SALISBURY NHS FOUNDATION TRUST

TRUST BOARD

MONDAY 8 DECEMBER 2014, 1.30PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
1.30pm	**1**	**APOLOGIES FOR ABSENCE** Ian Downie			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES**			1
		Public Board Meeting held on 6 October 2014			
	4	**MATTERS ARISING**			
1.35pm	**5**	**CHIEF EXECUTIVE**			
		1. Chief Executive's Report	PH	SFT 3596	9
1.45pm	**6**	**STAFF**			
		1. Friends & Family and Staff Survey Results Update	AK	SFT 3597	11
		2. Ward Staffing	LW	SFT 3598	21
2.00pm	**7**	**PATIENT CARE**			
		1. Quality Indicator Report to 31 October (month 7)	CB/LW	SFT 3599	29
		2. Report of Director of Infection Prevention & Control	LW	SFT 3600	37
		3. Sign up to Safety	LW	SFT 3601	93
2.30pm	**8**	**PERFORMANCE AND PLANNING**			
		1. Finance & Performance Committee Minutes 20 October	NM	SFT 3602	103
		2. Financial Performance to 31 October (month 7)	MC	SFT 3603	109
		3. Progress against Targets and Performance Indicators to 31 October (month 7)	LA	SFT 3604	121

Time	Item	Title	Lead	Ref	Page
		4. Update on Planning Process	LA	SFT 3605	Verbal
		5. Proposed Capital Programme for 2015/16	MC	SFT 3606	129
3.00pm	**9**	**PAPERS FOR NOTING OR APPROVAL**			
		1. Assurance Framework Update	LW	SFT 3607	133
		2. Estates Strategy Update	LA	SFT 3608	155
		3. Trust Strategy – Half-yearly Update	LA	SFT 3609	173
		4. 2014 PLACE Results	LA	SFT 3610	183
		5. JBD Minutes Evidencing Presentation of Assurance Framework and Risk Register	PH	SFT 3611	193
		6. Minutes from Clinical Governance Committee 25 September	LB	SFT 3612	195
		7. Minutes from Audit Committee 13 October	NA	SFT 3613	211
3.45pm	**10**	**ANY OTHER URGENT BUSINESS**			
	11	**QUESTIONS FROM THE PUBLIC**			
	12	**NEXT MEETING**			
		The next ordinary meeting will be held on Monday 2 February 2015, 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 6 October 2014
In the Boardroom, Salisbury District Hospital

Board Members Present:	Dr N Marsden	Chairman
	Mr N Atkinson	Non-Executive Director
	Dr L Brown	Non-Executive Director
	Dr C Blanshard	Medical Director
	Mr M Cassells	Director of Finance and Procurement
	Mr I Downie	Non-Executive Director
	Mr A Freemantle	Non-Executive Director
	Ms K Hannam	Chief Operating Officer
	Mr P Hill	Chief Executive
	Mrs A Kingscott	Director of Human Resources and Organisational Development
	Revd Dame S Mullally	Non-Executive Director
	Mrs L Wilkinson	Director of Nursing
Corporate Director:	Mr L Arnold	Director of Corporate Development
In Attendance:	Mr P Butler	Communications Manager
	Mr D Seabrooke	Secretary to the Board
	Mr P Lefever	Wiltshire Health Watch
	Councillor John Noeken	Governor
	Mrs J Sanders	Governor
	Mr B Fisk	Governor
	Mr R Jack	Governor
	Mr J Carvell	Governor
	Mr C Wain	Governor
	Mrs L Taylor	Governor
	Mr A Lack	Governor
	Mrs C Martindale	Lead Governor
	Mrs M Cripps	Governor
	Mr A Hyett	University Hospital Southampton (Observer)
	Mr M Wareham	Staff Side
Apologies:	Mr S Long	Non-Executive Director

2011/00 DECLARATIONS OF INTERESTS

Members of the Board were reminded that they had a duty to declare any interests arising from the discussion, any impairment to being fit and proper and to avoid any conflicts of interest. No member present declared any such interest.

2012/00 MINUTES – 4 AUGUST 2014

The minutes of the Public Board meeting held on 4 August were approved as a correct record.

2013/00 MATTERS ARISING

It was noted that an update would be provided on equality and diversity compliance. Information about surgical cancellations had been provided as requested under minute 2004/00. AK

2014/00 CHIEF EXECUTIVE'S REPORT - SFT 3572 - PRESENTED BY PH

The Board received the Chief Executive's Report and PH highlighted the following main points –

- The Trust's seasonal flu campaign was shortly to start.
- The Trust had been recognised by the Health Service Journal as one of the top 100 employers and this was supported by positive reviews by staff.
- The Breast Unit Campaign had been launched and was progressing well.
- The Pembroke Unit garden had been opened by the Earl of Pembroke in September.
- The refurbishment of Pitton Ward had been completed.
- The Trust's Annual Member's Meeting had been held in September marking the 21st Anniversary of the Salisbury District Hospital.

It was also announced that Kate Hannam, Chief Operating Officer had secured the post of Director of Operations at North Bristol NHS Trust and was expecting to start her new duties in December.

2015/00 STAFF

2015/01 Ward Staffing, Monthly Update - SFT 3573 - Presented by LW

The Board received the report relating to August 2014.

The report showed a combined fill rate of 99%. Night shifts were at or above 100% due to the higher risk factors. It was noted that 21 newly qualified nurses had arrived in September.

There were some instances of ward sisters working clinically – this was variable according to vacancies and patient acuity and was expected to reduce. There were some instances of training days being cancelled but this was not the Trust's first choice in the event of unexpected staff shortages. The cancellation rate was monitored.

It was noted that the ward staffing information provided should be reviewed over time as issues about what was required to be collected were being ironed out. Recruitment of people with the necessary skills remained a challenge both nationally and locally.

The Board noted the Ward Staffing Report.

2016/00 PATIENT CARE

2016/01 Quality Indicator Report to 31 August – SFT 3574 - Presented by CB and LW

The Board received the Quality Indicator Report. It was noted that there were no MSSA bacteraemias and that a second MRSA case was currently being investigated. The Sepsis 6 care bundle had been rolled out in A&E.

There had been four new cases of C-diff in August (none in September) and an action plan to address this was in progress.

It was noted that of the 13 attributed C-diff cases year to date, up to five were considered not to be a lapse of care by the Trust and these would be submitted to clinical commissioning groups for review under the procedure introduced for 2014/15.

CB reported a possible Never event that had occurred in theatres – this was currently being investigated.

The Board noted the Quality Indicator Report.

2016/02 Customer Care Report Quarter 1 – SFT 3575 – Presented by LW

The Board received the Quarter 1 Complaints Report. The Report highlighted three main themes from complaints – Clinical Treatment, Staff Attitude and Communication. Satisfaction rates with the complaints process itself suggested that one third of complainants remained dissatisfied. This would be among themes addressed at a half day workshop to take place later in the week.

Work continued to address the issue of noise on inpatient wards at night and board members expressed concern about the instances of complaints around the response to patient call bells.

The Board noted the Quarter 1 Complaints Report.

2017/00 PERFORMANCE AND PLANNING

2017/01 Better Care Fund – SFT 3576 – Presented by KH

KH gave a presentation on progress with implementing the Better Care Fund and progress with the 100 Day Challenge which started from 1 September, led by the Health and Wellbeing Board. The Council's Systems Thinking Team was working to analyse the very complex picture across health and social care in the locality. The 100 Day Challenge had made the issue of delayed transfers of care much more prominent and was leading to an alignment of views and actions as to how to address this. Help To Live At Home (HTLAH) was highlighted as a particularly important component. The Trust did not currently have the services of a community geriatrician.

The Board thanked KH for the presentation.

2017/02 **Skill Mix Review – SFT 3577 – Presented by LW**

The Board received the six monthly Skill Mix Review which had been prepared in line with the National Quality Board's twelve expectations which included a twice yearly skill mix review. It was noted that at the time the half yearly review was being researched the £800,000 investment previously agreed by the Board was still being implemented through the workforce. It was noted that Amesbury and Durrington Wards required additional resources. The review was also looking at the requirements of Avon Wards and particularly the resources required to support the respiratory beds.

The Safer Care Tool under the Allocate System continued to be rolled out and would be a source of additional information in respect of patient acuity. It was noted that the turnover of registered nurses per year was approximately 40 but there was concern that exit interviews were not being carried out consistently to help analyse whether there were any underlying themes in relation to vacancies.

There was further work to do in relation to the Amesbury Ward to determine the number of elective and non-elective beds that would be required, but LW did not feel that Amesbury Ward night shift was safe without the investment of £117,000 for additional registered nursing support (the sum included support for the Durrington night shift). At present it was not possible to identify a source in relation to this request for additional funding and the Chairman suggested that an integrated approach with the Finance Department should be adopted should future requests arise.

The Board agreed that the additional staffing for Amesbury and Durrington Wards costed at £117,000 should be supported.

2017/02 **Finance Committee Terms of Reference – SFT 3578 – Presented by NM**

The Board received the draft minutes of the 22 September meeting of the Finance Committee which included a recommendation to add to the Committee's Terms of Reference a new duty to review the preceding month's operational performance.

It was also noted that the Committee had expressed some nervousness at the September meeting around progress with cost improvement plans and transformation.

The Board agreed to rename the Finance Committee Finance and Performance Committee and agreed the recommendation to add to the Committee's Terms of Reference.

2017/03 **Financial Performance to 31 August 2014 (month 5) – SFT 3579 – Presented by MC**

The Board received the Financial Performance Report. MC informed the Board that income was slightly above plan but that the difference was slightly exceeded by expenditure.

The Continuity of Service Rating with Monitor remained a 4. Cash was marginally below plan. On activity, inpatient elective admissions were down, but non elective admissions were significantly up. This excess activity over the 2008/09 level was only paid for at 30% of tariff under national rules. The Trust was discussing this with the CCG.

Commissioners were concerned about over performance and there had been challenges on CQUIN payments.

There was concern about agency spend on medical locums – this was kept under review by the Executive Workforce Committee and there were issues with some areas of medical recruitment and with filling junior doctor posts by the deanery.

Cost improvement programmes were 90% achieved on a phased basis but on a straight line basis, approximately 50%.

The Board noted the Finance Report.

2017/04 Progress against Targets and Performance Indicators to 31 August (month 5) – SFT 3580 – Presented by KH

The Board received the targets and performance indicators report. KH reported that the emergency department had performed well in August. There was a planned failure of the 18 week referral to treatment target. The level of delayed transfers of care was the main factor in the requirement for additional inpatient capacity during August. One patient had breached in diagnostics- there was a 10% increase in referrals from GPs and ED.

The continuing transition to the SPIDA electronic system remained an issue in registering completed appraisals; work continued on this with the directorates.

The Board noted the report.

2017/05 Update on Planning Process – SFT 3581 – Presented by LA

LA reported that the Trust's five year strategy had been submitted to Monitor and that no specific response had been received. Staff briefings on the content of the strategy were underway supported by the cascade brief.

Business planning processes with directorates were underway. It was noted that at the 3 November awayday, a series of clinical presentations was getting underway.

The Board thanked LA for the update.

2017/06 Capital Development Report, June – September 2014 – SFT 3582 – Presented by LA

The Board received the Capital Development Report.

It was noted that the ITU expansion works were underway due to complete in mid-December to release winter escalation capacity. Discussions about the prospective south side development continued via competitive dialogue with two bidders. The first replacement CT scanner had now been commissioned and the second one was due to be delivered at the end of the month.

Work on the Springs entrance improvements had been rescheduled to early 2015.

The Board noted the Capital Development Report.

2017/07 Update on Provision of Cleaning Services – SFT 3583 – Presented by KH

The Board received a report informing it on the current status on the Cleaning Contract and looking at possible options for the future provision of this service to the Trust. The report had been brought forward following a decision in October 2011 to continue the existing arrangements for a further three years. The report described the performance and monitoring arrangements of the cleaning service and included a cost benchmark based on cost per occupied meters squared for smaller acute trusts outside London.

It was noted that there was other work going on to improve and review the cleaning service. It was suggested that any decision on next steps for the cleaning service should be deferred until this report was to hand.

2018/00 MATTERS FOR NOTING OR APPROVAL

2018/01 JBD Minutes Evidencing Presentation of Assurance Framework and Risk Register – SFT 3584 – Presented by PH

The Board received an extract of the minutes of the Joint Board of Directors meeting of 16 August 2014, noting that the Assurance Framework would receive its new review and gaps in control in relation to C-diff and the capacity to manage to deliver IT projects.

The Board noted the report.

2018/02 Risk Management Annual Report and Risk Management Strategy – SFT 3585/6 – Presented by LW

The Board received the Risk Management Annual Report and Risk Management Strategy.

The Board noted the achievements within the Annual Report 2013/14 and noted the Annual Risk Management Plan 2014/15. It

ratified the Risk Management Strategy 2014/15.

2018/03 Clinical Governance Annual Report 2013/14 – SFT 3587 – Presented by CB

The Board received the Annual Clinical Governance Report which had been discussed at length by the Clinical Governance Committee.

The Board noted the Report.

2018/04 Maternity and Neonatal Risk Management Strategy and Annual Report - SFT 3588 – Presented by LW

The Board received the Maternity Risk Management Strategy 2014/15. It was noted that it had been drawn up on a similar basis to the overall Trust Risk Strategy. The main change noted was in relation to the role of community midwives and safeguarding managers.

The Board approved the revised Maternity and Neonatal Risk Management Strategy 2014 and noted the Annual Report.

2018/05 Management Letter for 2013/14 - SFT 3589 – Presented by PH

The Board received for information a copy of the Management Letter 2013/14 which had been considered in detail by the Audit Committee. There were no matters to report arising from this and the Management Letter was noted.

2018/06 Minutes from Clinical Governance Committee 24 July 2014 - SFT 3590 – Presented by LW

The Board received for information a copy of the confirmed minutes of the Clinical Governance Committee.

It was noted that Jan Sanders had attended the most recent meeting as a governor observer.

2018/07 Minutes from Public Section of Council of Governors Meeting 21 July 2014 – SFT 3591 – Presented by NM

The Board received the draft minutes of the Council of Governors and it was noted that one newly-elected Governor, Katherine Saunders had stood down. The Board noted the Council of Governors draft minutes.

2019/00 ANY OTHER URGENT BUSINESS

Proposed Strike Action – 13 October

AK informed the Board that the Trust had been notified that Unison, Unite and the Royal College of Nursing were taking strike action on the morning of 13 October 2014, followed for the remainder of the

week by a work to rule. Work was underway to understand the potential impact of this action and it was noted that other unions may join in industrial action later in the year.

2020/00 QUESTIONS FROM THE PUBLIC

- In relation to a question from Brian Fisk the Chairman acknowledged that there was more to do on improving the visibility in the organisation of members of the Board.
- John Carvell reflected on concerns about the cleanliness of the A&E department including the external environment and performance on 18 weeks referral to treatment. The message the Trust had from commissioners was that patients should be treated towards the end of the 18 week timescale.
- Chris Wain reflected on his recent night time visit to the A&E Department indicating that the staffs were tremendously professional coping with a heavy workload. There were concerns about transport home for patients, particularly those coming to the hospital from out of area and also patients directed to A&E as a result of calls to the 111 service.
- Peter Hill undertook to check a concern about the security cameras in the A&E raised by Alastair Lack.
- Mark Wareham made a point about external tendering in relation to the Trust's cleaning contract.

2021/00 DATE OF NEXT MEETING

It was noted that the next public meeting of the Trust Board will be on Monday 8 December 2014, in the Board Room at 1.30pm.

CONFIDENTIAL ISSUES

The Board resolved to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reasons of confidential nature of the business to be conducted.

SFT 3596

CHIEF EXECUTIVE REPORT

MAIN ISSUES:

EBOLA PREPAREDENESS

While the risk to the UK from the Ebola virus continues to remain very low, we along with other hospitals across the country have been working closely with NHS England and Public Health England to put in place robust contingency plans to manage any patients with suspected infectious diseases based on agreed national guidelines. As part of our plans key clinical and non clinical teams meet twice weekly to monitor our own arrangements and ensure that any new guidance is issued to key staff groups as appropriate. We have enhanced our existing personal protective equipment, provided additional staff education and carried out exercises to test our plans against a number of possible scenarios. We also have robust plans to transfer any patients safely and appropriately to a specialist hospital unit.

NEW STATUTORY DUTY OF CANDOUR

Following the Francis Report into the care and treatment of patients in Mid Staffordshire, the Government has introduced a statutory Duty of Candour. The duty, which will be monitored by the Care Quality Commission (CQC), applies to all NHS organisations. The new duty is not significantly different to our current approach and all Trusts will have to identify that an incident causing harm has happened and tell the patient about it swiftly and honestly. Trusts will also have a duty to support the patient by allowing a member of the family, carer or a healthcare professional that the patient has confidence in to be present when they tell the patient what has happened, with ongoing support and treatment to reduce the harm provided. The new duty will be covered in our Adverse Event Reporting Policy and Adverse Events Supporting Those Involved Policy.

PATIENTS RATE A&E STAFF AND SERVICES AMONG BEST IN COUNTRY

People needing emergency treatment have rated our Accident and Emergency (A&E) Department as one of the best in the country, with confidence in staff, privacy and overall experience rated highly in an independent Care Quality Commission (CQC) survey. Around 850 people who attended A&E in the summer were asked their views on facilities, waiting times, the quality of care and the way they were treated.
When compared with most other Trusts in the survey, Salisbury District Hospital was better in five of the eight sections covered in the report (Arrival at A&E, Doctors and Nurses, Care and Treatment, Tests and Overall Experience). In three areas the Trust had the highest score in the country - help from doctors and nurses, the opportunity to discuss anxieties and fears, and the provision of information about their condition and treatment. It was in the higher end on all other questions. These survey results are particularly pleasing bearing in mind the significant pressure experienced by our staff throughout the year.

STAFF REWARDED FOR SERVICES TO PATIENTS

Staff have been rewarded for their professionalism and commitment and the way in which they have improved services for patients as part of our Striving for Excellence Awards. There were 11 categories in all, and award nominations were made by patients, staff and volunteers, with members of the public voting for the winners in the Service Improvement categories. In the year that we celebrate the 21st anniversary of Salisbury District Hospital it was particularly pleasing to be able to

acknowledge the enormous contribution our staff have made to local health services over the years and give them recognition for the outstanding work that has taken place this year. The press release and a full list of the winners and highly commended can be found in the Latest News section on the Trust website at: www.salisbury.nhs.uk . We will also be producing a limited edition newsletter which will be available later in December.

MAYOR PAYS TRIBUTE TO NHS STAFF

Mayor of Salisbury, Jo Broom said a special thank you to our staff for their contribution to the local community over the last 21 years and beyond at a special Mayor's at Home event in the Guildhall The celebration was the latest in a number of events organised to mark our 21st anniversary and we were very grateful to Jo and her team for putting on this event in recognition of our staff, past and present, who have served the local community with great loyalty and distinction over so many years. It was also an opportunity to celebrate the wonderful relationship between our hospital and Salisbury City Council and the real sense of community that marks Salisbury out as such a very special place to live and work.

NEW UROLOGY CENTRE OFFICIALLY OPENED

Mayor of Salisbury Jo Broom has officially open the Urology Centre, which now provides a range of diagnosis and treatment in one dedicated location. Before the change all clinics and treatment would have been carried out in general surgical outpatients or other specialist areas. The Centre has a comfortable and welcoming waiting area with more clinic space and an outside garden area that gives patients and their relatives a more relaxed environment when they come into hospital. Many of the additional improvements were made possible thanks to donations from the Salisbury Hospital League of Friends and Salisbury Independent Hospital Trust Ltd.

EMERGENCY DEPARTMENT WINS LOCAL HERO AWARD

Congratulations to the Emergency Department which won the Salisbury Journal/Spire FM Local Hero Award in the Emergency Services category. The citation said that they were " worthy for the nomination because of the hard work and dedication of the team and continued excellent care despite demand on resource for high patient attendances". The team picked up their award at the ceremony in Salisbury.

SALISBURY DISTRICT HOSPITAL RESPONSE TO INDUSTRIAL ACTION

As the debate continues between the Government and public sector unions about pay, over the last two months a number of unions have carried out several days of planned industrial action followed by a week of work to rule. The Trust has worked closely with unions to ensure that patient safety and quality of care was not compromised and all essential services provided by the Trust continued as normal. With more industrial action planned, the Trust will continue to monitor the possible impact on its services and prepare accordingly.

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

Trust Board meeting **SFT 3597**

FRIENDS & FAMILY AND STAFF SURVEY RESULTS

Date: 8 December 2014

Report from: Alison Kingscott and Victoria Downing-Burn Presented by: Alison Kingscott, Director of HR and OD

Executive Summary:
To provide a summary of the Trust Staff Friends & Family Test outcomes and to provide assurance on the actions relating to the Staff Survey Results 2013

Proposed Action:
To note the FFT results and to support the on-going work on securing improvements in staff experience of work through the survey actions.

Links to Assurance Framework/ Strategic Plan:
Staff are recognised as a key strand in our strategy.

Appendices:

Supporting Information

NHS Staff Friends and Family (FFT) Test 2014 Results and NHS Staff Survey 2013 Action Plan

Purpose

To provide the Trust Board with an update on the data received relating to the staff response to the Friends and Family Test for 2014, including data from Quarter 1 and Quarter 2 (released 27 November 2014). To provide assurance to the Board that the Action Plan supporting the outcomes from the 2013 Staff Survey is well established, with new practices embedded and all actions well progressed.

NHS Staff Friends and Family Test: Background

The NHS introduced the Friends and Family test for staff in April 2014. Its purpose is to provide staff with the opportunity to feedback their views on their organisation, at least once a year. It also provides staff with an opportunity to 'speak out' about their organisation in support of an open culture.

Following national guidance[1] the test has been issued to all staff during Q1 and Q2.

In the test staff are asked the following questions:

- "How likely are you to recommend this organisation to friends and family if they needed care or treatment?"
- "How likely are you to recommend this organisation to friends and family as a place to work?"

Each staff member can respond using a scale ranging from "extremely unlikely" to "extremely likely". Staff members also have the opportunity to provide free text answers / comments.

Output

Results from the NHS Staff FFT in SFT have been very positive. The combined results for quarter 1 and 2 include:

- a total of 857 responses to the Test, representing a 27% response rate to date
- 93.3% of respondents said they were "likely" or "extremely likely" to recommend SFT organisation to friends and family if they needed care or treatment
- 81.9% of respondents said they were "likely" or "extremely likely" to recommend SFTs organisation to friends and family as a place to work

The free text answers / comments have been analysed and shared with the Executive Workforce Committee and the Operational Management Board. They will also be used during the 3:3 Performance Meetings within Directorate.

[1] www.england.nhs.uk/wp-content/uploads/2014/02/staff-fft-guide.pdf

NHS Staff Survey 2013 Action Plan: Background

The annual survey provides staff with the opportunity to provide feedback to the organisation on their experiences of work, management, systems and process and allows the Trust to develop actions to improve the experiences for staff.

The Survey results for 2013 were reported to Trust Board (SFT3508) in April 2014, revealing that the Trust was overall performing well, and that it featured in the top 20% of trusts across a wide range of areas. The purpose of the action plan is to focus on the areas for improvement (see Appendix 1).

The action plan provides a focus on the following areas:

Our 2013 results	Details	Action plan areas
Where SFT is average	• % feeling satisfied with the quality of work and patient care they are able to deliver • % agreeing their role makes a difference to patients • Work pressure felt by staff • % working extra hours • % receiving job relevant training, learning or development in last 12 months • % reporting errors, near misses or incidents witnessed in the last month	Appraisal (KF7)
Where SFT is below average	• % experiencing physical violence from patients, relatives or the public in last 12 months	% experiencing physical violence from patients, relatives or the public in last 12 months (KF16)
Where SFT is in the bottom 20% of trusts	• % witnessing potentially harmful errors, near misses or incidents in the last month	% witnessing potentially harmful errors, near misses or incidents in the last month (KF13)
Where SFT has ambition to be above average / top 20%	• Staff experiencing stress at work	Stress (KF7)

Output and progress

Appraisals (KF7). Significant work has been conducted across the medical and non-medical workforce in supporting the appraisal process and the quality of appraisals. The new system is still being embedded and rates of appraisals have been affected by the new reporting structures. However, monitoring through 3:3 performance meetings is continuing with system issues being addressed as part of the feedback.

