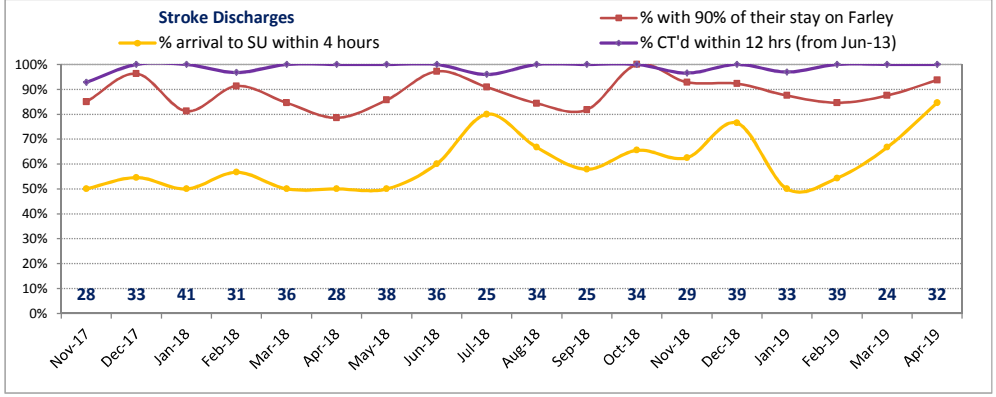


NHS Salisbury NHS Foundation Trust

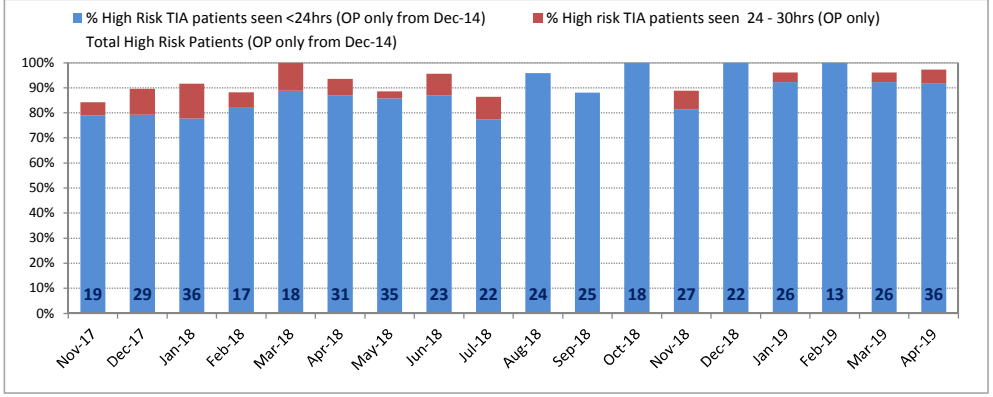
Trust Quality Indicators - April 2019

Quality Measures

Stroke Care



TIA Referrals



SSNAP Case Ascertainment Audit

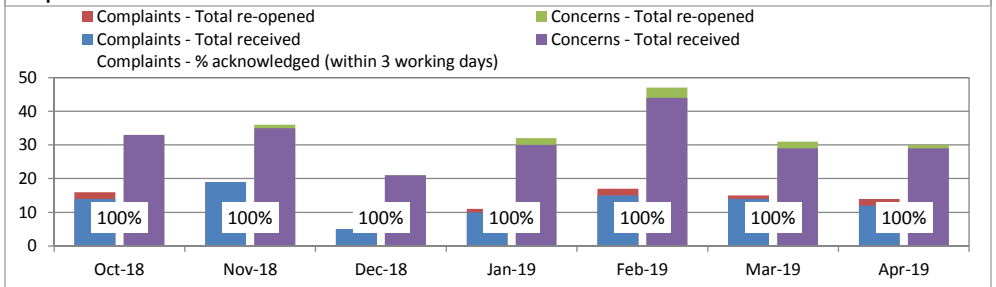
Highest level = Grade A

Lowest level = Grade E

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

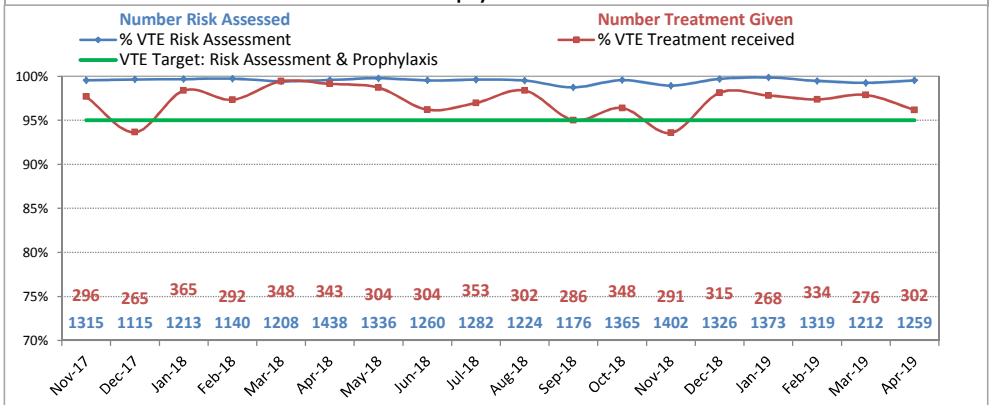
Quarterly	Q1	Q2	Q3	Q4
2018-19	B	C	B	
2019-20				

Complaints and Concerns



	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Complaints - Total received	14	19	5	10	15	14	12
Complaints - Total re-opened	0	2	0	1	2	1	2
Concerns - Total received	35	33	21	30	44	29	29
Concerns - Total re-opened	1	0	0	2	3	2	1

Venous Thrombous Embolism: Risk Assessment & Prophylaxis



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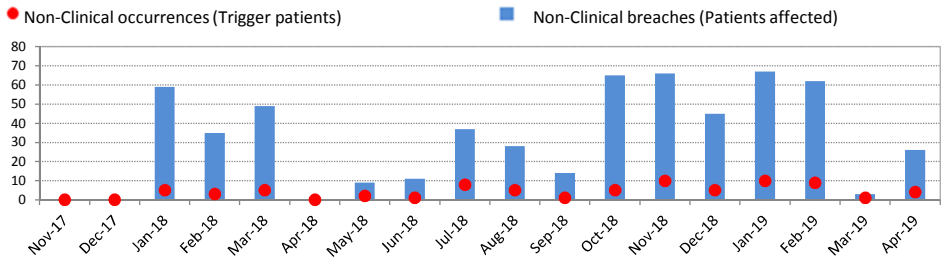
Trust Quality Indicators - April 2019

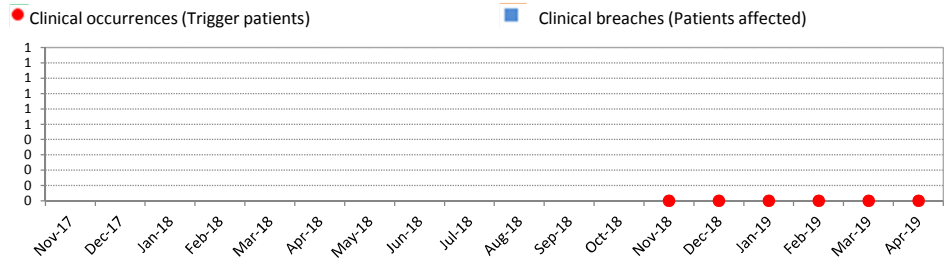
Quality Measures

Delivering Same Sex Accommodation - Non-clinical



	Nov-17	Dec-17	Jan-18	Feb-18	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
■	0	0	59	35	49	0	9	11	37	28	14	65	66	45	67	62	3	26
●	0	0	5	3	5	0	2	1	8	5	1	5	10	5	10	9	1	4

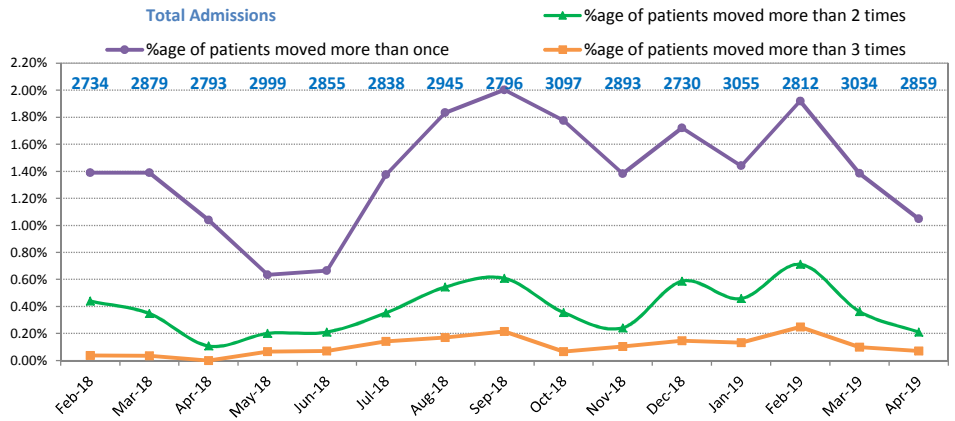
Delivering Same Sex Accommodation - Clinical



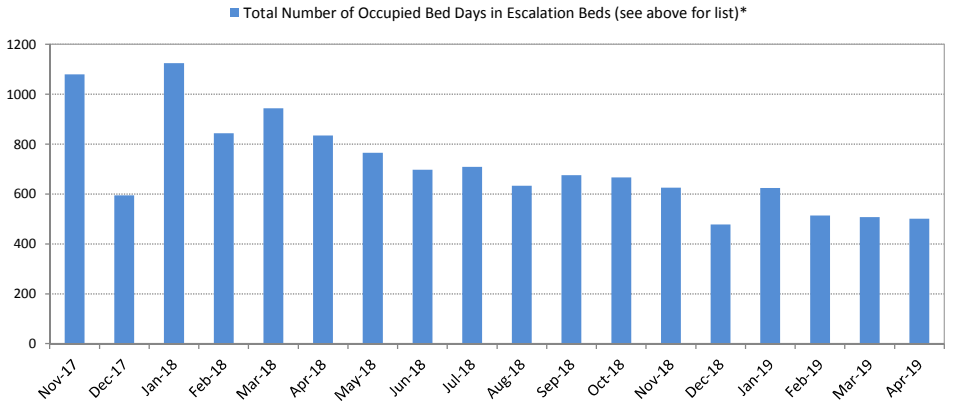
	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
■													0	0	0	0	0	0
●													0	0	0	0	0	0

Please note Clinical DSSA figures have been collected since June 2018

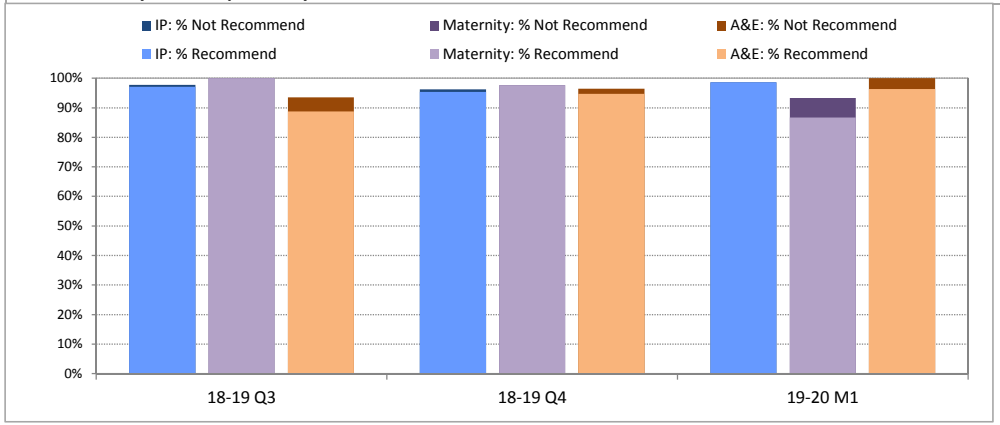
Patients moving multiple times during their Inpatient Stay

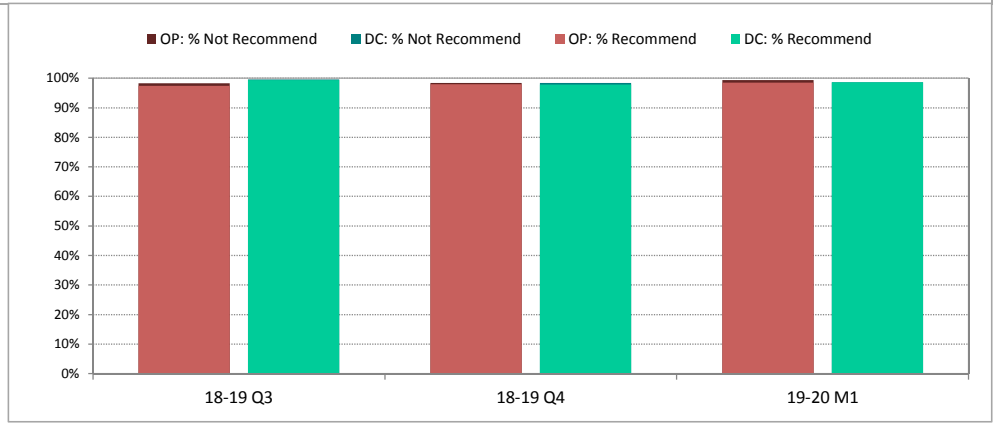


Escalation Bed Days

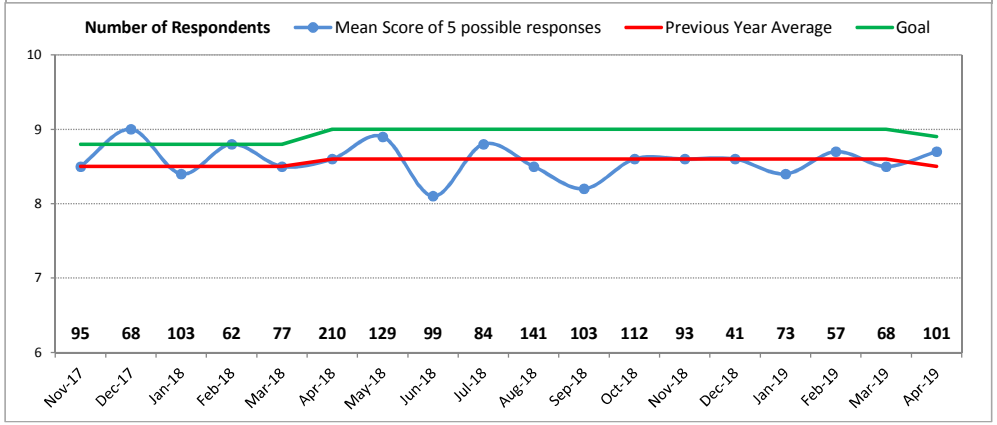


Friends & Family Test: Responses by Area

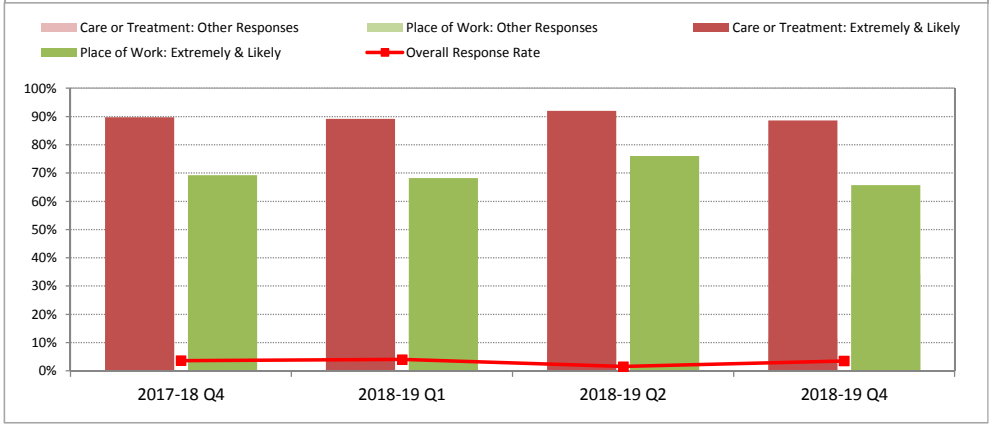




Real Time Feedback: Overall how would you rate the quality of care you received?



Friends & Family Test: Staff (% Responses)



The new score measures the % Recommended (Likely + Extremely Likely) and the % Not Recommended (Unlikely + Extremely Unlikely) to show the percentage of responses that would or wouldn't recommend the Trust.
Don't Know and Neither Likely or Unlikely responses are excluded from this measure.
From October 2014 the Net Promoter Score (NSP) will no longer be used as a headline score. NHS England have confirmed that FFT statistical publications will move to using the percentage of respondents that would recommend / wouldn't recommend the service provided, in place of the NSP. This percentage is calculated by dividing the Extremely Likely + Likely responses by the Total Responses, and the same for Extremely Unlikely + Unlikely. These two measures will not always total 100%.

NHS
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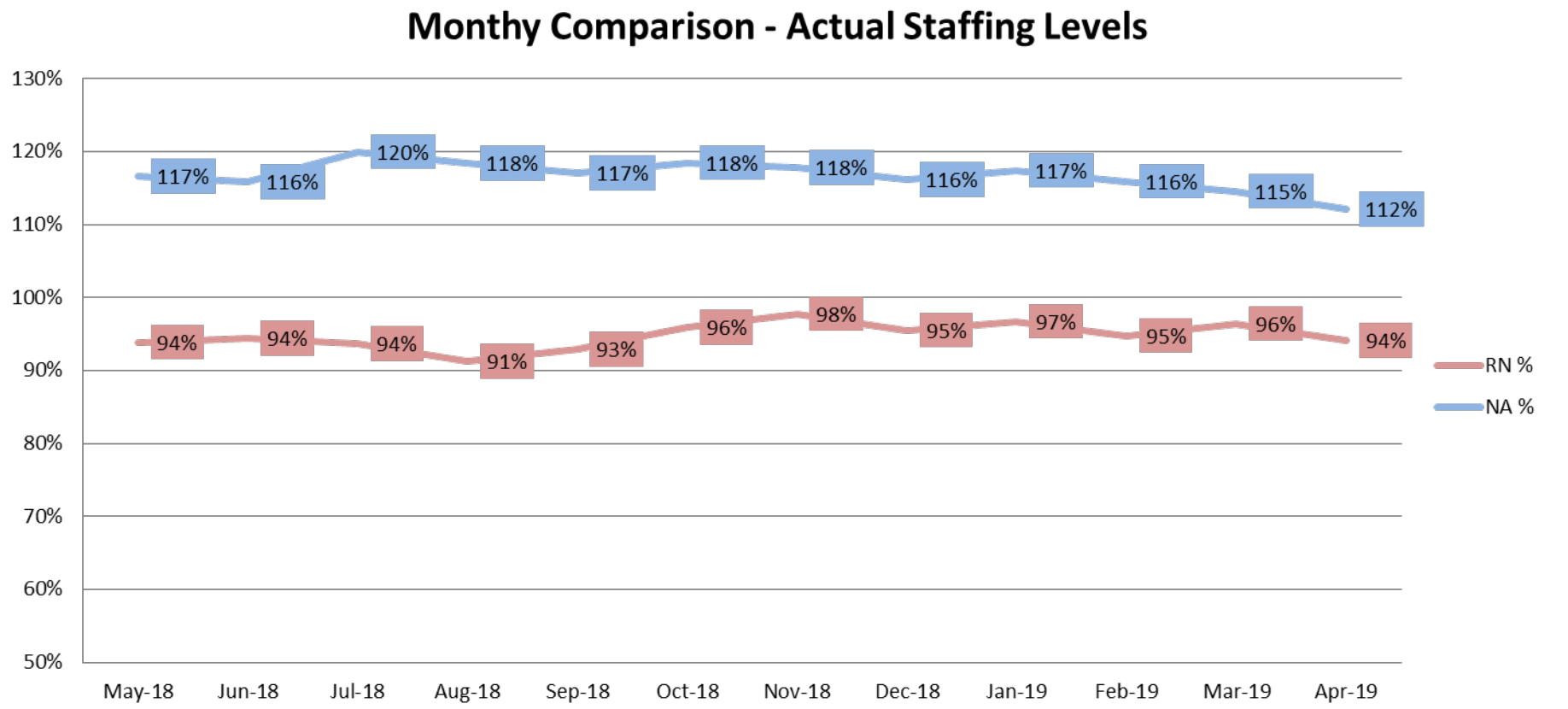
Safe Staffing NQB Report

April 2019

An outstanding experience for every patient

Monthly Comparisons – Actual Staffing Levels

	Registered Nurses			Nursing Assistants			Combined			Skill Mix	
Month	**Planned hours**	**Actual Hours**	**%**	**Planned Hours**	**Actual Hours**	**%**	**Planned Hours**	**Actual Hours**	**%**	**RN**	**NA**
April -19	60654	57051	94%	32469	36396	112%	93123	93447	100%	61%	39%



Overview of Nurse Staffing Hours – April 2019

Day	RN	NA
Total Planned Hours	36659	20237
Total Actual Hours	33941	22280
Fill Rate (%)	93%	110%

Night	RN	NA
Total Planned Hours	23995	12232
Total Actual Hours	23110	14116
Fill Rate (%)	96%	115%

The percentage hours are based on actual versus planned and are measured on a shift by shift basis.

Nursing Hours by Day Shifts

Row Labels	Day RN Planned	Day RN Actual	Day RN Fill Rate	Day NA Planned	Day NA Actual	Day NA Fill Rate
Medicine	**15487**	**14243**	**93%**	**10485**	**12166**	**114%**
AMU	2032	2243	110%	1403	1348	96%
Durrington	1193	1039	87%	867	1139	131%
Farley	2096	1705	81%	1434	1833	128%
Hospice	899	1010	112%	870	853	98%
Pembroke	909	897	99%	356	352	99%
Pitton	1817	1614	89%	1090	1283	118%
Redlynch	1563	1445	92%	1096	1129	103%
Tisbury	2124	1938	91%	688	698	102%
Whiteparish	1315	1062	81%	1022	1328	130%
Spire	1541	1292	84%	1661	2205	133%
Surgery	**7305**	**7110**	**97%**	**3049**	**3367**	**119%**
Britford	2002	1984	99%	1091	1240	114%
Downton	1329	1285	97%	925	879	95%
Radnor	2777	2697	97%	340	585	172%
Breamore Short Stay	1197	1144	96%	693	663	96%
MSK	**7865**	**6977**	**89%**	**6359**	**6416**	**103%**
Amesbury	1761	1633	93%	1382	1342	97%
Avon	1546	1368	89%	1752	1658	95%
Chilmark	1632	1568	96%	1095	1126	103%
Odstock	1572	1315	84%	727	872	120%
Tamar	1355	1093	81%	1403	1419	101%
CSFS	**6001**	**5611**	**95%**	**345**	**331**	**99%**
Maternity	2924	2525	86%	0	0	100%
NICU	1111	1084	98%	0	0	100%
Sarum	1966	2003	102.0%	345	331	96%
Grand Total	**36659**	**33941**	**93%**	**20237**	**22280**	**110%**

Key:	Less than 80%	Between 80 - 90%	Between 90 - 115%	Greater than 115%

Nursing Hours by Night Shifts

Row Labels	Night RN Planned	Night RN Actual	Night RN Fill Rate	Night NA Planned	Night NA Actual	Night NA Fill Rate
Medicine	**9979**	**9621**	**97.2%**	**5795**	**7616**	**127%**
AMU	1479	1481	100%	690	696	101%
Durrington	690	679	98%	690	828	120%
Farley	1035	955	92%	690	1070	155%
Hospice	570	570	100%	285	276	97%
Pembroke	690	694	101%	345	345	100%
Pitton	1378	1220	89%	690	874	127%
Redlynch	1035	1001	97%	690	966	140%
Tisbury	1380	1289	93%	345	414	120%
Whiteparish	690	713	103%	690	874	127%
Spire	1033	1022	99%	680	1274	187%
Surgery	**4740**	**4725**	**101%**	**2415**	**2483**	**102%**
Britford	1026	1037	101%	690	774	112%
Downton	690	713	103%	690	690	100%
Radnor	2335	2286	98%	345	332	96%
Breamore Short Stay	690	690	100%	690	687	100%
MSK	**4321**	**4089**	**95%**	**4022**	**4006**	**100%**
Amesbury	1035	1032	100%	1035	978	94%
Avon	1035	955	92%	1035	1037	100%
Chilmark	571	560	98%	572	612	107%
Odstock	1002	853	85%	690	702	102%
Tamar	679	690	102%	690	679	98%
CSFS	**4955**	**4675**	**96%**	**0**	**12**	**100%**
Maternity	2751	2510	91%	0	0	100%
NICU	1034	1041	101%	0	0	100%
Sarum	1171	1125	96%	0	12	100%
Grand Total	**23995**	**23110**	**96%**	**12232**	**14116**	**115%**

Key:	Less than 80%	Between 80 - 90%	Between 90 - 115%	Greater than 115%

Overview of Areas Flagging Red

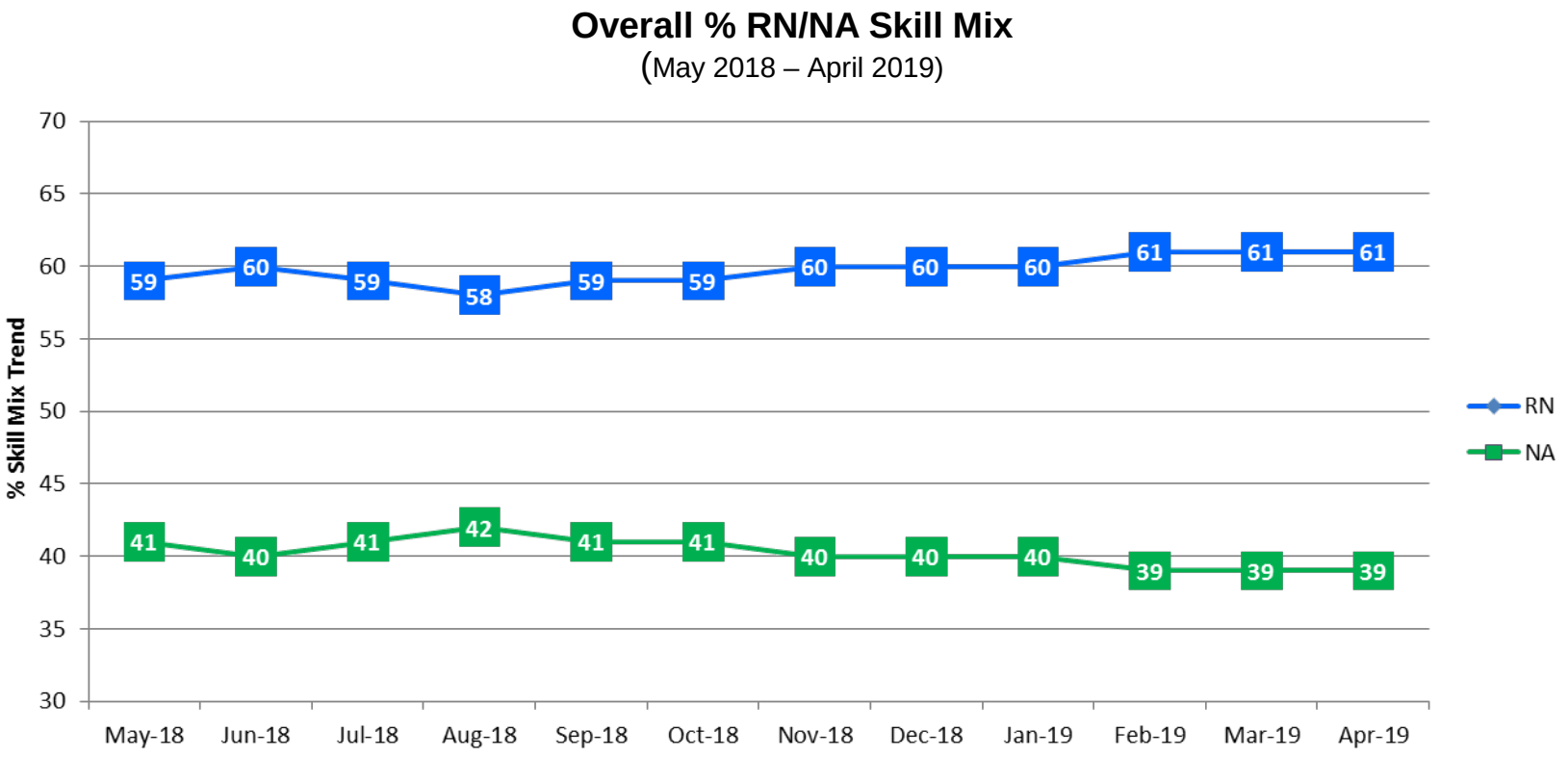
(Internal Rating Below 80%)

- There are no wards flagging Red for the second reporting month

- 8 wards are flagging for Amber for day shifts during April (plus Maternity).
- Some unfilled shifts are for Band 4 staff who currently sit within the NA mix, but are a hybrid role between band 5 and 2. These staff are skilled workers. A future system upgrade will amend this process within Eroster and should mitigate this issue.
- There is a high level of maternity/paternity leave across the Trust accounting for some of the drop in RN fill rate
    - All unfilled shifts are for RN /RM day shifts with two exceptions:
        - Odstock ward RN night shift fill rate at 85%
        - Pitton RN nights at 89%. (1 % under the acceptable internal rating of 90% for green)
    - NA overstaffing supports the uplift in staffing numbers to support the delivery of safe care. Many of these were locally skilled NA staff either at Band 3 or Band 4 (AP) staff who are rostered at NA level
    - All areas support the safe delivery of care by using other staff groups who are available during the day on an ad-hoc basis.

NB: Flags based on green 90% and above, amber 80-90%, red below 80% - no ratings yet agreed by NHS England

Trends and Themes



The skill mix trend for both RN & NA has been consistent for 3 reporting months now at RN 61% /NA 39% evidencing some sustainability

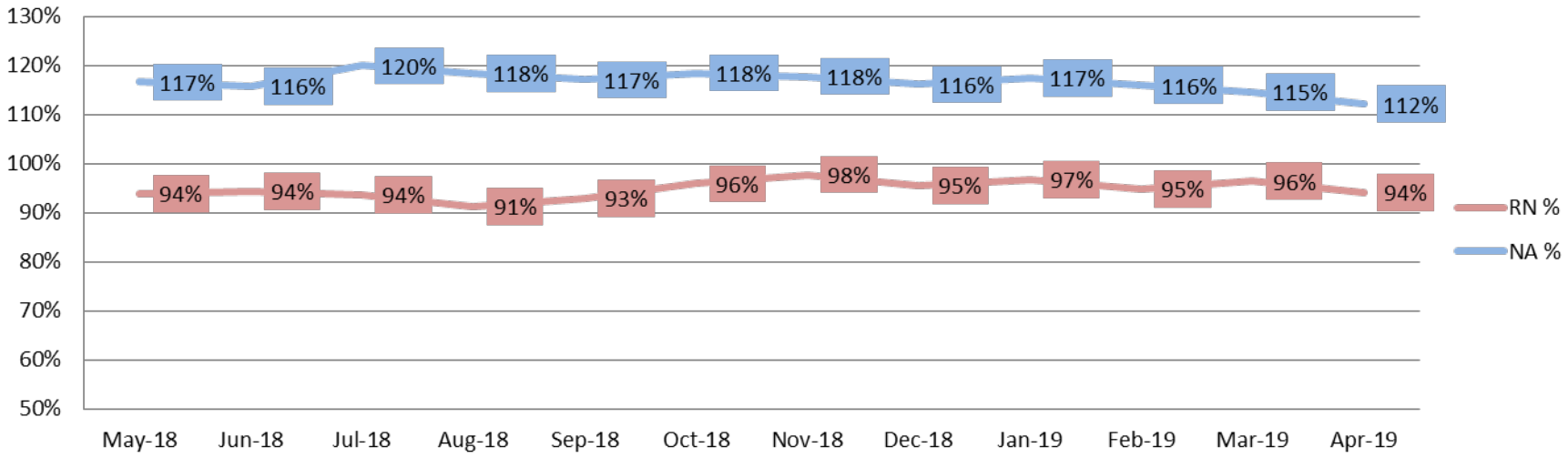
STAFFING NOTES

The reporting percentage *includes day time Ward Leader supervisory shifts* to reflect the continued demand for them to provide on-going clinical support from within this role & comply with CHPPD mandatory reporting . Whilst shifts may remain unfilled, staff of this calibre help guarantee the presence of high level skills sets to support the provision of safe care against existing challenges.

Themes and Trends

RN/NA Actual % Shift Fill Rate (Combined Day and Night)

(May 2018 – April 2019)



- The overall RN fill rate demonstrates a 2% reduction for this reporting month to 94%. This reflects the same RN levels experienced during May – July last year.

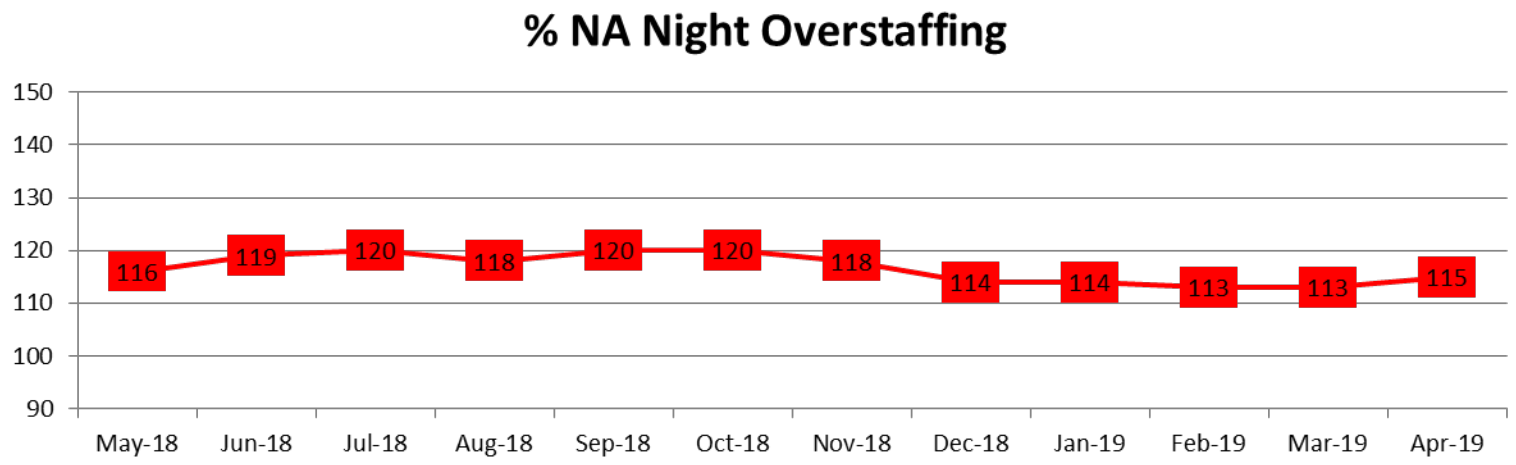
- The NA fill rate trend is at its lowest level for the reporting year and evidences a decrease for the 3rd consecutive month now at 112%.
-
- NA day shift fill rates continues to evidence overstaffing. This is where Band 4 (recorded as NA) or increased NA staff bolster shift numbers, some is where permitted over recruitment has taken place. Band 4 staff continue to be used where patients need enhanced care or to cover RN unfilled shifts.

