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Quality Account 2017/18

Contents

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Introduction

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

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

Part 1

Our commitment to quality - the Chief Executive's view

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

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

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

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

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

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

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

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

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

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

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

2.1 Progress against the priorities in 2017/2018

The quality account for 2016/2017 outlined the Trust's priorities for quality improvement for the year ahead (2017/2018). These priorities were identi ed by speaking to patients, families and carers, the public,

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

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

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

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

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

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

We achieved this by taking a fresh look at our approach to falls prevention and introduced a new risk assessment. This focused on a wider range of risks including removing trip hazards around the patient's bed space and putting the beside locker and belongings on the same side as the patient gets out of bed at home. We also focused on taking a patient's blood pressure when lying down and standing up to spot whether the blood pressure falls when the patient stands up. If so, medication that could be c0.6 (t(at home.)1(c0.6i)0.6 (bis)1(c0.6ion)0.6 (iewed.)1(c0.6W -0.001 Tw T* (blo6uding r)1

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

Better As expected Worse

Measure	2017/18 target	2016/17	2017/18	2017/18 overall performance
% of patients who met the criteria for sepsis screening and were screened for sepsis admitted via emergency rout65w1 sepsis admitted via	90%	96%	93.5%	

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

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

Table 7: Antibiotic consumption in 2017/2018

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

1.5 Continued with good antibiotic stewardship to reduce antibiotic resistance

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

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

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

out and provided a space for the results to be easily recorded. The new nursing documentation was

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

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

*SGA = small for gestational age

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

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

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

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

1.9

Priority 2 – ensure patients have an outstanding experience of care

Description of the issue and reason we prioritised it:

What we did to improve in 2017/2018:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 13: Delivering same sex accommodation (patient safety)

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

Better As expected Worse

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

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

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

Description of the issue and reason we prioritised it:

Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health signi cantly. Making every contact count (MECC) is an approach to behaviour change that uses the millions of day-to-day interactions that we have with people to encourage changes in

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

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

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

We have listened to our staff and this year run a very proactive 'Fighting u this winter' vaccination campaign. We have promoted the message that vaccination can help keep staff t and healthy throughout the winter and reduces the risk of spreading u to others, particularly those who are vulnerable. Our Occupational Health team have run drop in u clinics, trained peer vaccinators, provided information and weekly updates

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

The ‘Shape up at Salisbury’ campaign is a health and wellbeing programme for all our staff. We know that helping our staff to be happy and healthy improves the quality of patient care. This year we have continued to provide a range of physical activities through gym and swimming pool membership and a large range of physical exercise classes at our staff club. We encouraged staff to walk or cycle to work and promoted the weekly national ‘Park Run’ on a Saturday morning. http://www.parkrun.org.uk/events/events/
We have increased the range of mental health initiatives available for staff including stress management events, psychological resilience training, mindfulness and meditation sessions to help staff identify and deal witical exer.268 Tk or cya50mana9 Tw 0 -1 (hlmedi7.8 specie upt(range of

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

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

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

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

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

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

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

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

In this hospital doctors and nurses use the Early Warning Scoring system (EWS) to enable early detection of deterioration by categorising a patient's severity of illness which prompts nurses to request a medical review when the score is 3 or more. Patient's vital signs (pulse, blood pressure, respirations and oxygen levels) are recorded and each vital sign is given a score from 0 – 3 (a score of 0 is most desirable and a score of 3 or more is least desirable). The total score is the early warning score. The score can show a trend over time but also alerts when intervention is required quickly to prevent deterioration. Next year, we plan to introduce the 2)
the recornine or clinical observationaccor7.8 s is thNHS.s

Measure				
All vital signs scored	95%	96%	97%	
Escalation implemented	95%	83%	81%	
Better	As expected	Worse		