% experiencing physical violence from patients, relatives or the public in last twelve months (KF16). Monitoring and reviewing of incidents has been successfully embedded, and support to staff and shared learning is also occurring on a regular basis. At Executive level the 'walkround' process is incorporating questions about violence and aggression ensuring that teams and individuals are confident about reporting. Dedicated work is in progress around 'specialling' supported by a risk assessment process.

% witnessing potentially harmful errors, near misses or incidents in the last month (KF13). Higher reporting levels have been welcomed and are reviewed monthly. Further work is being conducted to introduce electronic incident reporting to support faster reporting and better opportunities to review themes.

% suffering work related stress (KF11). A number of actions have been completed in supporting the workforce including: workshops; access to a Registered Mental Health Nurse; use of online tools; new policy. Monitoring will occur through the Stress Action Team.

Appendix 1

Staff Survey Action Plan 2013
Updated: 24 November 2014.

Finding No	Finding Description	Action	Lead	To be complete by:	Progress
KF 13	37% of staff witnessed a potentially harmful error, near miss or incident in the previous month compared with 35% in 2012 and a national average of 33%. This was in the worst (highest) 20% of acute Trusts Scores high in nurses, other registered nurses, doctors, Medicine, MSK and CSFS directorates, full time staff, men and those not disabled	1. Implementation of DATIXweb and associated education relating to the reporting of incidents and escalation within the Trust. 2. Monitoring of near misses for themes and trends.	Head of Risk	September 2014	Action 1. Implementation of Datixweb ongoing across the Trust with good update of education across the Trust. Education given at the same time about reporting of incidents and near misses, supporting high reporting to ensure themes and trends visible. Action 2. Themes and or trends reviewed monthly at the Clinical Risk Group. Action 2. 'Go Live' dates being agreed with all departments for electronic incident reporting to support the capture of real-time data. (FH)
KF 16	17 % experiencing physical violence from patients, relatives or the public in the last 12 months. Trust score worse than average for acute Trusts where average score is 15%	1. Set up a task and finish group to scope the problem, review incidents and decide on actions to reduce physical violence. Include management staff in medicine and MSK, Risk.	Directorate Senior Nurse, CSFS	June 2014 July 2014	Action 1. A summary of incidents is discussed at the V&A sub group with more in-depth review of those where follow-up or support has been required. Outcomes of incidents shared for learning and dissemination. (FH) On-going. Action 1.All incidents are reviewed by a member of

Finding No	Finding Description	Action	Lead	To be complete by:	Progress
	Occurrences amongst nurses, nursing assistants, mainly in Medicine and MSK directorates, full time staff, and those aged 16 to 30.	2. Meet with Nursing assistants and junior nurses from Medicine wards, Spinal, ED, MSK wards to understand the view of affected group regarding the causes of violence and what we can do to reduce the risks. Also seek to understand the impact of physical violence on staff. 3. Monitor incidents of violence through V&A sub-group and set up a system for follow up in areas where this isn't done. 4. Continue to work on 'specialling patients' through the 'Reducing Agency Spend' group.	Colette Martindale KL and Fenella DSNs	Ongoing at Monthly meeting Ongoing at monthly meetings	the risk team on receipt and when investigation completed. All incidents reviewed by LSMS on receipt to identify where follow up, support and advice may be needed. (FH). On-going. Action 2. Two focus groups completed, and further dates are being agreed. Action 3. Ongoing work with Directorates to encourage continuing reporting of incidents and sharing ways of supporting staff and accessing support from other individuals within the Trust. (FH) Action 3. Questions on staff experience of V&A being added to Executive Quality and Safety Walkrounds. Action 4. Specialling is monitored daily in the ward areas. All patients are identified at the DSN walk round (pre bed meeting) in the morning and need for specials are challenged. We use the advanced risk assessment on all patients that are potentially at risk and always consider intentional rounding first. There are few specials needed within our directorate and the ones that we do can be divided into 2 categories: 1) vulnerable patients/dementia/post op or septic confusion and 2) clinical specials i.e. surgical VRAM Flaps. (LD). Report goes to PSG (DM and CM are working on a new scoring matrix for Specials.)

Finding No	Finding Description	Action	Lead	To be complete by:	Progress
KF 11	32% of staff suffering work related stress in the last 12 months (the same as in 2012 and compared to 22% in 2011) 2013 national average of 37% for acute Trusts. Our score is still in the best (lowest) 20% compared with all acute Trusts Scores highest for nurses, other registered nurses, other Scientific and Technical, other allied health professionals, CSFS Directorate, full time staff, staff aged 31 to 40, and white staff.	1. The Stress Action Team will continue to meet during 2014/15 to explore and offer organisational support to reduce staff stress wherever possible. This will link into the 'Shape up at Salisbury' initiative. 2. Consideration to the inclusion of a Mental Health Nurse in OH will be given dependant on available funding. There will also be closer links made between OH, Staff Counsellor and Clinical Psychology to improve staff support on areas of stress management. 3. The Staff Counsellor will provide workshops on 'stress management' for all staff which will include elements of personal resilience. The SAT will investigate the use of 'i-resilience' tool to complement current offering. 4. Management support in how to identify stress and what to do about it will be offered through HR Managers, Occupational Health, Education and the Staff Counsellor.	Director of HR and OD/ Stress Action Team Supported by the "Shape Up at Salisbury" Initiatives	March 2015 October 2014 October 2014	Action 1. Meetings continue on an adhoc basis. I-resilience tool trialled by members and now offered through Occupational Health with further promotion needed. A number of support mechanisms have been offered via the Stress Action Week in October Action 2. Completed. The RMN has started. Action 3. A number of workshops have been delivered and more are planned Action 4. This is being led by the new RMN in post.

Finding No	Finding Description	Action	Lead	To be complete by:	Progress
		5. It will be further strengthened by the launch of the new Psychological Wellbeing at Work Policy which also provides clarity and guidance for both managers and staff.			Action 5. Policy been agreed and launched. Further support to policy from RMN
KF7	86% of staff had received an appraisal in the previous 12 months (68% in 2010 and 80% in 2012). 2013 national average 84% - this Trust now better than average compared to acute Trusts These good rates need to be sustained. In a few areas rates still need to be ie CSFS, Medicine and Surgery Directorates, Nurses and other registered nurses, Medical directorate and Surgical directorate, staff aged 16 to 30, part time staff.	1. Continuation of appraisal compliance through directorate performance reviews. 90% achieved, 100% stretch target. 2. Provide appraisal training workshops for senior medical staff to increase the number of appraisals.	Directorate Management Teams Lead Medical Appraiser	Regular 3:3 meetings June 2014	Action 1. The new appraisal system is being embedded into the directorates well. Reporting of completed appraisals affected by second sign-off, with OWG engaged in rounding off the processes by supporting teams. Staff are being challenged and supported at their monthly 1:1 to improve completion rates. We are also training more staff to undertake appraisals in line with promotional opportunities we have done in nursing to increase the amount that can be done at one time. (LD) Action 2. Workshops have been run for appraisers, with good attendance and feedback.
KF8	41% of appraisals were well structured (agreed clear objectives, were helpful in improving how they do their job, left appraisee feeling valued by the organisation) compared to 36% in 2012. The	1. Focus groups to be run during May to ask staff how they can get the most out of their appraisal. Participants to be sought via Broadcast. Feedback to the OMB/DMTs once completed.	Head of Learning Development	Feedback to OMB and DMTs by July.	Action 1. Complete

Finding No	Finding Description	Action	Lead	To be complete by:	Progress
	national average in 2013 was 38% , trust results were better than average for acute Trusts Scores particularly low in .the following groups: Medical staff, Admin and Clerical, Surgical directorate , staff aged over 51 and between 31 and 40 and white staff	2. To run additional training sessions for appraisee's on "How to get the most out of your appraisal". 3. Issue objective writing materials onto the Intranet (SMART, golden thread) and communicate information to staff/managers via Broadcast, cascade brief, HR Newsletter. 4. Design and issue a crib sheet to enable the Appraiser and Appraisee to prepare for their appraisal. This is to be made available on the intranet and SpIda. 5. Issue information on the intranet to support and enable the appraiser and appraise get the most out of the appraisal discussion. Documents include leaflets on 10 top tips for performance discussion, what is a performance appraisal discussion, steps on how to	Start early June and run 1 per month until March 15 Directorate HR Manager, CSFS Directorate HR Manager, CSFS	April 2014 May 2014 Ready for the next phase of SpIda (poss. Oct 2014) October 2014	Action 2. Following the use of an external company the Trust ran a pilot exercise. Out of the 30 staff who were nominated to take part in the pilot, only 7 completed the training. Uptake was poor and the evaluation was also weak. Local training is continuing. A review of the next steps is being undertaken. (JO). On going. Action 3. Complete Action 4. Complete Action 5. Complete

Finding No	Finding Description	Action	Lead	To be complete by:	Progress
		undertake a performance appraisal discussion. Follow up with communications via broadcast, cascade brief, HR Newsletter. 6. Design a short quality questionnaire that will automatically "pop up" once the performance appraisal has been completed on SpIda. Development and implementation will be dependent upon IT resources. 7. Provide "How to get the most out of your appraisal" training for medical staff to improve the quality of appraisals.	Directorate HR Manager, Lead Medical Appraiser		Action 6. Spida phase 2 likely to commence in Jan/Feb 2015 Action 7. Further dates for appraisal training with a focus on the appraisee are under discussion

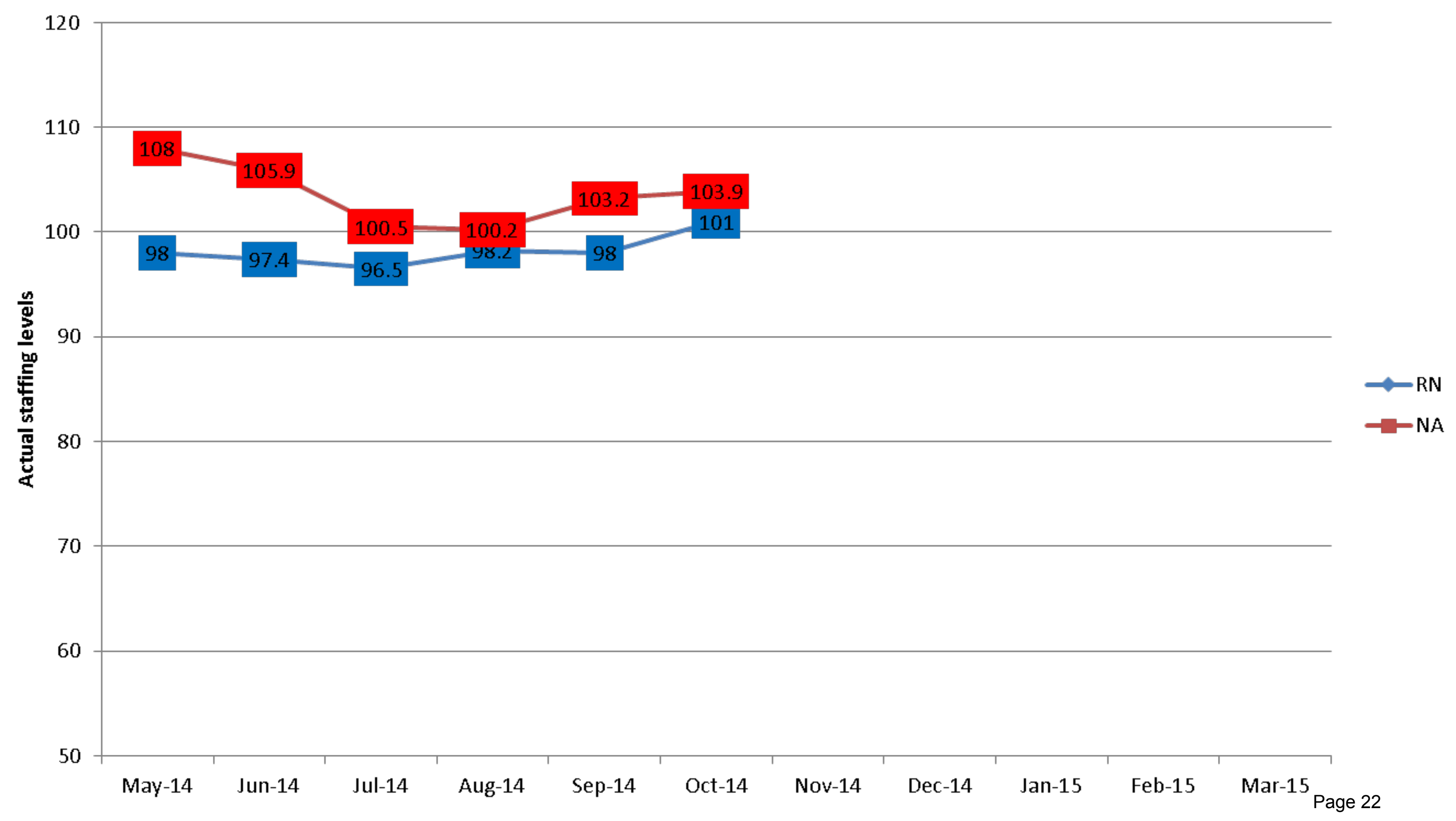
Safe Staffing NQB Report - October 2014
SFT 3598

Presentation for Trust Board
December 2014

Fiona Hyett
Deputy Director of Nursing

Monthly Comparisons – Actual Staffing Levels

Registered Nurses			Nursing Assistants			Combined			Planned Skill Mix		Actual Skill Mix	
P	A	%	P	A	%	P	A	%				
55279.5	55873.6	101	34094	35411.5	103.9	89373.5	91285.1	102	70	30	68	32



Overview of Nurse Staffing Hours – October 2014

	RN	NA
Total Planned hours (day shift)	33809	22298
Total Actual hours (day shift)	34222.9	23024.8
Percentage	**101.2%**	**103.3%**

Total Planned hours (night shift)	21470.5	11796
Total Actual hours (night shift)	21650.7	12386.7
Percentage	**100.8%**	**105%**

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

Nursing Hours by Day Shifts

	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**13695.8**	**13837.31**	**101.0%**	**10193.25**	**11051.26**	**108.4%**
Durrington	1195.25	1227.25	102.7%	869.5	1159.5	133.4%
Emergency Department	356.5	356.5	100.0%	356.5	356.5	100.0%
Farley Ward	1919.7	1846.45	96.2%	1490	1777.5	119.3%
Hospice	941	942	100.1%	657.5	685.75	104.3%
Pembroke Ward	816	819.5	100.4%	446	445	99.8%
Pitton Ward	1424.1	1369.35	96.2%	1131	1088.26	96.2%
Redlynch Ward	1573.5	1459	92.7%	1165	1235	106.0%
Tisbury Ward	2099.45	1986	94.6%	707.75	598.75	84.6%
Whiteparish Ward	1695.8	1931	113.9%	1088	982	90.3%
Winterslow Suite	1674.5	1900.26	113.5%	2282	2723	119.3%
Surgery	**6651.5**	**6242.85**	**93.9%**	**2745.5**	**2416.75**	**88.0%**
Britford Ward	2185	2286	104.6%	1163	1086.5	93.4%
Downton Ward	1402.5	1430.35	102.0%	1180.5	1020.25	86.4%
Radnor	3064	2526.5	82.5%	402	310	77.1%
Clinical Support	**3914.5**	**4414.25**	**112.8%**	**1966.5**	**1575**	**80.1%**
Maternity	2231	2409	108.0%	1299.5	1106.25	85.1%
NICU	713	1019.25	143.0%	356.5	170.25	47.8%
Sarum Ward	970.5	986	101.6%	310.5	298.5	96.1%
Musculo-Skeletal	**9547.31**	**9728.5**	**101.9%**	**7392.82**	**7981.84**	**108.0%**
Amesbury Suite	1841.75	1748.5	94.9%	1587	1517.61	95.6%
Avon Ward	1430.61	1327.85	92.8%	1501.62	1832.11	122.0%
Burns Unit	1481	2207.25	149.0%	543	505.8	93.1%
Chilmark Suite	1540.75	1505.29	97.7%	1127.25	1516.07	134.5%
Laverstock Ward	1864.25	1794	96.2%	1096.5	994	90.7%
Tamar Ward	1388.95	1145.61	82.5%	1537.45	1616.25	105.1%
Grand Total	**33809.11**	**34222.91**	**101.2%**	**22298.07**	**23024.85**	**103.3%**

Nursing Hours by Night Shifts

	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**9339.5**	**9166**	**98.1%**	**5475.5**	**6380**	**116.5%**
Durrington	655.5	701.5	107.0%	713	655.5	91.9%
Emergency Department	356.5	356.5	100.0%	356.5	356.5	100.0%
Farley Ward	1069.5	1081	101.1%	713	703.5	98.7%
Hospice	484.5	532	109.8%	485	449	92.6%
Pembroke Ward	713	713	100.0%	0	43	
Pitton Ward	1069.5	873	81.6%	713	931.5	130.6%
Redlynch Ward	1069.5	1035	96.8%	356.5	470	131.8%
Tisbury Ward	1426	1403	98.4%	356.5	333.5	93.5%
Whiteparish Ward	1426	1413.5	99.1%	713	713	100.0%
Winterslow Suite	1069.5	1057.5	98.9%	1069	1724.5	161.3%
Surgery	**4390.5**	**3976.5**	**90.6%**	**850**	**942.5**	**110.9%**
Britford Ward	930	940	101.1%	540	570	105.6%
Downton Ward	620	610	98.4%	310	372.5	120.2%
Radnor	2840.5	2426.5	85.4%	0	0	
Clinical Support	**4002**	**4077**	**101.9%**	**1748**	**1185.25**	**67.8%**
Maternity	2495.5	2225.5	89.2%	1069.5	881.75	82.4%
NICU	713	885.5	124.2%	356.5	184	51.6%
Sarum Ward	793.5	966	121.7%	322	119.5	37.1%
Musculo-Skeletal	**3738.5**	**4431.21**	**118.5%**	**3722.5**	**3879**	**104.2%**
Amesbury Suite	589	574	97.5%	883.5	883.5	100.0%
Avon Ward	550	729.25	132.6%	900	810	90.0%
Burns Unit	620.5	1168.33	188.3%	310	310	100.0%
Chilmark Suite	589	598.13	101.6%	589	861	146.2%
Laverstock Ward	770	740.5	96.2%	430	405.5	94.3%
Tamar Ward	620	621	100.2%	610	609	99.8%
Grand Total	**21470.5**	**21650.71**	**100.8%**	**11796**	**12386.75**	**105.0%**

Overview of Areas with Red/Amber

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	Radnor	77.1		√	Day	Small number of NAs used
Red	NICU	47.8		√	Day	Small number of NAs used (over on RNs)
Red	NICU	51.6		√	Night	Small number of NAs used
Red	Sarum	37.1		√	Night	Small number of NAs used (over on RNs)
Amber	Downton	86.4		√	Day	High threshold for use of agency
Amber	Tisbury	84.6		√	Day	High threshold for use of agency
Amber	Maternity	85.1		√	Day	Small numbers of MAs used
Amber	Radnor	82.5	√		Day	Lower numbers of patients (all staffing appropriate)
Amber	Tamar	82.5	√		Day	Additional RN shifts not always filled (NAs 105%)
Amber	Pitton	81.6	√		Night	3rd RN replaced by NA if unable to fill with RN (NAs 130%)
Amber	Radnor	85.4	√		Night	Lower numbers of patients (all staffing appropriate)
Amber	Maternity	89.2	√		Night	Escalation of staffing to cover gaps
Amber	Maternity	82.4		√	Night	Low numbers of MAs used

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

Mitigation of Risk

There are several wards this month flagging amber/red against our internal measures.

- Vacancies remain high in medicine and MSK– newly qualified nurses commenced end of September, and overseas recruitment being planned. All shifts are assessed daily by Directorate Senior Nurses to ensure they are safe.
- Maternity has had high sickness levels, internal escalation process used
- NA usage has remained lower reflected in the continued lower spend on specials this month.
- Agency fill rates have been challenging but all shifts are assessed daily by Directorate Senior Nurses to ensure they are safe.
- Wards often use staff on long days to cover 2 shifts – ward has the required level of staff but uses less hours resulting in shortfall in actual hours. DSNs monitoring to ensure appropriate numbers on shift.

Actions taken to mitigate risk

- Patient acuity assessed for staffing levels by individual wards by nurse in charge
- Trust wide staffing levels assessed against patient acuity and staff moved across wards by Directorate Senior Nurses and Clinical Site Team as required
- Staffing levels reduced when beds empty/ procedure lists reduced whilst maintaining appropriate staffing ratios
- Staff on training days brought back to work clinically as required
- Sisters on management days work clinically
- Additional NAs rostered to support unfilled RN shifts
- CCOT team support wards where acuity of patients high

TRUST QUALITY INDICATORS REPORT – OCTOBER 2014 SFT 3599

PURPOSE:

To provide the Board with October 2014 data and improvement actions where appropriate.

MAIN ISSUES:

- No cases of C Difficile for 2 months suggesting the action plan is having a positive effect.
- Two MSSA bacteraemias. Neither were line related.
- 1 new serious incident inquiry.
- An increase in the crude mortality rate but a downward trend in SHMI to 103 and SHMI adjusted for palliative care to 100 in March 2014. HSMR is 91 to July 14 but when remodelled is 100 for the same period which is as expected. The final remodelled HSMR for the financial year 13/14 is 109 and is higher than expected. Sepsis Six is the key improvement action.
- An increase in the adverse event rate in August 14 as measured through the global trigger tool.
- A decrease in grade 2 pressure ulcers. No grade 3 or 4 pressure ulcers.
- Safety Thermometer - 97% 'new harm free care'. 91% 'all harm free care' which indicates a proportion of patients are admitted to hospital with a harm. A decrease in new hospital acquired pressure ulcers on this one day snapshot.
- Two falls, one was a fractured pubic rami, the other a fractured finger. Both were managed conservatively.
- Fractured hip patients being operated on within 36hrs showed 88% compliance. The 'golden patient' initiative is in place.
- Escalation bed capacity has increased. 8 non-clinical same sex accommodation breaches all for patients waiting for transfer out of the Intensive Care Unit. Ward moves now reported as patients moved more than twice are at a low level.
- A decrease in the percentage of patients arriving on the stroke unit within 4 hours due to stroke unit capacity. A decrease in patients spending 90% of their time on the stroke unit. CT performance within 12 hours was 90%. 73% of high risk TIA referrals were seen within 24 hours. None were seen between 24 to 30 hours as 7 referrals were received with only a few hours to spare or beyond 24 hours. Improvement work continues with GPs and within the Trust.
- Real time feedback showed patients felt they were treated with care and compassion and rated the quality of care as good. The Friends and Family test response rates improved in inpatients and ED. The Maternity Services although improved remain below target. Day cases and outpatient response rates have declined. We will be trialling the use of an iPad in outpatients in November. NHS England has withdrawn the net promoter score.

CARE QUALITY COMMISSION OUTCOME:
Safe, effective, caring, responsive and well-led.

