SALISBURY NHS FOUNDATION TRUST

TRUST BOARD

MONDAY 5 DECEMBER 2016, 1.30 PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
1.30pm	**1**	**APOLOGIES FOR ABSENCE –** Malcolm Cassells			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES** Public Board Meeting held on 3 October 2016			1
	4	**MATTERS ARISING**			
1.35pm	**5**	**CHIEF EXECUTIVE**			
		1. Chief Executive's Report	PH	SFT 3829	9
1.45pm	**6**	**STAFF**			
		1. Workforce Performance Report to include Nurse Staffing	AK/LW	SFT 3830	11
		2. Actions from Staff Survey	AK	SFT 3831	35
		3. Report of Freedom to Speak up Guardian	AK	SFT 3832	39
2.00pm	**7**	**PATIENT CARE**			
		1. Quality Indicator Report to 31 October (month 7)	CB/LW	SFT 3833	41
		2. Report of Director of Infection Prevention Control	LW	SFT 3834	49
		3. Skill Mix Review	LW	SFT 3835	87
		4. Assurance Framework 2016/17 Proposals	LW	SFT 3836	97
2.30pm	**8**	**PERFORMANCE AND PLANNING**			
		1. Finance & Performance Committee Minutes 26 September and 24 October 2016	NM	SFT 3837	121
		2. Financial Performance to 31 October (month 7)	MC	SFT 3838	129
		3. Progress against Targets and Performance Indicators to 31 October (month 7)	AH	SFT 3839	-
		4 Major Projects Report	LA	SFT 3840	139

3.00pm **9** **PAPERS FOR NOTING OR APPROVAL**

1.	JBD Minutes evidencing presentation of Assurance Framework and Risk Register	PH	SFT 3843	149
2	Minutes from Audit Committee 11 July 2016	PK	SFT 3844	151
3.	Clinical Governance Committee minutes – 22 September and 20 October 2016	MM/JR	SFT 3845	155

3.45pm **10** **ANY OTHER URGENT BUSINESS**

11 **QUESTIONS FROM THE PUBLIC**

12 **NEXT MEETING**

The next public meeting will be held on Monday 6 February 2017, in the Board Room at Salisbury District Hospital starting at 1.30pm

13 **CONFIDENTIAL ISSUES**

To consider a resolution to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

SALISBURY NHS FOUNDATION TRUST

Minutes of the meeting of Salisbury NHS Foundation Trust Board Held on Monday 3 October 2016

Board Members Present:	Dr N Marsden	Chairman
	Mr P Hill	Chief Executive
	Ms T Baker	Non-Executive Director
	Dr C Blanshard	Medical Director
	Dr L Brown	Non-Executive Director
	Mr I Downie	Non-Executive Director
	Mr A Hyett	Chief Operating Officer
	Mrs A Kingscott	Director of Human Resources and Organisational Development
	Mr P Kemp	Non-Executive Director
	Mr S Long	Non-Executive Director
	Mrs K Matthews	Non-Executive Director
	Ms L Wilkinson	Director of Nursing
Corporate Directors Present:	Mr L Arnold	Director of Corporate Development
In Attendance:	Mr P Butler	Head of Communications
	Mr M Collis	Deputy Director of Finance
	Mr D Seabrooke	Secretary to the Board
	Dr A Lack	Lead Governor
	Mr N Alward	Public Governor
	Dr J Lisle	Public Governor
	Mr M Mounde	Public Governor
	Mr R Polkinghorne	Appointed Governor
	Sir R Jack	Public Governor
	Mrs J Sanders	Public Governor
	Ms L Taylor	Public Governor
	Ms D Major	Deputy Director of Nursing
Apologies:	Mr M Cassells	Director of Finance and Procurement
	Prof J Reid	Non-Executive Director

ACTION

2208/00 DECLARATIONS OF INTEREST AND FIT AND PROPER/GOOD CHARACTER

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.

2209/00 MINUTES – 8 AUGUST 2016

The minutes of the meeting of the Board held on 8 August 2016 were agreed as a correct record.

2210/00 MATTERS ARISING

There were no matters arising.

2211/00 CHIEF EXECUTIVE'S REPORT - SFT 3809 – PRESENTED BY PH

The Board received the Chief Executive's report. PH highlighted the on-going work on the Bath and North East Somerset, Swindon and Wiltshire Sustainability and Transformation Plan.

The Electronic Patient Record was expected to go live at the end of October. The seasonal flu campaign for 2016 would be shortly getting underway. The PLACE (Patient Lead Assessment of the Care Environment) had been reported and there were good results in relation to the range of factors that were assessed. He highlighted the achievement of Emma Ward who had won the Trust's Pride in Practice award.

Finally the Trust's AGM had taken place at the Salisbury Arts Centre on 27 September and had been a success. Presentations had been given by Dr Christine Blanshard and Lorna Wilkinson on the Trust's progress with the Care Quality Commission Action Plans and there had been presentations on behalf of one of the core areas inspected.

The Board received the Chief Executive's Report.

2212/00 STAFF

2212/01 Workforce Performance Report including Nurse Staffing - SFT 3810 - Presented by AK & LW

The Board received the Month 5 report. AK highlighted improvements in the appraisals rate which for non-medical staff was now at 85% and medical staff 91%. There was gradual improvement in mandatory and statutory training rates now at 82% which was still below the 85% target. There had been increased use of bank staff. Staff turnover was reducing and exit interview's quality was being improved. European and international recruitment for nurses continued and a new initiative 'Fresh Eyes' was being introduced for new starters. The sickness rate was 3.2% and causes of sickness were tracked at directorate level.

The Nursing and Midwifery Council continued to monitor the arrangements for planning the recruitment of nurses – the Chairman requested that this be expanded upon at board level at a seminar session. DS

In the Safer Staffing Report it was noted that a new methodology was being introduced nationally which would focus on care hours per patient. The rate of registered nurses was balanced by nursing assistants and ratios on wards were correct. There had been lower acuity on Avon Ward in August and the skill mix reflected this. A small number of areas showed as over-staffed – this was due to supernumerary inductions and instances of 1:1 care.

The Board noted the Workforce Report and the Safe Staffing Report.

2213/00 PATIENT CARE

2213/01 Quality Indicator Report to 31 August 2016 (Month 5) – SFT 3811- Presented by CB and LW

The Board received the Quality Indicator Report. It was noted that there had been 8 new Serious Incident Inquiries in August of which five had been

falls. The hospital had seen a high rate of activity during August. It was understood that there was in fact one CUSUM alert in relation to cancer of the pancreas (May 2016) and the other one mentioned in the report was an error. In relation to the mortality rates the availability of the Palliative Care Team affected the Trust's ability to code the relevant patients as palliative. Executives were working to address the understaffing in this area. Four out of eleven high risk TIAA cases were seen within 24 hours and CB described the reasons why other cases had missed the target. The ward moves data continued to be refined for example to show it as a run rate rather than an accumulative position. There had been no MRSAs or MSSAs in the month and no cases of C-Difficile. There was an amendment to the report in relation to mixed sex accommodation – all cases were resolved within two days rather than four days as stated.

The Board noted the Quality Indicator Report.

2213/02 Customer Care Report – Quarter 1 – SFT 3812 – Presented by LW

The Board received the Quarter 1 Customer Care Report. It was noted that there had been a slight decrease in the numbers of complaints and that clinical treatment remained the biggest category across a range of specialties. In relation to complaints received directorates were undertaking personal contact initiatives.

There had been one PHSO case which had not been upheld and one new report to the PHSO in the Quarter.

MSK were experiencing the highest numbers of complaints and delays. It was noted that this included some high volume and pressured specialties for example plastics and orthopaedics. Work to address this included the Orthopaedics' expansion work and greater clarity around patients' expectations arising from procedures. The Board was reminded that the Trust always responded to comments posted about the hospital on the NHS Choices. Where these were complimentary the comments were passed to the staff and were these were complaints a request was posted for the patient to contact the hospital to discuss matters further.

The Board noted the Quarter 1 Customer Care Report.

2213/03 Annual Quality Governance Report 2015/16 - SFT 3813 – Presented by CB

The Board received the Annual Quality Governance Report. CB highlighted the narrative on addressing falls and capital acquired UTIs. The CQC had rated the Trust as Good on Effectiveness and there was a good clinical audit process in place. The Duty of Candour had been successfully implemented and the Head of Litigation had played a key role in ensuring clinical teams knew how to approach this appropriately. £3.6m of CQUIN payments for 2015/16 had been achieved. The Trust's Quality priorities included addressing spinal VUD assessments and outpatient assessment. Good pilot work had been undertaken in redesigning the triage function in A&E. There had been a review of mortality and morbidity meetings to ensure greater consistency of approach. The Saving Babies' Lives care bundle had been rolled out aimed at reducing still births. The Sepsis 6 care bundle continued to be implemented. Work was underway to deliver the four priority standards on seven day working. Work continued to assess and reduce avoidable deaths. The good attendance at the Trust's regular Clinical Governance half day sessions was highlighted by LB. The Trust would continue to work with the local community via the Sustainability and

Transformation Partnership.

Actions in relation to the CQC Report received in April 2016 continued to be worked through and overseen by the CQC Steering Group.

The Board noted the Annual Quality Governance Report.

2214/00 PERFORMANCE AND PLANNING

2214/01 Finance & Performance Committee Minutes – 25 July and 22 August 2016 – SFT 3814 – Presented by NM

It was noted that the Committee continued to monitor the Trust's market share and relationships with GPs. It continued to monitor the Trust's financial position in detail and to review its segment of the Assurance Framework.

The Board received the minutes of the Finance and Performance Committee.

2214/02 Financial Performance to 31 August 2016 (Month 5)– SFT 3815 – Presented by MCo

The Board received the Finance and Contracting Report to 31 August 2016. It was noted that year to date there was a surplus of £242,000 and an in month surplus of £284,000. The Trust was ahead of its savings plan by £0.5 billion and there was good progress in making and identifying CIP savings. The risk section of the report set out a number of risks and four forecast scenarios for the year end.

A number of SFT staff had transferred from the Trust to the new joint venture for Sterile Services.

In relation to a question from PK about the achievement of Sustainability and Transformation funding in Quarter 2, it was noted that the Emergency Department target was not currently being delivered but the Trust had signalled a number of caveats around activity and delayed transfers of care in agreeing to the STF. The Trust was assuming that the full STP amount would be received.

Full details on the impact of the new Junior doctor's contract was awaited. A suitable accounting provision had made in this respect.

The Board noted the Finance Report.

2214/03 Progress Against Targets and Performance Indicators to 31 August – SFT 3816 – presented by AH

The Board received the Month 5 report. The Emergency Department had delivered 93.57% against the Four Hour Target. Acuity for patients was much higher as was the rate of attendances. There had been a 36% increase in attendances to the major's stream. For Referral to Treatment (18 weeks) The Trust had delivered 91% against the target of 92%. Diagnostics standards had been delivered. Cancer standards had been delivered in Quarter 1. The Trust had failed the 31 day standard in August. The Sustainability and Transformation fund was judged against the achievement of the 62 Day Target.

The Board noted the report.

2214/04 Major Projects Report - SFT 3817 - Presented by LA

The Board received the Major Projects Report. The report summarised progress with the Electronic Patient Record (stable at Amber), Scan for Safety (stable at Green), Wiltshire Health and Care (stable at Green), SDU (improving at Green). Under the Electronic Patient Record stream the data warehouse work stream was Red/improving with additional work resulting in steady progress towards the end of October. 85% of training for priority one and two users of EPR had been booked.

Having started on 1 July 2016, progress was being made with the Health and Care and in establishing a southern locality for this. The inter-agency workshop on Delayed Transfers of Care was highlighted.

The Board noted the Major Projects Report.

2214/05 Capital Development Report – SFT 3818 – Presented by LA

The Board received the Capital Development Report covering the past four months across buildings, information technology, technical equipment and infrastructure.

It was noted that the Laverstock Ward refurbishment had been completed and the accommodation handed back over. The planning application for the Maternity expansion had been approved. Work was underway to plan for an escalation facility to be built near the existing Day Surgery Unit. A bid for national monies had been submitted in support of this. The Trust continued to implement the POET system.

The Board noted the Capital Development Report.

2215/00 PAPERS FOR NOTING OR APPROVAL

22215/01 JBD Minutes from 27 July 2016 – Quarterly Review of Assurance Framework and Risk Register – SFT 3819 – Presented by PH

The Board received for information the minute extract from the Joint Board of Directors demonstrating the review of the Assurance Framework and Risk Register.

2215/02 Minutes of the Council of Governors – 18 July 2016 – SFT 3820 – Presented by NM

The Board received for information the draft minutes of the Council of Governors held on 18 July 2016.

2215/03 Risk Management Strategy 2016/17 – SFT 3821 – Presented by LW

The Board received the Risk Management Strategy 2016/17 for approval.

The Strategic objectives and key performance indicators had been updated for 2016/17 to include a single Risk Management Strategy, embedding Risk Management at all levels to create a safety culture, theming of incidents to highlight trends and areas requiring further investigation and ensuring compliance with the Duty of Candour requirement.

KPIs included compliance with the NHS Improvements Single Oversight Framework, forward registration with the Care Quality Commission, on-going participation in Sign up to Safety and incompletion of route cause analysis for cases of moderate or greater harm.

The Board approved the Risk Management Strategy 2016/17.

2215/04 Risk Management Annual Report 2015/16 – SFT 3822 – Presented by LW

The Board received the Risk Management Annual Report 2015/16. The report highlighted lessons learnt as a result of incident reviews, changes to risk processes and progress against key performance indicators. The report also confirmed the accountability and responsibility arrangements within the Trust and the monitoring of these to ensure continued compliance with national standards including CQC regulations, patient safety alerts and reporting to the national reporting and learning system.

The report was noted.

2215/05 Maternity and Neonatal Risk Management Annual Report – SFT 3823 – Presented by LW

The Board received the report which provided assurance around Risk Management and improvements to patient safety.

The Maternity Department had received a rating of Good from the CQC, reporting of incidents had improved, the Obstetric Theatre was now available 24 hours, seven days a week, the implantation of the Grow project, restructuring of PROMPT training.

The service planned to continue to promote an open and supportive approach to ensure that reporting rates were optimised, continued participating in each the Baby Counts, increase Antenatal Clinic capacity through new recruitment, continue midwifery recruitment and on-going focus and work on the medical staffing model.

The Board noted the report.

2215/06 Clinical Governance Committee – 21 July 2016 – SFT 3824 – Presented by LB

The Board received for information the minutes of the Clinical Governance Committee. LB highlighted a newly introduced section in the Committee's minutes (page 181) – Challenges.

2215/07 Management Letter 2015/16 – SFT 3825 – Presented by PH

The Board received for information the report the appointed auditor. The report had been considered by the Council of Governors at its July meeting and was considered to be a positive report. The need to improve the standard of 18 Weeks recording was highlighted in the report.

2216/00 ANY OTHER URGENT BUSINESS

2217/00 QUESTIONS FROM THE PUBLIC

In relation to a question about the junior doctor's contract it was noted that the guardian of safe working had been appointed and there had been good support by the training department to ensure that there was a good quality of training offered.

2218/00 DATE OF NEXT MEETING

The next public meeting of the Board would be held on Monday 5 December 2016 at 1.30 pm in the Board Room.

CHIEF EXECUTIVE REPORT

MAIN ISSUES:

SUSTAINABILITY AND TRANSFORMATION PLANS

As mentioned before in my report all NHS organisations and local authorities are working in partnership within geographical areas to develop Sustainability and Transformation Plans (STPs) and our footprint has published a summary of its Sustainability and Transformation Plan. While it recognises that we are at an early stage in the planning process, the aim of the summary is to begin to build on work undertaken so far with clinical and non-clinical teams and share current thinking ahead of wider public and staff engagement and, as part of this work, there are no plans for the closure or major reconfiguration of services. We have already started to work with staff in our support services and individual specialty workshops to identify areas where services in each hospital could benefit from closer working arrangements. The summary sets out the emerging priorities to improve health and care services and proposes new ways of working together in order to meet the many challenges facing the health and care system. The five priority areas have been identified as key programmes of work and cover the following themes: More focus on prevention of ill health and earlier intervention; transforming primary care; making best use of technology and our public estate; a modern workforce; improved collaboration across our hospital trusts. Full publication of the STP will take place shortly and I will keep the Board updated through my regular report.

STAFF REWARDED FOR SERVICES TO PATIENTS

Since my last report we have held our Striving for Excellence Awards and it was great to see the broad range of services represented this year and the innovation, enthusiasm and commitment of our staff, which was highlighted throughout the award categories. The awards reflect our Core Values and Behaviours and the principles of Striving for Excellence, which is fundamental to the clinical care we provide and our patients' experience. They also represent just a small sample of the fantastic work that takes place right across all our services each year and celebrate all that is good about our hospital and our staff. Each year we see so many examples of the outstanding work that takes place across the hospital and I want to congratulate all those who were successful on the night and thank all our staff for the positive contribution they make to our hospital and the local community.

SDH STAFF DO WELL IN HEALTH EDUCATION ENGLAND'S SHINE AWARDS

While we recognise the contribution our staff make through our own awards it is clear that they also make their mark in a number of regional and national awards each year. I want to congratulate Urology Lead Nurse Jonathan Borwell and Clinical Simulation Lead Claire Levi, who were commended finalists in this year's Wessex Health Education England's Shine Awards. The Awards celebrate excellence in education and training in the NHS and recognise the work taking place to improve services. Well done also to Henry Wilding, who was shortlisted in the Rising Star category of the national Health Service Journal Awards, which attracts entrants from all types of NHS organisation right across the country.

CATERING SERVICES RECEIVES TOP MARK

The Catering Department has received a maximum score of five following an unannounced inspection by the Senior Environmental Health Officer from Wiltshire

Council. The top rating means that the Trust has 'very good' hygiene standards, measured on its handling of food, the condition of buildings and the management and records that ensure food safety. This is an excellent achievement and reflects the hard work and commitment of all staff involved in the management of food on-site and our catering facilities and buildings.

MATERNITY AND NEONATAL UNIT RETAINS UNICEF'S BABY FRIENDLY STATUS

Our Maternity and Neonatal Unit has retained its Baby Friendly status following a successful re-assessment by the United Nations Children's Fund (UNICEF), recognising the high standards of care provided by our team. The Baby Friendly Initiative is a global programme set up by UNICEF and the World Health Organisation to provide a practical and effective way for health services to improve the care given to mothers and babies. This award recognises the way in which our staff have continued to increase breastfeeding rates among new mothers and promote awareness of the benefits.

ELECTRONIC PATIENT RECORD UPDATE

The Lorenzo Electronic Patient Record went live at the end of October. It was a tremendous effort on behalf of everyone who uses the system, the project team and the external floor walkers who have now completed their role. We are now going through a period of stabilisation where we "fine–tune" the system, before we start to focus on the next steps of expanding Lorenzo's use. This will include implementation of Theatre, Maternity and Electronic Prescribing and Medication Administration modules and the team will also be liaising with staff to work on paper light initiatives. As part of my regular message to staff I have thanked them all for their patience and understanding through the implementation period. I also want to place on record the enormous contribution the project team have made over what has been a sustained and challenging period for them.

SEASONAL FLU CAMPAIGN 2016

We are now at the half way mark in our staff flu vaccination campaign and so far 51% of frontline staff have been vaccinated. This compares favourably with last year, where the final figure for frontline staff vaccinations was 41%. It is essential that we continue to promote the benefits of vaccination for staff and make them as accessible as possible. As part of our plan, we have now completed the open staff sessions and will be increasing ward based opportunities for vaccination by the flu nurses and ward "peer" vaccinators who have more flexibility to carry out vaccinations in and out of normal working hours. As well as the clinical benefits of vaccination for staff, patients and the management of the hospital, there is also a financial incentive to increase vaccination rates as "performance" money from commissioners is attached to vaccination rates.

ACTION REQUIRED BY THE BOARD:
To note the report of the Chief Executive.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:
n/a

AUTHOR: Peter Hill

TITLE: Chief Executive

SFT 3830

Workforce Report
M7
2016-17

Alison Kingscott Director of HR&OD

Summary

Salisbury NHS
NHS Foundation Trust

- Staff sickness for the last year is above target at 3.4%. This compares favourably with latest NHS sickness rate of 4.24%. The reasons for this rise are being monitored and management action taken as appropriate.
- Appraisal compliance for non-medical staff is slightly below target this month at 84%. Medical staff appraisal compliance has increased to 93%.
- The Trust's Turnover rate in month 7 is 9.5%, which is up slightly. Reasons for turnover are being monitored and initiatives taken forward at Trust and Directorate level. The overall turnover trend for the last 2 years is downwards, with the Trust's turnover rate in line with or better than other Hospitals locally.
- The Trust vacancy rate (6%) has remained the same since last month. A number of recruitment initiatives are planned to recruit to unfilled posts. An increase in Nursing FTE establishment for month 7 reflects re-opening of additional beds across the Medicine Directorate.
- Mandatory training compliance remained at 82%, which is slightly below target (85%).

Achievements in Month

Salisbury NHS
NHS Foundation Trust

- We held a successful open day for Registered Nurses and Midwives. We appointed five midwives and four nurses as a result, with a further five leads to follow up for Theatres.
- We attended a careers event for third year Healthcare Science undergraduates at Southampton University. The Trust received positive interest from attendees for the careers we can offer.
- We have started to work with a headhunting agency to help recruit to medical vacancies in the Trust, with a view to filling hard to fill medical vacancies, and reducing our medical agency spend.
- We are in the process of making our first offer to an overseas doctor who we have recruited through an international staffing agency, with a view to filling a hard to fill medical vacancy.
- We are undertaking a targeted 'flu vaccination campaign for frontline healthcare staff, with vaccination teams visiting wards and departments, and a network of peer vaccinators across the Trust. Uptake is currently higher than in previous years.

- The Trust has been involved in a number of initiatives to promote equality and diversity. We attended this year's Pride event in Swindon to promote the Trust as a LGBT inclusive employer and have supported the Lorenzo team to assist staff with visual support needs and dyslexia in using the Lorenzo package.

Directorate headlines

Salisbury NHS
NHS Foundation Trust

CSFS

Sickness is slightly below target at 2.49%. Have retained good levels of medical and non-medical appraisal compliance. MAST levels have continued to stay on target.

MSK

Appraisal rates are slightly below target for Non-Medical staff at 82% and above target for Medical Staff at 91%. MAST compliance levels increased from 79% to 81%, and are below target. Sickness is 0.55% worse than the directorate target (2.75%) at 3.30%.

Facilities

Continues to have the highest achievement of appraisals. Also the highest MAST compliance at 94%. Sickness is 0.84% above (worse than) the directorate target (3.50%) at 4.34%.

Surgery

Sickness at 4.02% is higher (worse) than the directorate target (3.40%). Surgery are above target for Medical appraisals at 92%, with non –medical appraisals at 80%. Compliance on MAST levels increased again from 82.7% to 83.3%.

Corporate & Quality

Corporate are on target for MAST and Quality are above target. For appraisals, Corporate and Quality continue to be above the Trust Target (85%), at 87% and 89%.

Medicine

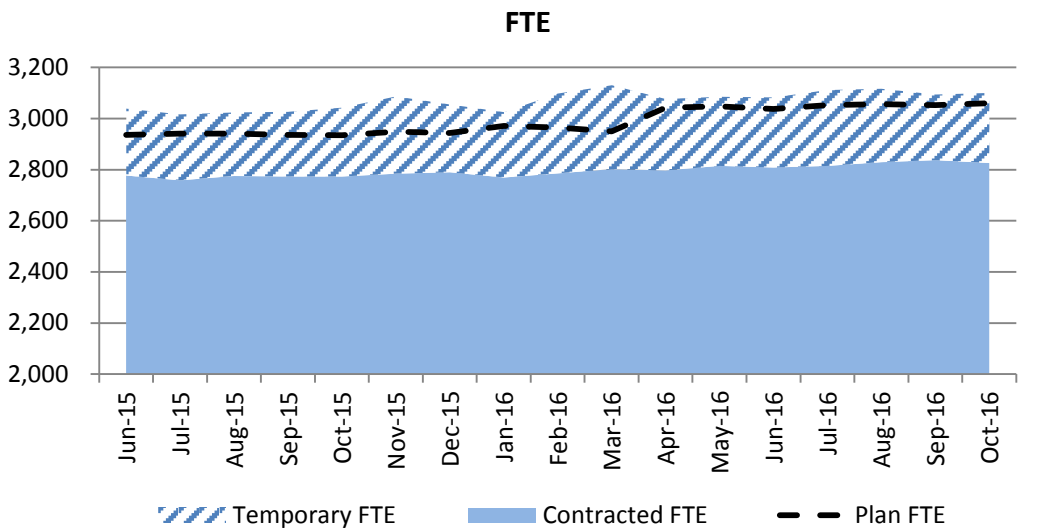
Sickness at 3.91% is above (worse than) Directorate target of 3.40%. Non-medical appraisals and MAST continue to require improvements to reach target. Medical appraisals are above target.

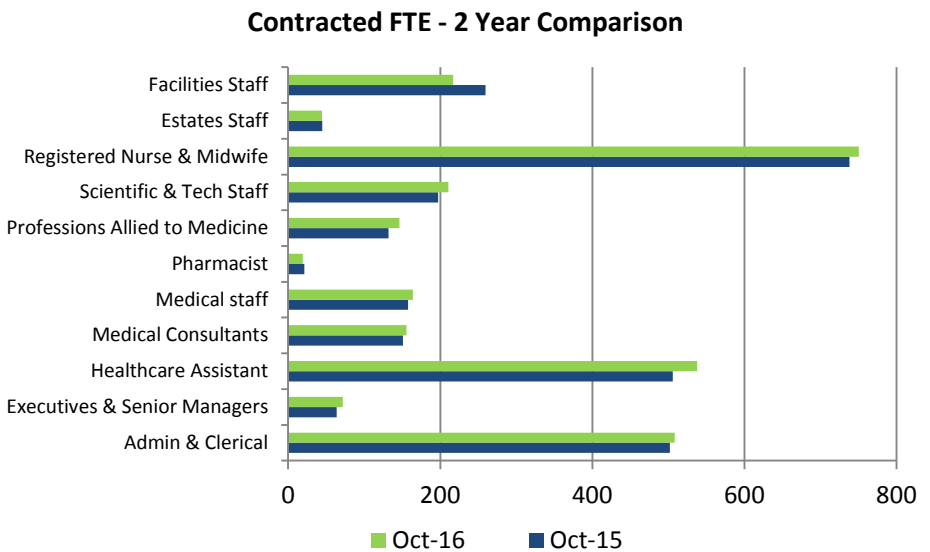
Workforce M7

Salisbury NHS Foundation Trust

October 16

Contracted Total FTE 2,826 (October 15 - 2,773)





Additional Notes

1. Overall staffing numbers are slightly over plan this month. The use of temporary staff is seen mainly in registered nursing and nursing assistant.

2. There have been increases in the number of contracted staff (FTE) up by 53 FTE compared with October 2015, due to recruitment to replace temporary staff and additional posts. Key areas of increase are :

- **Healthcare Assistant: 32 FTE**
- **Scientific and Technical Staff: 14 FTE**
- **Professions Allied to Medicine: 14 FTE**

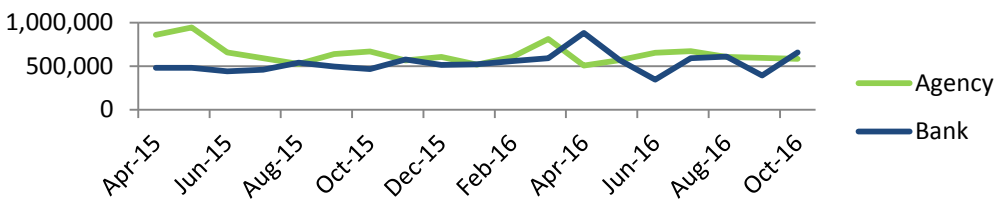
Patient-Centred & Safe | Professional | Responsive | Friendly

Temporary Workforce
M7

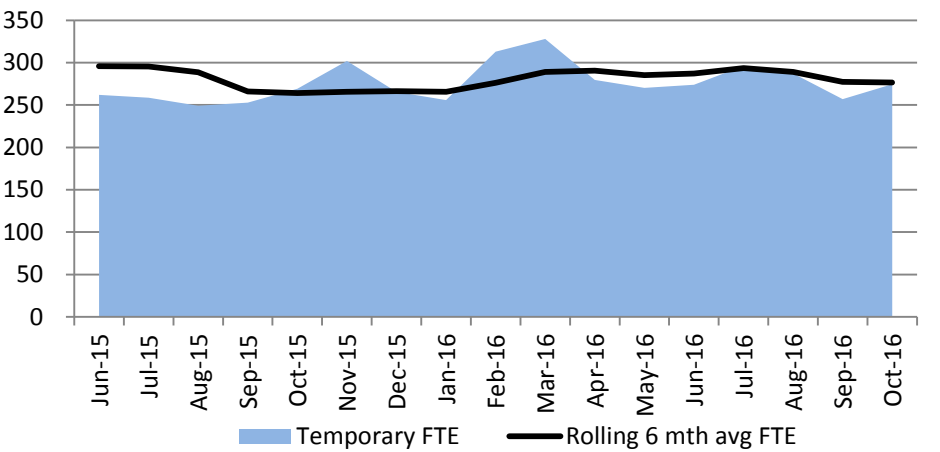
Salisbury NHS
NHS Foundation Trust

Temporary FTE 274
(October 15 - 269)

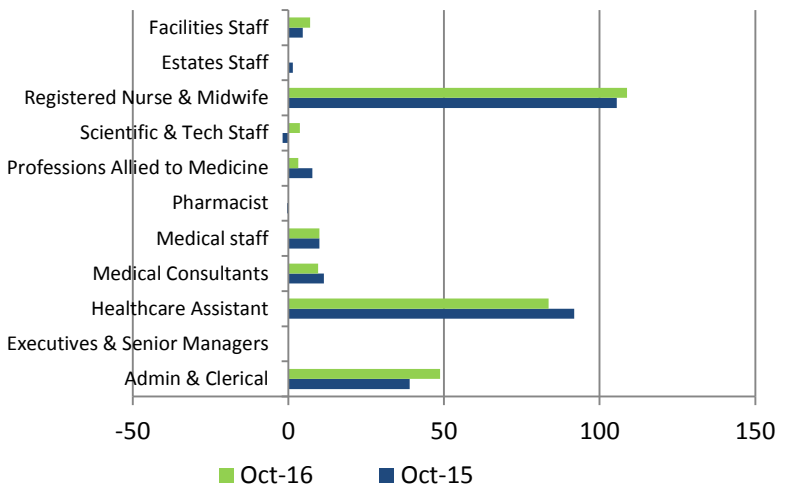
Agency and Bank Spend



Temporary FTE



Temporary FTE - 2 Year Comparison



Additional Notes

1. **Agency costs for the year to date stood at £4.2m, compared to £4.9m for the same period in 2015/16. Agency costs for October showed a decrease of £10k compared to the previous month.**
2. **Bank costs stood at £3.4m for the year to date, compared to £3.4m for the same period in 2015/16. Bank costs for October showed an increase of £265k compared to the previous month.**

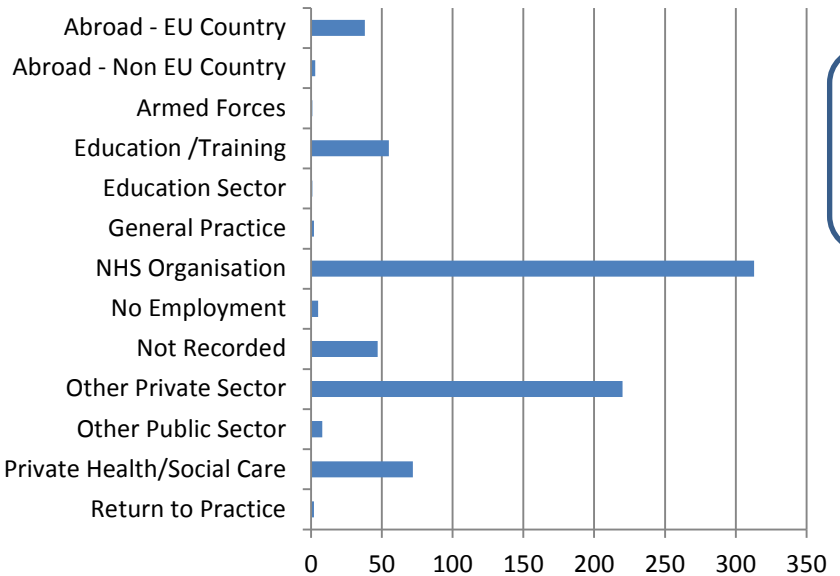
Note: Temporary FTE includes bank and agency staff.

Patient-Centred & Safe | Professional | Responsive | Friendly

Starters – Source of Recruitment M7

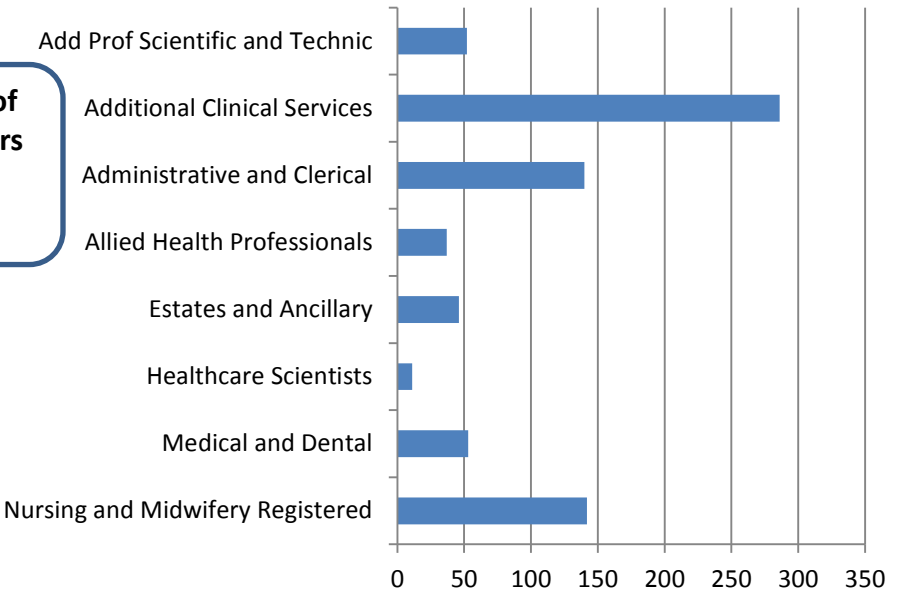
Salisbury NHS Foundation Trust

Number of Starters by Source of Recruitment



Number of M7 Starters 50

Number of Starters by Skills Group



Additional Notes

1. **There were 50 starters in month 7 compared to 73 in month 6.**
2. **As last month ,the most common source of recruitment to the Trust was from other NHS Organisations; with the most popular NHS organisations being Southampton University NHS Trust, followed by Basingstoke and Dorset Healthcare NHS Trust, Great Western Hospital, Swindon.**
3. **The skills group with the greatest number of starters was "Additional Clinical Services". This group includes Nursing and Therapy assistants.**

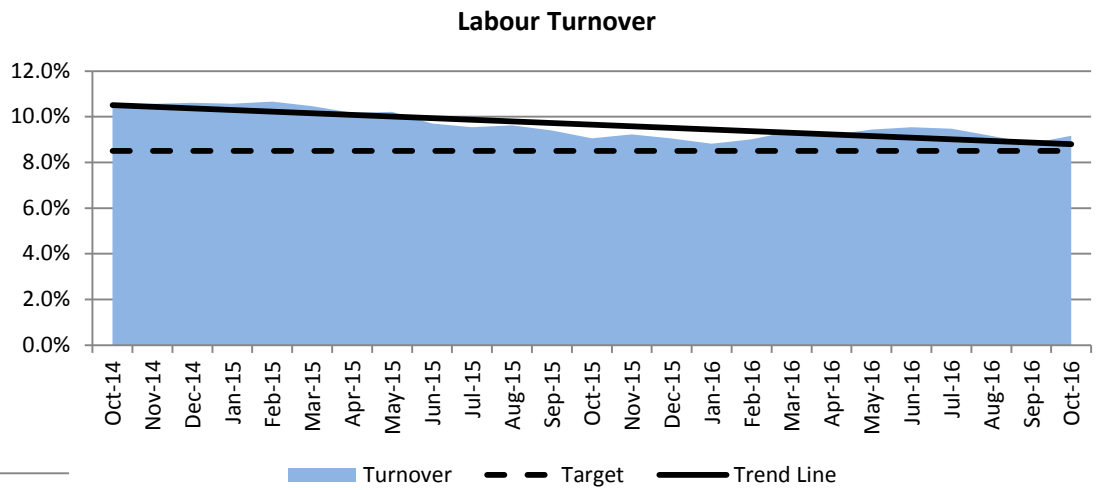
Figures are based on previous 12 months data and exclude trainee medical staff.

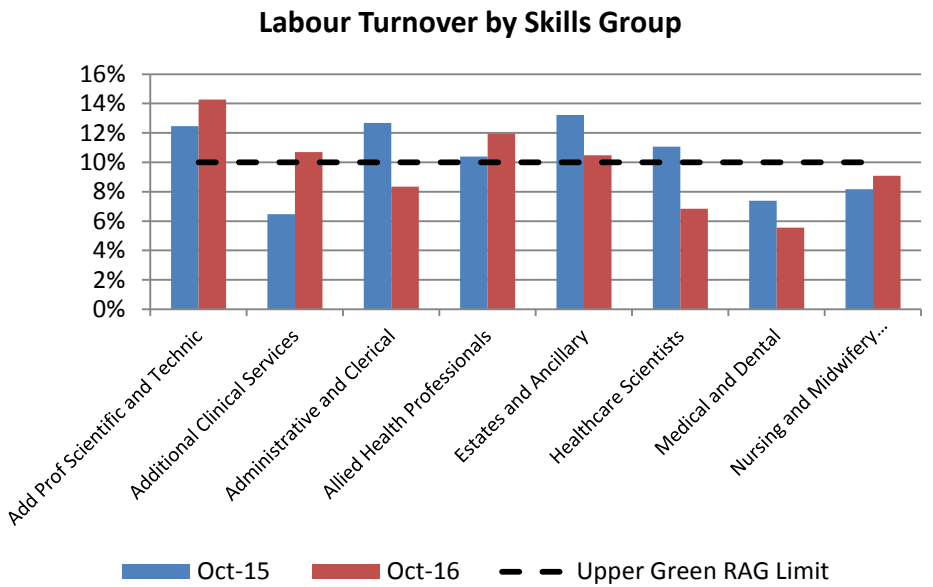
Labour Turnover
M7

Salisbury NHS Foundation Trust

October 16

9.5%
(October 15 – 9.8%)





Additional Notes

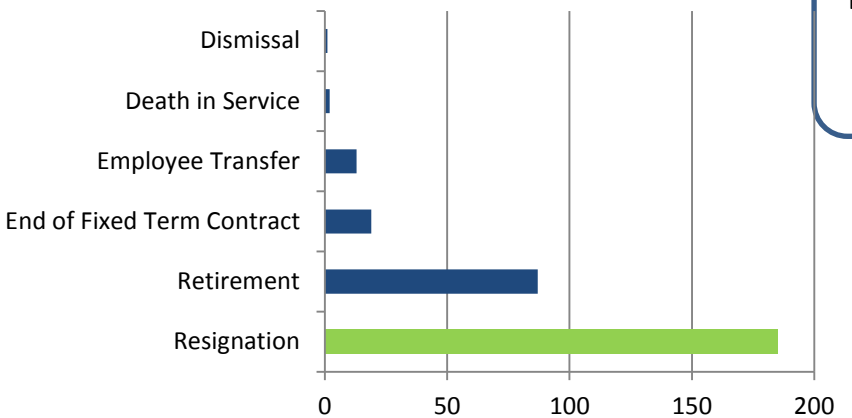
Note: Turnover figures are based on previous 12 months, and exclude bank staff and foundation and training doctors.

1. **Turnover in the year to October 2016 stood at 9.5% compared to 9.8% in the year to October 2015.**
2. **Groups with turnover higher than the Trust's 7-10% green RAG rating are being monitored closely at Directorate level and actions taken as appropriate.**
3. **The overall turnover trend is being closely monitored at Trust and Directorate performance meetings.**
4. **The Trust is conducting a review of the Exit Questionnaire process to encourage uptake and identify themes.**

Leavers
M7

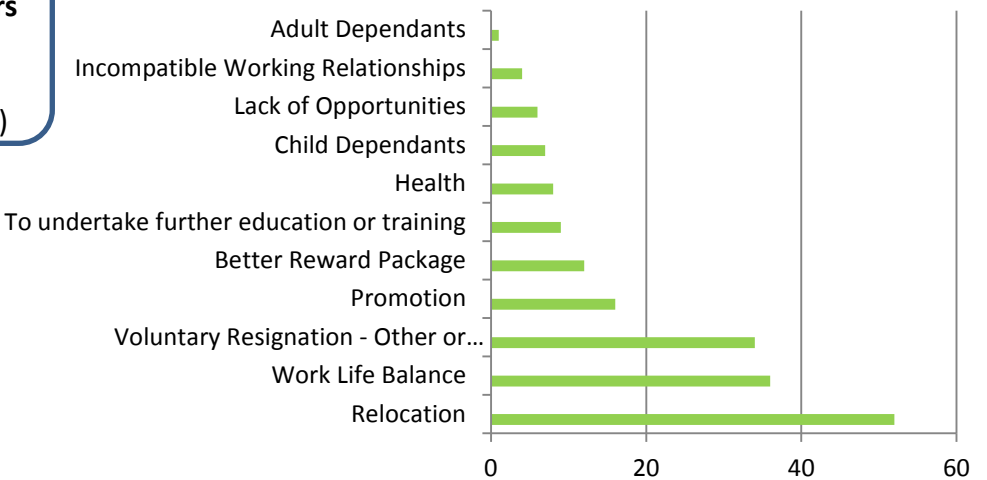
Salisbury NHS
NHS Foundation Trust

Number of Leavers by Reason

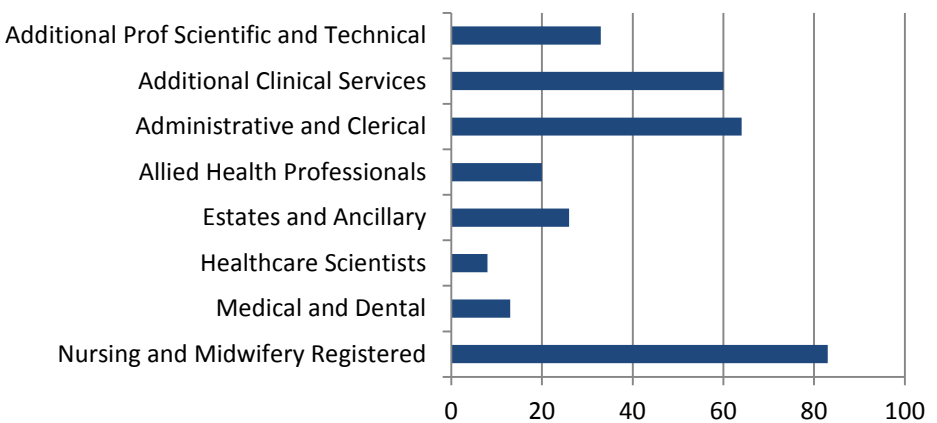


Number of M7 Leavers 31 (October 2015 - 22)

Number of Resignations



Number of Leavers by Skills Group



Additional Notes

1. **The most common reason for resignation was 'Relocation' which includes: family relocation due to re-basing of military partners.**
2. **All leavers can access an Exit Questionnaire or Interview. The Trust is conducting a review of the Exit Questionnaire process to encourage uptake and identify themes. These themes are fed back to managers for action.**

Note: Figures based on previous 12 months data.