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

One patient said

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

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

1) Reducing delays in prescribing take home medicines – we set standards to ensure that medicines are prescribed by 3.00 pm on the day of discharge. We measured this standard over one week in March 2017 and found 85% of prescriptions were dispensed by 3.00 pm on the day of discharge. We measured it again in September 2017 and found this had reduced to 77% of prescriptions being dispensed within the time frame. The pharmacy team continue to work with doctors to improve the timeliness of writing prescriptions so they are available for dispensing earlier in the day and the day before discharge.
2) Delays in patients making a choice about where to go after leaving hospital – we held education sessions with our staff to raise awareness of the importance of starting discussions about discharge at the point of admission and throughout the patient's stay along with the choices available once a patient is t to leave hospital.
3) Delays in home care provision - these often occur whilst patients who are t to leave hospital wait to be assessed for care at home. With our community partners we have introduced 'Home First' which enables patients to go home rst, and be assessed the same day by a community professional, who is able to provide short term support and care if needed. In this way, long term care needs can be assessed later when the actual level of care required can be accurately predicted and avoids patients being admitted to nursing homes unnecessarily.
4) Delays in assessment by nursing home providers - patients are often delayed in hospital whilst they wait to be assessed for transfer back to an existing care package at home or to a nursing home. We have started to work with care homes and develop the concept of a trusted assessor who is authorised to carry out an assessment on behalf of care providers with the decision accepted by all. This new process will start in June 2018.

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

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

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

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

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

What we did in 2017/2018:

6.0 Care Quality Commission inspection improvement plan progress.

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

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

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

6.1 Continued to review nursing and

6.12

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

We have improved the process of booking a bed for a patient who needs a critical care bed after their planned surgery by limiting the number to two patients a day.

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

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

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

In 2017/2018, we had ve very broad priorities with nearly 40 different work strr

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

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

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

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

What we will do in 2018/2019.

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

Coronary Angioplasty/National Audit of Percutaneous Coronary Intervention (PCI)	Yes	Yes	100%	The aim of the audit is to describe the quality and process of care and compare patient outcomes.
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	To assess the quality of paediatric diabetes care by comparing outcomes to NICE quality and clinical standards.
Elective surgery (National PROMs Programme)	Yes	Yes	2016/17 Pre-op 65.8% vs 75.7% nationally Post-op 62.8% vs 64.8% nationally	Patient reported outcome measures (PROMs) survey patients before and after surgery for the following planned procedures; 1) Groin hernia repair 2) Hip replacement 3) Knee replacement 4) Varicose veins
Endocrine and Thyroid National Audit	Yes	Yes	100%	Outcomes from endocrine surgery.
Falls and Fragility Fractures Audit Programme (FFFAP). 3 studies: 1) Fracture Liaison Service 2) Inpatient falls 3) Hip Fracture	Yes	Yes	Fracture Liaison Service -100% Inpatient falls – 100% Hip fracture – 100%	Fracture Liaison Service: Evaluates patterns of
Fractured neck of femur (care in A&E Departments)	Yes	Yes	100%	

National Audit of Intermediate Care (NAIC)	N/A
National Audit of Psychosis	N/A
National Bariatric Surgery Registry (NBSR)	N/A
National Cardiac Arrest Audit (NCAA)	Audit of in-hospital cardiac arrests in the UK and Ireland.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: 2 studies: 1) Pulmonary rehabilitation 2) Secondary care	To drive improvements in the quality of care and services provided for COPD patients.
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	N/A
National Comparative Audit of Blood Transfusion programme: 3 studies: 1) Audit of patient blood management in scheduled surgery 2) Audit of red blood cell transfusion in Hospices 3) Audit of red cell and p4239meslTex8up8 ulmonar Rd5p360f r e	Measures compliance with standards related to the recommended use of blood components.
	Measures the effectiveness of diabetes care compared to NICE guidance.
	Compares inpatient care and patient outcomes undergoing emergency abdominal surgery in England and Wales.
	Focuses on the clinical practice and patient outcomes of patients discharged following an emergency admission with a primary diagnosis of heart failure