ACTION REQUIRED BY THE BOARD

1. To note the report.

Author: **Dr Christine Blanshard**
Title: **Medical Director**
Date: **13 November 2014**

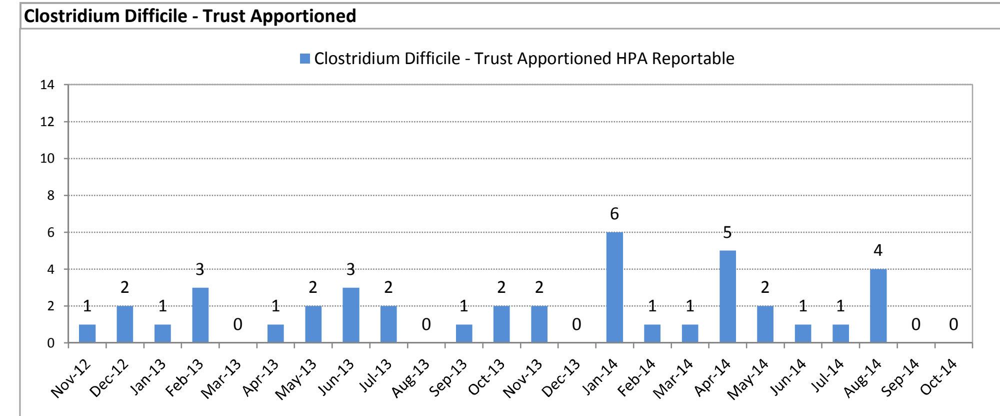
Trust Quality Indicators - October 2014

Quality Measures

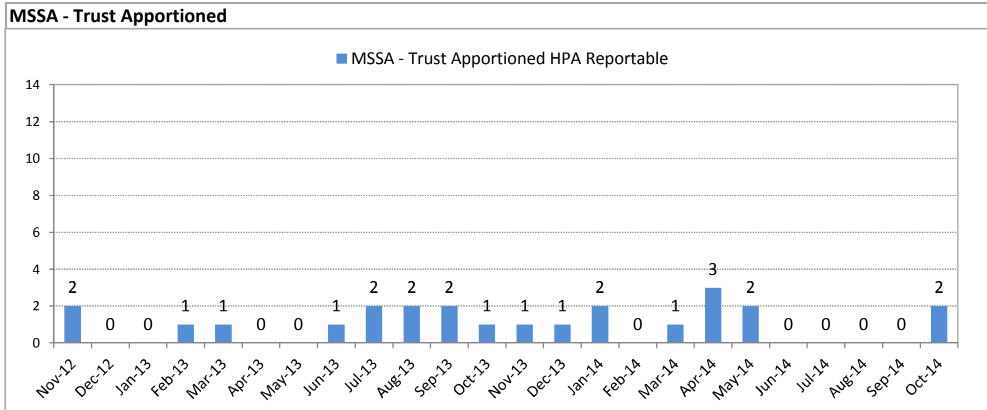
Infection Control	2012-13 Total	2013-14 YTD	2014-15 YTD
MRSA (Trust Apportioned)	3	0 (+2)	1 (+1)

Trust Incidents	2012-13 Total	2013-14 YTD	2014-15 YTD
Never Events	2	0	1
Serious Incidents Requiring Investigation	13	17	14

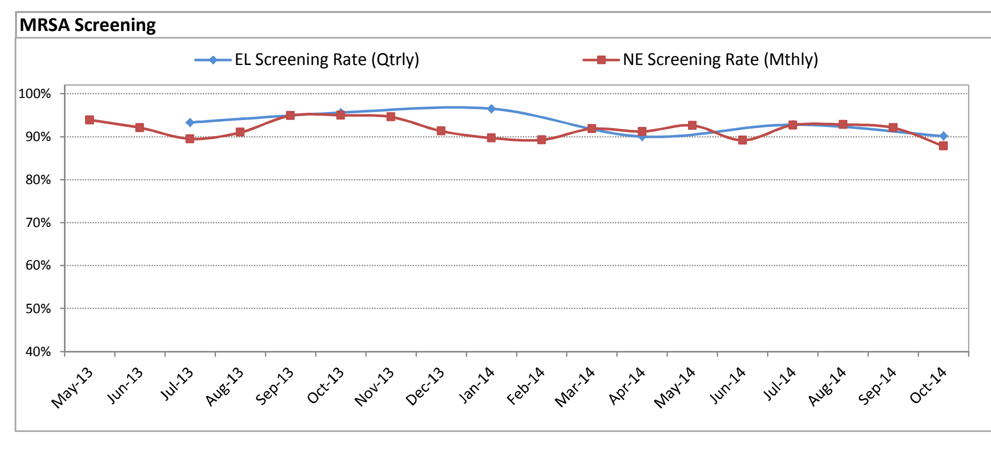
Clostridium Difficile - Trust Apportioned



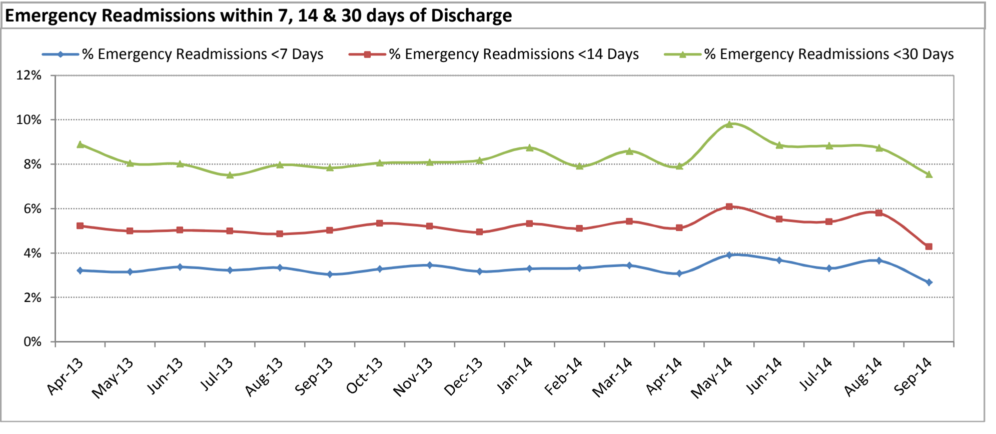
MSSA - Trust Apportioned



MRSA Screening



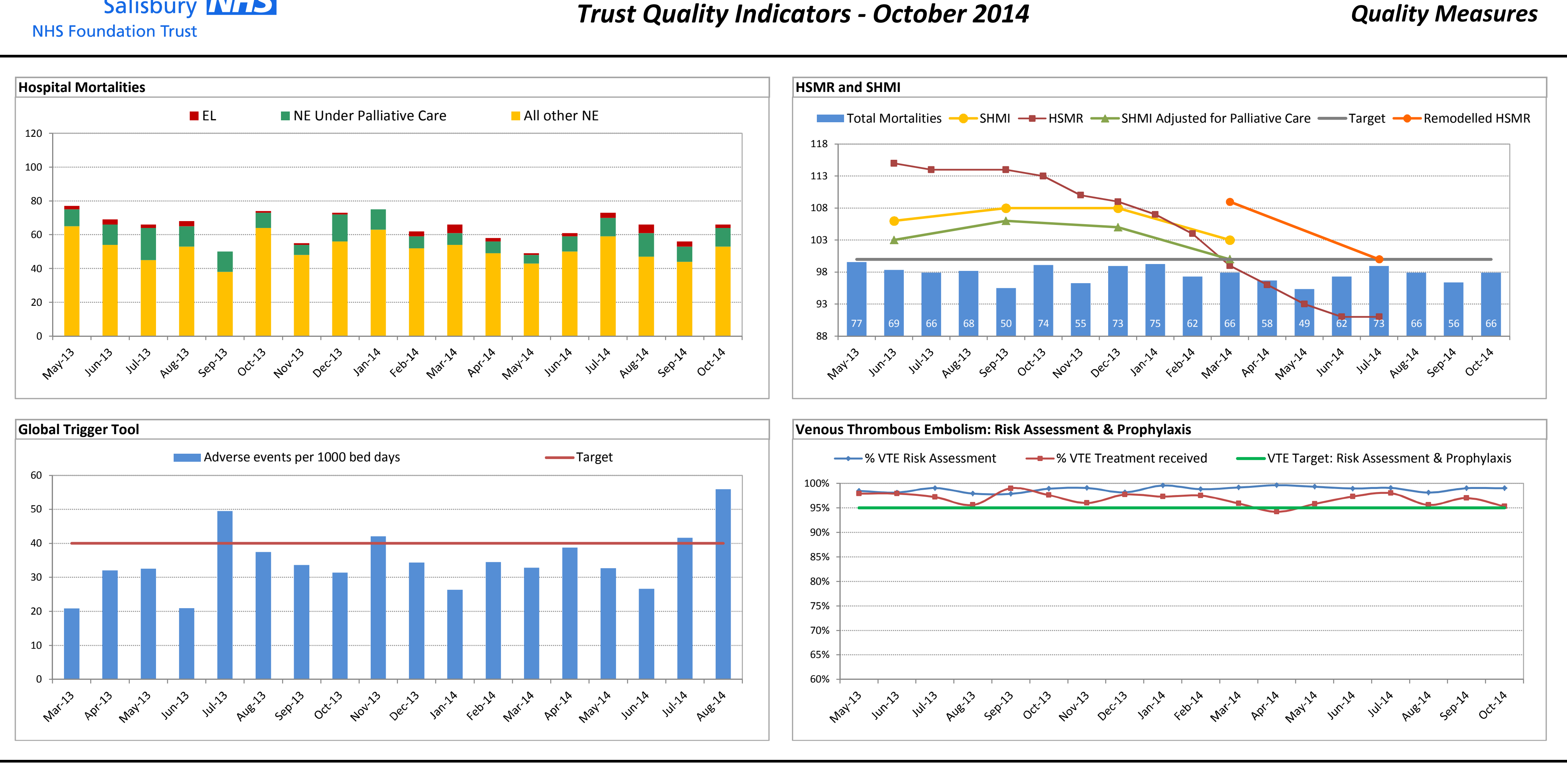
Emergency Readmissions within 7, 14 & 30 days of Discharge

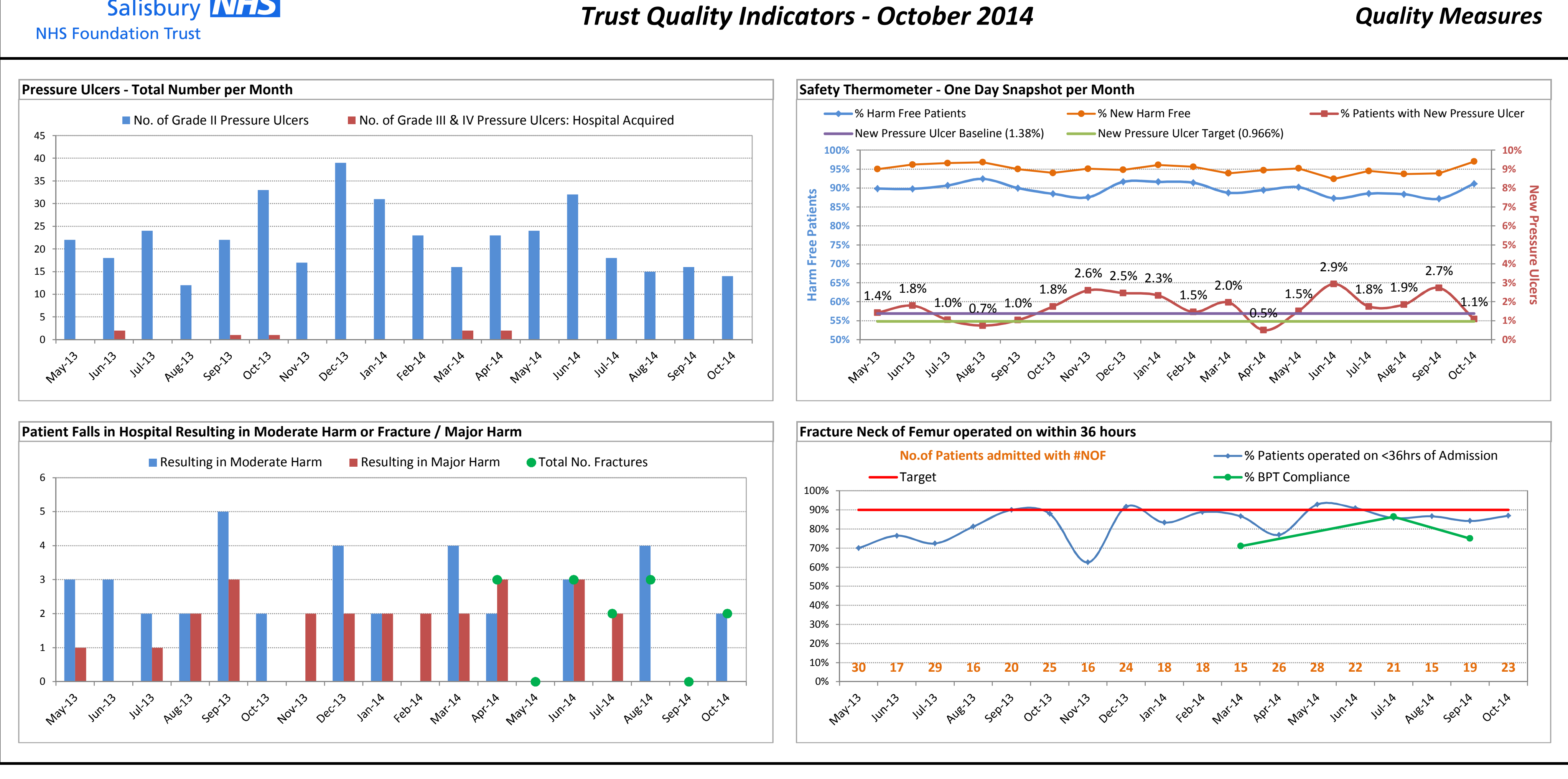


Salisbury NHS
NHS Foundation Trust

Trust Quality Indicators - October 2014

Quality Measures

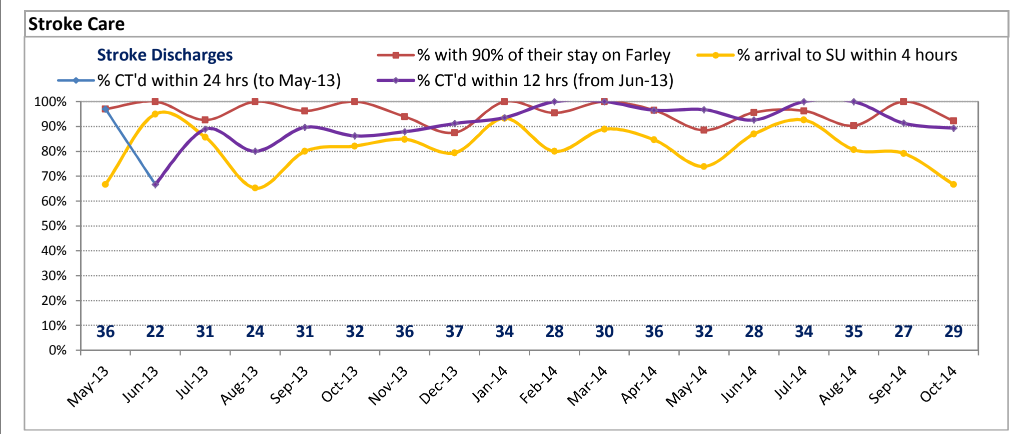



Salisbury NHS
NHS Foundation Trust
Trust Quality Indicators - October 2014
Quality Measures
Pressure Ulcers - Total Number per Month
No. of Grade II Pressure Ulcers
No. of Grade III & IV Pressure Ulcers: Hospital Acquired
Safety Thermometer - One Day Snapshot per Month
% Harm Free Patients
% New Harm Free
% Patients with New Pressure Ulcer
New Pressure Ulcer Baseline (1.38%)
New Pressure Ulcer Target (0.966%)
Harm Free Patients
New Pressure Ulcers
Patient Falls in Hospital Resulting in Moderate Harm or Fracture / Major Harm
Resulting in Moderate Harm
Resulting in Major Harm
Total No. Fractures
Fracture Neck of Femur operated on within 36 hours
No.of Patients admitted with #NOF
% Patients operated on <36hrs of Admission
Target
% BPT Compliance
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14

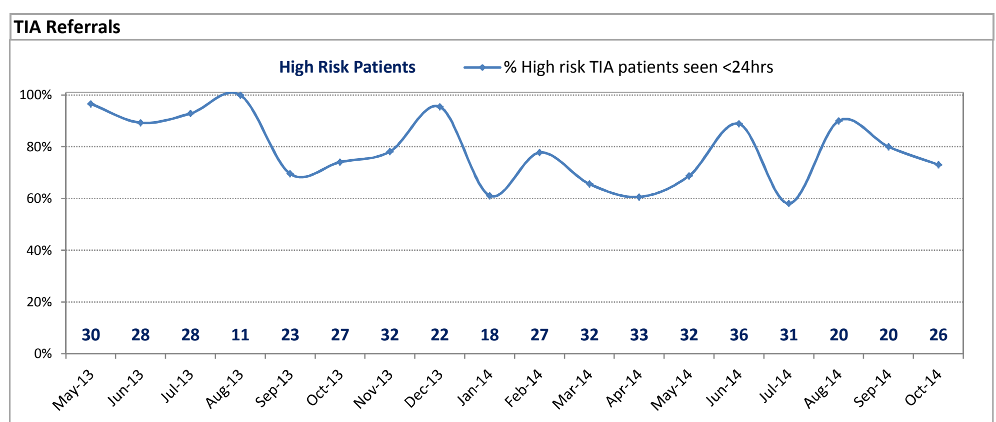
Trust Quality Indicators - October 2014

Quality Measures

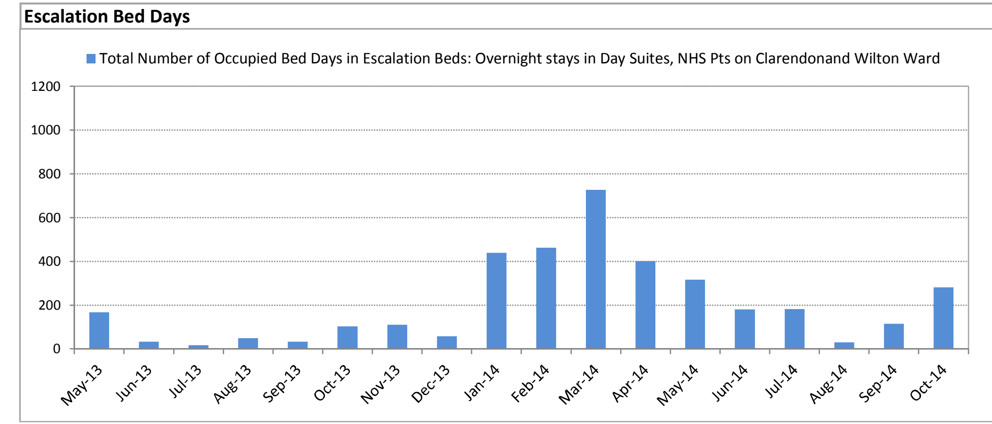
Stroke Care



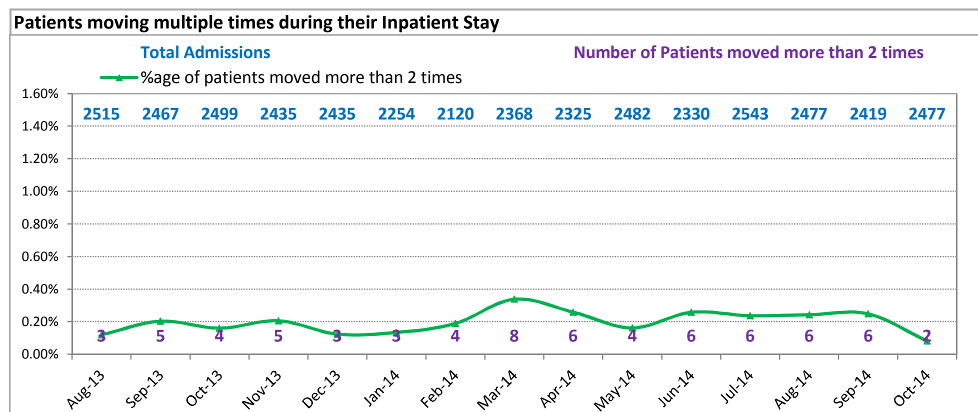
TIA Referrals



Escalation Bed Days



Patients moving multiple times during their Inpatient Stay

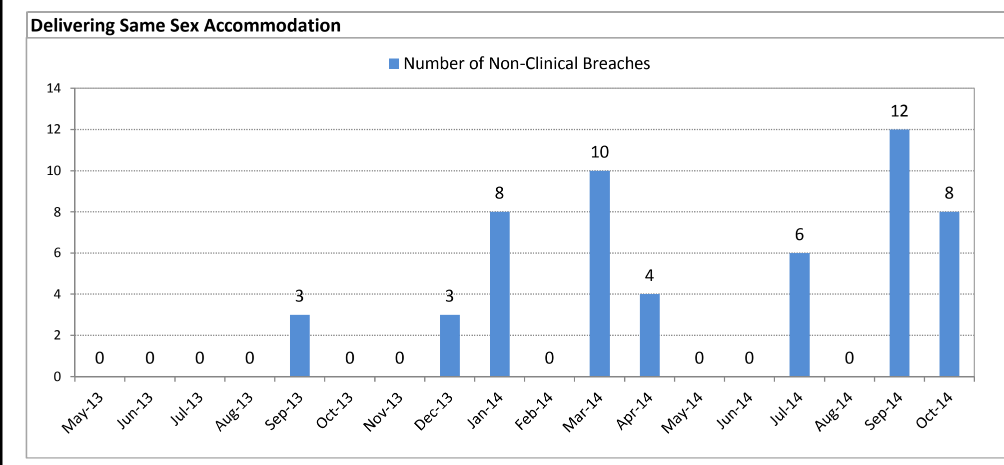


Please note, Durrington Ward (22 beds) was an escalation ward from Nov-11 to Mar-13 and has been counted within these figures for these months. The additional 10 beds above the Standard 30 beds on Winterslow Ward were escalation beds until Mar-13 and Breamore Ward has been included as an escalation ward from Apr-13 onwards. Wilton Ward opened as an excalation ward in Nov-13 and has been included in these figures since then. From Apr-14 Wilton (12 beds) and DSU if open overnight are the only escalation beds.