Vacancies by Skills Group
M7

Salisbury NHS
NHS Foundation Trust

Vacancies	Budget FTE	Contracted FTE	Vacancy FTE	%
Skills Group				
Admin & Clerical	539.68	508.18	31	6%
Executives & Senior Managers	66.94	71.83	-5	-7%
Healthcare Assistant	573.16	519.27	54	9%
Medical Consultants	*	*		
Medical staff	*	*		
Pharmacist	21.31	19.35	2	9%
Professions Allied to Medicine	147.19	146.18	1	1%
Scientific & Technical Staff	200.99	210.84	-10	-5%
Registered Nurse & Midwife	907.16	799.10	108	12%
Estates Staff	46.42	44.39	2	4%
Facilities Staff	219.47	217.01	2	1%
Total	3060.48	**2,862.24**	**198**	**6%**

Additional Notes

1. The overall vacancy rate has remain the same since last month at 6%, with some small changes within the workforce.

2. 86 offers have been made to Nurses in the Philippines due to start between January and March. 27 have so far dropped out due to a variety of reasons, including financial and personal reasons (and was known to be the likely impact, hence the large number of offers made initially), and unwillingness to retake the IELTS English Language test, which has proved very challenging for these nurses.

3. Bank Nursing budgets are not included in budgeted FTE . Within the nursing FTE, are included Nurses waiting for PIN numbers, and maternity leave circa 4%.

4. Where there are recognised gaps, risk assessments are conducted to establish the impact and identify mitigating actions.

5. Admin vacancies are principally in areas affected by Electronic Patient Record rollout, such as clinical admin areas, and medical records.

6. Some areas shown over establishment do not have a budgeted establishment as such, but earn income to cover staff costs. Others may be as a result of staff movements to cover projects, for example in Informatics, or overlap of staff for handover reasons.

Note: Vacancies shown as positive and over establishments shown as negative.

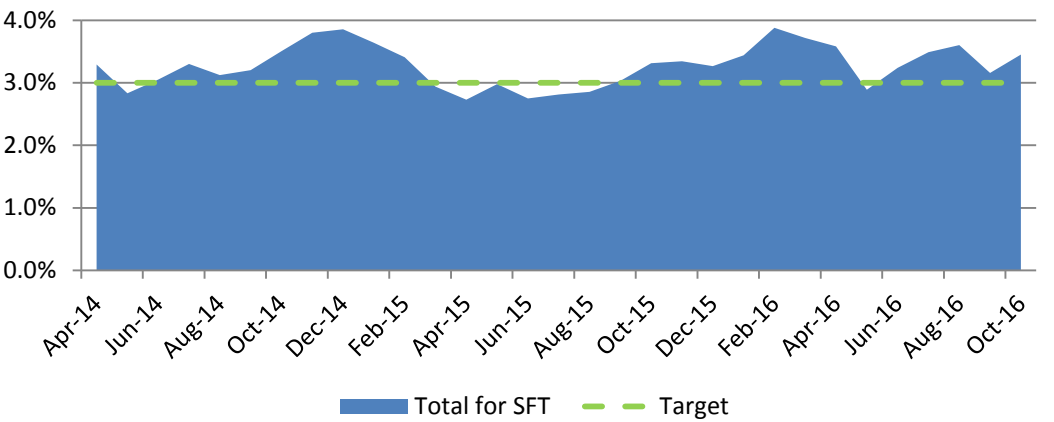
Sickness
M7

Salisbury NHS
NHS Foundation Trust

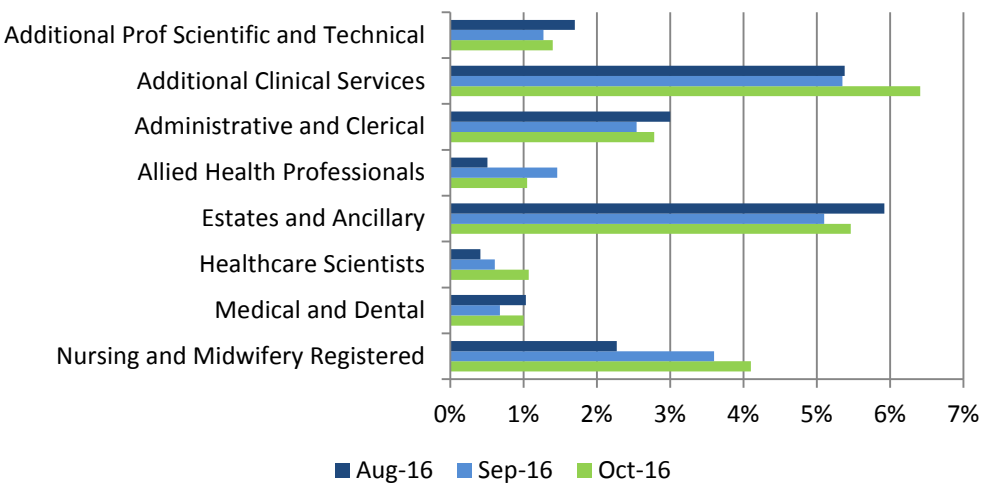
October 16

Percentage
3.42%
(October 15 – 3.17%)

Sickness Absence vs Target



Sickness Absence by Skills Group



Additional Notes

1. Each directorate has a set maximum tolerance for sickness and this is regularly monitored at performance meetings.

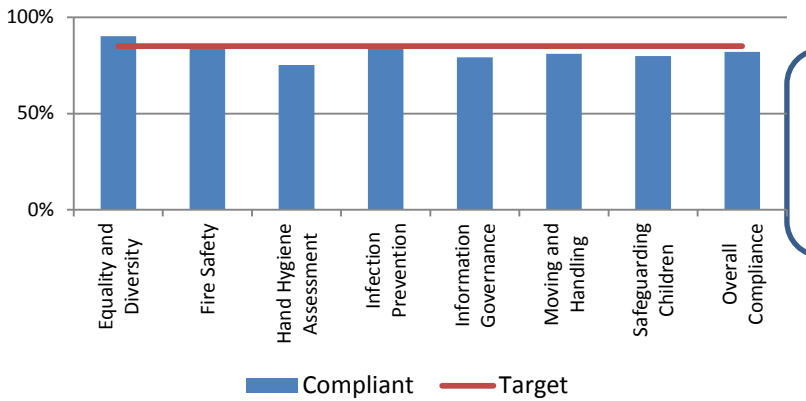
2. The most common reasons for sickness this month were the same as last month, 'Other musculoskeletal problems' and 'Anxiety/stress/ depression/other psychiatric illnesses'. Occupational Health are providing support in these areas, and they form regular discussions at Operational Management Board.

3. The skills group with the highest sickness rate was "Additional Clinical Services" with 6.4%, followed by "Estates and Ancillary" with 5.5%, which compare with the national NHS average sickness rates for these groups of 6.4% and 6.2% respectively.

Mandatory Training
M7

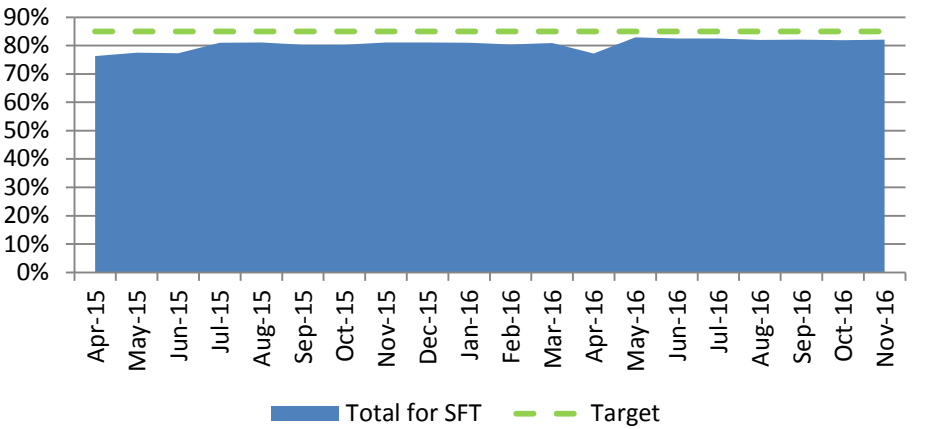
Salisbury NHS
NHS Foundation Trust

MLE Compliance by Category

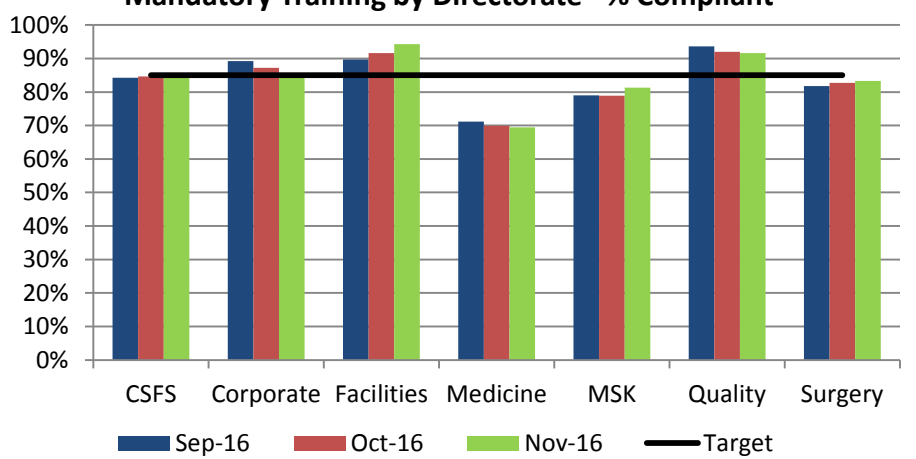


Compliance Percentage 82% (November 2015 – 81%)

Mandatory Training Compliance vs Target



Mandatory Training by Directorate - % Compliant



Additional Notes

1. The percentage of staff up to date with their mandatory training has remained at 82% for a third month against a target of 85%.
2. The directorate with the highest compliance rate was Facilities at 94%, and the directorate with the lowest compliance rate was Medicine with 69%.
3. Information Governance training has the lowest levels of compliance, and there is a review of training where training compliance is not currently recorded on the MLE system.
4. Highest compliance is in Equality and Diversity.
5. Hand Hygiene training is now being recorded in live time to give an up to date picture, currently at 75%.

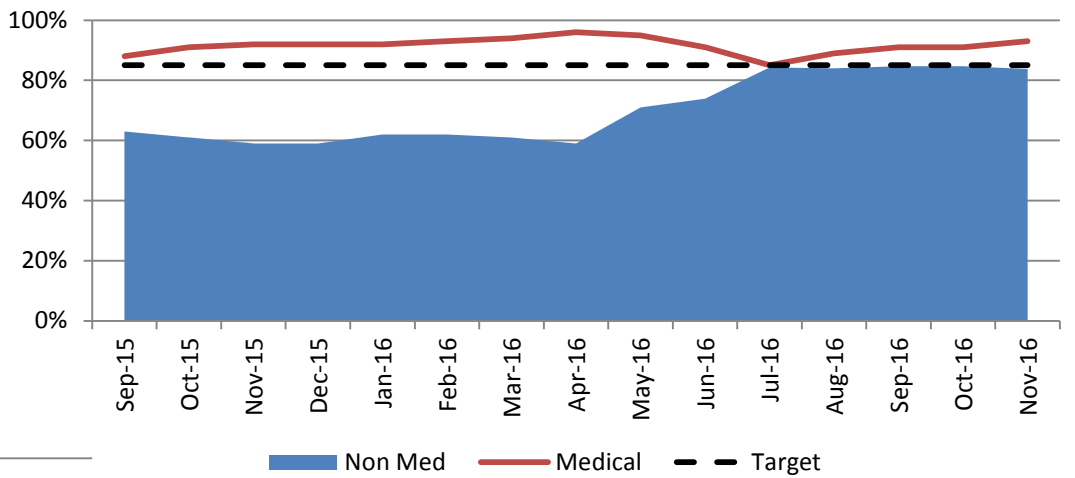
Appraisals
M7

Salisbury NHS
NHS Foundation Trust

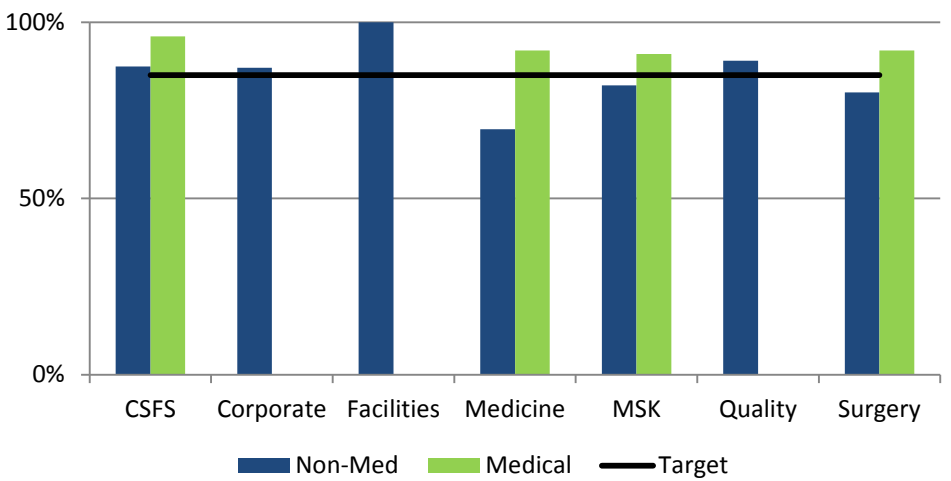
November 16

Compliance percentage - 84% non medical, 93% medical.

Appraisal Compliance vs Target



Annual Appraisal by Directorate - % Compliant



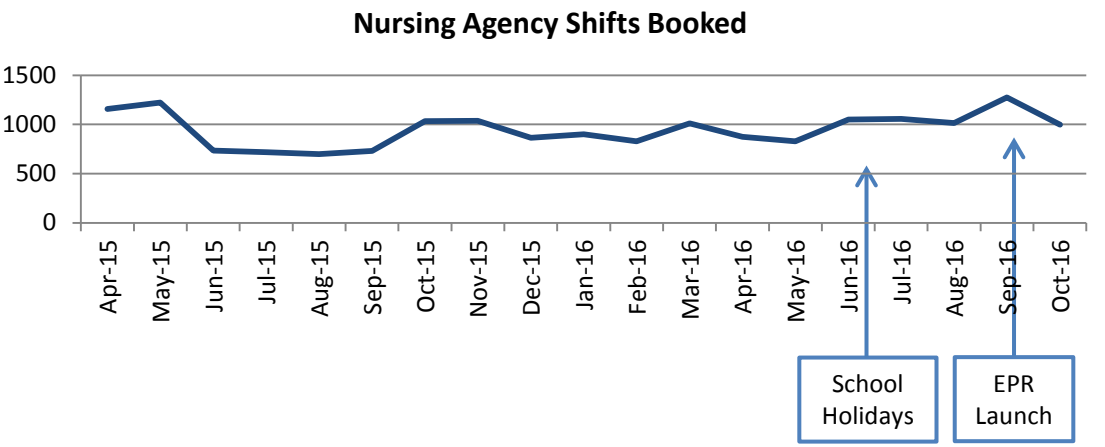
Additional Notes

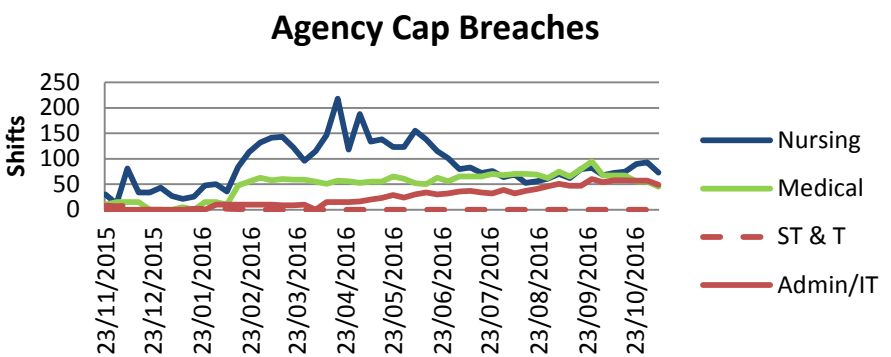
1. **Appraisal compliance for non-medical staff has slightly reduced from 85% to 84% this month. Data is taken from a 13 month window to more accurately reflect activity.**
2. **Detailed non-compliance reports are now live and available to managers (providing the names of non-compliant individuals) for further action.**
3. **The percentage of medical staff with an annual appraisal in the last 12 months has increased from 91% to 93% this month.**

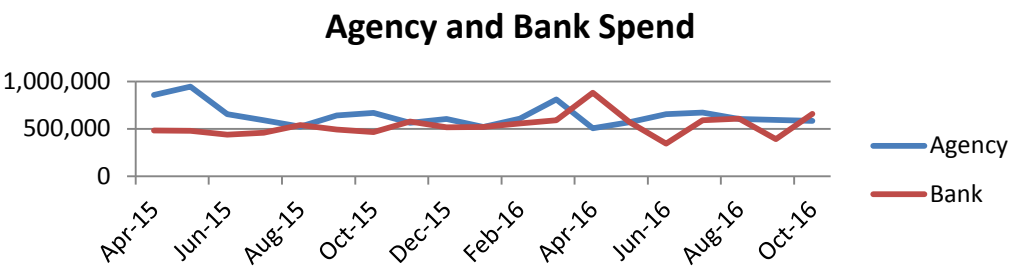
Agency Cap Breaches
M7

Salisbury NHS
NHS Foundation Trust

Agency Nursing Shifts 997
Agency Nursing Cap Breaches 305 (31%)
Agency Medical Shifts 256
Agency Medical Cap Breaches 256 (100%)







Additional Notes

1. **The data shows the trend on agency usage since April 2015 . The breaches of the NHSI caps reveals that the cost of agency is not reducing across all shifts and that the cost for agency, when it is used last minute, can be considerably high. The number of shifts booked for nursing (agency) has remained fairly static.**
2. **Efforts to negotiate contracts with agencies for the supply of locum Medical Staff "on-cap" are ongoing, and efforts are being made to recruit to hard to fill vacancies, to reduce reliance on agency.**

Key Risks/Assurances

Salisbury NHS Foundation Trust

- Appraisal compliance has reduced slightly, after an increase in the previous month. Information is accessible to managers allowing for transparency and better targeted action. There is an Appraisal and MAST Steering Group to oversee improvements, and share ideas.

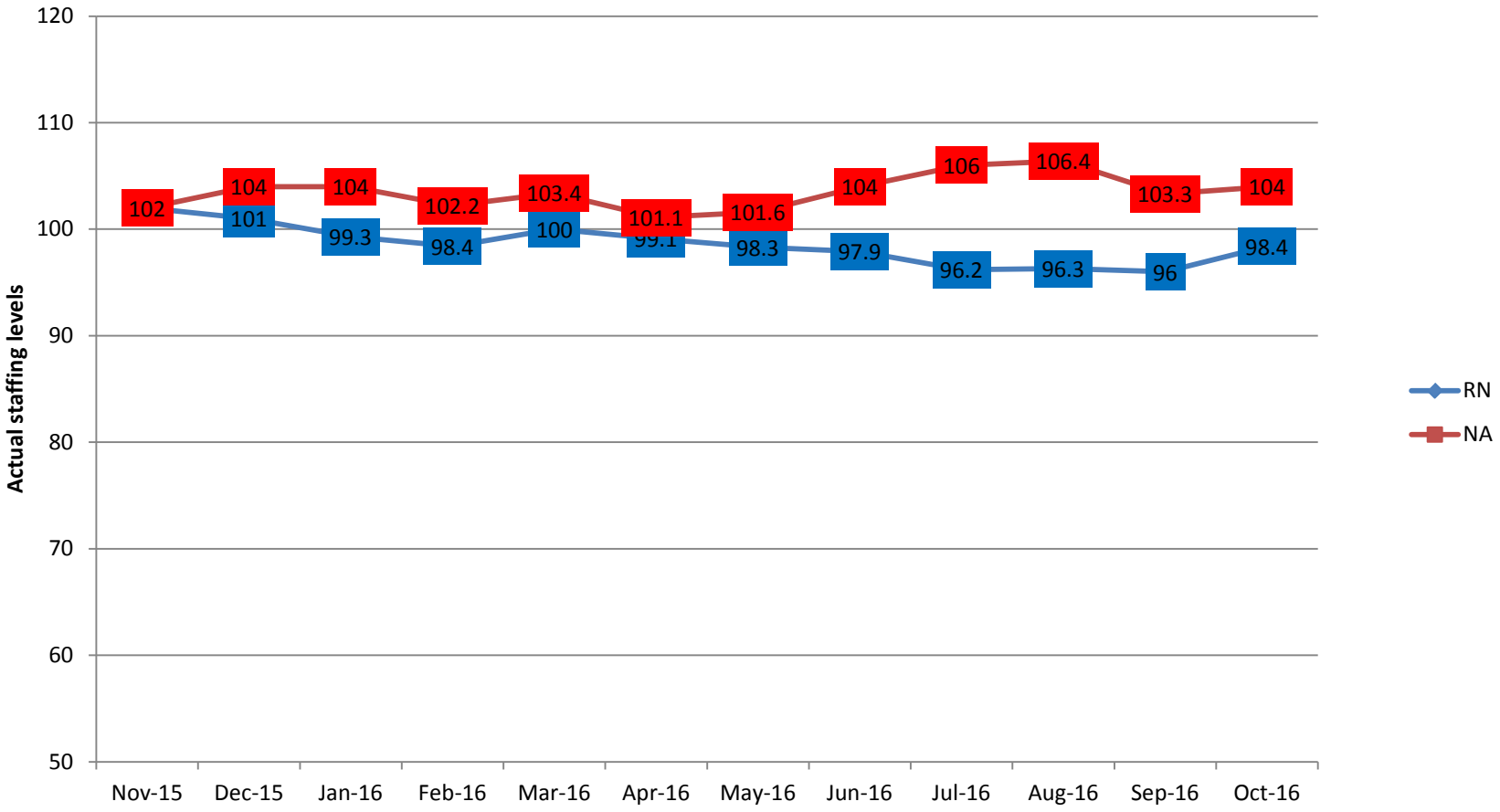
- Efforts to negotiate contracts with agencies for the supply of locum Medical Staff "on-cap" are ongoing, and efforts are being made to recruit to hard to fill vacancies, to reduce reliance on agency. NHSI cap breaches for the supply of Nursing agency shifts have remained steady, with a number of new contracts successfully negotiated with agencies for the supply of agency staff. Booking of all agency locum staff has been re-sited in the bank office so there is more resilience around identifying and supplying agency shifts.

- Although the overall turnover trend is down there has been a slight increase since January 2016. This trend is being closely monitored at Trust and Directorate performance meetings.

Safe Staffing NQB Report – October2016

Monthly Comparisons – Actual Staffing Levels

Registered Nurses			Nursing Assistants			Combined			Actual Skill Mix	
P	A	%	P	A	%	P	A	%		
57079.7	56187	98.4%	33419.5	34808.2	104%	90498.5	90995.2	100.5%	62	38



Overview of Nurse Staffing Hours – October 2016

	RN	NA
Total Planned hours (day shift)	33528	21831.5
Total Actual hours (day shift)	32211.2	22163.5
Percentage	**96%**	**102%**
Total Planned hours (night shift)	23551.7	11588.0
Total Actual hours (night shift)	23975.8	12644.7
Percentage	**102%**	**109%**

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

Nursing Hours by Day Shifts

Wards	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**13851.25**	**13796.58**	**99.6%**	**9851.25**	**10993.75**	**111.6%**
Breamore Ward	1081.50	947.00	87.6%	842.00	1007.50	119.7%
Durrington Ward	1024.50	1088.83	106.3%	766.50	1131.00	147.6%
Farley Ward	1754.00	1775.25	101.2%	1464.50	1609.00	109.9%
Hospice	882.50	901.50	102.2%	653.50	690.50	105.7%
Pembroke Ward	827.50	815.50	98.5%	367.50	337.75	91.9%
Pitton Ward	1686.50	1648.00	97.7%	1187.50	1149.50	96.8%
Redlynch Ward	1493.50	1448.75	97.0%	1153.50	1121.00	97.2%
Tisbury Ward	2012.25	1722.25	85.6%	702.75	748.75	106.5%
Whiteparish Ward	1550.00	1957.50	126.3%	1039.00	1064.75	102.5%
Winterslow Suite	1539.00	1492.00	96.9%	1674.50	2134.00	127.4%
Surgery	**5888.00**	**5723.50**	**97.2%**	**2385.00**	**2419.00**	**101.4%**
Britford Ward	1766.00	1708.00	96.7%	831.50	955.00	114.9%
Downton Ward	1344.00	1293.00	96.2%	1019.50	953.50	93.5%
Radnor	2778.00	2722.50	98.0%	534.00	510.50	95.6%
Clinical Support	**5112.33**	**4622.83**	**90.4%**	**2046.00**	**1551.75**	**75.8%**
Maternity	2659.08	2380.83	90 %	1340.75	1139.25	85.0%
Sarum Ward	1017.75	1164.75	114.4%	351.00	310.00	88.3%
Musculo-Skeletal	**8676.42**	**8068.25**	**93.0%**	**7549.25**	**7199.00**	**95.4%**
Amesbury Suite	1610.50	1401.75	87.0%	1416.85	1656.50	116.9%
Avon Ward	1545.67	1147.17	74.2%	1970.73	1623.42	82.4%
Burns Unit	1327.75	1235.25	93.0%	600.00	529.50	88.3%
Chilmark Suite	1540.25	1606.25	104.3%	1097.50	1008.25	91.9%
Laverstock Ward	1283.75	1441.75	112.3%	933.50	902.50	96.7%
Tamar Ward	1368.50	1236.08	90.3%	1530.67	1478.83	96.6%
Grand Total	**33528.00**	**32211.17**	**96.1%**	**21831.50**	**22163.50**	**101.5%**

Nursing Hours by Night Shifts

Row Labels	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**9715.50**	**10160.00**	**104.6%**	**5642.00**	**6845.20**	**121.3%**
Breamore Ward	713.00	712.00	99.9%	713.00	769.50	107.9%
Durrington Ward	713.00	713.00	100.0%	713.00	1319.50	185.1%
Farley Ward	1067.00	1124.50	105.4%	712.50	872.00	122.4%
Hospice	589.00	589.00	100.0%	398.50	401.20	100.7%
Pembroke Ward	713.00	702.50	98.5%	0.00	11.50	0
Pitton Ward	1035.00	1290.00	124.6%	713.00	701.50	98.4%
Redlynch Ward	1067.50	1102.00	103.2%	713.00	724.50	101.6%
Tisbury Ward	1426.00	1394.50	97.8%	356.50	379.50	106.5%
Whiteparish Ward	1426.00	1463.00	102.6%	356.50	366.50	102.8%
Winterslow Suite	966.00	1069.50	110.7%	966.00	1299.50	134.5%
Surgery	**4440.50**	**4463.25**	**100.5%**	**1263.00**	**1314.25**	**104.1%**
Britford Ward	1029.00	1061.00	103.1%	686.00	749.00	109.2%
Downton Ward	686.00	685.25	99.9%	577.00	565.25	98.0%
Radnor	2725.50	2717.00	99.7%	0.00	0.00	0
Clinical Support	**3539.75**	**3369.08**	**95.2%**	**1095.00**	**1030.75**	**94.1%**
Maternity	2470.25	2242.75	90.8%	1060.50	996.25	93.9%
Sarum Ward	1069.50	1126.33	105.3%	34.50	34.50	100.0%
Musculo-Skeletal	**4810.50**	**4977.00**	**103.5%**	**3231.50**	**3374.00**	**104.4%**
Amesbury Suite	1067.50	1069.50	100.2%	713.00	736.00	103.2%
Avon Ward	886.50	878.50	99.1%	600.00	610.00	101.7%
Burns Unit	713.00	716.00	100.4%	355.50	401.25	112.9%
Chilmark Suite	589.00	599.50	101.8%	586.50	596.00	101.6%
Laverstock Ward	954.50	1081.00	113.3%	356.50	341.00	95.7%
Tamar Ward	600.00	632.50	105.4%	620.00	689.75	111.3%
Grand Total	**23551.75**	**23975.83**	**101.8%**	**11588.00**	**12644.70**	**109.1%**

Overview of Areas with Red/Amber

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	**Avon**	74.2%	√		Day	The unit is carrying RN and NA vacancies . This % represents bank or agency shifts that remain unfilled. Shifts are reviewed on a shift by shift basis. If there are no respiratory patients requiring high level care then the skill mix is reviewed accordingly. During October there were no ventilated patients hence the staffing numbers were at times decreased.
Amber	**Avon**	82.4%		√	Day	As above
Amber	**Amesbury**	87%	√		Day	The unit is carrying 4 RN vacancies. Any unfilled bank/agency shifts represented by these figures are covered by the Band 7 relinquishing the supervisory role. The RN staffing gap is less than reported as supervisory shift s have not been changed for core shift cover. This is being corrected for the November reporting period The utilisation of trainee assistant practitioners is bolstering shift numbers resulting in a 116% overstaffing of NA shifts.
Amber	**Burns**	88.3%		√	Day	NA shift not always required following review of patient acuity . Daily ward round with DSN & ADSN any staffing concerns discussed.
Amber	**Breamore**	87.6%	√		Day	All shifts were covered however some are showing as “unfilled” as these were covered by experienced Band 4 staff . This group of staff are recorded as unqualified within Eroster. Daily ward round with DSN & ADSN for any staffing concerns discussed.
Amber	**Tisbury**	85.6%	√		Day	As above
Amber	**Maternity**	85%		√	Day	The unit is carrying NA vacancies and each shift is subject to a risk assessment based on patient acuity and demand. October was a very quiet month for births with a midwife to births ratio of 1:29 reducing the demand.
Amber	**Sarum**	88.3%		√	Day	Late temporary staff cancellations have resulted in some unfilled shifts . Some shifts have remained unfilled following risk assessments (based on acuity and dependency). The numbers involved are very small exaggerating the figures.

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

Mitigation of Risk

for Red/Amber

Red:- Only **Avon** has flagged for October for RN day shifts . There are no medical units flagging at Red for the first time since May 2016.

Any decision to leave shifts unfilled is based on patient acuity assessments if the ward is experiencing lower acuity due to reduced numbers of ventilated patients. The unfilled shifts are uncovered planned shifts put out to bank or agency patient. It patient acuity levels deem these safe to remain unfilled at late notice , then temporary staff are not used

Amber.

- **Avon:-NA days :-** The unit is carrying 5 NA vacancies and, as per RN shifts, cover is flexible around patient acuity and dependency needs. Daily discussions with the DSN regarding staffing, levels of acuity (including outliers) can result in some shifts remaining uncovered. The sharing staff of differing grades between the spinal wards helps cover for any unfilled shifts balancing the demand.
- **Amesbury**:- The ward has 4 RN vacancies resulting in unfilled shifts. The RN staffing gap is less than reported as errors have been identified where supervisory shifts have not been changed for core shift cover therefore giving the appearance of lower levels of unfilled shifts than in reality. This process is being corrected for the November reporting period.

Trainee Assistant Practitioners are utilised to help support unfilled shifts reflecting the unit as overstaffed for NAs (117% for October). Chilmark and Amesbury senior sisters are working together to cover unfilled shifts on either ward. Each shift is reviewed and the staffing managed accordingly.

- **Burns:**- All shifts are assessed daily and may remain unfilled following a review of patient acuity and dependency supported by Daily ward rounds with DSN & ADSN to address any staffing concerns.
- **Breamore & Tisbury** are utilising Band 4 staff to support unfilled shifts.

The Eroster system is designed only to accept staff who are qualified (& have a registration number) or unqualified staff whatever the profession. Band 4 staff have enhanced skills but do not have registration numbers & are therefore recorded as unqualified. This results in qualified shifts appearing unfilled if staffed with Band 4 and NA shifts evidenced as over staffing as per Breamore and Tisbury this month.

- **Maternity :- NA days**. The unfilled shifts are subject to midwife/birth demand and assessed on a shift by shift basis. As noted, October was a quieter month for births with the unit managing staffing around the demand.
- **NICU** continues to be unreported internally as there is still on –going validation with finance . The clarity offered by the e-roster system enabled the identification of budget vs staffing issues via the templates. Shifts are reviewed several times a day and ratios are met. Templates are expected to be signed off by 30th November 2016 for February reporting.

Overview of Overstaffed Areas >115%

Ward	%	RN	NA	Shift	Comments
Whiteparish	126%	√		Day	Level 2 patient with a tracheostomy requiring 1:1 care
Pitton	125%	√		Night	As above.
Amesbury	117%		√	Day	The overstaffing represents the flexible rostering of Band 4 staff who are reflected as untrained staff within e-roster. These skilled staff to help bolster shift numbers if there is a reduced number of RN staff.
Breamore	120%		√	Day	As above. The overstaffing of NA is due to Band 4 experienced staff covering any appropriate unfilled RN shifts
Britford	115%		√	Day	SAU has been covered with an NA Twilight shift when in escalation
Durrington	148%		√	Day	This is due to enhanced care following patient assessments which identify any patients who are at risk due to confusion, mentally ill or at risk of harm from falls
Durrington	185%		√	Night	As above. NA staff are utilised for enhanced care (following appropriate risk assessments) rather than more costly RN staff
Winterslow	135%		√	Night	As per Durrington
Winterslow	127%		√	Day	
Farley	122%		√	Night	This is due to enhanced care following patient assessments which identify any patients who are confused, mentally ill or at risk of harm from falls utilising NA skills.

Actions taken to mitigate risk

The RN skill mix % has increased very slightly from 61% - 62% for September with a corresponding decrease of 1% from 39% -38% for NA levels

Staffing levels are flexed according to patient acuity and dependency levels. These are assessed by the nurse-in-charge of individual wards.

- The skills set of staff is carefully accounted for when deciding on the band of staff needed.
- Additional NAs are rostered to support unfilled RN shifts as demonstrated
- All shifts are assessed on a shift by shift basis.
- Staff are 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.

Salisbury NHS
NHS Foundation Trust

SFT 3831

Salisbury NHS Foundation Trust
Staff Survey 2015 Update on Progress
(November 2016)

Presented for: Information

Presented by: Alison Kingscott, Director of Human Resources and Organisational Development

Authors: Victoria Downing-Burn, Deputy Director of HR (interim)

Previous Committees: None

Key points
The Trust Board is asked to consider this report and the actions taken to date to address the areas for improvement within the 2015 Staff Survey.

This report satisfies the following three, of four, strategic aims, and each of the Trust Values as outlined below:

Strategic Aims

Care - We will treat our patients with care, kindness and compassion and keep them safe from avoidable harm	✓
Our Staff - We will make SFT a place to work where staff feel valued to develop as individuals and as teams	✓
Value - We will be innovative in the use of our resources to deliver efficient and effective care	✓

Values

We will be Patient Centred and Safe, Professional, Responsive and Friendly	✓

1. Summary and background

This report provides a summary of the key actions taken to date in addressing a number of themes in the 2015 Staff Survey. It follows previous reports to Trust Board and the Executive Workforce Committee.

The Trust performs very well in comparison to other NHS organisations and Salisbury NHS Foundation Trust is in the Top 20% of all acute Trusts. Trust staff report feeling very well engaged because they can contribute to improvements at work, they recommend the trust as a place to work and they feel motivated.

2. Programme of work and progress

There were five key themes identified as key areas for focus in the 2015 survey: 2 new areas and 3 areas with existing work programmes. The Staff Survey Working Group has met this year to discuss and agree the course of actions to support the areas for development. The group, made up of clinical staff and support / admin / facilities staff, made recommendations for action and consolidation.

This report focuses on the corporate issues drawn from the survey. The actions and improvements adopted in response to these issues have been built into the directorate plans where relevant.

Work programme

New for this year

2.1 Working extra hours

74% of SFT respondents stated that this was their experience with the national average being 72%, and it forms the Trust's one area where we perform 'below average'.

In reviewing the percentage of staff reporting working paid or unpaid hours the breakdown is: 28% of staff report working additional paid hours, and 61% of staff report working additional unpaid hours.

There is no qualification in the survey as to whether the additional hours worked - paid or otherwise - is by choice or is undertaken unwillingly. Informal work undertaken at Directorate level to understand the nature of the impact of unpaid hours has not uncovered any unmet concerns about unpaid hours. Most staff and managers have acknowledged that unpaid hours are 'to support the service', 'doing an extra bit to keep the show running' and due to 'my own professional standards'.

Where there have been concerns, the focus has been on the root cause of the issue such as vacancies, and seeking alternative approaches to roles or recruitment activities.

Other staff report that their manager is flexible with hours and will accommodate time off in lieu. This is supported by survey questions including: 56% of staff report having opportunities for flexible working patterns; 79% of staff report being enthusiastic about their job; and 93% of staff report that they are trusted to do their job.

2.2 Levels of satisfaction with the quality of work and patient care staff are able to deliver

The Trust scored 3.91 (out of 5) against a national average of 3.93, with a higher score being better. The Trust is 'average' in this area.

Clinical staff in the working group were eager to establish that it is almost impossible to be wholly satisfied with the quality of work and patient care delivered as personal standards are very high. 80% of staff report being able to do their job to a standard that they are personally pleased with, however, 29% of staff report that, in their view, there are enough staff at the organisation to enable them to do their job properly. In the past 12 months there has been considerable attention given to the methods of recruitment and retention within the trust, with activities such as: trust-based Open Day's, international recruitment, skype-interviews and a push on the use of social media being adopted to reduce vacancies.

The staff survey working group encouraged the action in this area to focus on more celebration of the successes that we have a trust. Local actions have included the introduction of 'coffee and cake' sessions in new areas enabling staff to share successes and address concerns. The trust has also put greater focus on promoting our work by submitting examples of success as part of recognition awards. Achievement of our awards is then promoted through the cascade brief and the CEO messages.

Existing work areas

2.3 Staff / colleagues reporting most recent experience of harassment, bullying or abuse

The Trust scored 38%, against a national average of 37%, with a higher score being better. In this case the Trust is performing better than the national average, however the work in supporting staff in the working environment to a) be protected from bullying, harassment or abuse, b) to feel supported and have access to services and processes should they experience bullying, harassment or abuse c) to report such incidences will be continued.

The new Dignity at Work (Bullying and Harassment) Policy was endorsed by staff side and management earlier this year. The new policy is simpler than the previous one and is supported by a toolkit for staff and managers – a suite of eight reference documents.
http://intranet/website/staff/hr/bullyingandharassmenttoolkit/index.asp

The Dignity at Work Ambassadors have met regularly and recently held a drop in session within Springs, and used a questionnaire to identify the success of the promotion of the DAWA role. In addressing the issue of 'reporting bullying' the DAWA role is able to signpost individuals to policies and processes as well as support (see leaflet for the full range of support).
http://intranet/website/staff/hr/bullyingandharassmenttoolkit/genericsupportleaflet.pdf

There is a programme of work for the DAWA role including peer support, supervision and training.

2.4 Staff appraised in the last 12 months

The trust results show that 87% of staff report having an appraisal, which is above the national average.

Following the implementation of SpIda2 earlier this year - supported by drop in training sessions and dedicated help - the appraisal rate from the internal system has improved.

There is an Appraisal and MAST Steering Group which is chaired by the Director of HR & OD and is currently monitoring the actions and progress of appraisal uptake.

2.5 Work related stress and well being

The Trust scores in the top 20% of trust for 'staff experiencing stress', and 'trust and management interest and action on health and well-being'.

The programme of health and well-being has continued with a good level of focus this year and has included:

- The introduction of a weight monitoring machine accessible in the Education Centre, enabling staff to track weight loss, and blood pressure
- We have contributed to Britain's Healthiest Company survey with an improved response rate from staff this year, showing better engagement
- Work is well developed in securing external financial support options for staff, in direct response to the 2015 Britain's Healthiest Company report
- A dedicated Flu Campaign in support of the national CQUIN (Commissioning for Quality Innovations
- A dedicated Shape up at Salisbury website including access to resources such as: Stress – tools and resources; Staff Counsellor – details of how to access the service; Dementia – support documents for staff and managers; Staff Physiotherapist – purpose of the service and details of how to access; Mediation – our policy and guidance; Mental Wellbeing – information about depression and stress; Quitting Smoking – information and guidance; Healthy Eating
- Staff Club website with information about exercise, alcohol, getting fit etc.
- We continue to grow our health and wellbeing offer for staff who are experiencing mental health issues. These include funding a part time Registered Mental Health Nurse, quarterly psychological wellbeing courses, monthly mindfulness sessions, walk and wander and a colouring club.

November 2016

Freedom to Speak up Guardian Report for Board (Part One)

All NHS Trusts were required to nominate a Freedom to Speak up Guardian by 1st October 2016, in line with Sir Robert Francis QC's recommendations and the NHS Standard Contract 2016/15 (item 5.8 on page 5). The role has been designed to support NHS organisations to become a more open and transparent place to work, where staff are actively encouraged and supported to raise public interest concerns.

As a Trust we identified a Guardian who was independent, impartial and empowered to take the role forward. Isabel McLellan, Trust Governor was appointed as Freedom to Speak up Guardian from February 2016 and worked closely with the Director of HR and OD to develop a system for staff to be able to access the Guardian on a confidential informal basis. A confidential email was set up on NHS.net for staff to contact Isabel with any concerns, as well as access directly by telephone. Isabel also linked in with the Dignity at Work Ambassadors network which consists of a group of staff who are available to support staff that raise concerns about their working experience.

The role of the Guardian was communicated widely within the organisation and information was posted in local areas as well as on the Trust intranet. It continues to be regularly promoted.

Isabel as the Guardian has been actively engaging with the organisation through attendance at local and departmental meetings as well as holding open sessions.

Isabel has direct and regular access to the Chief Executive and the Executive Directors to raise any concerns flagged to her by staff, to enable her to support staff and keep them informed of progress in addressing their issues.

A regular report is produced by Isabel and provided to the Chief Executive in order that any themes or underlying trends can be identified and addressed. Some of the issues that have been raised include concerns around staffing, communication and organisational change. All these issues have been addressed with the relevant departments and the Guardian monitors any follow up. There have been no major concerns raised during this period.

There is a national Freedom to Speak up Guardian Office and a national guardian, Henrietta Hughes. The National Office for Freedom to Speak Guardian invited all its members to meet up with Henrietta Hughes in October and Isabel attended the meeting providing her with an opportunity to network and share good practice. Workshops are also being held and Isabel attended one in November at Bristol and there will be national conference in March 2017.

There will be a local review of the role in January 2017.

The Board are asked to note the report.

Alison Kingscott
Director of HR and OD
November 2016

Isabel McLellan
Freedom to Speak Up Guardian

Trust Board meeting **SFT 3833**

Quality indicator report – October 2016

Date: 24 November 2016

Report from: Dr Christine Blanshard, Medical Director & Lorna Wilkinson, Director of Nursing

Presented by: Dr Christine Blanshard, Medical Director & Lorna Wilkinson, Director of Nursing

Executive Summary:

- 3 cases of C Difficile. Ribotyping shows 2 cases share the same ribotype. Serious incident inquiry commissioned (Nov).
- 2 new serious incident inquiries commissioned.
- A decrease in the crude mortality rate in October. SHMI is 107 to March 16 and is as expected. HSMR is 117 to July 16 and is higher than expected. This may have been affected by a temporary reduction in the palliative care team in Q1 & Q2 and a significant reduction in co-morbidity coding. 3 new CUSUM alerts – skin & subcutaneous tissue infections (May 16), peripheral & visceral atherosclerosis (June 16), affective disorders (July 16) – all to be investigated.
- A decline in the percentage of patients being operated on within 36 – 48 hours of admission due to theatre capacity (5) and stabilisation of condition (3). Ongoing improvement work via the Theatre working group along with strategic plan to separate elective and non-elective orthopaedic surgery.
- Raw numbers of grade 2 pressure ulcers remain fairly static. However, there has been a reduction in grade 2 pressure ulcers per 1000 beds days from 1.09 to 1.00 when April to September 2015 is compared to the same period in 2016. Share and learn meetings continue to drive improvements.
- In October there were 2 falls resulting in major harm (fractured hip & fracture shaft of femur requiring surgery) and 2 falls resulting in moderate harm (both fractured pubic rami managed conservatively). Aggregated review of cluster reported to Clinical Risk Group and will go to the Clinical Governance Committee.
- All patients bar one had a CT scan within 12 hours. The majority of patients spent 90% of their time on the stroke unit. The 2 that did not required a specialist medical bed. Patients arriving on the unit within 4 hours improved, but 5 patients missed due to stroke bed capacity (3), missed diagnosis (1) & new neurology (1).
- A decrease of high risk TIA patients being seen within 24 hours affecting 7 patients as no available morning clinic and the wrong referral route used. Discussion held with GP practices concerned.
- A decrease in the number of complaints and concerns. Early contact with patients & relatives in the initial phase of a complaint is being proactively promoted.
- Escalation bed capacity increased in September with a decrease in the percentage of patients moved more than once. Multiple ward moves remain at a low level and work continues with our partners to transform patient flow.
- No non-clinical mixed sex accommodation breaches in October.
- Cumulative annual data of the time of patient moves is reported for ongoing monitoring purposes. The majority of overnight moves occur from Whiteparish, SSEU and Britford SAU to maintain patient flow. However, there were a number of moves from one ward to another to create appropriate bed capacity. The majority of discharges between 10 pm and 7 am are from ED/SSEU, Whiteparish and Britford SAU. Improvement work is led through the Transformation Programme.
- The mean score of patients rating the quality of their care was consistent with the previous year average. Responses to the Friends and Family test consistently show that patients would recommend wards, the maternity service, outpatients and care as a day case and improved in ED from the previous month.