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

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

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

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

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

Audit report	Reviewed by whom	Action taken or required to improve
National Diabetes Foot Care Audit published in March 2017	Clinical Management Board	The audit captures patients who were rst seen by the d T* [2%c pfot Ccre Aservice wthe a new wunda [2wen bJuly20174and e]TJ T* [(pApril201 rup a 5Tday a wenk fot Ccinica, butpatients waeprnt Cble 2o iself-]TJ T* [(pr)17.8 po incyutrgemAatients wo iself-pes nts.]TJ 0 -124 TD ((The and audit)r)17.9 (eq resorted o(83% vs 69%),Brisk docuent d o(7 % vs 56%),Btie rurgery 73%Mvs 62%).Tevieweby turgern tnd enageshe tit spep-]TJ T* [(poperat m(6% vs 4%),Br17.9 (e ur)1-7.9 (en)o ihe ate (.39% vs 3.%),Bunlanned bcritcal pphysonher apy followsg adischarem.TTThepe mprove phrev omeale d o
National Emergency Laparotomy Audit 2016 – 2nd audit	Clinical Management Board	
Elective surgery (national patient reported outcome measures programme) 2016/17 – published October 2017	Clinical Management Board	

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

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

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

*Note nal payment is subject to of cial noti cation of payment from NHS England

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

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

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

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

Care Quality Commission (CQC) registration

Salisbury NHS Foundation Trust is required to register

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

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

Data quality

Good quality information (data) underpins the effective delivery of patient care and is essential if improvements in the quality of care are to be made. Improving data quality will improve the delivery of patient care and improve value for money.

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

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

Salisbury NHS Foundation Trust submitted records during 2017/2018 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and General Medical Practice Code is set out in table 29 on following page. These are important because the NHS number is a key identi er for patient records and an accurate record of the General Medical Practice Code is essential to enable the transfer of clinical information about the patient.

Table 29: The percentage of records with a valid NHS number and General Medical Practice code

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

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

Information Governance Toolkit Attainment levels

Salisbury NHS Foundation Trust's Information Governance Assessment report overall score for 2017/2018 was 77% and was graded as satisfactory

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

Correct % 2014/15	Correct % 2015/16	Correct % 2016/17	Correct % 2017/18	
PrimaryDiagnosis	99.5%	98%	98.5%	99.0%
SecondaryDiagnosis	98.9%	94.5%	95.1%	97.2%
PrimaryProcedure	96.2%	97.8%	99.7%	98.8%
SecondaryProcedure	98.1%	97.9%	95.1%	97.8%

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

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

Learning from deaths

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

By 31 March 2018, 529 (90%) of 586 deaths had been screened to ascertain whether each case required a full h14ent basedavoidEcas,likely t6 3. case review. By 31 March 2018, 302 (36%) case record reviews and 0 investigations (serious incident inquiries) had been carried out in relation to 841 of the deaths included in table 31. In 0 cases was a death subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

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

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

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

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

minutes, recording treatment escalation plans in a

Patient reported outcomes measures (PROMS)

Table 33 presents the Trust's performance against the PROMS. Salisbury NHS Foundation Trust considers that

Emergency re-admissions within 28 days of discharge

Table 34 presents the Trust's performance on emergency re-admissions within 28 days. Salisbury NHS Foundation Trust considers that the percentage of emergency re-admissions within 28 days of discharge from hospital is as described for the following reasons:

- Every time a patient is discharged and re-admitted to hospital the staff code the episode of care. The Data Quality Service continually monitors and audits data quality locally and we participate in external audits which enable the Trust to compare its performance against other Trusts.

Salisbury NHS Foundation Trust has taken the following actions to reduce re-admissions within 28 days of

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

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

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

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

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

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

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

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

- Reducing noise at night.

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

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

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

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

The Friends and Family Test – Patients

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

- The Trust follows the Friends and Family Test national technical guidance published by NHS England to calculate the response rate and the percentage who would recommend the ward or the A&E Department. The score measures the percentage of patients who were extremely likely or likely to recommend the hospital and the percentage of patients who were extremely unlikely or unlikely to recommend the hospital. 'Don't know' and 'neither likely nor unlikely' responses are excluded from the score.

Salisbury NHS Foundation Trust has taken the following actions to improve the response rate and the percentage of patients who would recommend the hospital to friends and family needing care and improve the quality of its services by:

- Providing a range of different methods for patients to give their feedback, such as postcards, child-friendly postcards, the Trust website, a Friends and Family Test App for patients with a smartphone.

- Publishing the percentage who would recommend every month by ward and department with patient comments and the improvements we have made in response to feedback.

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

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

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

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

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

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

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

± Develop our patient and public engagement programme and involve our staff, Healthwatch, Wiltshire and other stakeholders in collecting patient feedback to drive quality improvement.