- RN night shifts evidence a 96% fill rate with flexible rostering being used to ensure the focus is on the priority of RN cover at night at a time when temporary staff may be less familiar with patient needs and cover is more challenging and expensive.

Unfilled shifts:- often there is utilisation of alternative grade cover. Some shifts may remain unfilled but are managed within the existing skills sets. All are based on assessing staffing skills & numbers against patient acuity and demand to ensure they are both manageable and the provision of safe care.

Over-staffing

- Additional shifts are evidenced for both for NA night & day shifts.
- Some NA uplift continues for day shifts due to various permitted NA over-recruitment accounting for increased numbers.
- NA overstaffing at nights was mainly for medical wards (Durrington, Farley, Pitton ,Redlynch, Tisbury, Whiteparish and Spire) plus ICU (where the small numbers involved exaggerate the percentage) and Odstock ward.
- This needs to be considered in the context of the previous slide where the overall NA fill rate is demonstrated at its lowest level for the reporting year with a 3 month consistent decrease.
- The overall trend for NA overstaffing on nights shifts reflects the RN reduction to 96% fill rate on nights where locally skilled NA staff were used to bolster some shifts



The reasons for NA Overstaffing remains the same Enhanced 1:1 care for patients at risk of falls, mental health needs or confusion

1. Flexing bed stock and staffing levels to meet fluctuating patient demands
2. Supporting RN shifts.
3. Permitted over -recruitment

Actions taken to mitigate risk

The nurse-in-charge of individual wards in discussion with the DSN/ADSN review the following on a shift by shift basis.

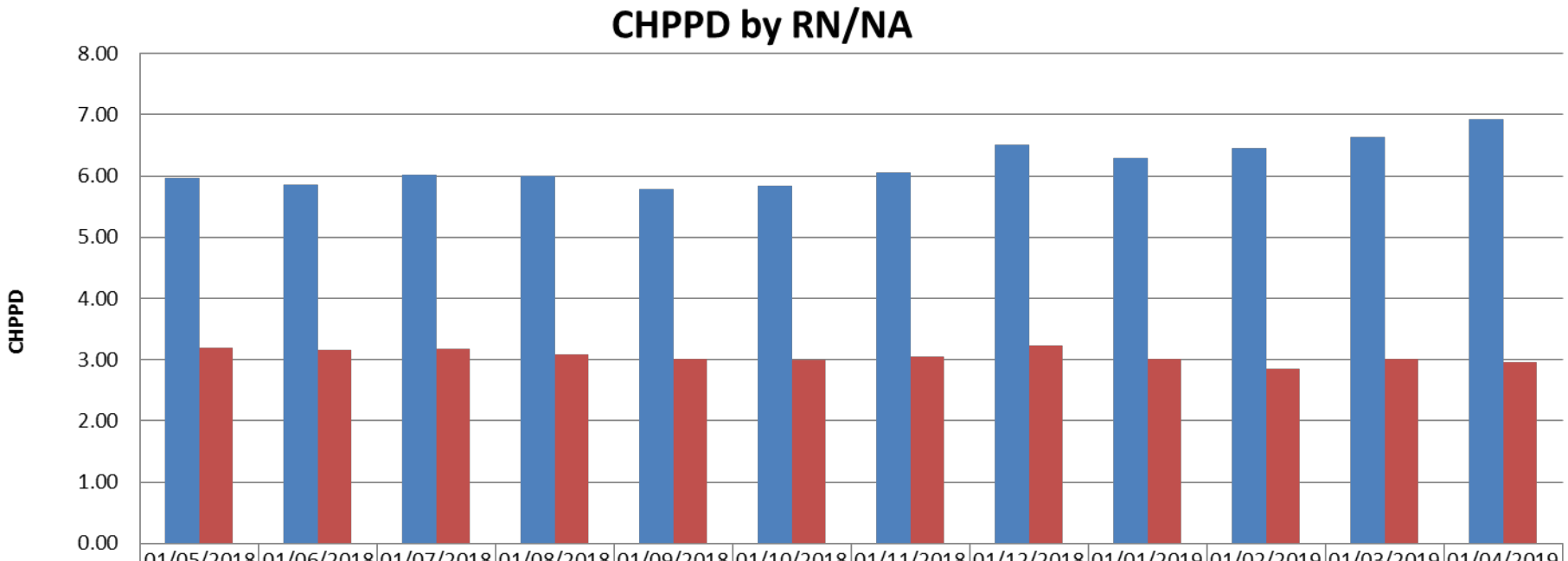
- The accounting of the staff skills set when deciding on the band of staff needed.
- Staffing is discussed via SafeCare using Shelford methodology at least twice daily with senior nurses in attendance.
- All shifts are gauged with staff moved across wards by Directorate Senior Nurses and Clinical Site Team as required. This ensures safe levels of care are maintained whilst trying to reduce reliance on expensive temporary staff
- Staffing levels are reduced when beds empty/ procedure lists reduced whilst maintaining appropriate staffing ratios
- Shifts that are difficult to cover (nights and weekends) are prioritised.
- If all of the above measures have been taken there may be a requirement that staff on training days are brought back to work clinically as required and / or Sisters on supervisory shifts work clinically.
- CCOT team support wards where acuity of patients high.

Internal CHPPD Reporting

Internal CHPPD

Monthly Trust aggregated figures showing Year Trend

Period :- **May 2018 – April2019**



	01/05/2018	01/06/2018	01/07/2018	01/08/2018	01/09/2018	01/10/2018	01/11/2018	01/12/2018	01/01/2019	01/02/2019	01/03/2019	01/04/2019
RN CHPPD (avg)	5.97	5.86	6.03	6.01	5.78	5.83	6.06	6.52	6.28	6.46	6.64	6.92
NA CHPPD (avg)	3.19	3.15	3.18	3.09	3.02	2.99	3.04	3.22	3.01	2.85	3.01	2.96

The CHPPD calculation is made over a whole month :- total actual hours vs the total number of patients at midnight.

CHPPD
April 2019

Inpatient Ward Breakdown

Row Labels	RN CHPPD	NA CHPPD	Overall CHPPD
Medicine	**4.2**	**3.2**	**7.4**
AMU	6.4	3.5	9.9
Durrington	3.0	3.4	6.4
Farley	3.3	3.6	6.9
Hospice	7.0	5.0	12.0
Pembroke	5.6	2.5	8.1
Pitton	3.6	2.7	6.3
Redlynch	3.2	2.7	6.0
Spire	2.6	3.9	6.5
Tisbury	4.8	1.7	6.4
Whiteparish	2.6	3.3	5.9
Surgery	**10.7**	**3.7**	**14.4**
Britford	5.8	3.9	9.6
Breamore Short Stay	3.7	2.7	6.4
Downton	3.2	2.5	5.7
Radnor	30.4	5.6	36.0
MSK	**3.5**	**3.3**	**6.8**
Amesbury	3.3	2.8	6.1
Avon	3.7	4.3	7.9
Chilmark	3.5	2.8	6.3
Odstock	4.5	3.2	7.7
Tamar	2.9	3.4	6.2
CSFS	**16.5**	**0.6**	**17.1**
Maternity	16.8	0.0	16.8
NICU	16.5	0.0	16.5
Sarum	16.3	1.8	18.1
Grand Total	**6.9**	**3.0**	**9.9**

N.B.

- Comparisons need to be viewed with caution i.e. Radnor where the nurse/patient ratio is widely different

Report to:	Trust Board (Public)	**Agenda item:**	2.2.4
Date of Meeting:	06 June 2019		

Report Title:	Workforce Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Mark Geraghty, Head of Workforce Information & Planning Glennis Toms, Deputy Director of OD and People			
Executive Sponsor (presenting):	Paul Hargreaves, Director of OD and People			
Appendices (list if applicable):	Executive Summary of Key Workforce Performance Month 1 Workforce KPIs Month 1 2019/20 Workforce KPI Heat Maps Month 1 2019/20			

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

Executive Summary:
The Executive Summary of Key Workforce Performance and the Month 1 Workforce Dashboard (see appendix) details the Trust's performance against the key workforce indicators. The pay bill is underspent by £337k year to date. Agency spend has decreased in month by £154k to £384k, with reductions in all staff groups, with the largest reductions in Registered Nursing (£70k), Consultant Medical Staff (£28k) and Allied Health Professionals (£22k). The Trust's sickness rate is Amber, over the 3% target in this month at 3.45%, and the year to date rolling absence figure is at 3.41%. Compared to last month's figure of 3.38%, both short and long term sickness have increased slightly. There were 45 starters in April, and slight decrease in leaver numbers at 22. FTE turnover increased to 9.20%, although still below the 10% target.

	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	☒

1. Purpose

This report provides the position against workforce key performance indicators at Trust level, with trend analysis over time, and sets out actions underway or necessary to achieve targets.

2. Background

Month 1 data shows a £337k underspend on the pay bill year to date. Underspend on substantive staff e.g. Nursing due to vacancy levels, is offset by an overspend on temporary staffing.

Agency spend has decreased by £154k to £384k, sickness absence has increased to 3.45% and the vacancy rate has decreased slightly from 5.93% in month 12 to 5.91% in month 1.

Mandatory training compliance remains green at 92.19%. Appraisal compliance for non-medical staff is green at 86.70%, an improvement on last month's compliance total of 86.00%.

Appraisal compliance for medical staff is above the 90% target at 90.65%, a deterioration on last month's compliance rate of 92.62%.

3. Resourcing:

3.1. Recruitment & Retention Strategy

The Strategy is in draft and being consulted upon internally before going out to a wider audience. Once ratified it will be approved at Workforce Committee in July.

3.2. 95/5 fill across all staff groups

Nursing remains a challenging area to recruit; using the Month 1 baseline, the Trust needs to recruit 32.8 wte ward nurses to achieve a fill rate of 90% of establishment. Over the last year the Trust has recruited an average of 10.6 ward nurses per month, with 6.1 WTE leaving. This figure includes those who reduced to zero hours contracts.

If ward nurse recruitment remains at 10.6 wte per month (on average), it would take 8 months to reach our revised target of 90% establishment fill.

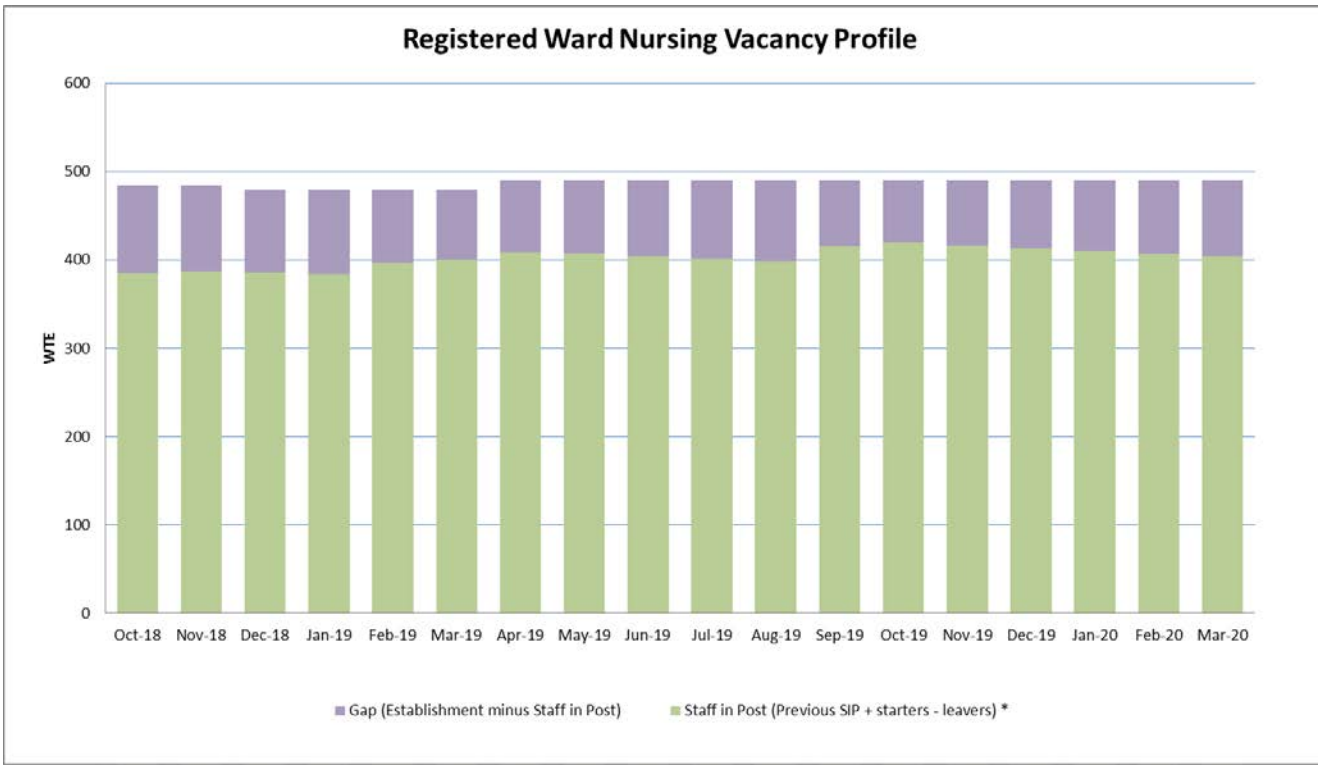
The recruitment pipeline for all groups of staff, from May to July 2019, shows increasing vacancies, from the current 197 to 203, and taking into account predicted turnover. Of this total, Registered Nursing vacancies are forecast to reduce from 132 to 121, including nurses due to commence in May.

Nursing Summary

An increase in establishment by 11.17 FTE occurred in April 2019 due to the introduction of additional posts in ED, AMU, Pitton and Amesbury.

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Prediction	Prediction	Prediction	Prediction	Prediction
Ward Registered Nursing FTE	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**
Total Ward Nursing Leavers, Transfers, Hours Reductions	7.61	6.12	9.49	7.75	2.83	2.43	6.09	6.05	6.05	6.05	6.05	6.05
International Recruits Due to Arrive	**0.00**	**0.00**	**0.00**	**0.00**	**9.00**	**5.00**	**8.00**	**9.00**	**6.00**	**6.00**	**6.00**	**6.00**
International Nurses Arrived and Pending OSCE	**22.20**	**28.49**	**19.41**	**13.00**	**6.00**	**18.00**	**19.00**	**19.00**	**6.00**	**6.00**	**6.00**	**6.00**
International Nurses Passed OSCE (in Month)	**0.00**	**0.00**	**0.00**	**0.00**	**12.00**	**1.00**	**10.00**	**2.00**	**0.00**	**0.00**	**0.00**	**0.00**
Newly Qualified	**12.80**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**	**0.00**	**0.00**	**20.00**
Other Recruitment Hrs Increases etc (from induction lists	**3.08**	**8.43**	**7.48**	**6.65**	**3.46**	**5.16**	**4.23**	**2.00**	**3.00**	**3.00**	**3.00**	**3.00**
Budgeted Establishment *	484.83	484.83	479.27	479.27	479.27	479.27	490.44	490.44	490.44	490.44	490.44	490.44
Staff in Post (Previous SIP + starters - leavers) *	384.87	387.18	385.17	384.07	396.70	400.43	408.57	407.52	404.48	401.43	398.39	415.34
Gap (Establishment minus Staff in Post)	99.96	97.65	94.10	95.20	82.57	78.84	81.87	82.92	85.96	89.01	92.05	75.10

The vacancy profile is shown in the following table:



Voluntary Services

- Volunteering applications from Helpforce and Daily Mail campaign have been released to us. We have received 42 enquiries and will begin to process these.
- Physiotherapy Study Day planned for 18th April 2019.

- Work Experience applications are again available with closing date for completed form to be returned of 30th April 2019.
- Current volunteer numbers are as follows:

Month	Total No. of Volunteers registered	Total No. of Volunteers currently deployed	Total No. of new applications	Total No. of new starters	Total No. of new Department requests	No. of outstanding Department requests
April 19	728	In process of being collated.	7	4	0	17xTrustwide 15 x Engage

3.3. TRAC Implementation

Month	Total number of WTE vacancies advertised in Month	Total number of offers processed in Month in WTE	Average days from vacancy authorised to start date (Overall Recruit to hire)
Target			**60**
Aug-18	73.82	35.94	
Sep-18	87.79	62	
Oct-18	116.4	70.52	
Nov-18	132.09	80.3	
Dec-18	35	12.69	
Jan-19	32.4	46.68	
Feb-19	38.57	37.59	
Mar-19	82.57	20.53	**74.80**
Apr-19	80.46	67.77	**68.00**

3.4. Retention Programmes

Staff turnover is below our 10% target, and increased slightly at 9.20% compared to last month's 9.04%.

Exit questionnaire responses (only 1 received) have been very disappointing this month, although we will be writing to everyone who has voluntarily left in the last 6 months.

In terms of our commitment to the 4th wave NHSi nursing retention programme, our progress is as follows:

- 1st retention lead meeting held to confirm leads for each of the workstreams.
- Workstreams cover flexible working, career progression, relaunch of existing tools eg career clinics and introduction of a breakfast club for managers.
- Meetings to be scheduled for the delivery of the NHSi Retention Plan.

3.5. Centralisation of Bank

Month 1 agency spend has decreased to £384k which is a £54k overspend against our £330k NHSI agency control total for April.

Of this overspend, £54k relates to AHP agency spend and £12k to Medical agency spend. Nursing Agency was underspent by £18k in month. Compared to expenditure for the same period last year (£545k) the expenditure this year YTD is £161k less, at £384k.

The following table shows a breakdown of agency spend by staff group:

Excluding STL and OML	In-Month Expenditure			Year to Date Budget & Expenditure		
AGENCY STAFF SPEND BY STAFF GROUP	Month 12 2018/19	Month 1 2019/20	Change (+ / -)	Budget	Actual	Variance
Registered Nurses - Agency	£213,976	£143,714	-£70,262	£161,894	£143,714	-£18,180
Allied Health Professionals - Agency	£121,453	£99,311	-£22,142	£45,270	£99,311	£54,041
Health Care Scientists - Agency	£7,266	£5,785	-£1,481	£1,735	£5,785	£4,050
Support to nursing staff - Agency	£13,854	£3,203	-£10,651	£8,259	£3,203	-£5,056
Consultants - Agency	£87,977	£59,642	-£28,334	£91,934	£59,642	-£32,292
Career/Staff Grades - Agency	£0	£0	£0	£13,869	£0	-£13,869
Trainee Grades - Agency	£76,750	£60,133	-£16,616	£1,815	£60,133	£58,318
NHS Infrastructure Support - Agency	£16,481	£12,275	-£4,206	£5,560	£12,275	£6,715
Total	**£537,756**	**£384,064**	**-£153,692**	**£330,336**	**£384,064**	**£53,728**

- Locums Nest fill rate for April is 65%. There was increase in requested shifts 111, compared to 90 in March and the number of unfilled shifts was 39 compared to 20 in March.
- Nurse Bank activity for April (March as comparison) is as follows:

Temporary Staffing Services (Nurse Bank) SLA KPI's							
KPI's	**March**	**April**	**May**	**June**	**July**	**August**	**Sept**
Bank fill rate non- registered (%)	**75%**	79%					
Bank fill rate registered (%)	**55%**	57%					
Agency fill rate non-registered (%)	**1%**	1%					
Agency fill rate registered (%)	**25%**	25%					
***Agency filled by level 1 (%)**	n/a	n/a					
***Agency filled by level 2 (%)**	n/a	n/a					
Total unfilled (%)	**14%**	18%					
Thornbury shifts	**8**	2					
Adverse Incidents/Complaints for the month: Bank	**0**	0					
Adverse Incidents/Complaints for the month: Agency	**3**	9					
****Mandatory training Temporary workers as %**	**77%**	77%					
Mandatory training service team compliance as %	**100%**	100%					
Temporary workers: Personal reviews	**8**	11					
Recruitment of non-registered	**3**	10					
Recruitment of registered nurses	**3**	1					
***** until new contract implemented please refer to weekly spreadsheet**							
**due to temporary nature, start dates cannot be 100% compliant.							

4. Education, Inclusion, Communications & Engagement:

4.1. Staff Engagement

The Let's Get Engaged Meeting was held on 24th April and was described in last month's report.

4.2. Learning & Development Infrastructure and Strategy

Mandatory training

Compliance levels have increased this month to 92.19%, this compares to last months position of 92.09%. Compliance for the same period last year stood at 85.59%.

Appraisals

Compliance for non-medical staff has increased this month to 86.70%, this compares to last months position of 86.00%. Non-medical appraisal compliance for the same period last year stood at 84.10%.

Medical staff appraisals are down but still green at 90.65, compared with last month's compliance rate of 92.62%, against the target of 90%.

The NMC standards for Student Supervision and Assessment will affect our workforce from Sept 2019 and require all our registrants to receive training to enable them to meet these requirements for our learners in practice. We have provided large numbers of training sessions (1 hour drop in) for our current mentor workforce (n=200) but have only successfully delivered to 83. From the end of May to September 2019 training needs to be delivered to the 600 other registrants who do not have a mentor qualification.

In order to increase our pre-registration student capacity by 25% we aim to roll out our CLiP role to include 8 wards by October 2019. This will provide enhanced in situ capacity.

4.3. Leadership Development

Clinical Leadership Development Programme

The Clinical Leaders Leadership programme is now underway with a third cohort starting. The numbers have dropped and therefore the marketing plan is under review. A date has been set for the second Action Learning Set for cohort one.

We will be inviting the DSNs to join the programme with their own action learning set.

The business case to support the development of the programme and recruitment of a member of staff to drive the programme was approved. This will build our internal capacity to support leadership development within the trust.

Senior Leadership Forum

The third Senior Leaders Forum focused on how leadership development is embedded within the OD&P strategy. The group heard Professor Michael West's vision for compassionate and collective leadership across the NHS through a video clip. A focused discussion on what needs to be in place to realise the vision in Salisbury generated a direction of travel. This will be played back at the next session led by Cara Charles-Barks.

4.4. Apprenticeship set up & implementation

We currently have 74 apprentices on programme with the long awaited Senior Leader Level 7 apprenticeship commencing their induction with the University of Gloucester. There are plans for 17 new apprentices to start their programme in the next two months which is encouraging.

There have been some problems with levy payments this month which led to no payments being made into the levy account. We are working with the National Apprenticeship Service to resolve this but we anticipate a double payment next month. We are also having an issue with Training Providers setting up cohorts and drawing off funds from the levy in a timely way and so these levy figures do not match the numbers on programme currently. This has been reported to ESFA.

April Apprenticeship Levy	
Paid in	£0
Paid out	-£11,639.77
TOTAL LEFT IN POT	£1,006,209.00
Funds due to expire in AUGUST 2019	£20,482

4.5. Communications

The Communications Team supported colleagues to ensure that the 'Service Improvement Awards' event held in April 2019 was well attended and highly successful. The Team carried out work to prepare for the 'Striving for Excellence' Awards, to be held in June 2019, including developing a sponsorship package with the League of Friends.

Proactive media relations work includes a series of articles in the Salisbury Journal featuring different aspects of the hospital and information, in advance of Easter, to help direct our local community to different places for help, other than ED.

4.6. Diversity & Inclusion

The contribution to the regular Trust induction has resulted in a number of people joining the Allies program (Rainbow lanyards) and also an individual coming forward as a Diversity Champion who has experience of working with ED&I.

The draft Gender Pay Gap report has been drafted for comment and will be considered in detail at the July Workforce Committee.

Freedom to Speak Up

There has been a significant increase in concerns brought to FTSUG. In April, 17 cases were brought compared to 4 cases in March. Of the cases brought forward, only one did not have an element of bullying/harassment or culture issues.

The increase in concerns being raised by staff is possibly due to the fact that when one person speaks up in a department it gives others courage to do the same. The FTSUG role is gradually being promoted through inductions, training and word of mouth which could also be contributing to the increase in activity.

The FTSUG continues to work closely with the Head of ED&I to drive forward culture change and support managers.

5. Health & Wellbeing:

5.1. Staff Engagement

As reported in section 4.1 above.

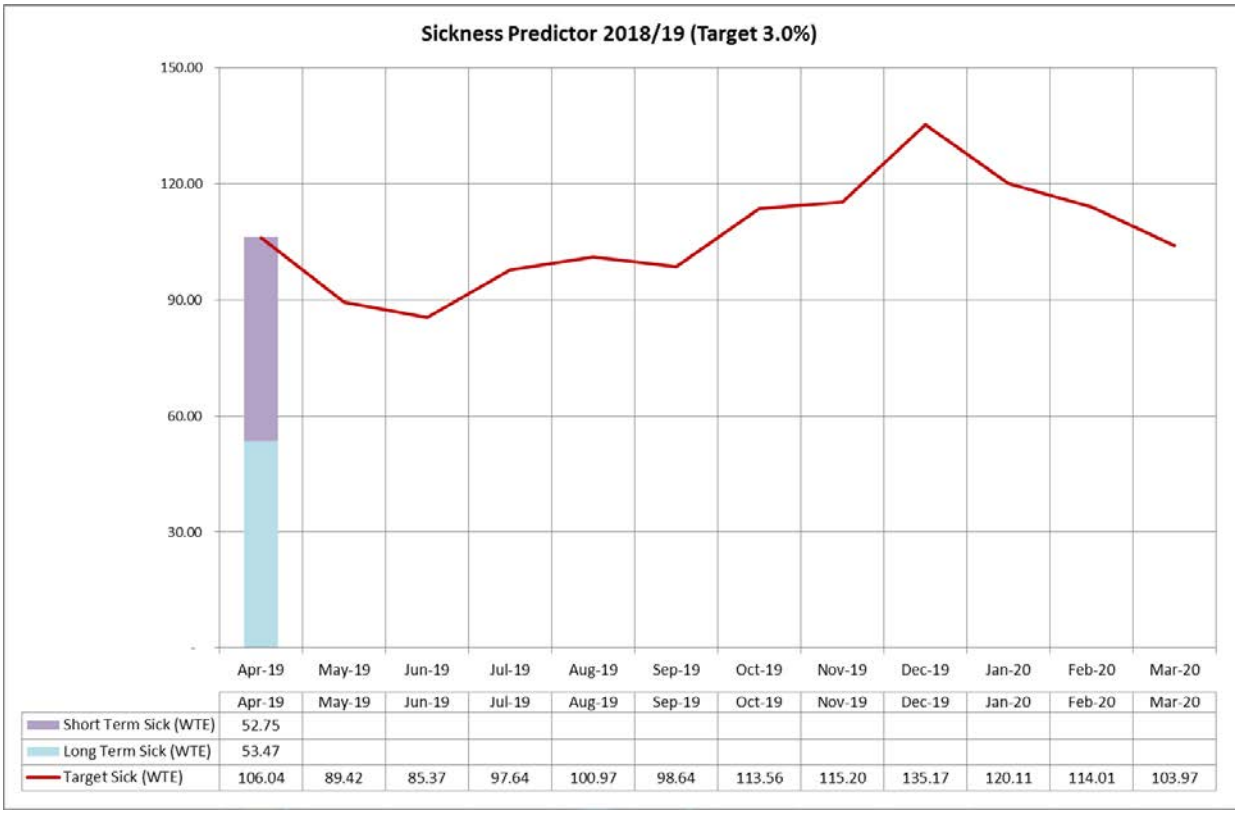
Flu Campaign: The planning for the 2019/20 flu campaign is well under way. The quadrivalent influenza vaccine as well as an egg free vaccine has been procured for the 2019/20 campaign. The PGD has been written and ratified in readiness for the start of the active campaign which is scheduled for October 1st 2019 and the Peer vaccinator annual training package is being reviewed this week.

5.2. Attendance Management

Our current sickness absence rate of 3.45% in month 1 is over our 3% target and a 0.07% deterioration on last month. There has been a slight increase in both long and short term sickness.

Please note, sickness figures contain all returns input as at sickness cut-off date, and may be subject to change due to late receipt of information/corrections.

The chart below shows current and anticipated sickness absence for the year:



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Short Term Sick (WTE)	52.75											
Long Term Sick (WTE)	53.47											
Target Sick (WTE)	106.04	89.42	85.37	97.64	100.97	98.64	113.56	115.20	135.17	120.11	114.01	103.97

Occupational Health Advisors

It is recognised that being able to recruit into the vacant OH Advisor role may be difficult at this time due to the lack of qualified OH advisors nationally. Should a suitable qualified recruit not be found, we have planned to replace with a training post.

Management Referrals (New)	**Feb 19** 16 cancelled/DNA (4)	**Mar 19** 36 cancelled/DNA (8)	**Apr 19** 23 cancelled/DNA (4)	**Total** 75 (16)
Self Referrals	**Feb 19** 6 (1)	**Mar 19** 3 (1)	**Apr 19** 5 (1)	**Total** 14 (3)

Occupational Health Physician

Some initial streamlining of existing processes has begun to result in more efficient use of appointment times. This has led to more appropriate and more complex referrals being able to be allocated to the physician and we are beginning to see time of referral to appointment time improvements. It is predicted that this will continue to improve as the service is streamlined and standardised.

Management Referrals (1 day)	**Feb 19** 3 (0)	**Mar 19** 11 (0)	**Apr 19** 4 (1)	**Total** 18 (1)

Self Referrals	Feb 19	Mar 19	Apr 19	Total
	0	0	1	1

5.3. Stress & Mental Health issues

Activity for the 3 months to April 2019 is as follows:

Staff Counsellor (F/T)	**Feb 19**	**Mar 19**	**Apr 19**	**Total**
New Referrals (each referral has 5 further sessions)	13 (1 DNA)	22	10	45 (1 DNA)
Mental Health Nurse Management Referrals (2 day contract) Self Referrals	(Canc/DNA) 5 (1) 0 (3)	Canc/DNA/postpone) 5 (3) 2 (3)	(Canc/DNA) 6 (5) 0 (0)	Total 16 (8) 2 (6)

5.4. Ergonomic/MSK issues (Physiotherapists)

There are medium and longer term plans to streamline physiotherapy services and utilise skills more effectively to address identified needs within the Trust with respect to MSK and sickness absence related to this. In the meantime, physio referrals for the three months to April 2019 are:-

Management Referrals (New) (F/T 1.00)	Feb 19 3 (1)	Mar 19 2 (1)	Apr 19 2	Total 7 (2)
Self Referrals	Feb 196 1	Mar 19 2	Apr 19 2 (1)	Total 5 (1)

6. Business Partnering:

6.1. ESR Optimisation

The Business Case for all three Phases of the ESR Optimisation Project has yet to receive formal approval, however, the first Phase is going ahead as planned. The first Phase consists principally of a hierarchy review/reset and relaunching of employee self-service.

6.2. Workforce Planning

Genetics are to write a workforce paper to make a case for more resource to satisfy an increase in activity in certain areas as a result of the tender. DMT has instructed them this must be written in the context of the consortium's plans.

Pharmacy will begin working on a paper for 7 day working after August, when their current staffing situation relying on agency stabilises.

6.3. Policies

Policies continue to be reviewed and approved through consultation, including with JCC, and are currently up to date.

6.4. Business Partner role

Business Partners are heavily involved in all formal employee relations cases in the Trust and the table below shows current activity:

Employee Relations Cases - Formal										
	Performance/ Capability		Disciplinary		Grievance		Bullying and Harassment		Total Cases Opened	Total Cases Closed
	Opened/closed cases within the month - Source of Data - ESR									
Month	Cases Opened in Month	Cases Closed in Month	Cases Opened in Month	Cases Closed in Month	Cases Opened in Month	Cases Closed in Month	Cases Opened in Month	Cases Closed in Month	Total Cases Opened in Month	Total Cases Closed in Month
Apr-18	7	1	5	1	1	1			13	3
May-18	7			1					7	1
Jun-18	7	3	1	1					8	4
Jul-18	2	8			2	1			4	9
Aug-18	1	6		1					1	7
Sep-18	5	3							5	3
Oct-18	2	1					1		3	1
Nov-18	9				1				10	0
Dec-18	1	2			1				2	2
Jan-19	14	3	2			2			16	5
Feb-19	10	6		2					10	8
Mar-19		1							0	1
Apr-19	5	3					1		6	3
	70	37	8	6	5	4	2	-	85	47

7. Workforce Risks

Work continues to align our risks to the revised Board Assurance Framework and our key priorities in the developing People Strategy, namely:

- Resourcing - Failure to recruit and retain staff will result in SFT being unable to deliver safe, sustainable services for patients.
- Business Partnering – Inaccurate workforce information will result in misalignment between the organisational and workforce strategies.

- Health and Wellbeing - Failure to achieve an outstanding experience for every patient because staff do not feel valued and able to contribute fully to work as a consequence of low morale.
- Organisational Development and Engagement - Failure to deliver excellence for all patients if the workforce is not appropriately skilled and staffed to the right level
- Leadership - inability to develop strong leadership capability across all levels of the organisation to support an innovation culture.

The Corporate Risk Register, and the Directorate Register have both been updated this month and actions are ongoing to mitigate the risks recorded.

8. Summary

The situation remains challenging, although improving in most areas including Agency spend this month. However, it is acknowledged that the key areas of pressure remain recruitment, temporary staffing overspend and sickness absence.

Our focus at a local level continues to be supporting both managers and staff in resolving these difficult areas whilst we begin to build sustainable solutions through the OD & People restructure at Salisbury. In doing this we continue to be at the centre of the workforce collaboration in the STP and the emerging STP Workforce strategy.

9. Recommendations

The Trust Board note the report, areas of concern, and actions underway and/or planned.