Proposed Action:

1. **To note the report**

Links to Assurance Framework/ Strategic Plan:
CQC registration

Appendices:
Trust quality indicator report – October 2016

Supporting Information

Salisbury NHS
NHS Foundation Trust

Trust Quality Indicators - October 2016

Quality Measures

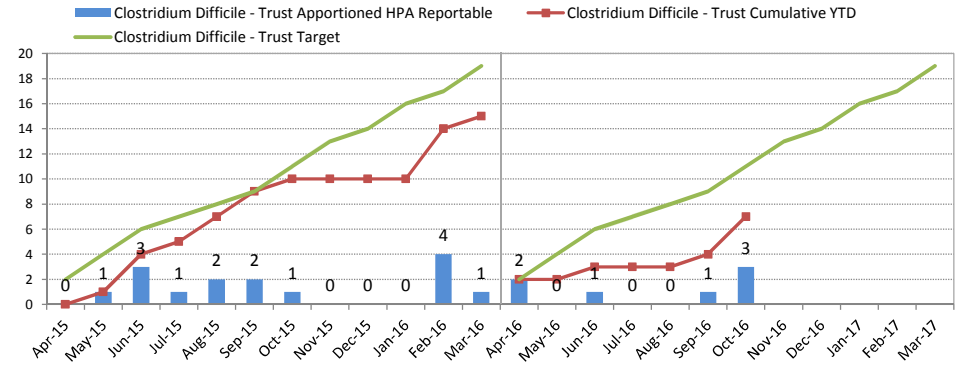
Infection Control	*2015-16 YTD*	*2016-17 YTD*
MRSA (Trust Apportioned)	**0**	**0**

Trust Incidents	*2015-16 YTD*	*2016-17 YTD*
Never Events	**2****	**0**
Serious Incidents Requiring Investigation	**28*****	**31**

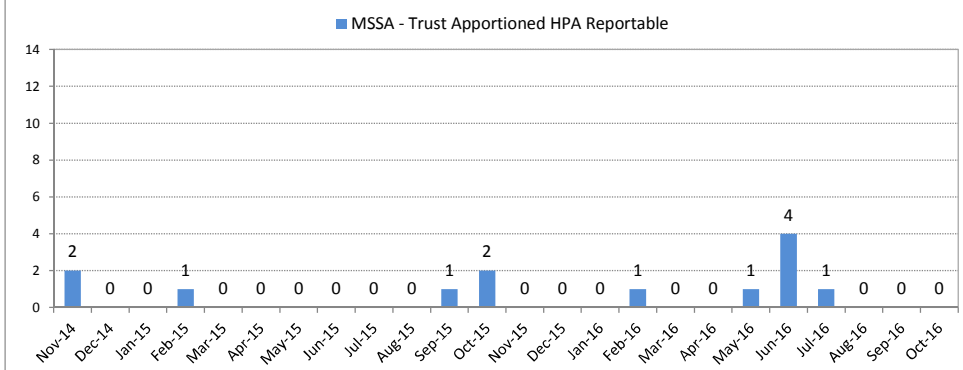
** A formal agreement was reached with the CCG to downgrade a third never event as it did not meet the definition.

*** Of these SIIs commissioned, 2 have been downgraded following a formal agreement with the CCG as they did not meet the SI definition.

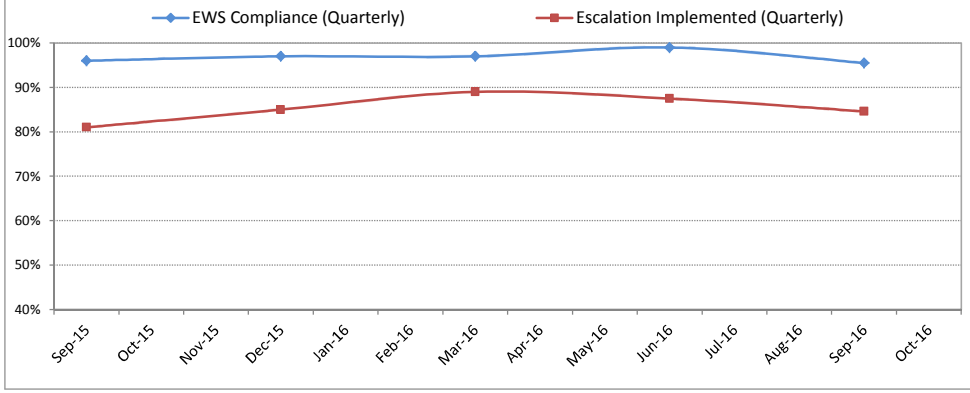
Clostridium Difficile - Trust Apportioned



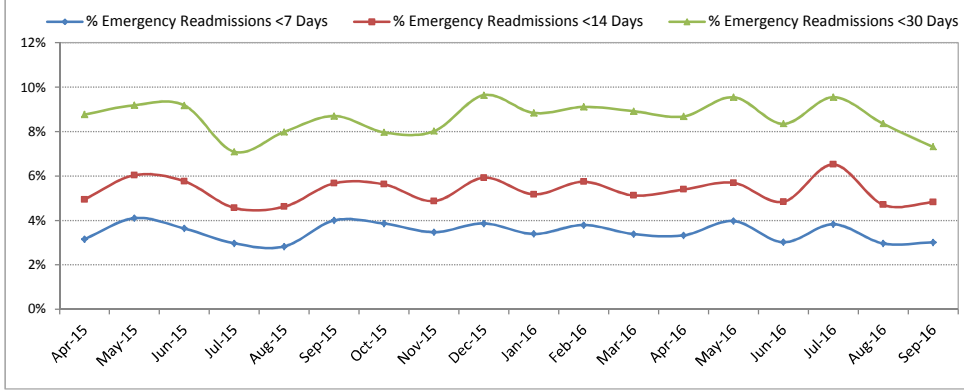
MSSA - Trust Apportioned



EWS (Early Warning Score) & Escalation



Emergency Readmissions within 7, 14 & 30 days of Discharge

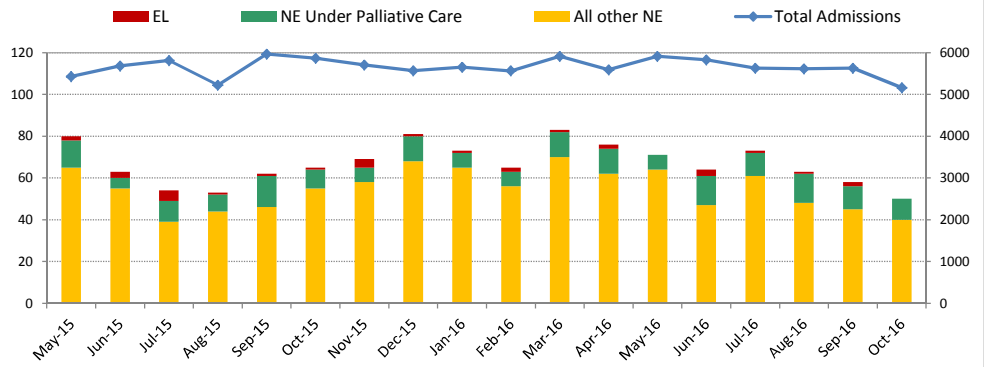


Salisbury NHS
NHS Foundation Trust

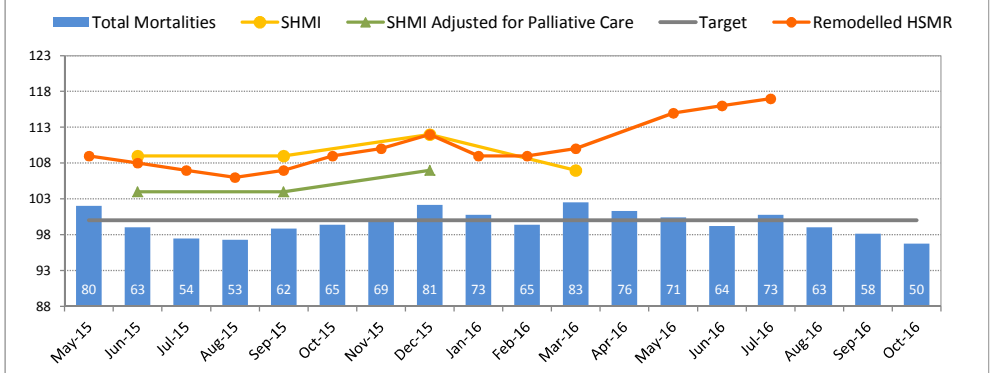
Trust Quality Indicators - October 2016

Quality Measures

Hospital Mortalities

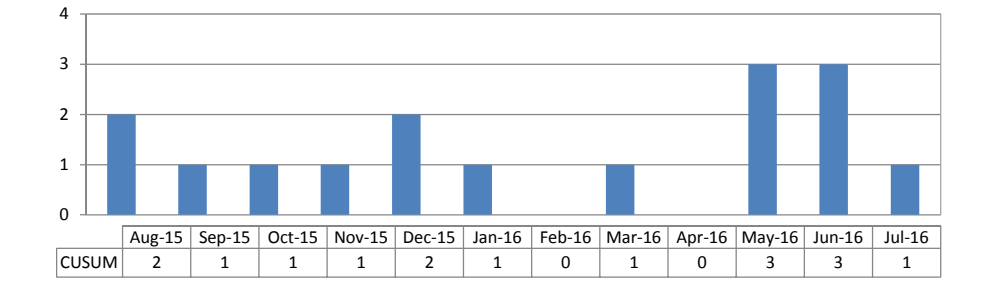


HSMR and SHMI



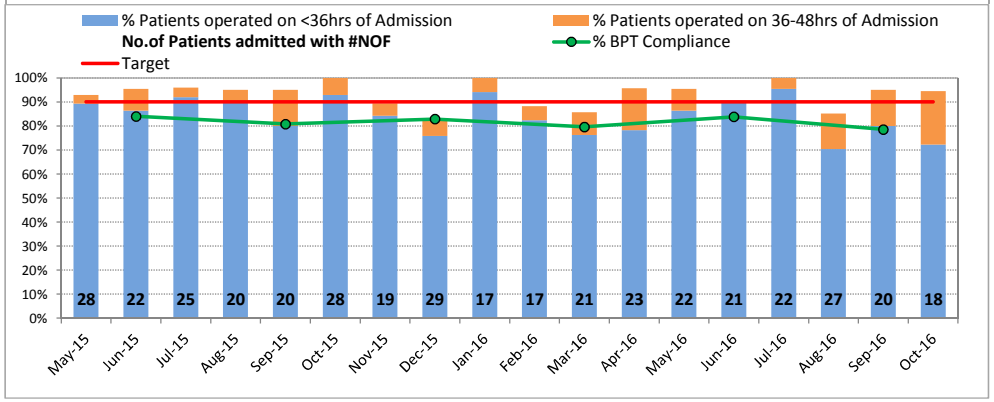
CUSUM Alerts

Cumulative sum of mortality outcomes (Observed > Expected)



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
CUSUM	2	1	1	1	2	1	0	1	0	3	3	1

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

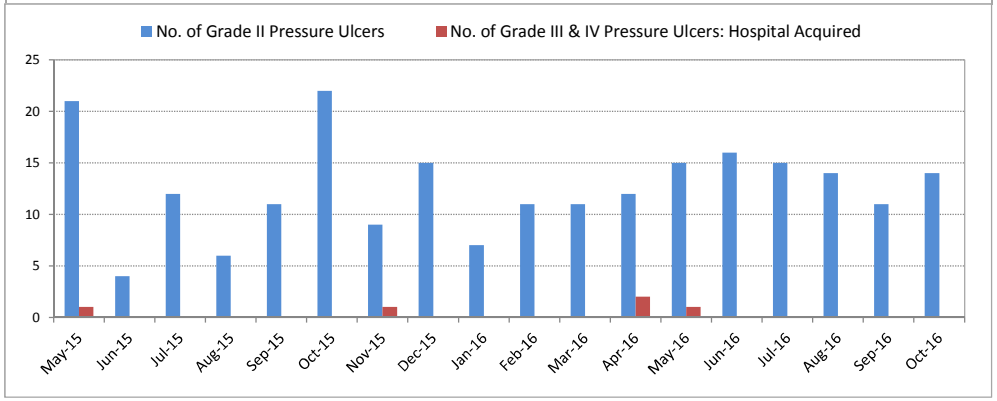


Salisbury NHS
NHS Foundation Trust

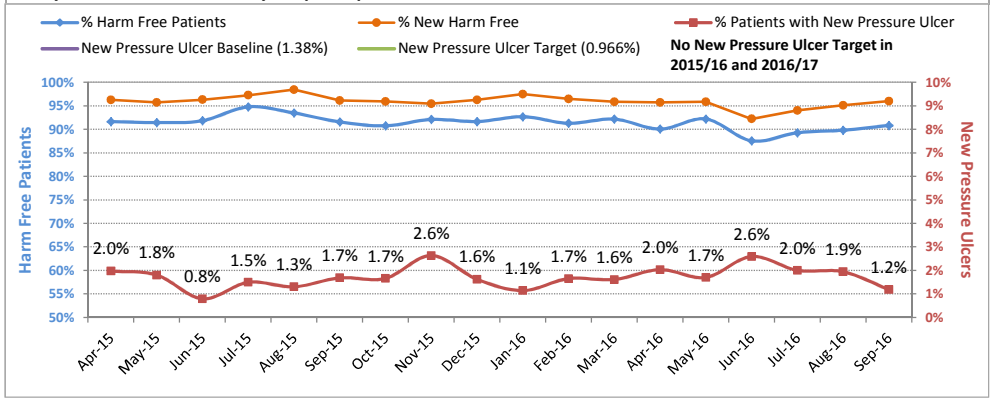
Trust Quality Indicators - October 2016

Quality Measures

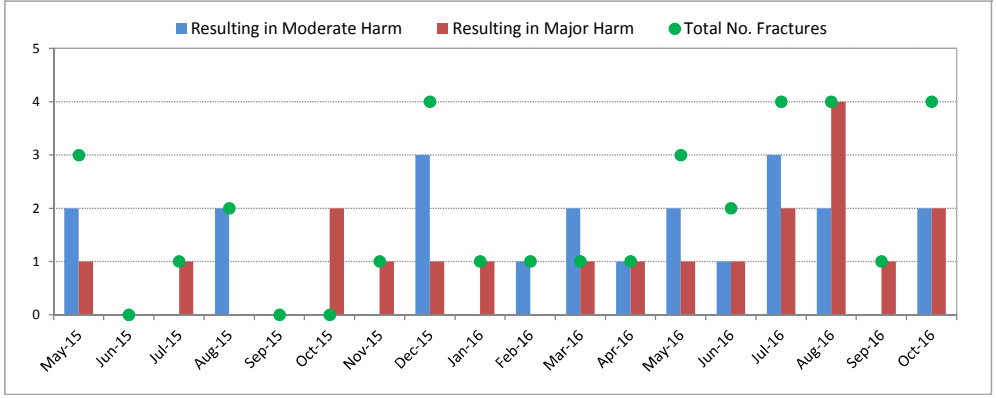
Pressure Ulcers



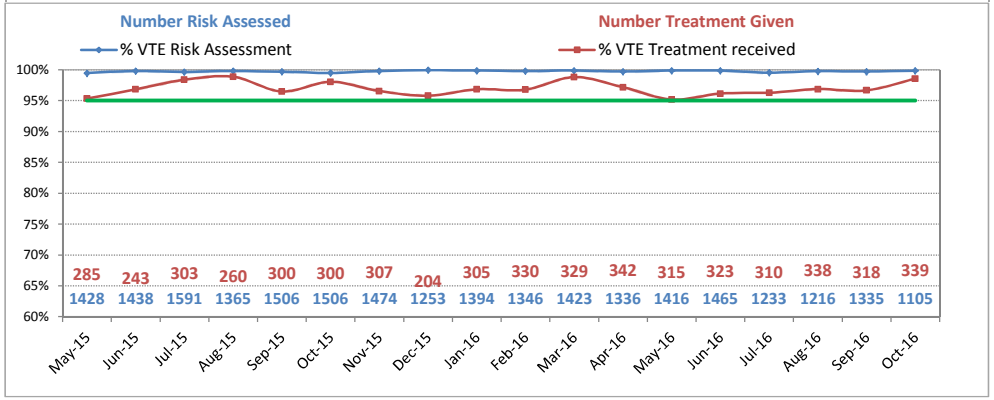
Safety Thermometer - One Day Snapshot per Month



Patient Falls in Hospital

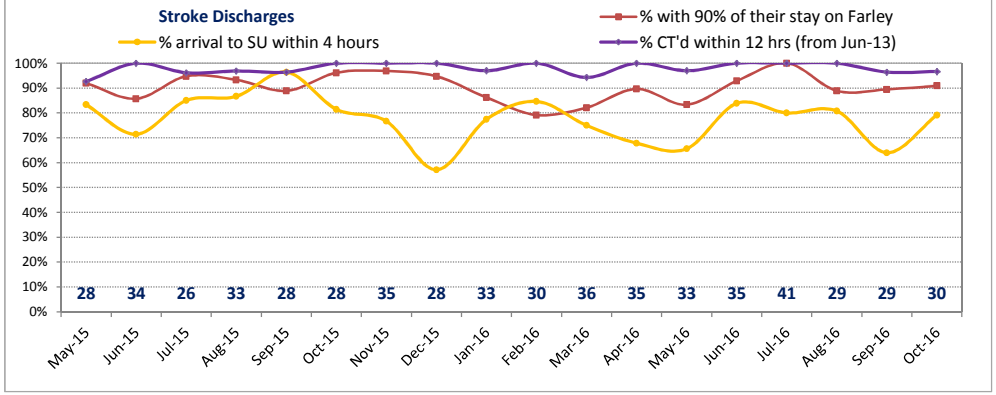


Venous Thrombous Embolism: Risk Assessment & Prophylaxis

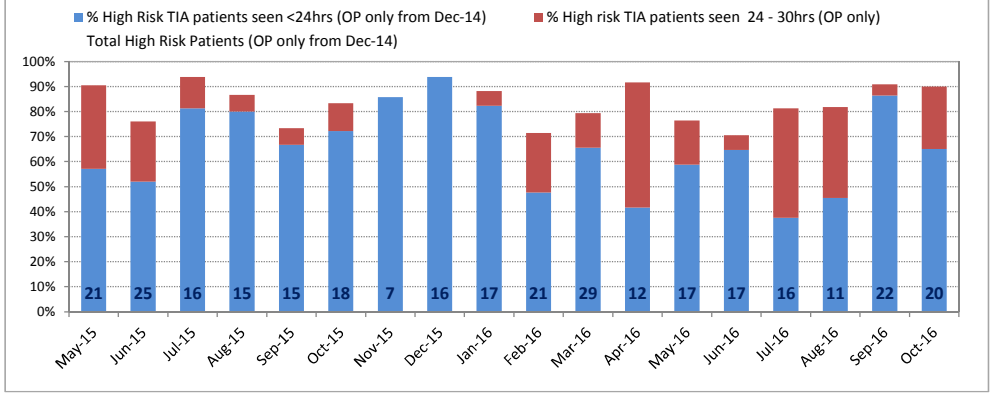


Please note, due to the time it takes to complete Clinical Coding, the current months Fracture Neck of Femur data will be subject to change over the following months.

Stroke Care



TIA Referrals



SSNAP Case Ascertainment Audit

Highest level = Grade A

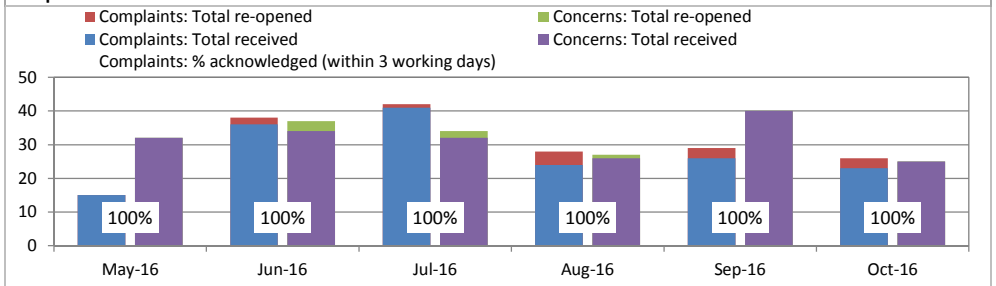
Lowest level = Grade E

Quarterly	Q1	Q2	Q3	Q4
2014-15	B	D	C	C
2015-16	D	C	C	C

Tri-annually	Apr - Jul	Aug - Nov	Dec - Mar
2016-17	B		

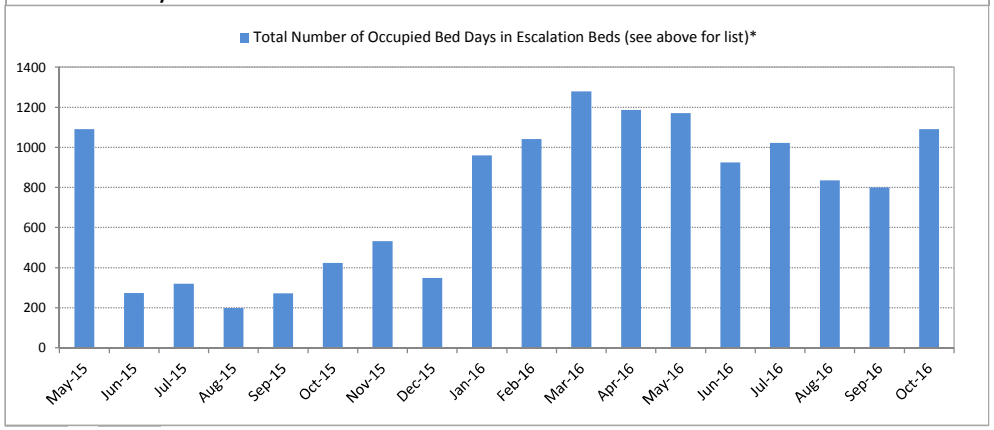
*From April 2016 escalation capacity includes beds on Breamore, DSU, Clarendon, Endoscopy, Avon, Burns cots, Britford SAU overnight stays, Whiteparish AMU overnight stays, Clarendon NHS, Pembroke Suite and Burns assessment room.

Complaints and Concerns

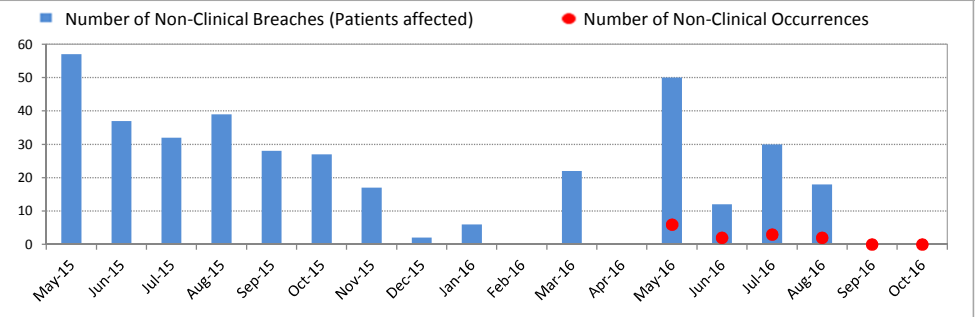


	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Complaints: Total received	15	36	41	24	26	23
Complaints: Total re-opened	0	2	1	4	3	3
Concerns: Total received	32	34	32	26	40	25
Concerns: Total re-opened	0	3	2	1	0	0

Escalation Bed Days

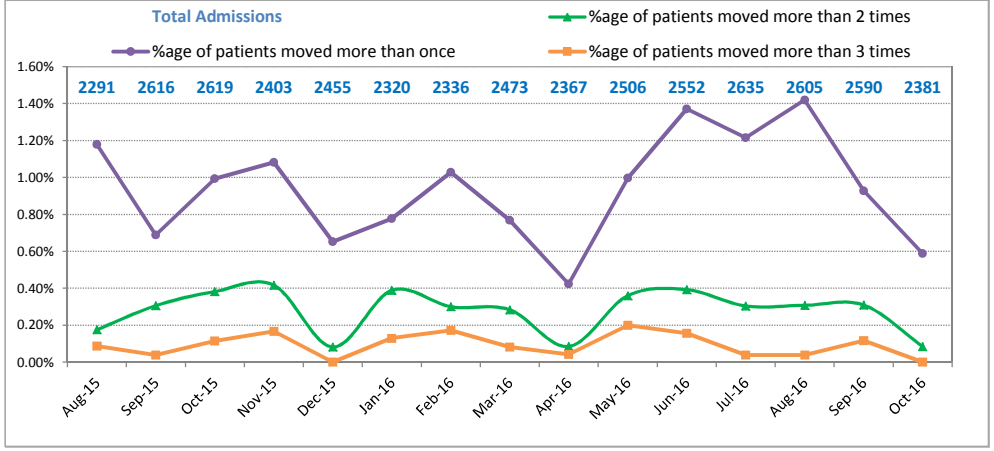


Delivering Same Sex Accommodation



	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
■	57	37	32	39	28	27	17	2	6	0	22	0	50	12	30	18	0	0
●													6	2	3	2	0	0

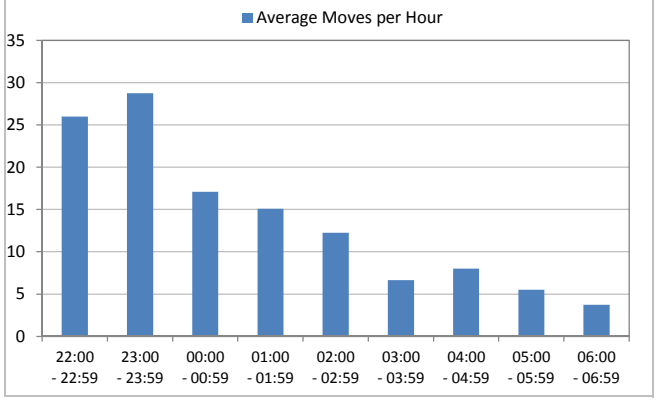
Patients moving multiple times during their Inpatient Stay



Please note, the number of Non-Clinical Breach Ocurrences is being reported from May 2016.

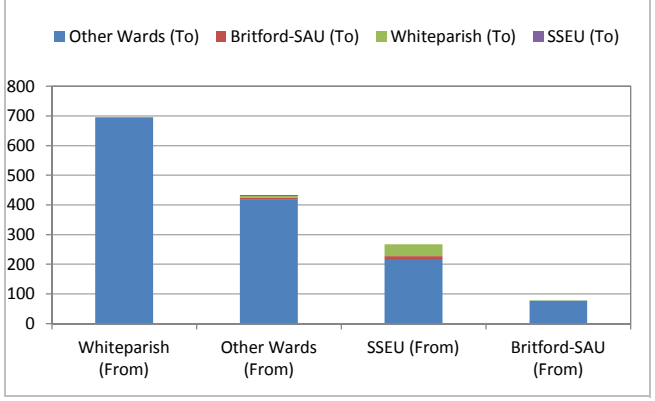
Ward moves between 22:00 and 07:00

01 April 2016 to 31 March 2017



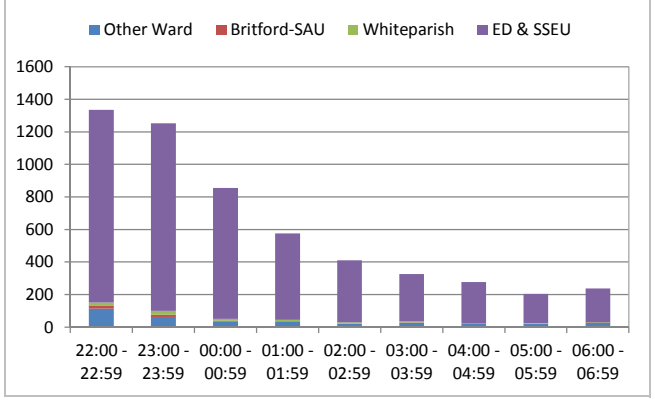
Ward to Ward moves between 22:00 and 07:00

01 April 2016 to 31 March 2017

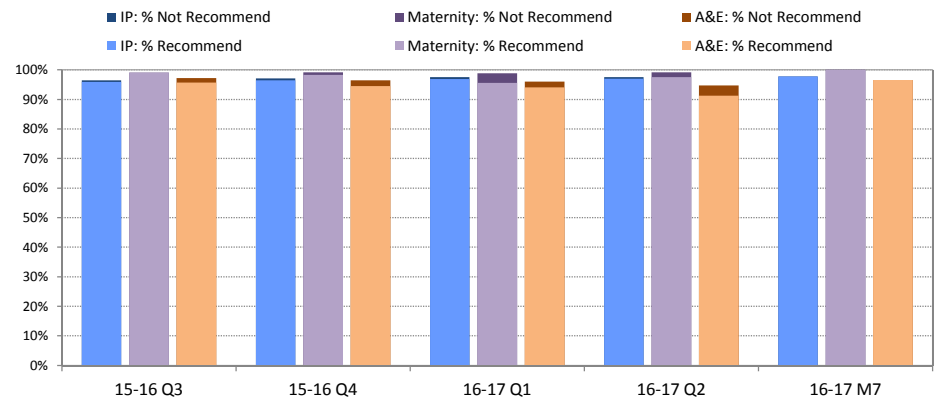


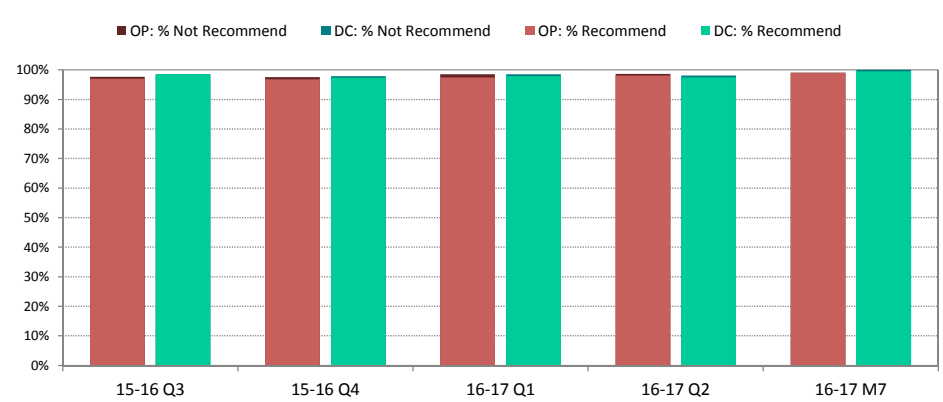
Discharges by Hour

01 April 2016 to 31 March 2017

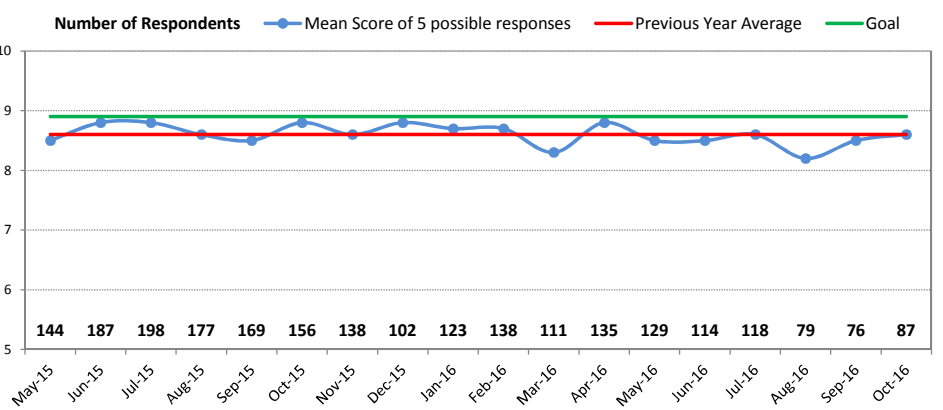


Friends & Family Test: Responses by Area

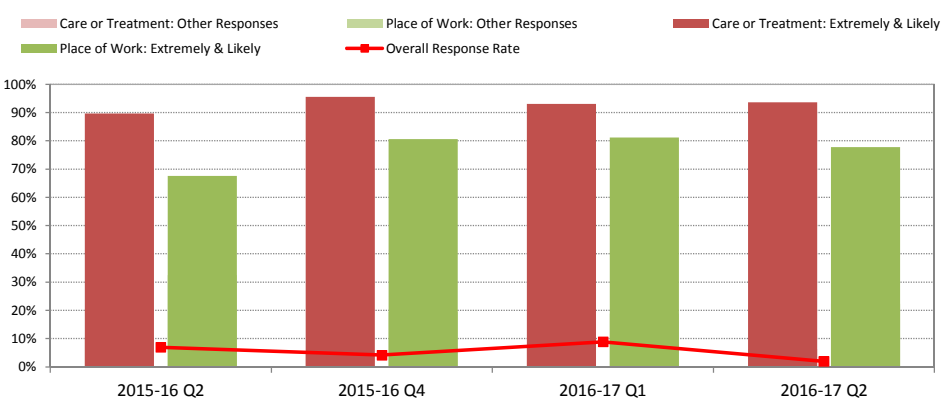




Real Time Feedback: Overall how would you rate the quality of care you received?



Friends & Family Test: Staff (% Responses)



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

Salisbury NHS
NHS Foundation Trust

PAPER: SFT3834

DIRECTOR OF INFECTION PREVENTION AND CONTROL REPORT

PURPOSE: The Director of Infection Prevention and Control (DIPC) 6 monthly update report, together with the monthly Quality Indicator 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 this report is to inform the Trust Board of the progress made against the 2016/17 Annual Action Plan, to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

MAIN ISSUES:
Infection prevention and control is a key risk that has been identified on the Trust's Assurance Framework. The DIPC Report provides significant assurance to Board members that all areas of infection prevention and control are being managed effectively.

HCAI management
During quarters 1 and 2 of 2016/17, there have been no outbreaks.

Mandatory surveillance update
- **MRSA bacteraemia cases –** There have been no MRSA bacteraemia cases identified during the reported period.
- **MSSA bacteraemia cases –** There have been 6 Trust apportioned cases during this reporting period, which is an increase on the previous reporting quarters for 2015/16. All incident review investigations have been presented to the IPCWG members for information and discussion, with no themes identified.
- **Clostridium difficile –** There have been 4 Trust apportioned C.difficile cases during the reported period, which is a decrease on the previous reporting quarters for 2015/16 of 9 cases.
- **Surgical Site Infection Surveillance (SSIS) –** During quarter 1, surgical site infection surveillance was carried out for patients undergoing knee replacement surgery, with no reported infections.

Audit
- **Hand hygiene –** During quarters 1 and 2 of 2016/17, hand hygiene compliance audits have continued to be completed across the clinical directorates. The audit tool captures all of the '5 moments for hand hygiene'. The identified poor compliance area continues to be predominantly missed opportunity number 5, which relates to contact with patient surroundings. The results have been fedback to the relevant Clinical Leaders and DSNs with actions identified, and additional education and support provided for staff groups.
- **Antimicrobial stewardship CQUIN** – The audit plan is now based on the CQUIN requirement and improvements have been documented.

Water Safety Management
- The Trust manages the safety of water systems in line with the appropriate national technical guidance documents. The Trust Water Safety Group (WSG) has been active during 2016 in response to the management of events involving the water systems on site. To assist the management process in respect of the water systems across the site,

regular meetings of teams from Estates Technical Services (ETS) and FES Ltd (PFI maintenance contractor) are held on a monthly basis, to review progress with planned preventative maintenance (PPMs) and actions in respect of water safety.
- Routine sampling continues for legionella and pseudomonas
- The flushing of all outlets in clinical areas across the hospital continues with, non clinical areas self-managing their flushing regime, and reporting direct to ETS.
- An external Water Authorised Engineer (AE) has been appointed by the Trust and is making a positive contribution to the Water Safety Group.

Education and Training:
- **Mandatory training –** Compliance has improved slightly but remains below target across both areas assessed. Executives continue to pursue this issue through the Directorate Performance meetings, and the Infection Control Nurses have increased availability of the drop in hand hygiene sessions for staff. This continues to be a focus through quarters 3 and 4 of 2016/17.

Cleaning services
- The Trust participated in the National PLACE assessment during quarter 4 of 2015/16 (March 8th 2016). A total of 10 wards and the Emergency Department (ED) were visited, 4 food assessments undertaken, 3 outpatient areas as well as external spaces and communal areas were also assessed as required under the PLACE criteria. The results were positive and were published nationally in August 2016. The results from PLACE are analysed and key themes form the basis of improvement plans within the Trust.
- In addition, the report summarises progress in relation to further education, training and innovations, and outlines the updated positions for the decontamination strategy.

ACTION REQUIRED BY THE BOARD:

The Board is asked to:
1. Note the report and how the contents relate to Board assurance.
2. Minute/document that the Board continues to acknowledge their collective responsibility as described above and detailed within the DIPC report.

ATTACHMENT AVAILABLE TO VIEW ON WEBSITE:

The DIPC 6 monthly Update Report 2016/17

Author: Lorna Wilkinson
Title: Director of Nursing & Director of Infection Prevention & Control

Salisbury NHS
NHS Foundation Trust

Director of Infection Prevention & Control (DIPC)

6 monthly update Report 2016/17

Lorna Wilkinson
DIPC

December 2016 (Final v.3)

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 designated to the Director of Infection Prevention & Control (DIPC).

The DIPC annual report and the monthly Key Quality Indicators (KQI) report provide assurance to the Trust Board that prevention and control of infection risks are being managed effectively.

The purpose of the DIPC report is to inform the Trust Board of the progress made against the 2016/17 annual action plan (Appendix 1) 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.

2. Governance Arrangements

The work to achieve the objectives of the Annual Action Plan 2016/17 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and the Clinical Governance Committee (CGC), which completes the governance arrangements (Appendix 2).

3. Infection Control Arrangements

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

The IPCT currently comprises of an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (w.t.e) Infection Control Nurses (ICNs) and secretary (0.61 w.t.e) (Appendix 3). In addition, there are 2 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead.

4. Budget Allocation for Infection Prevention and Control Nursing team

The total budget for the Infection Prevention & Control nursing team is £160K comprising:

Pay	
Nursing	£140K
Administrative	£18K
Non-Pay	
Non- staff	£3K
Income	- £1k

5. Assurance Activity

The Infection Prevention & Control Committee (IPCC)

- 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 IPCT.
- Benchmark the Trust's delivery of control of infection standards in various accreditation systems, and against 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 of Legionellosis and Pseudomonas water management, via the Water Safety Committee.
- Receive regular reports from the Decontamination Committee.
- Provide regular assurance reports to the CGC.

6. HCAI Management and Statistics

6.1 HCAI

The investigation and management of communicable and hospital acquired infections in the Trust is the role that is most often associated with infection control and is an important and visible function of the service.

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, 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 quarters 1 and 2 of 2016/17, the Trust has had **no** declared outbreaks of:

- Staphylococcus aureus, including Methicillin Resistant Staphylococcus aureus (MRSA)
- Methicillin Sensitive Staphylococcus aureus (MSSA)
- Clostridium difficile
- Norovirus
- Carbapenemase producing enterobacteriaceae (CPE)
- Invasive Group A Streptococcus (iGAS)
- Acinetobacter baumannii
- Chickenpox (Varicella zoster)
- Extended Spectrum Beta Lactamase (ESBL) producers
- Pertussis
- Respiratory Syncytial Virus (RSV)
- Influenza
- Vancomycin Resistant Enterococcus (VRE)

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 bed space. 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, with additional written documentation provided to support staff in the ongoing management of these patients.

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

6.2 Carbapenemase Producing Enterobacteriaceae (CPE)
The Trust has continued to implement the PHE toolkit published in December 2013, for the early detection, management and control of Carbapenemase producing enterobacteriaceae across the inpatient and outpatient clinical areas.

Following the increase in the number of cases of CPE infection identified at other regional hospitals, the ICNs have provided advice in relation to the safe transfer of patients to the Trust from other countries or UK hospitals with a known higher prevalence of CPE.

During quarter 1 of 2016/17, a patient known to be previously CPE positive was nursed within the medical and surgical directorates during two inpatient admissions to the Trust.

6.3 Clostridium difficile (C.difficile)
During quarter 2 of 2016/17, a period of increased incidence (PII) of C.difficile was declared internally for an inpatient area within the medical directorate. Both Trust apportioned cases were **not** reportable to PHE and both patients had not been nursed in the same bay/area. However, the ICD arranged for both stool samples to be sent to the External Reference Laboratory for ribotyping.

6.4 Influenza
During quarters 1 and 2 of 2016/17, patients continued to be admitted to the Trust with respiratory and 'flu-like' symptoms. Where there has been a high suspicion of influenza, patients have been isolated within sideroom facilities on admission.

The IPCT provide support and guidance to staff groups within the ward teams in the ongoing management of identified patients, including use of personal protective equipment (PPE).

6.5 Invasive Group A Streptococcus (iGAS)
During quarter 1, there were three cases of invasive Group A streptococcal infection identified for patients admitted to the Trust. These were unrelated cases, and the patients were nursed at separate times within the surgical and medical directorates.

Patients identified with invasive Group A streptococcus were isolated within sideroom facilities, and ongoing management advice was provided by the IPCT.

6.6 MRSA
During quarter 2 of 2016/17, one bay on a medical ward was closed as a direct result of MRSA colonisation in one patient. The management of this bay was in accordance with Trust policy.

The Trust continues to screen patients for MRSA in accordance with national guidelines, with screening either undertaken prior to admission (for planned or elective admissions) or immediately following admission to the Trust (emergency admissions). The Trust is currently reviewing screening processes following the publication of updated national guidance.

6.7 Norovirus
There were no declared outbreaks of Norovirus during quarters 1 and 2 of 2016/17 however the Trust has experienced a continued level of diarrhoea and vomiting activity. This included patients who were admitted with symptoms of diarrhoea and/or vomiting and isolated in a sideroom from admission, and patients who were nursed in a bay environment and developed symptoms during their admission.

6.8 Salmonella

During quarter 2 of 2016/17, two patients who were nursed on a ward within the Clinical Support and Family Services directorate, were identified to be positive for Salmonella, although the cases were not linked. The first patient had been admitted to a sideroom facility on the ward with symptoms attributed to gastroenteritis. The patient was discharged from hospital the following day, and Salmonella was identified from a stool culture taken whilst in hospital. The result was communicated to PHE, for further follow up.

The second patient had returned from recent travel abroad, and was isolated in a sideroom facility on admission due to ongoing symptoms of profuse diarrhoea and fever. Salmonella typhi was identified from a blood culture sample 2 days after admission, and PHE notified in order to instigate the required screening of close family contacts in the community.

Management advice and education was provided to the ward staff by the ICNs, and additional environmental cleaning undertaken by Housekeeping. Patient information leaflets were also accessed to provide additional information.

6.9 PVL Staphylococcus aureus

Panton-Valentine Leukocidin (PVL) is a toxin that is produced by some strains of Staphylococcus aureus (S. aureus), and commonly causes skin infections, cellulitis, abscess formation, boils and carbuncles.