± Develop and deliver quality improvement training to 10% of our staff in 2018/19.

± Embed quality improvement within the culture of the Trust.

± Continue to develop the staff health and wellbeing programme.

Venous thromboembolism (VTE)

Table 39 on the following page presents the Trust's performance on VTE risk assessment. Salisbury NHS Foundation Trust considers that the percentage of patients admitted to hospital and who were assessed for the risk of VTE (blood clots) is as described for the following reasons:

- Patient level data is collected monthly by the ward pharmacist from the patients' prescription chart. The data is captured electronically and analysed by a senior nurse. The work is overseen by the Trust's Thrombosis Committee.

Salisbury NHS Foundation Trust has taken the following actions to improve the percentage of patients admitted to hospital who were risk assessed for VTE to improve the quality of its services:

- Salisbury NHS Foundation Trust continues to be an exemplar site for the prevention and treatment of VTE (blood clots) and has continued to achieve 99.5% of patients being assessed for the risk of developing blood clots and 97.5% receiving appropriate preventative treatment. We will continue to monitor our progress and feedback the results to senior doctors and nurses.

- We continued to conduct detailed enquiries of patients who develop blood clots to ensure we learn and improve.

Salisbury NHS Foundation Trust intends to continue with the actions described above to sustain the percentage of patients admitted to hospital who are risk assessed for VTE and given preventative treatment.

Clostridium dif cile infection

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

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

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

- Maintaining and monitoring good infection control practice including hand hygiene, prompt isolation and sampling of patients with suspected C. dif cile.

- Maintaining and monitoring standards of cleanliness and taking actions to improve.