Paul Hargreaves
Director of Organisational Development and People

Executive Summary of Key Workforce Performance

Area of Review	Key Highlights	Status	Trend	Target
Turnover/ Retention	**In Month:** In month there were 22 leavers (headcount), and 45 starters (headcount), compared to 29 leavers and 42 starters in the month before. **Year to Date:** For the rolling year to date, the turnover rate was below target at 9.20%, this compares to last month's rate which was 9.04%. For the rolling year to M1 2018/19, the Trust's turnover rate was 10.28%. **Top 3 Hotspots:** The Directorate with the highest turnover rate for the rolling year was Facilities at 13.24%, followed by Musculo-Skeletal (10.50%) and Clinical Support & Family Services (9.70%).	GREEN		10.00%
Vacancies	**In Month:** Vacancies have decreased from 5.93% in month12 to 5.91% in month 1. **Year to Date:** The average vacancy rate is 6.11%, this compares to last month's average position which was 6.93%. The Trust's vacancy rate for the same period last year was 7.47%. **Top 3 Hotspots:** The Directorate with the highest vacancy rate for the month was Facilities at 13.7%, followed by Musculo-Skeletal (10.48%) and Corporate (7.11).	AMBER		5.00%
Temporary Spend	**In Month:** There has been a decrease in agency spend this month to £384,064, compared to last month's position which was £537,756. **Year to Date:** The financial year to date total agency spend is £384,064, compared to the spend for the same period in the previous year which was £544,973. **Top 3 Hotspots:** The Directorate with the highest agency spend for the month was Medicine with £195,946, followed by Musculo-Skeletal (£73,796) and Clinical Support & Family Services	RED		£330,336
Sickness	**In Month:** There has been an increase in the sickness rate this month at 3.45%, this compares to last month's position of 3.38%. **Year to Date:** The year to date rolling sickness rate has decreased from 3.45% to 3.41% The sickness rate for same month last year was 3.53%. **Top 3 Hotspots:** The Directorate with the highest sickness rate for the month was Surgery with 5.02%, followed by Facilities (4.51%) and Medicine (3.65%). ***Please note: Sickness figures contain all returns input as at sickness cut-off date, and may be subject to change due to late receipt of information/corrections.***	AMBER		3.00%
Training	**In Month:** Mandatory training compliance levels have increased this month to 92.19%, this compares to last month's position of 92.09%. Compliance for the same period last year stood at 85.59%. **Year to Date:** The calendar year to date average compliance level is 91.91%, this compares to last month's position of 91.81%. **Top 3 Hotspots:** The Directorate with the lowest compliance rate was Corporate with 87.78%, followed by Medicine (89.91%) and Clinical Support & Family Services (92.39%).	GREEN		85.00%
Non-Medical Appraisals	**In Month:** Non-Medical Appraisal compliance has increased this month to 86.70%, this compares to last month's position of 86.00%. Non-medical appraisal compliance for the same period last year stood at 84.10%. **Year to Date:** The calendar year to date average compliance is 85.98%, this compares to last month's position of 85.73%. **Top 3 Hotspots:** The Directorate with the lowest compliance rate was Corporate with 79.78%, followed by Medicine (82.87%) and Clinical Support & Family Services (86.70%).	GREEN		85.00%

Salisbury NHS Foundation Trust Workforce Dashboard

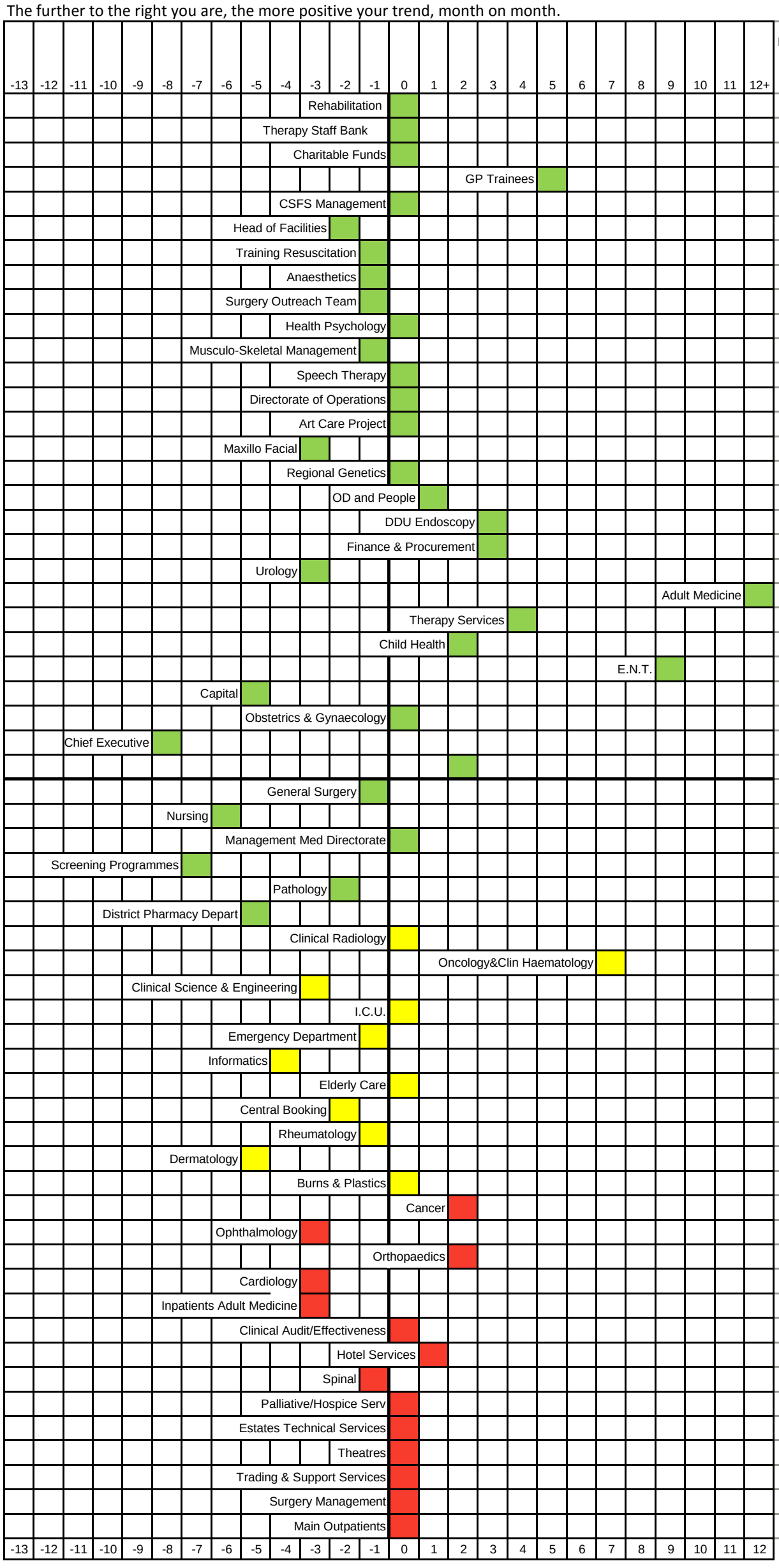
	Strs/Lvrs				Turnover (FTE)			Vacancies				Temporary Spend				Agency Budget	Sickness						Training	Appraisal	
	Starters *(head count in month)*	Starters *(FTE in month)*	Leavers *(head count in month)*	Leavers *(FTE in month)*	Average Heads *(in year)*	Number of Leavers *(in year)*	Turnover *(rolling year)*	Budget Wte (Ledger)	Staff In Post Wte *(Ledger - month end)*	Vacant Wte	Vacancy Rate	spend on Agency	% Temp Spend on Agency *(in month)*	spend on Bank	Total Temp Spend		Long Term Sick WTE lost *(in month)*	%	Short Term Sick WTE lost *(in month)*	%	Total WTE lost to Sickness *(in month)*	Sickness Rate	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
YTD Trend	*Data excludes: Docs in Training, Tupe Transfers, Bank Staff*																								
Month Trend																									
Target			29			260	10.00%			-	5.00%	£ 330,336	40.00%								92.22	3.00%	85.00%	90.00%	85.00%
Jan-19	56	48.23	29	25.77	3,053	282	9.24%	3,266.78	3,073.92	192.86	5.90%	£ 708,719	51.17%	£ 676,229	£ 1,384,948	Over	57.32	48%	62.79	52%	120.11	3.95%	91.32%	88.16%	86.30%
Feb-19	44	38.59	19	16.57	3,064	282	9.20%	3,305.58	3,084.69	220.89	6.68%	£ 504,816	36.90%	£ 863,124	£ 1,367,940	Over	50.51	44%	63.49	56%	114.01	3.73%	92.03%	91.46%	84.90%
Mar-19	42	37.57	29	24.72	3,077	278	9.04%	3,306.58	3,110.37	196.21	5.93%	£ 537,756	37.45%	£ 898,286	£ 1,436,042	Over	53.37	51%	50.60	49%	103.97	3.38%	92.09%	92.62%	86.00%
Apr-19	45	38.42	22	16.81	3,078	283	9.20%	3,311.92	3,116.92	195.66	5.91%	£ 384,064	34.63%	£ 724,834	£ 1,108,898	Over	53.47	50%	52.75	50%	106.22	3.45%	92.19%	90.65%	86.70%
totals	187	162.81	99	83.87		Average	9.17%			Average	6.11%	£ 533,839									Rolling Year	3.41%	91.91%		85.98%

Note: Month 1 position shows an underspend on workforce of £337K.

Sickness Absence Heat Map M1 2019/20 (Rolling Year)

The higher up you are, the better your department is performing against other departments.
The further to the right you are, the more positive your trend, month on month.

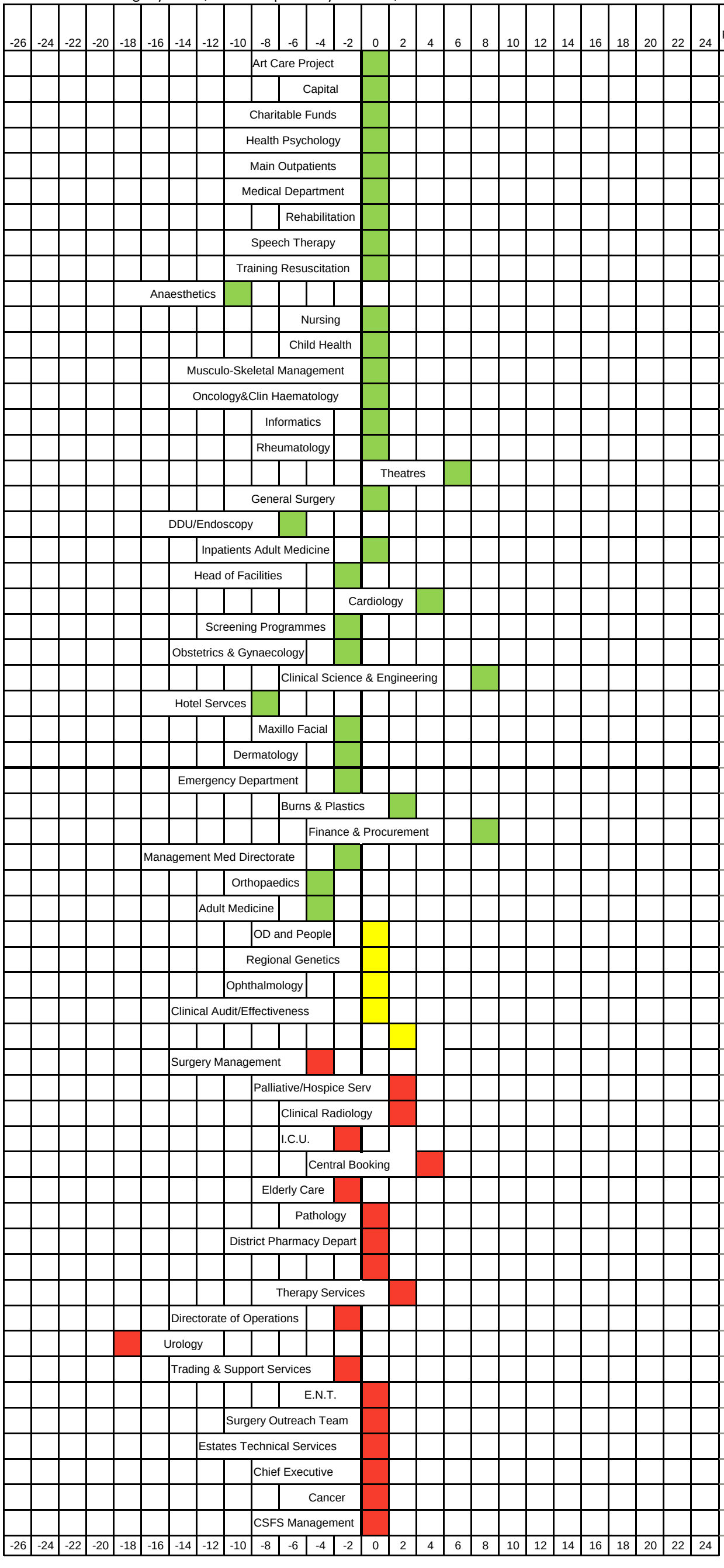
M1 Department	M1 Position	Change	M12 Sickness Absence % YTD	M1 Sickness Absence % YTD	M12 Position
Rehabilitation	1	0	0.00%	0.00%	1
Therapy Staff Bank	2	0	0.00%	0.00%	2
Charitable Funds	3	0	0.25%	0.25%	3
GP Trainees	4	5	0.87%	0.33%	9
CSFS Management	5	0	0.48%	0.48%	5
Head of Facilities	6	-2	0.44%	0.59%	4
Training Resuscitation	7	-1	0.49%	0.73%	6
Anaesthetics	8	-1	0.79%	0.86%	7
Surgery Outreach Team	9	-1	0.82%	0.94%	8
Health Psychology	10	1	1.01%	1.00%	11
Musculo-Skeletal Management	11	-1	0.93%	1.06%	10
Speech Therapy	12	1	1.34%	1.32%	13
Directorate of Operations	13	1	1.44%	1.37%	14
Art Care Project	14	1	1.46%	1.46%	15
Maxillo Facial	15	-3	1.18%	1.56%	12
Regional Genetics	16	0	1.78%	1.58%	16
OD and People	17	1	1.87%	1.63%	18
DDU Endoscopy	18	3	1.97%	1.89%	21
Finance & Procurement	19	3	1.99%	2.10%	22
Urology	20	-3	1.85%	2.18%	17
Adult Medicine	21	16	3.23%	2.25%	37
Therapy Services	22	4	2.60%	2.33%	26
Child Health	23	2	2.56%	2.38%	25
E.N.T.	24	9	2.92%	2.47%	33
Capital	25	-5	1.95%	2.48%	20
Obstetrics & Gynaecology	26	1	2.64%	2.60%	27
Chief Executive	27	-8	1.94%	2.63%	19
Medical Equip Manager	28	2	2.73%	2.72%	30
General Surgery	29	-1	2.67%	2.72%	28
Nursing	30	-7	2.36%	2.72%	23
Management Med Directorate	31	1	2.77%	2.73%	32
Screening Programmes	32	-8	2.37%	2.73%	24
Pathology	33	-2	2.73%	2.77%	31
District Pharmacy Depart	34	-5	2.68%	2.85%	29
Clinical Radiology	35	0	3.06%	3.13%	35
Oncology&Clin Haematology	36	7	3.76%	3.26%	43
Clinical Science & Engineering	37	-3	2.99%	3.38%	34
I.C.U.	38	1	3.50%	3.43%	39
Emergency Department	39	-1	3.39%	3.48%	38
Informatics	40	-4	3.11%	3.49%	36
Elderly Care	41	0	3.60%	3.70%	41
Central Booking	42	-2	3.56%	3.75%	40
Rheumatology	43	-1	3.66%	3.81%	42
Dermatology	44	5	4.36%	3.83%	49
Burns & Plastics	45	0	4.17%	3.86%	45
Cancer	46	2	4.36%	4.04%	48
Ophthalmology	47	-3	3.99%	4.09%	44
Orthopaedics	48	2	4.37%	4.18%	50
Cardiology	49	-3	4.26%	4.18%	46
Inpatients Adult Medicine	50	-3	4.29%	4.43%	47
Clinical Audit/Effectiveness	51	0	4.74%	4.72%	51
Hotel Services	52	1	4.84%	4.75%	53
Spinal	53	-1	4.74%	4.76%	52
Palliative/Hospice Serv	54	0	5.17%	5.03%	54
Estates Technical Services	55	0	5.34%	5.04%	55
Theatres	56	0	5.44%	5.46%	56
Trading & Support Services	57	0	6.13%	6.17%	57
Surgery Management	58	0	6.87%	6.96%	58
Main Outpatients	59	0	8.24%	9.19%	59



Turnover Heat Map M1 2019/20 (Rolling Year)

The higher up you are, the better your department is performing against other departments.
The further to the right you are, the more positive your trend, month on month.

M1 Department	M1 Position	Change	M12 LTR FTE % YTD	M1 LTR FTE % YTD	M12 Position
Art Care Project	1	1	0.00%	0.00%	2
Capital	2	1	0.00%	0.00%	3
Charitable Funds	3	1	0.00%	0.00%	4
Health Psychology	4	1	0.00%	0.00%	5
Main Outpatients	5	1	0.00%	0.00%	6
Medical Department	6	1	0.00%	0.00%	7
Rehabilitation	7	1	0.00%	0.00%	8
Speech Therapy	8	1	0.00%	0.00%	9
Training Resuscitation	9	1	0.00%	0.00%	10
Anaesthetics	10	-9	0.00%	2.79%	1
Nursing	11	0	2.23%	2.81%	11
Child Health	12	0	3.25%	3.24%	12
Musculo-Skeletal Management	13	0	3.48%	3.43%	13
Oncology&Clin Haematology	14	1	5.17%	5.17%	15
Informatics	15	1	5.41%	5.66%	16
Rheumatology	16	1	5.94%	5.89%	17
Theatres	17	5	6.94%	5.95%	22
General Surgery	18	0	6.11%	6.30%	18
DDU Endoscopy	19	-5	3.84%	6.36%	14
Inpatients Adult Medicine	20	1	6.92%	6.51%	21
Head of Facilities	21	-1	6.49%	6.59%	20
Cardiology	22	4	8.84%	6.96%	26
Screening Programmes	23	1	7.59%	7.56%	24
Obstetrics & Gynaecology	24	-1	7.35%	7.59%	23
Clinical Science & Engineering	25	7	9.81%	7.80%	32
Hotel Services	26	-7	6.49%	8.06%	19
Maxillo Facial	27	-2	8.04%	8.09%	25
Dermatology	28	-1	8.90%	8.80%	27
Emergency Department	29	-1	8.98%	8.86%	28
Burns & Plastics	30	3	10.03%	9.09%	33
Finance & Procurement	31	7	10.68%	9.22%	38
Management Med Directorate	32	-2	9.40%	9.30%	30
Orthopaedics	33	-4	9.26%	9.57%	29
Adult Medicine	34	-3	9.74%	9.75%	31
OD and People	35	0	10.36%	10.30%	35
Regional Genetics	36	0	10.38%	10.35%	36
Ophthalmology	37	2	11.28%	11.16%	39
Clinical Audit/Effectiveness	38	2	11.38%	11.29%	40
Spinal	39	3	11.55%	11.54%	42
Surgery Management	40	-3	10.42%	12.31%	37
Palliative/Hospice Serv	41	3	13.04%	13.11%	44
Clinical Radiology	42	3	13.53%	13.34%	45
I.C.U.	43	-2	11.48%	13.40%	41
Central Booking	44	5	16.01%	13.43%	49
Elderly Care	45	-2	11.91%	13.56%	43
Pathology	46	0	14.27%	14.66%	46
District Pharmacy Depart	47	0	14.47%	15.71%	47
Medical Equip Manager	48	2	16.07%	15.98%	50
Therapy Services	49	3	19.06%	17.14%	52
Directorate of Operations	50	-2	15.75%	17.69%	48
Urology	51	-17	10.07%	17.92%	34
Trading & Support Services	52	-1	18.66%	18.69%	51
E.N.T.	53	0	19.86%	19.86%	53
Surgery Outreach Team	54	0	19.94%	20.00%	54
Estates Technical Services	55	0	21.22%	21.33%	55
Chief Executive	56	0	22.82%	22.97%	56
Cancer	57	0	27.82%	27.58%	57
CSFS Management	58	0	47.79%	48.00%	58

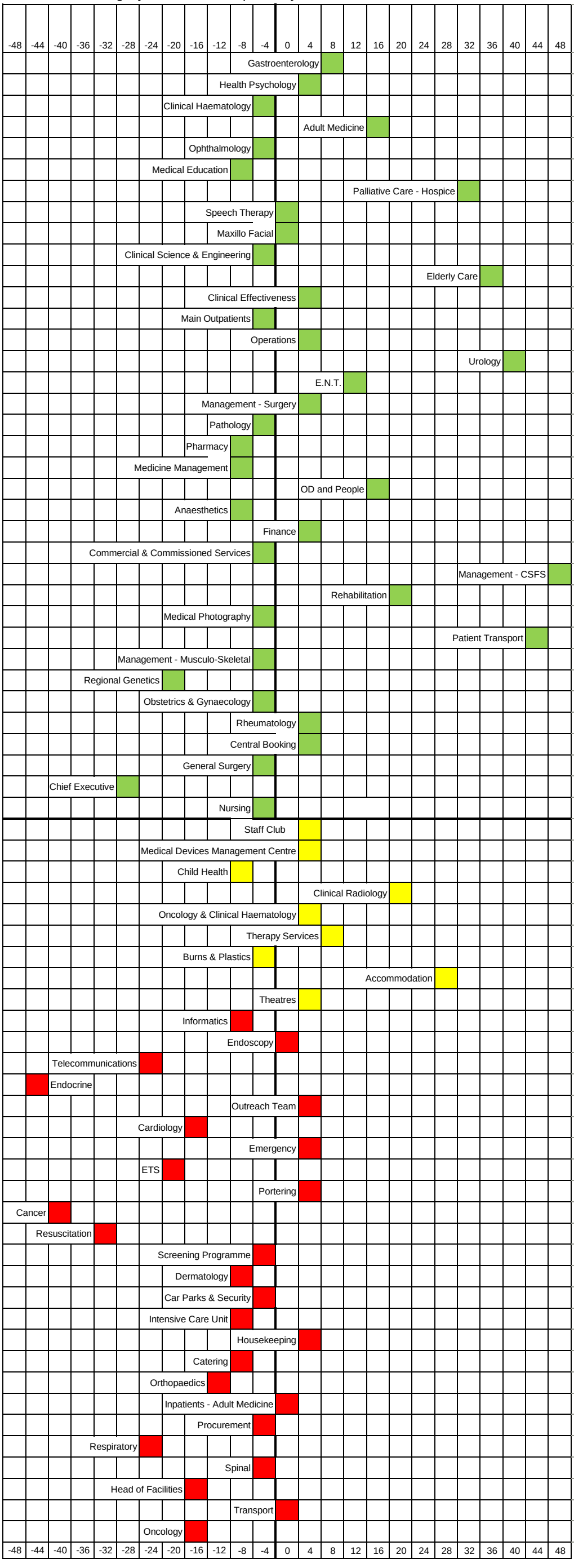


Vacancies Heat Map M1 2019/20 (Rolling Year)

The higher up you are, the better your department is performing against other departments.

The further to the right you are, the more positive your trend, month on month.

M1 Department	M1 Position	M12 Position	Change	M12 Vacancies %	M1 Vacancies %
Gastroenterology	**1**	7	**6**	-14.02%	**-23.57%**
Health Psychology	**2**	5	**3**	-20.17%	**-22.34%**
Clinical Haematology	**3**	1	**-2**	-41.10%	**-16.07%**
Adult Medicine	**4**	20	**16**	-2.07%	**-15.80%**
Ophthalmology	**5**	3	**-2**	-23.70%	**-11.89%**
Medical Education	**6**	2	**-4**	-23.94%	**-10.85%**
Palliative Care - Hospice	**7**	37	**30**	2.99%	**-9.82%**
Speech Therapy	**8**	9	**1**	-10.53%	**-8.38%**
Maxillo Facial	**9**	11	**2**	-6.01%	**-7.93%**
Clinical Science & Engineering	**10**	8	**-2**	-10.91%	**-7.85%**
Elderly Care	**11**	48	**37**	7.26%	**-7.30%**
Clinical Effectiveness	**12**	18	**6**	-2.45%	**-7.22%**
Main Outpatients	**13**	12	**-1**	-5.99%	**-5.99%**
Operations	**14**	19	**5**	-2.26%	**-5.95%**
Urology	**15**	58	**43**	12.73%	**-5.85%**
E.N.T.	**16**	30	**14**	1.89%	**-5.36%**
Management - Surgery	**17**	21	**4**	-0.24%	**-4.96%**
Pathology	**18**	17	**-1**	-4.46%	**-4.33%**
Pharmacy	**19**	13	**-6**	-5.97%	**-4.03%**
Medicine Management	**20**	14	**-6**	-5.84%	**-2.58%**
OD and People	**21**	40	**19**	3.74%	**-1.64%**
Anaesthetics	**22**	16	**-6**	-4.49%	**-1.04%**
Finance	**23**	28	**5**	0.73%	**-0.68%**
Commercial & Commissioned Services	**24**	22	**-2**	0.00%	**0.00%**
Management - CSFS	**25**	71	**46**	43.06%	**0.00%**
Rehabilitation	**26**	47	**21**	6.54%	**0.00%**
Medical Photography	**27**	23	**-4**	0.00%	**2.02%**
Patient Transport	**28**	70	**42**	41.20%	**2.03%**
Management - Musculo-Skeletal	**29**	27	**-2**	0.25%	**2.41%**
Regional Genetics	**30**	10	**-20**	-8.20%	**2.90%**
Obstetrics & Gynaecology	**31**	29	**-2**	1.29%	**3.18%**
Rheumatology	**32**	38	**6**	3.25%	**3.46%**
Central Booking	**33**	39	**6**	3.62%	**3.48%**
General Surgery	**34**	32	**-2**	2.46%	**3.88%**
Chief Executive	**35**	4	**-31**	-22.40%	**4.08%**
Nursing	**36**	34	**-2**	2.65%	**4.22%**
Staff Club	**37**	43	**6**	5.04%	**4.55%**
Medical Devices Management Centre	**38**	44	**6**	5.05%	**5.13%**
Child Health	**39**	33	**-6**	2.47%	**5.28%**
Clinical Radiology	**40**	60	**20**	13.79%	**5.63%**
Oncology & Clinical Haematology	**41**	46	**5**	5.77%	**5.91%**
Therapy Services	**42**	31	**-11**	2.20%	**6.12%**
Burns & Plastics	**43**	42	**-1**	4.65%	**6.37%**
Accommodation	**44**	72	**28**	49.32%	**6.57%**
Theatres	**45**	50	**5**	8.09%	**6.60%**
Informatics	**46**	41	**-5**	4.22%	**7.13%**
Endoscopy	**47**	49	**2**	7.39%	**9.73%**
Telecommunications	**48**	26	**-22**	0.18%	**10.03%**
Endocrine	**49**	6	**-43**	-14.29%	**11.11%**
Outreach Team	**50**	54	**4**	11.38%	**11.38%**
Cardiology	**51**	36	**-15**	2.79%	**11.54%**
Emergency	**52**	56	**4**	11.98%	**11.81%**
ETS	**53**	35	**-18**	2.74%	**12.05%**
Portering	**54**	61	**7**	13.85%	**12.58%**
Cancer	**55**	15	**-40**	-4.80%	**13.13%**
Resuscitation	**56**	24	**-32**	0.00%	**13.24%**
Screening Programme	**57**	59	**2**	13.52%	**13.29%**
Dermatology	**58**	63	**5**	14.33%	**13.97%**
Car Parks & Security	**59**	62	**3**	14.29%	**14.29%**
Intensive Care Unit	**60**	53	**-7**	11.18%	**14.46%**
Housekeeping	**61**	65	**4**	15.75%	**15.10%**
Catering	**62**	52	**-10**	11.09%	**15.51%**
Orthopaedics	**63**	51	**-12**	10.31%	**15.61%**
Inpatients - Adult Medicine	**64**	67	**3**	22.79%	**17.15%**
Procurement	**65**	64	**-1**	15.18%	**17.55%**
Respiratory	**66**	45	**-21**	5.69%	**18.22%**
Spinal	**67**	66	**-1**	20.89%	**19.74%**
Head of Facilities	**68**	55	**-13**	11.91%	**19.85%**
Transport	**69**	69	**0**	32.64%	**22.87%**
Oncology	**70**	57	**-13**	12.08%	**30.82%**

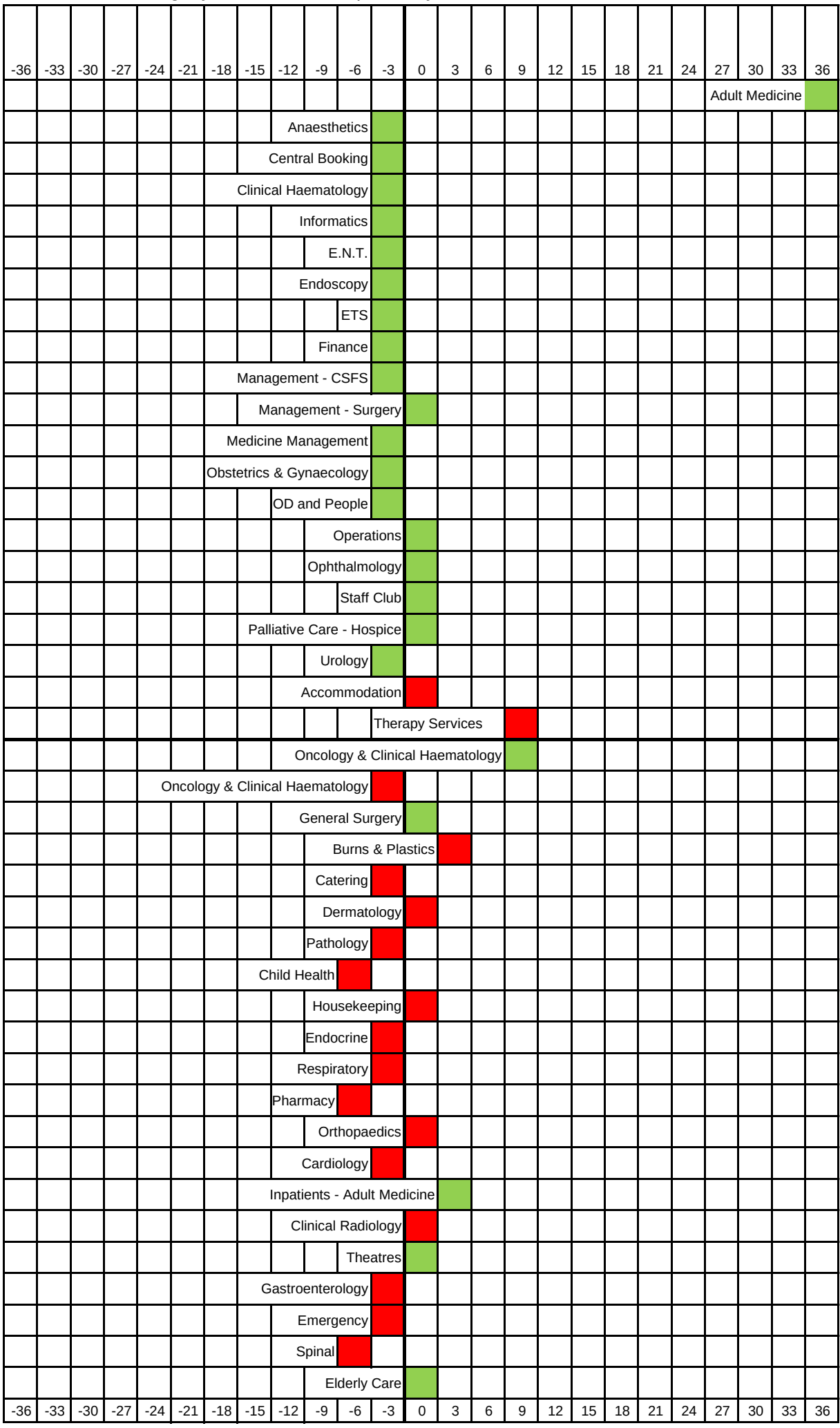


Agency Spend Heat Map M1 2019/20 (Rolling Year)

The higher up you are, the better your department is performing against other departments.

The further to the right you are, the more positive your trend, month on month.

M1 Department	M1 Position	M12 Position	Change	M12 Agency Spend £	M1 Agency Budget £	M1 Agency Spend £
Adult Medicine	**1**	35	**34**	29,995	10,706	**-5,085**
Anaesthetics	**2**	1	**-1**	0	0	**-235**
Central Booking	**3**	2	**-1**	0	2,083	**0**
Clinical Haematology	**4**	3	**-1**	0	0	**0**
Informatics	**5**	4	**-1**	0	3,477	**0**
E.N.T.	**6**	5	**-1**	0	0	**0**
Endoscopy	**7**	6	**-1**	0	0	**0**
ETS	**8**	7	**-1**	0	0	**0**
Finance	**9**	8	**-1**	0	0	**0**
Management - CSFS	**10**	9	**-1**	0	0	**0**
Management - Surgery	**11**	10	**0**	0	0	**0**
Medicine Management	**12**	11	**-1**	0	0	**0**
Obstetrics & Gynaecology	**13**	12	**-1**	0	0	**0**
OD and People	**14**	13	**-1**	0	0	**0**
Operations	**15**	15	**0**	0	0	**0**
Ophthalmology	**16**	16	**0**	0	0	**0**
Staff Club	**17**	17	**0**	0	0	**0**
Palliative Care - Hospice	**18**	19	**1**	169	2,472	**471**
Urology	**19**	18	**-1**	0	4,167	**732**
Accommodation	**20**	21	**1**	1,372	0	**805**
Therapy Services	**21**	31	**10**	13,590	0	**947**
Intensive Care Unit	**22**	32	**10**	15,427	1,416	**1,370**
Oncology & Clinical Haematology	**23**	20	**-3**	1,038	1,292	**1,913**
General Surgery	**24**	24	**0**	4,329	11,400	**3,302**
Burns & Plastics	**25**	29	**4**	10,587	0	**4,564**
Catering	**26**	23	**-3**	3,255	0	**4,785**
Dermatology	**27**	-	**0**	0	0	**5,500**
Pathology	**28**	25	**-3**	7,266	1,735	**5,785**
Child Health	**29**	22	**-7**	3,031	1,815	**6,051**
Housekeeping	**30**	30	**0**	11,854	0	**6,685**
Endocrine	**31**	28	**-3**	10,008	0	**9,328**
Respiratory	**32**	27	**-5**	9,944	6,250	**10,111**
Pharmacy	**33**	26	**-7**	7,605	3,914	**11,657**
Orthopaedics	**34**	35	**1**	31,549	368	**17,608**
Cardiology	**35**	33	**-2**	28,770	11,836	**19,499**
Inpatients - Adult Medicine	**36**	41	**5**	69,209	54,114	**26,740**
Clinical Radiology	**37**	38	**1**	38,925	10,939	**36,453**
Theatres	**38**	40	**2**	52,077	53,190	**36,931**
Gastroenterology	**39**	36	**-3**	35,852	22,532	**38,060**
Emergency	**40**	39	**-1**	42,443	35,000	**42,462**
Spinal	**41**	37	**-4**	36,225	11,005	**45,177**
Elderly Care	**42**	42	**0**	71,334	66,756	**52,446**

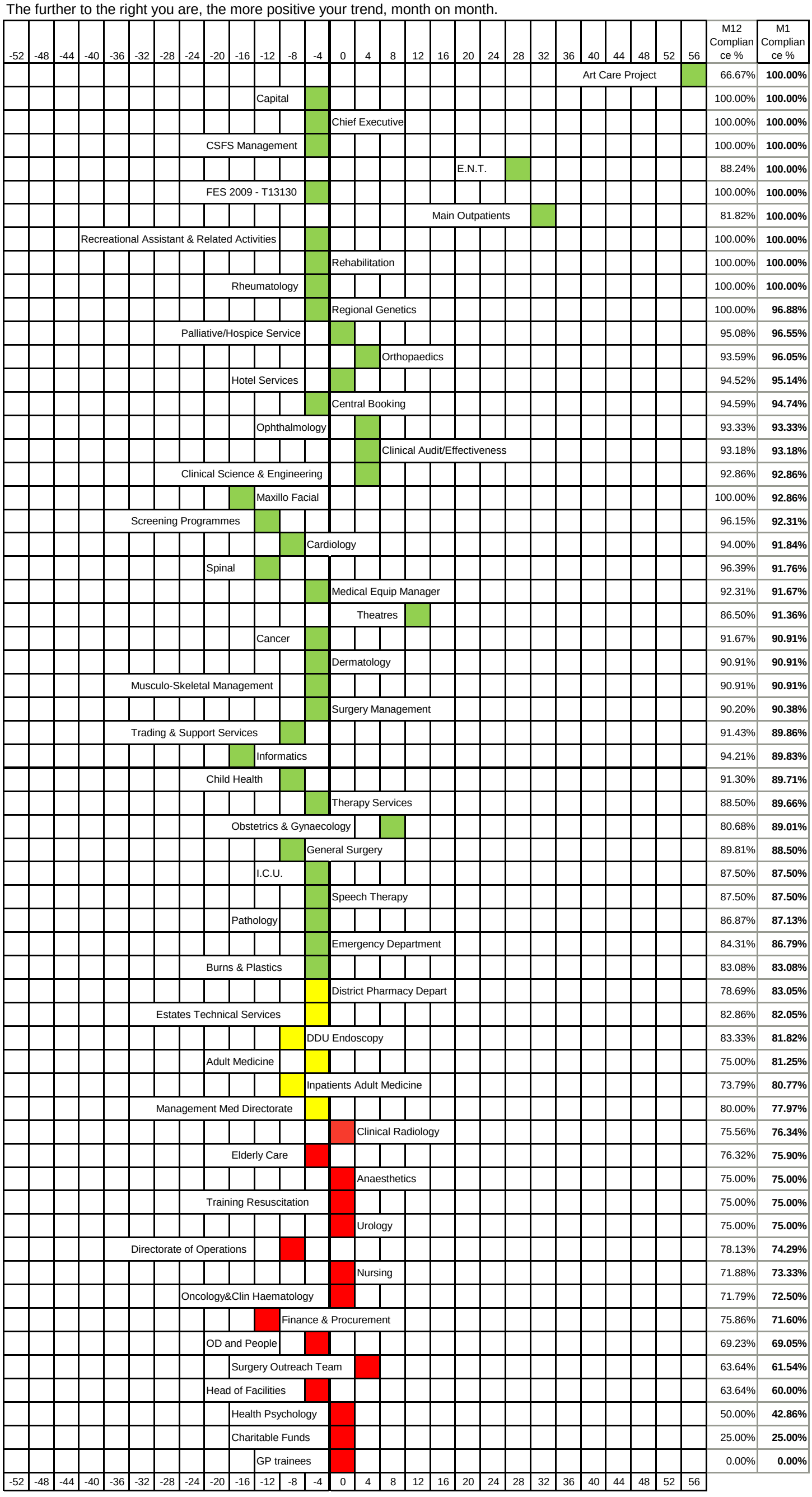


Appraisals Heat Map M1 2019/20 (Rolling Year)

The higher up you are, the better your department is performing against other departments.