A patient, who had been nursed on a ward within the Clinical Support and Family Services directorate, was identified to be PVL positive following discharge from hospital. Following the receipt of the positive result, and discussion with the Consultant Microbiologist a number of actions were undertaken to include the completion of terminal environmental cleaning of the room occupied by the patient whilst on the ward, and identification of any patients nursed in the same area.

6.10 Vancomycin Resistant Enterococcus (VRE)

During quarters 1 and 2 of 2016/17, new cases of VRE have been identified, with a number of patients also identified to be VRE positive either in the community, or on admission to the Trust. When inpatient cases have been identified, required actions were agreed following discussion with a Consultant Microbiologist. These have included strict isolation precautions, the completion of additional environmental and equipment cleaning, and where indicated screening of identified patient contacts, with the continuation of antibiotic stewardship.

Patients previously VRE positive require isolation in a sideroom facility on admission wherever possible, and risk assessments undertaken to identify those patients suitable to be safely managed within bays. Although currently there is no plan to cohort VRE positive patients, this may be a consideration for the future.

7. Mandatory Surveillance

7.1 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; various surgical procedures 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.

- The category for knee replacement surgery was commenced on 1st April 2016, and by 30th June 2016 the required number of new patients undergoing knee replacement surgery had not been achieved. Therefore, the decision was made to extend the data collection period to the end of quarter 2 (2016/17), in order to achieve a comparable cohort.
- The final cohort for quarter 1 of 2016/7, consisted of 50 patients, and identified no surgical site infections, as defined by the criteria set by PHE. The data was submitted to PHE within the agreed timeframe.
- During quarter 2 (2016/17), the ICNs completed active surveillance data collection and follow up for patients who had undergone knee replacement surgery during the previous quarter.
- Data collection will be finalised during quarter 3 of 2016/17, with end of category result updates for knee replacement surgery being presented at the IPCC meeting in January 2017.

Formal reports outlining progress with SSIS were presented at the IPCC meetings and disseminated to relevant Trust personnel.

7.2 Methicillin Resistant Staphylococcus aureus (MRSA)

The Department of Health (DH) Mandatory MRSA Bacteraemia Surveillance scheme is used to measure the effectiveness of infection prevention & control practices in all NHS Trusts. The rationale for the surveillance is that it is sometimes difficult to distinguish between colonisation and true infection caused by MRSA, but culture of the bacterium from blood almost always represents significant infection.

The Trust continues to undertake MRSA screening for all elective and emergency admissions to ensure continued improvement in reducing infections. MRSA screening compliance rates are monitored by the Directorate Management Teams (DMT) and reported as a key quality performance indicator. The ICNs undertake a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit. Feedback is provided to DMT's about compliance rates and any identified missed screens for follow up actions and outcome reported to the Matrons Monitoring Group (MMG).

Tables 1 and **2** below relate to the overall compliance for both elective admission and emergency admission MRSA screening audit figures, for 1st April 2016 to 30th September 2016. Figures are provided for April 2015 to September 2015 for comparison.

Table 1: MRSA Compliance Data – Elective Admissions

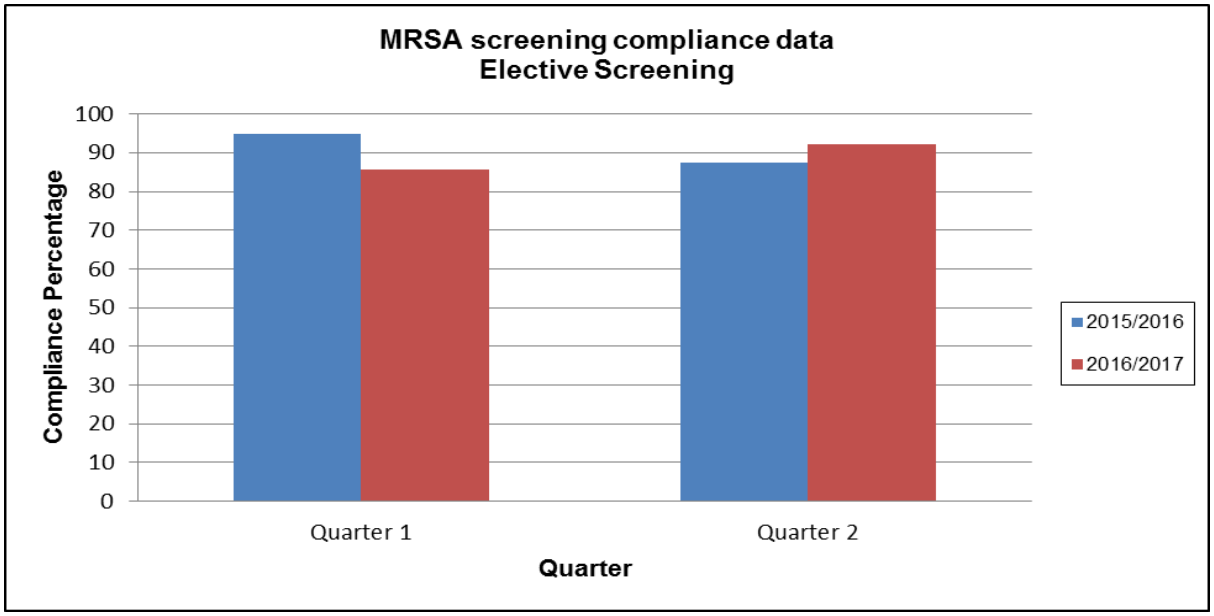
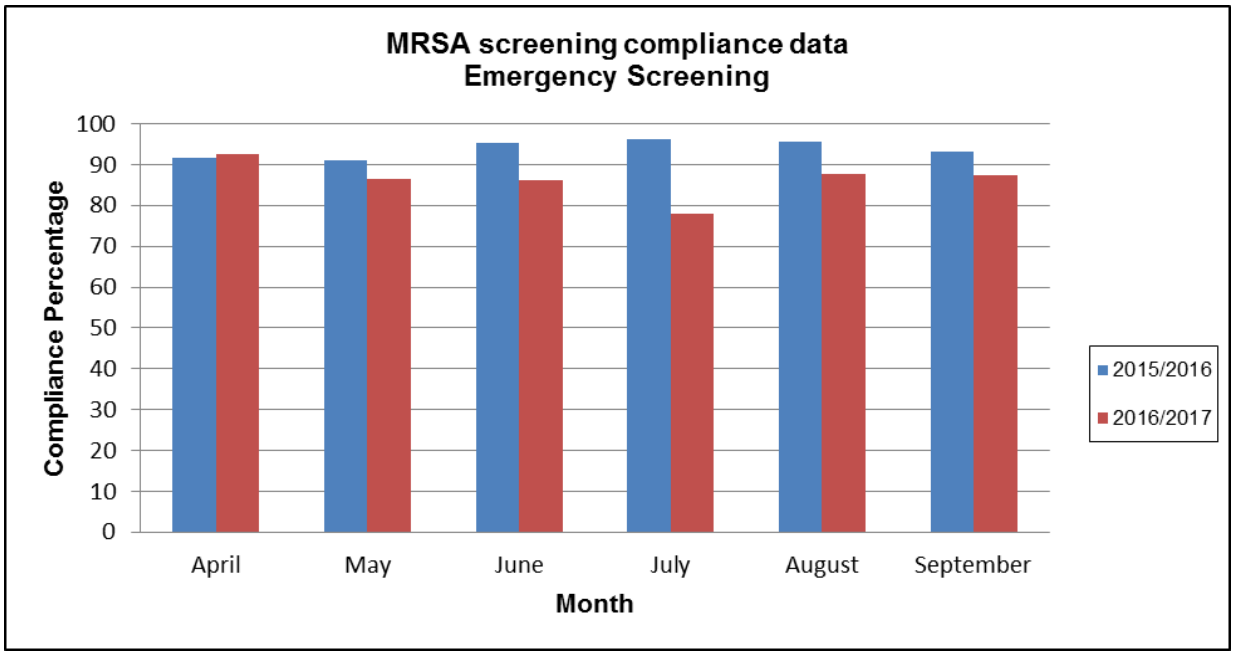


Table 2: MRSA Compliance Data – Emergency Admissions



Overall emergency screening compliance rates have fallen. Feedback received from the clinical areas indicates that the increased patient activity has contributed to this workload. The ICNs continue to support areas to ensure an improvement with screening compliance.

The Trust continues to report mandatory surveillance in line with PHE requirements onto the national HCAI Data Capture System. 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.

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').

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

Table 3: Breakdown of total number of Trust cases recorded April 2016 to Sept 2016 (Figures in brackets show number of cases recorded April 2015 to Sept 2015)

	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)**	**0 (0)**	**0 (0)**	**0 (0)**	**1 (2)**	**0 (0)**							**1 (2)**
Non Trust apportioned cases	0 (0)	0 (0)	0 (0)	0 (0)	1 (2)	0 (0)							**1 (2)**
Trust apportioned cases	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)							**0 (0)**

The Trust's MRSA Trust apportioned cases target for 2016/17 is zero, which has been achieved to date. A Post Infection Review (PIR) investigation was undertaken by the relevant Clinical Commissioning Group (CCG) for the non-Trust apportioned case identified during August 2016. The case was assigned to the CCG.

7.3 Clostridium 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.

7.4 Monitoring and diagnostic C.difficile testing

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.

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.

All patients with a stool sample confirming the presence of C.difficile require the implementation of strict infection control measures and practice, e.g. isolation in a sideroom facility, the completion of terminal and enhanced cleaning by Housekeeping and a review by the relevant clinicians to determine if C.difficile treatment is indicated. The formal reporting process to PHE is managed by the ICNs under direction of the DIPC and ICD, and has had an impact on the team's workload.

Table 4 below relates to the breakdown of all inpatient reportable cases of C.difficile. Table 5 relates to the total reportable cases of C.difficile recorded by the Trust.

Table 4: Breakdown of reportable cases recorded for all inpatients April 2016 to Sept 2016 (Figures in brackets show number of inpatient reportable cases April 2015 to Sept 2015)

	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 (1)**	**1 (3)**	**0 (2)**	**0 (3)**	**1 (3)**							**4 (12)**
Non Trust apportioned cases	0 (0)	0 (0)	0 (0)	0 (1)	0 (1)	0 (1)							**0 (3)**
Trust apportioned cases	2 (0)	0 (1)	1 (3)	0 (1)	0 (2)	1 (2)							**4 (9)**

Table 5: Breakdown of total number of reportable C.difficile cases recorded April 2016 to Sept 2016 (Figures in brackets show total number of reportable cases recorded April 2015 to Sept 2015)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Inpatients	**2 (0)**	**0 (1)**	**1 (3)**	**0 (2)**	**0 (3)**	**1 (3)**							**4 (12)**
Community Hospitals	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)							**0 (0)**
General Practitioners (GPs)	2 (4)	2 (1)	0 (1)	1 (0)	0 (2)	1 (3)							**6 (11)**
Residential/Nursing Home	0 (0)	0 (0)	0 (0)	0 (1)	0 (0)	0 (0)							**0 (1)**
Other (e.g. Coroner, Private Hospital, Day Attender, A&E, Outpatient)	0 (1)	1 (1)	0 (0)	1 (1)	0 (0)	0 (0)							**2 (3)**
Total	**4 (5)**	**3 (3)**	**1 (4)**	**2 (4)**	**0 (5)**	**2 (6)**							**12 (27)**

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

The Trust's reported four Trust apportioned C.difficile cases for quarters 1 and 2 of 2016/17 which did not exceed the target set for the Trust by NHS England of 19 for the full year. For each inpatient episode, an infection control incident investigation is completed. This process is led by the ICNs, with the increased involvement of staff in the relevant clinical areas and the Antimicrobial Pharmacist (or area Pharmacist), to complete the required documentation.

Key findings and learning are identified and reported to relevant staff via e-mail, with an appropriate action plan for implementation. Actions taken include patient education and completion of High Impact Intervention (HII) auditing, to ensure the safe management of these patients. Action is taken when non-compliance with Trust policy is identified.

Multidisciplinary C.difficile ward rounds have continued, with the involvement of the ICD and/or Consultant Microbiologist, ICNs and Antimicrobial Pharmacist. 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. The group members also ensure that information is shared with the ward teams and this is supported by an entry within the patient healthcare records. The membership of this group has been reviewed, and a Gastroenterologist and Dietician will be involved as required.

7.5 Methicillin Sensitive Staphylococcus aureus (MSSA)

The Trust continues to report MSSA bacteraemia cases via the HCAI Data Capture System. 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 6: MSSA bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2016 to Sept 2016
(Figures in brackets show number of cases recorded April 2015 to Sept 2015)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**5 (3)**	**4 (2)**	**6 (1)**	**5 (2)**	**4 (2)**	**0 (6)**							**24 (16)**
Non Trust apportioned cases	5 (3)	3 (2)	2 (1)	4 (2)	4 (2)	0 (5)							**18 (15)**
Trust apportioned cases	0 (0)	1 (0)	4 (0)	1 (0)	0 (0)	0 (1)							**6 (1)**

During quarters 1 and 2 of 2016/17, there have been 6 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. During quarter 2, the DIPC requested all incident review investigations be presented to the IPCWG members for information and discussion.

Emphasis has been placed on the need for continued monitoring of 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.

7.6 Escherichia coli (E.coli)

The Trust continues to input data in accordance with current guidance from the DH and the PHE. Currently, there is no national guidance for data definition of E.coli bacteraemia cases for targets to be set. 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 7: E.coli Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2016 to Sept 2016
(Figures in brackets show total number of cases recorded from April 2015 to Sept 2015)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**11 (6)**	**6 (9)**	**8 (10)**	**13 (11)**	**8 (12)**	**12 (7)**							**58 (55)**
Non Trust apportioned cases	10 (6)	5 (7)	5 (8)	9 (10)	7 (9)	12 (6)							**48 (46)**
Trust apportioned cases	1 (0)	1 (2)	3 (2)	4 (1)	1 (3)	0 (1)							**10 (9)**

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 to determine.

Of the 10 Trust apportioned cases identified during quarters 1 and 2 of 2016/17, 3 were determined as likely HCAI related, 6 cases as possibly HCAI related and for one case it was not known if it was HCAI related. This data was entered onto the HCAI Data Capture site. Where concern is highlighted by the Microbiologist for an individual case, further investigation is undertaken. For these Trust apportioned cases, no further follow up was identified.

8. Hand Hygiene

All inpatient and outpatient clinical areas are required to undertake monthly hand hygiene audits. Compliance rates are calculated, and individual tables are produced for each area within the directorates. These are provided to clinical leaders, DMTs and DIPC via the monthly Matrons Monitoring Group (MMG) meetings.

To promote hand hygiene best practice, a Uniform Policy and Workwear Guidance including 'Bare Below the Elbow' (BBE) policy remains in place. Compliance with the policy and audit results is monitored by the DMTs and feedback provided to the DIPC.

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the directorates of measures implemented to improve non- compliance. This target is reflected in the clinical leaders and DSNs personal objectives, with ongoing work required by the DMTs to sustain improvements. To promote hand hygiene compliance the ICNs continuing to train and update the Infection Control Link Professionals (ICLPs) to undertake hand hygiene assessments for staff in their own areas. This has proved successful in raising the profile of hand hygiene behaviour and compliance with BBE. It also provides an alternative opportunity for staff to complete their annual mandatory hand hygiene assessment. The directorates are encouraged to share successes within individual areas at the MMG meetings.

Analysis of the hand hygiene audit data demonstrates that the key factors influencing the compliance scores are

- Non completion of audits by areas
- Non compliance with hand decontamination by other staff groups, lowering the overall score for the area concerned
- Audit delegated to a staff member(s) unfamiliar with the audit process

When compliance is poor the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results are now 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.

The ICNs have continued to facilitate the completion of hand hygiene audits by an external auditor, the Healthcare Manager for GOJO Industries, across selected clinical areas. The external auditor utilised the World Health Organisation (WHO) hand hygiene audit tool, and assessed the hand hygiene practices of all staff groups against the '5 moments for hand hygiene':

- Moment 1: Before patient contact
- Moment 2: Before a clean/aseptic procedure
- Moment 3: After body fluid exposure risk
- Moment 4: After patient contact
- Moment 5: After contact with patient surroundings

For quarters 1 and 2 of 2016/17, the overall compliance rate from external auditing of 7 inpatient and outpatient areas was 78.6%. This is a slight compliance increase on the previously reported

overall compliance of 69.3% from auditing of 9 inpatient clinical areas during the same period in 2015/16.

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 the audit findings.

The IPCWG members agreed a provisional 'Red, Amber and Green' rating for the hand hygiene compliance audits. This included 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.

The number of hand hygiene assessment sessions facilitated by the ICNs has increased to weekly, which is in addition to the assessments undertaken as part of planned educational sessions completed by the team, plus assessments undertaken by ICLPs and trained assessors. Table 8 below demonstrates the total number of sessions undertaken and attendees.

Table 8: Additional Hand Hygiene Sessions

2016/17 Month	Total number of hand hygiene sessions held using a UV light box	Total number of attendees
April	15	285
May	15	284
June	18	399
July	8	197
August	21	398
September	20	367
TOTAL	**97**	**1930**

9. 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 (Appendix 4). 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 quarters 1 and 2 of 2016/17, including the follow up and outcomes from auditing against infection control policies. Reports are generated for each completed audit and resulting action plans approved by the IPCWG. In addition, the following formal reports were presented to CMB in August 2016 (reports are available from the IPCT):

- 2% Chlorhexidine Gluconate in 70% Alcohol Isopropyl Wipes.
- Handling & Disposal of Linen
- MRSA Prescription Treatment & Monitoring Pathway, & Isolation Policy

The ICNs continue to undertake additional observational audits of staff practices within clinical areas. Feedback is provided at the time of the audit to the nurse in charge, and where non-compliance has been identified this is addressed with the individual staff member. Feedback is provided to the relevant Clinical Leader. Practice observations have included application of standard precautions, isolation nursing precautions and linen management.

The monthly audit programme for the safe use of mattresses continues and is led by the Medical Devices Management Centre (MDMC), with six monthly reporting to the MMG. In addition, the Trust identified the requirement to ensure that patient pillows are fit for purpose and a mechanism

for monitoring in place. Guidance for staff to ensure pillows remain fit for purpose and are replaced when required is available in the linen policy. Work is underway via MMG to ensure ward staff are conversant with this guidance.

All approved audit reports generated by the ICNs are uploaded on to the Clinical Audit electronic database system, accessible via the Trust intranet site. This ensures the opportunity for all staff groups to access this important audit work.

10. Innovations

The IPCWG continue to lead the review of technologies and innovations related to the reduction of HCAIs, with the involvement of key personnel across the Trust site. This has been incorporated as a standing agenda item at the IPCWG meetings, with innovations measured against the best practice evidence/research available, which has included DH recommendations.

The IPCWG continue to strive to ensure that the Trust implements only those technologies and innovations that have been peer reviewed and appropriately approved. During quarters 1 and 2, the use of the GLOSAIR 400 room decontamination system (RDS) has been undertaken and additional hydrogen peroxide vapour (HPV) machines investigated. In addition, the use of ultraviolet (UV) rays for disinfection purposes has also been explored, with feedback reported via the IPCWG.

11. Antibiotic Prescribing *(information provided by Emma Taylor, Principal Pharmacist Antibiotics)*

The Antibiotic Reference Group (ARG) meets monthly to maintain oversight of the issues relating to antimicrobial use in the Trust and the community services. The group review of audits results provides the assurance required of the appropriate antimicrobial stewardship. The group develops practice guidelines to support practice improvement.

Guideline development/review

The ARG continually works to ensure policies on ICID (the trust guidelines database) are easily accessible and up to date.

Guidelines reviewed this year to date:

- Antifungal guidelines
- Surgical Antimicrobial policy
- Sepsis of Unknown Origin / Septic Shock
- Diabetic Foot Guideline
- GUM guideline

Audit

Regular Antimicrobial Stewardship Audits

The way in which antimicrobial stewardship audits are undertaken has changed significantly this year, largely due to the antimicrobial stewardship CQUIN agreed for 2016/17. The ARG has taken the decision that in order to ensure work is not duplicated we will cease to undertake the 'rolling programme of audit' instead basing our audit plan going forward on the CQUIN requirement.

Clostridium difficile – Antibiotic Treatment Review

All cases of C.difficile are reviewed by a member of the Pharmacy team, to ascertain whether past or current antibiotic treatment may have been a contributory factor. Other medications which may impact upon the patients clinical conditions are also noted and reviewed i.e. use of laxatives, antimotility drugs, proton pump inhibitors (PPIs).

Ward Rounds

A designated Senior Pharmacist attends the multidisciplinary ward rounds when required. This is undertaken by a Consultant Microbiologist together with the ICNs. It provides an opportunity to

review the treatment and management of inpatient C.difficile cases, and is also a forum to discuss any management issues or concerns. In addition, the group will liaise with the appropriate clinicians/nursing staff for the patient if required, and an entry is made within the healthcare records.

Antibiotic Awareness Day
An 'Antibiotic Awareness Day' campaign is planned during quarter 3, for which the Trust will be involved.

Risk Management
Any concerning incident reports (DATIX) relating to or involving antibiotics are highlighted at the ARG to identify any trends.

Defined daily doses (DDD)
As recommended in the DH document 'C.difficile – How to deal with the problem', a mechanism for capturing DDD data is in place. This is necessary to ensure cost effective use of antimicrobials and it also allows the Trust to monitor drug usage and compare it to that of other Trusts.

The following drug usage reports are provided to the ARG every six months:

- Cephalosporins, Ciprofloxacin, Clindamycin and Co-amoxiclav
- Ceftazidime, Cefalexin and Cefaclor
- Daptomycin, Vancomycin, Teicoplanin and Linezolid
- Imipenem, Meropenem, Ertapenem and Tazocin
- Clindamycin, Clarithromycin and Doxycyline

National Antimicrobial Commissioning for Quality & Innovation (CQUIN) 2016/17
This year a national CQUIN around Antimicrobial Resistance and Stewardship has been agreed, with standards as follows:

- **CQUIN 5a –** Reduction in antibiotic consumption (as DDDs) per 1000 admissions (3 parts)
    1: Reduction of total antibiotic consumption (DDDs per 1000 admissions)
    2: Reduction in total consumption of Carbapenems (DDDs per 1000 admissions)
    3 Reduction in total consumption of Piperacillin/Tazobactam (DDDs per 1000 admissions)

All of the above must be reduced by 1% of 2013/2014 values.

- **CQUIN 5b –** Empiric Review of Antibiotic prescriptions

A local audit of 50 antibiotic prescriptions per month is undertaken, to ascertain if a documented review has taken place at 72 hours. Milestones set for the CQUIN as follows: Quarter 1 = 25%; Quarter 2 = 50%; Quarter 3 = 75% and Quarter 4 = 90%.

Data has been collected and audits undertaken as per the CQUIN requirements. Awareness of this work has also been raised through the following forums: presentation at Trust Clinical Governance Core Session; discussion at F1 and F2 training sessions; presentation at the Nursing, Midwifery & Allied Health Professionals (AHPs) Forum and training sessions for Pharmacy staff. The antimicrobial stewardship team have also arranged to attend a variety of clinicians meetings going forward.

- **Part 5a –** Consumption

Table 9 below shows the change in antibiotic consumption against the baseline of 2013/2014 consumption data. It clearly exhibits that a significant reduction in consumption has been elicited in each of the three groups and suggests that we are on track to meet the CQUIN target for Carbapenems and All Antibiotics.

Unfortunately, due to the fact that Piperacillin/Tazobactam usage has increased so greatly since 2013/14 this reduction is still, as yet, not sufficient to bring our usage to 1% lower than 2013/14 levels as required.

	2013/14	2014/15	2015/16	2016/17 average to date
Carbapenems	0	7.2	-14.4	-44.5
Piperacillin/Tazobactam	0	20.7	18.8	8.7
All Antibiotics	0	1.0	-1.0	-8.4

- **Part 5b –** Prescription review within 72 hrs

Quarter 2 data showed that a documented review within 72 hrs had taken place for 89.3% of prescriptions audited. This is an improvement on quarter 1 results (of 85%) and easily meets the 50% target stipulated for the end of quarter 2; almost reaching the final target of 90% required by the end of quarter 4.

12. Decontamination *(information provided by Robert Warburton, Decontamination Lead and Sterilisation and Disinfection Unit (SDU) Manager)*

The decontamination lead attends and advises the Theatre Risk Group and the Endoscopy Clinical Group. The Trust Decontamination Group has quarterly meetings, with formal feedback to the IPCWG and IPCC.

12.1 Progress against Decontamination Strategy

The Decontamination Strategy remains in place with aspects of key objectives reviewed at each decontamination meeting. Risk assessments are monitored and updated when necessary.

12.2 Activity to promote compliance with decontamination arrangements

- Decontamination Policy and CJD Policy has been reviewed and in place
- Tray Tracking – the Trust progressed this work with Synergy Health PLC as part of the joint venture with Sterile Supplies Limited (SSL) and launched the new tracking system on 19th September 2016. The 'go live' was very successful with a great deal of support provided from Synergy staff to help train and advise clinical staff. This has also been 'rolled out' into Main Theatres and the Day Surgery Unit (DSU).
- Instrumentation – Inventory audits have taken place to identify capital requirements. Procurement, Main Theatres and SSL have met with the Instrumentation supplier and reviewed the quality of the instrumentation. The meeting was very productive and 'fit for use' devices should be in circulation by November 2016.
- Holes in tray wraps are an ongoing issue the main causes are storage and handling in user locations and transportation. The Sterilisation and Decontamination Unit (SDU) and the Main Theatre Department have worked collaboratively to provide a permanent solution, with the replacement of theatre racking and SDU trolleys.
- The SDU continues to process all flexi scopes used within the Trust including the additional weekend lists for the Endoscopy Department, evening lists in Ear Nose and Throat Outpatients department and lists in Obstetrics & Gynaecology. Speech Therapy has also been included into the central decontamination of flexible endoscopes. This ensures all endoscope decontamination takes place in fully compliant washers and is in line with MDS DB2002 (05).

12.3 Decontamination Audit plan

For quarters 1 and 2 of 2016/17, review audits have been conducted in the Day Surgery Unit (on two occasions), Oncology, Intensive Care Unit (ICU), Spinal Unit, Cardiac Suite, Ear, Nose and Throat (ENT) Outpatients Department and the Maternity Unit. Good progress had been made against actions identified from the previous audits which were forwarded to the directorate teams and area leads.

12.4 Maintaining a fully complaint SDU

The SDU continues to maintain compliance and accreditation to the latest European Standards in Sterile Services. However, SDU has now transferred to the joint venture under the company name of Sterile Services Limited (SSL). So far this has been successful with the Trust experiencing the benefits of an average '21 hour' turnaround on sets. This is creating new challenges to Theatre management for example, storage space available to hold all their equipment.

12.5 The Decontamination Committee

The decontamination committee has oversight of the usage of equipment around the Trust such as bedpan washers, mortuary washing machine, endoscope washer disinfector, cabinet washer disinfectors, and autoclaves in SDU and the pathology laboratory which ensure safe conditions are maintained. However, this does not include any SSL equipment.

The decontamination committee scrutinises test results and planned preventative maintenance schedules for Trust decontamination equipment to ensure safety and compliance is achieved.

12.6 Choice Framework Documents (CFPP)

The Choice Framework Documents 01-01 'Management and Decontamination of Surgical Instruments used in acute care' and 'Choice Framework for Local Policy and Procedures 01-06: Reprocessing of flexible endoscopes: management and decontamination', are planned to revert to Health Technical Memorandums (HTMs). These were published June 2016 and the Trust will need to review and action any applicable changes to machine testing. The majority of these standards will relate to SSL operations.

13. Education and Training Activities

It is widely recognised that ongoing education in infection control is required in order to improve health care worker compliance with infection prevention and control practices. The ICNs undertake a number of induction and educational updates to a wide range of key staff within the Trust. The ICNs keep attendance data from these sessions and supports the Trust in its delivery of mandatory education for all staff. The infection prevention and control computer based learning (CBL) package is accessible for all staff on the MLE via the Trust intranet site.

At the request of the Trust Board, the figures presented in Appendix 5 reflect the percentage of staff in each directorate that have completed a hand hygiene assessment at the end of each quarter and identifies the figures for the IP&C computer based learning (CBL) modules completed via the intranet site during quarters 1 and 2 of 2016/17.

The ICNs have continues to focus on the promotion of opportunities for staff to complete their hand hygiene assessment. This has included arranging sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the musculoskeletal DMT facilitated the completion of hand hygiene assessments for staff by utilising a UV light box for rotation through the 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.

14. 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 over quarters 1 and 2 of 2016/17. This includes monitoring, remedial action that has been taken in respect of the management of the water systems.

The Trust manages the safety of water systems in line with the HTM 04-01 (Part B) Safe Water in Healthcare Premises and HTM 04-01 (Part C) Pseudomonas aeruginosa (guidance for augmented care units), together with the technical guidance document HSG 274 Part 2.

The Trust Water Safety Group (WSG) has been active during 2016 in response to the management of events involving the water systems on site. The WSG is formed of technical and non-technical staff that can recommend, change and enforce issues relating to water safety across the Trust. The WSG includes representatives from all of the high risk areas identified in the policy and the Trust's independent advisor (Mr Daniel Pitcher), Authorising Engineer (AE).

To assist the management process in respect of the water systems across the site, regular meetings of teams (RP and dRP water) from Estates Technical Services (ETS) and FES Ltd (PFI maintenance contractor) are held on a monthly basis, to review progress with planned preventative maintenance (PPMs) and actions in respect of water safety.

The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution in the challenge of Legionella control. 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.

14.1 Routine water sampling results (Legionella)

Further rounds of legionella sampling commenced in September 2016 and 50 separate outlets have been sampled to date (400 + routine samples are taken on an annual basis).

All positive samples are managed in line with the Trust's Water Safety policy. Table 10 below lists the outlets which are being resampled in line with the Trust policy. In cases where the levels recorded have exceeded the 1000 cfu/l threshold, a meeting has been called and an action plan agreed to reduce the risks to patients and staff.

	Ward / Department	Location	DATIX
1	Amesbury Suite	Level 4 Sector 10	90229
2	Chilmark Ward	Level 4 Sector 10	90229
3	Emergency Department	Level 3 Sector 1	97579, 97999, 98071
4	Nunton Unit	Level 2 Sector 1	
5	Farley/Durrington Wards	Level 2 Sector 2	97655, 98069
6	Pre Op Assessment Unit (POAU)	Block 81	

Several emergency review meetings have taken place in the Trust as a result of the sample results. The actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of e-mails as events occur, and as regular reports to the WSG and IPCC. Actions taken have included the cleaning and disinfection of outlets, with temperature checks and increased flushing where necessary.

14.2 Routine water sampling results (Pseudomonas)

Routine sampling (six monthly of 250 + outlets) for Pseudomonas is completed in the following augmented areas: Avon Ward, Burns Unit, Neonatal Unit (NNU), ITU and Pembroke Unit.

14.3 Flushing

The flushing of all outlets in clinical areas across the hospital continues, with the total percentage of flushing for quarters 1 and 2 at 52%. These low rates of flushing were due to issues with labour resource (sickness), which have now been resolved. It is anticipated that the level of compliance in this area should now improve. Office and support areas (non-clinical) are required in line with the amended water safety policy to self-manage the flushing regime, and report this direct to ETS.

14.4 Copper/Silver Ionisation Plant

There have been no recorded issues. Regular maintenance continues on the Silver/Copper ionisation plant serving the Spinal Unit and central areas of the hospital supporting the overall management of Legionella prevention.

14.5 Independent advice

The Trust has appointed Mr Daniel Pitcher of the Water Hygiene Centre as Water AE in line with recommendation of HTM 00. Mr Pitcher attended the WSG on the 23rd of September, and has made some recommendations for the Trust which include the following:

i. Water Safety Policy, review and separate policy and procedure
ii. Record keeping, introduce a new filing system, and review records
iii. Training updates are required for all staff as appropriate to their roles
iv. Review augmented areas
v. Review sampling frequency for Legionella

14.6 Drain Blockages

There has been a significant improvement in this area overall, however it is clear that the message in respect of the correct disposal of wipes and handtowels must continue. This is now highlighted on all 'staff induction' days.

15. Cleaning Services *(information provided by Michelle Sadler, Facilities Manager)*

This section summarises the key components of the Trust's cleaning programme, to ensure the provision of a safe clean environment for patients and their relatives, visitors and staff. This ongoing work is provided by the Housekeeping Department and Facilities directorate.

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

The Trust has developed and implemented a programme of PLACE audits for 2016/17 and plans to undertake 50 internal PLACE assessments between August 2016 and March 2017.

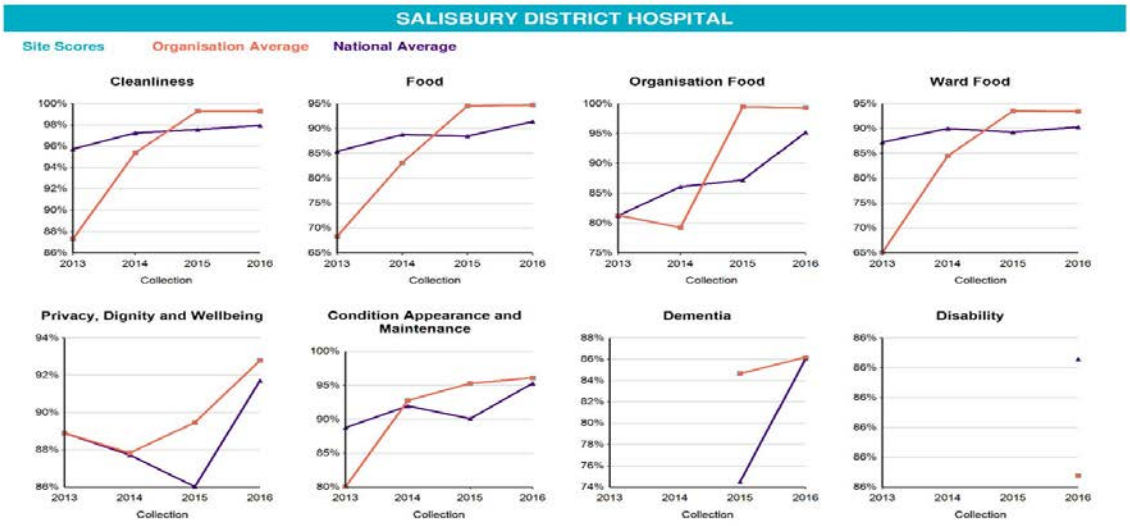
We continue to achieve active engagement and good support from Governors, Volunteers and the local Health Watch representatives to undertake the audits. Each ward produced their own action plans and reported progress via the MMG meetings. Focus is given to themes from the ward or department, and learning 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 result of each assessment is submitted within the PLACE Lite tool linked to the Health and Social Care Information Centre. The PLACE Lite plan for 2016/2017 began in August 2016 and will be completed by March 2017, undertaking 50 internal PLACE Lite assessments using the new criteria and PLACE paperwork.

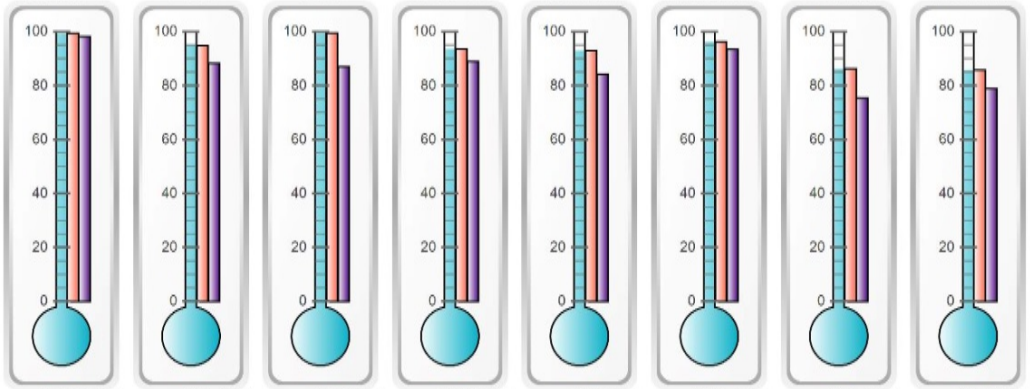
15.2 National PLACE

The Trust participated in the National PLACE assessment during quarter 4 of 2015/16 (March 8th 2016). A total of 10 wards and the Emergency Department (ED) were visited, 4 food assessments undertaken, 3 outpatient areas as well as external spaces and communal areas were also assessed as required under the PLACE criteria. The results reflect improvements have been made in most areas. The score for this Trust was published in August 2016. The results from PLACE are analysed and key themes form the basis of improvement plans within the Trust.

Table 11 below shows the scores for our Trust against the national average for 2016.



SALISBURY DISTRICT HOSPITAL- Collection: 2016



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2929.0000	475.4955	110.0502	365.4453	412.0000	1444.0000	516.3193	370.5882
Available Score (Actual)	2950.0000	501.8148	110.8065	391.0083	444.0000	1502.0000	599.0756	432.5882
Site Score	99.29%	94.76%	99.32%	93.46%	92.79%	96.14%	86.19%	85.67%
Organisation Average	99.29%	94.76%	99.32%	93.46%	92.79%	96.14%	86.19%	85.67%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

Table 12 demonstrates the additional cleaning activity arising as a result of the internal PLACE audit findings, Housekeeping audits and the requirements linked to the patients' needs on the wards.

Table 12: Additional cleaning activity

Area of Focus	KPI	APRIL 2016	MAY	JUNE	JUL	AUG	SEP
Departmental Data	Post Infection Cleans	393	363	342	299	380	397
	Enhanced cleaning hours	67	63.75	35.50	52.75	43.75	57.75
Cleaning	Total audits	93	93	109	93	94	110
	Passes	51	47	55	48	52	63
	Qualified Passes	42	46	54	45	42	47
	Fails	0	0	0	0	0	0

15.3 Terminal enhanced and double cleaning

Table 13 below illustrates the additional cleaning undertaken in clinical areas between April 2016 and September 2016 (excluding the deep clean programme).

Table 13: Terminal enhanced and doubles cleaning

Month/Year XX –Highest XX- Lowest	2015/16 Number of terminal cleans	2015/16 Enhanced cleaning hours	2015/16 Double cleans in hours	2016/17 Number of terminal cleans	2016/17 Enhanced cleaning hours	2016/17 Double cleans in hours
April	373	109.75	47	393	**67**	83.50
May	471	50.75	79	363	63.75	64
June	416	34.50	103.25	342	**35.50**	**59.75**
July	**367**	10.25	70.5	**299**	52.75	63.50
August	385	26	63.25	380	43.75	**120**
September	457	31.75	64.25	**397**	57.75	69.25
October	400	49.75	86			
November	414	44.75	81.75			
December	374	**2.5**	64			
January	384	16.75	**115.50**			
February	395	43.75	**45**			
March	**530**	**125.75**	108.25			
Year to Date total	**4966**	**546.25**	**927.75**	**2174 @ 6 months**	**320.50 @ 6 months**	**460 @ 6 months**
Totals for Year	**6440**			**2954.50**	**6 months**	

15.4 Deep clean programme/rapid response team

An agreed deep clean and decorating programme started in April 2016 and is well under way (a copy of the deep clean programme is available from the Facilities Directorate). A monthly review of this plan is undertaken at the MMG and IPCWG meetings.

Concerns have been raised that the Housekeeping Team are unable to 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 by the IPCWG members. This contingency plan 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 GLOSAIR 400 RDS treatment will be undertaken.

In addition to the deep clean programme, the demand on the GLOSAIR 400 RDS remains high and reflects the robust measures in place to ensure appropriate infection control measures. Table 14 below reflects the activity in 2015/16 and 2016/2017 to date.

Table 14: GLOSAIR 400 room decontamination

2016/17 MONTH	**APRIL**	**MAY**	**JUNE**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
GLOSAIRS (Not including Deep Clean Plan)	64	26	21	18	22	17						
Total to date	**168**											
2015/16 MONTH	**APRIL**	**MAY**	**JUNE**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
GLOSAIRS (Not including Deep Clean Plan)	28	16	31	28	26	50	21	32	27	43	26	30
Total to date	**358**											

15.5 Housekeeping resources

The Head of Facilities presented the Housekeeping options paper (with a value of £171k) to the Executive Directors during quarter 4 of 2105/16 (January 2016) to better ensure that cleaning resources can meet the demands on the service, and ensure national cleaning standards and infection control needs are met.

The Executive Directors agreed to fund a proportion of the paper with a value of £76,582 from October 2016. This will enable the Housekeeping Team to extend the operational hours to include 20.00hrs to 23.45hrs every day, extend the weekend cover between the hours of 12noon to 16.00hrs and increase the number of Housekeeping Supervisors on shift to accommodate these extra operational hours. Our Housekeeping Service continues to strive to work in a multi-disciplinary team way, communicates well and be responsive to the needs of our patients.

15.6 Improvement Work Projects

The Housekeeping Management Team are undertaking a gap analysis review to identify what actions/changes would be required to fully implement the cleaning management tool advocated by the British Standards Institute (BSI). At this time, we are developing the training competency document (identified within the BSI model), with a view that this could be used with other support service teams.

A capital bid has been submitted to support the purchasing of two new hydrogen peroxide vapour (HPV) room decontamination units. The GLOSAIR 400 RDS machines (currently in use) are reaching the end of their life expectancy and are no longer manufactured.