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

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

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

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

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

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

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

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

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

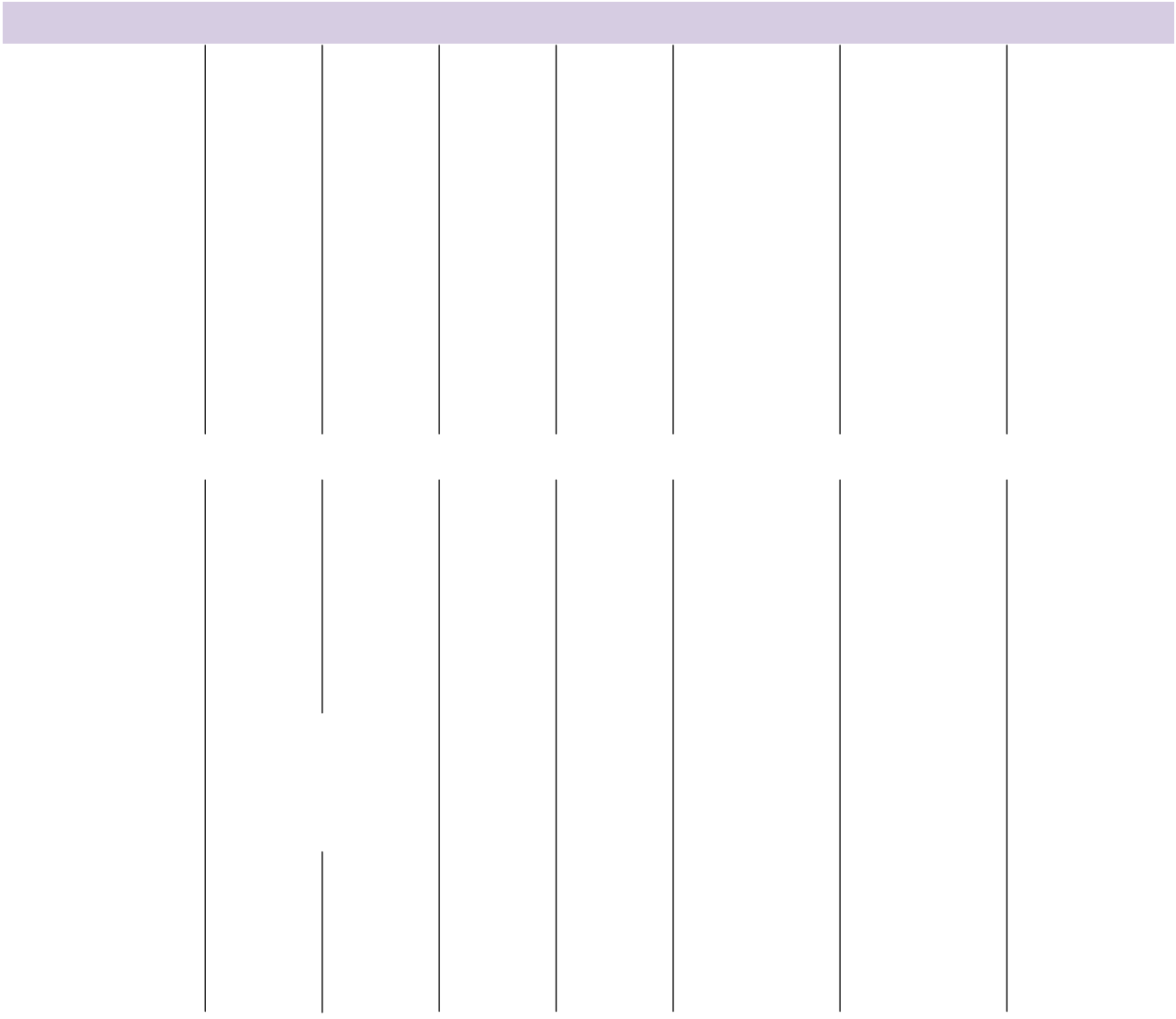
Duty of Candour

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

Part 3: Other information

Review of Quality Performance

This section gives an overview of the quality of care offered by Salisbury NHS Foundation Trust based on performance in 2017/18 against a range of selected indicators on patient safety, effectiveness and experience. These areas have been chosen to cover the priority areas highlighted for improvement in this Quality Account, as well as areas which our patients have told us are important to them, such as cleanliness and infection prevention and control. Our commissioners measure a number of these areas and our CQUIN contract supports improvement measures. These indicators are included in a monthly quality indicator report that is reported to the Board and Clinical Governance Committee.



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

* In 2016/2017 HSMR was reported as 116.4 to January 2017. The full year rate was 117. In 2016/2017 SHMI was reported as 104 to 30/9/2016. The full year rate was 106.
** In previous annual reports the Trust quoted Trust and non-Trust apportioned MRSA noti cations as a total gure. This will have included community hospital and GP patients. The total gure is quoted in brackets in the table.
**** Never events are adverse events that should never happen to a patient in hospital. An example is an operation that takes place on the wrong part of the body. The national never events list increased from 8 to 25 on 1 April 2011.
# The patient safety indicator name has been changed from 2013. Mean score of patients stating the quality of care was very good or better' to 'Mean score of patients rating of quality of care' as it is no longer rated between excellent and poor but is on a sliding scale from 10 to zero.
8.2## to be con rmed on publication of the 2017 national inpatient survey results.

NHS Improvement Single Oversight Framework 2017/18

Indicators

Table 43: Trust performance indicators

Measure	2016/2017	2017/2018	Standard

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

Part 3: Annex 1

Statement from Wiltshire Clinical Commissioning

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

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

Care across the lifecourse is demonstrated through other key Public Health priorities captured in data showing the outcomes of smoking cessation services

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

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

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

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

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

Statement from the Governors – 14 May 2018

Our statement last year began "the last year has been as dif cult for the NHS as any we can remember." For our Trust the year has been yet more dif cult. We refer in particular to the problems caused by the in ux of patients in December and January, the unique dif culties posed by the Skripal incident, and w [0pre0.6imberctif are ce. Fossn (e Gover)-1ieurof e provided throug
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Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the NHS foundation trust annual reporting manual issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the NHS foundation trust annual reporting manual and supporting guidance

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

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

We read the quality report and consider whether it addresses the content requirements of the “NHS foundation trust annual reporting manual” and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the following:

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

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Salisbury NHS Foundation Trust as a body, in reporting Salisbury NHS ns 2009

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering suf cient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non- nancial performance information is subject to more inherent limitations than nancial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a signi cant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the “NHS foundation trust annual reporting manual” and supporting guidance.

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

Conclusion

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance
- the Quality Report is not consistent in all material respects with the sources speci ed in the Detailed requirements for external assurance for quality reports 2017/18; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

[redacted]

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

NHS

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