The further to the right you are, the more positive your trend, month on month.

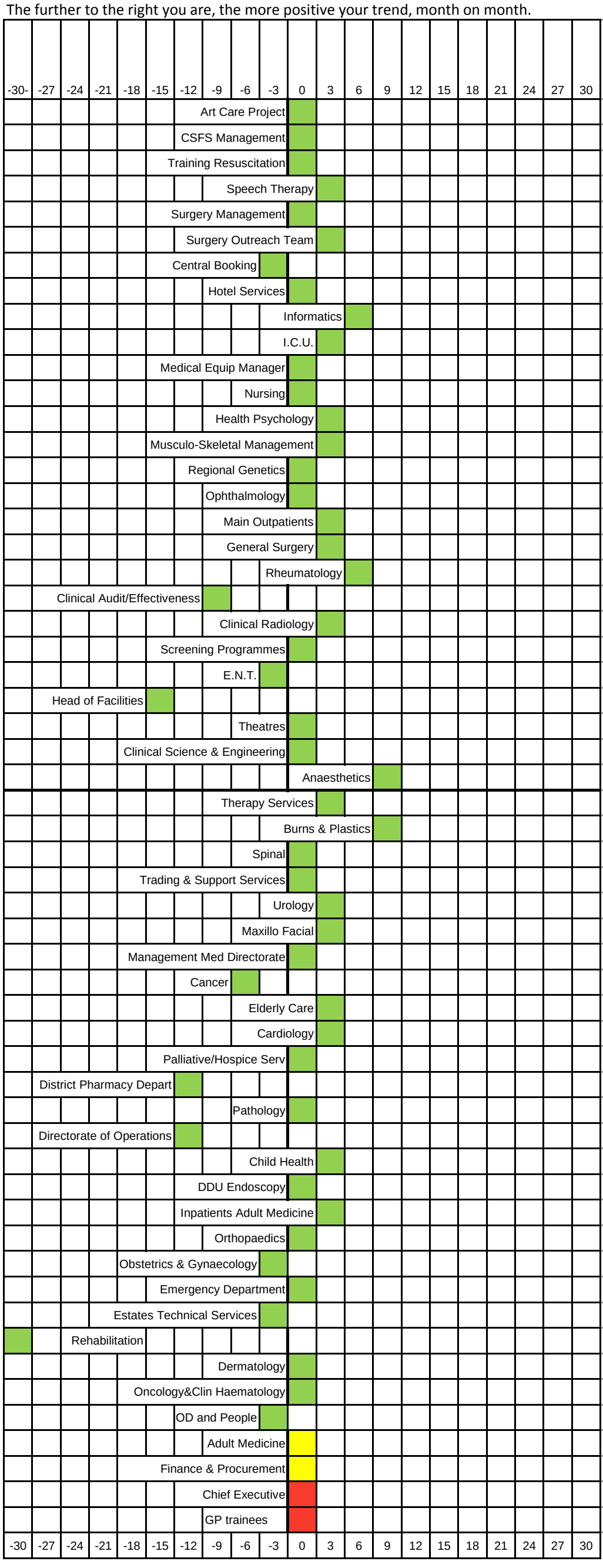
M1 Department	M1 Position	M12 Position	Change	M12 Compliance %	M1 Compliance %
Art Care Project	**1**	55	**54**	66.67%	**100.00%**
Capital	**2**	1	**-1**	100.00%	**100.00%**
Chief Executive	**3**	2	**-1**	100.00%	**100.00%**
CSFS Management	**4**	3	**-1**	100.00%	**100.00%**
E.N.T.	**5**	30	**25**	88.24%	**100.00%**
FES 2009 - T13130	**6**	4	**-2**	100.00%	**100.00%**
Main Outpatients	**7**	39	**32**	81.82%	**100.00%**
Recreational Assistant & Related Activities	**8**	6	**-2**	100.00%	**100.00%**
Rehabilitation	**9**	8	**-1**	100.00%	**100.00%**
Rheumatology	**10**	9	**-1**	100.00%	**100.00%**
Regional Genetics	**11**	7	**-4**	100.00%	**96.88%**
Palliative/Hospice Service	**12**	12	**0**	95.08%	**96.55%**
Orthopaedics	**13**	17	**4**	93.59%	**96.05%**
Hotel Services	**14**	14	**0**	94.52%	**95.14%**
Central Booking	**15**	13	**-2**	94.59%	**94.74%**
Ophthalmology	**16**	18	**2**	93.33%	**93.33%**
Clinical Audit/Effectiveness	**17**	19	**2**	93.18%	**93.18%**
Clinical Science & Engineering	**18**	20	**2**	92.86%	**92.86%**
Maxillo Facial	**19**	5	**-14**	100.00%	**92.86%**
Screening Programmes	**20**	11	**-9**	96.15%	**92.31%**
Cardiology	**21**	16	**-5**	94.00%	**91.84%**
Spinal	**22**	10	**-12**	96.39%	**91.76%**
Medical Equip Manager	**23**	21	**-2**	92.31%	**91.67%**
Theatres	**24**	34	**10**	86.50%	**91.36%**
Cancer	**25**	22	**-3**	91.67%	**90.91%**
Dermatology	**26**	25	**-1**	90.91%	**90.91%**
Musculo-Skeletal Management	**27**	26	**-1**	90.91%	**90.91%**
Surgery Management	**28**	27	**-1**	90.20%	**90.38%**
Trading & Support Services	**29**	23	**-6**	91.43%	**89.86%**
Informatics	**30**	15	**-15**	94.21%	**89.83%**
Child Health	**31**	24	**-7**	91.30%	**89.71%**
Therapy Services	**32**	29	**-3**	88.50%	**89.66%**
Obstetrics & Gynaecology	**33**	40	**7**	80.68%	**89.01%**
General Surgery	**34**	28	**-6**	89.81%	**88.50%**
I.C.U.	**35**	31	**-4**	87.50%	**87.50%**
Speech Therapy	**36**	32	**-4**	87.50%	**87.50%**
Pathology	**37**	33	**-4**	86.87%	**87.13%**
Emergency Department	**38**	35	**-3**	84.31%	**86.79%**
Burns & Plastics	**39**	37	**-2**	83.08%	**83.08%**
District Pharmacy Depart	**40**	42	**2**	78.69%	**83.05%**
Estates Technical Services	**41**	38	**-3**	82.86%	**82.05%**
DDU Endoscopy	**42**	36	**-6**	83.33%	**81.82%**
Adult Medicine	**43**	47	**4**	75.00%	**81.25%**
Inpatients Adult Medicine	**44**	51	**7**	73.79%	**80.77%**
Management Med Directorate	**45**	41	**-4**	80.00%	**77.97%**
Clinical Radiology	**46**	46	**0**	75.56%	**76.34%**
Elderly Care	**47**	44	**-3**	76.32%	**75.90%**
Anaesthetics	**48**	48	**0**	75.00%	**75.00%**
Training Resuscitation	**49**	49	**0**	75.00%	**75.00%**
Urology	**50**	50	**0**	75.00%	**75.00%**
Directorate of Operations	**51**	43	**-8**	78.13%	**74.29%**
Nursing	**52**	52	**0**	71.88%	**73.33%**
Oncology&Clin Haematology	**53**	53	**0**	71.79%	**72.50%**
Finance & Procurement	**54**	45	**-9**	75.86%	**71.60%**
OD and People	**55**	54	**-1**	69.23%	**69.05%**
Surgery Outreach Team	**56**	57	**1**	63.64%	**61.54%**
Head of Facilities	**57**	56	**-1**	63.64%	**60.00%**
Health Psychology	**58**	58	**0**	50.00%	**42.86%**
Charitable Funds	**59**	59	**0**	25.00%	**25.00%**
Medical Department	**60**	60	**0**	0.00%	**0.00%**



Mandatory training Heat Map M1 2019/20 (Rolling Year)

The higher up you are, the better your department is performing against other departments.
The further to the right you are, the more positive your trend, month on month.

M1 Department	M1 Position	Change	M12 Mandatory training %	M1 Mandatory training %	M12 Position
Art Care Project	1	0	100.00%	100.00%	1
CSFS Management	2	0	100.00%	100.00%	2
Training Resuscitation	3	1	100.00%	100.00%	4
Speech Therapy	4	3	98.68%	98.68%	7
Surgery Management	5	1	99.02%	98.43%	6
Surgery Outreach Team	6	4	97.39%	98.29%	10
Central Booking	7	-2	99.11%	97.63%	5
Hotel Services	8	0	97.78%	97.49%	8
Informatics	9	7	97.05%	97.41%	16
I.C.U.	10	4	97.18%	97.40%	14
Medical Equip Manager	11	1	97.25%	97.25%	12
Nursing	12	1	97.24%	96.95%	13
Health Psychology	13	5	96.92%	96.92%	18
Musculo-Skeletal Management	14	5	96.84%	96.84%	19
Regional Genetics	15	0	97.12%	96.79%	15
Ophthalmology	16	1	96.95%	96.61%	17
Main Outpatients	17	3	96.58%	96.58%	20
General Surgery	18	3	96.05%	96.23%	21
Rheumatology	19	6	95.20%	96.07%	25
Clinical Audit/Effectiveness	20	-9	97.37%	95.91%	11
Clinical Radiology	21	3	95.48%	95.88%	24
Screening Programmes	22	1	95.58%	95.58%	23
E.N.T.	23	-1	95.92%	95.56%	22
Head of Facilities	24	-15	97.78%	95.56%	9
Theatres	25	2	94.26%	94.12%	27
Clinical Science & Engineering	26	0	94.40%	94.02%	26
Anaesthetics	27	7	92.92%	94.02%	34
Therapy Services	28	3	93.04%	93.98%	31
Burns & Plastics	29	9	92.32%	93.30%	38
Spinal	30	2	93.00%	93.12%	32
Trading & Support Services	31	2	92.96%	92.96%	33
Urology	32	4	92.80%	92.86%	36
Maxillo Facial	33	4	92.74%	92.74%	37
Management Med Directorate	34	1	92.87%	91.90%	35
Cancer	35	-5	93.13%	91.60%	30
Elderly Care	36	5	91.39%	91.59%	41
Cardiology	37	5	90.92%	91.54%	42
Palliative/Hospice Serv	38	1	92.28%	91.51%	39
District Pharmacy Depart	39	-11	94.24%	91.28%	28
Pathology	40	0	91.81%	91.08%	40
Directorate of Operations	41	-12	93.46%	90.65%	29
Child Health	42	5	88.05%	90.45%	47
DDU Endoscopy	43	0	90.65%	90.29%	43
Inpatients Adult Medicine	44	4	87.85%	90.17%	48
Orthopaedics	45	0	89.50%	89.97%	45
Obstetrics & Gynaecology	46	-2	89.91%	89.88%	44
Emergency Department	47	2	87.80%	88.72%	49
Estates Technical Services	48	-2	88.34%	88.04%	46
Rehabilitation	49	-46	100.00%	87.50%	3
Dermatology	50	2	86.00%	87.25%	52
Oncology&Clin Haematology	51	0	87.10%	86.77%	51
OD and People	52	-2	87.20%	86.42%	50
Adult Medicine	53	0	82.76%	83.72%	53
Finance & Procurement	54	0	82.00%	82.39%	54
Chief Executive	55	0	74.60%	74.60%	55
GP Trainees	56	0	57.14%	56.80%	56



Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.2.3
Date of Meeting:	06 May 2019		

Report Title:	Finance Report Month 01			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Mark Ellis, Deputy Director of Finance			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the financial position for April 2019, the key risks and the actions being taken to mitigate them.

Executive Summary:

The purpose of this report is to set out the Trust's financial performance for the period to 30th April 2019.

The Trust met its control total in April 2019, reporting a control total deficit of £1.9m, leading to additional payments of £513k for MRET funding, PSF, and FRF. An underperformance against the activity plan offset by an underspend in expenditure budgets.

Pay expenditure of £13,262k in April includes c£400k of one-off payments to staff at the top of their band, as per the three year Agenda for Change pay deal agreed in 2018/19. The 2019/20 cost of living uplift has also been applied in full.

Delivery of the 2019/20 financial plan is contingent on the delivery of a £10m in cost improvement programme as well as managing any arising in year pressures. At this time the key risks are as follows:

- Increasing demand and pressures from Non Elective activity and delayed transfers of care placing additional pressure the Trust managing within its planned bed base.
- The successful recruitment and retention of clinical staff required to deliver the Trust's People Strategy, and therefore Workforce CIP.
- The financial pressure arising from the delivery of required performance standards in Endoscopy through outsourcing.
- Under utilisation of theatre lists in both main and day theatres.

In response the Trust is:

- The Trust is working to a detailed list of performance KPIs, managed through the patient flow PMB. The PMB also forms the intra hospital component of the health system plan linking with the pre and post hospital programme
- On-going work means that the Trust has a recruitment pipeline of overseas nurses. The People Strategy includes strands for focusing on difficult to recruit areas across the clinical professions.
- The Trust has engaged with a third party supplier to increase Endoscopy capacity and continues to seek opportunities to expand capacity further.
- The Trust has a detailed diagnostic by specialty to identifying incremental opportunity by specialty for increased theatre utilisation, and is undertaking weekly forward look monitoring on scheduled lists.

Cash flow continues to be monitored weekly but the Trust does not anticipate any further cash borrowing in 2019/20.

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	☐

Executive Summary of Key Financial Performance - April 2019

Page	Area of Review	Key Highlights	Status against Plan
1	Income & Expenditure	The Trust met its control total in April 2019, reporting a control total deficit of £1.9m, leading to additional payments of £513k for MRET funding, PSF, and FRF. An underperformance against the activity plan offset by an underspend in expenditure budgets.	Green
2	NHS Clinical Income	Overall income in month was £16,053k, £476k below plan. Contract values have been agreed for all NHS commissioner contracts. A contract has been signed with Wiltshire CCG and a longstop date is in place for 1st July 2019 to finalise the contract schedules.	Amber
3	Workforce	Pay expenditure of £13,262k in April includes c£400k of one-off payments to staff at the top of their band, as per the three year Agenda for Change pay deal agreed in 2018/19. The 2019/20 cost of living uplift has also been applied in full. Agency premium for the period is estimated at c£190k, spread evenly across the professional groups. The Trust has plans to increase its focus on hard to recruit areas in 2019/20 in order to continue the successful recruitment trend of the last 12 months.	Green
4	Non Pay	A Non Pay underspend of £370k has been driven by significantly reduced utilities costs versus expectation, Directorate underspends against clinical supplies and services, and delays to two contracts for the provision of healthcare by third parties (Spinal rehab and Salisbury WIC).	Green
5	Efficiency - Better Care at Lower Cost	The Trust has reported CIP delivery of £458k (72%) in April 2018, the shortfall in month one has been offset by non-CIP related budgetary underspends. Although the impact of non-delivery is mitigated in the short term, recurrent savings must be achieved to deliver the required improvement in the Trust's underlying financial performance.	Amber
6	Use of Resources	The Trust's overall risk rating score remains at 3, as had been planned for this stage in the year. The liquidity score continues to benefit from the payment of PSF in 2018/19, as does the capital service cover, although the level of the operating deficit means this remains at a 4. The Trust has forecast remaining at a score of three until the second half of the year, when the planned improvement in the operating deficit should drive improvements to both the capital service cover and I&E margin scores.	Amber
7	Capital Expenditure	The Trust is financing its capital spend in 2019-20 through depreciation. Although the Trust is behind plan in April 2019, expenditure is expected to come back in line with plan over the coming months. Plans are being monitored through the operation Capital Control Group which now reports into a Strategic projects group chaired by the Director of	Green
8	Risks and mitigations	The Trust has identified two key schemes as high risk in its NHSI planning returns: workforce, and patient flow. The former has performed well in M01 following recruitment in 2018/19, making retention now a key focus for the organisation. The latter is likely to come under pressure throughout the year, as year on year demand on the system continues to increase. Productivity in planned key remains a key areas of focus, with weekly monitoring leading to escalation where specialties' booking are below planned expectations. Capacity in Endoscopy remains a key financial and operational risk for the organisation, an allowance was made for the cost of planned outsourcing in 2019/20 planning and this area is being constantly appraised.	Amber

Page 1 - Income & Expenditure

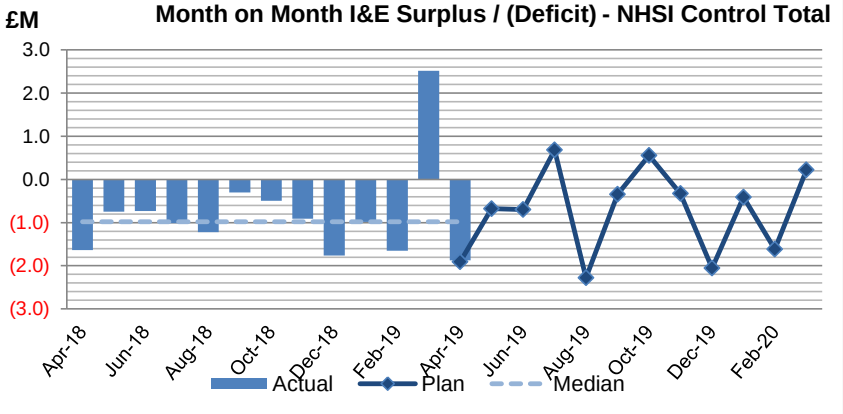
Status

Income & Expenditure

Position

	Apr '19 In Mth			Apr '19 YTD			2019/20
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical Income	16,529	16,053	(476)	16,529	16,053	(476)	196,036
Other Clinical Income	769	619	(150)	769	619	(150)	21,449
Other Income (excl Donations)	2,320	2,424	104	2,320	2,424	104	28,307
Total income	**19,618**	**19,097**	**(521)**	**19,618**	**19,097**	**(521)**	**245,792**
Operating Expenditure							
Pay	(13,472)	(13,262)	210	(13,472)	(13,262)	210	(157,326)
Non Pay	(6,622)	(6,252)	370	(6,622)	(6,252)	370	(80,163)
Total Expenditure	**(20,094)**	**(19,513)**	**581**	**(20,094)**	**(19,513)**	**581**	**(237,489)**
EBITDA	**(476)**	**(417)**	**59**	**(476)**	**(417)**	**59**	**8,303**
Financing Costs (incl Depreciation)	(1,430)	(1,455)	(25)	(1,430)	(1,455)	(25)	(17,157)
NHSI Control Total	**(1,906)**	**(1,872)**	**34**	**(1,906)**	**(1,872)**	**34**	**(8,854)**
Add: impact of donated assets	*105*	*(53)*	*(158)*	*105*	*(53)*	*(158)*	*1,260*
Add: Impairments	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: MRET, PSF, & FRF	*513*	*513*	*(0)*	*513*	*513*	*(0)*	*8,854*
Surplus/(Deficit)	***(1,288)***	***(1,412)***	***(124)***	***(1,288)***	***(1,412)***	***(124)***	***1,260***

Trend



Variation & Action

The Trust met its control total in April 2019, reporting a control total deficit of £1.9m, leading to additional payments of £513k for MRET funding, PSF, and FRF. An underperformance against the activity plan offset by an underspend in expenditure budgets.

Drivers of the underperformance against clinical income were: Elective and Day Case Orthopaedics (£0.2m), Critical Care bed days (£0.1m), and RTAs (£0.1m). The latter two a subject to an element of volitility, but the former has resulted in management action being taken in order to ensure available threatre lists are utilised to the same extent as 2018/19 after the implementation of changes to the theatre timetable.

As part of year two of the three year AfC pay deal, £0.4m of one-off lump sums were paid to those already at the top of their pay scales, this was included within the phasing of the financial plan. Agency costs were 39% of the total pay bill, representing a significant decrease on 2018/19 when

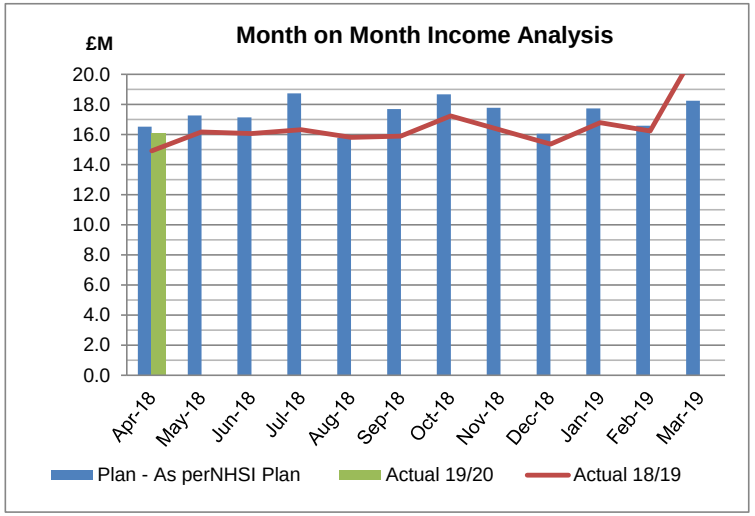
Page 2 - NHS Commissioner Income

Status	Position	Trend

NHS Clinical Income

Income by Point of Delivery (PoD) for all commissioners	Apr '19 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	710	706	(4)
Elective inpatients	1,493	1,378	(115)
Day Case	1,391	1,291	(100)
Non Elective inpatients	4,493	4,390	(103)
Obstetrics	862	836	(26)
Outpatients	2,623	2,619	(4)
Excluded Drugs & Devices (inc Lucentis)	1,443	1,404	(39)
Other	3,514	3,429	(85)
TOTAL	**16,529**	**16,053**	**(476)**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
Wiltshire CCG	8,778	8,649	(129)
Dorset CCG	1,872	1,736	(136)
Hants CCG	1,328	1,345	17
Specialist Services	2,831	2,371	(460)
Other	1,720	1,952	232
TOTAL	**16,529**	**16,053**	**(476)**



Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
Elective	422	399	(23)	384	15
Day case	1,765	1,668	(97)	1,562	106
Non Elective	2,312	2,231	(81)	1,925	306
Outpatients	20,855	20,883	28	18,953	1,930
A&E	4,086	4,054	(32)	3,817	237

Variation & Action

Overall income in month was £16,053k, £476k below plan. Income under performed against all points of delivery with notable under performance on Day cases, and Elective. Elective Orthopaedics were 19 spells below the in month plan of 100 and the Wiltshire CCG blended tariff adjustment drove the Non Elective position. The financial element of the Non Elective POD includes chargeable bed days (e.g. excess bed days), the reporting of such bed days requires the spells to be fully coded and a prudent estimation was made in M01.

Contract values have been agreed for all NHS commissioner contracts. A contract has been signed with Wiltshire CCG and a longstop date is in place for 1st July 2019 to finalise the contract schedules. Contract documentation for West Hampshire CCG and NHSE specialist has yet to be finalised and we are awaiting responses from respective commissioners. Commissioners and the Trust are working towards concluding all outstanding contract issues by 1st July 2019.

Page 3 - Workforce

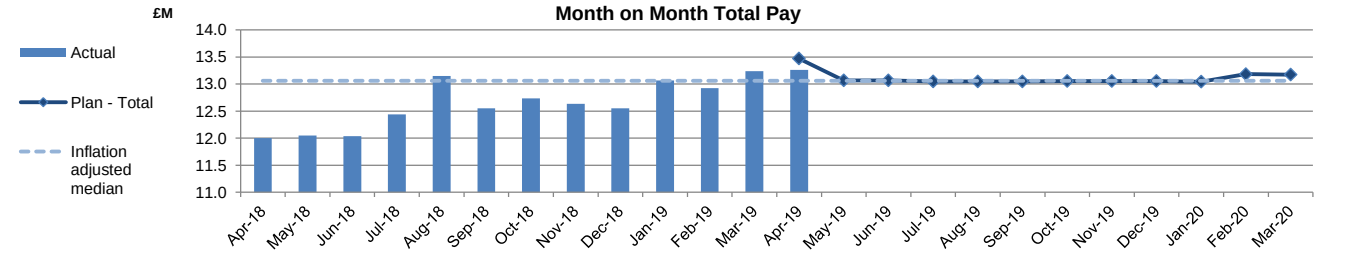
Status	Position	Position

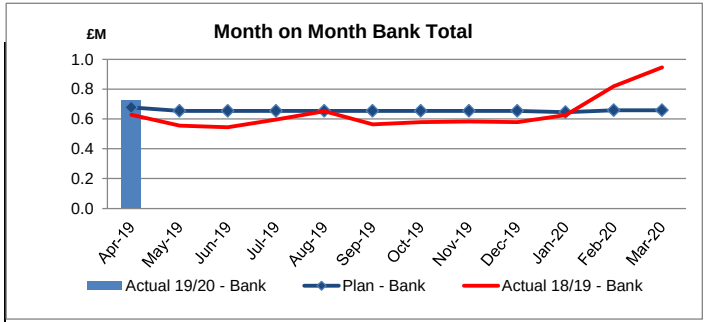
PAY

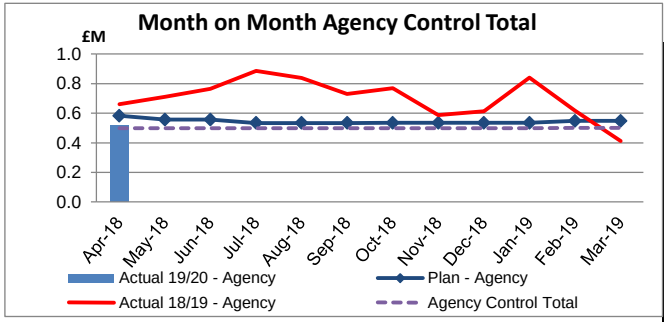
	Apr '19 YTD Plan £000s	Actual £000s	Variance £000s
Pay - In Post	12,131	520	11,611
Pay - Bank	678	727	(49)
Pay - Agency	583	11,966	(11,383)
Other (eg. Apprenticeship Levy)	80	49	31
TOTAL	**13,472**	**13,262**	**210**
Medical Staff	3,487	3,441	46
Nursing	3,584	3,353	231
HCAs	978	1,105	(127)
Other Clinical Staff	2,143	2,163	(20)
Infrastructure staff	3,200	3,151	49
Other (eg. Apprenticeship Levy)	80	49	31
TOTAL	**13,472**	**13,262**	**210**

	Apr '19 Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	383.2	402.3	(19.1)
Nursing	950.2	895.2	55.0
HCAs	405.3	500.0	(94.7)
Other Clinical Staff	608.1	610.4	(2.3)
Infrastructure staff	1,186.0	1,145.2	40.8
TOTAL	**3,532.8**	**3,553.1**	**(20.2)**

Trend







Variation & Action

Pay expenditure of £13,262k in April includes c£400k of one-off payments to staff at the top of their band, as per the three year Agenda for Change pay deal agreed in 2018/19. The 2019/20 cost of living uplift has also been applied.

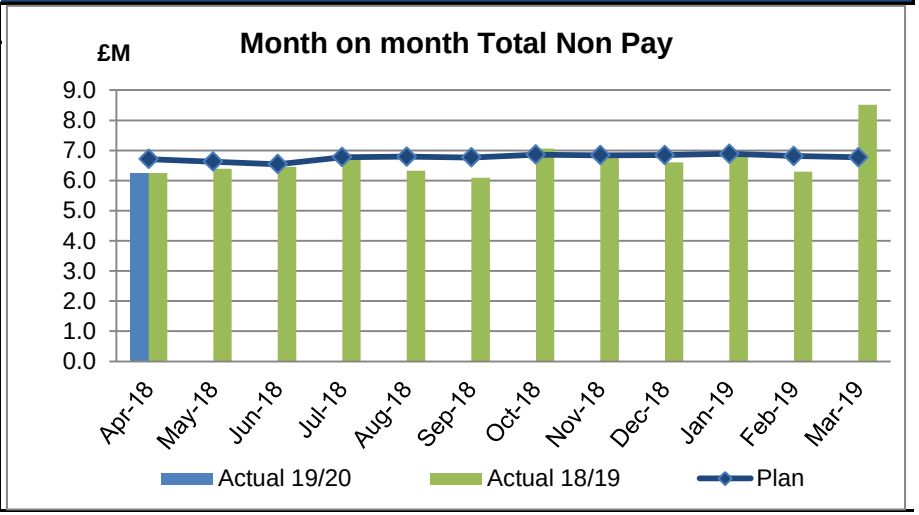
Continued control over Agency costs, as well as a reduction in bank costs following the end of winter incentives and the closure of escalation beds have underpinned the Trust's underlying month-on-month reduction in Pay expenditure. All Clinical Directorate have delivered within the Pay budget envelopes, with a small pressure (£12k, 0.7%) experienced in Corporate areas.

The Surgery and Medicine Directorates continue to mitigate nursing vacancies with the usage of Nursing Assistants.

Agency premium for the period is estimated at c£190k, spread evenly across the professional groups. The Trust has plans to increase its focus on hard to recruit areas in 2019/20 in order to continue the successful recruitment trend of the last 12 months.

Page 4 - Non Pay Expenses (excluding Finance Charges & Depreciation)

Status	Position				Trend
		Apr '19 YTD			
		Plan £000s	Actual £000s	Variance £000s	
NON-PAY	Drugs	1,677	1,687	(10)	
	Clinical Supplies	2,000	1,800	200	
	General Supplies	283	385	(102)	
	Outsourced healthcare	527	409	118	
	Other Non Pay expenses	2,135	1,971	164	
	TOTAL	**6,622**	**6,252**	**370**	



Variation & Action

The Non Pay underspend in April was driven by a number of key areas:

- The utilities budget is phased on a historic basis, a warm April led too much lower costs than anticipated, resulting in a spend £60k less than planned. This variance will reduce as we move into the warmer months.

- Outsourced healthcare had three key variances, the usage of spinal beds (£40k) had initially been planned from April, however procurement processes and negotiations with NHS mean there have been delays (this is offset by reduced clinical income). A contingency against a contractual increase in the bowel scoping provision that the Trust had planned for (£50k), again offset by income. Due to contractual delays, Wilts CCG continued to pay the £70k for the SWIC contract directly in M01.

- Clinical supplies was well within planned expenditure for all Directorates except CSFS, where reagent in the Regional Genetics lab caused a cost pressure, although this was offset by the income generated through provider to provider activity.

Page 5 - Efficiency - Better Care at Lower Cost

Status	Position							
	Directorate	Annual Plan £000s	Apr '19			YTD		
			Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
	Medicine	2,192	161	89	(72)	161	89	(72)
	Musculo Skeletal	1,385	84	74	(10)	84	74	(10)
	Surgery	1,728	130	45	(85)	130	45	(85)
	Clinical Support & Family Services	1,965	134	90	(44)	134	90	(44)
	Corporate Services	1,730	134	160	26	134	160	26
	Strategic	1,000	-8	0	8	-8	0	8
Efficiency	**TOTAL**	**10,000**	**634**	**458**	**(177)**	**634**	**458**	**(177)**

Position							
Scheme	Annual Plan £000s	Apr '19			YTD		
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Theatres	1,156	96	0	(96)	96	0	(96)
Workforce	1,001	83	74	(9)	83	74	(9)
Diagnostics	600	42	42	0	42	42	0
Patient Flow	825	69	23	(46)	69	23	(46)
Outpatients	500	0	0	0	0	0	0
Non-Pay Procurement	1,494	74	74	0	74	74	0
Medicines Optimisation - Drugs	500	0	0	0	0	0	0
Clinical Directorate Plans	2,547	162	109	(53)	162	109	(53)
Corporate Directorate Plans	1,378	108	136	28	108	136	28
TOTAL	**10,000**	**634**	**458**	**(177)**	**634**	**458**	**(177)**

Variation & Action

The Trust has reported CIP delivery of £458k (72%) in April 2018, the shortfall in month one has been offset by non-CIP related budgetary underspends. Although the impact of non-delivery is mitigated in the short term, recurrent savings must be achieved to deliver the required improvement in the Trust's underlying financial performance.

Although the Theatres programme has not delivered savings in April a work plan is in place to deliver significant productivity benefits within DSU, phased from the beginning of Q2.

The patient flow programme has mitigated the need to open escalation areas in the month, delivering a saving of £23k versus the baseline plan. This should be set in the context of over performance against the non-elective plan, which even after applying the contractual 'blended tariff' payment mechanism over performed by £21k within the existing bed base, similar productivity benefits will be recognised from M02 reporting.