16. Summary

This 6 monthly update report has provided the Trust Board with evidence of the measures in place that make a significant contribution to improving infection prevention and control practices across the Trust. The report has detailed the continuing progress against the Action Plan for 2016/17 in reducing HCAI rates for the Trust and the key priorities include:

- Continued focus on the reduction of all reportable Trust HCAIs and ensure preventable infections are avoided.
- Ongoing reinforcement to improve compliance with hand hygiene practices and behaviours.
- Continued focus on 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 1

Infection Prevention & Control – Annual Action Plan 2016/17

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	IP&CT	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/RW	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/IP&CT	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/IP&CT	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	IP&CT	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/RW	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/IP&CT	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.	HL	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)	JHo	In place
Disinfection policy	MS	In place
Antimicrobial prescribing	JH/ET	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	PJ	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	RW	In place

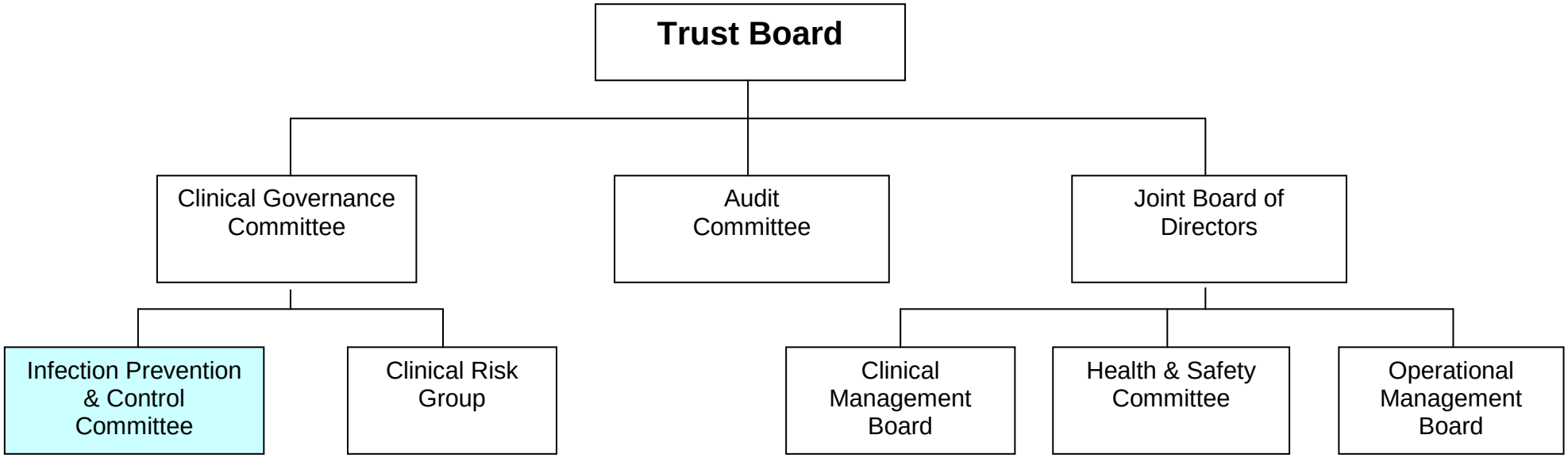
Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs.		
Ensure all staff can access relevant occupational health services	AK	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	HL	Continuous
Continue the provision of infection prevention and control education at induction	IP&CT	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IP&CT	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

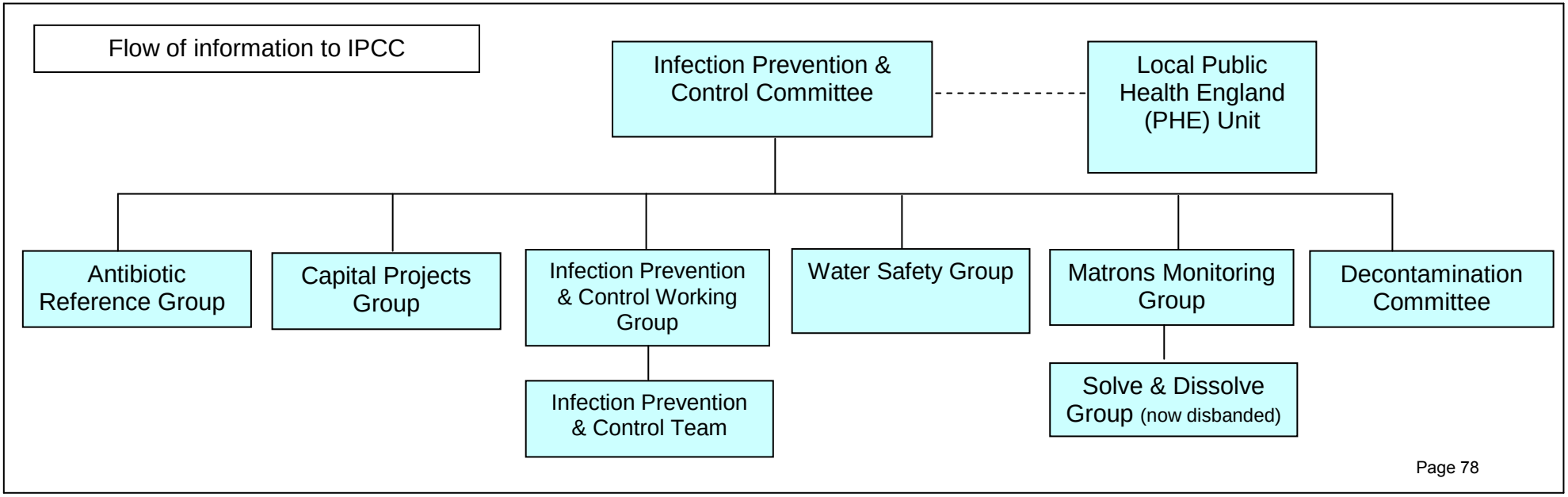
KEY INITIALS

DIPC	Lorna Wilkinson, Director of Infection Prevention & Control
DDIPC	Fiona Hyett, Deputy DIPC
RW	Robert Warburton, Decontamination Lead & SDU Manager
JH	Julian Hemming, Consultant Microbiologist & Infection Control Doctor
SC	Stephen Cotterill, Consultant Microbiologist
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
JH	Janet Hope, Head of Patient Flow
PK	Paul Knight, Health & Safety Manager, OH Department
GL	Geoff Lucas, Safety Advisor, OH Department
HL	Heidi Lewis, Manager OH Department
ET	Emma Taylor, Principal Pharmacist
JD	Jacqui Dalley, Neonatal Unit Sister
MF	Maria Ford, Nurse Consultant in Critical Care
PJ	Paul Jackson, Energy and Waste Manager, Facilities
AK	Alison Kingscott, Director of Human Resources
MS	Michelle Sadler, Facilities Manager

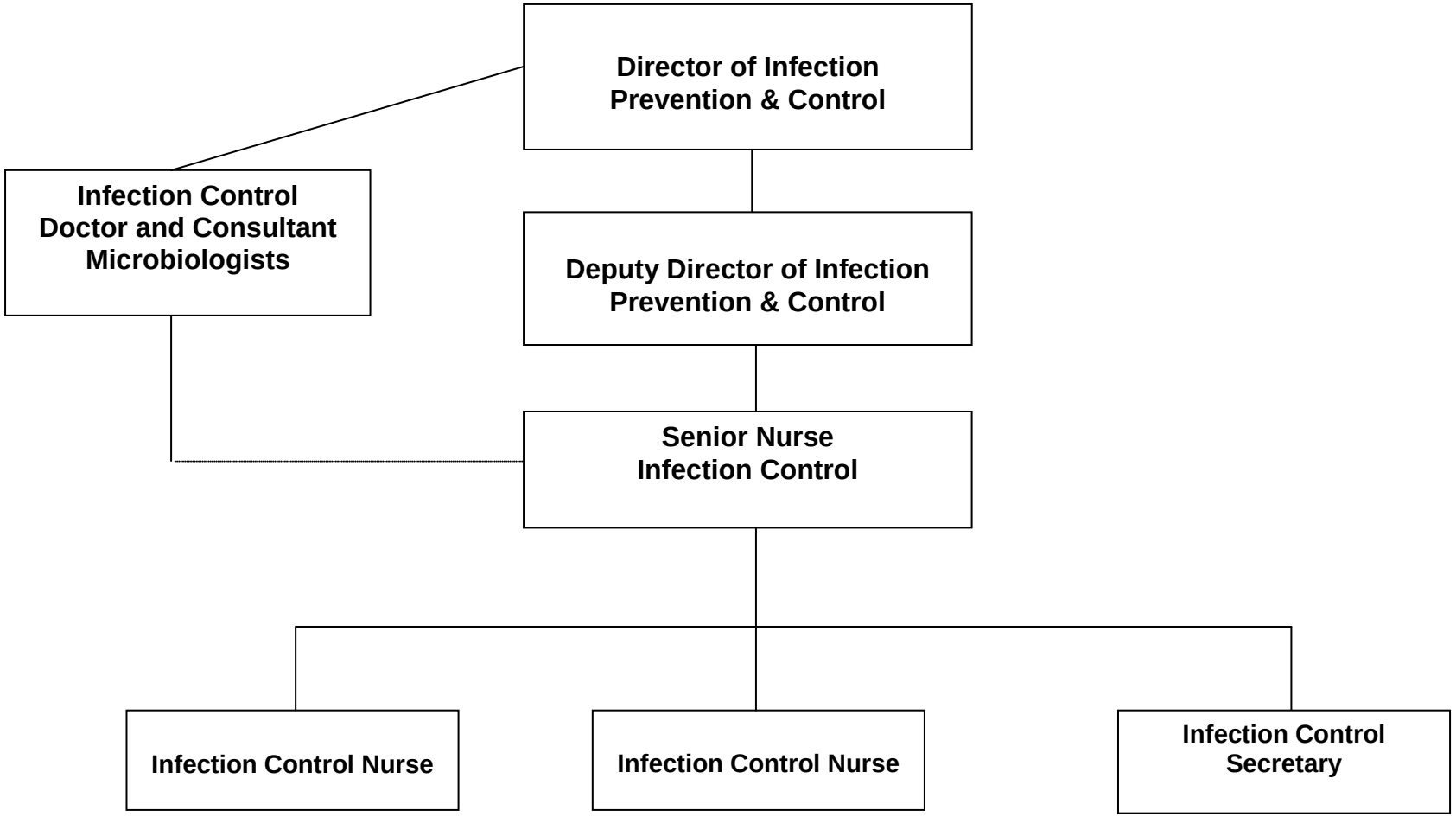
Appendix 2

Formal Trust Reporting Structure





Infection Prevention & Control Team



Appendix 4

Infection Prevention & Control Annual Audit & Policy Review Programme 2016/17

No	Aim	Audit	When by/How	Person(s) responsible/main author
1	Active surveillance & investigation.	Mandatory SSIS - Orthopaedic Surgery	Yearly, with minimum data set of 50 cases and/or 3 month period.	Facilitated by ICNs, including key personnel from relevant areas.
		Root Cause Analysis (RCA)/Post Infection Review (PIR)/incident investigations – • Mandatory alert organisms (MRSA, MSSA & E.coli bacteraemias & C.difficile infection) • Outbreaks e.g. Norovirus, C.difficile • PII e.g. C.difficile • Targeted others e.g. Tuberculosis, VRE	As required.	Led by the ICD, DIPC and ICNs, including key personnel from affected areas.
2	Reduction of infection risk from the use of catheters, tubes, cannulae, instruments & other devices.	Patient Safety Work – ongoing implementation of care bundles e.g. central line & peripheral vascular devices.	5 year programme (ended October 2014), however work continues to progress.	Facilitated by ICNs, including Clinical Leaders/DSNs and educational support from key staff.
		Saving Lives: High Impact Interventions (HII).	• Priorities & timescales agreed with DIPC. • Plus, targeted audits.	Clinical Leaders/DSNs IPCT
3	Reduce the reservoirs of infection.	Environmental & equipment cleanliness	• Priorities & timescales agreed with DIPC. • Plus, targeted audits.	Clinical Leaders/DSNs IPCT
		In house Patient Led Assessment of the Care Environment (PLACE) visits.	Programme led by Facilities Directorate.	Facilities/Housekeeping Manager with the involvement of DMTs.
4	High standards of hygiene in clinical practice.	Hand hygiene, including Isolation nursing and use of personal protective equipment (PPE).	• Priorities & timescales agreed with DIPC. • Plus, targeted audits.	Clinical Leaders/DSNs IPCT

No	Aim	Audit	When by/How	Person(s) responsible/main author
5	Prudent use of antibiotics.	Antibiotic prescribing & usage.	Action Plan agreed & monitored by the Antibiotic Reference Group (ARG).	Chief Pharmacist & Antimicrobial Pharmacist
6	Management & organisation – • Policy, guideline & information development & review programme (review dates according to ICID or SDH intranet site).	Patient information leaflet - Acinetobacter.	Review January 2018.	ICNs.
		Microbiology/Infection Control Alerts Policy.	Review February 2019.	Stephen Cotterill.
		Aseptic technique.	Review October 2017.	ICNs.
		Central Line Policy	Review June 2019.	Sarah Clark.
		Clostridium difficile Policy.	Review February 2018.	ICD.
		Patient information leaflet - C.difficile.	Review February 2018.	ICNs.
		Contractors/Procurement information leaflet – infection prevention in hospital.	Review June 2018.	ICNs.
		Creutzfeldt Jacob Disease (CJD) Policy.	Review May 2019.	Decontamination Lead & ICD.
		Decontamination Policy.	Review April 2018.	Decontamination Lead.
		Patient information leaflet - ESBL.	Review May 2017.	ICNs.
		Glove Usage Policy & Chart.	Under review 2016.	ICNs.
		Patient information leaflet - Group A Strep (GAS).	Review February 2019.	ICNs.
		Staff information leaflet - Hand Hygiene.	Review January 2018.	ICNs.
		Infection Control Policy.	Review June 2017.	ICNs.
		Infection Prevention & Control Practice in the Operating Department.	Review September 2017.	Lucinda Pluck.
		Inpatients with diarrhoea algorithm.	Review September 2017.	ICNs.
		Isolation Policy (including diarrhoeal infections & other alert organisms).	Review June 2017.	ICD.
		Hand Hygiene Policy.	Review June 2017.	ICNs.
		Patient information leaflet - Invasive GAS Disease.	Review February 2019.	ICNs.
		Linen Management Policy.	Under review 2016.	ICNs.
		Legionellosis Management & Water Safety Policy.	Review February 2019.	Terry Cropp.
		Clinical Management of MRSA Policy.	Review November 2018.	ICD.
		Patient information leaflet - MRSA.	Review February 2018.	ICNs.

No	Aim	Audit	When by/How	Person(s) responsible/main author
6	Continued	Patient information leaflet - MRSA Contact Bay.	Under review 2016.	ICNs.
		Patient information leaflet - MRSA Screening.	Review July 2018.	ICNs.
		Outbreak Management Policy.	Under review 2016.	IPCT.
		Outbreak Management of Norovirus Policy.	Review June 2017.	IPCT.
		Patient information leaflet – Norovirus.	Review February 2019.	ICNs.
		Patient information leaflet – 'Now that I am in Isolation – some practical advice'.	Under review 2016.	ICNs.
		Prevention of Occupational Exposure to Blood Borne Virus Policy.	Under review 2016.	ICNs.
		Prevention of Spread of Carbapenem Resistant Organisms Policy.	Review January 2018.	ICD.
		Patient information leaflets – CPE C3 – Colonised. C4 – Carrier. C5 – Contact.	Review August 2017.	ICNs.
		Peripheral Venous Cannulation Policy.	Review November 2017.	ICNs.
		Patient information leaflet – Having a 'drip' (peripheral venous cannula)	Review February 2019.	ICNs.
		Standard Precautions Policy.	Review November 2018.	ICNs.
		Surveillance Policy.	Review January 2019.	ICNs.
		Taking Blood Cultures Policy – Adults.	Review July 2017.	ICNs.
		Tuberculosis Infection Control Policy.	Review December 2017.	ICD.
		Ebola and other Viral Haemorrhagic Fevers Policy.	Review August 2017.	ICD.
		Management of VRE Policy (New policy)	Under development 2016.	ICD & Deputy ICD.
		Patient information leaflet – GRE.	Review September 2018.	ICNs.
		Patient information – Infection Control Advice to Patients	Review November 2018.	ICNs.
		Staff information – MERs CoV	Review September 2018.	ICD.

Appendix 5

Reports accessed from the Managed Learning Environment (MLE) on 6th July 2016, and outlines the directorate compliance rates for Hand Hygiene Assessments and Infection Control CBL Packages completed for Quarter 1 of 2016/17

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Hand Hygiene Assessment 122014	Ambulatory Care (Direct)	0	1	1	0%
	Balance Sheet (Direct)	1	1	2	50%
	Capital (Directorate)	33	2	35	94%
	Clinical Support & Family Services (Direct)	666	283	949	70%
	Corporate Directorate (Direct)	362	55	417	87%
	Facilities Directorate (Direct)	292	49	341	87%
	Finance - Charitable Funds (Direct)	4	1	5	80%
	Medical Directorate (Direct)	6	3	9	67%
	Medicine Directorate (Direct)	393	258	651	60%
	Musculo-Skeletal (Direct)	327	157	484	68%
	Nursing & Admin Staff Bank (Direct)	0	2	2	0%
	Nursing Directorate (Direct)	0	1	1	0%
	Odstock Medical (Direct)	15	1	16	94%
	Quality Directorate (Direct)	253	220	473	53%
	Surgery (Direct)	488	169	657	74%
	Therapy Staff Bank (Direct)	0	1	1	0%
		5	62	67	7%
Hand Hygiene Assessment 122014		**2845**	**1266**	**4111**	69%

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Infection Control CBL package 122014	Ambulatory Care (Direct)	1		1	100%
	Balance Sheet (Direct)	2		2	100%
	Capital (Directorate)	33	2	35	94%
	Clinical Support & Family Services (Direct)	786	163	949	83%
	Corporate Directorate (Direct)	374	43	417	90%
	Facilities Directorate (Direct)	312	29	341	91%
	Finance - Charitable Funds (Direct)	4	1	5	80%
	Medical Directorate (Direct)	6	3	9	67%
	Medicine Directorate (Direct)	496	155	651	76%
	Musculo-Skeletal (Direct)	406	78	484	84%
	Nursing & Admin Staff Bank (Direct)	0	2	2	0%
	Nursing Directorate (Direct)	0	1	1	0%
	Odstock Medical (Direct)	16		16	100%
	Quality Directorate (Direct)	392	81	473	83%
	Surgery (Direct)	551	106	657	84%
	Therapy Staff Bank (Direct)	1		1	100%
		4	63	67	6%
Infection Control CBL package 122014		**3384**	**727**	**4111**	82%

Appendix 5

Reports accessed from the Managed Learning Environment (MLE) on 5th October 2016, and outlines the directorate compliance rates for Hand Hygiene Assessments and Infection Control CBL Packages completed for Quarter 2 of 2016/17

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Hand Hygiene Assessment 122014	Balance Sheet (Direct)	1	2	3	**33%**
	Capital (Directorate)	35	4	39	**90%**
	Clinical Support & Family Services (Direct)	742	283	1025	**72%**
	Corporate Directorate (Direct)	354	68	422	**84%**
	Facilities Directorate (Direct)	261	69	330	**79%**
	Finance - Charitable Funds (Direct)	4	1	5	**80%**
	Medical Directorate (Direct)	1	8	9	**11%**
	Medicine Directorate (Direct)	370	275	645	**57%**
	Musculo-Skeletal (Direct)	296	146	442	**67%**
	Nursing & Admin Staff Bank (Direct)	0	2	2	**0%**
	Nursing Directorate (Direct)	0	1	1	**0%**
	Odstock Medical (Direct)	13	3	16	**81%**
	Quality Directorate (Direct)	270	188	458	**59%**
	Surgery (Direct)	524	164	688	**76%**
	Therapy Staff Bank (Direct)	0	3	3	**0%**
		5	32	37	**14%**
Hand Hygiene Assessment 122014		**2876**	**1249**	**4125**	**70%**

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Infection Control CBL package 122014	Balance Sheet (Direct)	3		3	**100%**
	Capital (Directorate)	39		39	**100%**
	Clinical Support & Family Services (Direct)	887	138	1025	**87%**
	Corporate Directorate (Direct)	368	54	422	**87%**
	Facilities Directorate (Direct)	302	28	330	**92%**
	Finance - Charitable Funds (Direct)	4	1	5	**80%**
	Medical Directorate (Direct)	6	3	9	**67%**
	Medicine Directorate (Direct)	473	172	645	**73%**
	Musculo-Skeletal (Direct)	362	80	442	**82%**
	Nursing & Admin Staff Bank (Direct)	0	2	2	**0%**
	Nursing Directorate (Direct)	0	1	1	**0%**
	Odstock Medical (Direct)	15	1	16	**94%**
	Quality Directorate (Direct)	363	95	458	**79%**
	Surgery (Direct)	576	112	688	**84%**
	Therapy Staff Bank (Direct)	3		3	**100%**
		2	35	37	**5%**
Infection Control CBL package 122014		**3403**	**722**	**4125**	**82%**

Trust Board Meeting

SFT 3835

Title of Report: Six monthly Skill Mix Review to Trust Board

Date: December 2016

Report from: Lorna Wilkinson

Report by: Lorna Wilkinson

Executive Summary:
The nursing and midwifery skill mix review has been completed and is being presented to the Trust Board to allow for a discussion on the findings and recommendations.

It is the Director of Nursing's responsibility to oversee a twice yearly skill mix review and present the findings to the Board in an open and transparent manner. The Trust Board have a collective responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability (NQB). It is therefore the role of the Board collectively to receive the skill mix review, consider the findings, and agree a way forward with any recommendations.

This review covers the in-patient wards and maternity, excluded is the Emergency Department, Paediatric Services and Spinal as these are all subject to separate reviews as agreed at the last skill mix review. All the areas included have been subject to a detailed skill mix review using a defined approach to ensure consistency for comparison, which included a range of information; triangulating the ward staffing levels against nurse sensitive indicators, NICE standards, quality indicator / outcome data, Care Hours Per Patient Day (demand and required), HR indicators, and financial information, as well as CQC findings. Professional judgement was ensured as each review has been undertaken by the Deputy Director of Nursing with the Ward Sister and a Directorate Senior Nurse.

The paper also updates the Board with the policy context, particularly the most recent updated NQB guidance for Safe Staffing.

Proposed Action:
The Board are asked to:
• Discuss and agree the findings from this skill mix review paper and agree that no areas require additional investment at this review.
• Support the recommendations listed in section 6 with a review of any outcomes being incorporated into future skill mix reviews
• Support the further review of headroom to be undertaken now that robust data is available from Healthroster
• Support the continuation of recruitment and retention activities

Trust Board December 2016

Title	Six Monthly Skill Mix Review – September 2016
Meeting Date	December 2016
Sponsoring Executive	Lorna Wilkinson – Director of Nursing
Author	Fiona Hyett – Deputy Director of Nursing

1.0 Background

This is the 4th year of skill mx reviews and is part of the reporting requirements that every Trust are expected to have in place.
The Trust was inspected by the Care Quality Commission (CQC) in December 2015 with their report published in April 2016. These recommendations were reviewed in the April skill mix review and form this there was a decision for the Emergency Department, Spinal Services and Children's services to be subject to their own individual reviews. This review therefore covers all other acute wards and maternity services.

The report provides an assessment of the current nurse staffing position at Salisbury NHS Foundation Trust (SFT) as assessed locally, against national guidance and validated tools and the CQC feedback. All in-patient wards as identified above have been subject to a detailed skill mix review during August/September 2016. The reviews were undertaken using a defined approach to ensure consistency for comparison which includes a range of information; triangulating the ward staffing levels against nurse sensitive indicators, quality indicator / outcome data, Care Hours per Patient Day data (SafeCare), HR indicators and financial information. Professional judgement was encapsulated through the presence at each review of the Ward Leader, Directorate Senior Nurse and the Deputy Director of Nursing.

It is important to note that whilst no additional resource is recommended in this paper, nursing requirements will change overtime due to the acuity/dependency and overall case mix changes which leads to the requirement to review staffing levels twice per year.

2.0 Policy Context

In February 2013, Sir Robert Francis QC published his final report of the inquiry into failings at Mid Staffordshire NHS Foundation Trust. Compassion in practice, the strategy for nurses, midwives and care staff (2012), the Francis report and the government response, Hard truths: the journey to putting patients first, led to fundamental changes in how NHS provider boards are expected to assure they are making safe staffing decisions. In November 2013 the National Quality Board set out these expectations in relation to getting nursing, midwifery and care staffing right. It provided a clear governance and oversight framework alongside recommended evidence-based tools, resources and examples of good practice, to support NHS providers in delivering safe patient care and the best possible outcomes for their patients. The National Institute for Health and Care Excellence (NICE) undertook work to produce guidelines on safe staffing for specific care settings, which led to the publication of Safe Staffing for Nursing in Adult In-patient Wards in Acute Hospitals and Safe Midwifery Staffing for Maternity Settings.

The Carter report and the NHS Five Year Forward View planning guidance make it clear that workforce and financial plans must be consistent to optimise clinical quality and the use of resources. The Carter report highlighted variation in how acute trusts currently manage staff, from annual leave, shift patterns and flexible working through to using technology and e-rostering. It underlined that, in addition to good governance and oversight, NHS providers need a framework to evaluate information and data, measure impact, and enable them to improve the productive use of staff resources, care quality, and financial control. Lord Carter's report recommended a new metric, care hours per patient day (CHPPD), as the first step in developing a single consistent way of recording and reporting staff deployments.

Nursing and midwifery leaders have built on Compassion in practice to create a national nursing, midwifery and care staff framework, Leading change, adding value. This framework is aligned to the Five Year Forward View, with a central focus on reducing unwarranted variation and meeting the 'Triple Aim' measure of better health outcomes, better patient experience of care and better use of resources.

The 2015 Shape of Caring report recommended changes to education, training and career structures for registered nurses and care staff and is aimed at maximising the capabilities and contribution of healthcare assistants/ support workers/nursing associates to meet patient needs and provide fulfilling job roles and career pathways in nursing.

As an integral part of developing their Sustainability and Transformation Plans, local health and care systems need to develop local plans for how they will develop, support and retain a workforce with the rights skills, values and behaviours in sufficient numbers and in the right locations.

In July 2016 the NQB published an updated set of expectations for nursing and midwifery staffing which are aimed at helping NHS providers make local decisions that deliver high quality care for patients within their available staffing resource.
The first two sections of this guidance brings together the work of the Carter team and sets out key principles and tools which Boards can use to measure and improve their use of staffing resources to ensure safe, sustainable and productive services.
The third section updates 3 of the expectations that form a triangulated approach (Right time, right staff, right place) to making staffing decisions. This triangulated approach moves from having judgements made based solely on numbers or ratios to one which decides staffing levels based on patients' needs, acuity and risk.
The box below show measures that can be used alongside CHPPD to demonstrate and understand the impact of staffing decisions on the quality of care that patients are receiving in acute inpatient wards.
NHS Improvement are also due to publish a range of safe staffing improvement resources for a range of care settings across 2017.

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability -- report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

3.0 Previous Investment

The most recent skill mix review saw investment of nearly £300k, which was offset by savings from the reduction across all wards of B7 supervisory time.
The areas invested into were:

- B2 night shift Redlynch
- Substantive funding of weekend RN for Redlynch and Pitton
- B5 long-day Pitton
- ED minors nurse 10:00-22:00
- Avon B3 establishment increase
- Whiteparish RN at weekends

Redlynch and Pitton have only recently appointed staff into these additional posts and have a revised roster template from October, so full benefits not yet realised. Whiteparish are starting to feel the benefit of additional staffing at weekend on flow and meeting the acuity and dependency of the patient need however have a very junior skill mix so supported development required.
The investment into staffing in both Avon and ED will be reported through the individual skill mix reviews that are being undertaken in these areas.

4.0 Assessment/Findings

Initial findings and analysis are included in Appendix A .

The budgeted RN: Patient Staffing ratio is demonstrated by shift alongside the RN: NA ratio. In addition this year we have developed this ratio further to compare RNs to B3/4 to B2 – this is in recognition of the increasing use of Band 4 roles across the Trust.
In light with the most recent NQB guidance the reviews triangulate staffing ratios, with acuity and dependency levels (via SafeCare), HR and quality indicator data and professional judgement.

Overall there were no areas identified for specific focused investment arising from this skill mix review however broad themes were identified:

4.1 SafeCare

The use of SafeCare via Allocate, which assesses the acuity and dependency levels of the patients on a shift against both the budgeted roster template and the actual staff on shift, is starting to be fully embedded across the Trust. Each ward's data was reviewed as part of the skill mix discussions to triangulate with establishment and quality indicator data and alongside professional judgement, Appendix B demonstrates the most recent CHPPD data. As the data is starting to be more robust we are now able to address some of the anomalies where the use of the Shelford Tool does not sit comfortably with the ward type eg Pembroke, Sarum, Whiteparish. The Trust is working with Allocate to view alternative models that could be utilised so that robust and reliability data is gained. The Trust was also involved in a ValueAdd pilot with Allocate in April. The learning from this pilot has been considered through the skill mix reviews and all wards have been asked to undertake an audit which compares staff and ward leader scores and also undertake a peer review with another ward. This will help to further improve the robustness of the data collated. It is also intended to commence using the real time SafeCare data to support decision making on daily staffing issues.

4.2 Recruitment

For several wards, predominantly in medicine, there remain significant vacancies and a reliance on temporary staffing. This is due to the challenges recognised nationally with RN recruitment but also the increasing demand. The nurse recruitment activity has been subject to separate paper which was presented to the Board in November 2016 and so the detail is not included in this review. However, the nursing teams continue to remain focused on recruitment at local, national and international levels. Several ward leads report that they would be more confident with their ward staffing levels if they had a permanent team or a less junior skill mix. The junior skill mix has been recognised and there is on-going work to support these wards through roles such as Education Nurse Supervisors and the Preceptorship programme ensuring all new recruits are supported and a focus on retention.

4.3 Band 4 Roles

The ratios of RN:NA is listed within Appendix A and as expected there is a variation between wards, and as previously described this year also includes Band 3 and Band4.
In response to the Shape of Caring report 2015 wards are reviewing how they can embed differing roles for the nursing support workforce into their teams. This in turn provides a career pathway for a nursing assistant coming into the organisation to progress through to a Registered Nurse and the supports the ability to grow our own registered workforce.
At the time of this review the Trust is awaiting to hear if it has been successful in being part of a national pilot for the role of the Nursing Associate.

4.4 Headroom

When the E-rostering system was introduced it was agreed that once embedded the headroom included within the ward establishment would be reviewed and this has been a theme in previous skill mix reviews. The e-rostering system is now sufficiently embedded to enable headroom to start to be analysed. This review has included the actual headroom required across the wards from March – end of July (Appendix C) with the data being taken directly from the electronic rostering system. Currently headroom provision within the ward establishments is set at 19%, which does not include maternity leave (held centrally). The data within the templates shows both actual total headroom and actual headroom with maternity leave removed. The data reviewed shows wide variation across the wards, which is to be expected, from 17 – 35% with an average of 28%, with maternity leave removed the range is 17 – 30% with an average of 24%.

The unavailability data within Allocate includes annual leave, other leave (carers/compassionate), parenting, sickness, study leave and working day. Working day has covered a variety of reasons

where staff appear on a roster but do not contribute to the numbers of staff on shift for example staff on supernumerary as new to ward.
Across the wards annual leave sits within the required percentages of 11-17%, sickness varies from 1.2% to 8.7%, study leave 0.7% -4.5% and working day 0.5% to 8.6%.

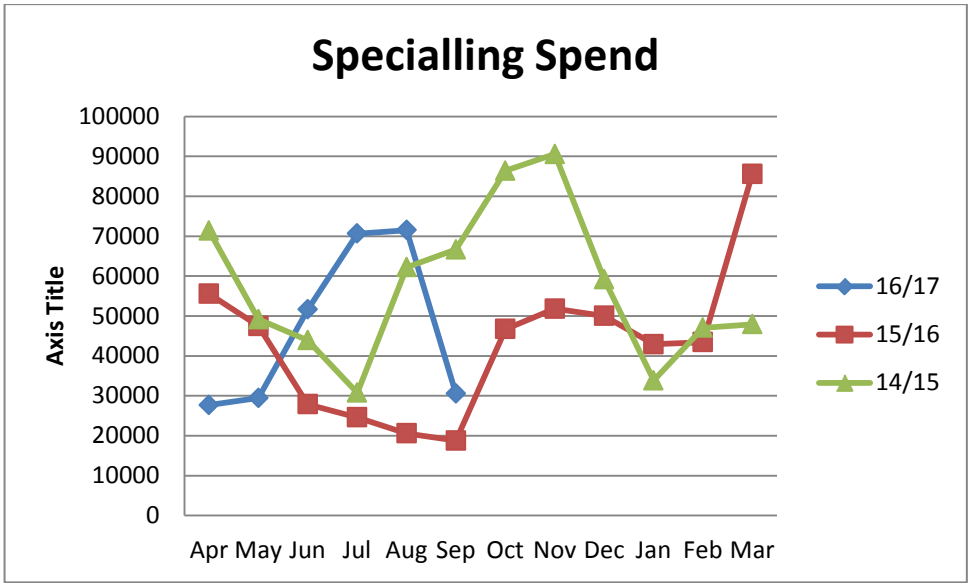
Through the Safe Staffing Steering group these metrics are continually reviewed. The use of Working Day has been reviewed and going forward will only be used for KIT days and administrative days where supervisory cannot be allocated, so a reduction should be seen which brings us in line with other organisations.

4.5 Supervisory

Sisters across the directorates continued to report challenges with taking their 80% of supervisory shifts. This was generally due to vacancies and short notice sickness which resulted in them needing to work as part of the numbers. The impact of the supervisory role on the quality of patient care and staff satisfaction has been well documented and so the focus will be on supporting the Ward Leaders to have this time.

4.6 Specials

The use of additional staff to support patients with enhanced care needs continues to be challenging across the wards.
The graph below shows expenditure year to date and also a comparison with previous years:



Through the Safe Staffing Steering group work is underway to ensure accurate recording of Additional Duties and it is envisaged that going forward it will be possible to gain establishment data on the requirements not just financial.
The Trust has requested to participate in a collaborative piece of work with NHSi looking at alternative ways of supporting these patients whilst reducing expenditure.

5.0 Maternity and Neonatal

Following the workforce review in 2015 and the investment from the Board for 10 WTE registered midwives the department has struggled to recruit to the requisite numbers to maintain a Midwife to birth ratio of 1:32 or lower.

Key challenges have also been an increase in sickness and 8% maternity leave peaking in the summer. This resulted in a decision to use agency midwives for the first time with key controls in place to mitigate risks associated with this, to date there has been no negative impact on quality indicators resulting from this decision.

The service has had some success in recent months especially through the Trust recruitment day and the vacancies currently stand at 10 WTE. There will now be a gradual return from maternity leave and sickness has improved. Midwife to birth ratios are improved as there has been a temporary drop in birth numbers (Appendix D).

Overall recruitment looks set to rise over the 4th quarter as we have seen interest coming through from midwives looking to move jobs. The department are monitoring the staffing numbers on a monthly basis using the Birth rate plus methodology and monthly acuity monitoring. HR and finance are supporting the service and a staffing predictor tool is now in place.

Neonatal

A workforce review was undertaken in 2016. The department is expected, as a level 2 Local new born unit (LNU) to comply with staffing ratios recommended by the British Association of Perinatal Medicine (BAPM). This expectation derives from the Neonatal network and specialist commissioning. The review considered the staffing, capacity and activity data for the last 3 years. This has resulted in a reduction in cots from 14 to 10 and an investment of 0.5 WTE registered nurses. These changes ensure that the unit is compliant with the BAPM ratios.

Within the staffing numbers 70% of RNs are expected to be Qualified in speciality QIS and the unit is currently at 56%. The QIS nurses are difficult to attract to a local new-born unit so the strategy of 'growing our own' is in place and is robustly pursued. This requires some backfill to enable staff to complete the qualification but this is managed successfully with experienced bank currently.

6.0 Recommendations

- All ward areas to undertake comparative audits of Shelford tool scores with aim of improving reliability and validity of data to be able to use to inform future skill mix reviews
- Further analysis to be undertaken of the impact of the previous investment on the areas that were given monies from previous skill mix review and reported in next review.
- To continue the work on developing the Band 4 role
- Surgical Directorate to undertake a review of the impact of the introduction of the ward managers assistant on enabling the ward lead to focus on providing clinical leadership and the impact on providing quality care
- To continue with the focus on recruitment and ensure this is focused on NAs as well as RNs
- Have further discussion on the level of headroom provided within ward establishment and what level this should be set
- Revisit the opportunities to provide the requirements for the provision of enhanced care

WARD STAFFING REVIEW
March 2016 - August 2016

NB All these indicators are for period of March 2016 - August 2016

Current Position

Wards/department	Beds	Total Funded Establishment WTE	Funded Establishment B6 and 7 WTE	Funded Establishment Band 5 WTE	Funded Establishment Band 4 WTE	Funded Estabalishment Band 3 WTE	Funded Establishment Band 2 WTE	Budget (financial)	Current maternity leave WTE	Average % uplift during March 16 - August 16	Sisters/Charge Nurses: No Band 7	Sisters/Charge Nurses: No Band 6	Vacancies: Band 6 Vacancy WTE	Vacancies: Band 5 Vacancy WTE	Vacancies: Band 4 vacancy WTE	Vacancies: Band 3 vacancy WTE	Vacancies: Band 2 vacancy WTE
Whiteparish	21+4	36.73	4	21.87	1.8	0.51	8.55	1,217,751	3.7	27% (19.4%)	1	3	0	5.50			0.44
Tisbury	23	33.08	4	21.42	2	0	5.66	1,170,653	3.92	35% (26%)	1	3	0	5.1	0.0	0.0	0.0
Redlynch	27	30.98	3	16.36	0.5	0.67	10.43	981,904	1	33.6% (30.4%)	1	2	1.2	3.0			2.8
Pitton	27	33.77	3	18	1.69	1.31	9.77	1,021,199	3	29.8% (23.9%)	1	2	0	4.5	0.0	1.3	0.0
Breamore	20+4	25.45	3	10.57	0	0	11.88		0	17% (17%)	1	2	0	7.0			8.0
Farley	30	39.11	3	19.5	1 in RN num	0.8	15.81	1,226,492	0	29.3% (27.9%)	1	2	0	5.3		0.0	2.3
Durrington	21	28.49	2.59	12.13			12.77	831073	0	23% (23%)	1	2		4.8			7.9
Winterslow	20	31.22	3	14.11	3 within 5	0	14.11		0	24.8% (24.7%)	1	2	0	0.7			over
Hospice	10	21.77	0.9	11.58			9.23	743067	1	31% (26.6%)		0.9	0	0.0			0.0
Pembroke total		24.41	3.8	16.38		2	4.73			24.4% (23.7%)				0.0		2.0	1.5
Pembroke	10	15.1	2	9.8			3.3				1	2					

Wards/department	Total Number of staff per shift: E- registered	E - Band 4	E - Band 3	E - Band 2	L -Registered	L -Band 4	L -Band 3	L - B2	N - Registered	N - Band 4	N - Band 3	N -Band 2	Shift patterns (ie 2 or 3 shift pattern)	Admin support (WTE): Ward Clerk	Housekeeping Assist	Ward managers Assistant	Sisters/Charge Nurses: Average % supervisory	Skill mix as a proportion of total staff (RCN note national benchmark of RN 65%): Registered %	Band 3 / 4 %	Band 2 %
Whiteparish	5	N numbers		3	5			3	3+twi			1	2	1.9			25	70%	7%	23%
Tisbury	6	RN numbers		2	6	RN numbers		2	4	RN numbers		1	2	1	0	0	60	76%	6%	17%
Redlynch	4			4	4			2	3			2	2	0.91			50	62%	4%	34%
Pitton	4(5)	NA numbers		4	4(5)			2	3			2	2	0.91	0	0	54	61%	9%	29%
Breamore	3			3	3			2	2			2	2	1(0.66)			40	54%		46%
Farley	5	N numbers	IA numbers	5	5			3	3			2	2	1	0	0	40	56%	4%	40%
Durrington	3			3	3			2	2			2	2	1			60	53%		47%
Winterslow	3	N numbers	0	3	3	RN numbers		2	2			2	mixed	1			50	45%	12%	45%
Hospice	2			2	2			1+twi	2			1	3	0			70	58%		42%
Pembroke total													3							
Pembroke	2			1	2			1	2									78		22

Wards/department	Trained nurse staffing relative to patients (early / day shift): RN	No Patients	Trained nurse staffing relative to patients (late shift): RN	No of patients	Trained nurse staffing relative to patients (night shift): RN	No Patients	Staffing relative to population served ie nurses per occupied bed (NPOB) on a eaerly/day shift: Nurses	No. beds	Staffing relative to population served ie nurses per occupied bed (NPOB) on a late shift: Nurses	No beds	Staff Turnover %	Sickness absence (average) %	Nursing Sensitive Indicators March 2016 - August 2016: No of PU Grade 2 or above	Complaints	No of Falls	No of MRSA Bactaraemia	No of MSSA Bactaraemias	No of C-diff (reportable and non-reportable)	% Compliance Appraisals	% compliance Stat and Mand training	No of Red Flag Incidents	SafeCare in Place
Whiteparish	1	5.25	1	5.25	1	7	1	3	1	3	25.0%	4.10%	4	3	27	0	3	?1			23	No
Tisbury	1	6	1	6	1		1	3	1	3	9.6%	6.07%	1	1	14	0	1	0	84%	80%	0	Yes
Redlynch	1	6.75		6.75		9		3.4		4.5	3.2%	2.70%	3	3	45	0	2	0	75%		11	Yes
Pitton	1	6.75	1	6.75	1	9	1	3.4	1	4.5	16.0%	4.65%	15	4	35	0	0	0	86%		24	Yes
Breamore	1	6.66	1	6.66	1	10	1	3.4	1	4	N/A		2	0	36	0	0	0	N/A	N/A	4	Yes
Farley	1	6	1	6	1	10	1	3	1	3.8		9.23%	4	1	38	0	0	0	65%	88%	2	Yes
Durrington	1	7	1	7	1	10.5	1	3.5	1	4.2	16.2%	2.51%	0	2	23	0	0	0	78%	84%	2	Yes
Winterslow	1	7	1	7	1	10					1.2%	5.04%	9	1	50	0	0	0	53%	80%	0	Yes
Hospice	1	5	1	5	1	5	1	2.5	1	2.5	17.0%	8.80%	7	0	12	0	1	0	78%		3	Yes
Pembroke total	1	5	1	5	1	5	1	3.3	1	3.3	5.0%	4.40%	2	1	15	0	0	0	48%		0	
Pembroke																						Yes

WARD STAFFING REVIEW
March 2016 - August 2016

NB All these indicators are for period of March 2016 - August 2016

Current Position

Wards/department	Beds	Total Funded Establishment WTE	Funded Establishment Band 6 and 7	Funded Establishment Band 5 WTE	Funded Establishment Band 4 WTE	Funded Estabalishment Band 3 WTE	Funded Establishment Band 2 WTE	Budget (financial)	Current maternity leave WTE	Average % uplift during March 16 - August 16	Sisters/Charge Nurses: No Band 7	Sisters/Charge Nurses: No Band 6	Vacancies: Band 6 Vacancy WTE	Vacancies: Band 5 Vacancy WTE	Vacancies: Band 4 vacancy WTE	Vacancies: Band 3 vacancy WTE	Vacancies: Band 2 vacancy WTE
Amesbury	32	39.15	3	16.88	1.6	1	16.67	104,274	1	29.6%	1	2	1.2	2.3	0	0	4.5
Chilmark	24	29.67	3	13.9	0.8	0	11.97	959,396	0	19.6%	1	2	0.25	1.59	0.8		2.69
Burns	14+3	24.57	3	14.79	0	0	6.78	840,626	1.8	28.6%	1	2	1	2	0	0	3
Laverstock	26	28.95	3	16.62	1.2	0.8	7.33	1,067,237	1.4	?	1	2	0	0	0	0	1.47

Wards/department	Total Number of staff per shift: Early - RN	Early - Band 4	Early - Band 3	Early - Band 2	Late -RN	Late -Band 4	Late -Band 3	Late - Band 2	Night - Registered	Night - Band 4	Night - Band 3	Night -Band 2	Shift patterns (ie 2 or 3 shift pattern)	Admin support (WTE): Ward Clerk	Housekeeping Assist	Ward managers Assistant	Sisters/Charge Nurses: Average % supervisory	Skill mix as a proportion of total staff RCN note national benchmark of RN 65%: Registered %	B3 / B4 %	B2 %
Amesbury	4	1		4	3	1		4	3			2	2	1	0	0	60	51%	6%	43%
Chilmark	4			3	3			2	2			2	3	1			50	57%	3%	40%
Burns	4			2	3			1	2			1	2	1.4			50	72%		38%
Laverstock	5	*1	*1	3	3	*1	*1	2	3			1	2	1.6	0	0	60	59%	6%	35%

Wards/department	Trained nurse staffing relative to patients (early / day shift): RN	No Patients	Trained nurse staffing relative to patients (late shift): RN	No of patients	Trained nurse staffing relative to patients (night shift): RN	No Patients	Staffing relative to population served ie nurses per occupied bed (NPOB) on a eaerly/day shift: Nurses	No. beds	Staffing relative to population served ie nurses per occupied bed (NPOB) on a late shift: Nurses	No beds	Staff Turnover %	Sickness absence (average) %	Nursing Sensitive Indicators March 2016 - August 2016: No of PU Grade 2 or above	Complaints	No of Falls	No of MRSA Bactaraemia	No of MSSA Bactaraemias	No of C-diff (reportable and non-reportable)	% Compliance Appraisals	% compliance Stat and Mand training	No of Red Flag Incidents	Shelford Tool Used
Amesbury	1	6	1	8	1	10	1		1	4		3.5%	1	3	22	0	0	0	81%		0	Yes
Chilmark	1	6	1	8	1	12	1	4	1	5	0.8%	1.2%	0	0	26	0	1	0	96%	93%	0	Yes
Burns	1	4.3	1	5.6	1	8.5	1	2.8	1	4.25		3.6%	2	0	14	0	0	0			0	Yes
Laverstock	1	5.2	1	8.6	1	8.6	1	3.25	1	5.2	0.0%		1	2	10	0	0	0	90%			Yes

* band 4 included within RN shift numbers and band 3 within NA shift numbers
Skill mix ratios based on total RNS and B4's vs Band 2 and 3's

Sickness absence taken from Allocate

Surgery
March 2016 - August 2016

Current Position

Wards/department	Beds	Total Funded Establishment WTE	Funded Establishment Band 6 + 7	Funded Establishment Band 5 WTE	Funded Establishment Band 4 WTE	Funded Estabalishment Band 3 WTE	Funded Establishment Band 2 WTE	Budget (financial)	Current maternity leave WTE	Average % uplift during March 16 - August 16	Sisters/Charge Nurses: No Band 7	Sisters/Charge Nurses: No Band 6	Vacancies: Band 6 Vacancy WTE	Vacancies: Band 5 Vacancy WTE	Vacancies: Band 4 vacancy WTE	Vacancies: Band 3 vacancy WTE	Vacancies: Band 2 vacancy WTE
Britford	20+6	39	3	21.37	1	4.32	9.31	1,294,799	0.0	28%	1	1.5	0.5	2.00			1.00
																	SAU
Downton	24	25.38	3	11.83	0	0	10.55	815,695	0.0	27%	1	2		0.00	0.00	0.00	1.15
Radnor	10	54.91		34.89	0	0	5.11	2,202,705	0.0	35%	7	8		0.00			1.27
DSU	32 trolleys	18.16	3.5	10.26	0	0	5.4	not split	1.7	Not known	1	2.5	0.46				

Wards/department	Total Number of staff per shift: E- registered	E - Band 4	E - Band 3	E - Band 2	L -Registered	L -Band 4	L -Band 3	L - B2	N - Registered	N - Band 4	N - Band 3	N -Band 2	Shift patterns (ie 2 or 3 shift pattern)	Admin support (WTE): Ward Clerk	Housekeeping Assist	Ward managers Assistant	Sisters/Charge Nurses: Average % supervisory	Skill mix as a proportion of total staff RCN note national benchmark of RN 65%: Registered %	B3 / B4 %	B2 %
Britford	5			2	4			2	3			2	2	0.5		0.26	76	63%	13%	24%
(SAU)	1	1			1		1													
Downton	4			3	3			2	2			2	2	0.5		0.26	76.8	58%		42%
Radnor	9			1	9			1	9			1	2	1.57			100	86%		14%
DSU	5			3	5			3					3				100			

NB All these indicators are for period of March 2016 - August 2016

Wards/department	Trained nurse staffing relative to patients (early / day shift): RN	No Patients	Trained nurse staffing relative to patients (late shift): RN	No of patients	Trained nurse staffing relative to patients (night shift): RN	No Patients	Staffing relative to population served ie nurses per occupied bed (NPOB) on a eaerly/day shift: Nurses	No. beds	Staffing relative to population served ie nurses per occupied bed (NPOB) on a late shift: Nurses	No beds	Staff Turnover %	Sickness absence (average) %	Nursing Sensitive Indicators March 2016 - August 2016: No of PU Grade 2 or above	Complaints	No of Falls	No of MRSA Bactaraemia	No of MSSA Bactaraemias	No of C-diff (reportable and non-reportable)	% Compliance Appraisals	% compliance Stat and Mand training	No of Red Flag Incidents	Shelford Tool Reviewed
Britford	1	4	1	5	1	6	1	2.8	1	3.3	3.0%	4.50%	2	3	14	0	0	1	91%	77%	17	Yes
(SAU)																						
Downton	1	8	1	8	1	12	1	3.4	1	4.8	7.8%	4.70%	5	2	22	0	0	0	92%	93%	4	Yes
Radnor											2.1%	4.70%	4	0	0	0	0	0	80%	76%	21	Yes
DSU	1	6.4	1	6.4			1	4	1	4		3.21%	0	11	3	0	0	0	48%	68%	7	N/A

Trust Board meeting
Assurance Framework Update

Date: 5 December 2016

Report from: Fenella Hill, Head of Risk Management **Presented by: Lorna Wilkinson**

Executive Summary:
The Assurance Framework provides the Trust Board with a vehicle for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being met to satisfy internal and external requirements. In turn it will inform the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. This informs the Annual Governance Statement and annual cycle of business.