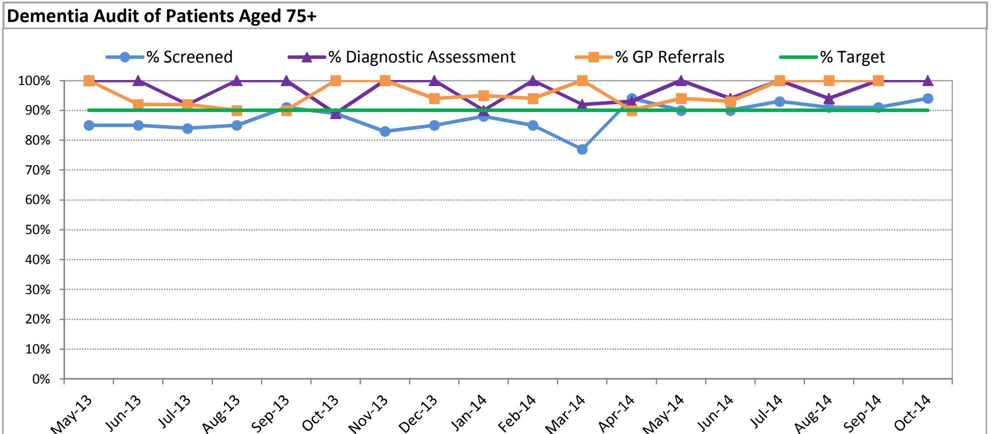
Trust Quality Indicators - October 2014

Quality Measures

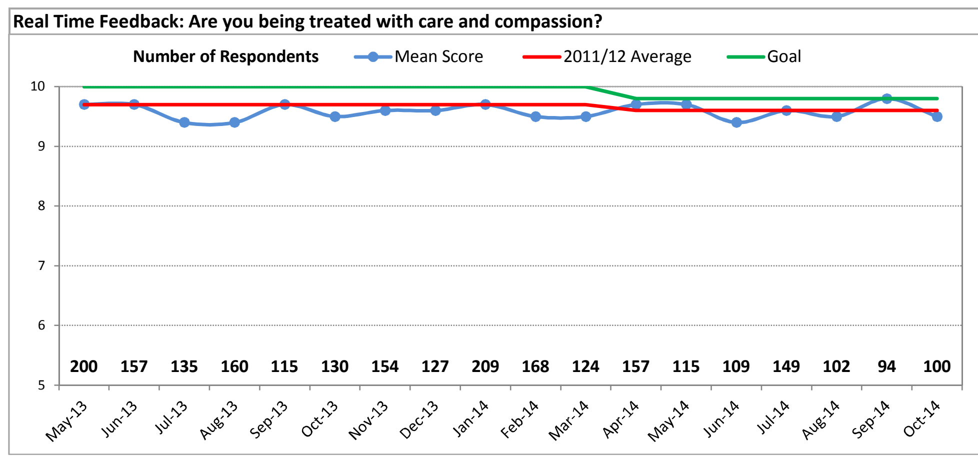
Delivering Same Sex Accommodation



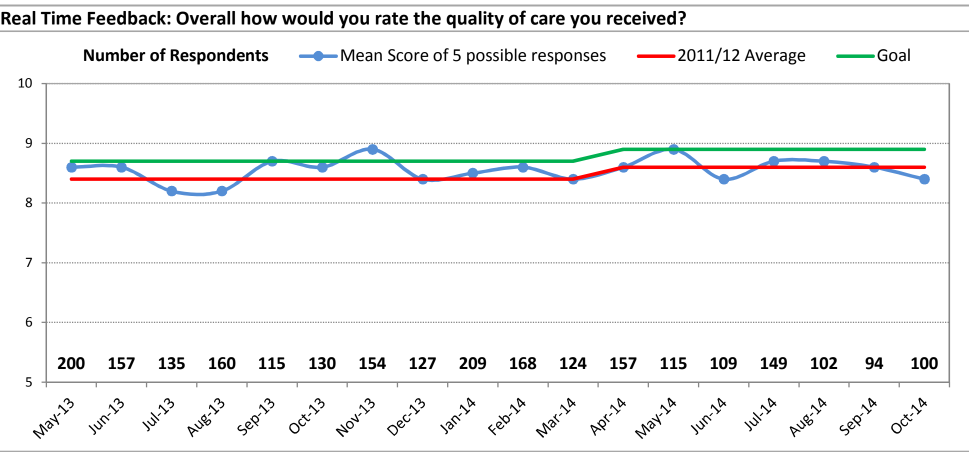
Dementia Audit of Patients Aged 75+

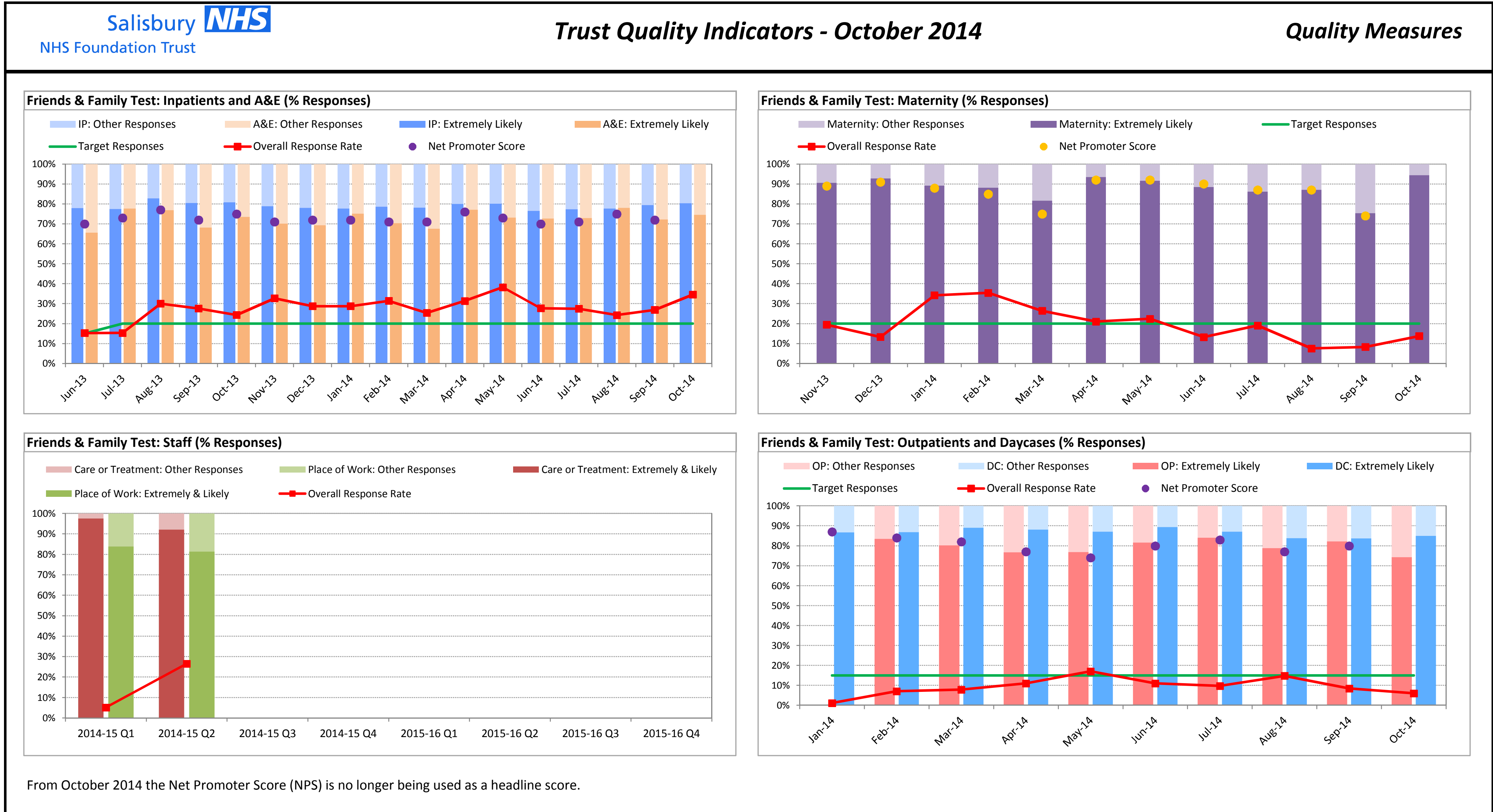


Real Time Feedback: Are you being treated with care and compassion?



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





From October 2014 the Net Promoter Score (NPS) is no longer being used as a headline score.

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Director of Infection Prevention & Control (DIPC)

SFT3600

Six Monthly Report for 2014/15

Lorna Wilkinson
DIPC

November 2014
Version 3

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1. Introduction

The Trust Board recognises and agrees 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 and bi-annual Report, together with the monthly Key Quality Indicators (KQI) Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively and that the Trust remains registered with the Care Quality Commission (CQC) without conditions.

The purpose of the DIPC Report is to inform the Trust Board of the progress made against the 2014/15 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 Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (December 2010), which identifies criteria to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible. This document includes references to other national strategy initiatives in infection control including –

- 'Clean, safe care: reducing infections and saving lives' (2008)
- 'Essential steps to safe clean care: reducing healthcare associated infections' (2007)
- 'Saving lives: reducing infection, delivering clean and safe care' (2007)
- 'Winning ways: working together to reduce healthcare associated infection in England' (2003)

The CQC has used the Code of Practice as a key feature of registration. Failure to observe the Code may either result in an improvement notice being issued to the Trust by the CQC following an inspection, or in it being reported for significant failings and placed on "special measures".

All NHS organisations must be able to demonstrate that they are complying with the Code of Practice. The Trust continues to be registered with the CQC, for Outcome 8 (Regulation 12) Cleanliness and infection control.

2. Overview and Action Plan

The work towards achieving the objectives of the Annual Action Plan 2014/15 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC).

3. Description of Infection Control Arrangements

A comprehensive infection prevention and control service is provided Trust-wide. The Infection Prevention & Control Team (IP&CT) provides a liaison and telephone consultation service for all inpatient and outpatient services, with arrangements for service cover during declared Norovirus outbreaks.

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

4. DIPC Reports to the Board

The IPCC monitors the action plan on behalf of the Trust Board, and has responsibility for over viewing and coordinating CQC Outcome 8 (Regulation 12) Cleanliness and infection control. This is achieved through the following actions:

- Agree an annual infection control programme and monitor its implementation.
- Oversee the implementation of infection control policies and procedures.
- Monitor and review the incidence of HCAI.
- Develop and review information regarding infection prevention and control.
- Monitor the activities of the IP&CT.
- Monitor 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 on Legionellosis and Pseudomonas water management, via the Water Safety Committee.
- Receive regular reports from the Decontamination Committee.

The IPCC also provides regular progress reports to the CGC, as shown in Appendix 3.

5. Budget Allocation for Infection Control

The total budget for Infection Prevention & Control for 2014/15 is £154K comprising:

Staff

Nursing	£131K
Administrative	£20K

Support

Non staff	£3K

Training

Training budgets are held centrally in the Trust.

6. HCAI Management and Statistics

6.1 Management

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

The Trust is required to report any HCAI outbreaks externally as serious incidents requiring investigation (SIRI). 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. Monitor, 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). This process is in line with information and guidance produced by the NHS Commissioning Board Serious Incident Framework (2013), and the Health Protection Agency HCAI Operational Guidance & Standards for Health Protection Units (2012, Health Protection Agency now Public Health England (PHE) from 1st April 2013).

During quarters 1 and 2 of 2014/15, there were 2 separate outbreaks of Clostridium difficile identified within the medical directorate which are discussed in detail below.

During quarters 1 and 2 of 2014/15, the Trust had no declared outbreaks of viral gastroenteritis (Norovirus); Staphylococcus aureus, including Methicillin Resistant Staphylococcus aureus (MRSA) and Methicillin Sensitive Staphylococcus aureus (MSSA); Carbapenemase producing enterobacteriaceae (CPE); invasive Group A Streptococcus (iGAS); Acinetobacter baumannii; Chickenpox (Varicella zoster); Extended Spectrum Beta Lactamase (ESBL) producers; Respiratory Syncytial Virus (RSV); Influenza or Vancomycin Resistant Enterococcus (VRE). Additional information relating to Trust activity with alert organisms is included in Appendix 10.

Areas that the IP&CT have been particularly involved with include:

Norovirus
There were no declared outbreaks of Norovirus during quarters 1 and 2 (2014/15), 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. The testing of inpatient stool samples identified 1 confirmed case of Norovirus during the reported period.

Where patients developed symptoms after admission, the appropriate infection control measures were implemented, and environmental cleaning completed. The level of diarrhoea and vomiting activity necessitated the closure of 12 bays in wards across the medical, surgical and musculoskeletal directorates at different times, to ensure the safe management of patients and continued service provision.

Where bays or wards were closed due to patients with symptoms of diarrhoea and vomiting, patients assessed as medically fit were able to be discharged to their own homes. The Trust did not advise that patients were discharged to other care facilities from affected closed bays or wards, to avoid spread to other facilities. The management was reviewed by the ICNs in conjunction with the ward staff, the outcome of clinician reviews and the relevant directorate management teams (DMTs). Use of the Trust algorithm for the management of inpatients with diarrhoea was reinforced with all staff to further support their decision making process.

Additional daily enhanced cleaning by Housekeeping was instigated when bays were closed. The required environmental and equipment cleaning prior to the reopening of bays and/or areas was agreed with the directorate. This included terminal environmental and equipment cleaning. Where bays could be completely vacated, a programme of deep cleaning of the ward environment, equipment cleaning and the use of the GLOSAIR 400 room decontamination system was undertaken by Housekeeping.

The ICNs increased their attendance at the bed meetings to help contribute to the safe management of patients. This included working with the DMTs to identify measures, and risk assessment to devise management plans to enable continued service provision and ensuring that the identified environmental cleaning was completed.

Clostridium difficile (C.difficile)
During quarters 1 and 2 (2014/15), there have been 2 separate outbreaks of C.difficile and 1 period of increased incidence (PII) of C.difficile identified in the medical directorate.

- Following the identification of 2 patients with C.difficile (Trust apportioned reportable cases), who had been nursed in the same bay on Durrington Ward within the medical directorate, the bay was closed under isolation precautions from 28th April 2014. Immediate actions implemented included enhanced environmental cleaning and additional monitoring and audit of practices by ward staff. An outbreak of C.difficile was declared on 1st May

2014, with management discussed at the Infection Control update meetings and separate review meetings were held with attendance by key personnel. The remaining patients in the bay were risk assessed and the bay reopened on 7th May 2014, following the completion of deep cleaning and use of the GLOSAIR 400 room decontamination system. The outbreak was declared over on 8th May 2014. A formal report was written by the directorate with the involvement of the IP&CT and was signed off by the Chief Executive.

- Following the identification of 3 patients with C.difficile (3 Trust apportioned cases, 1 case not reportable to PHE), who had been nursed in the only bay (4 bedded) on Pembroke Ward within the medical directorate, the bay was closed under isolation precautions from 28th May 2014. Immediate actions implemented included enhanced environmental cleaning and additional monitoring and audit of practices by ward staff. An outbreak of C.difficile was declared by the Trust on 3rd June 2014, which was initially reclassified by the CCG as a PII of C.difficile until ribotyping results were known. Ward and patient management was discussed at the Infection Control update meetings and separate review meetings were held with attendance by key personnel. Symptomatic patients were moved to sideroom facilities on the ward and the bay reopened on 5th June 2014 following the completion of deep cleaning and use of the GLOSAIR 400 room decontamination system. Following ribotyping results a formal outbreak was declared retrospectively. A formal report was written by the directorate with the involvement of the IP&CT and was signed off by the Chief Executive.
- A PII of C.difficile was declared following the identification of 2 patients with C.difficile (2 Trust apportioned reportable cases), who had been nursed in separate areas on Redlynch Ward within the medical directorate. Immediate actions implemented included enhanced environmental cleaning and additional monitoring and audit of practices by ward staff. Ward and patient management was discussed at the Infection Control update meetings and separate review meetings were instigated with directorate representation. From ribotyping samples, results have indicated that these cases could not be linked. However, meetings continued to provide ongoing assurance for the management of patients on both Redlynch and Pitton Wards. The directorate are writing a formal report regarding the events on Redlynch Ward with identified learning outcomes. This report is expected to be completed at the beginning of quarter 3 (2014/15).

Positive stool samples were sent for ribotyping at the external Reference Laboratory, to establish epidemiological data and aid the Trust in further understanding the presentation of C.difficile. The Consultant Microbiologists facilitated this work, and the outcome of results included within a formal report presented to the CGC during quarter 2 (2014/15).

A comprehensive action plan to reduce the incidence of C.difficile is in place following a thorough review of practice in June 2014. This is discussed in detail in section 6.2.3 and is available in Appendix 11.

Vancomycin Resistant Enterococcus (VRE)
Enterococci are bacteria which are normally found in the gut of humans, and usually cause no harm. They can however be the cause of urinary tract and wound infections, and can lead to the development of a bacteraemia if they enter the bloodstream. Patients who require specialist care in units such as intensive care, or while receiving chemotherapy, or have a prolonged hospital stay are recognised to be at increased risk due to the complexity of their care needs. Because enterococci are resistant to many antibiotics in common use, treatment for VRE infections may be limited. There has been an established rise in the incidence of VRE reported nationally, and it is not known what percentage of the population may be colonised with VRE. Currently there is no national guidance regarding patient screening for VRE, either prior to or on admission to hospital.

During quarters 1 and 2 of 2014/15, cases of VRE have been identified from inpatient samples sent as part of routine clinical assessment, for patients nursed across the medical, surgical and musculoskeletal directorates. Cases of VRE have also been identified from samples taken in the community setting. Where inpatient cases were identified, required actions were agreed following discussion with a Consultant Microbiologist. These have included the completion of additional

environmental and equipment cleaning, and where indicated screening of identified patient contacts, with the continuation of antibiotic stewardship.

It has also been recognised that the incidence of inpatients identified to be VRE positive, and who will require isolation nursing, will continue to impact on the availability of sideroom facilities across the Trust. Currently all patients identified to be VRE positive during their admission, or on readmission, are risk assessed and isolated as appropriate within sideroom facilities. The risk assessment process identifies those patients who can be nursed using standard precautions in bays. The possibility of cohorting VRE positive patients has also been considered. Additional daily cleaning by Housekeeping is completed for all siderooms where VRE positive patients were being isolation nursed. When a sideroom is vacated after the transfer or discharge of a VRE positive patient, the sideroom is deep cleaned and the GLOSAIR 400 room decontamination system deployed. Written information is available for VRE positive patients and the IP&CT continue to support ward teams with all aspects of patient management.

6.2 Mandatory Surveillance

6.2.1 Surgical Site Infection Surveillance (SSIS)

The ICNs collect 'alert organism' and 'alert condition' surveillance data within the Trust. This data is used in the detection of outbreaks and monitoring of trends. In addition, the ICNs coordinate data collections for the national SSIS programme and within this there are various surgical procedures that 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, and the surveillance categories completed during quarters 1 and 2 of 2014/15 are as follows:

- Hip replacement surgery was completed in quarter 1 (2014/15).
- During quarter 2 (2014/15), the ICNs completed data collection and follow up for patients who had undergone hip replacement surgery during the previous quarter. The data was submitted to PHE within the required time frame. Of the 75 hip replacement procedures recorded, 1 superficial surgical site infection and 1 deep infection was identified, and gives an infection rate of 2.66%.
- This can be compared to the category of hip replacement surgery completed during the same period for 2013/14, where a total of 98 hip replacement procedures were recorded with 2 surgical site infections identified, giving an infection rate of 2.04%.
- Knee replacement surgery was commenced in quarter 2 (2014/15). It is planned to continue to undertake active surveillance for this category through to the end of quarter 3 (2014/15). The extension of the surveillance period from 3 to 6 months is in response to the increased infection rate seen for knee replacement surgery during 2013/14. At this time, 4 superficial wound infections were identified (72 procedures in total, infection rate 5.55%). As reported in the DIPC Annual Report for 2013/14, there was no evidence to indicate that these infections could have been prevented, or that they could be linked in any way, as the causative organisms were not similar.

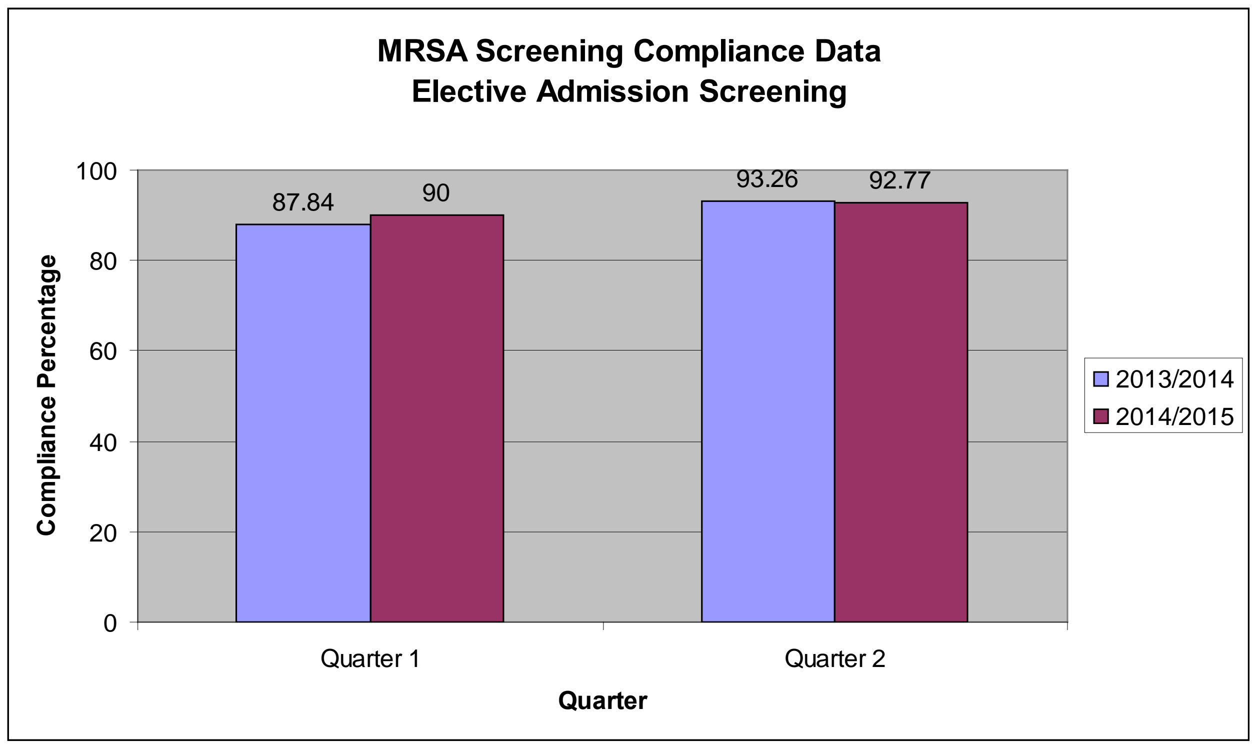
The ICNs produce a formal report outlining progress with SSIS each quarter, which is presented at the IPCC and disseminated to relevant Trust personnel.

6.2.2 Methicillin Resistant Staphylococcus aureus (MRSA)

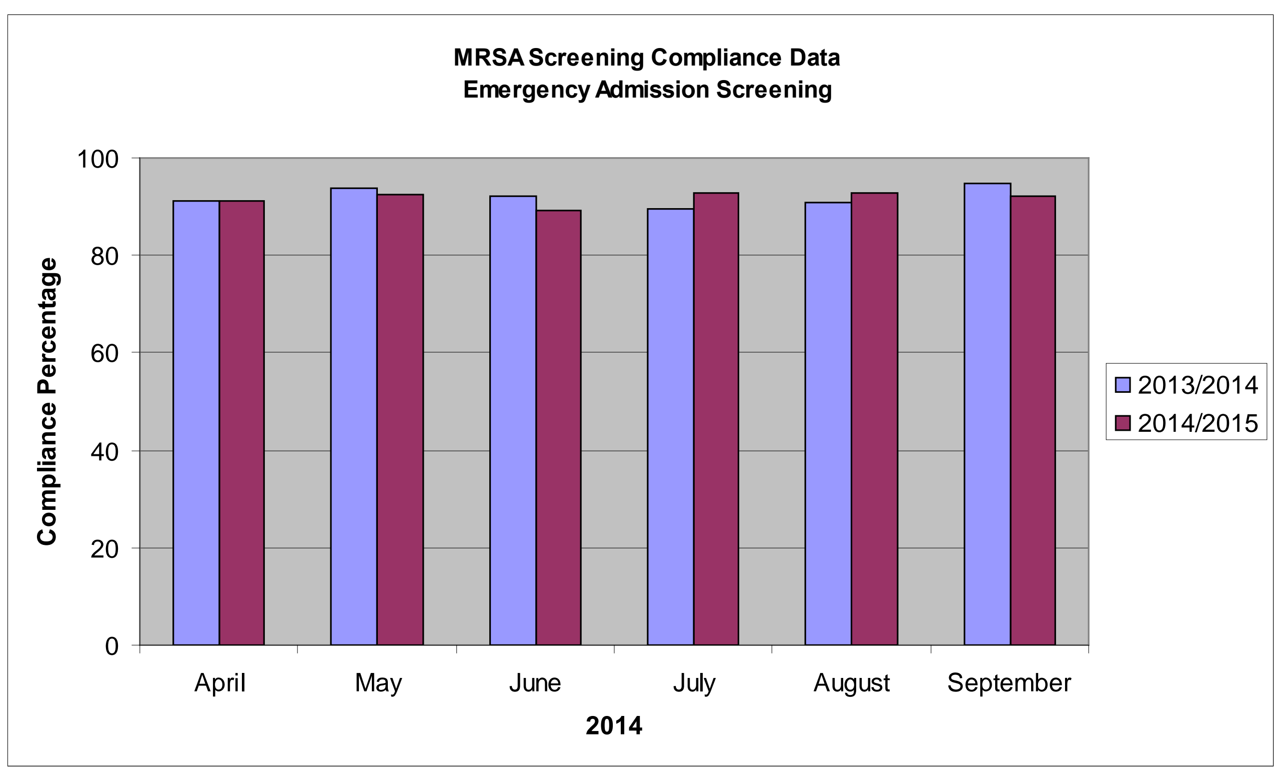
The Department of Health (DH) Mandatory MRSA Bacteraemia Surveillance scheme has been used to measure the effectiveness of infection prevention & control practices in all NHS Trusts. The rationale behind this scheme is that it is sometimes difficult to distinguish between colonisation and true infection 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 with reducing infections. MRSA screening compliance rates are monitored by the DMTs and reported as a key quality performance indicator. The ICNs continue to be responsible for generating the monthly emergency admission screening MRSA audit, and the quarterly elective admission MRSA screening audit figures. The compliance rates and any identified missed screens are fedback to the DMTs for follow up actions with outcome reporting to the Matrons Monitoring Group (MMG).

Tables 1 and 2 relate to the overall compliance for both elective admission and emergency admission screening audit figures, for April to September 2014, with figures provided for April to September 2013 for comparison.