Page 6 - Use of Resources

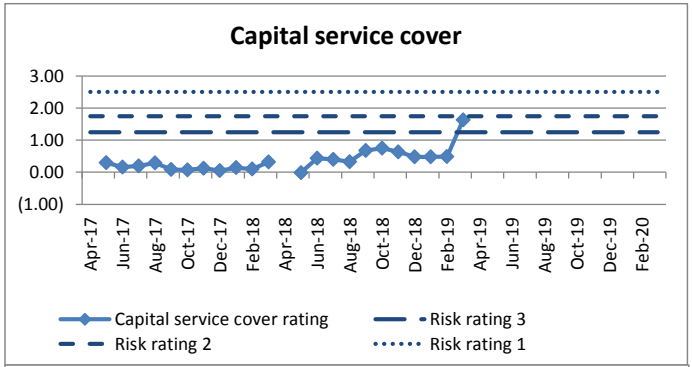
Status	Description	Position			
		Metric	Definition	YTD Plan Number	YTD Actual Number
Use of Resources	NHSI measures an organisation's use of resources on a scale of 1-4 with 4 being the highest risk and 1 the lowest risk	Capital service cover rating	Degree to which income covers financial obligations	4	4
		Liquidity rating	Days of operating costs held in cash	1	1
		I&E margin rating	I&E surplus/deficit / total revenue	4	4
		I&E margin: distance from control total	YTD actual I&E surplus/deficit compared to YTD plan	1	1
		Agency rating	Distance from cap	3	2
		Risk rating after overrides		3	3

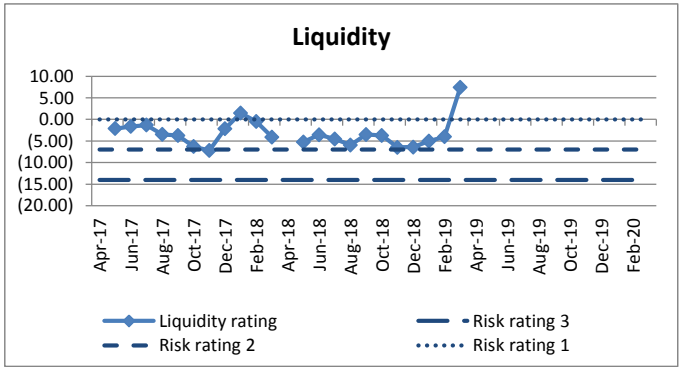
Variation & Action

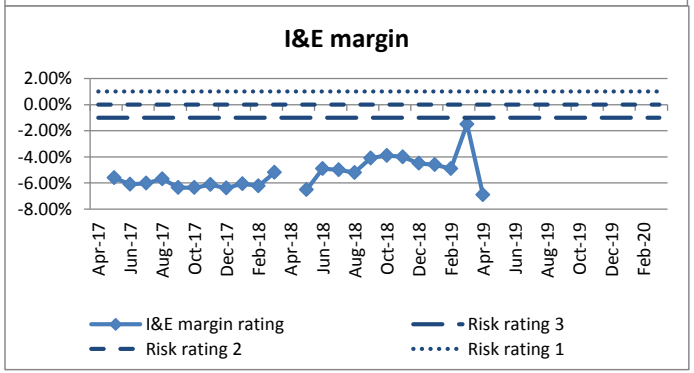
The Trust's overall risk rating score remains at 3, as had been planned for this stage in the year. The liquidity score continues to benefit from the payment of PSF in 2018/19, as does the capital service cover, although the level of the operating deficit means this remains at a 4.

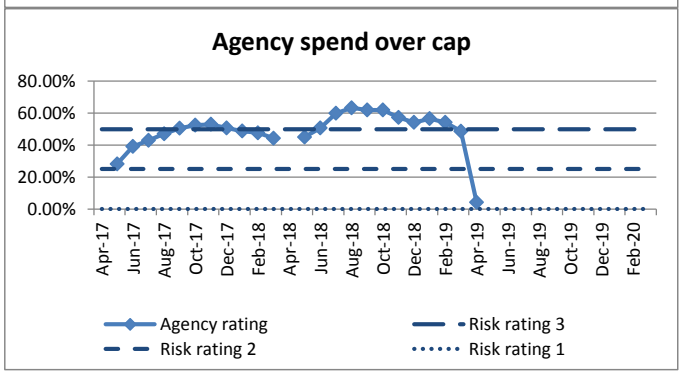
The Trust has forecast remaining at a score of three until the second half of the year, when the planned inprovement in the operating deficit should drive improvements to both the capital service cover and I&E margin scores.

The Trust continues to monitor progress against the NHS enforcement notice action plan.



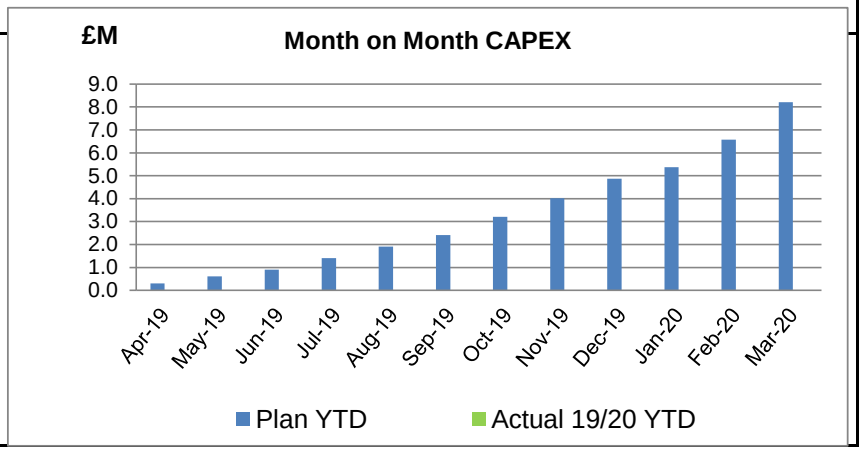






Page 7 - Capital Expenditure

Status	Position				
	Schemes	Annual Plan £000s	Apr '19 Plan £000s	Apr '19 Actual £000s	Apr '19 Variance £000s
Capital Spend	Building schemes	1,124	0	10	(10)
	Building projects	1,055	65	13	52
	IM&T	3,414	150	7	143
	Medical Equipment	2,008	50	6	44
	Other	603	37	37	0
	TOTAL	**8,204**	**302**	**73**	**229**



Variation & Action

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

Although the Trust is behind plan in April 2019, expenditure is expected to come back in line with plan over the coming months. Plans are being monitored through the operation Capital Control Group which now reports into a Strategic projects group chaired by the Director of Finance.

Report to:	Trust Board (Public)	**Agenda item:**	**3.1**
Date of Meeting:	6 June 2019		

Report Title:	Learning from deaths Q4 2018 - 2019			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Prepared by:	Dr Belinda Cornforth, Consultant Anaesthetist Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Christine Blanshard, Medical Director			
Appendices (list if applicable):	Appendix 1 – Mortality dashboard Q4 2018/19 Appendix 2 - Learning from death themes and improvement actions. Appendix 3 – Mortality dashboard explanation of terms			

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

Executive Summary:
The mortality dashboard for the full year 2018/19 shows the number of deaths, outcome of reviews, learning themes and actions taken to improve. The vast majority of deaths were unavoidable and expected but five (0.62%) were considered probably avoidable and 4 are subject to serious incident inquiries. The support of bereaved families has been strengthened by the bereavement support service and will be linked to the Medical Examiner system once an option is agreed. HSMR has remained stable within the expected range but the increasing trend of weekend HSMR is of concern. The Trust intends to undertake a detailed case notes review to understand this further and take improvement actions as needed. The relative risk of deaths in 3 high risk diagnosis groups is showing an upward trend. The report was presented at the Clinical Governance Committee in May 2019.

Board Assurance Framework – Strategic Priorities	
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒

People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐

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 during 2019/20 to strengthen the support of bereaved families and drive improvements.

3.0 Medical Examiners (ME)

We continue to explore options for delivering the ME service to ensure excellence in care for the bereaved but also ensuring the service remains cost effective. Alternatives under consideration are:

1. Continuing with our current system but introducing a Medical Examiner's Officer to undertake the majority of interactions with relatives (after prior consultation with the ME's). This will require the current clinicians who discuss death certification with a junior to undergo training to become Medical Examiners, and will also require expansion of the end of life care specialist nursing team.

2. Significantly changing the current system to ensure all conversations with the bereaved are conducted by consultants. This will require approximately 80 consultant hours/month, training and also administrative support.

4.0 Working with bereavement families

In July 18, the National Quality Board published guidance for NHS Trusts on working with bereaved families and carers on how we should support and engage with families after a loved one has died in our care.

A detailed action plan is in place and actions will be linked to the new Medical Examiner system. Actions completed so far:

- A 'What to do when someone dies in Salisbury Hospital' leaflet has been updated to align with the national leaflet. This is given to relatives by the bereavement suite staff.
- Condolence cards designed by Trust staff and patients along with a leaflet on 'Support and advice following a bereavement' are sent to relatives 3 weeks after the death.
- Restart the bereavement survey in June 2019 with a telephone advice and support service when needed.
- Longer term – redesign the Trust's website to signpost people to the right information when a person has died.

5.0 Mortality dashboard, learning, themes and actions

For the full year 2018/19, 799 deaths occurred in the Trust. Of these, 778 (97%) were screened to ascertain whether the death needed a full case review. 304 (38%) deaths had a full case review. Five (0.62%) deaths were considered probably avoidable (4 serious incident inquiries), 30 deaths had slight evidence of avoidability and 2 were possibly avoidable but not very likely, less than 50/50 chance. Key themes arising from the 74 learning points were:

1. Recognising deteriorating patients and escalating to the appropriate level.
2. End of life care – communication with patients and families, and early involvement of the end of life care team or hospital palliative care team to support patients, families and clinical teams.
3. End of life care – rapid discharge to the preferred place of care.
4. DNACPR decisions, documentation and discussion with patients and families.
5. Treatment escalation plans being discussed with patients and families and acted upon.

6.0 Improvement actions in 18/19

1. Redesign the PICC line service – the team now insert Midline catheters as an alternative to PICC lines in suitable patients. No patient delays were identified from case notes reviews in 18/19. Performance and improvements are monitored by a Line Working Group. Completed.
2. Introduction of the ReSPECT form – led by the Resuscitation Committee. A business case, to support the training and roll out of RESPECT, has been agreed with a plan to have it in place by November 2019. This is now aligned with a piece of work across the BSW STP.
3. Development of a frailty unit for acutely unwell elderly patients – has been developed and supported by the Older People's Liaison Team (OPAL). Four hours of a second on call medical consultant was introduced in September 2018 to ensure weekend reviews are undertaken when needed. Completed.
4. Continue the end of life care education programme to support teams review ceilings of care – the Specialist Palliative Care Team continue to provide education sessions for doctors in training as a core topic. The end of life care team also provide ward based training and other educational events. In 18/19, 46% of hospital deaths had specialist care input. Case notes reviews show end of life discussions are recorded well. Completed.
5. Introduction of LocSSips (standard operating procedures) for local procedures – LocSSip for lumbar puncture completed, chest drain insertion checklist is partially completed and ascitic tap drainage requires further work. Partially completed.
6. Timely escalation of deteriorating patients – NEWS2 was successfully implemented in February 2019 with compliance >90%. An escalation protocol is in place with further work required to ensure clinicians escalate to the appropriate level. A H@NT escalation protocol when workload exceeds the ability to respond promptly is in place. Completed.

7.0 Bereavement support

In 18/19, 7 families raised concerns about the care of their relatives and were contacted to enable them to express their concerns and were offered a discussion with a consultant or senior nurse or attend a meeting.

8.0 CUSUM alerts

Six new CUSUM alerts arose:

In Q3 18/19:

- Cancer of bronchus (2nd alert) - 25 observed deaths vs 13.9 expected with a relative risk of 180 to July 2018. The 1st alert in January 2018 arose in the Hospice, but the acute Trust did not have a CUSUM alert. These cases were investigated and no evidence of avoidability in the 14 cases reviewed was found, nor any learning points. No further investigation required.
- Cancer of brain and CNS - 9 observed deaths vs 2.7 expected with a relative risk of 327 to August 2018 (3 patients died in the Hospice). These were reported in the Q3 report. All the deaths were expected and none were considered avoidable. One learning point was identified related to thromboprophylaxis which is not required for patients admitted to the Hospice at the end of life.

In Q4 18/19:

- Anxiety, somatoform, dissociative & personality disorder - 1 death vs 0.1 expected with a relative risk of 1677 to October 2018. The Mortality Surveillance Group considered this alert did not need to be investigated as the patient had a secondary diagnosis of dementia. No further action required.
- Lung biopsy - 1 death vs 0 expected with a relative risk of 5600 to October 2018. The Mortality Surveillance Group felt this CUSUM alert did not need to be further investigated as the patient notes had been reviewed and he had died of secondary malignancies.
- Repair of umbilical hernia - 1 death vs 0 expected with a relative risk of 3427 to October 2018. 92 year old patient had an open repair of a strangulated hernia, optimal post-operative management in ITU but

had a STEMI treated medically as the patient was not suitable for PCI. Death unavoidable, no learning points.

- Secondary malignancies (3rd alert) - 32 death vs 16 expected with a relative risk of 195 to November 2018. A 2nd alert for secondary malignancies arising from June 2018 was investigated and reported in the Q3 18/19 report. All the deaths were expected and none were considered avoidable. One learning point was identified about the ordering of home oxygen.

9.0 Death following a planned admission to hospital

In Q4 18/19, there were 2 deaths of patients following a planned admission:

- A patient with a refractory T cell lymphoma treated with a curative intent but with poor prognostic indicators. He was treated with full dose IV combination chemotherapy treatment with full supportive medication to minimise toxicity. The patient was adamant he wanted full treatment despite the awareness of the associated risks. His disease did not respond to first or second line treatment and he deteriorated and died very quickly from disease progression. Death not avoidable.

  Learning point: ensure realistic and clear expectations are given about the likely outcomes when treatment is discussed with the patient including the associated risks of chemotherapy. The team plan to introduce the national chemotherapy consent forms when available later this year.

- Patient with previous breast cancer and mastectomy admitted for a biopsy of an intra-oral mass of 6 – 8 weeks duration. Surgery and anaesthetic were complicated by an upper airway problem which required intubation and tracheostomy. Biopsy confirmed metastatic breast cancer and CT confirmed liver involvement. Planned withdrawal of treatment but the patient died beforehand of disease progression. Death not avoidable.

  Learning point: Well recognised complication related to airway management. To be discussed at the ITU mortality and morbidity meeting.

A total of 11 deaths in 2018/19 following a planned admission to hospital. Deaths in Q1, Q2 and Q3 have been previously reported.

10.0 Unexpected deaths

In Q4, there were 3 unexpected deaths. One was probably avoidable with a greater than 50/50 chance:

1) An 85 year old patient admitted with knee pain following a fall. No fracture identified. Community and hospital DNACPR in place. Patient progressed well but 3 days into admission had a sudden onset of shortness of breath and wheeze leading to apnoea. Escalated appropriately with a diagnosis of significant pulmonary embolism. The patient was already been prescribed prophylactic anticoagulation and antiplatelet treatment. Death not considered avoidable. No learning points.
2) A 74 year old patient admitted from Fountains Way (self neglect, depression and chronic delusional disorder) with haematemesis, acute kidney injury and aspiration pneumonia. Fully investigated and maximal treatment with regular reviews including ITU. The team were unable to contact the next of kin initially so made clinical decisions on a best interests basis. The team eventually located her daughter on day 11. Death not considered avoidable.
   Learning point: Every attempt should be made to find the next of kin to permit early discussions regarding DNACPR and end of life care.
3) A 53 year old patient attended the Emergency Department with a history of a drug overdose, depression and binge drinking – appropriate treatment given. Mental health team review established a lack of suicidal intent and considered the patient low risk. Further investigation required. Death possibly/probably avoidable to be reported in Q1 19/20.

11.0 Stillbirths, neonatal deaths and child death

One stillbirth in March of an intra-uterine death at term. No neonatal deaths in Q4. One child death which is subject to a serious incident inquiry 301.

12.0 Patients with a learning disability

In Q3 18/19, two patients with a learning disability died:

- A patient with a history of schziophrenia, dementia and seizures, COPD and ongoing urinary tract infection. Patient was recorded as having a learning disability. Suffered a large haemorrhagic stroke with midline shift and aspiration pneumonia. Maximal treatment for 48 hours with little improvement. In discussion with the patient's family the decision was made for palliative management. Treatment was stopped and anticipatory medications prescribed. Death was not avoidable. No learning points.
- An 89 year old patient with a learning disability admitted from a nursing home, bedbound and frail. Diagnosis of widespread previously undiagnosed hepatic cancer of unknown primary origin. Good consultant led care and decision making with the family involved in the decision for palliative management. Death not avoidable. No learning points

In Q4 18/19, three patients with a learning disability died and these will be reported in Q1 19/20.

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

13.0 Patient with a serious mental illness

One patient with a serious mental illness died in Q3 18/19:

- A 79 year old man admitted from Fountains Way (under section 2 with a diagnosis of dementia). Had an unwitnessed fall at the mental health provider and reduced responsiveness. On admission to SFT he was treated for presumed chest sepsis and became fit for discharge but later deteriorated with end stage dementia and died within 24 hours. Death not avoidable and no learning points.

In Q4 18/19, three patients with a serious mental illness died and these will be reported in Q1 19/20.

14.0 Care Quality Commission mortality outlier alert

In January 2019, the Trust was notified of a mortality outlier alert of patients admitted with a primary diagnosis of chronic obstructive pulmonary disease (COPD) and bronchiectasis, with codes J40 – J44 and J47 who died between 1st June 2017 and 31 May 2018. 25 cases were identified and all 25 cases were reviewed by a team of two Consultants, Lead Respiratory Nurse and the Head of Clinical Effectiveness.

In addition, a separate audit to ascertain compliance with the British Thoracic Society chronic obstructive pulmonary disease standards for admission was undertaken of 14 patients whose cause of death was recorded as 1a chronic obstructive pulmonary disease. Of these 14 patients, 2 were excluded, as they were end of life on admission and died within 12 hours of arrival.

A significant proportion of the patients in the investigation did not have COPD as a primary diagnosis once the notes were fully examined. However, we included all patients in the review. The reviewers concluded that the management of COPD was of a good standard and that compliance with most aspects of the British Thoracic Standards COPD admission care bundle was also good. No deaths were considered avoidable. Learning points generated from case note reviews unrelated to COPD management have been been disseminated. It is recognised that increased capacity for consultant review at the weekends and bank holidays is associated with better quality of care. The second-on medical consultant cover was increased by a total of 4 hours over the weekend in September 2018, with any further increase being limited by available resources.

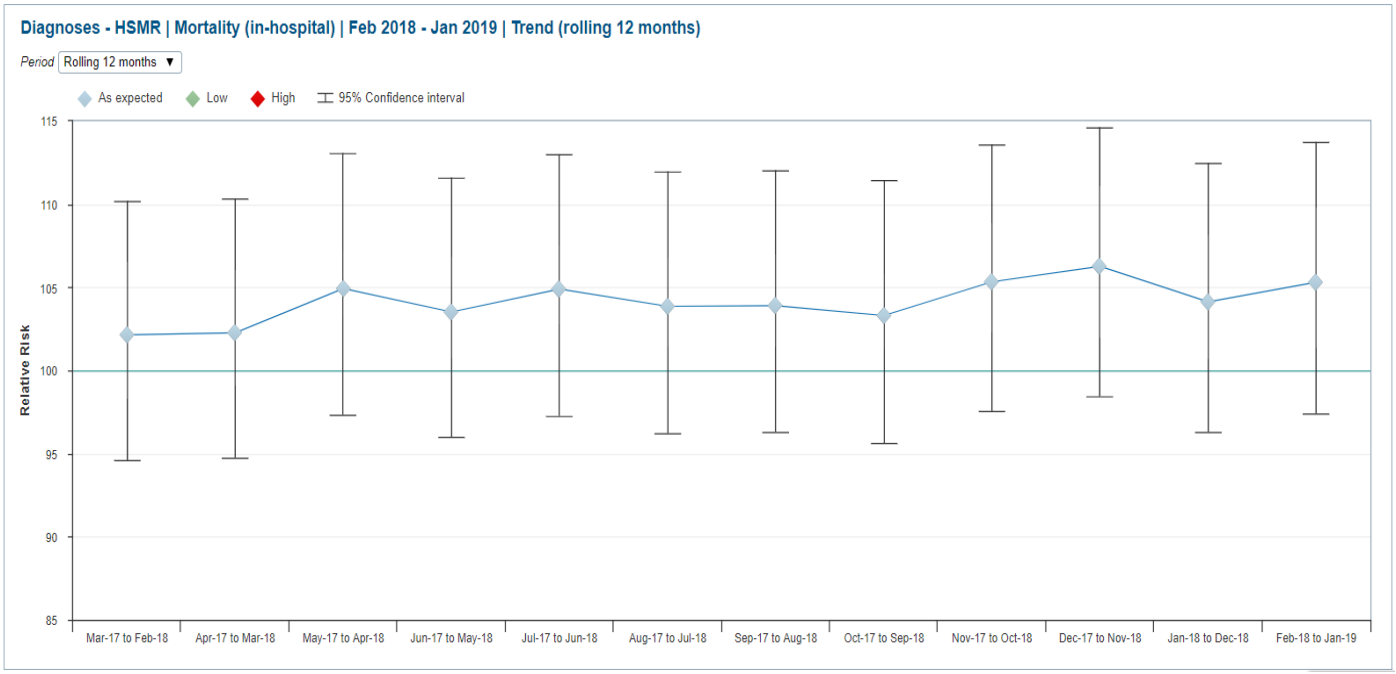
Areas for improvement:

1. More rapid referral to a respiratory specialist team and an improvement in time taken for the patient to then be reviewed by a respiratory specialist team. It was agreed that this would require increased resources.

2. Whilst repeat audit has shown improvements in oxygen prescribing and signing for the administration of oxygen, there remains work to be done in this area.
3. In 6 cases the quality of care was rated as adequate but with some issues and of these, five were related to reduced capacity for a senior review at weekends and bank holidays.
4. Most of the patients were known to the respiratory team and a review of clinic letters by the admitting team would have resulted in a more accurate diagnosis.

15.0 HSMR rolling 12 month trend to January 2019

Table1: HSMR relative risk of all non-elective diagnoses May 2017 – January 2019



HSMR remains stable within the expected range.

16.0 SHMI January 2018 – December 2018

SHMI reduced from 105.1 to June 18 to 100 to December 2018 as is within the expected range.

SHMI adjusted for palliative care reduced from 97.7 to June 18 to 94 to September 2018.

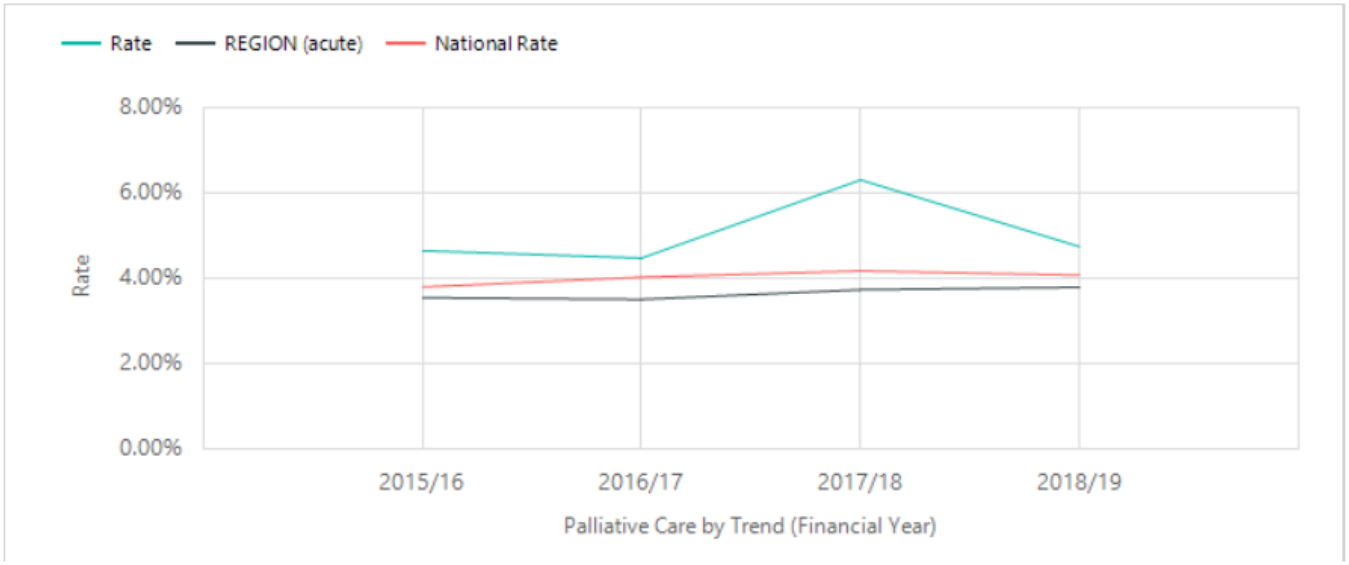
17.0 Comorbidity and palliative care coding 18/19

Table 2: Trend in Charlson Comorbidity upper quartile rate

	2015/16	2016/17	2017/18	2018/19
Upper-quartile comorbidity	26.1%	24.2%	24.4%	24.5%
as index of national (100)	105	97	98	98

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	8,506	403	4.74%	4.07%	3.79%



The Trust's palliative care coding rate has decreased in 2018/19 compared to 2017/18.

18.0 Weekday/weekend HSMR

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

Table 4: Emergency weekday/weekend HSMR February 2018 – January 2019

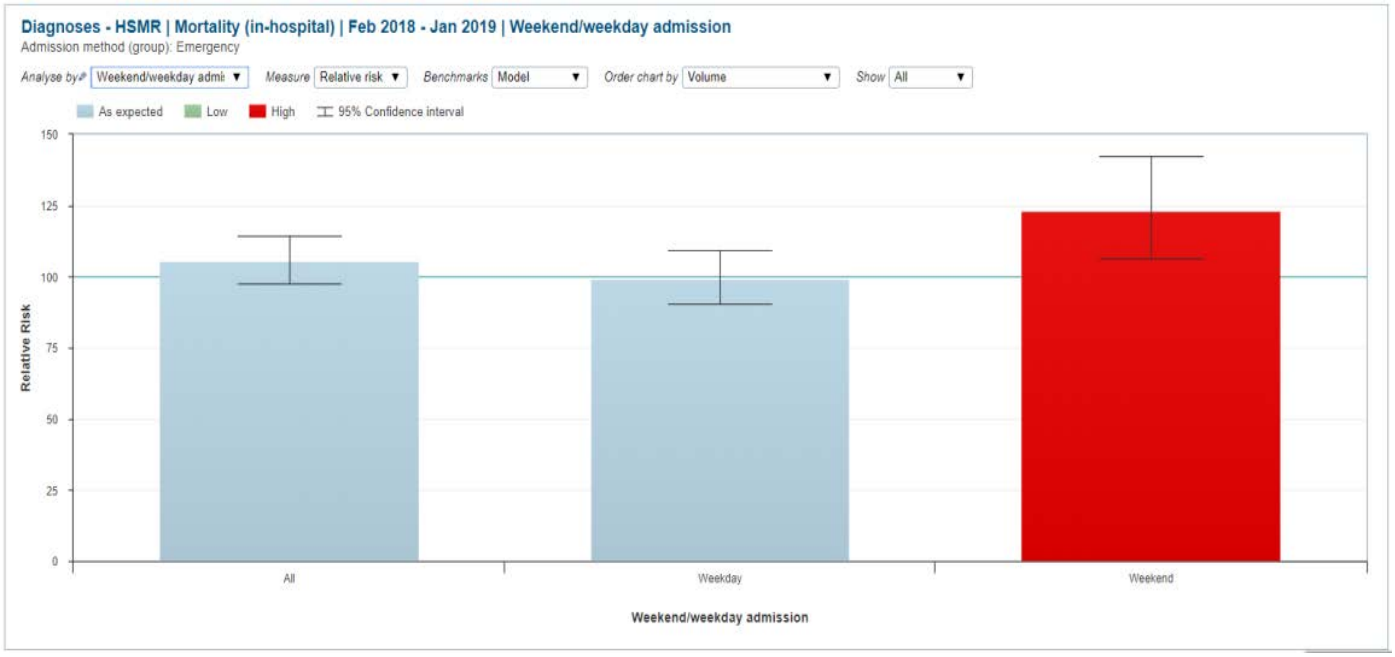
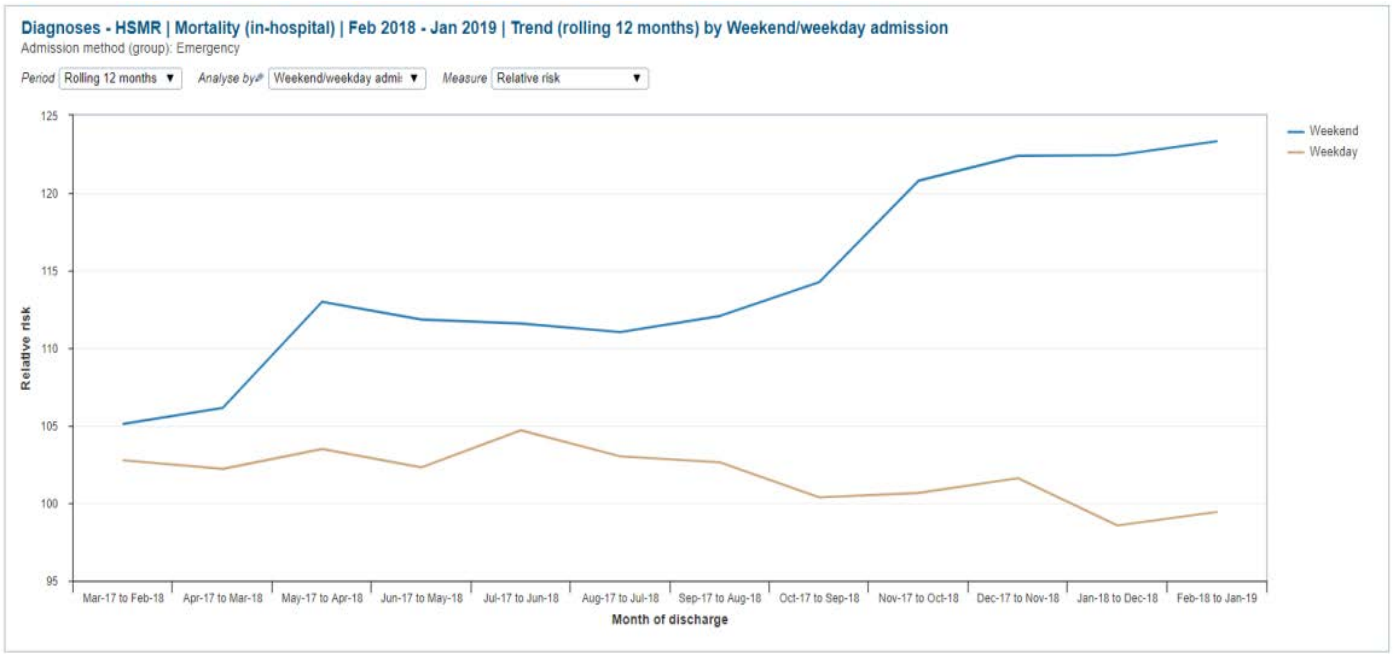


Table 5: Rolling 12 month trend in emergency weekend and weekday HSMR



The emergency weekend HSMR has been increasing and has been statistically significantly higher than expected for the last 4 rolling 12 month data periods.

With the help of the Dr Foster's team, when examining the HSMR for emergency admissions at the weekend (Saturday and Sunday) between February 2018 to January 2019 it shows:

- The acute hospital site is statistically significantly higher than the expected relative risk.
- For the acute hospital site, April 2018 had a statistically significantly higher than expected relative risk. This related to the pneumonia diagnosis group with 7 observed deaths vs 1.5 expected. A review of these cases found 100% compliance with 5 of the 6 care bundle standards. Only, one of the 7 patients had a documented CURB score. This needs improvement, although none of the patients were adversely affected by the lack of a score. Six of the 7 patients had a consultant review within 14 hours

of admission and all the patients who remained acutely unwell at a weekend had a regular medical review.