The Trust Board carries out an annual review of the Assurance Framework process to ensure that the risks described are the most valid and the document remains fit for purpose to be managed and monitored via the Assurance Committees. The Assurance Framework was reviewed during a Trust Board workshop in October 2016. Trust Board members agreed the principal risks for inclusion in the 2016/17 Assurance Framework.

The revised Assurance Framework is attached for Trust Board agreement as an appropriate document for the Assurance Committees to monitor quarterly and report to the Trust Board throughout the coming year.

Any changes that occur in year e.g. new and emerging risks or gaps shall be reported to the Trust Board via the Assurance Committee Chairs.

Proposed Action:
To agree the 2016/17 Assurance Framework risks.

Links to Assurance Framework/ Strategic Plan:

Choice - To be the hospital of choice, we will provide a comprehensive range of high quality local services enhanced by our specialist centres

Appendices:
Board assurance Framework – Trust Board December 2016

Salisbury NHS
NHS Foundation Trust

ASSURANCE FRAMEWORK

December 2016 – Trust Board

Corporate Objectives and Key to Care Quality Commission Outcomes

Corporate Objectives – Service Plan and associated risks on the Board Assurance Framework

AF1 - Choice - To be the hospital of choice, we will provide a comprehensive range of high quality local services enhanced by our specialist centres
Linked Risks
1.1 Failure to deliver key performance targets would result in patients losing trust in SFT as a provider of high quality care and result in intervention by regulators.
1.2 Impact of demand changes (up or down) and available capacity will have a detrimental impact on the sustainability of individual services and a cumulative impact for the organisation.
1.3 Failure to listen and act on feedback themes which are provided by patients and key stakeholders could result in:

- Poor patient experience for current and future patients
- Lack of learning and positive changes to practice as a direct result of feedback
- Loss of reputation - The hospital is not seen as the hospital of choice

1.4 SFT's involvement in the Bath Swindon & Wiltshire STP may compromise the Trust's overall strategy to provide a comprehensive range of services to patients in the Wessex area and given the clinical links with UHS and providers in Dorset.

AF 2 - Care - We will treat our patients with care, kindness and compassion and keep them safe from avoidable harm
Linked Risks
2.1 If there is poor compliance with infection prevention practice and policy this could lead to:

- Increase in HAI rates
- Loss of reputation and public confidence
- Failure to achieve reduction targets

2.2 If there is a failure to comply with internal and external expectations on quality of care this could result in any of the following

- Reputational damage and loss of public confidence
- Patient harm
- Ineffective /inefficient treatment
- Poor patient experience
- Failure to satisfy contractual and regulatory requirements
- Loss of associated income linked to CQUIN or contractual fines

2.3 If safeguarding policies and procedures for children, young people, and adults are not applied appropriately then we may fail to protect the most vulnerable and comply with our statutory and regulatory requirements.
2.4 If the organisation does not respond robustly and timely to the requirements of the CQC Improvement plan, the impact could be

- Failure to improve services in line with the findings from the CQC report
- Reputational compromise
- Failure to progress from RI to Good
- Regulatory involvement

AF 3 - Our Staff - We will make SFT a place to work where staff feel valued to develop as individuals and as teams

Linked Risks
3.1 Failure to recruit sufficient staff in order to deliver safe, sustainable services for patients.
3.2 Failure to deliver excellence for all patients if the workforce is not appropriately skilled and staffed to the right levels.
3.3 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 due to low morale.

AF 4 - Value - We will be innovative in the use of our resources to deliver efficient and effective care
Linked Risks
4.1 The implementation of the Electronic Patient Record (EPR) will have a substantial impact over the next 18 months and has the potential to impact on other IT projects, requirements and cause substantial organisational disruption.
4.2 Failure to secure income due to not mitigating against the following key examples:

- CCG challenges and fines
- Shifting case mix
- Coding issues
- CQUIN non delivery
- Contract breaches resulting in penalties
- Readmissions
- EPR

4.3 Failure to contain capital and revenue in budgets and achieve recurring efficiency savings will impact on the Trust's financial position.
4.4 Capacity and demand models need to reflect changing clinical practice and referral patterns.

Care Quality Commission - Outcomes

SAFE
EFFECTIVE
CARING
RESPONSIVE
WELL LED

Assurance Framework Template Headings

Principal Objective – What the organisation aims to deliver

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Which CQC Standard the Principal Objective maps to	What could prevent the above principal objective being achieved?	The assuring committee that has responsibility for reporting to the Board on the risk. Executive lead for the risk	What management controls/systems we have in place to assist in securing delivery of our objective	Where we gain independent evidence that our controls/systems, on which we are placing reliance, are effective.	What evidence demonstrates we are reasonably managing our risks, and objectives are being delivered	Where do we still need to put controls/systems in place? Where do we still need to make them effective?	Where do we still need to gain evidence that our controls/systems, on which we place reliance, are effective?

AF1 - Principal Objective: Choice - To be the hospital of choice, we will provide a comprehensive range of high quality local services enhanced by our specialist centres

1.1

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Effective Responsive Well Led	Failure to deliver key performance targets would result in patients losing trust in SFT as a provider of high quality care and result in intervention by regulators.	Joint Board of Directors Chief Operating Officer	Operational focus on key performance delivery Established performance monitoring and accountability framework – WTAG/Task Force/ OMB/ JBD Regular performance reviews with directorates – 3:3's Access Policy Central booking – consistent approach to delivery of key waiting list targets Winter pressures plan – maintaining performance at times of increased emergency demand Monitoring activity against plan Governance oversight via EPRR and Security Management Committee Steering Group Annual self assessment for EPRR Business continuity plans for essential services	Board reviews performance across a range of indicators every month. To be expanded via Finance and Performance Committee. JBD and Task Force review with CD engagement. Management of referrals in line with contract through contract activity notice.	Strong track record of delivery Green governance rating from Monitor. Reflected in 'light touch' approach. CQC banding 6 May 2015 Limited issues raised by commissioners in terms of performance Strong benchmarking across a range of indicators. Capacity and demand modelling highlighting future challenges. Delivery of the diagnostic recovery plan Delivery of pathway level KPI's i.e. primary PCI, Stroke etc.	a) Some (sub)specialty issues for RTT, resulting from increasing demand and capacity constraints b) Ensuring good knowledge of Access Policy rules for key staff c) Limited ability of IT systems to record waiting list position i.e. follow up appts d) Inability to recruit to specific clinical posts e) Effect of actions taken by neighbouring trusts to deliver their performance standards f) Access Policy not suitable in light of recent RTT rules g) Ability of Commissioners to manage referrals in.	

Actions Agreed	By Who:	By When:	Date Completed:
a) Undertake capacity and demand analyses for key specialties. Use additional workforce where absolutely necessary (eg impending consultant unavailability for sick leave, significant gaps in rotas)	COO/Head of Information/DM's	December 16	2 areas complete. Rolling to 2 more using
b) Training plan developed to sit alongside the Access Policy and clear resource on the Trust intranet to give staff an easy to access source of good practice re waiting times management	Central Booking Manager / Head of Training	July 16 (Ongoing)	In place – with COO attending
c) Ensure new EPR system allows accurate waiting list monitoring.	AH/LA	December 16	
d) Review service models in IR, Opthalmology, oral surgery, Gynae and plastics	AH/CB/LW	March 17	
e) Continuous briefing to CCG of risks and mitigation where possible	AH	December 16	
f) Review of access policy, supported by IMAS	AH/DS	July 16 Delayed December 16	
g) Activity notice issued to CCG's	AH	August 16	August 16
Action plan implementation	AH	March 17	

1.2

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Responsive Well Led	Impact of demand changes (up or down) and available capacity will have a detrimental impact on the sustainability of individual services and a cumulative impact for the organisation.	Joint Board of Directors Chief Operating Officer Director of Corporate Development	Finance and Performance Committee Waiting List Task Force Plus Waiting Times Action Group (WTAG) Engagement with commissioners – local and specialist Finance and Performance Committee	Market intelligence – foreseen and predicted changes in competitor activity and commissioning changes Review of market share by HRG Waiting times now and predicted in future. Marketing strategy – link to Trust Strategy Specialist services designation process Success rate of bidding for tenders Process established for determining whether SFT will submit tenders – informed decision making.	Market share relatively stable. SFT good reputation amongst both patients and GPs Positive NHS Choices feedback and Friends and Family ratings across a range of settings (ED, maternity, cancer services, inpatients) Large degree of compliance with designation. Strong relationships with commissioners High quality outcomes proven Good quality tenders submitted. Purchasing authority feedback High degree of commissioner satisfaction with performance of SFT services. Successful tender for Community Services to be provided by 3 acute trusts in Wiltshire.	a) Waiting times rising (eg orthopaedics, ophthalmology) b) Greater engagement of primary and secondary care clinicians via work on clinical pathways d) Spinal services – time to admit to unit and outpatient wait times. e) Service specifications driven by specialist centres and focused on inputs, not outcomes. g) Expertise and support for major tenders may be required.	c) Time lag in Dr Foster data (only source of market share information) f) Need robust data on outcomes

Actions Against Gaps in Control/Assurance:	By Who:	By When:	Date Completed:
a) Demand and capacity work required for most challenged specialties (see AF1, 1.1 above)	COO/Head of Information/DM's	December 16	Summer 2016
Surgical CD leading redesign of Ophthalmology services	DM	March 17	
Performance monitoring processes reviewed and new delivery group established	AH	June 2016	May 2016
b) Ongoing engagement of SFT clinicians in the redesign of clinical pathways across South Wiltshire	AH	Ongoing	
c) Review contract with Dr Foster re lack of data. Contract renewed for another year but timeliness issues remain.	AH/CB		
d) Interim management in place whilst permanent structure established	AH	November 2016	November 2016
Recovery action plan developed in response to CQC letter	AH/LW/CB	January 17	May 2016
Delivery of action plan	AH/DMT	January 17	
Review leadership structure for spinal unit	MD/COO/DoN	January 17	
Workforce review	AK	March 17	
e) Engage with specialist commissioners to ensure designation reflects outcomes	CEO/MD/DoF	Ongoing	
f) SFT to collect outcomes data to reflect quality of specialist services being provided – review service by service	MD/COO	Ongoing	
Data to be monitored by JBD/CGC	AH	Ongoing	
g) Commission external tender support on an 'as and when required' basis	AH	Ongoing	

1.3

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Caring Responsive Well Led	Failure to listen and act on feedback themes which are provided by patients and key stakeholders could result in: • Poor patient experience for current and future patients • Lack of learning and positive changes to practice as a direct result of feedback • Loss of reputation - The hospital is not seen as the hospital of choice	Joint Board of Directors Clinical Governance Committee Director of Nursing Director of Corporate Development	Methods of obtaining feedback from patients: • FFT • National and local surveys • RTF • Patient Stories at CGC Complaints policy and process Customer Care department Customer Care training – working with NHS Elect to provide bespoke training in complaints management and PPI Joint Investigator training being provided in collaboration with risk Customer Care reports to CGC and Trust Board Implementation of learning from incidents and complaints in all clinical areas Revised approach to ward based action plans drawn up from intelligence across all avenues for user feedback	National Patient Survey Reports Customer care reports reviewed by CGC and Trust Board Patient survey action plans resulting from annual reports Directorate level action plans and learning as a result of complaints NHS Choices feedback GP feedback via stakeholder forums and CQRM Healthwatch feedback	Positive feedback from the Ombudsman on individual complaints management of cases brought before them. 4.5/5 star rating on NHS choices Positive 2015 surveys published for outpatients, inpatients, maternity, and Cancer		a) Clear evidence of direct learning from complaints
Actions Against Gaps in Control/Assurance: a) Customer Care working with Directorates to ensure actions are captured and recorded					**By Who:** HH	**By When:** March 17	**Date Completed:**

1.4

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Effective Well Led	SFT's involvement in the Bath Swindon & Wiltshire STP may compromise the Trust's overall strategy to provide a comprehensive range of services to patients in the Wessex area and given the clinical links with UHS and providers in Dorset.	Joint Board of Directors Director of Corporate Development	Regular meetings at CEO/Chairman level with UHS and commissioners in Dorset and Hampshire. Network arrangements (e.g. cancer, Wessex trauma centre) necessitate close linkages between the organisations	Close working relationships with key players in Dorset and Hampshire. Strong personal links at a number of levels, both managerial and clinical. Good engagement by SFT within local networks		a) Drive for SFT to work more closely within providers in the STP footprint. b) Allocation of STP wide control totals. c) Commissioners in host STPs focus purely on in-county solutions. d) Resource implication to ensure that SFT is engaged in a number of geographical areas.	
Actions Against Gaps in Control/Assurance: a) Need to maintain good working relationships outside of BSW footprint. b) Review financial implications of any STP control totals c) Engagement with commissioners to ensure that wider context and interdependencies of SFT's services are well understood d) Prioritise resources to ensure SFT is well represented for strategically important discussions					**By Who:** Exec. Team DoF (MC) Execs CEO	**By When:** Ongoing As required Ongoing Ongoing	**Date Completed:**

AF 2 - Care - We will treat our patients with care, kindness and compassion and keep them safe from avoidable harm

2.1

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Safe Well Led	If there is poor compliance with infection prevention practice and policy this could lead to: • Increase in HAI rates • Loss of reputation and public confidence • Failure to achieve reduction targets	Clinical Governance Committee Director of Nursing	Infection Prevention and Control suite of policies on the intranet accessible to all staff Induction and mandatory training Operational infection update meetings Internal PLACE audits, and annual PLACE audit Infection Prevention and Control team with link nurses in clinical areas. DIPC role at Board level Infection Control Assurance Framework: • Infection Prevention and Control Committee • Infection Prevention and Control Working Group • Infection Control Team meetings • Reporting via Matrons Monitoring meetings • KQIs reported from ward level up Surveillance Programme Enhanced and deep cleaning programme Outbreak Policy and Procedure MRSA screening programme RCA process for reportable events and subsequent learning for practice Antibiotic stewardship	National surveillance on c-difficile, MRSA, MSSA, and e-coli bacteraemias Monthly mandatory surveillance reporting on HCAIs to Public Health England website Review of quarterly surveillance data generated by Public Health England CQC inspection regime Infection Control practice audit reports RCA/Incident investigation reports following MRSA bacteraemia and C Difficile cases, PIIs, and outbreaks. Mandatory surgical site infection surveillance data for orthopaedic surgery. DIPC reports to Trust Board	6 monthly DIPC report to Board (June 2016) Monthly hand hygiene audits showing reliable practice across most areas. HCAI data report from SW shows SFT in best performing quartile for rates of MRSA/ /C.Diff Improved PLACE scores across all categories placing Trust above average nationally	a) Variability in practices areas as evidenced through CQC inspection b) Annual hand hygiene practical lightbox assessment compliance below 85% across the Trust.	c) 2016/17 CQUIN requirement to reduce antimicrobial prescribing poses a significant challenge

Actions Against Gaps in Control/Assurance:	By Who:	By When:	Date Completed:
a) Confidence in care rounds implemented across all Directorates	DSN's	July 16	July 2016
Clinical audit developing the above into an electronic tool available on the i-pads	LD/KM	Jan 17	
b) Extra light box sessions being held by IPC team	FMc	ongoing	Continuing
Link professionals encouraged to take light box into their areas	FMc	April 16	Continuing
Performance management against target of DMTs through Performance meetings	LW	June 16	Continuing
c) Antimicrobial reduction plan associated with national CQUIN being drawn up	ET/PR	September 16	Sept 16
Implementation of CQUIN plan following resource agreement at EDs	ET/PR	Jun 16	June 16

2.2

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Safe Effective Well Led	If there is a failure to comply with internal and external expectations on quality of care this could result in any of the following • Reputational damage and loss of public confidence • Patient harm • Ineffective /inefficient treatment • Poor patient experience • Failure to satisfy contractual and regulatory requirements • Loss of associated income linked to CQUIN or contractual fines	Clinical Governance Committee Director of Nursing Medical Director	Quality Governance framework and regular monitoring internally via Trust committees and sub committees such as Clinical Risk Group, Clinical Management Board, Clinical Governance Committee Key Quality Indicators reported monthly – corrective actions Directorate performance reviews Patient safety work programme Risk Management policies and procedures: • Risk and incident reporting • Quality Walks Clinical Effectiveness policies and procedures: • National audit process • National surveys • Clinical audit programme • Mortality review process Patient and user feedback mechanisms • RTF/FFT • Patient surveys • Complaints process SFT Organisational Risk Tool (SORT) Contract Quality Reporting Meeting	Internal audit programme Internal reports to CGC and CMB CQC reports and risk rating via intelligent monitoring KQI report Quality Account NRLS reports Peer reviews National audit reports CPA/JAG and other externally led inspections of services Dr Foster data and HSMR/SHMI Survey results	Mid year Quality account report 2016/17 shows good progress across some priority areas – reduction in pressure ulcers, HCAIs. Improving compliance with sepsis 6. Downward trend in MSA breaches	a) Reducing the number of falls resulting in harm b) Proactive management of single sex within a capacity challenged environment such as AMU	

Actions Against Gaps in Control/Assurance:	**By Who:**	**By When:**	**Date Completed:**
a) Renewed focus on falls as part of Safety Programme with linked KPIs Update of falls action plan following aggregated rca review of Q2 data	CG	Nov 16	Nov 16
b) • Exploration of longer term plan to meet AMU capacity requirements	COO	September 16	Bid requires further work
• Participation in NHS South workshop on defining and reducing MSA	LW	Oct 16	Oct 16

2.3

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Safe Caring Well Led	If safeguarding policies and procedures for children, young people, and adults are not applied appropriately then we may fail to protect the most vulnerable and comply with our statutory and regulatory requirements.	Clinical Governance Committee Director of Nursing	Named professionals: • Named Nurse (children) • Named Doctor (children) • Named midwife • Adult Safeguarding Lead Safeguarding Policies on intranet: • Adults (reflects WSAB) • Children (reflects WSCB) • Domestic abuse Annual audit programme Annual section 11 audit return Training: • Safeguarding face to face training session on induction. • Safeguarding update training via MLE and internal programme (mandatory) • Multi agency training • Mental Capacity Act CBT • Domestic Abuse training Senior level representation on Wiltshire Boards (adults and children) Internal meeting structure for key personnel: • Integrated Safeguarding Committee • Safeguarding working Group • Safeguarding Children Forum Supervision: Coordinated by Lead Nurse for safeguarding Children and offered individually, group and ad hoc as per policy. Safeguarding schedule of NHS contract	Reports submitted to: • Integrated Safeguarding committee • Clinical Risk Group • Clinical Governance Committee • CQRM • Wiltshire Safeguarding Boards Commissioning and contractual requirements Audit reports Safeguarding training records and reports CQC registration, review, and inspection Serious Case Review learning and outcomes	Quarterly Safeguarding report to Integrated safeguarding Committee, CGC, and CQRM showing positive activity across safeguarding adults and children Audit on staff understanding of child protection processes and escalation procedure (April 15) continues to demonstrate good level of understanding and knowledge of individual staff responsibility to safeguard children Action plan achieved following CQC inspection of Wiltshire Council Safeguarding Children	a) TNA in response to Intercollegiate document now completed but in early days of implementation b) Best Interests assessments not being carried out in a timely way by the LA c) OFSTED concerns raised re: management of early years provision in nursery and play scheme	d) Variability of safeguarding (adult) and MCA knowledge across depts.

Actions Against Gaps in Control/Assurance:	By Who:	By When:	Date Completed:
a) Quarterly reporting on completed training in line with TNA	AC	Apr 16	Apr 16
b) Continue to work with LA on this issue and ensure local documentation and processes are robust	GC	In place	Ongoing
c) Implementation of recovery plan	AK	December 2016	
d) Launch and evaluate MCA training	GC	Mar 17	
Continue active safeguarding adults champion programme	GC	In place	Ongoing

2.4

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Responsive Well Led Safe	If the organisation does not respond robustly and timely to the requirements of the CQC Improvement plan, the impact could be • Failure to improve services in line with the findings from the CQC report • Reputational compromise • Failure to progress from RI to Good • Regulatory involvement	CGC Director of Nursing	CQC Improvement Plan Monitoring and Performance Framework: • Directorate 3:3s • CQC Steering Group • CGC • Core service presentations to CGC and JBD Spinal Services Improvement Plan and governance in response to warning notice	Core service presentations to CGC and JBD Exec walk rounds Action plan update reports ALG Repeat inspections of services/Trust by CQC		a) Current operational pressure in the non-elective pathway is limiting pace of improvement plans in ED and patient flow PMB.	A) maintaining the pace of improvement in the spinal injuries unit – particularly with regard to the warning notice

Actions Agreed	**By Who:**	**By When:**	**Date Completed:**
a) Weekly executive oversight meetings to continue	AH/DMT	In Place	Ongoing
DMT feedback and involvement of the SIU team	DMT	Ongoing	
Monthly submission of updated action plan	DMT	Ongoing	
Response to November 2016 visit once report published	DMT	December 16	
b) Activity notice issued to CCG's	AH (COO)	March 17	
Implement all aspects of action plan			

AF 3 - Our Staff - We will make SFT a place to work where staff feel valued to develop as individuals and as teams

3.1 (New Risk)

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Safe Well Led	Failure to recruit sufficient staff in order to deliver safe, sustainable services for patients.	Joint Board of Directors Director of Human Resources and Organisational Development	Strategic level EWC with Executive leadership of the workforce agenda. Workforce Redesign Group for the development and use of workforce planning and workforce redesign tools and monitoring Nursing skill mix review regularly reviewed and updated Medical Workforce discussed regularly at medical transformation board, EWC, MET committee, MAC Other workforce issues discussed regularly at EWC and other management committees.	Medical Appointments Committee Workforce Controls Panel Nursing and Midwifery Steering Group Recruitment and Retention Steering Group Monthly Board Workforce Report Workforce Issues are part of the discussions (and are minuted) at Directorate Performance meetings including: staffing and or skill shortages related to business as usual and change projects, Annual Staff Survey. Annual review of workforce and training needs through Health Education Wessex Retention strategy includes Health and Wellbeing offer and good staff engagement.	Numbers of new starters averaging at 75 per month. Continuing EU nursing and international recruitment Medical Headhunter agency signed up and international recruitment agency for medical staff. Shape up at Salisbury offering for staff well supported. Good levels of staff engagement scores in Staff Survey outcomes. Turnover remains steady with no spikes in staff groups. Within NHS benchmark levels. In HSJ top 100 places to work		a) Impact of Brexit not yet clear b) Impact and delay of IELTs and OSCE for international recruits

Actions Against Gaps in Control/Assurance:	**By Who:**	**By When:**	**Date Completed**
a) & b) Continue to link into national agenda	AK	Review March 2017	

3.2

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Safe Caring Well Led	Failure to deliver excellence for all patients if the workforce is not appropriately skilled and staffed to the right levels.	Joint Board of Directors Director of Human Resources and Organisational Development	Strategic level EWC with Executive leadership of the workforce agenda. Emergent Leadership and Talent strategies to create a high performing workforce with effective succession plans. HR Policies including: Security of Employment, Attendance Management. Directorate 3:3 Staff Wellbeing Project http://intranet/website/staff/hr/shapeup/strategy/home.asp Organisational Change processes supported by HR policies and adoption of learned good practice. Workforce Redesign Group for the development and use of workforce planning and workforce redesign tools and monitoring Nursing skill mix review regularly reviewed and updated	Governance: EWC, OMB, JBD, Trust Board receive reports on: sickness absence; disciplinary and grievances data; stability/turnover; vacancy rates; safer staffing reports; Training and Development compliance (MLE); appraisal rates. Nursing and Midwifery Steering Group Recruitment and Retention Steering Group CQC Improvement Plans: MAST and Appraisal Monthly Board Workforce Report Proactive management of sickness/absence by Directorate Managers with HR support. Workforce Issues are part of the discussions (and are minuted) at Directorate Performance meetings including: staffing and or skill shortages related to business as usual and change projects, Annual Staff Survey. Annual review of workforce and training needs through Health Education Wessex	Staff sickness at 3.2% (M12) Review of admin occurring in departments across the trust, with co-ordination across directorates and consideration of EPR to ensure efficiencies are achieved. Salisbury Organisational Trigger Tool assesses workforce planning needs as one of its measures Positive staff survey reports on appraisal uptake.		a) Trust not reporting compliance in Training (range 74%-91%) – Sept 16 rate 82% b) Difficulty in recruiting junior and senior medical staff in some specialities

Actions Against Gaps in Control/Assurance:	By Who:	By When:	Date Completed
a) Focus on MLE provision and compliance using e-assessments and bespoke training (e.g. light box on site)	AK (J Osmond)	Mar 2017	
b) Working with medical head hunters and medical agencies to source and recruit to hard to fill posts	AK/CB	March 2017	

3.3 (Previously 3.1)

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Safe Well Led	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 due to low morale.	Joint Board of Directors Director of Human Resources and Organisational Development	Strategic level EWC with Executive leadership of the workforce agenda. Emergent Leadership and Talent strategies. Trust Values and Behaviours. Equality and Diversity Steering Group Effective use of HR Policies such as Bullying and Harassment Policy; Flexible Working; Equal Opportunities Policy; Psychological Well-being and Effectiveness at Work. Staff Wellbeing Project http://intranet/website/staff/hr/shapeup/strategy/home.asp Risk assessments for significant staffing changes regularly reviewed by DSNs and reflected in Directorate risk registers and reported through 3:3's, to maintain appropriately skilled teams. Executive Walkround. Health and Safety Committee	Governance: EWC, OMB, JBD, Trust Board receive reports on: sickness absence; disciplinary and grievances data; stability/turnover; vacancy rates; safer staffing reports; Training and Development compliance (MLE); appraisal rates and the Staff Survey action plan. This provides evidence of progress in the two risk areas. Monthly Board Workforce Report Leadership and Talent Strategy with Executive Sponsorship progress monitored through EWC. Staff Survey Results Staff Friends and Family Test Equality Delivery Scheme Public Sector Equality Duty Compliance H&S Committee receive reports on all staff related incidents with actions taken and recorded.	Staff turnover average 9.7% (excluding rotational medical staff), a reduction on previous months. Staff sickness at 3.2%. Results from the 2015 Staff Survey show that the Trust was in the best 20% of acute Trusts in the country for 25 of the 32 key findings; above average for 4; average for 2; and below average for 1. This shows an improved position as reported by staff since 2014. Below are some key highlighted from the top 20% for the Trust. • recognition and value of staff by managers and the organisation • percentage of staff able to contribute to improvements at work • staff recommendation of the trust as a place to work or receive treatment • percentage agreeing they would feel secure about raising concerns about unsafe clinical practice (this was a new question in 2014) • staff motivation at work • percentage of staff reporting good communication between senior management and staff • staff's role makes a difference to patients and service users • witnessing potential harmful errors, near misses or incidents in the last month • reporting potential harmful errors, near misses or incidents in the last month • experiencing discrimination in the past 12 months Development and launch of Dignity at Work Advisors. Staff Friends and Family Test results remain positive. Staff Health and Wellbeing established: shapeup@salisbury, including Stress workshops, access to RMN and physiotherapy support. Striving for Excellence Award nominations. Executive Walkround and Feedback. Values and Behaviour embedded in Induction, Recruitment and Appraisals, with work occurring at team level to translate the V&B into service settings. Health and Safety Annual Report. In top 100 places to work		a) Trust not reporting compliance levels in: -Training (range 70%-85%) – 82% at Sept 16

Actions Against Gaps in Control/Assurance:	By Who:	By When:	Date Completed
a) Focus on MLE provision and compliance using e-assessments and bespoke training (e.g. light box on site)	AK (J Osmond))	Mar 2017	

AF 4 - Value - We will be innovative in the use of our resources to deliver efficient and effective care

4.1

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Responsive Well Led	The implementation of the Electronic Patient Record (EPR) will have a substantial impact over the next 18 months and has the potential to impact on other IT projects, requirements and cause substantial organisational disruption.	Joint Board of Directors Director of Corporate Development / Chief Operating Officer	Informatics Strategy Steering Group (ISSG) chaired by the Chief Executive and attended by many of the Executive Board members along with the IT Clinical Lead meets every month and will oversee the project. Project Management Board will manage the project according to Prince2 methodology. Experienced Programme Manager appointed. Appointed supplier with reasonable track record for delivering projects successfully.	Regular review of project progress against plans and objectives. Review of expenditure against budgets Monthly input from NED who is experienced in delivery of such projects. Business case following the accepted Monitor 5 case (strategic, commercial, financial, economic, management) format.	Experience of delivering a number of major, organisational wide projects, eg PACS, test requesting (ordercomms). Initial stages of the project have progressed smoothly with all timescales achieved and good progress made. Good engagement to date – 80+ clinical leads and champions identified. Extremely strong engagement from Executive Directors (eg 5 present on ISSG, 2/3 on PMB) Positive view from CSC on how the project is being managed. Trial Load 2 data from iPM successfully imported into Lorenzo with 99.8% accuracy. Impact of phase 1 go live did not lead to substantial organisation wide disruption. Subsequent phases are potentially more contained in their scope and therefore potential impact.	a) Ensuring sufficient clinical engagement to provide input such that user expectations are known. b) Ensuring organisational wide commitment to the project at a time of much change, eg ensuring made available for training. c) Delivering the benefits described in the business case. d) There may be delays to Payment By Results (PBR) data reporting around the time of implementation. e) Hospital wide infrastructure is unable to support the increased flows of information. f) Resource plan for the delivery of the phase 2 schemes of the Lorenzo deployment not developed and agreed with CSC. g) ensuring that CSC provide service in line with contract	h) training of agency staff – ensuring that agency staff are able to use the system.

Actions Against Gaps in Control/Assurance:	By Who	By When	Date Completed:
a) Ensure support from all Exec directors to the overall project and ensure sufficient resources included in the business case for backfill.	DoCD/Programme Lead/DoI	December '15	December 16 Ongoing
b) Ensure that importance of the EPR project is well known and that recognised by all as an organisational priority. Extensive communication programme required.	All Execs	Ongoing	Ongoing
c) Recruit staff to the project focussed on benefits identification and realisation. EPR Transformation lead to report to COO. Benefit tracker in place and review of benefits against business case	DoCD/COO/MC	Ongoing Ongoing	Ongoing
d) Informatics to review infrastructure available in line with CSC requirements and ensure that infrastructure is adequate and to report back to PMB. Further monitoring and tracking post go live.	DoI/Programme Lead	Ongoing	
e) Develop plans for the replacement of the data warehouse in good time to prepare for data switch over, communicate clearly to commissioners and Regulators the risk, but seek to have double running for at least 3 months before switchover.	DoCD	December 2016	Plans in place but risk – identified to ISSG and Board
f) Develop project plan (including resources required) for second phase(s) of Lorenzo development and seek ISSG approval. Subject to that approval being received, work up the scheme further with CSC.	Programme Lead/Business Change Manager	December 2016 Ongoing	
g) Work with procurement to develop a monitoring regime to ensure that CSC are held to account under the contract for their performance and delivery of a robust service.	Programme Lead/Business Change Manager	January 2017	
h) Develop plans with operational staff, Procurement and local agencies to train most frequently used agency staff on the Lorenzo system	Programme Lead/Business Change Manager	January 2017	

4.2

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Effective Responsive Well Led	Failure to secure income due to not mitigating against the following key examples: • CCG challenges and fines • Shifting case mix • Coding issues • CQUIN non delivery • Contract breaches resulting in penalties • Readmissions • EPR Will impact on the Trust's financial position and undermine the financial viability of the Trust.	Finance Committee Director of Finance	Contract monitoring systems in place Regular contract performance review meetings with key NHS Commissioners Monthly performance reports to Trust Board & Finance and Performance Committee Clinical Quality Review Group Monthly Directorate performance review meetings Use of standard NHS SLA contract & timetable for contract negotiations All contracts signed with key NHS Commissioners	Regular contract performance review meetings in place with key NHS Commissioners Contract monitoring action tracker & issues log Robust tendering process Coding Audits and performance monitoring Audit reports (External & Internal)	Achievement of SLAs performance metric & closure of items on action tracker and issues log Delivery of CQUIN schemes All commissioners challenges are proactively managed Contingency in place to allow for potential penalties & fines Successful award of tendered contracts Monthly Un-coded activity < % of total monthly activity & all activity coded at SLAM freeze date	1. The implementation of the new EPR system & the associated data warehouse fails to provide accurate & timely activity data for contract monitoring 2. Proactive management of single sex within a capacity challenged environment such as AMU	
Actions Against Gaps in Control/Assurance: 1. Data warehouse in place and reporting accurately (see Risk 4.1) 2. Exploration of longer term plan to meet AMU capacity requirements – Business plan and Capital Bid					**By who:** DoCD COO	**By When:** November 2016 June 2017	**Date Completed:** November 2016

4.3

CQC Outcome Link	Principal Risk	Classification of Principal Risk	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Responsive Well Led	Failure to contain capital and revenue in budgets and achieve recurring efficiency savings will impact on the Trust's financial position.	Finance Committee Director of Finance	Finance and Audit committees Trust Board Established planning, reporting & monitoring systems Monthly Directorate performance review meetings (3:3s & stocktakes) Internal Audit programme Monitoring of performance with budget managers Budget setting guidance/processes in place Established Cost Improvement plans (CIPs) Programme Steering Group External Audit of Annual Accounts Benchmarking Reference costs Workforce Committee monitoring agency spend	Monthly performance reports to Trust Board & Finance Committee Audit reports Monitor's Continuity Services Risk Rating (CoSR) Monitor's financial performance reports Monthly reporting of CIPs target to PSG, Trust Board and Finance and Performance Committee	Internal Audit reports – Low priority recommendations External Auditors unqualified opinion of Annual Accounts Achievement of CoSR of at least 3 out of 4 (4 being the lowest risk). Reference cost index <100	1. Tracking & delivery of CIPs and lack of development of 3 year CIPs plan 2. Continuing development of Service Line Reporting (SLR) 3. £9.5 million saving programme required and not fully identified 4. Non-Finance management training programme 5. Ability to achieve performance trajectories to secure S&T fund	1. Non delivery of recurrent CIPs 6. Accuracy of financial plans and forecasting at Directorate level 3. Usability of SLR

Actions Agreed:	**By Who:**	**By When:**	**Date Completed:**
1. Development of robust savings plan and rolling CiP plan with stretch targets. Repeat CiP plan and meetings for 2017/18	MC/AH	On-going	
2. Development of SLR & PLICs reporting	MC	30.09.15	Ongoing
3. Refresh planning & budget setting guidance 2017/18	MC	November 2016	November 2016
4. Develop non-financial management training programme	MC	October 2016	Not proceeding currently.
Awaiting executive and DoF sign off. Decision not to implement this year due to EPR implementation but support financial module for aspiring clinical leaders programme.	MC	March 2017	

4.4

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Effective Responsive Well Led	Capacity and demand models need to reflect changing clinical practice and referral patterns.	Joint Board of Directors Chief Operating Officer	Demand and capacity planning should be undertaken annually as part of the contractual round to ensure risks to delivery against commissioners intentions are identified at an early stage and mitigated. This work should be undertaken initially by the DMT and utilised by the COO and the finance and contract teams to negotiate annual contracts. Proactive reviews of demand and capacity should be an ongoing process which is undertaken by the DMTs and capacity flexed to meet known increases/changes in demand. The use of WTAG on a weekly basis to review waiting lists and any imbalances between capacity and demand, highlights areas for focus. Utilisation of IST model to consider real time forward view will support a more proactive approach.	The effectiveness of the management controls are reviewed as part of WTAG (weekly), WLTF (monthly and chaired by the chief executive) and also at JBD and finance committee and Trust Board through high level dashboards against regulatory and agreed efficiency and effectiveness targets. Externally, a commissioner report of our performance is produced which is reviewed at the monthly contractual meetings. Performance at Directorate level reviewed at 3:3 monthly meetings.	Achievement of all regulatory and internal targets regarding performance provides assurance that the balance is correct in terms of matching capacity and demand within the resources available.	a) Capacity and demand modelling too higher level. Informs contract setting and needs to be at operational level and recognise sub speciality of services.	b) IMAS tool not fully implemented and unable to provide assurance of the ongoing balance of demand and capacity. Contractual performance - income and activity meeting expected budgeted levels.

Action Agreed:	**By Who:**	**By When:**	**Date Completed:**
a) Role out use of IMAS capacity and demand modelling tool	AH/DM's	December 16	
b) Full implementation of the IMAS model	Informatics and DMs	December 16	
SFT to be trial site for new IMAS bed management tool	AH	December 16	

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
Held on 26 September 2016

Present	Dr N Marsden	Chairman
	Dr L Brown	Non-Executive Director
	Mr I Downie	Non-Executive Director
	Mr P Hill	Chief Executive
	Mr A Hyett	Chief Operating Officer
	Mr M Cassells	Director of Finance and Procurement
	Mr P Kemp	Non-Executive Director
	Mrs K Matthews	Non-Executive Director
In Attendance:	Mr D Seabrooke	Head of Corporate Governance
Apologies:	Mr L Arnold	Director of Corporate Development
	Professor J Reid	Non-Executive Director

1. FINANCE AND PERFORMANCE COMMITTEE MINUTES – 22 AUGUST 2016

The minutes of the meeting of the Committee held on 22 August 2016 were agreed as a correct record.

2. FINANCE AND CONTRACTING REPORT TO 31 AUGUST 2016 (MONTH 5)

The Committee received the Finance and Contracting Report which indicated an in-month surplus of £284,000 a favourable variance against the plan of £2132,000. Activity continued to be up against plan and elective cases slightly down on the previous year and on plan. The CCG had challenged the reported rise in regular day attenders. Further challenges were being processed. The consolidated cash position at the end of August was ahead of plan by £548,000.

The Committee noted that the ITFF had given its approval to the loan in relation to the Electronic Patient Record and that this decision was now with the Department of Health and Treasury, and that the national position on Capital Funding was severely challenged.

The CCG had confirmed that it would pay for excess activity.

The Committee discussed progress with the achievement of the £2.5m of required savings that had not been allocated to directorates.

It was also reported that the joint venture with Sterile Supplies Limited had started from 1 September and there was already improvements to the operation of this service. It was also noted that the Single Oversight Framework to take effect from 1 October and replacing the Risk Assurance Framework had now been published by NHS Improvement.

The Committee noted the Finance and Contracting Report.

3. TRANSFORMATION AND COST IMPROVEMENT

The Committee received the Operational Performance Report for Month 5 and the Programme Management Office Report for Month 5. It was noted that the Trust had achieved 115% of planned savings to date. Work was underway to identify schemes for 2017/18. Executives continued to challenge Directorates to firm up their recurring savings.

The achievements of the Theatres Transformation and patients flow work would have beneficial impacts on other pathways.

4. OPERATIONAL PERFORMANCE – MONTH 5 & WORKFORCE REPORT – MONTH 4

The Committee received the two reports. The Trust had delivered 91% on RTT in August following validation of the information and this was based on a late submission. Cancer targets in Quarter 1 had been delivered and there were good prospects on this for Quarter 2. For ED the performance was 93.6%. The service needed to grow its capacity to meet continuing demand and there was active recruitment of consultants and nursing staff. The service had also been trialling a new triage system which it was hoped would continue into the longer term, that reduced waiting times in the Department.

Diagnostic waiting times had been delivered.

5. CAPITAL DEVELOPMENT REPORT

The Committee received the Capital Development Report for the preceding four months relating to buildings, information technology, medical equipment and other infrastructure. Quarter 3 was likely to be significant as the Breast Care Unit was completed and the refurbishment of Laverstock Ward. Planning permission for the Maternity Unit expansion had been given and detailed work on this scheme was underway. The Trust was seeking planning permission for the proposed modular build ward.

6. TRUST OWNED COMPANIES – OVERVIEW

The Committee received a report summarising the background to the Trust's portfolio of companies. The companies included Odstock Medical which had started from 1 April 2006 to market the technology developed to enable people to walk better following the effects of a stroke. NHS Innovations South West Limited started trading on 2 June 2006 which had led to the development of NHS Innovations South West Limited to Leverage Innovations Funding. Odstock Private Care Limited was established by the Trust and then relinquished and was now owned by the Salisbury Charitable Trust as a vehicle through which to provide private health care for the benefit of Salisbury NHS Foundation Trust. Salisbury Trading Limited was formed in September 2008 and was a dormant company until October 2013 when the Trust's on site laundry was transferred to it. Replica 3DM Limited had started in February 2012 and was formed to take forward 3D printing technology. Sterile Services Limited was a joint venture with Synergy, a market leader in the area of sterilisation and disinfection for hospitals and this would be providing this service to the Trust going forward. My Trusty Co Limited was formed at the end of 2014 and was currently dormant. Healthcare Storage

Solutions was formed in April 2016 as a means to market a bed stacker facility in the health service.