(Table 1)



(Table 2)

The Trust continues to report as per the requirements of PHE, with a weekly reporting format for mandatory surveillance 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 is different to previous classification reporting formats. Results from this scheme are as given in the summary below, and cite the definitions of 'Trust apportioned' cases and 'non Trust apportioned' cases.
MRSA Bacteraemia Trust apportioned cases include patients who 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: These include all cases that are **NOT** apportioned to the acute Trust.

Breakdown of total number of Trust cases recorded April – September 2014.
The figures in brackets show the number of cases recorded April – September 2013.

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

(Table 3)

*The MRSA bacteraemia case identified from blood cultures during September 2014 was classed as a contaminant.
**The MRSA bacteraemia case identified from blood cultures during September 2013 was classed as a contaminant.

The Trust's MRSA target for 2014/15 is zero Trust apportioned cases. A Post Infection Review (PIR) investigation process was performed for each of the Trust apportioned cases identified during July and September 2014. The purpose of the PIR process was to review the patient information and data collected following the identification of the MRSA bacteraemia case. The PIR process and related guidance was first introduced nationally from 1st April 2013, with revised guidance published in April 2014.

The review process included the participation of key personnel from the Trust, and communication with the relevant staff groups. The ICNs commenced completion of the MRSA bacteraemia PIR Toolkit with information gathered from reviewing the patient healthcare records. Meetings were held and followed the format of the toolkit with direct group discussion, in order to populate the document in full and agree any identified actions. It was emphasised that the meeting and PIR process should be viewed as a positive learning exercise.

For the non Trust apportioned case identified in May 2014, the PIR investigation was undertaken by the relevant CCG, with the cooperation of the Trust with this process.

Findings and key learning from the Trust apportioned PIR investigations:

July 2014 – (Farley Ward Stroke Unit, Medical Directorate)

- The case was not linked with any other cases.
- In addition to the PIR toolkit, a local action plan was generated with ongoing learning outcomes agreed by the directorate. The acquisition during the hospital admission could not be excluded for this patient. Therefore, the Lead/Stroke Clinicians and ICD to review the management of MRSA on Farley Ward, to include screening and isolation practices. Final agreement to be made by the DIPC.
- Although not identified as a factor contributing to the development of the MRSA bacteraemia, the PIR group agreed that the following was an important practice issue:
    - To ensure that the insertion and continuing care of all devices are consistently and accurately recorded.
    - To clarify the insertion and continuing care management of percutaneous endoscopic gastrostomy (PEGs). Actions were identified to be implemented in the Endoscopy Unit and Farley Ward settings in relation to MRSA screening pre-procedure and enhanced mouth care.
- Completion of actions is being monitored by the directorate with reporting via the appropriate forums e.g. directorate specialty meetings and MMG.

September 2014 – (Pembroke Ward – Haematology & Oncology, Medical Directorate)

- The case was not linked with any other cases.
- This MRSA bacteraemia case was agreed to be a contaminant, based on the information established at the PIR meeting and group discussion. It was agreed that the patient was a high risk patient (due to their medical condition), and had received appropriate care and antibiotic therapy in line with Trust policy during their admission period. MRSA was only isolated in one blood culture bottle. The decision that this case was a contaminant was formally agreed with the relevant CCG representatives.
- In addition to the PIR toolkit, a local action plan was generated and learning outcomes agreed by the directorate. Although there had been full compliance with the Trust's Clinical Management of MRSA policy, the PIR group identified a recommendation for the Lead Haematology Clinicians and ICD to review the MRSA screening of patients on the Haematology & Oncology Unit.
- Completion of actions is being monitored by the directorate with reporting via the appropriate forums e.g. directorate specialty meetings and MMG.

6.2.3 C.difficile

The control of this infection has been through the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

Monitoring and diagnostic C.difficile testing

The Trust continues to use DH guidance on C.difficile testing and the previously agreed revised C.difficile testing and reporting algorithm for the Trust. All C.difficile positive stool samples that test toxin positive are reportable to PHE.

All patients with a stool sample confirming the presence of C.difficile require the implementation of strict infection control measures/practices, e.g. isolation in a sideroom facility, the completion of required terminal and enhanced cleaning by Housekeeping and review by the relevant clinicians to determine if C.difficile treatment is indicated. The impact of the revised C.difficile testing is on the formal reporting process to PHE and is managed solely by the ICNs under direction of the DIPC and ICD (a copy of the C.difficile testing algorithm is available from the IP&CT).

In accordance with PHE definitions, C.difficile Trust apportioned cases include patients who 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: These include all cases that are **NOT** apportioned to the acute Trust.

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

Breakdown of reportable cases recorded for inpatients April – September 2014.
The figures in brackets show the number of reportable cases recorded April – September 2013.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**6 (1)**	**2 (2)**	**1 (3)**	**2 (4)**	**5 (1)**	**0 (3)**							**16 (14)**
Non Trust apportioned cases	1 (0)	0 (0)	0 (0)	1 (2)	1 (1)	0 (2)							3 (5)
Trust apportioned cases	5 (1)	2 (2)	1 (3)	1 (2)	4 (0)	0 (1)							13 (9)

(Table 4)

Breakdown of total number of reportable Trust C.difficile cases recorded April – September 2014. The figures in brackets show the number of reportable cases recorded April – September 2013.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Inpatients	**6 (1)**	**2 (2)**	**1 (3)**	**2 (4)**	**5 (1)**	**0 (3)**							**16 (14)**
Community Hospitals	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)							0 (0)
General Practitioners (GPs)	3 (2)	0 (0)	3 (1)	1 (1)	1 (1)	3 (1)							11 (6)
Residential/Nursing Home	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)							0 (0)
Other (e.g. Coroner, Private Hospital, Day Attender, A&E, Outpatient)	0 (0)	0 (1)	0 (1)	0 (0)	1 (1)	0 (0)							1 (3)
Total	**9 (3)**	**2 (3)**	**4 (5)**	**3 (5)**	**7 (3)**	**3 (4)**							**28 (23)**

(Table 5)

These are the numbers of positive episodes. In a single patient, a positive test occurring after a previous positive test is considered a new episode only after 28 days.

The Trust's C.difficile target for 2014/15 is no more than 18 Trust apportioned reportable cases. For each inpatient episode, an infection control incident investigation is completed. From 1st April 2014 this process has continued to be led by the ICNs, but with the increased involvement of staff in the relevant clinical area and the area Pharmacist to complete the required documentation.

The findings are reported via e-mail and include an action plan for implementation. This includes patient education and the ongoing monitoring of infection control practices using the HII C.difficile audit tool, whilst the patient remain an inpatient. This audit tool aids the ward teams to ensure the safe management of these patients and provides evidence of compliance with the Trust policy. The audit criteria covers antibiotic stewardship, hand hygiene, environmental cleaning (includes equipment cleanliness), the wearing of PPE and isolation nursing. All areas are reminded on the importance of completing this compliance documentation, with actions taken when any non compliance is identified.

Multidisciplinary C.difficile ward rounds have continued weekly, 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 ICNs have continued to facilitate these rounds, and full attendance on occasions has been variable by key members. The membership of this group remains under review, with the challenge to expand to include a Gastroenterologist and Dietician.

During quarter 1 (2014/15), 7 Trust apportioned reportable cases of C.difficile had been identified in the first two months against the trajectory of 18 cases set for 2014/15. The Trust was concerned that if this trend continued, the trajectory set would be exceeded. In response to these concerns

regarding potential over performance against the C.difficile trajectory set for 2014/15, the Trust asked NHS Wiltshire CCG to undertake a ‘critical friend’ visit and review the Trust management of C.difficile to establish if there was anything else the Trust could be doing to reduce the risk of patients acquiring C.difficile during their care episode.

The visit was undertaken on Monday 2nd June 2014 by the Infection Prevention Lead Nurse and Infection Prevention Nurse from Wiltshire CCG and with agreement from the Trust, the Clinical Development Nurse, Infection Prevention and Control from West Hampshire CCG. The Trust was represented by the Senior ICN and interim Director of Nursing/DIPC. The purpose of the visit was to provide the Trust with an objective review to see if there is more that could be done to improve the prevention and management of C.difficile using the CCG’s Infection Prevention knowledge and experiences of practices in other organisations. This involved review of relevant policies, procedures and data, meeting with those leading the strategy, Housekeeping staff, clinical staff and visits to clinical areas.

The ‘critical friend’ review was designed to be supportive and constructive and the CCG’s welcome the opportunity to collaborate with the Trust through taking part in this process. The CCG’s recognized that the review was only a ‘snapshot’ of the hospital gained over the course of the one day visit and this was taken into consideration when making recommendations.

The observations made during the visit were grouped under four main headings where existing practice was reviewed and strengthened:

- Policies and Procedures
- Assurance
- Clinical practice, Cleaning and the Environment
- Training and Education

The recommendations for consideration by the Trust were developed into an action plan. This action plan was tabled at the IPCC meeting in July 2014 for feedback, information and approval, and was presented at the CGC in July 2014 with an update provided in September 2014, and continues to be monitored through the Infection Prevention and Control Working Group. (Appendix 11).

6.2.4 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. Commissioners are working with the Trust to develop a baseline for target setting.

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’.

MSSA Bacteraemias figures recorded for blood cultures from inpatients, and blood cultures taken in outpatient areas and the Emergency Department, from April – September 2014. The figures in brackets show the number of cases recorded from April – September 2013.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**4 (1*)**	**3 (1)**	**5 (3)**	**2 (5)**	**3 (3)**	**2 (6*)**							**19 (19*)**
Non Trust apportioned cases	1 (1)	1 (1)	5 (2)	2 (3)	3 (1)	2 (4)							14 (12)
Trust apportioned cases	3 (0)	2 (0)	0 (1)	0 (2)	0 (2)	0 (2)							5 (7)

(Table 6)

*During April and September 2013, additional MSSA bacteraemia cases were identified from blood cultures taken from attendees at the Salisbury Dialysis Unit.

During quarters 1 and 2 of 2014/15, there were 5 Trust apportioned cases identified. The ICNs undertake an infection control incident investigation for Trust apportioned inpatient cases, in conjunction with staff from the clinical area concerned. It is important to emphasise 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.

The presence of an indwelling device could be identified as a potential contributory factor i.e. central venous catheter (CVC), peripherally inserted central catheter (PICC) or peripheral vascular cannula (PVC), for 3 of the Trust apportioned cases. From the incident investigations undertaken for each of the cases, it was established that they were unrelated and could not be linked to any other cases.

- Durrington Ward – Patient with complex clinical history and also identified to have other alert organisms. Practice concerns were identified relating to inconsistent ongoing care documentation.
- Laverstock Ward – Long term patient with complex clinical history, transferred to the Trust for specialty care, having undergone multiple surgical interventions. No practice concerns were identified by the Clinical Leader from the completion of spot checks.
- Radnor Ward – Patient had undergone complex surgery with post operative complications. Inconsistent documentation noted, and further audit work identified by the Lead Nurse for completion by the designated ICLP.

6.2.5 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'.

E.coli Bacteraemias figures recorded for blood cultures from inpatients, and blood cultures taken in outpatient areas and the Emergency Department, from April – September 2014. The figures in brackets show the total number of cases recorded from April – September 2013.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**13 (2)**	**3 (9)**	**7 (4)**	**9 (7)**	**14 (3)**	**9 (4)**							**55 (29)**
Non Trust apportioned cases	9 (2)	3 (8)	5 (4)	7 (5)	10 (2)	5 (3)							39 (24)
Trust apportioned cases	4 (0)	0 (1)	2 (0)	2 (2)	4 (1)	4 (1)							16 (5)

(Table 7)

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

Of the 16 Trust apportioned inpatient cases identified during quarters 1 and 2 of 2014/15, 7 were determined as likely HCAI related, 4 cases as possibly HCAI related, for 1 case it was unknown if it was HCAI related, and the final 4 cases were determined as not HCAI related. The classification of whether the bacteraemias are HCAI related is completed by the Microbiologist, based on the information obtained from the relevant clinicians. This data is entered onto the HCAI Data Capture site by the ICNs.

6.2.6 Carbapenemase producing enterobacteriaceae (CPE)

In the last 5 years PHE have reported a rapid increase in the incidence of infection and colonisation by multi-drug resistant carbapenemase producing organisms. This reflects similar problems worldwide and indicates the urgent need for guidance, particularly on infection prevention and control management. As a result, PHE published in December 2013 the acute Trust toolkit for the early detection, management and control of Carbapenemase producing enterobacteriaceae. It provides expert advice on the management of these organisms to prevent and reduce spread into (and within) healthcare settings. The toolkit includes practical advice for clinicians and staff at the frontline in acute care settings. It also provides some basic public health risk assessment tools and advice and information for the patient. The Trust have continued to implement this toolkit across the inpatient and outpatient clinical areas.

7. Hand Hygiene

All inpatient and outpatient clinical areas are required to undertake monthly hand hygiene audits. Compliance rates continue to be calculated, and individual tables for each area within the directorates are produced by the ICNs. These are fedback direct to the clinical leaders, DMTs and DIPC via the monthly MMG meetings.

In additional support of this practice, a robust Uniform Policy and Workwear Guidance including ‘Bare Below the Elbow’ (BBE) policy remains in place, and compliance is monitored by the DMTs and findings fedback directly to the DIPC.

The Trust target for hand hygiene compliance rates is 100%, with formal reporting by the directorates of measures implemented to improve any lower compliance. This target is reflected in the clinical leaders and DSNs personal objectives, with ongoing work required by the DMTs to sustain improvements. Part of this has involved 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 is a successful and useful method to further raise 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.

Appendix 4 shows a breakdown of the clinical directorates hand hygiene monthly compliance scores. On further analysis of the data over quarters 1 and 2 (2014/15), key factors that have influenced the compliance scores:

- Non completion of audits by areas
- Non compliance with hand decontamination by other staff groups, lowering the overall score for the area concerned.

As a result, the ICNs have supported individual clinical areas and staff groups in raising the profile of patient safety and hand decontamination. The audit results are now disseminated according to staff groups for areas, which has provided further evidence to strengthen the feedback process for the directorates to action.

During quarters 1 and 2 (2014/15), the ICNs have continued to facilitate the completion of hand hygiene audits across selected clinical areas by an external auditor, the Healthcare Manager for GOJO Industries. 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'. The overall compliance rate from external auditing of 8 inpatient clinical areas was 71%, which is an improvement of the previously reported overall compliance of 62% for quarters 3 and 4 of 2013/14. The identified non compliance continues to be predominantly missed opportunity number 5, which related to contact with patient surroundings. The results were fedback to the relevant Clinical Leaders and DSNs with actions identified, and additional education and support provided for staff groups.

The requirement to complete an annual hand hygiene assessment is indicated on each staff member's Learning Plan on the Managed Learning Environment (MLE). During quarters 1 and 2 (2014/15), the ICNs have undertaken hand hygiene assessment 'drop-in' sessions for departments/staff to attend. The sessions continue to promote effective hand care and skin health for both clinical and non clinical staff. If an attendee identifies concerns regarding their skin health, the ICNs direct them to Occupational Health for further advice/involvement. The total number of hand hygiene assessments completed during quarters 1 and 2 of 2014/5 is 1684 assessments, compared to 1142 for the same period in 2013/14 (Appendix 5 – This includes the total number of hand hygiene assessments recorded by the ICNs and ICLPs, and staff members may complete more than 1 assessment during the year).

All completed hand hygiene assessments are entered onto the MLE by the ICNs. This is achieved by creating a 'workshop' on the MLE and then uploading onto the workshop the name of every staff member who completed a hand hygiene assessment on the date concerned. The MLE system then automatically updates the staff members' individual learning plans, and resets the electronic reminder facility. Unfortunately it continues to be identified that the automatic update of learning plans and reset of the reminder facility is not always happening. The Education Department have investigated with the external company MLE supplier, and currently when a staff member for whom this applies contacts the ICNs, their learning plans are accessed individually (by the ICNs) and amended. This remains an ongoing issue.

The ICNs have continued to review hand hygiene posters and signage across the Trust site, and utilised educational resources from the National Patient Safety Agency (NPSA). The dissemination

of the ‘5 moments for hand hygiene at the point of care’ initiative remains a key focus for education. The opportunity to emphasise the importance of hand hygiene for patients, relatives and visitors, has been enhanced by the installation of a new notice board sited along the main corridor on Level 4. This facility has also allowed for the provision of health promotion messages, including food hygiene and safety.

During quarter 1 and 2 (2014/15), the refurbishment of the alcohol hand rub gel stations sited outside the inpatient and outpatient clinical areas has continued to progress, and is being undertaken by the Trust ArtCare Department. New hand hygiene signage has been developed by the ICNs to complement this work, with the replacement of gel dispensers in the public areas with automated gel dispensers to further promote hand decontamination opportunities for patients, visitors and staff members.

8. 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 6). 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 2014/15, including the follow up and outcomes from auditing against infection control policies:

- Commode Cleanliness – update on completed reaudits
    - Commode cleanliness audits continue to be facilitated by the DSNs with results fedback via the Infection Control Update meetings and the directorates report findings and outcomes via their existing forums/meetings.
- Handling and Disposal of Linen in the Clinical Areas
    - The report for the reaudit completed during 2013/14 was presented to the IPCC in July 2014. The reaudit included the inpatient areas and all outpatient areas where patient linen was in use, and assessed the management of clean linen and the clean linen store, and observed the practice of staff in the clinical areas. Across the directorates the reaudit identified similar themes compared to the findings from the previous audits. These included dust in clean linen cupboards, inappropriate items stored in the clean linen cupboards, and used linen bags more than two thirds full. Staff were not always observed to wear disposable plastic aprons when handling clean linen and/or used linen. The relevant clinical areas implemented actions to resolve the identified issues at the time of the audit. Continued vigilance in these areas has been requested through MMG.
- Observation of Practice Audits
    - The ICNs have undertaken additional observational audits of staff practices within clinical areas, as part of the Trust C.difficile Prevention Action Plan. Results are fedback at the time of the audit to the nurse in charge, and where non compliance has been identified this has been addressed with the individual staff member and fedback separately to the relevant Clinical Leader.
    - The DSNs were also tasked by the interim DIPC to undertake similar observational audit work, with reporting via the Infection Control Update meetings.
    - Improvements in practice have also been achieved following the implementation of colour coding the use of plastic disposable aprons in the inpatient clinical areas.

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.

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.

8.1 Innovations

The ICNs 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.

During quarter 2 (2014/15), the Neonatal Unit (NNU) facilitated a trial of an alternative door handle sited at the entrance to the unit. The handle dispenses alcohol hand rub gel when the door is pulled opened (Purehold Gel). The Purehold alcohol hand rub gel is a different product to the existing Purell (GOJO) alcohol hand rub gel used across the Trust. The design encompasses a facility to collect any surplus gel and requires daily cleaning. NNU staff reported that positive comments were received from parents and visitors to the unit, and these informed their decision to continue to utilise this product after the end of the trial. The Senior ICN has requested further evaluation to establish whether this product is appropriate for use elsewhere in the Trust, and reporting of outcome via the IPCWG. Due to the potential concerns for skin health with the use of an alternative alcohol hand rub gel, Occupational Health were fully informed of the trial details.

The ICNs were invited to attend a presentation by a company called ‘Kwikscreen’, for screens that can either be portable or fixed permanently to walls. The involvement of the ICNs was to consider whether these screens could contain images and/or be used as additional signage for key infection control messages. These will be considered with any future clinical area refurbishment.

During quarter 2 (2014/15), an alternative decontamination wipe was trialled on Redlynch and Pitton Wards. This was a sporacidal product in the form of a single wipe (activated by water), to be used for the decontamination of patient commodes only. Evaluation forms are being completed by the ward teams, and will be reviewed during quarter 3 (2014/15) by the IPCWG.

The IPCWG continue to strive to ensure that the Trust implements only those technologies and innovations that have been peer reviewed and appropriately approved.

9. Antibiotic Prescribing *(information for this section has been provided by Emma Taylor, Principal Pharmacist, and Simon Howe, Antimicrobial Pharmacist)*

Overview

The Antibiotic Reference Group (ARG) is a sub group of the Drugs and Therapeutics Committee (DTC) which meets monthly and provides a focus for all work linked with antibiotics, advising and promoting good practice and optimal antibiotic prescribing across the Trust. The work of the ARG is aimed at delivering the DH agenda to minimise the development of antimicrobial resistance and to reduce HCAIs as set out in the ‘Winning Ways’ document. Continued support for this work is documented in the 2007 Saving Lives Document: Antimicrobial Prescribing: A Summary of best practice, and the 2012 ‘Start Smart then Focus’ publication.

The Lead Antimicrobial Pharmacist is a member of the IPCWG and provides antibiotic stewardship audit and update reports monthly to the IPCWG, and quarterly at the IPCC.

Key work areas 2014/15 include:

9.1 Guideline development/review

The following guidelines are currently being reviewed by members of the ARG:

- Work plan for 2014
- Antibiotic quick reference guidance
- Burns and plastics guidelines
- General adult surgical guidelines.

Guidelines recently completed and approved:

- Paediatric antibiotic policy.

Literature searches have been conducted to review the evidence around the following:

- The efficacy of probiotics in reducing risk of C.difficile for patients on antibiotics
- The link between proton pump inhibitors and C.difficile.

This work helps to ensure that the Trust is taking all possible measures to reduce the risk of C.difficile for patients. A short memo has been devised in each instance to summarise the evidence and will be referenced as an appendix to the Trust C.difficile policy.

Recently the antimicrobial pharmacist has been working with the Integrated Clinical Information Database (ICID) department to refine the way in which the Antimicrobial Team are alerted to any policies approaching their review date. The driver for this is to ensure that up to date antimicrobial guidelines are always readily available to staff via ICID.

9.2 Audit

Regular Antimicrobial Stewardship Audits

The rolling programme of antibiotic stewardship audit is ongoing. The aim is to audit one ward every fortnight, to provide a snapshot of antimicrobial prescribing practice within the Trust.

The audits takes the form of four brief questions focusing on:

- Documentation of stop/review date
- Indication
- Prescribing within policy
- Use of antibiotics implicated in C.difficile, e.g. cephalosporins, ciprofloxacin.

Audits are carried out by the Lead Antimicrobial Pharmacist and Consultant Microbiologist/ICD, and therefore this allows for a multidisciplinary review of antimicrobial prescribing to be carried out, with interventions made as necessary.

The information is entered onto a spreadsheet which yields a percentage performance score for the ward in question, and is fedback as follows:

- To the Team on the ward at the time of audit
- Via email within a week of the audit. This email is sent to any consultant who is caring for a patient audited, the Lead Consultant for the area in question, the Medical and Nursing Directors, the IP&CT, the Lead or Ward Pharmacist and all members of the Microbiology Team.
- At medical and surgical teaching sessions where appropriate.

Work to examine and update the way in which this data is recorded and analysed is ongoing. The aim is to build up a clearer picture of prescribing practice throughout the Trust. Results can now be broken down by directorate, speciality and consultant thus allowing the team to identify more clearly where issues with antimicrobial prescribing lie.

Previous results have shown that in general areas for attention have been documentation of the indication for antibiotic prescribing and the specification of a course length/review date. However compliance with both of these standards has significantly improved following the introduction (in March 2013) of a new design of prescription chart which incorporates a page dedicated to the prescribing of antimicrobials. This section includes guidance on the ‘Start Smart Then Focus’ philosophy, and also has a space for documentation of indication and an ‘automatic review date’ prompt at forty eight hours.

If results show that an area is not meeting the expected standard of antimicrobial stewardship, i.e. scores less than 80%, an action plan is formulated which usually involves discussion with the lead clinician, presentation by the antimicrobial team at clinical governance sessions and review of

antimicrobial guidelines in that area. It is planned that each ward is audited every six months to ensure that improvements are being maintained.

In April 2014, this data was included in the Wiltshire CQUIN scheme, therefore reports are submitted to the commissioners quarterly via the Clinical Effectiveness team.

Recent audit results
During quarters 1 and 2 of 2014/15, the target of auditing an average of 2 wards per month has been met. In summary, performance in these audits has been steadily improving with an average score for quarter 1 of 81.3%, and for quarter 2 of 96.7% (with 5 wards scoring 100%).