- The relative risk is highest for the most recent 12 month period (February 2018 – January 2019) at 122.
- For the acute hospital site, patients admitted on a Sunday had a statistically significantly higher than expected relative risk.
- For admissions on a Sunday the following cohorts have a statistically significantly higher than expected relative risk:
  - Secondary malignancies diagnosis group 3 vs 0.6 expected
  - 7-13 day length of stay
  - Age 65-74
  - Charlson comorbidity score of zero

- In order to understand this the Trust will undertake a case notes review to include the diagnosis groups with the biggest number of observed deaths:
  - Pneumonia 19 deaths vs 13.3 expected
  - Septicaemia (except in labour) 13 vs 10.6 expected
  - Sunday admissions with a 7 – 13 day length of stay, aged 65 – 74 with a Charlson comorbidity score of zero (62 deaths)

19.0 Deaths in high risk diagnosis groups (February 2018 – January 2019)

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

Table 6: Trend in relative risk for septicaemia

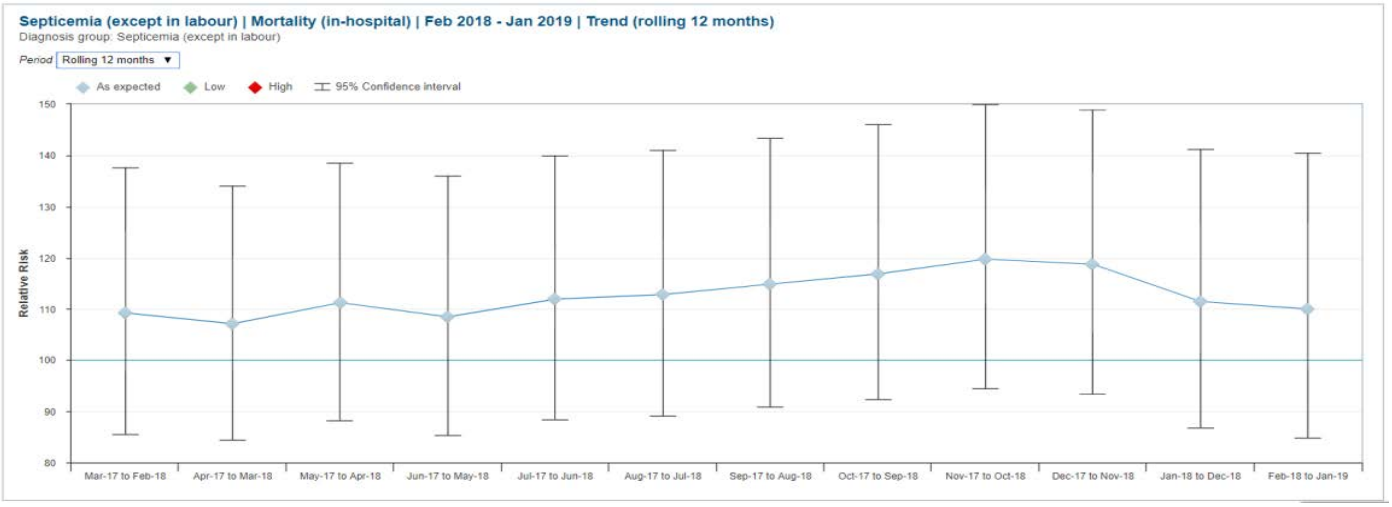


Table 7: Trend in relative risk for pneumonia

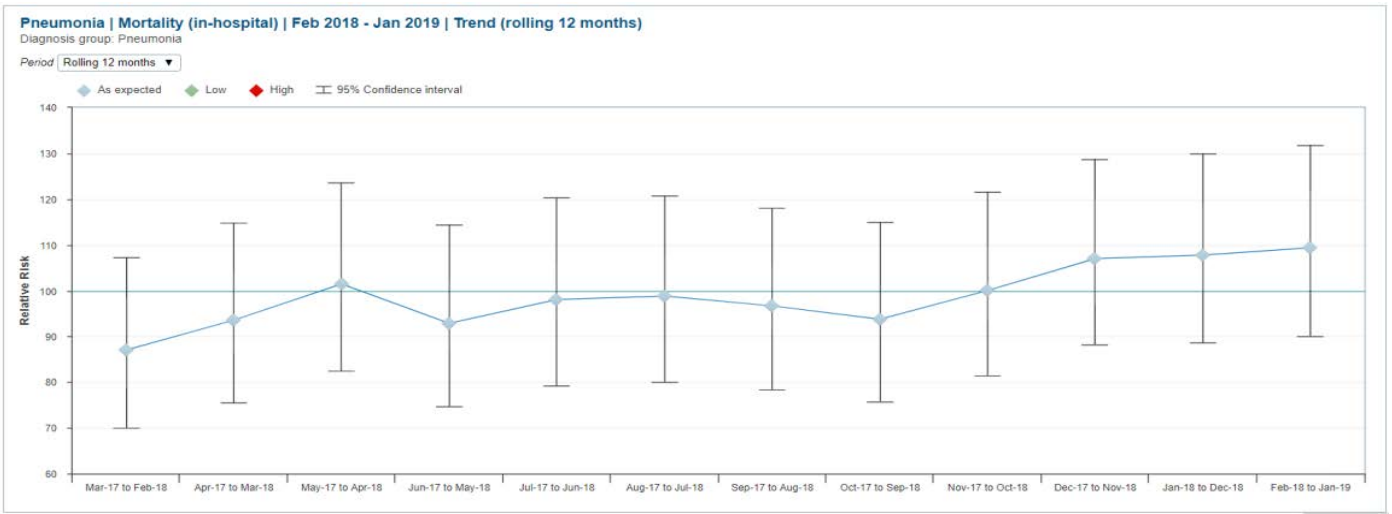


Table 8: Trend in relative risk for acute cerebrovascular disease

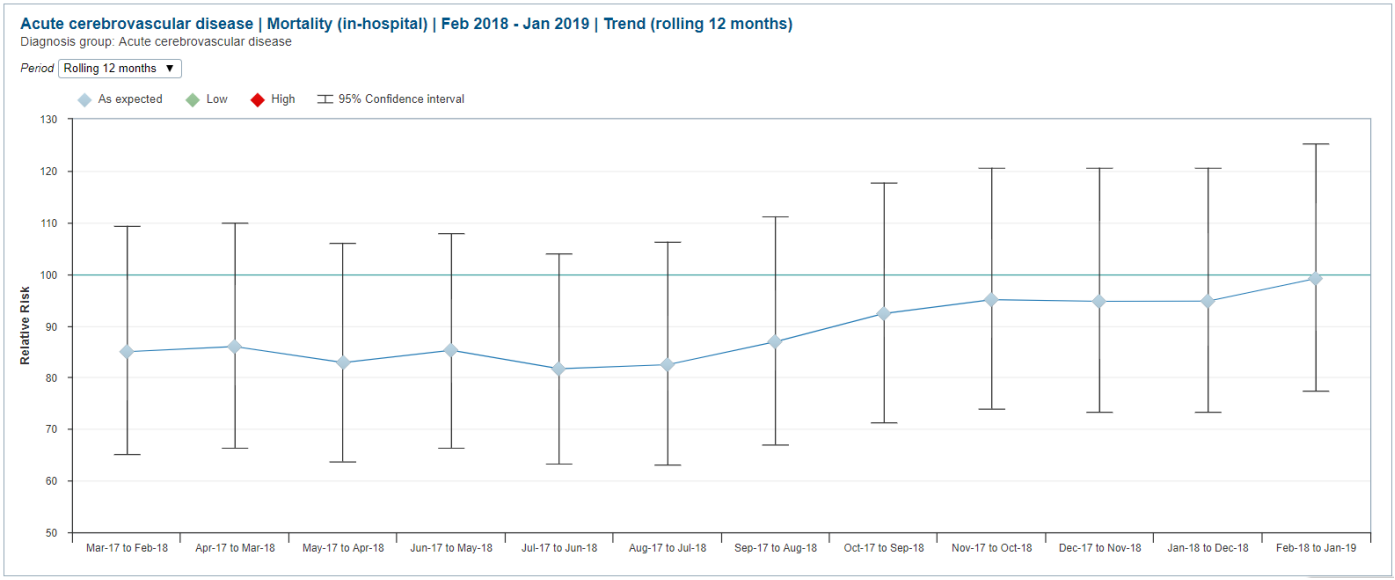


Table 9: Trend in relative risk for acute myocardial infarction

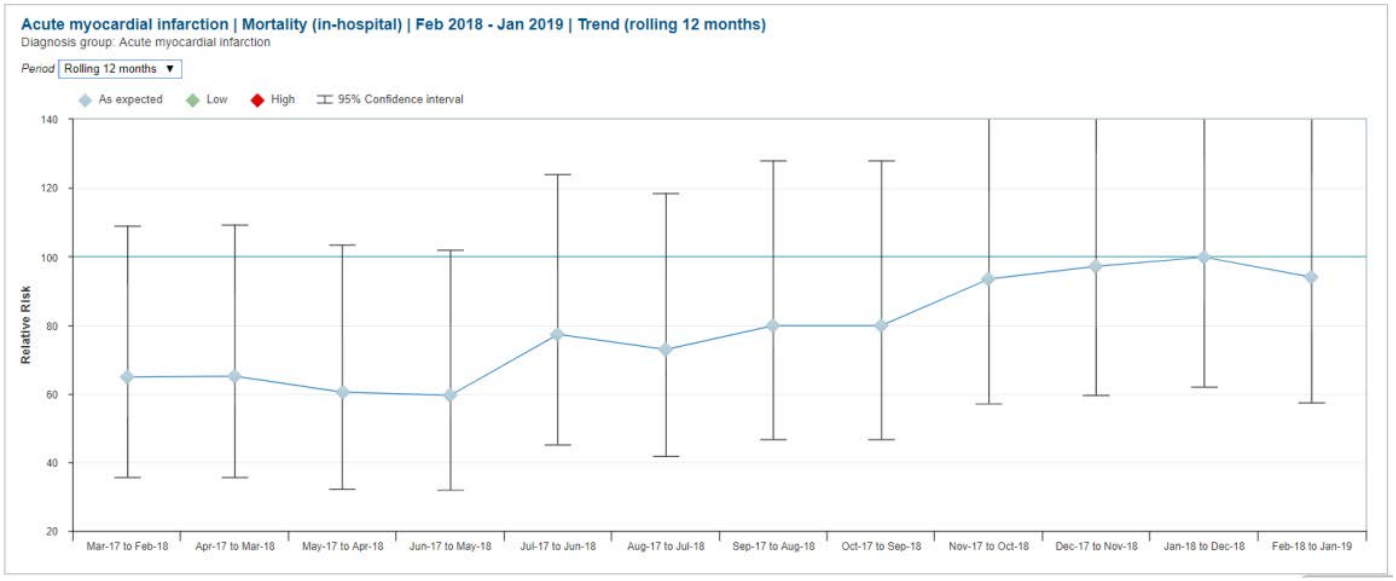


Table 10: Trend in relative risk for congestive cardiac failure

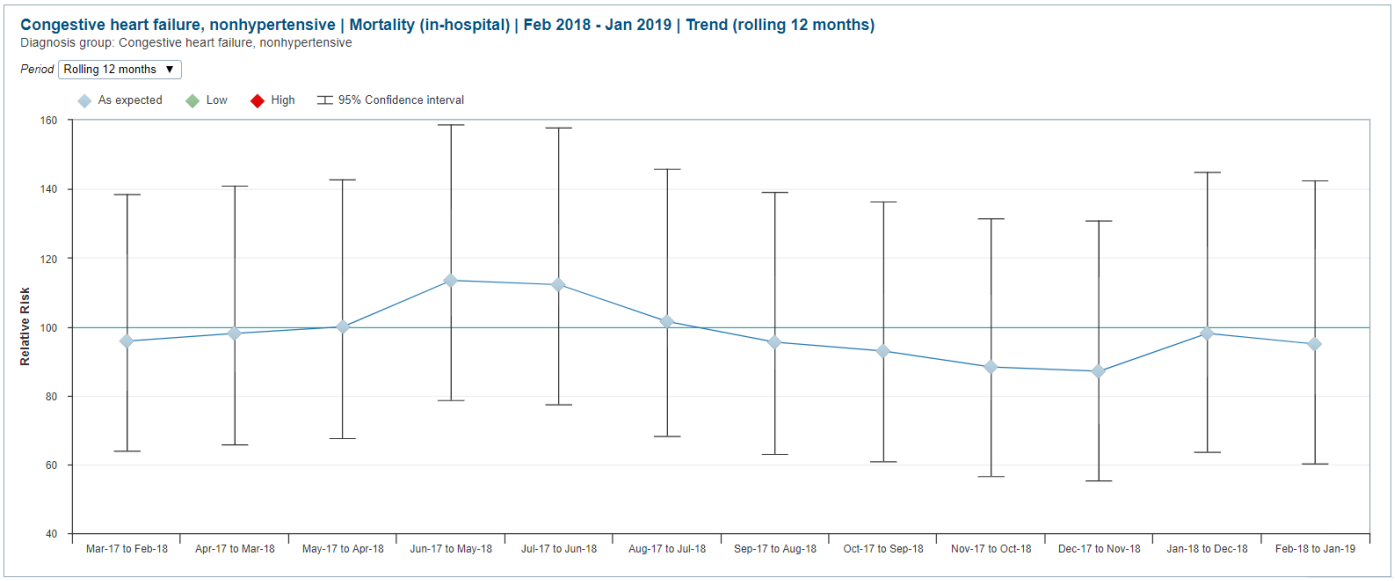


Table 11: Trend in relative risk for acute and unspecified renal failure

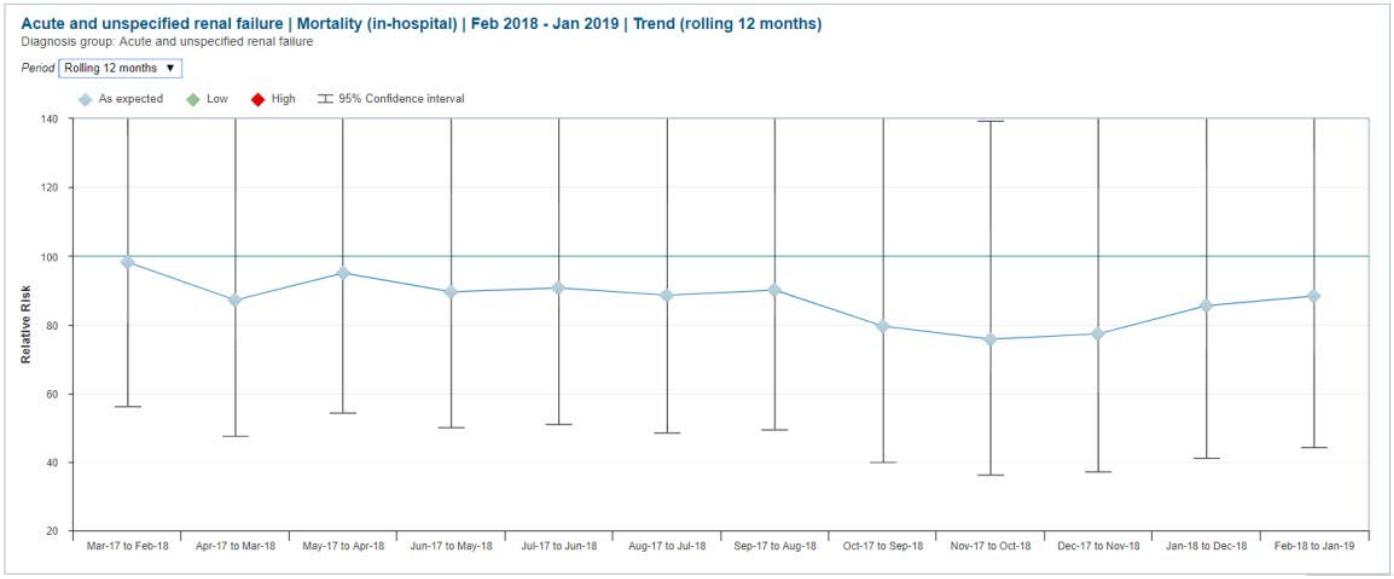
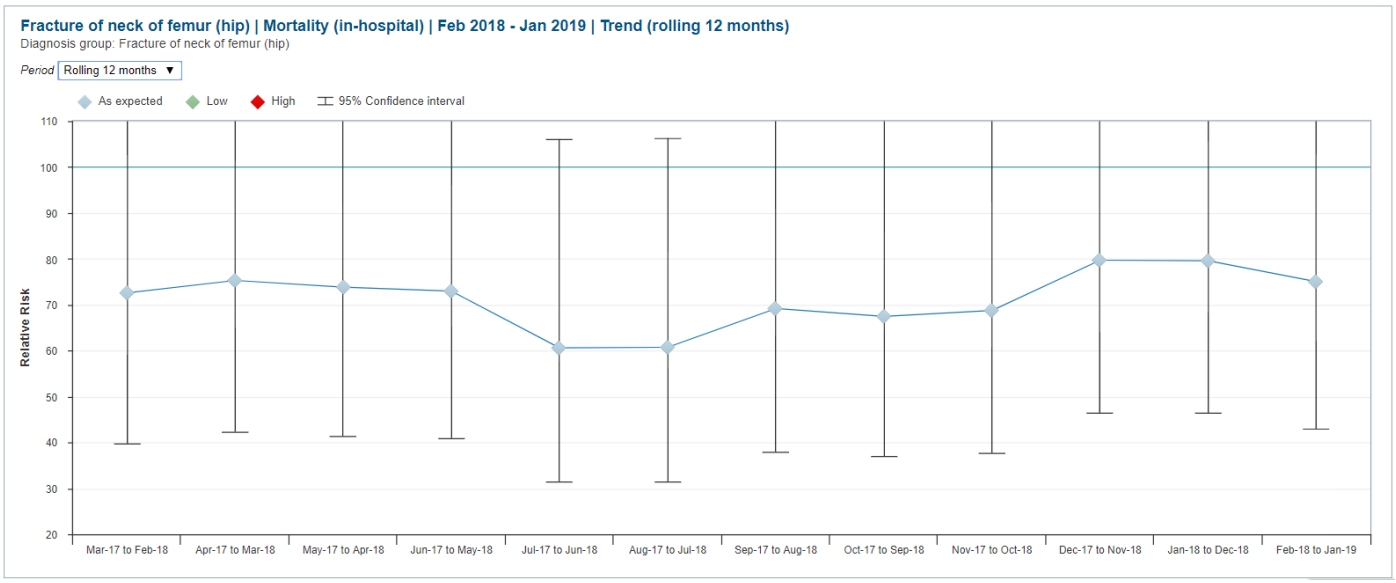


Table 12: Trend in relative risk for fracture of neck of femur



Although all 7 diagnosis groups remain within the expected range septicaemia, acute cerebrovascular disease and acute myocardial infarction have all shown an upward trend over the last 5 - 6 data points.

20.0 Summary

The mortality dashboard for the full year 2018/19 shows the number of deaths, outcome of reviews, learning themes and actions taken to improve. The vast majority of deaths were unavoidable and expected but five (0.62%) were considered probably avoidable and 4 are subject to serious incident inquiries. The support of bereaved families has been strengthened by the bereavement support service and will be linked to the Medical Examiner system once an option is agreed. HSMR has remained stable within the expected range but the increasing trend of weekend HSMR is of concern. The Trust intends to review relevant cases to understand this further and take improvement actions as needed. The relative risk of deaths in 3 high risk diagnosis groups is showing an upward trend.

21.0 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, 3 May 2019

SALISBURY NHS FOUNDATION TRUST
MORTALITY DASHBOARD 2018/2019

	Apr 18	May 18	Jun 18	Q1	Jul 18	Aug 18	Sep 18	Q2	Oct 18	Nov 18	Dec 18	Q3	Jan 19	Feb 19	Mar 19	Q4	Total
Deaths	69	61	55	**185**	53	67	56	**176**	68	60	72	**200**	88	81	69	**238**	**799**
1st screen	69	59	55	**183**	50	67	52	**169**	68	57	67	**192**	84	80	69	**233**	**778**
% 1st screen	100%	97%	100%	**99%**	94%	100%	93%	**96%**	100%	95%	93%	**96%**	95%	99%	100%	**98%**	**97%**
Case reviews	29	19	24	**72**	9	26	26	**61**	38	32	27	**97**	35	15	24	**74**	**304**
% case reviews	42%	31%	42%	**39%**	17%	39%	47%	**35%**	56%	53%	37%	**48%**	40%	18%	35%	**31%**	**38%**
Deaths with Hogan score 1	68	58	52	**178**	49	60	54	**163**	65	58	69	**192**	82	80	67	**229**	**762**
Deaths with Hogan score 2 - 3	1	3	3	**7**	3	5	2	**10**	3	2	2	**7**	6	1	1	**8**	**32**
Deaths with Hogan score 4 - 6	0	0	0	**0**	1	2	0	**3**	0	0	1	**1**	0	0	1	**1**	**5**
Learning points	5	8	5	**18**	8	5	2	**15**	6	5	9	**20**	10	5	6	**21**	**74**
Family/carer concerns	1	1	0	**2**	0	0	0	**0**	1	0	0	**1**	2	1	1	**4**	**7**
CUSUM alerts	1	2	3	**6**	0	0	2	**2**	1	1	0	**2**	3	1	0	**4**	**14**
CUSUM investigated	0	1	2	**3**	0	0	1	**1**	0	0	0	**0**	1	0	0	**1**	**9**
Deaths investigated as an SII	1	1	1	**3**	0	2	1	**3**	0	1	1	**2**	0	1	0	**1**	**9**
Death following an elective admission	0	1	0	**1**	2	0	2	**4**	1	1	2	**4**	1	0	1	**2**	**11**
Unexpected	2	1	1	**4**	1	2	0	**3**	1	1	1	**3**	2	0	1	**3**	**13**
Stillbirths/ neonatal/child death	2	3	1	**6**	1	2	0	**3**	1	1	0	**2**	0	1	1	**2**	**13**
Learning disability deaths	0	0	0	**0**	2	0	0	**2**	0	1	1	**2**	2	0	1	**3**	**7**
Reported to LeDeR programme LeDeR	0	0	0	**0**	0*	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3***
Serious mental illness	1	0	0	**1**	0	0	1	**1**	1	0	0	**1**	1	0	1	**2**	**5**

Note: Appendix 3 - explanatory notes *Cases to be reported to LeDeR following case review

MORTALITY DASHBOARD THEMES AND ACTIONS 2018/2019 **Appendix 2**

No	Learning points	Action point	By whom	By when	Progress update to 1/5/19	Status
1	PICC line service – Monday to Friday service and single handed practitioner	Redesign service to provide capacity required.	S Williams, Surgical DMT	31/03/19	The team now insert Midline catheters as an alternative to PICC lines in suitable patients. No patient delays were identified from case notes reviews in 18/19. Performance and improvements are monitored by a Line Working Group	
2	Plan the introduction of the ReSPECT form (Treatment Escalation Plan & DNAR form)	Work programme to be developed in 2018/19	Resuscitation Committee	31/03/19	A business case, to support the training and roll out of RESPECT, has been funded with a plan to have it in place by November 2019. Work linked with BSW STP.	
3	Insufficient senior medical review over a weekend of acutely unwell elderly patients which has led to late recognition of deterioration	Development of the frailty service	Dr J Drayson, Medicine DMT	31/03/19	Service developed and supported by the Older People's Liaison Team (OPAL). Four hours of a second on call medical consultant was introduced in September 2018 to ensure weekend reviews are undertaken when needed	
4	Continuing to review the ceiling of care regularly as condition changes.	Part of EOLC ongoing training and introduction of ReSPECT	SPCT & EOLC teams	31/03/19	The SPCT continue to provide education sessions for doctors in training as a core topic. The EOLC team also provide ward based training and other educational events. In 18/19, 46% of hospital deaths had specialist input and case note reviews show end of life discussions are recorded well in the health care record.	
5	Improve documentation of consent, risk and benefits of ward based procedures such as chest drains, lumbar punctures and ascitic taps	Ongoing education programme on consent Implementation of LocSSip	B Cornforth Risk Team	31/03/19	LocSSip for lumbar puncture completed. Chest drain insertion sticker - partially completed. Ascitic tap drainage requires further work.	
6	Timely escalation of deteriorating patients	1.Introduction of NEWS2 & escalation process. 2. Agree a HANT escalation protocol when workload exceeds the ability to respond promptly (Jan 19).	1) M Ford 2) HANT Board	1) 31/03/2019 2) 31/1/19	NEWS2 successfully implemented in February 2019 & compliance is >90%. Escalation protocol in place with further work required to ensure clinicians escalate to the appropriate level. A HANT escalation protocol when workload exceeds the ability to respond promptly is in place	

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.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.2
Date of Meeting:	06 June 2019		

Report Title:	Director of Infection Prevention & Control (DIPC) Annual Report 2018/19			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Fiona McCarthy, Senior Nurse, Infection Prevention & Control Team			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing and DIPC			
Appendices (list if applicable):	Included within the report			

Recommendation:

The Board is asked to:

1. Note the report, and the performance against Infection Prevention and Control requirements for the year.

2. Minute/document that the Board continues to acknowledge their collective responsibility as described within the DIPC report and confirm receipt of assurance on IPC actions and controls for the year.

Executive Summary:

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC).

The DIPC Reports together with the monthly Key Quality Performance Indicators Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of the annual DIPC Report is to inform the Trust Board of the progress made against the 2018/19 Annual Plan, to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The Trust has experienced a positive year for infection prevention and control performance. The Trust has achieved good outcomes to date and maintained compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Department of Health, 2015).

This report takes the opportunity to celebrate the successes and highlights the increasing challenges moving forward:

1. There has been 7 reported Trust apportioned Clostridium difficile (C.difficile) cases against a trajectory of 18 for 2018/19. For 2019/20, it is important that the Trust Board are aware of the updated Public Health England (PHE) classification of C.difficile cases, which will be a significant performance challenge for the organisation.

2. There have been 3 Trust apportioned Methicillin Resistant Staphylococcus aureus (MRSA) bloodstream infections against a target of zero for 2018/19. Key learning includes improving MRSA screening and decolonisation, and management of indwelling catheter devices.

3. Mandatory surveillance of orthopaedic surgery has continued with no identified deep infections for knee replacement surgery.

4. The Trust has maintained a safe water system, although due to complex and aged water system this requires continuous oversight as detailed within the report, particularly regarding the management of legionella counts. There are robust monitoring and mitigation activities in place.

5. Significant amounts of work have been completed and remain ongoing for decontamination services.

6. Environmental cleanliness standards, which are monitored regularly and validated quarterly, are maintained to a high standard. The Patient Led Assessment of the Care Environment (PLACE) scores showed an improvement to what was already a high standard of environmental cleanliness and is above the national average.

7. Perfect Ward App was implemented and gives transparency of infection prevention and control practices through monthly audit in each ward area.

8. Antimicrobial stewardship continues to be one of the key measures to reduce the risk of Clostridium difficile infection and the single most important measure to reduce the selection of multiple antibiotic resistant bacteria. There have been considerable achievements with antibiotic prescribing standards over the years. Concerted effort continues with antimicrobial stewardship and decreases in consumption for the use of all antibiotics.

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	☐

Salisbury
NHS Foundation Trust

DIRECTOR OF INFECTION PREVENTION & CONTROL (DIPC) REPORT

ANNUAL UPDATE FOR 2018/19

LORNA WILKINSON
DIPC

JUNE 2019 (Final Draft v.2)

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1. INTRODUCTION

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC).

The DIPC Reports together with the monthly Key Quality Performance Indicators (KQPI) Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of the annual DIPC Report is to inform the Trust Board of the progress made against the 2018/19 Annual Action Plan (Appendix A), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The action plan focuses on the Trust achieving the standards identified in 'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (2015), to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

The Trust has experienced a positive year for infection prevention and control performance. This has involved:

- Extending our collaborative working with others (including external agencies) as part of major incidents in relation to decontamination and practices.
- The Trust continues to report low HCAI rates overall, although it was disappointing that there were 3 Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia cases identified during the year.
- Significant amounts of work have been completed and remain ongoing for antibiotic stewardship and decontamination services.
- Water safety has been the subject of ongoing focus, with our ageing estate and environment posing challenges, to ensure we have effective controls and proactive management in place.

2. GOVERNANCE ARRANGEMENTS

The work towards achieving the objectives of the Annual Action Plan 2018/19 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC), which completes the governance arrangements (Appendix B).

3. INFECTION PREVENTION & CONTROL ARRANGEMENTS

A comprehensive infection prevention and control service is provided Trust wide. The Infection Prevention and Control Team (IPCT) provides a liaison and telephone consultation service for all inpatient and outpatient services, with additional arrangements for seven day service cover by an Infection Control Nurse (ICN) during declared Norovirus outbreaks.

The IPCT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (w.t.e) ICNs and secretary (0.6 w.t.e). In addition, there are 2 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead.

4. ASSURANCE ACTIVITIES

The IPCC monitors the action plan on behalf of the Trust Board, which is achieved through the following actions:

- Agree an annual infection control programme and monitor its implementation
- Oversee the implementation of infection control policies and procedures
- Monitor and review the incidence of HCAI

- Develop and review information regarding infection prevention and control
- Monitor the activities of the Infection Prevention and Control Team
- Benchmark the Trust's delivery of control of infection standards in various accreditation systems, and against Care Quality Commission (CQC) Regulations
- Monitor the implementation of infection prevention and control education
- Receive regular updates from the Antibiotic Reference Group (ARG)
- Receive regular updates from the IPCWG
- Monitor compliance and formal reporting on Legionellosis and Pseudomonas water management, via the Water Safety Group (WSG)
- Receive regular reports from the Decontamination Working Group (DWG)
- Provide regular assurance reports to the CGC.

5. HEALTHCARE ASSOCIATED INFECTION (HCAI) MANAGEMENT & STATISTICS

5.1 HCAI

The Trust is required to report any HCAI outbreaks externally as a serious incident (SI). An outbreak is defined as the occurrence of two or more related cases of the same infection over a defined period. When a HCAI outbreak is declared, the Trust initially reports the outbreak to the relevant Clinical Commissioning Group (CCG) and other regulatory bodies, e.g. NHS Improvement (NHSi), within 2 working days, and must undertake an investigation and submit a formal written report within 45 working days.

The Trust is also required to record these incidents on the strategic executive information system (STEIS) in line with the Serious Incident Framework: Supporting learning to prevent recurrence (NHS England, 2015), and the Health Protection Agency HCAI Operational Guidance & Standards (2012), Health Protection Agency now Public Health England (PHE) from 1st April 2013.

During 2018/19, the Trust has had **no** declared outbreaks of:

- Viral gastroenteritis (Norovirus)
- Clostridium difficile (C.difficile)
- Staphylococcus aureus, including Methicillin Resistant Staphylococcus aureus (MRSA)
- Methicillin Sensitive Staphylococcus aureus (MSSA)
- Carbapenemase producing enterobacteriaceae (CPE)
- Invasive Group A Streptococcus (iGAS)
- Multi-drug resistant Acinetobacter baumannii (MDRAB)
- Chickenpox (Varicella zoster)
- Extended Spectrum Beta Lactamase (ESBL) producers, including Klebsiella Pneumoniae
- Pertussis
- Respiratory Syncytial Virus (RSV)
- Influenza ('flu)
- Vancomycin Resistant Enterococcus (VRE)
- Tuberculosis (TB).

Additional information regarding alert organisms can be accessed from the PHE website:
https://www.gov.uk/government/organisations/public-health-england

The ICNs provide clinical teams with infection control advice, support and education on a daily basis to all inpatient areas. The management of patients admitted with suspected and known alert organisms is discussed, and risk assessments undertaken. The Isolation Risk Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway have been developed and implemented to assist staff competency and confidence in the management of cases.

The availability of sideroom facilities across the Trust site to isolate infected patients can be limited at times when demands on capacity are high. In such instances, risk based decisions are necessary. Patients with alert organisms can be safely managed either within cohort bays, or

isolation nursed in a bedspace. The ICNs continue to review patients nursed in siderooms on a daily basis to prioritise high risk patients. Information and guidance is communicated to the ward nursing and medical teams and the Clinical Site Coordinators (CSC), with additional written documentation provided to support staff in the ongoing management of these patients.

6. MANDATORY SURVEILLANCE

6.1 Surgical Site Infection Surveillance (SSIS)

Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends. The ICNs coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust.

Where orthopaedic surgical procedures are performed, Trusts are required to undertake mandatory SSIS every year. This must be for a minimum of a three months surveillance period or until a cohort of 50 cases has been achieved, in at least one of these categories listed below:

- Hip (prosthesis) replacement
- Knee (prosthesis) replacement
- Repair of neck of femur
- Reduction of long bone fracture.

The Trust complies with this annual requirement to undertake SSIS. Formal reports outlining progress with SSIS were presented at the IPCC meetings and disseminated to relevant Trust personnel. There were no identified deep infections for knee replacement surgery during quarters 1 and 2 of 2018/19 (when active surveillance was undertaken).

6.2 Methicillin Resistant Staphylococcus aureus (MRSA)

The Trust has continued to report MRSA screening rates for all elective and emergency admissions to ensure continued improvement in reducing infections. These screening compliance rates are monitored by the Directorate Management Teams (DMTs) and reported as a KQPI. The ICNs undertake a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit.

Feedback is provided to DMTs about compliance rates and any identified missed screens for follow up actions. For 2018/19, the Trust compliance rate for MRSA emergency screening ranged from 80.57 – 91.2% and for MRSA elective screening, 82.72 – 95.45%. Outcomes of any follow up of actions undertaken by the clinical directorates are included within their current reporting processes and to include any shared learning. The current Trust screening policy exceeds the requirements outlined within the Department of Health (DH) guidance published in 2015, and is under further review by the Trust for 2019/20.

The Trust reports mandatory enhanced surveillance in line with PHE requirements onto the national HCAI Data Capture System (DCS) website. The Trust adheres to the classification of cases in accordance with the set definitions. This is applicable to MRSA bacteraemia cases and C.difficile cases, and differs from previous classification reporting formats. Results are provided in the summary below, and include the definitions of ‘Trust apportioned’ cases and ‘non-Trust apportioned’ cases. The Trust's MRSA Trust apportioned cases target for 2018/19 was zero.

(Of note: During quarter 2 of 2018/19, PHE revised the apportionment algorithm to reflect how data is presented on the HCAI DCS website. ‘Trust apportioned’ has changed to ‘Hospital onset’ and non-Trust apportioned has changed to ‘Community onset’. This has not changed the way the algorithm works; it is simply the name change).

MRSA Bacteraemia Trust apportioned cases include patients that are –

1. Inpatients, day patients and emergency assessment patients; **AND**
2. have had a specimen taken at an acute Trust; **AND**
3. specimen is **3 or more** days after date of admission (admission date is considered day ‘1’).

Community onset (previously Non-Trust apportioned) cases include all cases that are **NOT** apportioned to the acute Trust.

Table 1: Breakdown of total number of Trust MRSA cases recorded April 2018 to March 2019
(Figures in brackets show number of cases recorded April 2017 to March 2018)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**0 (0)**	**1 (0)**	**0 (0)**	**0 (0)**	**0 (0)**	**0 (0)**	**1 (0)**	**0 (0)**	**1 (0)**	**0 (0)**	**0 (0)**	**0 (0)**	**3 (0)**
Community onset (previously Non-Trust apportioned) cases	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Hospital onset (previously Trust apportioned) cases	0 (0)	1 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (0)	0 (0)	1 (0)	0 (0)	0 (0)	0 (0)	**3 (0)**

During 2018/19, there have been 3 unrelated Trust apportioned MRSA bacteraemia cases identified for inpatients within the medical and surgical directorates (Downton Ward, Pitton Ward and Radnor Intensive Care Unit (ICU)). For all the cases, a post infection review (PIR) investigation process was undertaken.

The purpose of the PIR process was to review the patient information and data collected following the identification of the MRSA bacteraemia case. The review process included the participation of key personnel from the Trust, and communication with the relevant staff groups. For each case, a meeting was held and followed the format of the MRSA bacteraemia PIR toolkit with direct group discussion, in order to populate the document in full and agree any identified actions. It was emphasised that the meeting and PIR process should be viewed as a positive learning exercise.

These cases were reported as a 'cluster' and a further review meeting for **all** 3 cases was held in quarter 4 of 2018/19 (January 2019). A summary of key learning from the discussions included:

- These cases were not linked.
- Incomplete/missed opportunities for MRSA screening (for two cases)
- Non-compliance with MRSA pathway, including delay in topical decolonisation administration and missed doses (for two cases)
- Suprapubic catheter (SPC) care not fully implemented (for one case)
- Poor documentation of peripheral cannula care for insertion, ongoing care and removal of devices and completion of visual infusion phlebitis (VIP) scores (for two cases).

Of note: For one of the cases (from Radnor ICU), it was established that the bacteraemia was unavoidable with no identified lapses in care or missed opportunities. However, the group identified areas for further investigation, and agreed local actions with deadlines which related to targeted or universal topical decolonisation of ICU patients and revisiting the use of chlorhexidine gluconate (CHG) impregnated line securement dressings on the unit.

In addition to the completion of the PIR toolkit, and agreement of local action plans agreed by the relevant personnel/DMTs, Trust wide recommendations were also made and included:

1. Review and update of Trust policies (including the use of audit outcomes and literature reviews) relating to:
   a) Line management – Peripheral vascular devices/cannula care
   b) Clinical management of MRSA (including screening and topical decolonisation/treatment); consideration of targeted or universal topical decolonisation of ICU patients and use of 2% chlorhexidine gluconate (in 70% alcohol isopropyl) impregnated line securement dressings following risk assessment
   c) SPC care bundle implementation.

6.3 Clostridium difficile (C.difficile)

The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

The Trust continues to apply DH guidance for C.difficile testing and the previously agreed revised C.difficile testing and reporting algorithm. All C.difficile positive stool samples that test toxin positive are reportable to PHE. (Of note: from April 2017, changes were made regarding the mandatory reporting requirements for Trusts. This is in relation to the classification of C.difficile cases with a focus on previous healthcare interactions/episodes. Following further clarification from PHE, the definition of Trust apportioned and non-Trust apportioned cases has not changed).

In accordance with PHE definitions, C.difficile Trust apportioned cases include patients that are –

1. Inpatients, day patients and emergency assessment patients; **AND**
2. have had a specimen taken at an acute Trust; **AND**
3. specimen is **4 or more** days after date of admission (admission date is considered day '1').

Non-Trust apportioned cases include all cases that are **NOT** apportioned to the acute Trust.