It was noted that Tania Baker had been requested by the Chairman to lead on the oversight and monitoring of the companies activity.

7. REPLICA 3D UPDATE

It was noted that shares secured now were over 75% of the equity.

8. WILTSHIRE HEALTH AND CARE

The Committee received the report arising from the 15 September meeting of the Wiltshire Health and Care Board provided by Laurence Arnold, the Trust's representative.

The dashboard provided with the report was noted and the committee discussed what further benefits the new arrangement could have and how services delivered in South Wiltshire could be monitored more specifically.

9. DATE OF NEXT MEETING /

Monday 24 October at 9.30 am.

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
Held on 24 October 2016

Present:	Dr N Marsden	Chairman
	Dr L Brown	Non-Executive Director
	Mr I Downie	Non-Executive Director
	Mr A Hyett	Chief Operating Officer
	Mr M Cassells	Director of Finance and Procurement
	Mr P Kemp	Non-Executive Director
In Attendance:	Mr D Seabrooke	Head of Corporate Governance
	Professor J Reid	Non-Executive Director
	Ms F Hill	Head of Risk Management (for item 7)
	Mr R Webb	Associate Director of Procurement (For item 8)
	Mrs C Gorzanski	Head of Clinical Effectiveness (for item 2)
	Ms L Wilkinson	Director of Nursing (For item 2)
Apologies:	Mr P Hill	Chief Executive
	Mrs K Matthews	Non-Executive Director

1. FINANCE AND PERFORMANCE COMMITTEE MINUTES – 26 SEPTEMBER 2016

The minutes of the meeting of the Committee held on 26 September 2016 were agreed as a correct record.

2. CQUINS 2016/17 – QUARTER 2 POSITION

The Committee received the CQUIN report. It was noted that payments for Quarter 1 had been achieved for Wiltshire and Dorset with a loss of £19,000 mainly in relation to Sepsis. The total value was £471,000 in Quarter 1. In Quarter 2 £822,000 had been achieved with a potential loss of £37,000 in relation to smoking reduction – the target had not been agreed with the CCG. It was expected to achieve all West Hampshire targets. An update to the November Committee meeting would be made in relation to Critical Care Transfers Within 24 Hours – a West Hampshire target.

It was noted that CQUINs for 2017/18 and 2018/19 had been published with a value of 2.5%, 0.5% of which would be available for engagement with the STP. Principal themes included NHS staff health and wellbeing, proactive and safe discharge, reducing the impact of serious infections – Sepsis and AMR, improving services for people with mental health needs at ED, E-referrals, preventing ill health by reducing alcohol and tobacco use and advice and guidance.

The Committee noted the CQUIN report.

3. FINANCE REPORT TO 30 SEPTEMBER (MONTH 6)

The Board received the Finance and Contracting Report. The year to date position was a surplus of £36,000 which assumed Sustainability and Transformation Funding. This position was a favourable variance of the plan of £241k but an in month deficit of £206k. The in-month deficit was explained principally by a reduction in Sustainability and Transformation Funding of £197k due to non-achievement of the A&E planned trajectory of 94%. The Trust was anticipating achieving all other trajectories as well as the financial plan at this stage. There was a reduction in NHS clinical income by around £265k due to a continuation of emergency care pressures. The position was off-set by a reduction in pay costs compared to the previous month by £115k. It was noted that on a straight line basis, to achieve the Trust's control total, it should have a surplus of £900,000 at this stage but that the Trust plan was phased to reflect a higher rate of savings in the second half of the year.

It was noted that NHS England had now published the standard contract documentation for 2017/19. The testing of HRG4 was delayed by the EPR implementation.

An activity query notice remains in place with West Hampshire CCG. It was noted that CCGs were requiring advance authorisation in relation to interventions not normally funded.

Guidance on NHS Improvement on financial performance and accountability had recently been published and would be discussed at a forthcoming Board seminar day. The requirements included a protocol for declaring an adverse budget variance at the Quarter 2 or Quarter 3 reporting point and a template assurance statement requiring consideration by the Joint Board of Directors, Finance and Performance Committee as well as the Trust Board.

It was noted that enabling works for the proposed new 23 hour surgical ward were continuing and there was believed to be a three month lead time from a final decision.

The Trust had been segmented by NHS Improvement as a level two performer.

Finally it was noted that a major supermarket was planning to stock the My Trusty range from February.

The Committee noted the report

4. TRANSFORMATION AND COST IMPROVEMENT

The Committee received the Transformation and Cost Improvement Report which showed an identified position of 100% of savings identified against the target of £6.5m. The Programme Steering Group continued to review the mixture of recurring and non-recurring savings plans. A target of £6.5m for 2017/18 had been provisionally set and directorates were 30% identified against this at this stage.

The committee noted the report.

5. OPERATIONAL PERFORMANCE (MONTH 6 INCLUDING MONTH 5 WORKFORCE REPORT)

The Committee received the Operational Performance Report. It was noted that the Trust had not yet finalised its 18 Weeks position as verification work continued – performance was 91% against the target of 92%. Cancer targets had been delivered. The Trust had delivered 92.8% in September against the STF trajectory of 95.5% and the national target of 95%.

6. GP REFERRALS/MARKET INTELLIGENCE

The Committee received the report. The Trust's market share was holding steady. It was noted that a pilot referrals management for Ophthalmology had been introduced.

7. ASSURANCE FRAMEWORK AND RISK REGISTER QUARTERLY REVIEW

The Committee received the quarterly review report which was accompanied by the current Assurance Framework and the Finance Committee extract of the Trust Risk Register. There were no new gaps and no new assurances to report. The Assurance Framework was in the course of being updated following the September board workshop.

It was agreed to review the amount of detail in the descriptions with a view to possible consolidation at the 28 November meeting.

8. PROCUREMENT TRANSFORMATION PLAN

The Committee received the Procurement Transformation Plan which had been developed in response to a Lord Carter recommendation. The plan set out how the Trust will aim to meet the model hospital benchmarks, enter into collaboration and discuss the challenges the service faced in taking this forward.

The Procurement service was making steady progress towards achieving level two standards against the targets set by Lord Carter. There were capacity issues as part of the service was now dedicated to the Scan 4 Safety initiative and recruitment was challenging. The plan was however considered to be achievable.

It was agreed that Jane Reid would be the Procurement Champion requested in the report.

The Committee supported the objectives set out in Transformation plan.

9. ANY OTHER BUSINESS

An update was given on new contracts won by the Trust's in-house laundry service. It was believed that the Trust was in the position to offer its services more broadly within the NHS to help other Trusts manage down their laundry requirements.

10. LYDIA BROWN

The Chairman thanked Dr Lydia Brown for her service to the Finance and Performance Committee which she had been a member of since 2013.

11. DATE OF NEXT MEETING

Monday 28 November at 9.30 am.

TRUST BOARD

FINANCE & CONTRACTING REPORT TO 31st October 2016

1. Introduction

This paper outlines the Group consolidated financial position for the period ending 31st October 2016.

The Income & Expenditure (I&E) position was a Year-to-Date (YTD) surplus of £40k (after adjusting for donated income & assuming sustainability & transformation funding), a favourable variance against the plan of £2,042k, but an in-month surplus of £4k.

Summary of Key Financial Information	Year to Date (YTD)			
	Plan £000s	Actual £000s	Var £000s	Var %
Income	120,440	123,033	2,593	2.2%
Expenditure	117,985	118,412	-427	-0.4%
EBITDA	**2,455**	**4,621**	**2,166**	
Finance and Depreciation Costs	8,413	8,268	145	1.7%
I+E Surplus /(Deficit) excl donated income & STF	**-5,958**	**-3,647**	**2,311**	
Donated Asset Income Adjustment	281	209	**-72**	
Sustainability & Transformation Fund	3,675	3,478	**-197**	
I+E Surplus (+ve) / Deficit (-ve)	**-2,002**	**40**	**2,042**	
Favourable Variances are shown as +ve				

During the month there were a number of non-recurring income and expenditure adjustments which resulted in little net impact on the bottom-line.

It is important to note that on a straight line basis to achieve the control total we should have a surplus of £1,050k after seven months but the plan is phased to reflect more savings in the latter part of the year.

2. Sales

Contract Activity Performance 2016/17	Actual 2015-16	Actual 2016-17	Plan 2016-17	Year on Year Variance	Plan Variance
Elective inpatients	3,256	3,042	3,185	-214	-143
Elective PSDs/day attenders	13,451	12,893	13,390	-558	-497
Regular Day Attenders	4,802	5,465	4,752	663	713
Non Elective Inpatient	15,389	15,765	15,130	376	635
Outpatient initial attendances	39,433	38,956	38,299	-477	657
Outpatient follow-up attendances	65,047	61,668	64,452	-3,379	-2,784
Outpatient procedures	21,363	21,334	21,188	-29	146
A&E attendances	26,716	28,264	26,830	1,548	1,434
Favourable Variances are shown as +ve					

NHS activity revenue was £105.04m (excluding sustainability & transformation funding) which was £745k above the plan. Of this sum 'excluded pass-through drugs & devices' over-performance was £525k and this was offset by a similar overspend on expenditure, and as such adds no benefit to the bottom line. The Electronic Patient Record system went live on 30th October and to facilitate reporting this month we have estimated 2 days of activity and income (Sunday & Monday). Reporting should catch up next month when the new data warehouse goes live.

- Elective spells were down by 143 against plan and down on the year on year comparison by 214, with notable reductions in Plastic Surgery, Gastroenterology, Gynaecology and interventional radiology. This has been partly offset by over-performance in Breast Surgery, Colorectal Surgery, and T&O. The under-performance was due to a lack of capacity with procedures being cancelled due to non-elective pressure on beds.

- Day Cases were down by 497 against plan and down on the year on year comparison by 558. There were notable adverse variances in Plastic Surgery, Gastroenterology, and Dermatology. This has been offset by over-performance in Urology, Colorectal Surgery, T&O and Ophthalmology. The adverse performance can be mainly attributed to use of the Day Surgery Unit for escalation purposes resulting in cancellations.

- Non-Elective activity has over-performed by 635 spells against plan with activity up in General Medicine, Trauma & Orthopaedics and A&E.

- Overall Outpatient attendances were down by 1,981 when compared to plan.

- A&E activity was up against plan by 1,434 attendances (5.3%). There was a continuation of unprecedentedly high level of activity during the month.

Other income was ahead of the YTD plan by £2,151k due partly to the reclassification of some clinical income and the insurance rebate.

3. Cost of Sales including indirect costs

The total YTD net expenditure for all Directorates was £101,397k, resulting in an adverse variance of £1,394k. The position is summarised below:

Directorates	In Month			Year to Date		
	Plan	Actual	Var	Plan	Actual	Var
	£000s	£000s	£000s	£000s	£000s	£000s
Medicine	3,483	3,752	-269	24,789	25,844	-1,055
Musculo Skeletal	2,533	2,459	74	17,323	16,870	453
Surgery	2,965	3,095	-130	20,960	21,661	-701
CSFS	3,335	3,448	-113	22,749	23,160	-411
Facilities	333	340	-7	2,676	2,539	137
Corporate	653	501	152	11,506	11,323	183
TOTAL	**13,302**	**13,595**	**-293**	**100,003**	**101,397**	**-1,394**

All pay and non-pay costs and provisions have been fully accrued, and inflation and other reserves, including agreed cost pressures, have been added to budgets as appropriate.

The main drivers of the overall Directorates' adverse variance were:-

- Continuation of the nursing overspends due to vacancies and the resultant premium paid to agency staff;
- An increase in the number of Nurse 'Specials' used in the month and this needs further challenge.

4. Cost Improvement Plan

The Trust achieved YTD savings and Income Generation schemes of £3,707k against the plan phased target of £3,238k a favourable variance of £469k.

The CIP programme is back loaded and therefore on a straight line basis the Trust would be £1,835k (66.9%) below where it should be. At the time of preparing this report, unidentified schemes relating to the £6.5m distributed target amount to £340k (5.2%).

The Directorates are indicating the achievement of the £6.5m distributed target. This requires the Directorates in the second half of the year to achieve the same level of savings as realized in the first half of the year plus an extra £1m.

5. Statement of Financial Position

Overall the working capital position (current assets less liabilities) was better than plan by £3,297k mainly due to Debtors being higher than plan and the Trust currently retaining £2,000k cash, which is due to be loaned to the new SDU joint venture company (the Trust's plan includes this sum as a long term investment). NHS debtors include both quarter two accrued income and the sum for October 2016 in respect of the Sustainability and Transformation Fund (£1,903k) together with a sum of £1,000k for over-activity to date.

6. Cash

The consolidated cash position at the end of October was behind plan by £1,867k. The plan includes a sum of £1,500k, being the anticipated drawdowns of the £6m ITFF loan the Trust has applied for (see below).

The cash flow forecast only reflects the Trust's position and excludes any sums for the subsidiary companies or joint venture with SSL. The cash flow reflects the actual position for the first seven months of the year and a forecast for the remaining five months. It is based on a number of assumptions; some of the key ones are as follows:-

- NHS income is based on contract values plus additional income received to date (£1m from Wiltshire CCG) and a further £1m for additional activity as part of a year-end settlement with Wiltshire CCG (see below). The cash for this is expected to be received in December 2016.
- It is assumed the Trust will receive the full Sustainability and Transformation Fund (STF) for quarter's 3 and 4, which will be paid in February and March. The cash flow has been amended to reduce the sum for quarter 2 by £198k (payable partly in November and partly in December) to reflect the non-achievement of the A&E planned trajectory. This reduces the total anticipated STF from £6,300k to £6,102.
- Although the Trust has applied to the ITFF for a £6m loan towards the EPR project, this funding has yet to be approved and no income is included for this loan. No receipts have been included either for the recent funding application submitted for the new ward proposal.
- Expenditure includes a sum of £2m for the loan to Sterile Supplies Ltd, expected to be transferred in December 2016.

- Expenditure is based on known figures wherever possible and best estimates if these are not available.
- Capital expenditure for the year is forecast to exceed the source of funding available if the loan from the ITFF is not available.

The Trust will continue to monitor the cash flow position on a daily basis to highlight any potential requirements for additional funding.

7. Capital Expenditure

Expenditure for the first seven months of the financial year was £4,951k which was behind plan by £712k. The Trust is still waiting to hear whether either its loan application of £6m to the Independent Trust Financing Facility or the application for funding of the new ward have been successful. The capital position in the NHS is seriously bad and so the likelihood of funding is not great.

8. NHS Commissioner Contracts

The Activity Query Notices which have been issued to Wiltshire and West Hampshire CCGs remain in place and there continues to be ongoing discussions and review of the respective action plans.

The Trust has reached a final agreement with Wiltshire CCG in relation to the quarter 1 challenges. The majority of the challenges being upheld relate to procedures being carried out without prior approval. The number of challenges from Wiltshire CCG is reducing but there are on average 40 procedures a month being challenged. However, the Trust has agreed with the CCG a year-end position which includes over-performance money of circa £2m which is broadly in line with the Trust's own expectations. In addition an offer of £200k has been made to support RTT waiting time initiatives and the details of the offer are expected to be received shortly.

West Hampshire CCG continues to challenge every aspect of their over-performance and continue to dispute the increase in activity.

There are ongoing discussions with the NHS England specialist commissioners which have led to a partial sign off of the Q1 challenges and an over-performance invoice for £256k has been issued against the YTD over-performance of circa £900k. Despite a request for 'cash on account' the commissioners insist on reviewing each month's challenges separately before agreeing a value to be invoiced. This has led to a significant increase in workload for Trust staff to close down the monthly challenges.

The SHIP (Southampton, Hampshire, Isle of Wight and Portsmouth CCGs) consortia have recently updated their policies and the main changes are a move to criteria based assessment for second eye cataract surgery and prior approval requirements for patella resurfacing and shoulder decompression surgery. The policies have been circulated to the Directorates for review.

Although the Trust had not achieved its Sustainability and Transformation Fund (STF) trajectory for ED discharges in Q2, an appeal has been submitted in case NHSI makes a deduction to the STF payment. It is hoped that the appeal will be upheld as the Trust has maintained an excellent rating nationally for ED performance despite the significant increase in ED attendances and emergency inpatient activity. Current 4 hour performance in ED is poor and this may be to do with Lorenzo in which case we may need to seek a dispensation from NHSI.

The new draft guidance and tariff for the financial years 2017 to 2019 has now been published. The Trust has received the majority of commissioner's contract financial offers and has responded appropriately. The Trust has asked Wiltshire CCG to act as the lead commissioner with Dorset, West Hampshire (SHIP consortia) and Somerset CCGs all being an associate to the Wiltshire contract. The arrangement with West Hampshire is yet to be confirmed.

The contract documentation has now been released and progress can be made towards achieving the 5th December deadline for agreement on whether or not arbitration will be required. The gaps at present based on the offers are:

- Wilts CCG - £5m including £2.9m QIPP,
- W.Hants CCG - £1.2m including £0.5m QIPP and £0.7m growth,
- Dorset CCG – offer received and being evaluated
- NHSE specialist - £0.5m all QIPP
- NHSE military - £0.4m for reasons not understood

Accordingly the risk on the contract discussions is significant. The expectation is that QIPP risk resides with the commissioners, but nevertheless because they pay a twelfth of the contract value our cash flow is slightly impacted by built in QIPP until they pay for overperformance.

9. Risks & Forecast Outturn

As the in-month result was breakeven, we have not changed our forecast outturn scenarios.

The key financial risks continue to be:

- The level of DTOCs and 'green to go' patients in the hospital affecting flow;
- Delivery of the CIP target of £9.5m; this is the greatest financial challenge;
- Developing CIPs for future years;
- Contractual challenges from and penalties from commissioners;
- Securing the Sustainability and Transformation Funding (S&T Fund);
- Delivery of CQUIN targets;
- Unplanned growth of non-elective activity which has a detrimental impact on elective work;

The out-turn scenarios which incorporate the impact of the risks identified above, are as follows:-

- Scenario 1 (Upside) has been calculated using the actual YTD position and shaping the forecast using the income and expenditure monthly planning profiles. The forecast outturn would be a surplus of £1.8m which is in accordance with our approved plan. This does assume that: the S&T Fund payment is £6.1m; all targets are achieved for the rest of the year; the allocated savings target of £6.5m and the balance of £3m savings are achieved. Without the S&T funding there would be a deficit of £4.3m.

- Scenario 2 (Downside) has been calculated using the same methodology as Scenario 1, but we have assumed a shortfall on savings of £2m (£0.5m against allocated target £6.5m and £1.5m against the £3m strategic schemes); failure to achieve our STF performance trajectories for A&E for the year resulting in a loss of £0.6m; and failure to achieve our finance plan in the last quarter by £1.1m. The forecast outturn deficit

would be £1.9m which is worse than plan by £3.8m. This would be a deficit of £6.6m before S&T funding.

- Scenario 3 has been calculated using a simplistic straight-line methodology excluding the S&T Fund. This would give a deficit £5.9m and if we assume S&T funding of £5m (non-delivery of the Financial & A&E targets for one quarter) this would give an outturn deficit of £1m.

- Scenario 4 has been calculated using the Directorate forecasts and this would result in a deficit before S&T funding of £4.6m. This is broadly in line with scenario 1 (upside). However, the Directorates are assuming NHS Clinical Income over-performance will be £1m more than scenario 1 but this is offset additional expenditure.

In terms of the forecast outturn for all the scenarios, the following assumptions have been used:-

- CQUIN is delivered in full.
- There is no escalation of challenges, contractual fines and penalties (this does not apply to Wilts CCG as we have agreement).
- Resilience funding has been allocated to the Directorates and assumes costs will be managed accordingly.
- All Electronic Patient Record (EPR) project costs are capitalised.
- Inflation pressures are zero to allow the inflationary contingency reserve to offset the shortfall in strategic savings (£3m gap).

10. Other Financial issues

Following in-depth discussions by the Board the control total offers for the next two years were rejected and a counter-offer made. Discussions are expected with NHSI over the next few weeks.

We have been advised that ‘My Trusty’ products will be stocked by three retail chains and others are also interested. It is expected to be on supermarket shelves in March 2017.

11. Conclusions

The Group reported position for October was a surplus of £40k giving a favourable variance of £2,042k against plan.

The Trust’s overall risk rating score was 2 under the new single oversight framework, 1 being the highest score with maximum autonomy. A score of 2 may result in targeted support for one or more of the 5 themes but the Trust is not in breach of its licence. However, the current score is not considered a true reflection of the Trust’s financial situation.

12. Recommendation

The Trust Board is asked to note the report and consider any further actions necessary.

Malcolm Cassells
Director of Finance and Procurement
28 November 2016

Appendix 1 - SUMMARY STATEMENT OF COMPREHENSIVE INCOME

	In month			YTD (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Operating Income						
NHS Clinical Income	13,985	13,669	(316)	95,419	95,639	220
High cost drugs income	1,268	1,328	60	8,876	9,401	525
Other Clinical Income	722	754	32	4,296	4,498	202
Research & Development & Education	580	641	61	3,799	3,993	194
Other (Excluding Donated Asset income)	1,102	1,511	409	8,050	9,502	1,452
TOTAL INCOME	**17,657**	**17,903**	**246**	**120,440**	**123,033**	**2,593**
Operating Expenditure						
Pay - In post (includes bank & locums)	10,493	10,577	(84)	73,883	73,494	389
Pay- Agency	530	606	(76)	3,739	4,398	(659)
Drugs	1,567	1,593	(26)	11,019	11,107	(88)
Clinical Supplies & purchase of healthcare	2,319	2,414	(95)	14,669	14,737	(68)
Non-Clinical Supplies	531	548	(17)	3,809	3,752	57
Other (incl PFI unitary charge)	1,532	1,559	(27)	10,866	10,924	(58)
TOTAL EXPENDITURE	**16,972**	**17,297**	**(325)**	**117,985**	**118,412**	**(427)**
EBITDA (Earnings Before Interest, Tax, Depreciation & Amortisation)	**685**	**606**	**(79)**	**2,455**	**4,621**	**2,166**
Financing Costs	1,204	1,195	9	8,413	8,268	145
SURPLUS / (DEFICIT) excluding donated income & STF	**-519**	**-589**	**(70)**	**-5,958**	**-3,647**	**2,311**
Donated Asset Income	0	68	68	281	209	(72)
Sustainability & Transformation Fund	525	525	0	3,675	3,478	(197)
SURPLUS / (DEFICIT)	**6**	**4**	**(2)**	**-2,002**	**40**	**2,042**

Appendix 2 - CAPITAL EXPENDITURE

Project Name / Category	Approved Annual Plan 16/17 £000s	Agreed Changes 2016/17 £000s	Slippage to 2017/18 £000s	Revised Annual Plan 2016/17 £000s	YTD spend (Oct 2016) £000s	Anticipated Under/(Over) spent on Projects £000s
Donated Assets						
Bariatric Bed	11,140	0	0	11,140	0	
Clinical Radiology 2 x Ultrasound	17,700	0	0	17,700	0	
Orthodontics & Oral Surgery Cone Beam CT Scanner	110,000	0	0	110,000	0	
Small Donated Additions	0	127,772	0	127,772	127,772	
Donated Assets - Totals	**138,840**	**127,772**	**0**	**266,612**	**127,772**	**0**
Phase 3 Building Schemes						
Breast Unit enabling	10,194	54,911	0	65,105	639,840	(574,735)
Car Park PV	0	0	0	0	165	(165)
CT Scanner Building and Enabling	9,013	0	0	9,013	0	9,013
Laverstock Ward (Decant Ward Project)	354,720	0	0	354,720	358,987	(4,266)
Modular Ward	0	0	0	0	0	
SAU Refurb (Decant Ward Project)	88,147	4,087	0	92,234	75,295	
Maternity development	354,712	0	-300,000	54,712	5,380	
Radnor Ward Development	12,594	-12,594	0	0	0	
SDU Development	30,338	0	0	30,338	17,128	
Springs entrance development	1,228,718	-1,228,718	0	0	0	
Ward changes - Dementia Patient Care	1,457	0	0	1,457	1,741	(284)
Building Schemes - Totals	**2,089,894**	**-1,182,314**	**-300,000**	**607,580**	**1,098,535**	**(570,437)**
Building and Works						
Accommodation H&S Work	40,000	0	0	40,000	0	
Accommodation Boilers (Wylye House & Victoria Drive)	80,000	0	-30,000	50,000	848	
Accommodation replacement of kitchens and bathrooms	46,850	0	0	46,850	26,999	
Accommodation Roof Repairs (Compton & Langley)	60,000	0	-60,000	0	0	
AHU replacement yr 4 (2016/17) of 7	170,596	33,700	0	204,296	581	
Asbestos management	17,776	0	0	17,776	0	
Avon and Bourne Boiler Replacement	52,000	11,532	0	63,532	60,193	
Block 24 Cavity Wall Insulation	0	15,000	0	15,000	0	
BMS upgrade	44,023	-33,700	0	10,323	0	
Car park machinery replacement	10,071	37,000	0	47,071	25,978	
Catering Changing Area	19,000			19,000	0	
Catering Dishwasher	49,066	0	0	49,066	6,122	
Catheter Suite - Rebalance of Heating System	6,048	0	0	6,048	0	
Central booking relocation - block 79 (Wilton ward)	101,439	0	0	101,439	77,596	
DSU Roof Repairs	5,822	0	0	5,822	0	
DSU Salto	13,668	0	0	13,668	13,658	
Ductwork & Fire Damper Cleaning Whole Site	129,483	0	0	129,483	7,564	
Electricity at Work Regulations Compliance	84,239	0	0	84,239	8,292	
Estates health and safety	4,725	0	0	4,725	1,910	
Estates - Oracle software interface	24,000	0	0	24,000	0	
Fertility Centre Upgrade	15,000	0	0	15,000	11,364	
Fire compartmentation SDH north - remedial works	18,271	0	0	18,271	0	
Fire Door Compliance	40,000	0	0	40,000	712	
Flooring Replacement	40,534	0	0	40,534	20,699	
General laboratory replacement autoclave and Motuary Disinfector	54,075	0	0	54,075	47,040	
Genetics Coolong	36,000	0	-36,000	0	0	
Genetics Modular cold room	0	0	0	0	5,160	(5,160)
Helipad Temporary Parking	0	17,870	0	17,870	15,578	
Hillcote Sale Costs	0	0	0	0	182	(182)
Hospice Fire Alarms (was Hospice and Finance)	45,295	2,000	0	47,295	350	
Lab Medicine Cold Room	0	0	0	0	2,049	(2,049)
Level 4 Bedspace Power Sockets	41,610	0	0	41,610	0	
LIfts overhaul - year 3 (2014/15) of 3	40,488	25,000	0	65,488	3,392	
Main boiler burners	5,549	-5,549	0	0	0	
Main Entrance L3 Upgrade	5,807	0	0	5,807	0	
Maternity Obstetric Theatre Refurbishment	1,030	0	0	1,030	0	
Maternity Post Natal Upgrade	6,437	0	0	6,437	300	
Mattress Laundering	2,521	0	0	2,521	0	
Medical Gas Hoses 2nd year of 2 (2015/16)	147,000	0	0	147,000	0	
MSK Notes Preparation	6,500	0	0	6,500	0	
Nurse Call System Upgrade - SDH North & Maternity - 2nd year of 2	123,167	0	0	123,167	0	
OHSS replacement windows	5,270	0	0	5,270	2,055	
Old GUM Clinic Demolition	10,449	0	0	10,449	0	
Pathology - air tube upgrade	4,119	0	0	4,119	1,594	
Pathology - conversion of computer room to office	12,000	0	0	12,000	0	
Pathology Reception	6,370	32,800	0	39,170	4,541	
Pharmacy Cold Room	10,000	0	0	10,000	0	
Powered Door Curtains Level 2	30,000	-15,000	0	15,000	18	
Productive Operating Theatres	18,542	0	0	18,542	0	

Project Name / Category	Approved Annual Plan 16/17 £000s	Agreed Changes 2016/17 £000s	Slippage to 2017/18 £000s	Revised Annual Plan 2016/17 £000s	YTD spend (Oct 2016) £000s	Anticipated Under/(Over) spent on Projects £000s
Public & Staff WCs L5,L4,L3	53,357	0	0	53,357	97	
Public Spaces Fund	12,441	0	0	12,441	0	
Roads and paving repairs	214,259	0	-189,000	25,259	0	
Sarum Ward Playdeck	0	7,000	0	7,000	3,770	
SDH North Drain Survey	4,999	0	0	4,999	0	
Server Rooms - Air Conditioning	16,890	0	0	16,890	0	
Shower Cubicle Drainage Improvements	17,693	0	0	17,693	5,756	
Site Signage	7,517	0	0	7,517	303	
Spinal Boiler Replacement & Associated Pipework	5,983	-5,983	0	0	0	
Spinal treatment centre refurbishment	16,306	0	0	16,306	3,865	
Spinal Unit Doors and Locks	4,282	0	0	4,282	59	
Springs servery upgrade - floor and freezers only	75,000	0	-75,000	0	0	
Taps & IPS panels - sitewide	48,056	0	0	48,056	3,314	
Water Safety	42,000			42,000	0	
Water tanks access - main tanks only	30,000	0	0	30,000	0	
Building Projects/Building and Works Totals	**2,233,620**	**121,670**	**-390,000**	**1,965,291**	**361,937**	**(7,391)**
Information Technology						
Alternative to Microsoft products - review	75,000	0	0	75,000	0	
Blades	193,000	0	-133,600	59,400	24,750	
Blood Tracking Phases 1 - 3	185,945	0	0	185,945	52,063	
BMS Network Upgrade	987	0	0	987	1,771	(784)
Brocade Switch Replacement	5,004	0	0	5,004	3,527	
CALS	200,000			200,000	0	
Catering Cash Register Replacement	4,400	0	0	4,400	2,060	2,340
Citrix Support	102,276	0	-68,184	34,092	0	
Community Midwifery system trial	29,244	0	0	29,244	0	
Connectivity Upgrade for Warminster & Shaftesbury	19,023	0	0	19,023	13,647	
Data Warehouse (16/17 bid)	175,000	0	0	175,000	0	
EEG Neurophysiology Review Software	5,000	0	0	5,000	4,194	806
Electronic Letters	14,617	0	0	14,617	0	14,617
EPMA	405	0	0	405	0	405
EPR Contigency	0	511,000	0	511,000	43,559	
EPR Lines	11,000	0	0	11,000	0	
EPR Network Resilience	0	87,000	0	87,000	18,989	
EPR Implementation Costs	-170,248	2,102,500	0	1,932,252	1,234,275	
EPR Hardware	-188,526	713,000	0	524,474	409,016	
EPR Data Warehouse	0	528,200	0	528,200	166,911	
EPR Supplier Costs	0	1,570,200	0	1,570,200	0	
EPR Scanning	0	932,000	-892,000	40,000	0	
Genetics - software upgrade	7,836	0	0	7,836	0	
Genetics High Spec Analysis Equipment & Software	29,405	0	0	29,405	0	
Histopathology Hardware	10,773	0	-10,773	0	0	
IBD register	8,951	0	0	8,951	4,140	
Inhouse development team - applications, databases and Dashboards (subject to bus case)	101,465	0	0	101,465	60,899	
Maintenance renewal - estimate	38,034	0	0	38,034	28,410	
Mobile Computing	8,772	0	0	8,772	3,889	
Mortuary module	52,000	0	0	52,000	0	
Network Unsupportable	24,000	0	0	24,000	213	
Network Upgrade Consultancy	129,774	0	0	129,774	36,384	
Ophthalmology System	140,926	0	0	140,926	99,550	
Order Comms (includes System Admin Bid & Sexual Health Bid)	15,265	0	-15,265	0	0	
PACS	116,873	-54,000	-25,000	37,873	95	
PACS ED Machines	0	54,000	0	54,000	29,490	
Palliative Care EPR	39,437	0	-39,437	0	0	
PAS 2016 Replacement - Consultancy Costs	780	0	0	780	0	780
Patient Observations Monitoring and Decision Support/Early Warning System/POET	0	7,000	0	7,000	1,515	
Radiology - OrderComms	36,117	0	0	36,117	0	
Replace 6509x3 network hubs	67,479	0	0	67,479	28,460	
Reporting System	3,570	0	0	3,570	0	3,570
Results System in GP Practices 'Review' System	10,079	0	-10,079	-0	0	
SAN Storage	210,000	0		210,000	133,613	
SBAR Cardiology DICOM Migration	45,100	0		45,100	0	
SBAR for PAS	2,476	0	0	2,476	0	2,476
SBAR re NACS Update to ED Symphony	7,500	0	0	7,500	0	7,500
SBAR re UPS Replacement (formerly UPS Replacement - Room based for Computer Rooms)	21,150	0	0	21,150	0	
StarLIMS Upgrade	0	30,000	0	30,000	0	

Project Name / Category	Approved Annual Plan 16/17 £000s	Agreed Changes 2016/17 £000s	Slippage to 2017/18 £000s	Revised Annual Plan 2016/17 £000s	YTD spend (Oct 2016) £000s	Anticipated Under/(Over) spent on Projects £000s
Telecomms Voice Over IP - invest to save (non clinical areas - subject to a telephony strategy)	189,543	0	0	189,543	69,130	
Telepath enhancements	3,505	0	0	3,505	0	
Telepath to CSCLims (Phase 3 / Year 4 of 4 2016/17)	150,000	0	-150,000	0	0	
TMG-UAG	15,000			15,000	0	
UPS Replacement Programme	34,132	0	0	34,132	5,686	
Whiteboards	208,320	0	0	208,320	41,517	
XML for Pathology COSD Submission	11,900	0	0	11,900	0	
Information Technology Totals	**2,402,290**	**6,480,900**	**-1,344,338**	**7,538,852**	**2,517,753**	**31,710**
Medical Devices						
ANC Ultrasound (GROW Programme)	80,000	0	0	80,000	0	
Bariatric Bed (2016/17 bfwd)	346	-346	0	0	0	
Bed Buffers	0	15,000	0	15,000	0	
BED replacement programme - 4th (2016/17) yr of 4	58,996	0	0	58,996	59,277	(281)
Cone Beam CT Scanner Enabling Works	0	43,402	0	43,402	1,060	
DSU Camera Stack	98,000	0	0	98,000	0	
DSU Ophthalmic Microscope	120,000	0	0	120,000	0	
General x-ray machine - Westbury - radiology	99,000	64,000	0	163,000	0	
Genetics Centrifuge	0	5,327	0	5,327	0	
Genetics DNA Extractor	77,000	0	0	77,000	0	
Genetics Cytology Ozone Free Hood	0	23,500	0	23,500	20,939	
Grouped Items 2015/16	1	0	0	1	6,477	(6,476)
Grouped Items 2016/17	100,000	0	0	100,000	71,116	
Maternity Theatre Equipment	26,014	0	0	26,014	0	
Medical Equipment <£50k 14/15	26,400	-26,400	0	0	0	
Medical Equipment <£50k 15/16	11,635	0	0	11,635	0	
Medical Equipment <£50k 16/17	231,780	26,400	0	258,180	129,478	
Powered Patient Trolleys	0	0	0	0	0	
Radiology Lead Aprons	30,000	0	-20,000	10,000	0	
Radiology Room 2 Replacement	228,000	0	0	228,000	0	
Radiology Room 11 Ultrasouind Replacement	80,000	0	0	80,000	79,824	
Refrigerated Centrifuge	444	-444	0	0	0	
Rigid hysteroscopes x 4 plus stack	3,561	0	0	3,561	0	
Ringwood Ophthalmology Equipment	50,000	0	0	50,000	0	
Scopes	32,153	0	0	32,153	0	
Spinal Hoists	37,574	0	0	37,574	39,931	(2,358)
Static and Pressure Relieving Mattresses	22,209	0	0	22,209	1,003	
Theatre Instrumentation Replacement Programme	773,355	0	-200,000	573,355	300,051	
Thermometery Data Loggers	12,958	0	0	12,958	11,189	
VAC Terapy Machines	3,600	0	0	3,600	3,600	
Videoscopes x2 - main theatres	50,000	0	0	50,000	0	
Medical Equipment Totals	**2,253,026**	**150,439**	**-220,000**	**2,183,465**	**723,946**	**(9,115)**
Other						
Bed Stacking	36,494	0	0	36,494	29,503	
Bed Stacking - Commercial Related	0	30,000	0	30,000	354	
Car Park Machinery	37,000	-37,000	0	0	0	
Catering Boiling Pan	15,000	0	0	15,000	0	
Cold Servery Counters	70,000	0	0	70,000	0	
Demand Response Generator Conversion	178,920	0	0	178,920	0	
Efficiency schemes	222,170	-141,800	0	80,370	0	
Finance systems	90,000	0	0	90,000	0	
LED Lighting	30,737	0	0	30,737	3,584	
Lightning Repairs	0	0	0	0	0	
Outpatient Kiosks	65,953	0	0	65,953	9,142	
Phhotovoltaic's / Solarthermal PV	17,683	0	0	17,683	0	
Portering Bed Movers	0	0	0	0	0	
Procurement Tug 2015/16	2,050	0	0	2,050	0	
Project costs	25,529	0	0	25,529	1,813	
Scan4Safety (GS1)	0	109,000	0	109,000	34,536	
Security	40,000	0	0	40,000	29,627	
Telecoms Trunk Lines	8,280	0	0	8,280	1,650	
Theatres Storage and Trolleys	2,580	0	0	2,580	2,400	
Ward Waste Bins	60,643	0	0	60,643	8,788	
Other Totals	**903,040**	**-39,800**	**0**	**863,240**	**121,397**	**0**
Trust Totals	**10,020,711**	**5,658,667**	**-2,254,338**	**13,425,041**	**4,951,340**	**(555,233)**

Major Projects Report

Date: December 2016

Report from: **Laurence Arnold, Director of Corporate Development**
Presented by: **Laurence Arnold**

Executive Summary:

The Major Projects Report reflects the complexities of a number of the key projects which the Trust is currently engaged in. It describes the nature of four transformational projects which cover:

- **IT/technology (EPR and GS1) and the adaptive impact on the organisation with Lorenzo having gone live on 30th October**
- **a joint venture to improve the responsiveness and efficiency of sterilisation services which began on 1st September, and**
- **Wiltshire Health & Care went live on 1st July and is now fully operational**

Proposed Action:
To note the report.

Links to Assurance Framework/ Strategic Plan:
Value – "We will be innovative in the use of our resources to deliver efficient and effective care, eg be[ing] innovative in our use of technology to make the organisation more effective."
Choice – "provide a comprehensive range of high quality local services enhanced by our specialist centres"

Appendices:

Supporting Information

Introduction

The Trust is engaged in a number of high profile and organisational wide projects which will consume considerable resources during the next twelve months. The purpose of this paper is to provide the Board with assurance around how those projects are progressing and to ensure the intended deliverables are being realised. The projects included are:

- Electronic Patient Record
- The GS1 initiative
- Wiltshire Health and Care management of community services – now operational
- Joint venture to provide a sterilisation and disinfectant unit (SDU)
- Organisational development impact – a draft strategy and action plan has been discussed at Executive Workforce Committee in June and the Board in July. The action plan is being developed further with executives and senior managers. Monitoring of this action plan will be through the Executive Workforce Committee

Summary

Salisbury NHS Foundation Trust

Project	Lead	Status	Workstreams	Summary
EPR	LA	Stable at Amber	6 x green 5 x amber	**Go live over weekend of 28/10 – excellent staff commitment to achieve this. There was some disruption, but on the whole was well managed. System is now bedding in**
Scan for Safety	MC (LW)	Stable at Green	3 x green 1 x red	Phase 2 near completion – Wristband requires change to be compliant – CSC progressing this
Wiltshire Health & Care	LA	Stable at Green		New service operational from 1st July. Established southern locality group to promote integrated working locally.
SDU	MC	Improving at Green	3 x green	Contract now signed. SSL mobilisation well underway – SynergyTrak went live 19/9 and early signs of increasing throughput. Demolition began mid October.

Organisational Development

- Strategy developed
- Action Plan created and monitored through Executive Workforce Committee
- Current OD projects ongoing
  - EPR implementation
  - Emergency Department future workforce review
  - Theatres workforce review
  - Spinal Unit Medical Workforce Review
  - Save 7 champions and Quality Improvement skills
  - Impact of Apprenticeship levy on workforce models
  - Lead for STP digital project
  - Lead on STP Workforce stream for Values and Culture
  - Exploration of opportunities working across Wiltshire Health and Care

Electronic Patient Record (EPR)

To provide an electronic record of patient activity, visible across the organisation allowing real-time interaction and ensuring that information can be acted on immediately, improving efficiency and safety of care provided.

Workstream	Status	Trend	Actions
Infrastructure	Green	Improving	Continuing some further roll out of hardware.
Configuration	Amber	Stable	Configuration work still ongoing beyond go live, eg clinical documentation.
Integration	Green	Stable	Issues with two systems at go live. Now resolved.
Data migration	Green	Stable	Data migration saw few errors, 99.94% but issues remain with some migrated clinics
Data warehouse	Amber	Stable	Weeks 1 and 2 reporting successful. RTT report submitted late for October.

Electronic Patient Record (EPR)

Salisbury NHS Foundation Trust

Workstream	Status	Trend	Actions
Business change	Amber	Stable	Working through issues, as business becomes familiar with new system. A number of areas reporting that is slower to do some tasks.
Benefits	Amber	Stable	Further analysis being undertaken of the additional savings identified.
Role based access	Green	Stable	Limited issues at go live
Training	Green	Stable	Themed, more in depth training post go live.
Requests & Results (phase 2)	Amber	Stable	Challenges to achieving the expected timescales
Validation	Green	Stable	DQ team beginning to review Lorenzo data. Issues with unpicking data on the system.

Scan for Safety

Salisbury NHS Foundation Trust

To introduce GS1 standards to provide a consistent means of identifying and tracking patients, equipment, medications, equipment and locations across the Trust.

Work stream	Status	Trend	Actions
Global location numbering	Green	Stable	SOP for GLN Location agreed Physical location of barcodes continuing in November
Catalogue management	Green	Stable	Continue to improve master data available as areas rolled out. Draft guidance document being produced in association with GS1 due to be shared with wider group mid Jan
Patient identification	Red	Improving	POET ready to deploy awaiting roll out after EPR Blood hound – Ready to deploy in test area – awaiting improvement in wrist band Lorenzo wrist band issues printing compliant wrist band flagged with CSC for resolution.
Purchase to pay/Inventory	Green	Stable	Cardiology now live – Patient Level costing reports being developed further Orthopaedics plan being progressed. Directorate being engaged to discuss next areas to be rolled out in the 2017

Wiltshire HEALTH AND CARE

Salisbury NHS
NHS Foundation Trust

A limited liability joint venture has been established to enable SFT, together with RUH Bath and GWH Swindon Trusts, to manage adult community services and to aid the integration of services across acute and community settings. The service went live 1st July.

- Begun recruitment of rehabilitation support workers, to promote discharge
- WH&C have identified 6 priorities for 16/17:
  - ❶ Higher intensity care managed in the community
  - ❷ Early supported discharge for stroke patients
  - ❸ Health coaching
  - ❹ Musculo-skeletal physiotherapy provision in the community
  - ❺ Development of urgent care centres
  - ❻ Mobile working
- Detailed planning underway for ❶ and ❷with good engagement from SFT clinical staff – for ESD staff being recruited for January start. Frailty MDT's established with input from community geriatrician
- Community IV started from 1/10 for patients discharged from Pitton
- ❻Mobile working has been trialled in the Amesbury locality and is extending into other localities
- Developing clinical and operational links within the southern locality. First meeting held in October – good primary care engagement. Plan being developed for the Salisbury locality for 17/18

Salisbury NHS
NHS Foundation Trust

SDU Joint Venture

To establish a joint venture to provide sterile services with a private provider from a standalone facility on SDU South to develop as a local market leader in the provision of sterile services.