Point prevalence audit
The regional Annual Antibiotic Point Prevalence Audit was conducted in February 2014. This data provides a snapshot of antibiotic usage and prescribing practices within the Trust, and allows for a comparison with other Trusts in the southwest region and past results. Overall results showed that antibiotic stewardship at the Trust compares favourably to other Trusts in the southwest region, and shows a steady improvement in practice against standards.

Next Audit- February 2015

9.3 Additional information

C.difficile
Work this year to date includes:

- Inclusion of Fidaxomicin within Trust treatment guidelines in line with the PHE document 'Updated guidance on the management and treatment of Clostridium difficile infection'.
- Update of the Antibiotic Treatment Review Sheet to improve the quality of the information collected.
- Continuing to ensure a pharmacist is present at the weekly multidisciplinary C.difficile ward rounds.

Risk management
All reports of incidents involving antibiotics are reviewed monthly at the ARG to identify any concerning trends.

Antibiotic usage monitoring
As recommended in the DH document 'C.difficile – How to deal with the problem', a mechanism for capturing 'defined daily doses' data is now in place. This is necessary to ensure cost effective use of antimicrobials. 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.

To date these report have not flagged up any alarming or unexpected trends in drug usage. In October 2014, data was submitted to a regional benchmarking project to allow the Trust to compare data to that of other local Trusts. The Trust awaits the results from this work.

European Antibiotic Awareness Day
As part of the European Antibiotic Awareness Day on 18th November 2014, a campaign is planned to raise awareness of the need to use antibiotics responsibly, introducing a range of actions including:

- Advertising the European Antibiotic Awareness Day and key antibiotic messages throughout the hospital. Utilizing public notice boards, infection control notice board, the dispensary patient waiting area, education and training notice boards.
- Broadcast email and Cascade brief to all staff.
- Screensaver – detailing the principles of the 'Start Smart Then Focus' initiative.

10. Education and Training Activities

It is widely recognised that ongoing education activity 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. Appendix 7 identifies the figures for the IP&C Computer Based Learning (CBL) modules completed via the intranet site for quarters 1 and 2 of 2014/15.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments and also to study sessions organised by:

- Education Department (new starters, medical students and foundation course nursing assistants)
- Spinal Unit
- Volunteer Co-ordinators
- Durrington Ward ('look back exercise' for staff development days)
- Day Surgery Unit
- Mortuary Department.

Other teaching initiated by the ICNs has been to further support staff with practice issues, for example regarding the management of patients with different alert organisms, and reinforcing hand hygiene practices with specific teams. Sessions were organised on Winterslow Suite, specifically for the management of diarrhoea and use of the Trust Flowchart for inpatients with symptoms of diarrhoea, and on Redlynch and Pitton Wards for the management of patients with C.difficile.

Education was held to focus on the management of CPE, with a 'drop-in' session for all clinical staff and a session tailored for the leads on the Spinal Unit. Drop-in workshop style sessions have also been undertaken by the ICNs to provide staff members with an opportunity to update on infection control issues. This included the use of the Isolation Risk Assessment Tool, the MRSA Pathway, reinforcing the use of standard precautions and the wearing of PPE, and the management of C.difficile and diarrhoeal symptoms.

Opportunities continue to be provided for clinical staff to shadow the ICNs, by both new starters to the Trust, newly promoted (Band 6) and established staff members, including ICLPs. This aids improved understanding of infection control within an individual clinical area, reinforcing staff responsibilities in relation to infection control within their role, and the strategic impact across the Trust.

The ICNs invite representatives from all departments across the Trust to the ICLP formal meetings. These are held monthly and give the opportunity to discuss infection control matters, in relation to individual areas and Trust wide. Topics covered are included within Appendix 8.

The infection prevention and control CBL programme is accessible for all staff on the MLE via the Trust intranet site. This enables the Trust to ensure non-participants are followed up according to NHSLA standards by the relevant line manager. The ICNs have worked with the Education Department to review the content of the infection prevention and control CBL programme, and this is ongoing work.

In addition, the ICNs attended the Trust 21st Celebrations Open Day to provide information and guidance relating the decontamination of equipment and hand hygiene practices. The UV light box was also available for visitors to undertake a hand hygiene assessment.

11. Water Safety Management *(information for this section has been provided by George Atkinson, Person Responsible for Water)*

This section summarises the water safety management precautions that the Trust has taken over quarters 1 and 2 of 2014/15. This includes monitoring, remedial actions and improvements that have been made.

The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 including the addendum giving guidance on Pseudomonas control issued by DH in March 2013 and the Health & Safety Commission approved code of practice L8 "the control of Legionella bacteria in water systems" (4th edition 2014), together with the technical guidance document HSG274.

The advice and guidance from these documents is incorporated into the Trust Legionella and Water Safety risk management policy and procedures (the policy). The policy is managed by the Head of Estates Technical Services (ETS) as the Trust appointed Responsible Person (water) and was approved by the Water Safety Group prior to ratification by the Operational Management Board in October 2013. A review of the updated HSE guidance L8 & HSG274 was carried out by the Water Safety Group during 2014 but no changes were made to the policy.

The Trust Water Safety Group (WSG) has been active during 2014 in response to the management and response of events involving the water systems on site. The WSG is formed of technical and non-technical staff who 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.

In line with the policy requirements the Trust has carried out the recommended routine monitoring for Legionella and Pseudomonas during the last 6 months. The results of these are summarised below.

11.1 Legionella Monitoring

The annual Legionella sampling commenced in July 2014, 170 separate outlets have been sampled between July and September. 25 points have been reported as positive and have been the subject of investigative work to clear the outlets. The Trust currently has 14 positive results under review, 6 of these are less than 100 colony forming units/l (cfu/l) and whilst they are regarded as satisfactory by the test Laboratory and HSE L8, they are beyond the permissible range as detailed in the current Trust policy. The 8 other results (indicated * in the table below) are less than 1000 cfu/l and are investigated by the WSG members as required. The results will be discussed further at the WSG meeting in November 2014.

Description	Room No	Asset	As at 2nd Oct
Labour ward Birth pool	82-21 Rm 7	Shower	20
Whiteparish Bay 4	4.1.38	WHB mixed	40
Block 65 Old Breamore	RM 15 Sluice	Sluice tap hot	20
Block 77 NICU Prep room	Rm 77.11	WHB cold tap	440*
Vascular	3.12.63	Cold tap	600*
Ortho O/P	3.0.17	Sink cold tap	40
Ortho O/P	3.0.18 utility room	WHB cold tap	80
Ortho O/P	3.0.08 plaster room	WHB cold tap	600*
Ortho O/P	3.0.08 plaster room	Sink cold tap	480*
Ortho O/P	3.0.13	WHB cold tap	240*

ED resuscitation	Resus room Paed sink	WHB mixed	80
ED Disabled W/C	3.1.25	WHB mixed	160*
ED Majors	3.1.13	WHB mixed	200*
ED minors	3.1.52	WHB mixed	760*

The Trust continues to keep the domestic water temperature elevated above 65°C as a precaution against spreading the bacteria throughout the hospital system. The Trust has dedicated staff to carry out and record routine flushing of all outlets in the clinical and patient areas of the hospital.

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 to ETS. Flushing of the systems is currently recorded centrally by ETS staff and an electronic data system is under development by the Trust IT department to capture this directly from the areas.

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 emails as events occur and as regular reports to the WSG and IPCC.

11.2 Pseudomonas

Guidance issued by DH on the monitoring and control of Pseudomonas in water systems in augmented care units (high risk areas) HTM-04-01 addendum is incorporated into the Trust water safety policy.

The Trust has commenced with the routine sampling of outlets in April 2014. 258 points were sampled and 17 outlets were identified as positive. All were reviewed with the department leads, infection control and cleaning staff. The outlets were cleaned, replaced as required and retested. Following the appropriate remedial actions there are no current outlets with positive results.

A summary of the points is given in the table below.

Description	Sample ref	Room No	Asset	First Count	Action Summary	Last Count
NICU Kitchen	GJ 61	77.5	Sink mixed	1	Resample	0-(3rd)
NICU	GJ 66	77.7	WHB mixed	110	Resample	0-(3rd)
Avon ward	GJ 72	Rm 69	Shower	>100	Resample	0-(2nd)
Avon ward	GJ 75	Rm 106	Shower	1	Resample	0-(1st)
Avon ward	GJ 77	Rm 67	WHB mixed	5	Resample	0-(1st)
Avon ward	GJ 81	Rm 110	Shower	>100	Resample	0-(4th)
Avon ward	GJ 82	Rm 111	Male WC WHB	10	Resample	0-(2nd)
Avon ward	GJ 85	Rm 66	Adj WHB mixed	4	Resample	0-(1st)
Avon ward	GJ 86	Rm 66	WHB mixed	7	Resample	0-(3rd)
Sarum Rm 5 En-suite	GJ 116	4.6.12	Shower	2	Shower head and hose removed, resampled	0-(2nd)
Sarum Staff WC	GJ 146	4.5.16	WHB	22	Shower head and hose removed, resampled	0-(4th)
Sarum Parents	GJ 150	4.5.11	Shower	>100	Shower head and hose removed, resampled	0-(2nd)
Burns W/C	GJ 160	4.11.06	WHB	33	Resample	0-(4th)
Burns Rm 2	GJ 166	4.11.21	WHB	51	Resample	0-(2nd)

En-suite						
Burns Rm 9 En-suite	GJ 186	4.11.38	Shower	>100	Resample	0-(2nd)
Burns HD En-suite	GJ 224	4.11.28	Shower	51	Shower head and hose removed, resampled	0-(3rd)
Sarum Assess	GJ 227	4.6.42	WHB	9	Resample	0-(3rd)

11.3 Events

PHE is undertaking a joint research project with the Health & Safety Executive. The project is looking at the effectiveness of Legionella testing, and continues to collect samples from different types of water systems over the 12 month period. The water samples from Salisbury District Hospital (approx. 20 samples on a monthly basis – to be advised by Consultant Microbiologist) are being analysed for Legionella by traditional plate culture and rapid polymerase chain reaction (PCR) to give results within 24 hours. The results from the research project will be analysed to help understand interpretation of the results and to determine whether PCR results can be used in a meaningful way to understand microbial risk in relation to the action limits currently set by culture results in L8. There will be no cost to the Trust for being part of this study. Jimmy Walker the PHE lead or his colleague will attend the WSG meetings to discuss the results and outcomes of the Legionella testing project to date with the WSG members.

11.4 Independent advice

A meeting has been scheduled on the 28th October 2014 with Interserve who have purchased the water safety arm from Initial Rentokil. This will be to agree the ongoing support arrangements and the delivery of training to water staff involved in the maintenance and monitoring of the water system safety.

The contract for future independent Legionella risk assessment support is to be tendered through procurement.

12. Decontamination *(information for this section has been provided by Robert Warburton, Acting Decontamination Lead and Sterile Services Manager)*

The Trust Decontamination Lead retired in June 2014. In the interim period the Sterilisation and Disinfection Unit (SDU) Production Manager is acting up to cover the responsibilities of the Decontamination and Sterile Services Manager. This includes attendance at the Theatre Risk Group and the Endoscopy Clinical Group. The Trust Decontamination Committee has quarterly meetings, with formal feedback to the IPCWG, and IPCC.

Personal protective equipment (PPE)

Stock levels are held in SDU and monitored by the department. This includes full face protection (FFP) Level 1, 2 and 3 facemasks, visors, and water repellent gowns. FFP3 facemask training continues to progress. Key personnel met and agreed the format of the required training for the nominated trainers in each directorate throughout the Trust. A risk assessment was completed and training took place by an external company 3M in March 2014. Following the training the identified trainers were required to cascade training to colleagues, new starters and medical staff.

The Health and Safety Manager, Infection Control Senior Nurse and Decontamination Lead met to review progress in September 2014, and findings were that almost all areas have a nominated trained person to conduct fit testing. These trainers have been contacted to provide a progress update on their cascade training of colleagues. This work will continue into quarter 3 (2014/15).

Progress against Decontamination Strategy

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

Decontamination policy is under review by the Decontamination Committee, and will be approved by the IPCC in January 2015 and for ratification by the Clinical Management Board.

12.1 Ensure fully compliant decontamination practice – ongoing Trust-wide

Tray tracking
Tray tracking via the Sentinel System has been delayed due to information technology (IT) issues. No progress has been seen from the company and the SDU is now identifying alternative suppliers.

The Decontamination Lead has created a risk assessment for the tracking of reusable medical devices to patient records. The Capital Bid for a replacement tracking system to include Endoscopy and patient records tracking has been submitted to the Capital Controls Group.

Instrumentation issues
The MDMC is examining the various issues concerning instruments.

- Bbraun project is replacing high risk instruments which were found to be faulty. Theatres, SDU and Procurement are concerned with the progress being made by Bbraun. Data is being requested from Bbraun of audit findings for Theatres to consider completing rationalisation work themselves and with SDU.
- A trial is to be undertaken of arthroscopes following issues in the Day Surgery Unit (DSU), relating to the taps on these devices. Adverse Event Report (AER) form done and MDMC are investigating.
- SDU are working with Main Theatres to remove unnecessary consumable products from trays. This has improved the turnaround time for trays and released £39K from the SDU budget. Theatres now purchase presterile products for use in operating rooms, this has reduced wastage in Theatres and is considered best practice when compared to the previous method. As a result of this the SDU has then been able to change the packing process in the inspection, assembly and packing area which has been a further improvement of tray turnaround.
- New detergent has been supplied for the bedpan washers. The Decontamination Lead and Estates Operations Officer arranged commissioning tests to use the same product in use on the SDU washer disinfectors. This will provide greater cleaning efficacy (evidenced in two medical papers with the SDU and PHE), and produced 63% cost reduction compared to the previous brand.

Guidance documents
MHRA guidance for healthcare and social organisations has been circulated via the Decontamination Committee and is currently under review for Trust compliance. BSG guidance for the GI endoscopy was amended and discussed at the IPCWG and Endoscopy Unit, current processes in place were found to be compliant.

CJD
The Decontamination Lead and Consultant Microbiologist have conducted a look back exercise on a patient suspected at risk of CJD/vCJD. The concluding report will be reported through the IPCWG.

12.2 Ensure all endoscope decontamination takes place in fully compliant washers and is in line with MDS DB2002 (05) by March 2007

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 (ENT) outpatient department and lists in the Obstetrics and Gynaecology service. During 2014 there have been issues of delays in processing flexi scopes due to additional demand, automatic endoscope reprocessing (AER) failures, and SDU staffing levels. Endoscopy plan to increase demand in quarter 3 and 4 of 2014/15, by conducting additional evening lists.

A Capital Bid has been submitted and approved for the SDU to supply a vacuum packed flexible scope option using hydrogen peroxide. This will enable lesser used scopes to be stored for up to

35 days which will save staff time and be more cost effective, as currently these scopes have to be reprocessed through SDU every 3 days whether used or not. This will also increase the life cycle of the devices as it will reduce wear and tear.

12.3 Maintain a fully compliant SDU until at least 2017

The SDU continues to maintain its compliance and accreditation to the latest European Standards in Sterile Services. The yearly review and audit of the SDU quality system, by the external auditor (notified body) will be undertaken in October 2014.

The SDU is replacing the labour intensive paper based quality system with an IT based quality system which is more robust and less time consuming to manage and update. With this new system the SDU will be making the transition from HTMs to CFPPs for national guidance and quality objectives. This work continues to be on schedule and the SDU should by fully converted by 2015.

12.4 Marketing the SDU services to increase the external customer base

This continues to be an ongoing piece of work with any opportunities taken to expand our customer network and income channels. The following has been achieved:

- The SDU continues with the Ministry of Defence (MOD) Army, Royal Marines and Navy contracts until May 2015.
- The Wiltshire Community Health Services contract for its South Wiltshire Podiatry Tray Service continues to progress but continues to be under review.
- The SDU continues to expand its decontamination contract with an external independent healthcare provider BMI. This contract is progressing and the next BMI hospital is due to mobilise in November 2014. This has been delayed due to BMI not providing the instrumentation details for SDU to enter on the tracking system; and BMIs internal instrument sourcing process which is delayed through the summer.
- Following the approval of the Capital Bid for the SDU to supply a vacuum packed flexible scope option using hydrogen peroxide, the SDU has looked to secure an off site scope decontamination service with BMI. This will make SDU the first in the country to offer such a service and will produce a significant revenue.

12.5 Additional work of the Decontamination Committee

The sections listed below detail standard agenda items:

- **Decontamination equipment within the Trust update** – The committee examines, and raises the profile of decontamination equipment around the Trust, including bedpan washers, Mortuary washing machine, AER machines, Dekomed cabinet washers, autoclaves in SDU and within the Pathology Laboratory.
- **Data and test results from decontamination equipment used within the Trust** – Test results and planned preventative maintenance (PPM) schedules for Trust decontamination are discussed and minutes recorded within the meetings.
- **Reviewing national directives/documentation** – Making recommendations on other Choice Framework Documents, CFPP 01-01 Management and Decontamination of Surgical Instruments used in acute care, and CFPP 01-06 Reprocessing of Flexible Endoscopes: management and decontamination. The SDU is moving to CFPP 01-01 for its quality objectives via an eQMS and will be audited for the first time under CFPP instead of HTMs in 2015.

The Decontamination Committee continues to ensure all these objectives are met, with update reporting to the IPCWG and IPCC. A copy of the Decontamination strategy action plan is available from the Chair of the Decontamination Group.

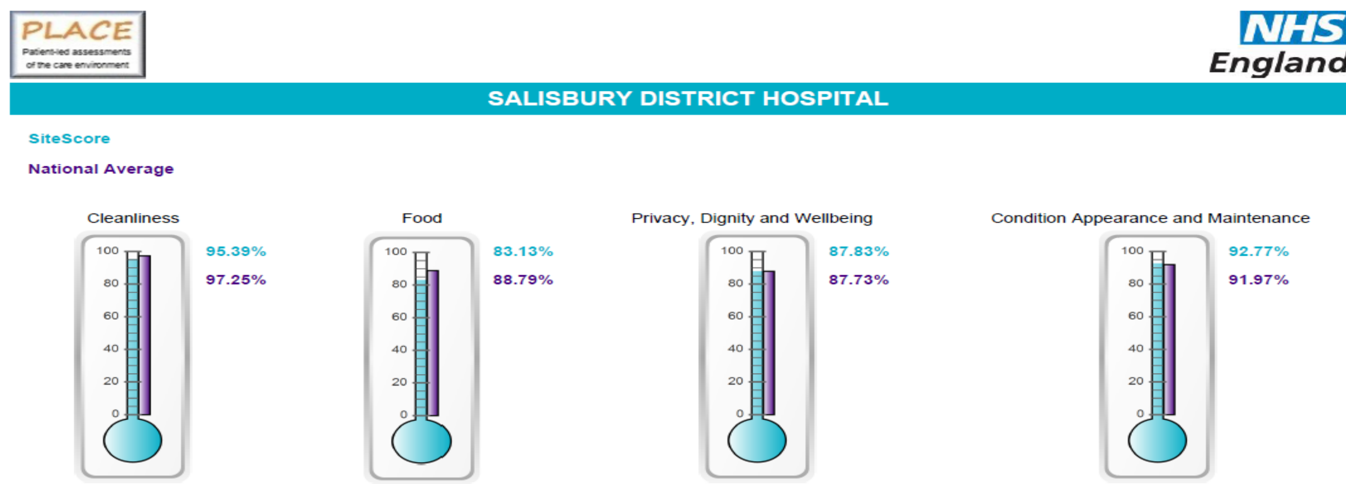
13. Cleaning Services *(information for this section has been provided by Maggie Cherry, Facilities Matron)*

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 led by the Housekeeping Department and Facilities directorate.

Patient led assessment of the care environment (PLACE) internal audits
Between July 2014 and September 2014, 3 internal PLACE assessments have been undertaken. These continue to receive good support from Governors and Volunteers and our local Healthwatch representatives. An action plan is produced and progress reported and monitored through the monthly MMG meetings. Focus is given to themes from the ward or department and learning that can be shared with other areas. The new PLACE audits are also helping inform and drive the capital bids and decorating programmes. The Health and Social Care Information Centre have published a tool for Trusts to use in their own audit systems, based on the annual programme, and this system is being utilised.

National PLACE
The Trust participated in the National PLACE assessment again this year. The assessment was conducted over two days on May 9th and 12th 2014, with 12 members of the public participating plus Trust staff. The teams visited 10 wards, tasted food on 3 wards and assessed 25% of the public spaces. The results were submitted to the Health and Social Care Information Centre on May 13th 2014. The results, shown below, were published nationally on August 27th 2014. A detailed Trust action plan has been produced for Cleanliness and Food. Cleanliness is monitored through the IPCWG and MMG (Appendix 9), and food is monitored by the Food and Nutrition Group.

Below are the scores for the 2014 PLACE audit showing the Trust site score against the national average.



Cleaning data

Area of Focus	KPI	Apr-14	May-14	June-14	Jul-14	Aug-14	Sept-14
Departmental Data	Post Infection cleans	326	287	389	360	321	330
	Enhanced cleaning hrs	77	101	179	201	74	80
Cleaning	Total audits	112	95	95	113	98	98
	Passes	43	22	23	43	30	36
	Qualified Passes	69	72	72	70	68	62
	Fails	0	1	0	0	0	0

When audits show a shortfall in cleaning, corrective action will be taken on the same day for very high risk areas and within 1 day for high risk areas.

Terminal, enhanced and double cleaning

The table below illustrates the additional cleaning undertaken in clinical areas between April to September 2014.

	Number of terminal cleans	Enhanced cleaning hours	Number of terminal cleans	Enhanced cleaning hours	Double cleans in hours
April	270	181	326	77.25	35.75
May	234	166.5	287	100.75	44.5
June	260	73	389	168.5	55
July	319	127.5	360	200.75	69
August	243	134.25	321	73.5	46.25
September	223	85.25	330	80	93.25
Year to date total	**1549**	**767.5**	**2013**	**700.75**	**343.75**

Deep clean programme/rapid response team

The Deep Clean programme was started in April 2014 on Winterslow Suite. Due to operational demands and the use of Breamore Ward as the decant area for the capital projects refurbishments of Redlynch and Pitton Wards, the programme was suspended. The Housekeeping Department have now re-introduced the plan and are working closely with the wards regarding access to ensure that this is delivered.

The use of the GLOSAIR 400 room decontamination system continues to increase.

Housekeeping resource

The Head of Facilities is reviewing the level of cleaning resources and funding that is available to meet current demands in order to meet national cleaning standards and infection control needs. A paper was presented to Executive Directors and is currently being developed further.

14. Summary

This six monthly Report has provided the Trust Board with evidence of the measures in place to work towards improving infection prevention and control practices across the Trust. The report provides assurance with regard to registration without conditions with the CQC standard for ‘Cleanliness and infection control’, Outcome 8 (Regulation 12).

The Report has detailed the continuing progress against the Action Plan for 2014/15 in reducing HCAI rates for the Trust and the key priorities include:

- Continued focus on the reduction of all reportable Trust apportioned cases and ensuring preventable infections are avoided.
- Ongoing reinforcement to improve compliance with hand hygiene practices and behaviours.
- Maintaining a clean and safe environment for our patients and staff through the Trust Housekeeping service.
- Monitoring of decontamination services.
- Continued focus on antimicrobial stewardship.
- Sustaining progress with education, training and audit relating to infection control practices and policies.

Continued implementation of the infection prevention and control Annual Action Plan highlights how the Trust will sustain compliance and further improve.