Table 2 below relates to the breakdown of all inpatient reportable cases of *C.difficile* and **Table 3** relates to the total reportable cases of C.difficile recorded by the Trust.

Table 2: Breakdown of reportable cases recorded for all inpatients April 2018 to March 2019 (Figures in brackets show number of inpatient reportable cases April 2017 to March 2018)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**0 (1)**	**1 (1)**	**0 (2)**	**0 (0)**	**3 (0)**	**0 (2)**	**0 (2)**	**0 (2)**	**1 (1)**	**3 (1)**	**0 (3)**	**3 (1)**	**11 (16)**
Non Trust apportioned cases	0 (0)	1 (1)	0 (2)	0 (0)	2 (0)	0 (1)	0 (1)	0 (0)	0 (0)	0 (1)	0 (1)	1 (1)	**4 (8)**
Trust apportioned cases	0 (1)	0 (0)	0 (0)	0 (0)	1 (0)	0 (1)	0 (1)	0 (2)	1 (1)	3 (0)	0 (2)	2 (0)	**7 (8)**

Table 3: Breakdown of total number of reportable *C.difficile* cases recorded April 2018 to March 2019 (Figures in brackets show total number of reportable cases recorded April 2017 to March 2018)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Inpatients	**0 (1)**	**1 (1)**	**0 (2)**	**0 (0)**	**3 (0)**	**0 (2)**	**0 (2)**	**0 (2)**	**1 (1)**	**3 (1)**	**0 (3)**	**3 (1)**	**11 (16)**
Community Hospitals	1 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (0)	0 (0)	0 (0)	0 (0)	0 (2)	**2 (2)**
General Practitioners (GPs)	0 (1)	0 (2)	2 (2)	1 (0)	1 (1)	1 (0)	1 (0)	0 (2)	0 (0)	1 (1)	2 (0)	1 (5)	**10 (14)**
Residential/Nursing Home	0 (0)	0 (0)	0 (0)	1 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	**1 (0)**
Other (e.g. Coroner, Private Hospital, Day Attender, ED, Outpatient)	1 (0)	0 (0)	0 (1)	0 (0)	0 (0)	0 (0)	0 (1)	0 (0)	1 (0)	1 (0)	0 (1)	0 (0)	**3 (3)**
Total	**2 (2)**	**1 (3)**	**2 (5)**	**2 (0)**	**4 (1)**	**1 (2)**	**1 (3)**	**1 (4)**	**2 (1)**	**5 (2)**	**2 (4)**	**4 (8)**	**27 (35)**

(Of note: In a single patient, a positive test occurring after a previous positive test is considered a new episode after 28 days).

For 2018/19, the Trust has reported 7 Trust apportioned C.difficile cases, which does not exceed the target set for the Trust by NHS England of <18 for the full year. For each inpatient episode, an infection control incident investigation is completed using a 'SWARM' approach. This process has been led by the ICNs, with the increased involvement of nursing and medical staff in the relevant clinical areas and the Principal Pharmacist Antibiotics (or area Pharmacist), to complete the required documentation.

Monthly 'Share & Learn' SWARM meetings have been held to facilitate shared learning, identify key themes and agree actions to contribute to the reduction the key areas of falls (with major harm), hospital acquired pressure ulcers and Trust apportioned C.difficile cases. The group also advise the Clinical Risk Group (CRG) of any key concerns that are unresolvable at ward level and require escalation. There has been good attendance and engagement by staff, and learning has identified improvements required for the use of the Diarrhoea Pathway and completion of stool chart; timeliness of patient reviews and sampling of symptomatic patients. *(Of note: since quarter 2 of 2018/19, other Trust apportioned HCAI cases are shared at these meetings).*

C.difficile ward rounds have continued to be held by the ICNs with the involvement of the ICD and/or Consultant Microbiologist when available, with any concerns regarding antibiotic prescribing identified from the clinical visits followed up with the Principal Pharmacist Antibiotics. Attendees can include the DIPC, Deputy DIPC and Medical Director. These rounds provide an opportunity to formally review and assess the patient's progress and management in relation to C.difficile. This includes the review of previous C.difficile positive patients as well as current C.difficile positive patients. The ICNs also ensure that information is shared with the ward teams and this is

supported by an entry within the patient healthcare records (HCRs). The membership of this group has been reviewed, and a Gastroenterologist and Dietician will be involved as required.
During 2018/19, the ICNs have completed additional investigations for C.difficile cases identified within the community setting, where these patients have previously had a recent inpatient episode of care at the Trust. This has resulted in the implementation of enhanced environmental cleaning of identified clinical areas.

In quarter 4, two separate periods of increase incidence (PII) of C.difficile were declared within the medical directorate (for Durrington Ward and Pembroke Ward). This was due to an increase in the number of Trust cases (both reportable and not reportable to PHE). The required incident investigations were completed with the involvement of relevant personnel. Further measures were also implemented across the areas, including additional environmental cleaning by Housekeeping and extra audits and monitoring of practices, overseen by the relevant Directorate Senior Nurse (DSNs).

The stool samples from the 4 Trust apportioned cases (2 reportable, 2 not reportable) were sent to the External Reference Laboratory for ribotyping. The ribotyping results were reviewed by the ICD and communicated to the DIPC, ICNs and medical directorate. All these results were identified to be different types, and therefore could not be linked.

During 2018/19, one Trust apportioned reportable case from Britford Ward was submitted to the 'Appeals Process Panel' and successfully appealed with the relevant CCG *(December 2018). (Of note: for the previously reported August 2018 case that was initially considered for appeal, the stool sample was sent to the Reference Laboratory for ribotyping. However, the result identified that C.difficile was not isolated from the specimen sent).*

In February 2019, NHSi published 'Clostridium difficile infection objectives for NHS organisations in 2019/20 and guidance on the intention to review financial sanctions and sampling rates from 2020/21'. This document sets out the changes to the C.difficile reporting algorithm for 2019/20 which are adding a prior healthcare exposure element for community onset cases, and reducing the number of days to apportion hospital onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

For 2019/20 cases reported to the HCAI DCS will be assigned as follows:

- **Hospital onset healthcare associated:** cases that are detected in the hospital three or more days after admission
- **Community onset healthcare associated:** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks
- **Community onset indeterminate association:** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous 12 weeks but not the most recent four weeks
- **Community onset community associated:** cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the Trust reporting the case in the previous 12 weeks.

Acute provider objectives for 2019/20 will be set using these two categories:

- Hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission
- Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks.

For 2019/20, the C.difficile case objective set for the Trust by NHSi and NHS England (NHSE) is no more than 9 cases. These objectives have been set using the data from 1st April 2018 to 31st December 2018. Guidance for testing and reporting C.difficile cases remains unchanged and the safety and care of patients remains our concern and priority. It is important that the Trust Board are

aware that this poses a risk when such small numbers are considered, as it is one of the lowest ceilings set across the region due to previous good performances.

6.4 Methicillin Sensitive Staphylococcus aureus (MSSA)

The Trust continues to report MSSA bacteraemia cases via the HCAI DCS website. Currently, there is no national guidance for data definition of MSSA bacteraemia cases for targets to be set. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either Trust apportioned or non-Trust apportioned.

Table 4: MSSA bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2018 to March 2019
(Figures in brackets show number of cases recorded April 2017 to March 2018)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**5* (2)**	**3 (2**)**	**3* (1)**	**3 (6)**	**2 (1)**	**2 (1)**	**3 (2)**	**2* (3)**	**3 (1**)**	**3 (5)**	**2 (5)**	**2 (2**)**	**33* (31**)**
Non Trust apportioned cases	2 (2)	2 (2)	2 (0)	2 (4)	2 (0)	2 (1)	3 (1)	2 (1)	2 (1)	2 (5)	1 (2)	2 (1)	**24 (20)**
Trust apportioned cases	3 (0)	1 (0)	1 (1)	1 (2)	0 (1)	0 (0)	0 (1)	0 (2)	1 (0)	1 (0)	1 (3)	0 (1)	**9 (11)**

**May 2017 – 2 additional MSSA bacteraemia cases noted: one identified from blood cultures taken whilst the patient was attending Salisbury Dialysis Unit and later admitted to the Trust via the Emergency Department (ED): one identified from blood cultures taken whilst the patient was attending an outpatient clinic, and later admitted to the Trust from the clinic.
**December 2017 – 1 additional MSSA bacteraemia case noted: identified from blood cultures taken whilst attending Salisbury Dialysis Unit, and discharged. Seen again in the Emergency Department, but not admitted to hospital.
**March 2018 – 1 additional MSSA bacteraemia case noted: identified from blood cultures taken whilst attending Salisbury Dialysis Unit. Patient later admitted to the Trust.

*April 2018 – 1 additional MSSA bacteraemia case noted: identified from blood cultures taken whilst the patient was attending an outpatient clinic, and not admitted to the Trust from the clinic. However, the patient was admitted after the positive result was identified.
*June 2018 – 1 additional MSSA bacteraemia case noted: identified from blood cultures taken whilst the patient was attending Salisbury Dialysis Unit.
*November 2018 – 1 additional MSSA bacteraemia case noted: identified from blood cultures taken whilst the patient was attending Salisbury Dialysis Unit. The patient was admitted to the Trust after the cultures were taken.

During 2018/19, there have been 9 Trust apportioned cases identified. The ICNs undertake an infection control incident investigation for all Trust apportioned inpatient cases, in conjunction with relevant staff from the clinical area concerned. One of the cases was identified to be line related, with two other cases being likely and possibly line related. The reviews also identified that these patients had complex medical histories and conditions. Emphasis has been placed on the need for continued monitoring of all invasive devices by staff, adherence to the relevant Trust policies relating to the taking of blood cultures and skin disinfection/decontamination and maintaining the required care documentation.

6.5 Gram-negative bloodstream infections (GNBSIs)

6.5.1 Escherichia coli (E.coli)

The Trust continues to input enhanced surveillance data for E.coli bloodstream infections (BSI) in accordance with current guidance from the DH and PHE. From 1st April 2012, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the E.coli bacteraemia cases recorded

within the Trust. This allows the cases to be classified as either Trust apportioned or non-Trust apportioned.

Table 5: E.coli Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2018 to March 2019 (Figures in brackets show total number of cases recorded from April 2017 to March 2018)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**4 (9)**	**4 (9)**	**6* (10)**	**8 (8)**	**4 (9)**	**7 (9)**	**14 (9)**	**13 (12)**	**9 (8)**	**9 (7)**	**4 (10)**	**12 (9)**	**94* (109)**
Non Trust apportioned cases	3 (7)	4 (6)	5 (10)	5 (7)	2 (8)	7 (8)	11 (8)	12 (9)	7 (7)	8 (7)	3 (5)	11 (8)	**78 (90)**
Trust apportioned cases	1 (2)	0 (3)	1 (0)	3 (1)	2 (1)	0 (1)	3 (1)	1 (3)	2 (1)	1 (0)	1 (5)	1 (1)	**16 (19)**

*June 2018 – 1 additional E.coli bacteraemia case noted: identified from blood cultures taken for a patient at Newhall Hospital. The patient was later admitted to the Trust via the Emergency Department.

Following the identification of a positive blood culture result for E.coli, a Consultant Microbiologist completes a PHE mandatory enhanced surveillance form. In consultation with the relevant clinician, key patient factors are considered in order to establish if the case is likely to be healthcare related. However, it may not be possible to determine.

Of the 16 Trust apportioned cases identified during 2018/19, seven were unknown or unclear source of infection and the remaining nine cases had a source of infection identified. Of these unrelated nine cases, the sources of infection were:

- Lower respiratory tract (one case)
- Urinary tract, including lower urinary tract (seven cases)
- Gastrointestinal, related to a surgical intervention/intra-abdominal (one case)

The Trust recognises the importance of continuing improvement work with the appropriate recognition and treatment of infections and adherence with National Institute for Health and Care Excellence (NICE) guidelines. This data was entered onto the HCAI DCS website. Where concern is highlighted by the Microbiologist for an individual case, further investigation is undertaken by the ICNs. For these Trust apportioned cases, no further follow up was identified.

The Trust will continue to work towards reducing the incidence of these GNBSIs. The ICNs are working collaboratively with the relevant CCGs who are leading on achieving the Quality Premium (from April 2017, for 2 years), aiming to reduce all E.coli BSIs by 10% in year 1.

6.5.2 Klebsiella sp. and Pseudomonas aeruginosa

From April 2017, the incidence of GNBSIs for Klebsiella sp. and Pseudomonas aeruginosa reported at the Trust now requires enhanced investigation and data entry onto the PHE DCS website. This work has been undertaken by the ICNs.

Table 6: Klebsiella sp. Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2018 to March 2019 (Figures in brackets show total number of cases recorded from April 2017 to March 2018)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**2 (0)**	**0 (0)**	**3 (2)**	**3 (2)**	**2 (0)**	**2 (1)**	**3 (2)**	**0 (2)**	**2 (4)**	**4 (3)**	**0 (6)**	**2 (1)**	**23 (23)**
Non Trust apportioned cases	2 (0)	0 (0)	2 (2)	1 (2)	2 (0)	2 (1)	1 (2)	0 (2)	2 (4)	3 (3)	0 (3)	2 (1)	**17 (20)**
Trust apportioned cases	0 (0)	0 (0)	1 (0)	2 (0)	0 (0)	0 (0)	2 (0)	0 (0)	0 (0)	1 (0)	0 (3)	0 (0)	**6 (3)**

Table 7: Pseudomonas aeruginosa Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2018 to March 2019 (Figures in brackets show total number of cases recorded from April 2017 to March 2018)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**0 (0)**	**1 (3)**	**3 (0)**	**1 (1)**	**0 (1)**	**0 (0)**	**2 (1)**	**1 (3)**	**0 (4)**	**1 (1)**	**0 (0)**	**2 (1)**	**11 (15)**
Non Trust apportioned cases	0 (0)	1 (2)	2 (0)	0 (1)	0 (1)	0 (0)	1 (1)	1 (1)	0 (4)	0 (0)	0 (0)	1 (0)	**6 (10)**
Trust apportioned cases	0 (0)	0 (1)	1 (0)	1 (0)	0 (0)	0 (0)	1 (0)	0 (2)	0 (0)	1 (1)	0 (0)	1 (1)	**5 (5)**

Further information relating to official statistics and benchmarking of performance can be found at: https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis

6.6 Infection in Critical Care Quality Improvement Programme (ICCQIP)

From April 2017, the Trust has participated in the surveillance of BSIs in patients attending the ICU and Neonatal Unit (NNU). From the data submitted so far, no further updates have been provided by PHE.

6.7 Private Healthcare Information Network (PHIN)

The Trust is now mandated to report externally regarding private patients via PHIN. In relation to infection prevention and control, this involves the ICNs undertaking monthly cross checking of a dedicated SharePoint database of private patients. If it is identified that a patient has a HCAI that is externally reportable (as per national mandatory reporting definitions), then this is added to the SharePoint database for the relevant patient, for submission to PHIN by the Trust.

From the data reviewed and provided by the ICNs, there have been no externally reportable infection alert organisms identified for this patient group.

7. WATER SAFETY MANAGEMENT *(information for this section has been provided by Terry Cropp, Responsible Person (RP) for Water and Head of Estates)*
This section summarises the water safety management precautions that the Trust has taken during 2018/19.

The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 (Pt B) Safe Water in Healthcare Premises and HTM 04-01 (Pt C) Pseudomonas (guidance for augmented care units), together with the technical guidance document Health & Safety Guidance (HSG) 274 part 2 (The control of Legionella bacteria in hot and cold water systems).

To assist the management process in respect of the water systems across the site, regular meetings of teams (Responsible Person (RP) and designated Responsible Person (dRP) for water) from Estates Technical Services (ETS) and FES Facilities Management (FM) Ltd (Private Finance initiative (PFI) maintenance contractor) are held on a monthly basis, to review progress with planned preventative maintenance (PPM) and actions in respect of water safety.

The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution. The water systems within hospitals are complex; therefore the testing and controls we have in place are designed to mitigate the risks to our patients and staff.

Emergency review meetings (see Table 8 below) have taken place in the Trust as a result of positive sample results, the actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of emails as events occur, and as regular reports to the Water Safety Group (WSG) and IPCC. Actions taken have included the cleaning and disinfection of outlets with temperature checks and increased flushing where necessary.

Legionella					
	Ward/ Department	Location	Action plan from review meeting	Latest test result	
				Pre	Post
1	Durrington Ward	Rooms 2.2.18 – 21	Ward chlorinated (24.10.18), local chlorination of outlets/systems scheduled for June 2019.	*2500	240
2	Amesbury Suite	4.10.245	Local pipework, TMV and tap to be replaced.	492	272
3	Pembroke Suite	Main bay	Disinfection, additional flushing + re-sample.	< 20	100
4	Radnor Ward (ICU)	4.2.17	Disinfection, additional flushing + re-sample.	< 20	< 20
5	Mortuary	Male Changing	Disinfection, additional flushing + re-sample.	< 20	< 20

Table 8

*Room 2.2.18 has the highest count from latest re-sample, all affected outlets fitted with point of use filters.

7.1 Achievements for 2018/19
At the beginning of the year, capital funding (£250K) was secured for significant investment in the facilities that generate the hot water for Maternity, Post Natal and Neonatal Unit (NNU). A new heating and hot water system was installed and commissioned for these areas during quarters 3 and 4 of 2018/19. This new system has improved the source (reliability) and delivery temperatures contributing to the safer management of these water systems for these wards and departments. Temperatures have increased on both flow and return circuits from circa 55 to 65 (on the flow) and

50 to 55 (on the return). In addition, this system has also been supplemented with Copper Silver Ionisation to reduce the incidence of bacteria recolonising.

Continued improvements with the levels of flushing achieved of 'little used outlets'. This is being achieved by the use of dedicated 'Bank' staff that can support this without the risk of being diverted to other tasks, which was often the case when delivered solely by the ETS Operations Maintenance Assistants. Flushing compliance figures for quarters 1 and 2 of 2018/19 for 'Priority 1' areas were recorded at 94.4% and 'Priority 2' areas recorded at 99.1%. The level of flushing compliance for clinical areas has been monitored with the figures for quarters 3 and 4 of 2018/19 being 91% for 'Priority 1' areas and 94% for 'Priority 2' areas.

Reduction in the leaks and subsequent impact on clinical services associated with drain blockages, though the total number of recorded incidents related to this is up by 17% in comparison to quarters 1 and 2 of 2017/18.

Formation of a Hydrotherapy Pool Group (Spinal Unit) which will meet six monthly (first meeting held on 11th June 2018) and will be supported by key members of the WSG and the Trust's Water Authorised Engineer (AE). A Hydrotherapy Pool Policy and 'Terms of Reference' have also been drafted.

Capital funding has been secured for new heating and water systems for Staff Accommodation (Compton, Grovely and Langley Houses) and the Staff Club. These schemes are scheduled to be completed in quarter 2 of 2019/20. Further funding has been requested as part of the Trust's five year Capital Plan and this will include a heating and hot water system for the Hospice Unit.

7.2 Key focus for quarters 1 and 2 of 2019/20

- Further works required on Durrington Ward, following the initial water system disinfection on 24th October 2018. This is to resolve the ongoing counts of Legionella from water resampling. The Trust Water AE has recommended disinfection of the system after evaluation of the previous method employed by the water treatment contractor. Local injection points for chemical to be installed to allow targeted local disinfection.
- Maintaining the temperature of the hot and cold water systems across the Trust.
- Ensuring sufficient resource (labour and financial) to complete all PPM's directly associated with water safety.
- Engagement of key members of the WSG in supporting action plans and quarterly meetings of the WSG.
- Delivery of Competent Persons (CP) training for water safety, initial focus will be on CPs for ETS staff. This has been scheduled for 10th June 2019. This will include all grades of ETS and FES Ltd staff that work on and maintain the water systems.
- Developing the Operational Procedures for Water Safety with the assistance of the Trust AE.
- Continued work and messaging on the 'Prevention of Drain Blockages' with regular broadcasts and key meetings with the clinical teams.
- Review of risk assessment for the Trust site water systems due to significant changes of the system allied to the ward reconfiguration project and including the Acute Medical Unit (AMU) and Pembroke Unit.

8. HAND HYGIENE

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the directorates of measures implemented to improve non-compliance. When compliance is poor, the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results continue to be disseminated according to staff groups for each area. This action has provided evidence to strengthen the feedback process for the directorates to take the necessary action.

For 2018/19, the overall compliance rate from 27 external audits completed across 17 clinical areas at different times was 74.16%, with several areas being audited more than once during the year. This is a slight decrease on the previously reported overall compliance rate of 78.82% from 19 external audits completed across 13 clinical areas (several areas audited more than once).

Detailed analysis was undertaken to identify the key areas of non-compliance, which was predominantly staff missing moment number 5, handwashing after contact with patient surroundings. The results were reported via the DIPC and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in practice. Additional education and support has been provided by the ICNs to staff groups focusing on these audit findings.

For the internal hand hygiene audits completed by the clinical areas the overall average compliance rate for 2018/19 ranges from 90 – 94.6%. The 'Red, Amber and Green' rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised and the impact of these measures is being monitored by the IPCWG, DMTs and MMG.

During quarter 4 of 2018/19, the ICNs have assisted the Deputy Directors of Nursing with the modification of the hand hygiene audit tool for the 'Perfect Ward' application (PWA). The format was trialled and discussed at the MMG meeting to ensure that user compliance was achievable. It is planned that this will be rolled out to those areas currently utilising the PWA during quarter 1 of 2019/20.

9. DECONTAMINATION

9.1 Progress against Decontamination Strategy

The Decontamination Strategy considers the 2016 Health Technical Memorandum (HTM) guidance and monitoring of decontamination in terms of Essential Quality Requirements (EQR) and Best Practice (BP) continues. Key objectives are reviewed at the quarterly Decontamination Working Group (DWG) meetings, and risk assessments are monitored and updated when necessary.

9.2 Activity to promote compliance with decontamination arrangements

- The Decontamination Policy remains current and continues to reflect local practices with Salisbury Sterile Services (SSL), and HTM regulations.
- Local decontamination audits and standard operating procedures (SOP) development continues.
- Tray tracking for instrumentation is in place however manufacturers' demonstrations for radio frequency identification (RFID) instrument tracking have been viewed positively by stakeholders. This development would represent improved practice however there is currently no identified funding for this work. Is this being progressed and can that be stated as cant leave it hanging that it would be a good thing to do – how is it being taken forward and also state how that would contribute to the smoother running of theatres and the kit availability issues that are raised
- Endoscope traceability is currently a paper system but an electronic option is being developed. A system developed by STERIS should be installed in SSL within quarter 1 of 2019/20 but discussions involving stakeholders as to the best option for Trust wide tracking is ongoing.
- Theatre tray wraps have changed from linen to paper although there are still a number of holes being reported. Audits have been undertaken to review practice through from SSL to receipt/storage and use in the Main Theatres Department (MTD) to identify if there are any trends/themes in damaged wraps. An action plan detailing the work undertaken has been created as additional evidence. New shelving has been installed for orthopaedic storage in MTD and workflow patterns looking at the number of handling points for the whole tray journey continues, with a view to further reduce incidence.
- The 'Vac pack' system trial was received positively in MTD (to create storage capacity within the department), and this practice will continue.

- The use of an agreed 'moisture spray' for used instrumentation to prevent instrumentation drying out prior to processing in SSL has not progressed further due to practical challenges. Alternative methods to improve retention of moisture (thus facilitate cleaning) are currently being explored for use in MTD, Day Surgery Unit (DSU) and Obstetrics Theatre.
- The Surgical Instrument Coordinator continues work around tray rationalisation, use of caskets and quality of instrumentation. This work ensures remaining instruments are fit for purpose as well as offering benefits such as reducing weight (impacting on damage to tray wraps which in turn affects availability of trays for patient procedures), improved processing times and reduced processing costs.
- Some instruments have been individually laser marked by SSL to aid identification and traceability however this could be extended further.
- SSL process flexible endoscopes on behalf of the Trust with consideration of the requirements set out in HTM 01-06. The ageing machinery continues to cause concern from a reliability perspective and two new automated endoscope reprocessors (AERs) have been purchased, the first of which is awaiting validation. Storage of scopes is under review to ensure we have sufficient storage options for the number of scopes in use, giving due consideration to the increase in patient numbers and likely development of the Endoscopy service.
- Discussions have taken place to explore alternatives to purchasing single patient use items which require processing in SSL prior to use. It is standard practice in Scotland, for example, that many screws or plates required for orthopaedic surgery are purchased 'pre-sterile' from the manufacturer and do not require local processing. A move locally to purchasing sterile items which are only opened when required would improve practice.

9.3 Decontamination Audit plan

- Re-audits have been performed in 10 areas during quarter 2 of 2018/19 and have included: Breast Care Unit, Dermatology Treatment Centre, Emergency Department, Gynaecology Clinic, Radnor Ward (ICU), IT devices, Laser Clinic, Maternity Unit, Neonatal unit and Urology Clinic.
- Re-audits have been performed in 19 areas during quarters 3 and 4 of 2018/19 and have included: Cardiac Suite, Children's Outpatient Department (OPD), DSU, Ear, Nose and Throat (ENT) OPD, Fertility Service, MTD and Pembroke Unit.
- General compliance with agreed SOPs is good but any processes which can be improved are highlighted, e.g. Medical & Surgical OPD have now moved to single use sigmoidoscopes with in-built light source following a successful trial. Laboratory Medicine (which includes the Mortuary) have been invited to participate in the decontamination audit for the first time. The 2019/20 audit schedule will also include Speech and Language Therapy who use nasendoscopes to assess their patients, and participation in this Trust wide audit will assist in the monitoring of their SOP.
- Post procedure cleaning (PPC) and manual high level disinfection (HLD) of nasoendoscopes has been revisited with the ENT OPD following 2 decontamination incidents reported. SOPs have been reviewed and fully accepted by the relevant departments.
- SOPs are also in use for a number of other areas performing agreed local decontamination of devices including Spinal pressure clinic, Dermatology Unit, Vascular OPD, Radnor Ward (ICU), Urology Clinic and Medical and Surgical OPD.
- Standards for the decontamination of semi-invasive ultrasound probes used intra cavity or on broken skin have been followed up with Vascular OPD and Radiology Departments. Since July 2018, the Radiology Department have been using an automated decontamination process for probes using Trophon Units (Trust owned). The Lead for Radiology Ultrasound has secured an ongoing revenue budget for consumables.
- There is ongoing work required to ensure robust processes are in place which provide assurance that the decontamination processes for ultrasound probes which are used intra-cavity or on broken skin meet EQR as a minimum. The Decontamination Lead continues to work with relevant departments and areas of concern are discussed at the DWG.

9.4 Joint Advisory Group (JAG) Accreditation Inspection for Endoscopy Services

Following an inspection during August 2018, re-accreditation was deferred for 6 months and a 'Task & Finish' Group was established to address the actions identified. Following re-submission of evidence, JAG accreditation has been awarded for 3 months with further assurance required to evidence sustained improvement, largely around scheduling and waiting times. There are however elements which relate to decontamination, specifically around evidencing scope processing and storage. Whilst the current paper processes meet EQR, the planned introduction of an electronic track and trace system will establish a more robust system which can be easily audited.

9.5 Maintaining a fully compliant sterilisation facility (SSL)

The Decontamination Lead continues to attend a monthly SSL Operational Management Board (OMB) and also meets weekly with SSL to discuss any issues arising. Compliance testing, which now includes residual protein testing, is reported to the DWG. Discussions are in place to handover the maintenance of the equipment in SSL to STERIS to manage. These discussions include service contracts and testing arrangements as well as establishing processes to ensure Salisbury Foundation Trust (SFT) staff continue to receive reports of the compliance testing results to provide appropriate assurance. The Trust is also awaiting news of a feasibility study for the refurbishment of the SSL facility.

9.7 Key focus for quarters 1 and 2 of 2019/20

- Continue with the agreed local decontamination audits and development of SOPs.
- Ensuring agreed SOPs are in place for the decontamination processes of invasive ultrasound probes used in the Trust.
- To progress with the development and implementation of software for endoscope traceability which will improve practice but also provide assurance for the JAG re-assessment.
- Ensure we have sufficient safe and secure storage facilities for Trust endoscopes to meet ongoing requirements with consideration of developing services.
- To ensure a safe transfer of responsibility from SFT to STERIS for maintenance of decontamination equipment within SSL.
- To test the business continuity plans for the decontamination and processing of instruments and scopes in the event of equipment or service disruption in SSL.

10. CLEANING SERVICES

10.1 Patient led assessment of the care environment (PLACE) internal audits

The Trust developed and implemented a programme of PLACE audits for 2018/19 and planned to undertake 58 internal PLACE assessments between June 2018 and March 2019 using the NHS improvement (NHSi) PLACE criteria.

In this time, we undertook 57 internal PLACE assessments with two new outpatient areas added to the plan (Vascular & Diabetes and Pathology OPD). We did not undertake internal PLACE assessments on Laverstock or Clarendon Wards due to their closures. Unfortunately, Tamar Ward was not assessed and this will be completed before the end of April 2019.

We continue to achieve active engagement and good support from Governors, Volunteers and the local Health Watch representatives to undertake the PLACE audits. Each ward produced their own action plans and reported progress via MMG monthly meetings. Focus is given to themes from the ward or department and learning that can be shared with other areas. The PLACE internal audits have produced evidence that supports capital bids and decorating programmes so funds are appropriately allocated. The Dementia Lead for the Trust has also engaged with the PLACE programme, with a joint approach to environmental aspects to ensure this patient group is well supported within these criteria.

A table top PLACE exercise continues to be undertaken at the planning stage, with ETS and ArtCare, for any new/refurbished departments and/or wards to ensure that consideration is given to PLACE criteria at the project design stage.

The result of each PLACE assessment is submitted to the Health and Social Care Information Centre (HSCIC) using the PLACE 'Lite' Tool.

10.2 National PLACE

The Trust has been informed that the National PLACE assessment will be delayed in 2019 to give NHSi chance to review the criteria, following this review the PLACE criteria may change. The Trust has been given a provisional indication that the 2019 National PLACE assessment will now take place between September 2019 to March 2020, and we are awaiting further information regarding changes to the assessment criteria.

The Trust's 2018 National PLACE assessment took place on May 10th 2018. In accordance with NHSi PLACE criteria, a total of 10 wards and the Emergency Department (ED) were visited, 4 food assessments undertaken, 6 outpatient areas audited. External spaces (including car parking), signage and communal areas were also assessed, as required under the PLACE criteria. The PLACE scores for the Trust were published in August 2018, and key themes form the basis of improvement plans within the Trust. Below are the Trust scores against the national average for 2018.

2018 PLACE results with National Average

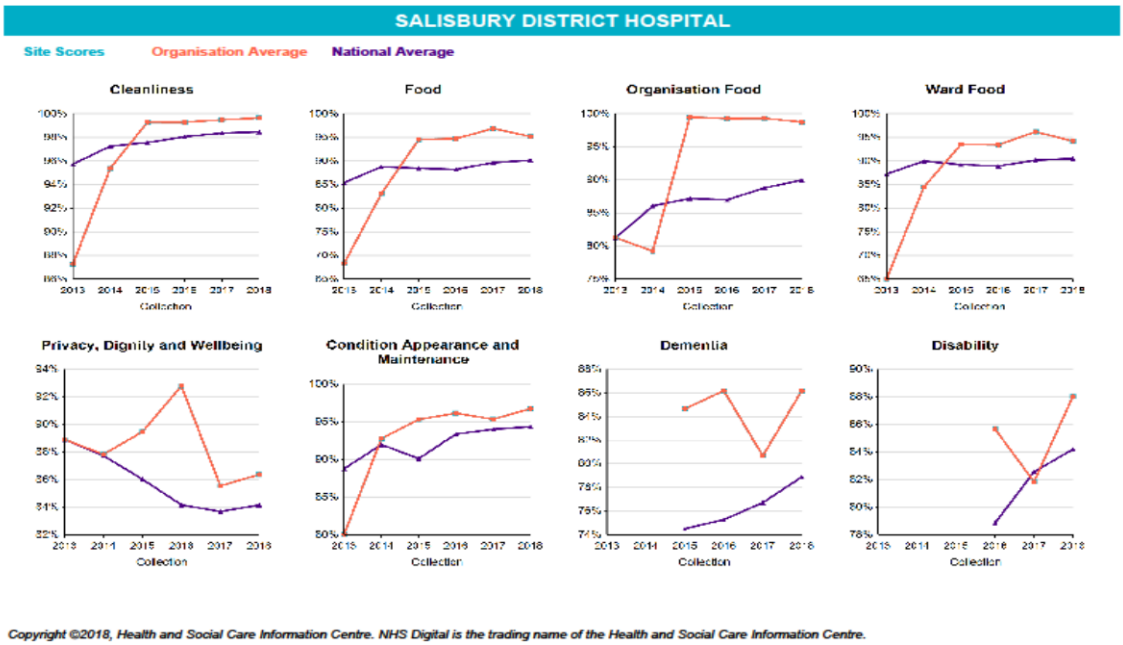


Table 9

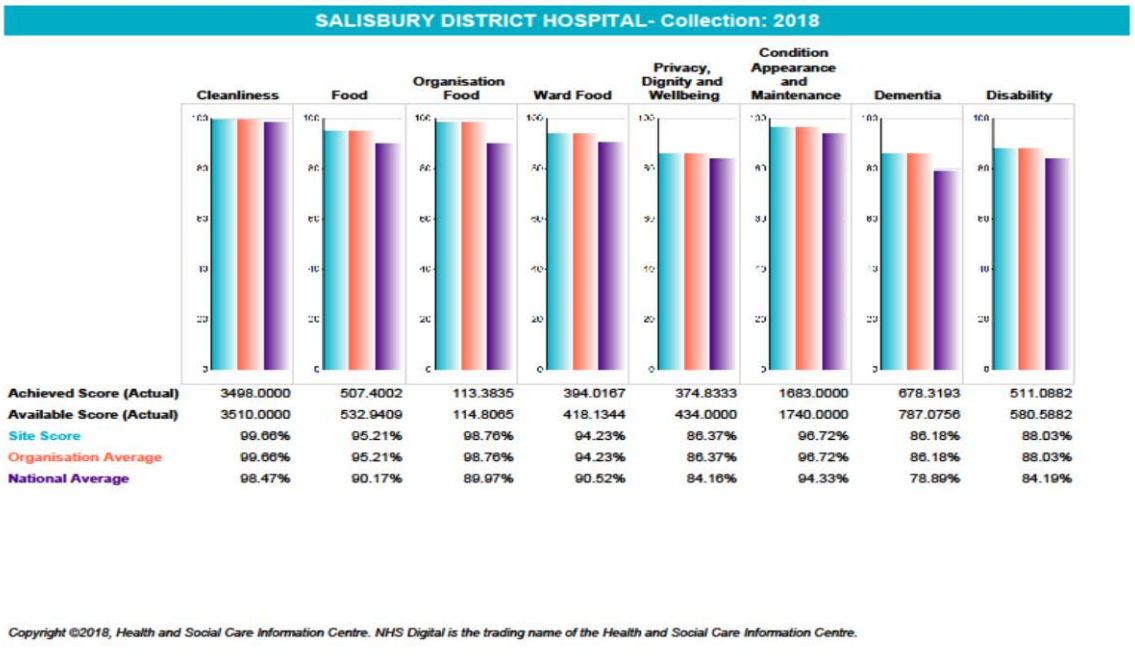


Table 10

10.3 Deep clean programme and rapid response team

The deep clean and decorating programme commenced in May 2018 (a copy of the Deep Clean programme is available from the Housekeeping Department). A monthly review of this plan is undertaken at MMG and discussed with the ICNs and DSNs at weekly meetings.