Workstream	Status	Trend	Actions
Commercial	Green	Improving	JV agreement , leases and service contract signed mid August
Operational	Green	Stable	SSL mobilised and new service in place – initial impressions favourable. Positive audit in late October and implementation of SynergyTrak system reaping early benefits.
Facility design	Green	Stable	Demolition work began on 10th October and is well underway. Preliminary design meetings proceeding well.

JOINT BOARD OF DIRECTORS (JBD) MINUTES FROM 26 OCTOBER 2016 RE: QUARTERLY REVIEW OF ASSURANCE FRAMEWORK AND RISK REGISTER

PURPOSE

To evidence the quarterly review by the JBD of the Assurance Framework and Risk Register for which it has delegated responsibility. This responsibility is set out in the JBD's Terms of Reference.

MAIN ISSUES

During the year delegated responsibility for reviewing the Assurance Framework and Risk Register falls to a combination of the Finance Committee, Clinical Governance Committee and the Joint Board of Directors (JBD).

Extract of JBD minutes – 26 October 2016

ASSURANCE FRAMEWORK REVIEW
The Board received the Assurance Framework Review and Update. It was noted that following the Trust Board review of the Assurance Framework in September new risks were being identified for approval by the December Trust Board. CB queried risk number 4241 – Junior Doctor Cover on Spinal Unit. The Risk Register was clearer now on outstanding actions and long standing risks were being reviewed.

ATTACHMENTS AVAILABLE TO VIEW ON WEBSITE

none

ACTION REQUIRED BY THE BOARD

To note updated assurance framework reviewed on the Board's behalf by JBD.

Nick Marsden
Chairman

SALISBURY NHS FOUNDATION TRUST
Minutes of the Audit Committee
Held on: Monday 11 July 2016

Present: Mr P Kemp (Chairman and Non-Executive Director)
Mr I Downie (Non-Executive Director)
Dr L Brown (Non-Executive Director)

In Attendance: Ms T Baker (Non-Executive Director)
Mr J Oldroyd (KPMG)
Mr J Brown (KPMG)
Mr M Cassells (Director of Finance and Procurement)
Mr M Stabb (TIAA)
Mr J Butler (TIAA, Counter Fraud)
Mr D Seabrooke (Head of Corporate Governance)

Apologies:

ACTION

1. MINUTES – 20 MAY 2016

The minutes of the meeting of the Committee held on 20 May 2016 were agreed as a correct record.

2. MATTERS ARISING

It was noted that the three items listed on the 20 May Minutes had been either actioned or were included in the reports to the Committee this time.

3. EXTERNAL AUDIT – PROGRESS REPORT AND TECHNICAL UPDATE

The Committee received the report from KPMG highlighting the NHS Improvement consultation on a new single oversight framework for providers, information about work on the 2017/18 National Tariff and Seven Day Services. It was requested that the Board be given a briefing on the future arrangements for the Tariff as the consultation and engagement process progressed during summer and autumn 2016. The Trust would engage with NHS Providers in this connection. **MC**

The Single Oversight Framework would apply to NHS Trusts and to Foundation Trusts and was understood to replace the Monitor Risk Assurance Framework and the equivalent from the Trust Development Authority.

The Single Oversight Framework included five elements which took into account quality of care, drawing on CQC assessments and the four priority standards highlighted in the KPMG update for Seven Day Hospital Services, the finance and use of resources and operational performance. The fourth element was strategic change and was a judgement on how well providers were delivering strategic change set out in the Five Year Forward View. At this stage this was the least developed strand of the consultation. The final element was built around a further alignment of the CQC and NHS Improvement methodology on Well-Led.

The Committee reflected on a successful year end close down. The findings of the 2015/16 audit would be reported to the Council of Governors later in July.

The Committee noted the report.

4. INTERNAL AUDIT

The Committee received the Summary Internal Audit Progress Report.

Arising from the 2015/16 programme the audit on starters and leavers processes had given reasonable assurance but based on the following key outcomes –

- Controls over the collection of ID badges for leavers needed improvement.
- Controls need to be improved in relation to the handling of Trust property such as mobile phones.
- The use exit questionnaires should be promoted as a source of knowledge.

MS agreed to discuss the management response with the Director of Human Resources and Organisation Development and the Chief Operating Officer to ensure that the management response brought about the required improvements. **MS**

An operational review of the processes around Delayed Transfers of Care had been requested arising from concern about the significant amount of administration time required to manage the process. The review highlighted a number of issues around the faxing of manual reports between the Trust and social care partners, notably Dorset and Hampshire. There were delays as many invoices generated by the Trust for Delayed Transfers of Care were disputed by the local authority. Dorset Council were not currently attending the DTOC meetings which the Trust held twice weekly.

Actions in response to the report included the implementation of a system of electronic whiteboards, the establishing of a single point of contact for each local authority and a renewed request for the local authorities to attend the meetings with the Discharge Team.

Appendix C to the report highlighted the progress with previous agreed actions and there was concern about delays with the completion of the actions arising from the estates compliance review where there was concern about delays to the completion of the appointment of authorised persons and authorised engineers. This would be reviewed again at the October meeting of the Committee if necessary.

5. COUNTER FRAUD UPDATE

The Chairman welcomed John Butler to the meeting. The following principal points from the report were highlighted –

- An addition to the fraud risk assessment in relation to consultant job plans – the Chairman felt that this was a compliance rather than a counter fraud issue.
- Agency checks - the Trust was no longer using the staffing agency where this concern had arisen. MC undertook to ascertain the arrangements in relation to the master vendor and it was suggested that the Trust should review the suppliers own audits of the pre-employment check process. **MC**
- The results of the counter fraud and whistle blowing awareness survey of the Trust was highlighted.

The Committee noted the Counter Fraud Report.

6. ANNUAL REVIEW OF TERMS OF REFERENCE AND COMMITTEE EFFECTIVENESS

The Committee received the Terms of Reference for review. It was noted that the size and quorum of the Committee as stated was in line with good practice in the sector. In regard to its role in examining the work of the other sub-committees, it was agreed to review the Trust's internal committee structure. An invitation to the Chief Executive to attend the next meeting would be made and it was thought that the Chief Operating Officer could usefully attend some meetings.

The terms of reference were approved.

7. LOSSES AND COMPENSATION REGISTER

The Losses and Compensation Register was viewed and signed by the Chairman.

There was a concern about continuing pharmacy losses being recorded and this would be investigated to ensure that it was error rather than fraud.

8. DATE OF NEXT MEETING

The next meeting of the Audit Committee will be held on Monday 17 October 2016 at 10 am.

<u>Meetings 2017</u>

Monday 13 March at 10 am
Friday 19 May at 10 am
Monday 18 September at 10 am
Monday 11 December at 10 am

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 22nd September 2016, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair) - Non-Executive Director
Dr Christine Blanshard - Medical Director
Claire Gorzanski – Head of Clinical Effectiveness
Fiona Hyett - Deputy Director of Nursing
Andy Hyett – Chief Operating Officer
Steve Long - Non-Executive Director
Hazel Hardyman – Head of Customer Care
Ian Downie - Non-Executive Director
Welcomed : Professor Jane Reid – Non-Executive Director
Welcomed : Tania Baker – Non-Executive Director

In attendance:

Kate Williams	Minute taker
Jan Sanders	Governor
Frances Williamson – Practice Development Midwife	CGC091606, CGC091607 & CGC091609
Dr Jo Baden-Fuller – Consultant, Gynaecologist and Obstetrician	CGC091606
Dr Carl Taylor – Consultant, Paediatrician	CGC091606
Jacqueline Dalley – Senior Sister, NICU	CGC091606
Katrina Glaister – Clinical Effectiveness Facilitator	CGC091608 & CGC091620
Clare Goodyear – Patient Safety Facilitator, Risk Management	CGC091621

CGC091601 Apologies:

Peter Hill - Chief Executive Officer
Lorna Wilkinson - Director of Nursing
Mark Stabb – Head of TIAA
Dr Samuel Williams – F1
Denise Jackson – Staff Nurse

CGC091602 – Minutes of the meeting held on 21st July 2016

The minutes were approved by the committee after the word 'medicine' on page 1 was amended to 'medicines' and removal of duplication on page 6 under item CGC071611B.

CGC091603 – Action Tracker

All items were agreed.

CGC091604 – Matters Arising – Feedback regarding presentation of Patient Stories – Katrina Glaister

This item was deferred to October 2016.

CGC071605 – CQC Inspection Report December 2015 – report on key issues – Christine Blanshard

- The CQC Steering Group meets monthly to review the action plan by core service area
- There is ongoing action across all areas, however Emergency Medicine is the area requiring most support to ensure progress is continued to be sustained.

- The committee viewed an update presenting achievements made as well as areas where focussed action is still required
- The most challenging areas within the action plan are focussed in the large areas of work such as patient flow, ED processes (triage), theatre and surgical pathways

CB noted that there will be a CQC visit on 3rd November to review the progress of reducing the outpatient Spinal Unit waiting list and VUD list.

ID sought clarification as to changes made at triage. CB reported that following PDSA cycles streaming will be introduced so that patients see a clinical navigator on arrival in the ED department and they are assessed as either 'major' or 'minor'. In the pilot this has allowed a dramatic improvement in waiting times for patients.

JR asked for completion dates for the action plans. CB confirmed that these would be complete by Q4 and that there would be a decision during Q3/Q4 regarding a CQC re-inspection.

STRATEGY

CGC091606 – Core Service presentation – Maternity and Gynaecology – Jo Baden-Fuller, Frances Williamson

JB-F and FW gave a presentation giving an overview of the CQC outcome.

The department received an overall rating of 'Good' but was noted as 'Requires Improvement' in the 'Safe' domain.

The action plan was presented and discussed, with JB-F and FW highlighting achievements and challenges.

TB asked how the WHO checklist was being monitored. FW and JB-F confirmed that the pathways were now being electronically ticked in Theatre to demonstrate that the monitoring was being completed.

FHy commented that SFT needs to be marketed well to recruit midwives and alleviate the staffing challenges. Junior staff will be encouraged and supported to progress.

LB thanked JB-F and FW for their helpful presentation.

CGC091606 – Core Service presentation – NICU – Jacqueline Dalley, Carl Taylor

JD gave a presentation giving an overview of the CQC outcome. The department received an overall rating of 'Requires Improvement' with a 'Good' rating for Effective, Caring and Responsive.

The action plan was presented and discussed, with JD and CT highlighting achievements and challenges.

JR asked who drives the question regarding making NICU a Level 2 neonatal unit. JD responded that this is a national drive to move towards centralised care. AH informed the committee that this has been considered by the board on occasion but that the focus is always on the outcomes and therefore the unit will stay as it is for now.

LB thanked JD and CT for the presentation.

CGC091607 – National Maternity Review Report – Frances Williamson

FW presented the position of SFT as at June 2016 against the National Maternity Review's Better Births Report Recommendations. This will enable women to make more decisions about their care. Achievements, progress and challenges were noted. FW confirmed that the hospital has direct entry midwives and JB-F noted that the CCOT team is excellent, with good liaison in place.

CGC091608 – Patient Story – Katrina Glaister

KG relayed the patient story to the committee. The woman had additional growth scans from 34 weeks of pregnancy due to concerns that the baby was not growing at a normal rate. By 40 weeks the woman was reassured that the baby had grown normally and at 41 weeks she went into labour. Following the birth, the woman was able to spend time with the baby before being stitched and was subsequently helped to wash before going to the ward for the night. There was no-one available to

check the baby before they left hospital so someone visited them at home the following day.

The woman felt that she should have been checked to see how dilated she was before giving her the diamorphine. The diamorphine stopped her contractions and delayed her delivery. She also had to ask for things to clean the baby 4 hours after he was born as no-one had been available to do this before.

However, she felt that she was in control and was given the opportunity to wait and deliver as naturally as possible. The woman liked the room and felt relaxed during the birth. She was informed throughout as to what was happening and felt that staff were professional. New midwives introduced themselves to her and her boyfriend during her labour. She was able to spend time alone with the baby on the postnatal ward which was what she wanted. The woman would choose to have her next baby in Salisbury.

AH commented that patient stories such as this, where it is not possible to attend, are very useful to hear.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC091609 – Maternity Survey 2015 – CQC Benchmark Report and Local Action Plans – Frances Williamson

FW reported on the National Maternity Services Survey 2015 and local action plan. FW highlighted the areas of satisfaction, challenges, and work being done to make improvements.

CGC091610 – Friends and Family Report – Hazel Hardyman

FFT is carried out in five patient areas – day cases, Emergency Department, inpatients, outpatients and Maternity Services.

The overall score for SFT continues to be high with an average of 96% of respondents recommending SDH as a place to receive care and treatment. Response rates and scores for individual wards and departments are set out in tables within the paper.

The vast majority of free-text comments received continue to be overwhelmingly positive. The report contains graphs showing the areas of concern for those who were unlikely or extremely unlikely to recommend the hospital as a place for treatment. Actions are taken wherever possible to address these concerns and examples are contained within the report.

The Next Steps

Work will continue to capture and report the free-text comments so that improvements can be made wherever possible.

Wards review the FFT comments on a quarterly basis in conjunction with comments received from national surveys, real-time feedback, complaints and concerns, in order to identify key areas where action is required.

The committee discussed ways of presenting this information to the wards so that the balance of positive and negative comments could be considered at the same time. HH confirmed that trends are escalated to CB or LW at the time and are dealt with by managers.

CGC091611 – Q1 Complaints Report – Hazel Hardyman

79 complaints were received in Q1 compared to 84 complaints in Q4 and 87 complaints for the same period in the previous year. The activity from comments, concerns and enquiries has decreased from 470 in Q1 last year to 450 in Q1 this year.

The main issues from complaints are:

- Clinical treatment (33), 2 more than Q4 (31) - sub-themes were 15 unsatisfactory treatment across14 different areas, 8 delay in receiving treatment, 2 each for pain management, further complications and inappropriate treatment, and 1 each for correct diagnosis not made, funding problems, surgery unsuccessful and treatment unavailable. Orthopaedics received 5 complaints about clinical treatment with 2 related to unsatisfactory treatment, 2 delays in receiving treatment and 1 further complications. Adult Medicine and the Spinal Treatment Centre both received 4 complaints relating to

clinical treatment with no themes.

- Staff attitude (13), 1 more than Q4 (12) – 9 related to medical staff and 4 nursing staff across 13 different areas.
- Communication (9), 7 less than Q4 (16) - sub-themes were 3 lack of communication, 3 wrong information and 1 each for letter sent incorrectly, information not given and delay in sending information.
- Appointments (7), 7 less than Q4 (14) – sub-themes were 2 each for cancelled appointments, appointment date required, appointment delays and 1 for appointment system procedures across 5 different specialties.

The main issues from concerns are appointments (30), clinical treatment (28) and staff attitude (18). The main specialties for appointments across concerns and complaints were Orthopaedics (6), Oral Surgery (4) and Plastic Surgery (4).

There was one new request for independent review by the Parliamentary and Health Service Ombudsman. A total of 378 inpatients were surveyed for real time feedback in the quarter. They made 230 positive and 224 negative comments. The three main areas of concern were food and nutrition on the ward, noise and communication.

The main area of concern from the Friends and Family Test was waiting times.

There were 5 new requests to undertake Patient and Public Involvement projects, four projects were completed and one put on hold.

NHS Choices received 18 comments in Q1 with 9 positive and 9 negative relating to 11 different areas.

SL challenged HH as to why the percentage of complaints responded to quickly has dropped. HH responded that this was down to directorate pressure.

CGC091612 Complaints Dip Sampling Report – Steve Long

The dip sampling exercise for this quarter focused on complaints relating to clinical treatment. The dip sampling suggests that the quality and consistency of investigations would be improved if staff investigating were to make early contact with the patient to fully understand their complaint / concern to ensure the response adequately addressed their issues. Customer care have developed a checklist to assist with the process.

The committee noted the report.

CGC091613 Annual Complaints Survey Results – Hazel Hardyman

This questionnaire enables us to find out how well we deal with complaints from people who have had first-hand experience of our complaints procedure and to identify if we need to make any changes to our service.

200 people who had made a complaint were sent an introductory letter and a questionnaire. To facilitate return of the questionnaire, a pre-paid envelope was also included. The letters and questionnaires were posted with the complaint response. No reminders were sent.

47 questionnaires were returned in total (23.5% response rate), which was 9.1% lower than the previous year (32.6%) where questionnaires were sent at the end of each quarter.

HH confirmed that a priority for 16/17 will be the checklist and action plan to go onto patient files and workshops run by HH and FHi.

The committee were in agreement that conversations need to happen at an early stage and that building relationships was an essential tool in dealing with complaints.

ASSURING CLINICAL EFFECTIVENESS

CGC091614 Quality Indicator including DSSA – Tabled only – Christine Blanshard

- No MSSA or MRSA bacteraemias. No cases of C Difficile.

- 8 new serious incident inquiries commissioned in August.

- A decrease in the crude mortality rate. SHMI is 107 to March 16 and is as expected. HSMR is 115 to May 16 and is higher than expected. 2 new CUSUM alerts – cancer of pancreas (May 16) and thyroid disorders (Dec 15) – both to be investigated.

- A reduction in grade 2 pressure ulcers. There has been a reduction in grade 2 pressure ulcers per 1000 beds days from 1.13 to 1.04 when April to August 2015 is compared to the same period in 2016. Share and learn meetings continue to drive improvements.

- There were 6 falls, 1 resulting in catastrophic harm (head injury), 3 resulting in major harm (all fractured hips requiring surgery) and 2 resulting in moderate harm (1 fractured wrist, and one patient with both a dislocated/lacerated finger and a head injury) both managed conservatively. Ongoing improvement work via the Falls Working Group.

- CT scan within 12 hours and patients spending 90% of their time on the stroke unit achieved for all patients. Patients arriving on the unit within 4 hours remained at 80% due to bed capacity (3), arriving 5 minutes after 4 hours (1) and admitted to AMU (1). Improvement work continues between the stroke unit and ED.

- Only 38% of high risk TIA patients were seen within 24 hours. 7 patients were not seen within the timeframe due to investigations & treatment completed just outside 24 hrs (5), 1 referral not sent to the single point of access and 1 delay in referral of over 24 hours. Discussion held with GP practices concerned.

- A decrease in the number of complaints and concerns in August. Re-opened cases remain at a low level. Early contact with patients & relatives in the initial phase of a complaint is in place.

- Escalation bed capacity decreased in August with an increase in the percentage of patients moved more than once. Multiple ward moves remain at a low level and work continues with our partners to transform patient flow.

- In August there were 2 non-clinical mixed sex accommodation breaches affecting 18 patients all on AMU, all resolved within 2 days and due to bed capacity issues.

- The time of patient moves is reported for ongoing monitoring purposes. The majority of overnight moves are from Whiteparish, SSEU and Britford SAU to maintain patient flow. However, there were a number of moves from one ward to another to create bed capacity and maintain flow. The majority of discharges between 10 pm and 7 am are from ED/SSEU, Whiteparish and Britford SAU.

- The mean score of patients rating the quality of their care dipped (note small sample) although the percentage of staff who would recommend the Trust as a place to work or receive care was sustained in Q1. Responses to the Friends and Family test consistently show that patients would recommend wards, ED, the maternity service, outpatients or care as a day case.

CB confirmed that patients who suffer severe harm as a result of a fall are followed to find the outcome.

CGC091615 – Internal Audit programme six-monthly update – Christine Blanshard

- Audit of the indicators in the Quality Report 14/15. Of the 7 recommendations, 6 are fully completed and work is on-going on the 1 outstanding action which has been extended to December 2016 to take into account the development of EPR and the management of pathways.

- Audit of the management of falls and pressure ulcers made 11 recommendations. 6 recommendations related to the management of falls of which 4 are complete and 2 are extended to October 16 to enable ward link nurses to be put in place and a training package to be developed. In respect of pressure ulcer prevention and management, 2 recommendations are complete and 3 have had their review date extended to October 2016 to enable the policy to be updated, a training programme introduced and an information leaflet updated.

- Audit of the review of safeguarding children recruitment practices. 5 recommendations of which

2 are complete, 1 is partially complete and 1 of the outstanding recommendations has been superseded by an e-DBS check which is much quicker than the previous process. One further outstanding action is the requirement for staff transferring internally within the Trust, for their DBS check to be held on the main staff personal files once the new recruitment packs are in place.

- A review of the bed management policy - all 4 recommendations completed.

- An assurance review of data quality - 8 recommendations complete. 1 is outstanding - the Data Quality Assurance Framework which needs to be reconsidered in the light of the development of EPR and the changes to the data warehouse.

- A review of Controlled Drugs & Pharmacy Fridge Management - 13 recommendations completed. It was decided 1 recommendation was not required.

- The implementation of the Duty of Candour - 1 action is complete and the other action partially completed will always be an ongoing action.

- Assurance review of the Medical Device Management Service. Of the 12 recommendations, 3 are complete, 8 are not due yet and 1 was not considered a practical or appropriate solution.

- A review of Temporary Staffing. 3 of the 4 recommendations are complete. The outstanding action will not happen as the agency tier system is constantly changing and would be out of date as soon as it went in the policy.

The committee noted the report.

CGC091616 – NHSI Quality Governance Framework Annual Self-assessment – Christine Blanshard

- The report is structured around the Quality Governance Framework and the work needed to ensure compliance with the NHS Outcomes Framework in 16/17.

- The Quality Strategy and the Quality Account are the key drivers for improvement across the patient pathway. The quality priorities in 16/17 reflect the needs of patients and other key stakeholders including improvements required as part of the CQC inspection report.

- The paper serves to provide the Board with assurance that effective arrangements are in place to continuously monitor and improve the quality of care, and areas that require improvement are effectively addressed. The CQC inspection report indicated that the 2015/16 report did not identify weaknesses or areas for improvement. A section on areas for improvement is included in this report.

- A new proposed NHS Improvement Single Oversight Framework to help Trusts improve strategically, operationally and provide high quality care is likely to be in place soon.

  The committee noted the report.

CGC091617 – Clinical Audit update – Christine Blanshard

Seventeen reports were published within the reporting period. Action plans are/will be agreed by CMB and are monitored by the clinical teams and Directorates to ensure improvements and completion of action plans.

Actions from 24 reports published in previous reporting areas are progressing satisfactorily.

CGz confirmed that national audits are the priority and each Directorate has clinical audit resource to support 5 local audits. There is a clinical audit annual plan to work to.

The committee noted the report.

CGC091618 – External Enquiries and External Agency Visits Biannual Report including Nat Conf Enqs, External Visits and Nat Reviews) – Christine Blanshard

<u>National Reviews</u>

One report was published between February and July 2016. An action plan has been developed.

Recommendations from five reports are outstanding from previous reporting periods but work is progressing.

National Confidential Enquiries

Two reports were published between February and July 2016.

The Trust is partially compliant with 12 recommendations from three reports in the previous reporting period.

External Visits

A total of six visits and inspections took place between February and July 2016. Action plans have been developed where necessary.

Actions from six visits which took place in previous reporting periods are still outstanding but work is progressing.

In relation to the School of Surgery visit, CB confirmed that previously lots of work has been done to improve the training ratings in Plastics to an A and that is now being reinforced following concerns raised at the visit. Most training posts are an A or A*

The committee noted the report.

CGC091619 Q1 Research and Development Report (information only) – Christine Blanshard

The NHS is encouraged to support the National Institute of Health Research Clinical Research Network research. The Trust is part of the CRN: Wessex network, and receives infrastructure funding from the network to support research staff and NIHR research activity.

The Trust is performance managed by both the NIHR and CRN: Wessex against a number of KPIs. These KPIs are reported to the CGC on an annual basis as part of the Trust Research Annual Report. We also make mandatory, quarterly KPI submissions to the NIHR, which are published on the Trust website.

It was agreed that CGC would monitor research performance via a quarterly research KPI report, and the Research Annual report.

CB commented that the hospital is performing very well in this area.

The committee noted the report.

ASSURING SAFETY

CGC091620 Sign Up to Safety Programme Report – Katrina Glaister

Patient Safety Priorities:
Our aim is to reduce avoidable harm by 50% and to reduce our HSMR further by 10% by 2018; this will be achieved through the following workstreams:

Workstream One – Reducing Harm in Frailty
1a) Reducing falls resulting in injury
1b) Reducing harm from pressure ulcers
1c) Reducing harm from catheter associated urinary tract infections (CAUTIs)
1d) Transfers of care (Collaboration with Wessex Academic Health Science Network)

Workstream Two – Deteriorating Patient
1a) Reducing harm from sepsis
1b) Reducing harm from acute kidney injury

Workstream Three – Perioperative Safety
1a) Reducing perioperative harm through use of safety checks and briefings

1b) Reducing surgical site infections through implementation of the surgical site infection bundle

Workstream Four – Maternity Safety
1a) Reducing still births and intrauterine deaths through improved recognition of growth issues in the unborn.

KG noted that good data is now being received and this report pulls together all the safety workstream. CGz reported that the work on reducing stllbirths is progressing and is supported by a national CQUIN.

The committee noted the report.

CGC091621 – Risk Annual Report (deferred from July 2016) – Clare Goodyear

The Risk Management Annual Report focuses on the progress that has been made against the strategic goals as set out in the Risk Management Strategy (2015), the lessons that have been learnt as a result of incident reviews undertaken, changes within the risk (particularly incident reporting) processes over the 2015/16 year and ongoing progress against agreed key performance indicators.

The report also confirms that accountability and responsibility arrangements are in place within the organisation and monitored on a regular basis and compliance is maintained with national standards and requirements including CQC regulations, NHS England Patient Safety Alerts and reporting to the National Reporting and Learning System.

The report concludes with the future developments that will be driven forward in 2016/17 to ensure the implementation of the Risk Management Strategy.

The committee noted the report.

CGC091622 – Safeguarding Children Q1 (deferred from July 2016) – Gill Cobham

GC reported on achievements and challenges relating to the safeguarding of children. Level 3 training of nursery staff has now been completed following the recent Ofsted inspection in that department. Ofsted and CQC will also be completing a planned inspection at SFT within the next 6 months with a focus on domestic abuse.

JR questioned the provision for adolescents. CB reported that up to the age of 16 there is a very clear process – a child is admitted to Sarum Ward and has a mental health assessment by the next day. There are more concerns for 16-18 year olds who should not necessarily be placed on Sarum Ward but equally should not necessarily be placed on an adult ward. These patients are currently assessed on an individual case basis but a clearer care pathway is needed. This is being looked at by the Children and Young People's Board who will consider the best pathway.

The committee noted the report.

CGC091623 – Safeguarding Adults Q1 (deferred from July 2016) – Gill Cobham

Included in the Q1 report is information around referrals, activity & themes in relation to the Adult Safeguarding/ MCA/ DoLS agenda.

The DoLS workload continues to be more manageable following the introduction of the 'Consideration of a DoLS' checklist.

The Local Authorities continue to struggle to complete the Best Interest & Mental Health Assessments within the 7 day Urgent Authorization period; only two patients had their Standard DoLS authorized. The CCG are re-visiting these concerns.
Initial proposals for a change in DoLS following the House of Lords review have faltered.

Accuracy of MLE eLearning reports has been escalated to the Head of Education again. The issues are with Kallidus

GC reported that MLE is providing the right level of training for staff. 80% of Level 2 training has been completed within the last 4 months. It has proved more difficult to obtain a good level of take up for Level 1 training as this is often for members of staff who have not had to complete this before. Multi-agency professional discussions are occurring for people who return repeatedly with situations of domestic violence. The Integrated Safeguarding Operational Group has a very high

volume of work and meet monthly in order to keep the flow going.

The committee noted the report.

Challenges

Item	Challenge	Action
CGC091610 Friends and Family Report	To accurately show the proportion of positive / negative comments.	Adjustment of Friends and Family report to include positive comments.
CGC091613 Annual Complaints Survey Results	To make early contact with complainants.	Staff investigating complaints need to have early conversations with complainants to fully understand and get to the nub of it. Customer care to encourage staff to make early contact and complete new checklist.
General	Recruitment of staff across the board.	Proactive and effective marketing of SDH to potential employees.

PAPERS FOR NOTING

CGC091624	Clinical Management Board meeting minutes (July, August 2016)	Noted
CGC091625	Information Governance Group meeting minutes (June 2016)	Noted
CGC091626	Clinical Risk Group meeting minutes (June, July 2016	Noted
CGC091627	Integrated Safeguarding Committee meeting minutes (April, July 2016)	Noted

CGC071623 - ANY OTHER BUSINESS

There was no other business.

NEXT MEETING

2016 dates will be Thursdays, 10am-12pm in the Boardroom – 20th October, 24th November. No meeting in December.

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 20th October 2016, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair) - Non-Executive Director
Peter Hill - Chief Executive Officer
Dr Christine Blanshard - Medical Director
Claire Gorzanski – Head of Clinical Effectiveness
Fiona Hyett - Deputy Director of Nursing
Andy Hyett – Chief Operating Officer
Ian Downie - Non-Executive Director
Tania Baker – Non-Executive Director

In attendance:

Kate Williams	Minute taker
Jan Sanders	Governor
Katrina Glaister – Clinical Effectiveness Facilitator	CGC101604
Dr Carl Taylor – Consultant, Paediatrician	CGC101609
Mandy Cooper – Senior Sister	CGC101609
Gill Cobham – Adult Safeguarding Lead	CGC101612
Fenella Hill – Head of Risk Management	CGC101615,
Clare Goodyear – Patient Safety Facilitator, Risk Management	CGC101616, CGC101617 & CGC101618

Observing:

Henry Wilding – Service Manager
Denise Major – Deputy Director of Nursing

CGC101601 Apologies:

Steve Long - Non-Executive Director
Hazel Hardyman – Head of Customer Care
Professor Jane Reid – Non-Executive Director
Lorna Wilkinson - Director of Nursing
Mark Stabb – Head of TIAA
Dr Samuel Williams – F1
Denise Jackson – Staff Nurse

CGC101602 – Minutes of the meeting held on 22nd September 2016

The minutes were approved by the committee.

CGC101603 – Action Tracker

All items were agreed.

CGC101604 – Matters Arising – Feedback regarding presentation of Patient Stories – Katrina Glaister

The study (carried out as part of a Master's Degree) sought to determine whether videoed stories would be an acceptable option to both patients and committee members. A concurrent mixed-method data collection strategy was used. Data was themed and coded in a seven-step inductive process.

Results showed that all participants valued patients' stories and learning had resulted from them.

Feedback to patients after they had told their story was key but found wanting here. Video was shown to be an acceptable option, although data protection issues were raised by online respondents.

Recommendations include videoing stories, holding focus groups with clinical teams to determine how patient's stories are shared and learning disseminated, and improving the feedback mechanism to patients.

KG reported that some patients wanted to know that the concerns they had raised within their patient story were being addressed, and that this feedback does not currently happen. The committee discussed this and agreed that the patients should be advised beforehand that in telling their story they are improving connectivity between themselves and the management of the hospital and that direct action would not be taken as a result of their attendance. It was suggested that the patient story could be taken to the Trust Board and this is something that will be considered. A small working group will be formed to re-evaluate the patient story terms of reference and will report back to the committee in 3 months. **KG**

CGC101605 – Clinical Governance Committee meeting dates 2017 – Lydia Brown

Approved dates for the Clinical Governance Committee meetings in 2017 :

January 26 , February 23, March 23, May 18, June 22, July 27, September 28, October 26, November 23

CGC101605 – Clinical Governance Committee meeting Terms of Reference – Lydia Brown

The committee approved the updated terms of reference and the 2017 reporting schedule which included the following amendments :

- Request attendance of the Chief Pharmacist 3 times a year.
- Receive the Supervision of Midwives assurance meetings minutes as a paper for noting.
- Ensure the CQC intelligent monitoring report is monitored and acted upon (removed as no longer published)
- Hear patient stories directly from patients, relatives or carers.

It was also agreed that the Governor role would continue to be recorded as 'in attendance' to satisfy insurance purposes, and that AH would now show as a full member of the committee, with 'ex-officio' to be removed.

CGC101606 – Clinical Governance Committee Reporting Schedule – Lydia Brown

The non-executive directors agreed that the 'Hot Topic' elements would be decided upon nearer to the meetings. The names of the clinical leads to be updated. **AH/KW (completed)**

The committee agreed that the Major Issues Report would now be heard twice a year and that the Dementia, End of Life Care and Learning Disabilities reports would be heard annually.

CGC101607 – Effectiveness of the Clinical Governance Committee meeting and attendance monitoring – Lydia Brown

The committee agreed to complete a survey in the early part of 2017 to be added to the reporting schedule. **KW (completed)**

STRATEGY

CGC101609 – Core Service presentation – Children & Young People's Services – Carl Taylor, Mandy Cooper

CT gave a presentation giving an overview of the CQC outcome.

CT reported that there have been significant structural changes to the services including the ongoing process of the community child health team moving to Virgin Care. A consultant has also moved to Virgin Care, meaning that there is currently no named doctor for child safeguarding. The position is being filled as a job share in the interim and training is being given to those members of staff. FHy noted that the members of staff have been a good addition to the safeguarding team and that they are working well with Angela Conway. Training of staff on Level 3 Safeguarding for other members of staff is under way but is at a low level of completion.

MC assured the committee that supervision sessions were now more robust and included looking at paperwork. Clinical Governance meetings happen 6 times a year and smaller unit meetings occur in addition to these.

CT noted that paediatric burns patients are now treated on Sarum and that this has had an impact on the staff and their training. The introduction of Lorenzo will ensure that the move to paperless is heading in the right direction and the department is looking to use iPads in the future.

LB thanked CT and MC for their presentation.

CGC091610 – Spinal Unit verbal update – Christine Blanshard

CB reported that very good progress has been made with VUD appointments and outpatients follow-up appointments following the CQC warning notice. Patient tracking lists are being monitored weekly. A review has been undertaken of the urology clinical pathway and this should reduce the number of patients needing VUD appointments. There is an ongoing medical workforce review. Results of investigations into the cause of death of spinal patients who were on a waiting list are still being received but none so far have been shown to have died as a result of a lack of follow-up. The CQC will be revisiting the department on 3rd November.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC101611 – CQC inspection action plan verbal update - Christine Blanshard

CB reported that there is continued monitoring of progress of the action plans. This is generally good, with some services making very good progress. The core services will be asked to rate themselves and information will be triangulated to see how improvements are being felt on the ground.

CGC101612 – Learning Disabilities mid year report 16/17 – Gill Cobham

Work continues on a daily basis in the clinical areas to support Adults with a learning disability. The Working Group is again challenged for attendance by partner agencies due to a significant amount of re-organisation in those agencies. There has been renewed interest from within SFT, and there are some new members on the Working Group. Two service users have also joined the Working Group.

2016/17 LD audit is planned for November 2016. The Working Group is developing a Pre-Admission assessment tool, which will identify additional support and reasonable adjustments required.

The committee noted the report.

ASSURING CLINICAL EFFECTIVENESS

CGC101613 – Quality Indicator including DSSA – for discussion – Christine Blanshard

- No MRSA bacteraemia in Q2.
- No MSSA bacteraemia in September. Q2 total – 1 MSSA bacteraemia.
- 1 case of C Difficile in Q2. 4 in total YTD against an upper limit of 19 cases.
- 4 new serious incident inquiries commissioned in September. Q2 total – 14. No never events in Q2.
- A decrease in the crude mortality rate in Q2. SHMI is 107 to March 16 and is as expected. HSMR is 116 to June 16 and is higher than expected. This may have been affected by a temporary reduction in the palliative care team in Q1 and a significant reduction in co-morbidity coding. 6 new CUSUM alerts - all to be investigated.
- A decline in Q2 of best practice tariff compliance to 79% for hip fracture patients due to waiting for theatre (8) from 38 to 79 hours, waiting for an orthopaedic surgeon/diagnosis (2) and unfit for surgery (2). Ongoing improvement work via the Theatre working group along with strategic plan to separate elective and non-elective orthopaedic surgery.

- A reduction in grade 2 pressure ulcers. There has been a reduction in grade 2 pressure ulcers per 1000 beds days from 1.13 to 1.04 when April to August 2015 is compared to the same period in 2016. Share and learn meetings continue to drive improvements.

- In September there was 1 fall resulting in major harm (fractured hip requiring surgery). In Q2 in total there were 12 falls resulting in harm, 1 resulting in head injury, 6 resulting in fractured hips requiring surgery and 5 falls resulting in moderate harm (1 fractured wrist, and one patient with both a dislocated/lacerated finger and a head injury, 1 fractured humerus, 1 fractured ankle and 1 head injury) all managed conservatively. Ongoing improvement work via the Falls Working Group.

- In Q2 all patients bar one (due to uncertain diagnosis) had a CT scan within 12 hours. The majority of patients spent 90% of their time on the stroke unit. Those that did not, required specialist care on other wards. Patients arriving on the unit within 4 hours reduced during the quarter due to bed capacity (8), patients arriving from ED 1 - 9 minutes after 4 hours (6), late GP referrals (4) and in-patient strokes with delayed referral (3). Improvement work continues between the stroke unit and ED and other specialties. SSNAP audit improved to B in Q1.

- An improvement in September of high risk TIA patients being seen within 24 hours. In Q2, 13 patients had their investigations & treatment completed just outside 24 hrs and 7 patients were not seen within the timeframe due to consultant leave. There were 3 delays in GP referrals and 2 referrals were not sent to the single point of access. Discussion held with GP practices concerned and improvement work led through the Stroke Strategy Group.

- An increase in the number of complaints and reopened complaints in Q2 but a decrease in the number of concerns and re-opened concerns. Early contact with patients & relatives in the initial phase of a complaint is being proactively promoted.

- Escalation bed capacity decreased in Q2 in comparison to Q1 and in September a decrease of the percentage of patients moved more than once. Multiple ward moves remain at a low level and work continues with our partners to transform patient flow.

- No non-clinical mixed sex accommodation breaches in September. In Q2, a total of 5 non-clinical mixed sex accommodation breaches affecting 48 patients all on AMU, all resolved within 2 days and due to bed capacity issues.

- The time of patient moves is reported for ongoing monitoring purposes. The majority of overnight moves occur from Whiteparish, SSEU and Britford SAU to maintain patient flow. However, there were a number of moves from one ward to another to create appropriate bed capacity. The majority of discharges between 10 pm and 7 am are from ED/SSEU, Whiteparish and Britford SAU. Improvement work is led through the Transformation Programme.

- The mean score of patients rating the quality of their care dipped in Q2 although the percentage of staff who would recommend the Trust as a place to work or receive care was sustained in Q2 (note low response rate). Responses to the Friends and Family test consistently show that patients would recommend wards, the maternity service, outpatients and care as a day case but dipped in ED in Q2 reflecting the pressures faced by the department.

The committee noted the report.

CGC101614 – Dr Foster Report and Mortality Reviews – Christine Blanshard

- SHMI is 107 and is as expected to March 2016 and 107 when adjusted for palliative care to December 15. HSMR is 116 to June 16 and is higher than expected which may be due to a temporary reduction in the palliative care service reflected by the reduction in coding. Co-morbidity coding also significantly declined. Deaths in low risk diagnosis groups are as expected. Deaths by day of admission are as expected on weekdays and weekends.

- Care Quality Tracker - for the period July 2015 to June 2016 the Trust's overall risk is 5, lower than the national median. The Trust remains in Band 6. There are two elevated risk and one risk.

- CUSUM alerts – 3 new diagnosis groups for the period. An assessment of avoidability and learning points are given where these groups have been investigated.

- A review has been completed of patients who died whilst overdue a follow-up appointment in the SIU and the deaths investigated in respect of the CQC enforcement notice of VUD and a summary will be presented in November 2016.

- Progress of the CQC national review of how Trusts investigate deaths is reported.

- A new National Mortality Case Review programme is to be introduced over the next 2 years supported by AHSNs.

CB noted that it has not yet been possible to publish avoidable death rates as no agreement has been reached nationally as to how this should be done. We have joined a scheme piloted by South West AHSN looking at optimising mortality reviews.

CGz reported that training has been undertaken for 'structured judgement review' which has proved very useful and gives a scored outcome.

The committee discussed coding issues and agreed that the drive for Lorenzo may have had an effect on recording.

The committee noted the report.

ASSURING SAFETY

CGC101615 – Assurance framework – Fenella Hill

The Assurance Framework must be reviewed and updated quarterly by the delegated Assurance Committees to ensure that scrutiny is applied to assure the Board that the Trust's principal risks are being managed and controlled effectively in order for the corporate objectives to be achieved.

A Trust Board reporting template identifying key changes since the last meeting is also prepared for the committee's consideration.

The Trust Risk Register (extract of clinical risks scoring 12 and above) is submitted to the committee for reference so that the Assurance Committee can either be assured that specific risks are being managed effectively locally or if not to identify how this may be ascertained.

The committee considered and noted the report.

CGC101616 – Risk Report Card Q2 – Fenella Hill

The Risk Management Report Card provides details on numbers of incidents reported, the severity and categories. This allows themes and trends to be identified.

- 2453 incidents reported over the quarter
- 5 incident categorised as catastrophic*
- 10 incident categorised as major*
- 6 major incident due to fractures within the quarter
- No new Never Event reported within the quarter*
- No new Clinical Review commissioned within the quarter
- No new Non-clinical Reviews commissioned within the quarter
- 14 new Serious Incident Inquiries commissioned within the quarter
- No new Local Reviews commissioned within the quarter

*Initial grading and subject to change following review.

The committee noted the report.

CGC101617 – SII / CR report Q2 – Fenella Hill

Updates to outstanding recommendations:

- SII 160
- SII 176
- SII 181
- SII 185

- SII 191
- SII 194
- SII 198
- SII 203.
- SII 196
- SII 204
- SII 205
- SII 206
- SII 207

Reviews with outstanding recommendations:

- SII 201/202
- SII 204
- SII 205
- SII 206
- SII 209
- SII 207
- SII 208
- SII 214

New Recommendations since July 2016 CGC

- SII 196
- SII 201/202
- SII 204
- SII 205
- SII 209
- SII 206
- SII 207
- SII 208
- SII 214

Serious Incident Inquiry/Clinical Review for Closure

- SII 160
- SII 176
- SII 181
- SII 185
- SII 191
- SII 194
- SII 198
- SII 203

The committee noted the report.

CGC101618 – NPSA NRLS – Fenella Hill

- Reporting rate per 1000 bed days shows the Trust to be in the middle of the middle 50% of the cluster group. Although this demonstrates a slight drop in our position within this cluster since the last report, we are now reporting a median rate of 39.34 incidents per 1000 bed days compared to 39.31 for the previous 6 month reporting period.

- Patient accidents continue to be the top reported incident at SFT (18.2% against the cluster reporting 16.8%).

- Nationally 73% of reported incidents result in no harm. We reported 90.7% of incidents as resulting in no harm, compared to 75.5% for the remainder of the cluster.

- Incidents reported in 6 of the 6 months 1 October 2015 – 31 March 2016

The committee noted the report.

Challenges

Item	Challenge	Action
CGC101604 Feedback regarding presentation of Patient Stories	To review Patient Stories	To review patient story terms of reference
CGC101609 Children & Young People's Services	To ensure that Clinical Governance sessions happen regularly	To use the Trust's Clinical Governance minutes template available on the intranet

PAPERS FOR NOTING

CGC101619	Clinical Management Board meeting minutes (September 2016)	Noted
CGC101620	Information Governance Group meeting minutes (August 2016)	Noted
CGC101621	Clinical Risk Group meeting minutes (August 2016)	Noted
CGC101622	Infection, Prevention and Control Committee meeting minutes (July 2016)	Noted
CGC101623	Children & Young People's Quality and Safety Board meeting minutes (June 2016)	Noted
CGC101624	Supervision of Midwives Assurance meeting minutes (August 2016)	Noted

CGC101625 - ANY OTHER BUSINESS

FHy reported that at the recent open day for Maternity services, 5 midwives were recruited. Feedback has been that SDFT is very friendly. A facebook campaign was used to advertise the open day and proved successful – this approach could be used in other areas.

FHy reported that Wiltshire have been selected to be jointly inspected by the CQC and OFSTED in respect of children and domestic abuse situations.

ID thanked LB on her last meeting for chairing the committee over the last few years on behalf of all.

NEXT MEETING

2016 dates will be Thursdays, 10am-12pm in the Boardroom – 24th November. No meeting in December.