Appendix 1

Infection Prevention & Control – Annual Action Plan 2014/15

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, including the Spinal Unit.	DIPC/PW	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/MC	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/IR/MC/ 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	GA	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/PW	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

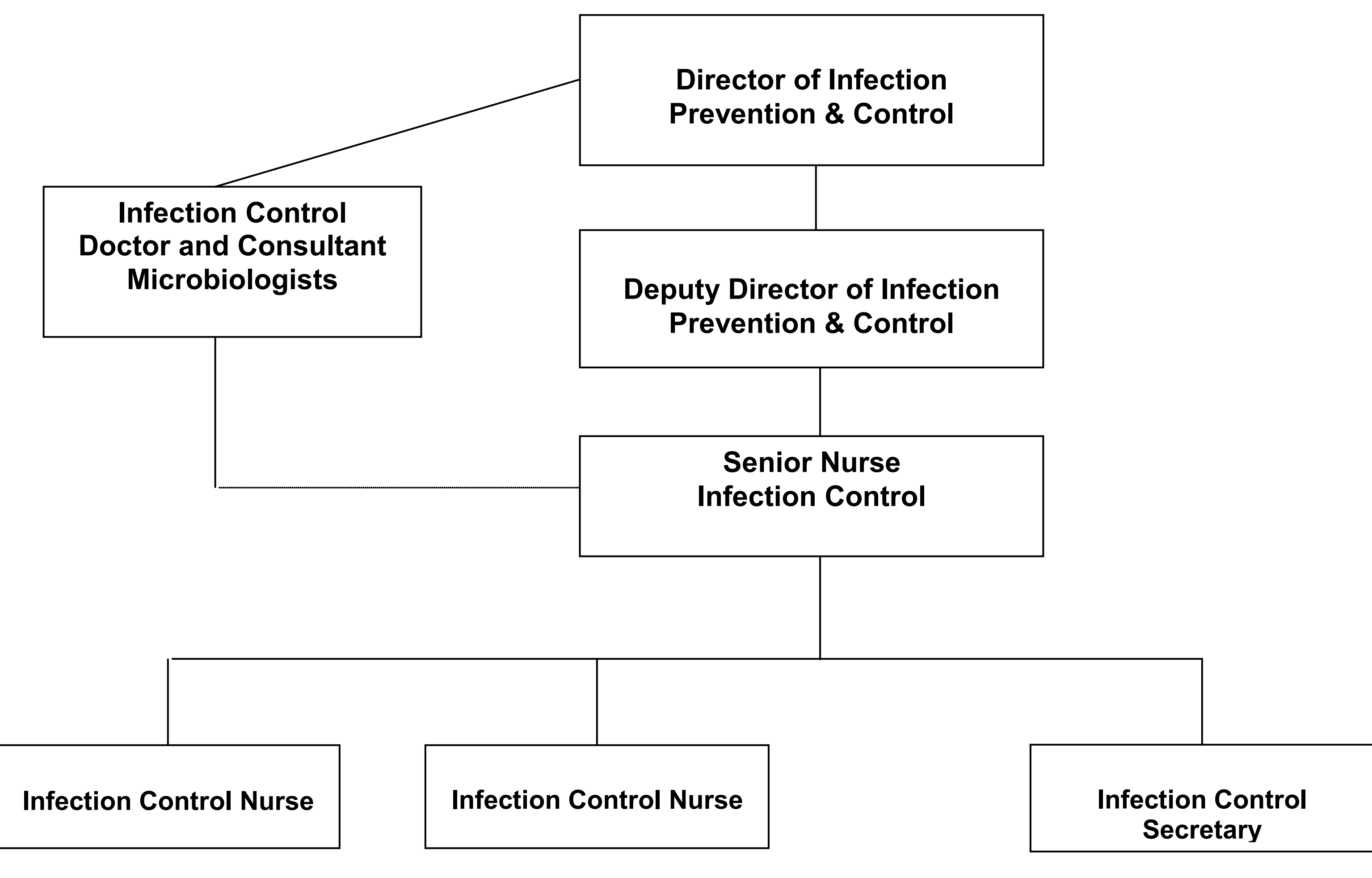
Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	IP&CT	In place
Isolation of patients	JH	In place
Safe handling and disposal of sharps	GL	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	IP&CT	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)	IP&CT	In place
Disinfection policy	MC	In place
Antimicrobial prescribing	JH/SH/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)	SK	In place
Infection control measures for ventilated patients	MF	In place
Tuberculosis	JH	In place
Legionellosis risk management policy and procedures, including pseudomonas	GA	In place
Strategic Cleaning Plan & Operational Policy	MC	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	GA	In place
Waste Management Policy	PJ	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	PW	In place
Laundry Management & Infection Control Policy	IR	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 PDPs of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals	DSNs/ICNs	Continuous

KEY INITIALS

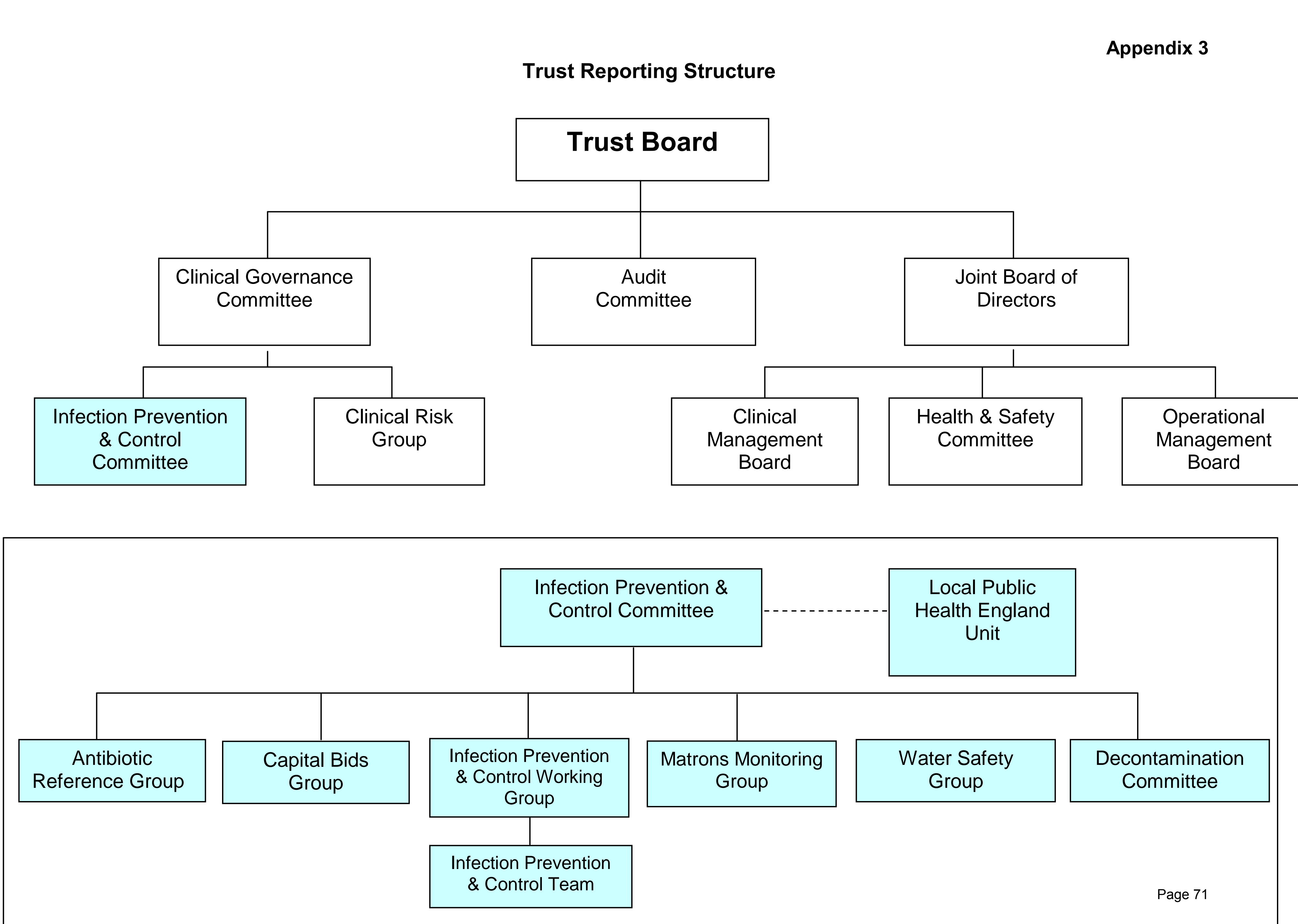
DIPC	Lorna Wilkinson, Director of Infection Prevention & Control (from August 2014)
DDIPC	Fiona Hyett, Deputy DIPC & Interim DIPC (March – July 2014)
PW	Peter Wells, Trust Decontamination Lead and SDU Manager (until June 2014) Robert Warburton (from Autumn 2014)
JH	Julian Hemming, Consultant Microbiologist & Infection Control Doctor
SC	Stephen Cotterill, Consultant Microbiologist
PR	Paul Russell, Consultant Microbiologist
IR	Ian Robinson, Head of Facilities
GA	George Atkinson, General Manager, Facilities
DSNs	Directorate Senior Nurses
GL	Geoff Lucas, Safety Advisor
HL	Heidi Lewis, Manager OH Department
SH	Simon Howe, Antimicrobial Pharmacist
SK	Shirley Kinsey, Neonatal and Postnatal Services Manager
MF	Maria Ford, Nurse Consultant in Critical Care
PJ	Paul Jackson, Energy and Waste Manager, Facilities
AK	Alison Kingscott, Director of Human Resources
MC	Maggie Cherry, Facilities Matron
ET	Emma Taylor, Principal Pharmacist

Infection Prevention & Control Team



Appendix 3

Trust Reporting Structure



Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables

Clinical Support & Family Services – April to September 2014

	Mean April %	Mean May %	Mean June %	Mean July %	Mean August %	Mean September %	**Mean Running %**
Sarum Ward	0	85.00%	95%	95%	80%	100%	**75.83%**
Labour Suite	90.48%	90.91%	100%	100%	84.21%	100%	**94.27%**
Beatrice Post Natal	100%	95.62%	100%	100%	100%	100%	**99.27%**
Neonatal Unit (NNU)	100%	100%	100%	100%	100%	100%	**100%**
Gynae Clinic	100%	100%	100%	100%	100%	100%	**100%**
Sexual Health	100%	100%	100%	100%	100%	100%	**100%**
Salisbury Fertility Centre	100%	100%	100%	100%	100%	100%	**100%**
Radiology Department	100%	0	100%	0	82.35%	0	**47.06%**
Endoscopy Department	100%	100%	100%	100%	100%	100%	**100%**
Mean Directorate Running Compliance % (9 areas)	**87.83%**	**85.73%**	**99.44%**	**88.33%**	**94.06%**	**88.89%**	**90.71%**

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables

Medicine – April to September 2014

	Mean April %	Mean May %	Mean June %	Mean July %	Mean August %	Mean September %	**Mean Running%**
Whiteparish AMU	100%	95%	90%	80.95%	82.61%	78.13%	**87.78%**
Tisbury CCU	90%	90.91%	80%	77.77%	75%	86.63%	**83.39%**
Pitton Ward	100%	100%	0	100%	96%	89.66%	**80.94%**
Redlynch Ward	100%	94.44%	100%	78.26%	100%	93.57%	**94.38%**
Farley Ward	94.74%	87.50%	100%	88.89%	100%	100%	**95.19%**
Winterslow Suite	100%	95%	70%	94.74%	95%	96.43%	**91.86%**
Pembroke Ward	100%	100%	100%	100%	100%	95.00%	**99.17%**
Pembroke Suite	100%	100%	99.78%	100%	100%	100%	**99.96%**
Durrington Ward	100%	100%	100%	100%	100%	100%	**100%**
Hospice	100%	100%	100%	100%	100%	100%	**100%**
Emergency Department	47.40%	72%	73.91%	52%	60%	45.99%	**58.55%**
Dermatology Department	100%	100%	100%	87.50%	Moved to Musculoskeletal		**96.88%**
Cardiac Suite	100%	95%	100%	95%	100%	100%	**98.33%**
Nunton Discharge Lounge	100%	100%	100%	100%	100%	100%	**100%**
Breamore/Wilton Ward	100%	100%	Closed	100%	Closed	Closed	**100%**
Directorate Running Compliance % (15 areas) 14 areas from August	**95.48%**	**95.32%**	**86.69%**	**90.34%**	**92.97%**	**91.19%**	**92.43%**

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables

Musculoskeletal – April to September 2014

	Mean April %	Mean May%	Mean June %	Mean July %	Mean August %	Mean September %	**Mean Running %**
Amesbury Suite	93.1%	0	0	0	92.6%	100%	**47.62%**
Chilmark Suite	64.65%	55%	77.27%	85%	90.48%	90%	**77.07%**
Laverstock Ward	80%	81.81%	0	0	100%	53.13%	**52.50%**
Burns Unit	85%	95.24%	95%	0	90%	90%	**75.87%**
Avon Ward	81.82%	90%	86.36%	0	95%	100%	**75.53%**
Tamar Ward	100%	90%	95%	95%	90%	0	**78.33%**
Spinal OPD	73.33%	100%	100%	0	80%	61.54%	**69.15%**
Orthopaedic OPD	100%	100%	96.88%	100%	93.75	100%	**98.44%**
Plastics OPD	0	100%	100%	100%	100%	86.36%	**81.06%**
Oral Surgery OPD	100%	100%	100%	100%	100%	100%	**100%**
Rheumatology	0	100%	100%	0	100%	100%	**66.67%**
Wessex Laser Centre	100%	100%	100%	100%	100%	94.44%	**99.07%**
Burns & Plastics Therapy	0	100%	0	0	85.7%	0	**30.95%**
Dermatology Department	N/A	N/A	N/A	N/A	100%	0	**50%**
Directorate Running Compliance % (13 areas) 14 areas from August	**67.53%**	**85.54%**	**73.12%**	**44.62%**	**94.11%**	**69.68%**	**71.59%**

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables

Surgery – April to September 2014

	Mean April %	Mean May %	Mean June %	Mean July %	Mean August %	Mean September %	Mean running %
Britford Ward	100%	78.26%	77.78%	100%	100%	83.33%	**89.90%**
Downton Ward	91.3%	70%	73.91%	82%	90%	80%	**81.20%**
Radnor Ward	100%	100%	88.89%	0	100%	90.1%	**79.83%**
Vascular & Diabetic OPD	100%	0	100%	0	100%	100%	**66.67%**
Medical & Surgical OPD	100%	100%	100%	100%	100%	100%	**100%**
ENT Department	100%	76.90%	91.67%	86.96%	100%	100%	**92.59%**
Ophthalmology	100%	100%	100%	100%	100%	100%	**100%**
Main Theatres and Recovery	100%	100%	100%	100%	88%	93.75%	**96.96%**
Surgical Admissions Lounge	100%	100%	100%	100%	100%	100%	**100%**
Day Surgery Unit	100%	100%	85%	90%	85.71%	95.83%	**92.76%**
Pre-op Assessment Unit	0	0	0	100%	100%	100%	**50%**
Clarendon Suite	100%	90%	Closed	88%	Closed	100%	**63%**
Directorate Running Compliance % (12 areas)	**90.94%**	**76.26%**	**83.39%**	**78.91%**	**96.70%**	**95.25%**	**84.41%**

Appendix 5

Completed Hand Hygiene Assessments for Quarters 1 & 2 of 2014 to 2015 – figures shown in brackets are for the previous year (2013/14)

Directorate	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Chief Executive	32 (19)	28 (20)			**60** (39)
Clinical Support and Family Services	156 (102)	178 (83)			**334** (185)
Consultants/Doctors/Medical students	37 (24)	93 (58)			**130** (82)
Contractors/Other	11 (24)	2 (0)			**13** (24)
Facilities	90 (149)	103 (67)			**193** (216)
Finance and Procurement	11 (30)	33 (13)			**44** (43)
Human Resources	15 (9)	16 (24)			**31** (33)
Medicine	108 (96)	150 (62)			**258** (158)
Musculo-Skeletal	118 (74)	149 (68)			**267** (142)
Quality	61 (27)	40 (20)			**101** (47)
Students/Work Experience	4 (4)	5 (6)			**9** (10)
Surgery	109 (56)	134 (76)			**243** (132)
Wiltshire Council	0 (21)	1 (10)			**1** (31)
Total	**752** (635)	**932** (507)			**1684** (1142)

- Figures include every hand hygiene assessment completed by staff members and recorded by the Infection Control Nurses or the Infection Control Link Professionals.
- It is a mandatory requirement for Trust staff to complete a hand hygiene assessment annually.
- In terms of comparison with figures for 2013/14, it is noted that the Facilities Directorate reduced by 86 staff from quarter 1 of 2014/15. This was following the transfer of Laundry staff and Non Urgent Patient Transport staff to Salisbury Trading Ltd and Arriva Transport.

Appendix 6

Infection Prevention & Control Annual Audit Programme

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 • PII e.g. C.difficile • Targeted others e.g. Tuberculosis, VRE	As required.	Led by IP&CT, including key personnel from affected areas.
2	Reduction of infection risk from the use of catheters, tubes, cannulae, instruments & other devices.	Patient Safety Stream Work – implementation of care bundles e.g. central line & peripheral vascular devices.	5 year programme (ending October 2014).	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 assisted by ICNs. IP&CT.
3	Reduce the reservoirs of infection.	Environmental & equipment cleanliness	• Priorities & timescales agreed with DIPC. • Plus, targeted audits.	Clinical Leaders/DSNs assisted by ICNs. IP&CT.
		In house Patient Led Assessment of the Care Environment (PLACE) visits.	Programme led by Facilities Directorate.	Facilities Matron/ Housekeeping Manager with the involvement of DMTs.

No	Aim	Audit	When by/How	Person(s) responsible/main author
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 assisted by ICNs. IP&CT.
5	Prudent use of antibiotics.	Antibiotic prescribing & usage.	Action Plan agreed & monitored by the Antibiotic Reference Group (ARG).	Chief Pharmacist & Interim Antimicrobial Pharmacist.
6	Management & organisation – • Policy, guideline & information development & review programme (review dates according to ICID or SDH intranet site).	Pt information leaflet - Acinetobacter.	Review 2015.	ICNs.
		Microbiology Alerts Policy.	Review 2015.	Stephen Cotterill.
		Aseptic technique.	Review 2015.	ICNs.
		Clostridium difficile Policy.	Review 2017.	ICD.
		Pt information leaflet - C.difficile.	Under Review.	ICNs.
		Contractors/Procurement information leaflet - Infection Control.	Review 2015.	ICNs.
		Creutzfeldt Jacob Disease (CJD) Policy.	Review 2015.	Decontamination Lead & ICD.
		Decontamination Policy.	Review 2014	Decontamination Lead.
		Pt information leaflet - ESBL.	Review 2017.	ICNs.
		Glove Usage Policy & Chart.	Review 2015.	ICNs.
		Pt information leaflet - Group A Strep (GAS).	Under Review.	ICNs.
		Staff information leaflet - Hand Hygiene.	Review 2015.	ICNs.
		Infection Control Policy.	Review 2014.	IP&CT.
		Inpatients with diarrhoea algorithm.	Review 2015.	ICNs.
		Isolation Policy (including diarrhoeal infections & other alert organisms).	Review 2017.	ICD.
		Hand Hygiene Policy.	Under Review.	ICNs.
		Pt information leaflet - Invasive GAS Disease.	Under Review.	ICNs.

No	Aim	Audit	When by/How	Person(s) responsible/main author
6	Continued	Linen Management Policy.	Under Review.	IP&CT.
		Legionellosis Management Policy.	Review 2015.	George Atkinson.
		Clinical Management of MRSA Policy.	Review 2015.	ICD.
		Pt information leaflet - MRSA.	Under Review.	ICNs.
		Pt information leaflet - MRSA Contact Bay.	Review 2016.	ICNs.
		Pt information leaflet - MRSA Screening.	Review 2015.	ICNs.
		Outbreak Management Policy.	Under Review.	IP&CT.
		Outbreak Management of Norovirus Policy.	Under Review.	IP&CT.
		Pt information leaflet – Norovirus.	Review 2015.	ICNs.
		Pt information leaflet – 'Now that I am in Isolation'.	Review 2016.	ICNs.
		Prevention of Occupational Exposure to Blood Borne Virus Policy.	Review 2015.	ICNs.
		Prevention of Spread of Carbapenem Resistant Organisms Policy.	Review 2015.	ICD.
		Pt information leaflets – CPE C3 – Colonised. C4 – Carrier. C5 – Contact.	Review 2017.	ICNs.
		Peripheral Venous Cannulation Policy.	Under Review.	ICNs.
		Pt information leaflet – Having a ‘drip’ (peripheral venous cannula)	Review 2015.	ICNs.
		Standard Precautions Policy.	Under Review.	ICNs.
		Surveillance Policy.	Review 2014.	ICNs.
		Taking Blood Cultures Policy – Adults.	Review 2017.	ICNs.
		Tuberculosis Policy.	Review 2014.	ICD.
		Ebola and other Viral Haemorrhagic Fevers Policy.	Review 2017.	ICD
		Management of VRE Policy.	Under development.	ICD.
		Pt information leaflet – new leaflet for VRE devised.	For final approval.	ICNs.

Appendix 7

Completed Infection Control CBL Package on the MLE for Quarters 1 & 2 of 2014 to 2015 - figures shown in brackets are for the previous year (2013/14)

Directorate	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Clinical Support and Family Services	84 (100)	108 (90)			**192** (190)
Facilities	40 (84)	70 (66)			**110** (150)
Medicine	72 (94)	92 (99)			**164** (193)
Musculo-Skeletal	46 (65)	44 (55)			**90** (120)
Quality	61 (41)	92 (62)			**153** (103)
Surgery	56 (89)	90 (84)			**146** (173)
Corporate	34 (45)	54 (43)			**88** (88)
Doctors	22 (12)	53 (48)			**75** (60)
Wiltshire Council	0 (0)	5 (0)			**5** (0)
Other Groups	17 (12)	8 (10)			**25** (22)
Total	**432** (542)	**616** (557)			**1048** (1099)

- It is a mandatory requirement for Trust staff to complete the infection control CBL package on the MLE every 2 years.
- In terms of comparison with figures for 2013/14, it is noted that the Facilities Directorate reduced by 86 staff from quarter 1 of 2014/15. This was following the transfer of Laundry staff and Non Urgent Patient Transport staff to Salisbury Trading Ltd and Arriva Transport.

Appendix 8

Topics covered at the ICLP monthly meetings during quarters 1 and 2 of 2014/15 have included the following:

- HCAIs – confirmation of the targets set for the Trust for 2014/15, in relation to MRSA bacteraemia and C.difficile Trust apportioned reportable cases.
- Carbapenemase Producing Enterobacteriaceae (CPE):
    - During quarter 1 – explanation and discussion of national publicity, the current Trust policy and recent DH guidance. Feedback was also provided regarding identified cases for patients in the intensive treatment unit at another Trust, and the measures they implemented in response to the cases.
    - During quarter 2 – background, detection, management and control of CPE, with reference to the toolkit guidance for acute Trusts produced by PHE.
    - Explanation of the established Trust policy for the 'Prevention and Spread of Carbapenem Resistant Organisms' and the CPE cases reported locally in other Trusts.
    - Discussion of the CPE information and patient management advice already disseminated within the Trust to the Clinical Leads and Directorate Teams.
    - Information produced by the PHE was made available at the meeting for the ICLPs, to aid the cascade of information to colleagues, with additional website links.
    - Notification that CPE patient information leaflets were available via the infection control section on ICID
- Influenza – confirmation of the outbreak of Influenza A declared for a ward within the medical directorate during March 2014. Discussion of how the situation developed and was managed by the Trust, and the requirement for a serious incident report to be generated for submission to the CCGs.
- C.difficile (discussed at each meeting during the quarter):
    - Reporting the number of inpatient cases identified each month since April 2014, the PII of C.difficile for the Trust, and reinforcing the Trust target of no more than 18 Trust apportioned reportable cases for 2014/15.
    - Notification that an outbreak of C.difficile had been declared for a ward within the medical directorate, following the identification of 2 cases geographically linked to a bay within a defined period of time.
    - Feedback from the PII of C.difficile declared for a ward within the medical directorate during June 2014, including the reporting requirements and the resulting serious incident investigation undertaken by the directorate (retrospectively declared as an outbreak).
    - The importance of maintaining accurate stool charts for patients, with patient assessment and appropriate sending of stool samples, utilising the Trust 'Flow Chart for Inpatients with Diarrhoea'.
    - Cascade of the revised measures required to be implemented when a new case of C.difficile is identified, with reinforcement of this at subsequent meetings. This included the immediate management and isolation of the positive patient in a sideroom facility, and where the patient was in a bay, the closure and monitoring measures required pending the completion of deep cleaning and GLOSAIR decontamination.
    - Discussion of the 'Critical Friend' review undertaken by the local CCGs, and details of the Trust C.difficile Prevention Action Plan.
    - Focus on environmental cleaning and the importance of ensuring that clinical environments are kept free of clutter with items not being stored on floors.
- Notification of the MRSA bacteraemia case identified during July 2014 for a patient on a ward in the medical directorate, outlining the PIR process and the identified learning outcomes.