Concerns have been raised that the Housekeeping Team cannot access a number of bays and siderooms due to bed pressures. For those areas that are not deep cleaned, a contingency "scrub" plan of action has been agreed. This contingency scrub plan including specific bedspaces will continue to be monitored to better ensure all areas have a level of annual deep clean. These areas will be prioritised should they become available and the deep clean and hydrogen peroxide vapour (HPV) treatment will be undertaken.

At the end of March 2019, Housekeeping were unable to access 17 bedspaces across the Trust to enable a deep clean/scrub clean to take place. These bedspaces/areas will be prioritised should they become available and the deep clean and hydrogen peroxide vapour (HPV) disinfection treatment will be undertaken.

10.4 Improvement work over 2018/19

The Housekeeping Management Team purchased two Bioquell hydrogen peroxide vapour (HPV) systems following capital investment. Following training undertaken in June and July 2018, these systems were operational in August 2018. The Bioquell system calculates the capacity of each room/area and items present, to determine the duration of the cycle, and has reduced the duration of time to decontaminate a sideroom facility by approximately one hour. This has released the bedspaces earlier to further support a more timely patient flow.

The previously used GLOSAIR 400 HPV room decontamination system (RDS) machines reached their end of life in December 2018, and have been decommissioned and removed.

Housekeeping were successful in achieving a PLACE score average, the national average (SFT 99.66% = National average 98.38%), at a cost significantly lower than the peer group average (Estates Return Information Collection (ERIC) scores for 2018: SFT = £29.23 per square metre, and ERIC medium = £38 per square metre).

A saving of £15k per annum was achieved by the reduction of office cleaning for non-clinical areas. Housekeeping now delivers a service to these communal areas (kitchen/bathrooms/emptying of communal bins) and visit non-clinical offices less frequently.

During quarters 1 and 2 of 2018/19, the Housekeeping Team supported the response for the two major incidents, with a significant demand upon resources. Decontamination was undertaken in all areas across the Trust and all the necessary documentation/paperwork fully completed as a record of this work. In addition to the Actichlor plus clean, a '50/50' household bleach clean was also required in a number of areas. The number of cleans linked to these major incidents totalled 213.

For quarters 1 and 2 of 2018/19, the Housekeeping Team completed 2501 terminal cleans, with only 14 falling outside of our KPIs (to commence the clean within 3 hours of request). *Of note: 99% of terminal cleans commenced within 3 hours.* For quarters 3 and 4 of 2018/19, a total of 3221 terminal cleans were completed by the Housekeeping Team, of which 13 fell outside of our KPIs. *Of note: 99.59% of terminal cleans commenced within 3 hours (see Table 10 below).*

Duration of Time	Number of Terminal Cleans	Number of Terminal Cleans falling outside the KPI	Percentage of Terminal cleans undertaken within the KPI
April 2018 – September 2018	2501	14	99.44%
October 2018 – March 2019	3221	13	99.59%

Table 11

The Housekeeping Department routinely monitor those bedspaces requiring a terminal cleaning (post infection clean) where furniture (including the patient's bed), is not present in the room/area at the time of the clean. This information is fedback to the relevant ward leaders/DSNs and ICNs for further investigation and to ensure any identified risks are reduced.

10.5 Key focus for quarters 1 and 2 of 2019/20

Recruitment and retention remains a challenge going forward as we continue to have limited applicants for vacant posts. The tendered staff agency supplier is unable to provide sufficient staff to meet our demand. We are working with the Organisational, Development & People (ODP) Department to fill vacant posts and monitor the staff agencies ability to meet our requests for staff.

A continued increase in the number of terminal cleans proves to be an ongoing challenge. During January 2019, the Housekeeping Team experienced the largest number of terminal cleans completed on record, totalling 768. During quarters 3 and 4 of 2018/19, as vacancies have come up, we have recruited more staff on the later shifts to ensure our staffing provision matches the requirement for terminal cleans later in the day/early evening. This better ensures we are able to respond to patient flow demands. The ongoing challenge will continue to be reviewed and redeploy staffing to meet the demand to turnaround bedspaces quickly.

11. ANTIBIOTIC STEWARDSHIP

11.1 Achievements for 2018/19

During 2018/19, the Antibiotic Reference Group (ARG) has focused on reducing the impact of serious infections (Antimicrobial resistance and sepsis) Commissioning for Quality and Innovation (CQUIN) as well as ensuring our antimicrobial guidelines are up to date. Quarters 3 and 4 of 2018/19 have been extremely challenging to complete this work and so concentrated efforts have been on Part 2c of the CQUIN, which the ARG felt was more achievable.

We have continued to carry out our fortnightly antimicrobial audits where we use this opportunity to feedback to prescribers on the ward and also identify areas where antibiotic reviews are not completed in line with the CQUIN.

CQUIN part 2c – Antibiotic review: Assessment of clinical antibiotic review between 24 – 72 hours of initiation in patients with sepsis who are still inpatients at 72 hours: We met our quarter 1, 2 and 3 targets, and the results of our quarter 4 audit will be available shortly.

Feedback from educational sessions with some consultant groups (medicine, urology, orthopaedics, spinal and elderly care), suggested that an antibiotic review sticker would be helpful in order to capture all the information required for part 2c of the CQUIN. A sticker was therefore designed, approved and rolled out to the wards during quarter 4 of 2018/19 (on 7th January 2019). Unfortunately there has been resistance to its use in some areas. Results of the quarter 4 audit for 2018/19 shows that 80% of prescriptions audited had a documented antibiotic review within 24 – 72 hours meeting all three review criteria. Unfortunately, this did not meet the target of 90% for this quarter.

CQUIN part 2d – Reduction in antibiotic consumption as Defined Daily Doses (DDD) per 1000 admissions:
This is divided into 3 parts:

- *Reduce all antibiotics – Reduction in antibiotic consumption per 1000 admissions:* This part of the CQUIN is most challenging for us. Our target for reducing antimicrobials is to achieve a 2% reduction in total antibiotic usage compared to our 2017/18 target. Preliminary data at the end of 2018/19 shows an increase of 7.6% in total antibiotics used.
- *Reduce Carbapenems* – We achieved an excellent reduction in Carbapenems last year and so this year the target is to maintain that 12.5% reduction. Our Carbapenem usage is very small and so one or two patients can dramatically affect the results. For 2018/19, we have achieved a 29.75% reduction. This far exceeds our 2% target reduction and shows that our work towards antimicrobial stewardship in this area has been successful.
- *Increase Proportion of antibiotics in the Access group of the AWaRe category* – The new target for part of the part 2d CQUIN is to increase the proportion of narrow-spectrum antimicrobials. All antibiotics have been divided into 3 categories – Access, Watch and Reserve. The target is to have at least 55% of our total antibiotic usage in the Access group or increase by 3% from 2016 calendar year data. Our 2016 data shows we had 50.17% of our antibiotics in the Access group therefore we need to increase this to 53.17%. Data at year end shows 50.14% of antibiotics came from the Access group. This is expected as workload and time constraints meant we were not able to focus on this piece of work.

In preparation for the removal of our Integrated Clinical information Database (ICID), all antimicrobial guidelines have been transferred across to Microguide. Use of this application in University Hospitals Southampton (UHS) led to a reduction in the prescribing of high-risk broad-spectrum antibiotics from 40% to 28% and we are hoping for similar success here once all guidelines have been updated in line with NICE guidance.

This year, 'World Antibiotic Awareness' week took place during quarter 3 of 2018/19 (12th – 18th November 2018). The Trust completed a range of actions to promote awareness of the need to use antibiotics responsibly. These included the use of posters throughout the hospital, the Pharmacy Team engaging with staff on the wards and messages via e-mail broadcasts to staff.

11.2 Action plan for 2019/20

The Microbiology Team have produced a business case to increase resources available. The aim of this would be to implement a Consultant Antimicrobial ward round to try and achieve the benefits described above.

Details of the Antimicrobial resistance CQUIN 2019/20 have now been released. There are 2 parts to the CQUIN:

- CCG1a: Improving the management of lower urinary tract infections (UTI) in older people
- CCG1b: Improving surgical prophylaxis in elective colorectal surgery

CCG1a is a large piece of work, however, the benefits of improving prescribing in this area could have many benefits and some Trusts have seen a large decrease in their antimicrobial usage by ensuring appropriate management of UTI in older people.

There is also a Medicines Optimisation CQUIN of which one part relates to Antifungal stewardship and focuses on reducing inappropriate use of anti-fungal agents and preventing the development of resistance to antifungals through the development of anti-fungal stewardship teams. This has yet to be discussed by the ARG.

Reducing total antimicrobial usage by 1% per year has now become part of the NHS contract. Due to the large increase in usage seen last year this is a large piece of ongoing work.

The main focuses for this quarter are to concentrate on identifying the work required for the new CQUINs and to ensure that all antimicrobial guidelines are updated on Microguide as per NICE guidelines. This is a substantial piece of work and will require great input from the antimicrobial team to achieve. Further resources are essential for us to be able to complete this work successfully.

12. AUDIT

In line with the requirements of the Health and Social Care Act 2008, a programme of infection prevention and control audits is illustrated in the annual audit programme. The programme ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust.

The ICNs have been involved with the following audit work during 2018/19, including the follow up and outcomes from auditing against infection control policies. Final reports are generated for each completed audit, with resulting action plans approved by the IPCWG before submission to the IPCC and Clinical Management Board (CMB):

- *Handling and Disposal of Linen Reaudit* – data collection was completed during quarter 1. A breakdown of results for each of the clinical areas identified key themes relating to storage of clean and used linen, and practices including the wearing of personal protective equipment (PPE). The report was presented at the IPCC during October 2018 and submitted to CMB during quarter 4 of 2018/19.
- *'Perfect Ward' Application'* – The ICNs continue to complete IPC inspections for identified clinical areas. Findings are fedback verbally to the clinical leader/nurse in charge at the time with instruction to access the results report to identify any required actions. The results are also available for the DSNs/Heads of Nursing to access (via the app), with formal reports fedback via MMG meetings. (Completion of these audits has been in addition to the 'spot checks' and observational practice audits undertaken by the ICNs during daily clinical visits to ward areas). Please see Appendix C for further details, the results show an improving direction and for the first time give us transparency across a number of IPC indicators at practice level.

13. EDUCATION AND TRAINING ACTIVITIES

During 2018/19, the ICNs continued to work with the Education Department to review the compliance data generated from the MLE system for both hand hygiene assessments (HHA) and IPC CBL modules. Further cleansing of the data was stipulated by the DIPC and this was progressed with the Education Department. Compliance scores for quarters 1 and 2 were 80% for staff completion of hand hygiene assessments and 92% for staff completion for IPC CBL package (as of 1st October 2018). For quarters 3 and 4 of 2018/19, compliance scores were 85% for staff completion of hand hygiene assessments and 95% for staff completion for IPC CBL package.

The ICNs have continued to focus on the promotion of opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical directorates facilitated the completion of hand hygiene assessments for staff by utilising a ultra-violet (UV) light box for rotation through their directorate areas and departments.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. These include core induction sessions in addition to specific topic requests. The facilitation of learning has also involved members of staff shadowing of the ICNs in addition to the monthly scheduled ICLP meetings. Details of education opportunities provided are available from the ICNs.

The ICNs continue to explore different methods for educational opportunities/activities e.g. social media (Twitter account) and a planned physical IPC 'Trolley Dash' for quarter 1 of 2019/20.

14. CONCLUSION

This annual report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust. The report has detailed the progress against the Action Plan for 2018/19 in reducing HCAI rates for the Trust.

For 2019/20, the key priorities for the Trust will include:

- Continued focus on the reduction of all reportable HCAIs and ensure preventable infections are avoided.
- Ongoing reinforcement to improve compliance with hand hygiene practices and behaviours.
- Continued achievements for antimicrobial stewardship.
- Monitor and manage decontamination services.
- Sustain progress with education, training and audit relating to infection control practices and policies.
- Monitor and manage water safety.
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2018/19

Please note: The numbering **does not** depict the order of priority for the Trust, but reflects the numbered duties within the Hygiene Code.

Domain and Key Actions	Who By	Status
1 Management, Organisation and the Environment **1.1 General duty to protect patients, staff and others from HCAIs** **1.2 Duty to have in place appropriate management systems for Infection Prevention and Control**		
Continue to promote the role of the DIPC in the prevention & control of HCAI	Chief Executive	Continuous
DIPC as Chair of the Infection Prevention and Control Committee	Chief Executive	In place
Lead infection prevention & control in the Trust and provide a six monthly public report to the Trust Board	DIPC	In place
Monitor and report uptake of mandatory training programme	IPCT	In place
Continue contribution to implementation of the Capacity Management policy	DIPC	In place
Ensure a programme of audit (incorporating Saving Lives High Impact Interventions) is in place to systematically monitor & review policies, guidelines and practice relating to infection prevention & control	IPCWG/IPCC	Monthly
Continue to review staffing levels via Workforce Planning	DDIPC	Continuous
Complete bedpan washer replacement and dirty utility room upgrade programme within the Trust (for inpatient clinical areas), including the Spinal Unit.	DIPC	Complete
1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks		
Maintain the role of DIPC as an integral member of the Trust's Clinical Governance & risk structures (including Assurance Framework)	Chief Executive	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these	DIPC/JH/IPCT	In place
Active Surveillance & Investigation:		
Continue implementation of mandatory Surveillance Plan for HCAI & produce quarterly reports for IPCC	ICNs	In place
Review implementation of 'alert organism' & 'alert condition' system	JH/SC/PR	Continuous
Use comparative data on HCAI & microbial resistance to reduce incidence & prevalence	JH/SC/PR	In place
Promote liaison with Public Health England (PHE) for effective management & control of HCAI	DIPC/JH/IPCT	Continuous

Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/IR/MS	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/IR/MS/ Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	IPCT	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	TC	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/FM	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	IR	Continuous
Ensure adherence to the uniform and BBE policies and workwear guidance through audit and formal reporting via the monthly Matrons Monitoring Group meetings	DIPC/DSNs	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit	DSNs/IPCT	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation	JH/SC/PR	Continuous

Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	In place
Isolation of patients	JH	In place
Safe handling and disposal of sharps	PK/GL	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	PK	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)	SK	In place
Disinfection policy	MS	In place
Antimicrobial prescribing	JH/LW	In place
Mandatory reporting HCAIs to the HPA	JH	In place
Control of infections with specific alert organisms; MRSA and C.difficile	IP&CT	In place
Additional policies:		
Transmissible Spongiform Encephalitis (TSE)	JH	In place
Glycopeptide Resistant Enterococcus (GRE)	JH	Included in
Acinetobacter species	JH	Isolation
Viral Haemorrhagic fever (VHF)	JH	Policy
Prevention of spread of Carbapenem resistant organisms	JH	In place
Diarrhoeal infections	JH	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	JD	In place
Infection control measures for ventilated patients	MF	In place
Tuberculosis	JH	In place
Legionellosis risk management policy and procedures, including pseudomonas	TC	In place
Strategic Cleaning Plan & Operational Policy	MS	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	TC	In place
Waste Management Policy	TC	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	FM	In place

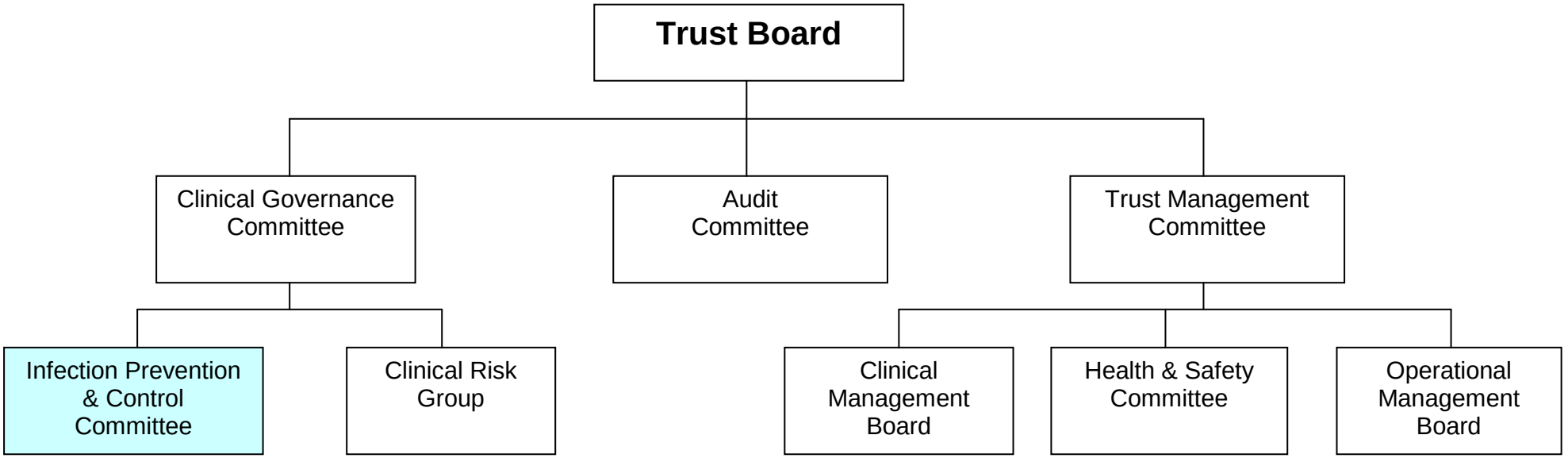
Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs.		
Ensure all staff can access relevant occupational health & safety services (OHSS)	PH	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	PK	Continuous
Continue the provision of infection prevention and control education at induction	IPCT	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPCT	Continuous
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals	DSNs/ICNs	Continuous

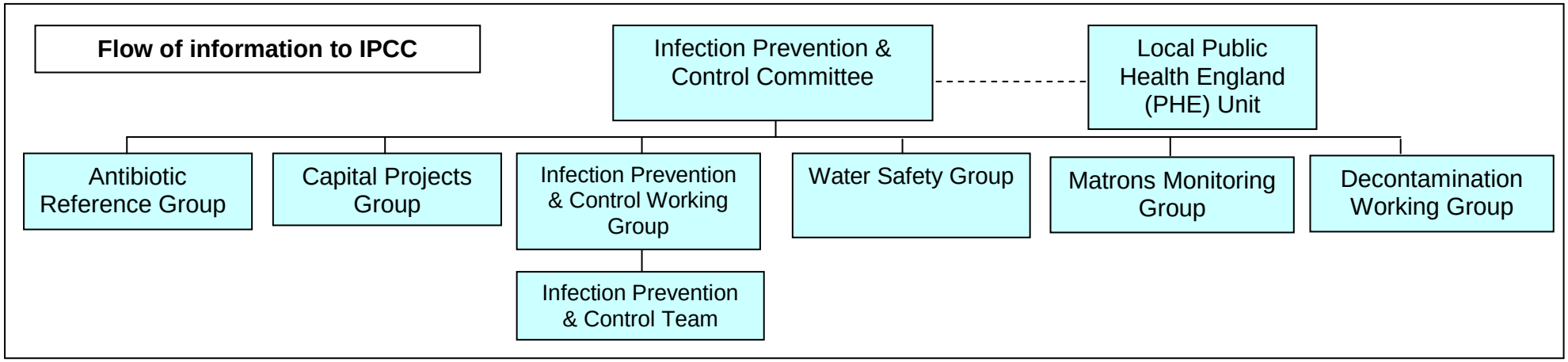
KEY INITIALS

DIPC	Lorna Wilkinson, Director of Infection Prevention & Control (DIPC)
DDIPC	Denise Major & Fiona Hyett, Deputy DIPCs
FM	Fiona McCarthy, Senior ICN & Interim Trust Decontamination Lead *(until 31st August 2018) Sarah Jennings returned to this Trust role post external secondment until 31st October 2018).*
CG	Trust Decontamination Lead *(from 1st November 2018)*
JH	Julian Hemming, Consultant Microbiologist & Infection Control Doctor (ICD)
SC	Stephen Cotterill, Consultant Microbiologist & Deputy ICD
PR	Paul Russell, Consultant Microbiologist & Antimicrobial Lead
IR	Ian Robinson, Head of Facilities
TC	Terry Cropp, Responsible Person for Water & Head of Estates
DSNs	Directorate Senior Nurses
SK	Sarah Knight, Head of Patient Flow
PK	Paul Knight, Health & Safety Manager, OH Department
GL	Geoff Lucas, Safety Advisor, OH Department
LW	Louise Williams, Principal Pharmacist
JD	Jacqui Dalley, Neonatal Unit Sister
MF	Maria Ford, Nurse Consultant in Critical Care
PH	Paul Hargreaves, Director of Human Resources
MS	Michelle Sadler, Facilities Manager

APPENDIX B

Formal Trust Reporting Structure





APPENDIX C

Ward/Department	Directorate	April - May 2018	June 2018	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018	January 2019	February 2019	March 2019
Sarum Ward	Clinical Support & Family Services	25.04.18 (80%)	06.06.18 (86.3%)	04.07.18 (82.4%)	02.08.18 (73.2%)	28.09.18 (78.2%)	14.10.18 (80.4%)	11.11.18 (80.4%) and 24.11.18 (84.9%)		09.01.19 (84.8%)	15.02.18 (78.4%)	29.03.19 (98.1%)
Acute Medical Unit	Medicine	04.05.18 (71.4%)	08.06.18 (82.5%)	27.07.18 (75.4%)	16.08.18 (75.4%)	27.09.18 (70.2%)	24.10.18 (61.4%)	13.11.18 (80.7%) and 23.11.18 (78.6%)		25.01.19 (92.3%)	25.02.19 (92.5%)	
Durrington Ward	Medicine	25.04.18 (75%)	01.06.18 (69.6%)	05.07.18 (84.2%)	01.08.18 (64.3%)	13.09.18 (77.2%)	22.10.18 (86%)		13.12.18 (84.6%)	09.01.19 (90.6%)	14.02.19 (88.7%)	18.03.19 (92.3%)
Farley Stroke Unit	Medicine	03.05.18 (61.4%)	15.06.18 (64.9%)	20.07.18 (64.9%)	10.08.18 (65.5%)	09.09.18 (94.7%) 12.09.18 (80.7%) 14.09.18 (62.1%)	23.10.18 (75.4%)	26.11.18 (67.2%)	19.12.18 (73.1%)	21.01.19 (88.5%)	07.02.19 (88.9%)	16.03.19 (90.2%) and 27.03.19 (92.3%)
Hospice	Medicine	24.05.18 (83.3%)	27.06.18 (87.8%)	26.07.18 (89.8%)	24.08.18 (82%)	25.09.18 (92%)		02.11.18 (91.1%)			25.02.19 (91.5%)	
Pembroke Ward	Medicine	10.05.18 (75%)	20.06.18 (71.4%)	24.07.18 (78.2%)	22.08.18 (82.5%)	26.09.18 (85.7%)		06.11.18 (86%)	24.12.18 (98.1%)		18.02.19 (78.4%)	27.03.19 (90.9%)
Pitton Ward	Medicine	02.05.18 (78.9%)	06.06.18 (68.4%)	18.07.18 (69.6%)	03.08.18 (61.8%)	06.09.18 (73.7%)	12.10.18 (80.7%) and 15.10.18 (84.2%)		20.12.18 (92.5%)	11.01.19 (74.5%)		14.03.19 (60.8%)
Redlynch Ward	Medicine	09.05.18 (62.5%) and 13.05.18 (91.2%)	01.06.18 (89.5%)	12.07.18 (78.6%)	03.08.18 (78.9%)	06.09.18 (77.2%)	12.10.18 (82.5%)		28.12.18 (66.7%)	31.01.19 (81.1%)		06.03.19 (78.4%)
Tisbury CCU	Medicine	11.05.18 (82.5%)	01.06.18 (64.9%)	20.07.18 (78.6%)	10.08.18 (85.5%)	18.09.18 (82.1%)		02.11.18 (80.7%)	27.12.18 (76%)	31.01.19 (88%)	08.02.19 (84.3%)	26.03.19 (72%)
Whiteparish Ward	Medicine	20.04.18 (66.7%) and 23.04.18 (81%)	05.06.18 (77.2%)	13.07.18 (86%)	03.08.18 (75.9%)	05.09.18 (78.9%)	16.10.18 (83.9%)		07.12.18 (86.5%)	03.01.19 (76.9%) 23.01.19 (100%)		15.03.19 (70.6%)
Spire (Winterslow) Ward	Medicine	30.04.18 (66.7%)	13.06.18 (70.2%)	23.07.18 (63.8%)	17.08.18 (71.9%)	14.09.18 (70.7%)	15.10.18 (84.2%)		28.12.18 (65.4%)	13.01.19 (98.1%)	19.02.19 (78.8%)	01.03.19 (96.2%)
Amesbury Suite	Musculoskeletal	11.04.18 and18.04.18 (55.4%)	07.06.18 (69.6%)	20.07.18 (77.2%)	09.08.18 (66%)	18.09.18 (66.1%)	25.10.18 (70.9%)	27.11.18 (74.5%)	19.12.18 (76.5%)	25.01.19 (70%)		06.03.19 (90.2%)
Avon Ward	Musculoskeletal	11.05.18 (73.2%)	12.06.18 (69.1%)	18.07.18 (69.6%)	08.08.18 (63.6%)	18.09.2018 (85.5%)		06.11.18 (73.2%)	28.12.18 (100%) and 31.12.18 (60.4%)	27.01.19 (90.2%)	21.02.19 (100%)	11.03.19 (96%)
Chilmark Suite	Musculoskeletal	24.04.18 (82.1%) and 02.05.18 (73.2%)	14.06.18 (74.5%)	10.07.18 (93%) and 20.07.18 (75%)	08.08.18 (83.6%)	24.09.18 (78.6%)	15.10.18 (91.2%)	05.11.18 (90.2%) and 26.11.18 (82.1%)	19.12.18 (96.1%)		27.02.19 (94.2%)	21.03.19 (94.3%)
Odstock Ward (Plastics & Burns)	Musculoskeletal	18.04.18 (87.7%) and 30.05.18 (72.7%)	22.06.18 (60%)	24.07.18 (73.2%)	29.08.18 (86%)	07.09.18 (80.7%)		28.11.18 (84.3%)	31.12.18 (92.3%)	29.01.19 (94.3%)	12.02.19 (100%)	29.03.19 (98%)
Tamar Ward	Musculoskeletal	15.05.18 (63.6%)	20.06.18 (71.4%)	18.07.18 (71.4%)	10.08.18 (69.1%)	21.09.18 (80.7%)		06.11.18 (89.1%)		03.01.19 (82.4%)		18.03.19 (96.2%)
Breamore Ward	Surgery	22.05.18 (93.8%) and 29.05.18 (69.1%)	20.06.18 (91.2%)	23.07.18 (80%)	10.08.18 (84%)	24.09.18 (92.9%)		06.11.18 (96.1%) and 27.11.18 (86.3%)		02.01.19 (90.2%)	22.02.19 (97.8%)	
Britford Ward	Surgery	03.05.18 (75.4%)	05.06.18 (82.5%)	12.07.18 (73.7%)	03.08.18 (77.2%)	13.09.18 (82.5%)	29.10.18 (91.1%)	30.11.18 (76.5%)	13.12.18 (80.8%)	08.01.19 (90.2%)	22.02.19 (96.1%)	20.03.19 (94.2%)
Downton Ward	Surgery	24.04.18 (91.2%) and 22.05.18 (77.2%)	13.06.18 (94.5%) and 29.06.18 (61.8%)	27.07.18 (86.5%)	16.08.18 (83.9%)	10.09.18 (94.4%)	02.10.18 (88.7%) and 24.10.18 (96.4%) and 30.10.18 (86%)		11.12.18 (96.2%) and 21.12.18 (96.1%)	14.01.19 (96.2%)	14.02.19 (96.2%)	13.03.19 (100%)
Radnor Ward	Surgery	25.04.18 (88%)	08.06.18 (76%)	27.07.18 (79.6%)	29.08.18 (89.1%)	28.09.18 (91.8%)		30.11.18 (96.1%)		03.01.19 and 07.01.19 (98.1%)		
Laverstock Ward	Escalation Ward											11.03.19 (79.6%)

	more than 90%
	70% - 90%
	less than 70%
	no inspection completed

Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.2
Date of Meeting:	06 June 2019		

Report Title:	Corporate Communications Strategy			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Justine McGuinness			
Executive Sponsor (presenting):	Paul Hargreaves / Cara Charles Barks			
Appendices (list if applicable):	N/A			

Recommendations:

Change from Public Relations to Corporate Communications – to cover marketing, internal communications, reputation management, media relations and stakeholder engagement (Public Affairs).

Ensure the delivery team is adequately resourced; produce a Trust-wide Corporate Communications plan and a dynamic 'grid' to schedule communications activities.

Introduce the necessary policy and guidance changes in Q2/3 2019/20 – including overarching guidance on who can communicate what, to whom and when

Define the Trust's core narrative, define the 'The Salisbury Way' and introduce a new 'message house'

Restructure the Trust's dispersed marketing function; review branding and introduce a new 'style-guide', to ensure consistent corporate branding and quality.

Review digital assets (including web site, app, intranet and video) and the web-development function to be shared between IT and Corporate Communications.

Introduce a new Corporate Communications 'helpdesk' to assist the planning, delivery and evaluation of activities.

To improve outreach and external communications, move away from reacting to events and to creating our own news.

Define the resources and equipment needed to deliver rapid improvements to the quality of outputs.

Establish evaluation processes and create a data dashboard, to assist reporting to the Board.

Executive Summary:

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	☒

Salisbury NHS Foundation Trust

Outstanding: our strategy for Corporate Communications 2019/20 to 2024/5

'To say something to the world, speak to a single human …'

Overarching Strategy:

- to be 'Outstanding' and to achieve an 'Outstanding' rating from CQC
- to embed our values
- to create internal culture change

In formulating this strategy the Communications team has:

- considered the national and local context
- considered purpose – why undertake or stop activities
- taken a five year view
- conducted a short qualitative stakeholder audit, to hear a range of views across the Trust
- considered the detail of individual activities/deliverables (to be covered by delivery plan and associated grid, not by this paper)
- considered alignment with other strategies, particularly 'digital' and 'transformation'

Objective

The purpose of reforming our Corporate Communications is to deliver the Trust's strategic message to all its audiences - patients, employees, local community, regulators and other stakeholders - using unique or appropriate methods in order to be recognised as being outstanding.

To demonstrate our Values, our objectives are:

- improve our 'outreach'
- transform corporate culture - improve 'in-reach'
- tackle the 'trust deficit' within and across the organisation
- spread a consistent approach to continuous improvement
- horizon scan and help prepare the business for the impact of external drivers, such as local demographic shift or national public policy changes
- demonstrate that the Trust is 'Outstanding' - search for evidence, make the case and bring it home

Mission

Mission: to ensure that the Trust

- is trusted
- has credibility
- consistently demonstrates its values

Functional Mission: to ensure that the Trust's Corporate Communications

- is an active reputation guardian – enhancing and protecting the Trust's reputation
- is best in class, providing expert advice and a professional service
- takes a matrix approach and is integrated across the business - no siloes
- creates an internal culture shift
- creates a sustainable corporate narrative, which serves as a frame around which to hang the full array of communications the hospital disseminates

Methods for delivery of objectives

The four most common types of corporate communications include interpersonal, nonverbal, written/ published and oral communication.

The first step is to plan what we will and will not do. While the function will need to continue with some of the current tactical delivery work there is need for greater structure to be introduced. To help move from ad hoc requests/unplanned activities to a more strategically focused approach, it is proposed that a Corporate Communications 'helpdesk' is established, coupled with the development of an internal coaching/training programme and providing more robust measurement of communications activities.

The Trust's marketing is frequently lead by fundraising not by our core business; it would be helpful to review this with the aim of ensuring that the hospital's marketing is led by the Trust's corporate strategy, values and corporate objectives.

Deciding what not to do; formulate a diagnosis by looking at what sort of organisation we want to be - and how far we are currently removed from being that ideal. (When an organisation does not have an easy to understand mission, it is easy to become distracted and to chase too many goals - not all of which lead to a strategic outcome.)

To improve 'Inward' reach - development of a range of dissemination methods to increase the reach of corporate messages and to assist delivery of culture change. It is proposed that methods include coaching / training (particularly for middle management), dynamic distribution lists for electronic marketing, quarterly staff newspaper, weekly corporate newsletter for staff and strengthening the relationship with Odstock Radio.

This includes creatively developing and directing our internal communications and collaborative leadership culture alongside community engagement programmes with key communities and our Members, and directing engagement across our development programmes.

Improve our Outreach by moving towards being a News gathering / content creation operation.

Establish issues management processes and develop a structured Stakeholder Engagement Programme, which will be rigorously managed and auditable. Introduce horizon scanning and develop internal intelligence analysis.

Evaluate performance and continually refine.

Key Recommendations to the Board:

Change from Public Relations to Corporate Communications – to cover internal communications, reputation management, marketing, media relations and stakeholder engagement (Public Affairs).

Ensure the Corporate Communications Team is adequately resourced.

Introduce the necessary policy and guidance changes in Q2/3 2019/20 – including overarching guidance on who can communicate what, to whom and when.

Define the Trust's core narrative, define the 'The Salisbury Way' and introduce a new 'message house'.

Restructure the Trust's dispersed marketing function; review branding and introduce a new 'style-guide', to ensure consistent corporate branding and quality.

Review digital assets; ensure the web-development function is shared between IT & Corporate Comms.

Publish a new, mobile-friendly, web site by the end of 2019 and liaise with stakeholders regarding web development, to ensure user experience informs technical and presentational changes.

Introduce a new 'helpdesk' to assist the planning, delivery and evaluation of activities – with the aim of moving from high volume, low impact activities to planned and consistent delivery.

To ensure consistent branding and improved quality, move publications (print and electronic) produced by the hospital to be under the restructured marketing function.

Improve internal Corporate Communications and improve the communications skills of management.

Improve outreach and external communications, move away from reacting to events and to creating and controlling our own news. With this aim, specific methods include:

- Introduce a content marketing approach and 'news gathering' process across the organisation
- Plan the use of platforms, including presentations / speaking opportunities (Corporate 'grid')
- Review and reform the Annual Report process and production, with the objective of improving our transparency, plus the quality and usefulness of reporting; review the Annual General Meeting and internal awards
- Map stakeholders and audit relationships, with the aim of developing one directed and effective stakeholder engagement programme for the Trust that is led by Corporate Communications and reported at Board level

- Set up processes for horizon scanning and introduce intelligence analysis reports for the Executive team with quarterly summaries for the Board
- Annual media training for all spokespersons and for each member of the Executive team
- Develop our brand to enhance our reputation; trial new products and establish one corporate image (photo & footage) library with appropriate management processes.

Define the resources and equipment needed to deliver rapid improvements to the quality of outputs.

Produce a Trust-wide Corporate Communications plan and a dynamic 'grid' to schedule communications activities

Establish evaluation processes and create a data dashboard, to assist reporting to the Board.

May 2019