- Viral Haemorrhagic Fever, Ebola – awareness of the increasing number of cases and reported deaths from the virus (at the time of the meeting in August 2014). Explanation of the infection risks associated with the care of infected people and the implications for a healthcare setting.
- Scabies – public health information and discussion of the management of a case within a hospital setting, and the required follow up of an identified patient contact from another hospital that had been transferred to the Trust.
- Group A Streptococcus – explanation of this organism and the management of cases identified for inpatients, and clarification of the follow up undertaken in the community by PHE when an invasive Group A Streptococcus case is identified.
- VRE – update on the incidence of cases nationally and locally within the Trust, and revisiting the previously reported PII of cases across the general surgical wards. Confirmation of the measures instigated and the strict adherence to infection control policies and practices when a case is identified. Reinforcement of the environmental cleaning instigated with the twice daily cleaning by Housekeeping for all siderooms occupied by positive patients and the utilisation of deep cleaning and the GLOSAIR decontamination system when patients are discharged.
- Group discussion with the consideration of how the ICLPs delivered care to patients in their areas. Emphasis was placed on the 'back to basics' principle, to break the chain of infection and prevent cross contamination.
- Presentation of the findings from the Handling and Disposal of Linen reaudit, and circulation of the report to the ICLPs and Clinical Leaders for cascade to colleagues.
- Discussion regarding the CQC mock inspection planned for the start of September 2014.
- Feedback regarding the Trust review of PPE, with the different coloured disposable plastic apron trial being undertaken by selected inpatient areas, and the non sterile single use disposable gloves review being led by the Procurement Department.
- Specific clinical related issues, including diarrhoea and vomiting activity within the Trust and the surrounding community, and a monthly update of the Trust apportioned reportable inpatient cases of Clostridium difficile identified. Notification of the closure of a local community hospital due to confirmed Norovirus. During quarter 2, discussion regarding the increase in the number of patients admitted with diarrhoea and vomiting symptoms, and that the level of activity had resulted in the closure of bays across the medical and surgical directorates.
- Hand hygiene audits – continued education and support with the audit method and the escalation of any identified non compliance and/or concerns. Explanation of the processes in place to address non compliance by an individual staff member, and the involvement of the relevant directorate management team. Notification that an external auditor would be visiting the Trust to undertake additional hand hygiene audits.
- Responding and advising on specific clinical related issues, in addition to the various concerns identified by the ICLPs, with a questions and answers session to encourage sharing of experiences and practices.
- Advice regarding staff health management in relation to diarrhoea and/or vomiting and the clearance time frame for returning to work.
- Confirmation of the innovations under review, including mobile/fixed screens and a door handle dispensing alcohol hand rub gel being trialled on the Neonatal Unit.
- Notification that the public alcohol hand rub gel stations refurbishment continued to progress, with the manual gel dispensers being replaced by automated dispensers.
- Reminders for the 'drop-in' sessions facilitated by the ICNs, for the completion of hand hygiene assessments and infection control updates. An opportunity was provided for the ICLPs to update their training on using the UV light box to undertake hand hygiene assessments.
- Feedback of the ongoing issue with the MLE not always recording the most up to date information for completed hand hygiene assessments, and reassurance that the issue had been raised via the Education Department to the external MLE supplier.

Appendix 9

Patient Led Assessment of the Care Environment (PLACE) Action Plan 2014/15 - Generated by Maggie Cherry, Facilities Matron

Theme	Group/Person Responsible	By when	Comments/Update
Hand bacterial rub available at bedside	IP&CT	March 2015	• Ward Leaders are ordering bedside and locker dispensers.
Outpatient areas issues with high level dust	Amanda Urch, Maggie Cherry	December 2014	• Housekeeping Supervisors and Outpatient Leaders to meet to identify areas to be rectified and develop a systematic plan of work with the cleaning teams. • Audits to be undertaken monthly. • Spot checks and weekly visits by Housekeeping Supervisor. • Progress monitored and reported at the IPCWG and MMG.
Decorating issues across wards and departments, and internal and external spaces	Terry Cropp, David Connolly - ETS & Geoff Walford – PFI	Commenced February 4th 2014 Rolling annual programme	• Align programme to Deep Clean and Refurbishment plans. • Prioritise areas to be decorated. • Submit plans to PFI Partner. • PLACE internal audits are helping to inform decorating issues and actioned immediately when possible.
Dementia friendly environments; Floors, signage, décor, clocks/calendars	Dementia Steering Group Signage Group Project Group (Sue Biddle)	Work ongoing	• Circulate PLACE assessment to groups. • Procure clocks/calendars Trust Wide. • Change toilet signs etc and heights as new/replaced signage works progress. • Redlynch and Pitton Wards fully compliant and setting standard that will be followed as wards are refurbished.

Appendix 10

Additional information relating to Trust activity with alert organisms

- **Acinetobacter baumannii**

Acinetobacter is a gram-negative bacterium that is readily found throughout the environment including drinking and surface waters, soil, sewage and various types of foods. Acinetobacter is also commonly found as a harmless coloniser on the skin of healthy people and usually poses very few risks. Acinetobacter infections acquired in the community are very rare and most strains found outside hospitals are sensitive to antibiotics.

Acinetobacter poses few risks to healthy individuals; however a few species, particularly Acinetobacter baumannii, can cause serious infections, mainly in very ill hospital patients. The most common Acinetobacter infections include pneumonia, bacteraemia (blood stream infection), wound infections, and urinary tract infections. 'Hospital-adapted' strains of Acinetobacter are sometimes resistant to antibiotics and are increasingly difficult to treat. Patients identified to have multi-drug resistant Acinetobacter are isolated in a sideroom for the duration of their hospital admission.

During quarters 1 and 2 of 2014/15, the ICNs were informed of 1 new case of multi drug resistant Acinetobacter identified for an inpatient. This patient had been isolated in a sideroom facility from admission to the Trust, due to being previously known to have other alert organisms.

- **Carbapenem Producing Enterobacteriaceae (CPE)**

Enterobacteriaceae are a group of bacteria carried in the gut of humans and animals. While they are usually harmless they may spread to other parts of the body where they can cause serious infections. Highly resistant Klebsiella pneumoniae and Escherichia coli have been identified, most commonly in India and Pakistan, with highly resistant Klebsiella pneumoniae being described as endemic in Greece. Cases may be imported into the United Kingdom as a direct result of the increase in foreign travel, and hospitalisation within these countries. CPE is the name given to some strains of the bacteria that have developed an ability to destroy the group of antibiotics known as called Carbapenems, making them resistant to these drugs. Carbapenems are considered to be antibiotics of 'last resort' and doctors rely on them to treat difficult infections when other antibiotics have failed. Infections caused by CPE can still be treated with antibiotics. However, treatment is more difficult and may require a combination of drugs, or the use of older antibiotics to be effective.

Cases of CPE infection were identified at Poole General Hospital in July 2014, and following this the ICNs contacted the Infection Prevention & Control Team at Poole Hospital to attain additional information. In light of the close geographical links to Poole Hospital, the ICNs circulated additional information relating to the management of all patient admissions, including the transfer of patients from other Trusts. In particular, advice was given regarding transfer from countries or UK hospitals with a known high prevalence of CPE.

During quarters 1 and 2 of 2014/15, the ICNs were not informed of any new inpatient cases of Carbapenem resistant organisms.

- **Chickenpox (Varicella Zoster)**

Chickenpox is a common illness, which does not normally cause complications in children. The likelihood of complications can increase in adults and especially if they are immuno-suppressed because of disease (e.g. leukaemia), and having high doses of steroids or chemotherapy. Non-immune women in the early or late stages of pregnancy are also potentially at risk.

During quarters 1 and 2 of 2014/15, the ICNs were informed of a patient admitted to the Trust with a diagnosis of suspected chickenpox. This patient was strictly isolated in a sideroom facility and was discharged home when medically fit.

In addition, there were 3 staff members identified with suspected chickenpox during quarters 1 and 2 (2014/15). These were unrelated cases in the medical directorate at different times. Meetings were held to ensure that the appropriate actions and necessary follow up for patient and staff contacts was completed. The IP&CT and Occupational Health (OH) Department worked together to complete this exercise.

- **Escherichia coli**

Escherichia coli (E.coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E. coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. E.coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E.coli bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood.

During quarter 2 (2014/15), 2 children (siblings) attending the Day Nursery and Playscheme facilities at the hospital were identified to have E.coli O157 from stool samples. On further investigation, the family recently returned from foreign travel and had initially recovered from diarrhoeal symptoms. Prior to formal confirmation of the positive result, both children had ceased to attend the Nursery/Playscheme. Following PHE guidance/advice, all potential contacts were identified and monitored and a programme of additional environmental and equipment cleaning was completed by Housekeeping and Nursery/Playscheme staff. Information was also communicated to the parents of the potential contacts by the Day Nursery Manager, under the direction of the local PHE and in conjunction with the ICD.

- **Invasive Group A streptococcus (iGAS)**

Group A streptococcus (GAS) is a bacterium, often carried in the throat and on the skin, with no outward sign of illness. Most GAS infections are relatively mild illnesses, such as 'strep throat' or a skin infection, such as impetigo. On rare occasions, these bacteria can cause other severe and even life-threatening diseases, e.g. invasive streptococcal disease.

During quarters 1 and 2 of 2014/15, there have been no linked cases of iGAS identified for inpatients. For cases identified, patients are managed according to the Trust Isolation policy, with treatment advised by a Microbiologist, with the involvement of the local PHE. This is to enable the required follow up of any identified household contacts in the community.

- **Pertussis ('whooping cough')**

Pertussis is an acute respiratory infection caused by the bacteria *Bordetella pertussis*. It usually begins with mild, cold-like symptoms, which develop over one to two weeks into coughing fits that can be severe. The incubation period is on average 7-10 days (range 5-21 days). Pertussis can affect people of all ages, with the highest incidence in infants under three months old, who are too young to be directly protected by routine immunisation and for whom the disease is often severe and even life-threatening. A high number of cases are also being confirmed in adolescents and adults who usually suffer a milder disease with a cough that may persist for many weeks. A case is considered infectious from onset of symptoms until completion of antibiotic treatment or for 21 days from onset of symptoms if they have not received appropriate antibiotic therapy.

During quarter 2 (2014/15), a confirmed case of Pertussis was identified in a staff member, who had been working in outpatient clinics across 2 departments. On the identification of a second suspected case in another staff member working in the same team, an investigation was instigated by a Consultant Microbiologist, in conjunction with the OH Department. Meetings were held and attended by key personnel, to agree the actions required for the follow up of identified patient and staff contacts. Discussions were also held with the local PHE to ensure the appropriate guidance was followed.

- **Respiratory Syncytial Virus (RSV)**

RSV is a viral infection that causes upper and lower respiratory infections, commonly affecting babies and young children. It is spread by aerosol droplets or by contact with contaminated surfaces. Although those affected usually present with mild symptoms, infants under 6 weeks old or premature babies are more at risk and the impact can be devastating, with an increased mortality rate. RSV is more prevalent during the winter months and the Trust has a policy for the management of RSV in the Neonatal Unit.

There were no declared outbreaks of RSV during quarters 1 and 2 of 2014/15.

- **Tuberculosis (TB)**

Any patients identified as suspected or confirmed pulmonary TB are isolated in a sideroom facility until a specific length of treatment has been completed. When notified of such patients, the IP&CT support staff within the clinical area to ensure that respiratory precautions are implemented and that the correct personal protective equipment (PPE) is in use. The Respiratory Department advises on the care and management of these patients. In addition, the OH Department and PHE will also be involved if there is a requirement for the follow up of any identified patient or staff contacts.

During quarters 1 and 2 of 2014/15, inpatients admitted with or identified during admission to have suspected pulmonary TB were isolated under respiratory precautions in sideroom facilities. There has been no indication for the follow up of other patients or staff members.

- **Vancomycin Resistant Enterococcus (VRE)**

Enterococci are bacteria that are found in the faeces of most humans and some animals. Infections caused by enterococci are commonly urinary tract and wound infections. VRE cause the same types of infections, but the range of antibiotics available for treatment is limited and treatment is dependent upon the antibiotic sensitivities. It is usual that patients with VRE have complex clinical presentations and require extensive appropriate antibiotic therapy. The treatment and management of these patients and subsequent clearance screening is completed in line with Consultant Microbiologist advice following best practice guidance.

The main report outlines the actions undertaken on the identification and management of patients identified to have VRE.

- **Viral Gastro-enteritis**

Noroviruses are the group of viruses formerly known as Norwalk-like viruses or small round structured viruses. These viruses have long been associated with outbreaks of a relatively short-lived form of gastroenteritis, often referred to as 'winter vomiting disease'.

There were no declared outbreaks of Norovirus during quarters 1 and 2 of 2014/15.

The Trust has a Norovirus Major Outbreak Plan Policy in place, which provides additional information and guidance on Salisbury NHS Foundation Trust's operational response to a major outbreak of Norovirus. The aims and objectives of this document are to ensure a procedure is in place to deal with the command and control of Norovirus issues that might affect the operational running of the Trust. This policy identifies appropriate areas for isolation nursing and the management of patients presenting with symptoms of viral gastro-enteritis direct from the community, and helps minimise disruption to the Trust, whilst continuing to operate effectively without the need to cancel elective admissions. The Trust did **not** need to utilise this policy during quarters 1 and 2 of 2014/15.

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

The former Health Protection Agency website has now been archived by PHE.

Appendix 11

Clostridium difficile Prevention Action Plan – 7th July 2014 (updated 05.09.14)

	Recommendations	Actions & steps	Person(s)/Lead Responsible	When by & progress update/completion
Policies and Procedures:				
1.	Review the current *C.difficile* infection (CDI) policy and procedures (including Diarrhoeal Algorithm), to include the prevention, early suspicion and detection of the disease.	The policy should include the following: • Initial management of suspected potentially infectious diarrhoea using the 'SIGHT' mnemonic protocol *(as per recommendation within the current national guidelines on Clostridium difficile infection: How to deal with the problem, 2009).* • Latest guidance on prudent antimicrobial prescribing and use of proton pump inhibitors (*as per 'Updated guidance on the management and treatment of Clostridium difficile infection, 2013'*). • Management of recovered CDI patients with evidence of risk assessment documented in healthcare records (not being routinely removed from sideroom facilities). • Environmental decontamination requirements. Key policy changes to be included within: • Trust and local area/ward inductions • *C.difficile* prevention workshops • Updates provided by Infection Control Link Professionals (ICLPs).	**JH/PR/SH/ET/FM**	**September 2014 – Update:** JH to review the medical aspect of the policy and link with FM. ET to provide and ensure the latest evidence base is included within the policy.

Cont:	Recommendations	Actions & steps	Person(s)/Lead Responsible	When by & progress update/completion
Isolation of patients with diarrhoea				
2.	Improve decision making around which patients should be isolated in sideroom facilities and operate a 'time to isolate' target.	• Undertake an audit of 'time to first symptoms to isolation' to establish current practices and ascertain extent of variance against best practice guidance, e.g. isolate within 2 hours of symptoms started/noted. • Undertake an audit of the time it takes to obtain and process diarrhoeal samples, to raise the profile of timely sampling following isolation.	**Infection Control Nurses (ICNs)** **ICNs**	**Complete baseline audit by 31st July 2014.** Baseline audit completed during July 2014 (review of patient healthcare records and communications with ICNs). Findings indicate areas of good practice where symptomatic patients isolated <2hours and stool samples were obtained, and times when patients are not isolated (>12 hours to 48 hours) for a variety of reasons (poor communication, lack of sideroom availability and Housekeeping provision). Audits to continue and be reported via the Infection Prevention & Control Working Group (IPCWG) and communicated to wider groups.
		• Review of diarrhoeal samples sent to the Laboratory to ensure that these patients are properly isolated and monitor timeliness of laboratory sample(s) testing. • Escalate non compliance with isolation, if a sideroom is not available within 2 hours via adverse event form (AER) reporting. • Implementation of 'time to isolate' target with clear escalation instructions to ensure it has clear, ambiguous procedures for managing patients with potentially infective diarrhoea.	**ICNs** **Ward Leaders** **JH/FM**	**Update:** Ongoing action, continue to work with areas to manage patients safely. **Ongoing** **September 2014 – Update:** Inclusion within revised policy.

Cont:	Recommendations	Actions & steps	Person(s)/Lead Responsible	When by & progress update/completion
Antimicrobial Prescribing				
3.	Ensure actions taken as a result of completing two antibiotic stewardship audits per clinical area/ward per month are fedback to the relevant staff in a timely manner (links to CQUIN requirements).	• Use of the antimicrobial pharmacist and consultant microbiologist (or allocating ward/speciality level auditing as a Junior Doctor project, e.g. HiMP). • Working with Prescribers to ensure antibiotic therapy prescribed where clinically appropriate and stopped in a timely manner i.e based on clinical review.	**SH/ET/JH/PR/SC** **ET/Doctor identified by Christine Blanshard**	**Ongoing – Update:** CQUINs completed (as per requirements) with audit results available from ET. Additional information: ET to report back following contact with Pharmacy Clinical Commissioning Group Lead. Christine Blanshard to report back following contact with local LMC chair regarding support for reduction in inappropriate prescribing of antibiotics in the community by GPs.
4.	Review of antimicrobial prescribing polices to ensure following best practice.	• Establish why using and compare policies with other NHS Trusts.	**SH/ET/PR**	**September 2014 – Update:** Evidence available from ET.
Assurance				
5.	**Epidemiology:** • Establish further profiling of CDI cases.	• Mapping of ribotypes against speciality and risk factors and understanding the time to onset of cases. • Consider access to CDRNE Enhanced Fingerprinting Service and undertake further epidemiological analysis on cases. • Trust's involvement within national project for DNA analysis of ribotyping profiling with Enhanced Fingerprinting Service.	**JH** **JH** **SC**	**Ongoing – Update:** Ribotyping profiling report for SDH written by SC. For presentation at Clinical Governance Committee 25.09.14. **August 2014 – Update:** SC in communication with Bristol Reference Laboratory. **Commenced June/July 2014**
6.	**Audit:** • Independent domestic/environmental cleaning audits to be undertaken to include areas of the clinical environment/ward that are not accessible to patients, e.g. dirty utility rooms and clean preparation areas/utility rooms.	• Independent audits of cleaning performed by Directorate Senior Nurses (DSNs) with Housekeeping Manager (and consider peer auditing), e.g. use of 'Confidence in Caring' forms to support PLACE audits.	**DSNs/AU**	**Immediate & ongoing – Update:** Clinical leaders liaising with Housekeeping Supervisors; completion of 'Confidence in Caring' audits by DSNs; exception reporting at 10am meetings held three times a week.

Cont:	Recommendations	Actions & steps	Person(s)/Lead Responsible	When by & progress update/completion
	• Improved compliance with adherence to infection control practice policies.	• DSNs, ICNs and Infection Control Link Professionals (ICLPs) to undertake periodic objective checks of care bundles and audit within the clinical areas, with audit outcomes and actions required to be fedback in real time to the relevant forums and committees. • DSN representation at Infection Prevention & Control Working Group (IPCWG) meeting.	**DSNs/ICNs/ICLPs** **DSN**	**Immediate & ongoing – Update:** Weekly walkrounds of clinical areas by Deputy DIPC and Senior ICN commenced August 2014. Exception reporting at 10am meeting held three times a week (Infection Control and Housekeeping in attendance). **Commenced June 2014 – Update:** DSN's for medicine and surgery in attendance during quarter 2 (2014/15).
7.	**Clinical Review:** • Strengthen the multidisciplinary *C.difficile* round team membership. • Investigate enabling ward staff with the decision making process for the management of patients with symptoms of diarrhoea (Type 5 – 7 stools).	• Inclusion of gastroenterologist and dietician within the team to ensure robust team review of *C.difficile* patients. • Consider use of electronic observations system to trigger Type 5 – 7 stools, e.g. Patients Observational Electronic Tool (POET).	**JH** **Ward Leaders/Infection Prevention & Control Team (IPCT)**	**End of August 2014 – Update:** JH to e-mail Sam Vyas (copy in DIPC) and recommend dietician involvement. **Trust Project – Update:** Meetings have started, with DIPC involvement.
Clinical practice, Cleaning and the Environment				
8.	**Clinical practice:** • Reinforcement to all clinical staff the importance of consistent compliance with standard infection control precautions, e.g. appropriate use of personal protective equipment (PPE).	• DSNs to undertake reviews of practices and audits of environmental and equipment cleanliness. • IPCT to work alongside staff to educate regarding key areas within infection prevention and control practices. • Trial of coloured disposable aprons within the clinical setting to minimise wearing of contaminated PPE in different areas. • Alcohol hand rub gel dispenser available at patient's bedside (end of bed).	**DSNs** **IPCT** **Tisbury CCU & Whiteparish AMU Clinical Leaders** **Ward Leaders**	**Immediate & ongoing – Update:** Completion of 'Confidence in Caring' audits by DSNs. **Immediate & ongoing** **September 2014 – Update:** Trial commenced in August. Good engagement from ward teams with positive feedback. 'Spot checks' of practices by ICNs and clinical leaders. Formal feedback to Matrons Monitoring Group. **Immediate – Update:** Required information e-mailed to clinical leads for action. DSNs to monitor implementation.

Cont:	Recommendations	Actions & steps	Person(s)/Lead Responsible	When by & progress update/completion
9.	**Patient Care Equipment and Environmental Decontamination:** • Review of cleaning agent and consider the implementation of a single stage cleaning regime. • Consider undertaking routine cleaning using a chlorine-releasing agent. • Terminal cleaning of infectious siderooms is available throughout the day (into the late evening). • Ensure all sideroom facilities vacated by a *C.difficile* patient are decontaminated using hydrogen peroxide, e.g. GLOSAIR 400 room decontamination system.	• Investigate other NHS Trusts cleaning policies and what chemicals/products in use and provide recommendations to IPCWG. • Submission of capital bids for additional cleaning monies for resources, if required. • Inclusion within the SDH Trust policies (including Operational Policy for Use of Hydrogen Peroxide GLOSAIR 400).	**MC** **MC** **MC**	**September 2014 – Update:** 3 other cleaning agent products identified for review by Housekeeping. Final decision to be made by the IPCWG members. **August 2014 – Update:** paper submitted to Operational Management Board (OMB) and Executive Directors. Capital bid submitted for use of microfibre (floor cleaning system). **September 2014 – Update:** To be an appendix to Strategic Cleaning Policy and approval at Infection Prevention & Control Committee in October 2014.
10.	**Education and Training:** • Review current methods of learning (including MLE) for infection prevention and control and consider reinstating 'face to face' learning for infection prevention issues specific to CDI. • Ensure 'SIGHT' mnemonic protocol is covered in induction with updates (as required) throughout 2014/15, including sampling processes for staff.	• Ensure current methods provide what is required in relation to management of CDI. • Establish how many staff have received education/training on the Trust Diarrhoeal Algorithm.	**IPCT** **IPCT**	**September 2014 – Update:** Review of Junior Doctors Handbook/teaching sessions by JH/PR. **September 2014 – Update:** as of July 2014, included within update workshops and scheduled educational sessions.

Person(s) responsible:

Julian Hemming – Infection Control Doctor (ICD) & Consultant Microbiologist
Paul Russell – Antimicrobial Lead/Consultant Microbiologist
Simon Howe – Antimicrobial Pharmacist
Emma Taylor – Principal Pharmacist
Fiona McCarthy – Senior Nurse, Infection Prevention & Control
Stephen Cotterill – Deputy ICD/Consultant Microbiologist
Amanda Urch – Housekeeping Manager
Maggie Cherry – General Manager, Facilities

Trust Board meeting **SFT3601**

SIGN UP TO SAFETY

Date: 8 December 2014

Report from: Lorna Wilkinson. Director of Nursing

Executive Summary:

Sign Up to Safety is a national campaign aimed at halving avoidable harm within the NHS over the next 3 years. Organisations are asked to sign up to 5 pledges which will strengthen patient safety. The 5 pledges are under the following headings:

- Put safety first.
- Continually learn.
- Honesty
- Collaborate
- Support

This document has been agreed through the Clinical Risk Group and Clinical Management Board and has been consulted on through various groups such as the Nursing, Midwifery, and Allied Health Forum. Following sign off by the Trust Board this document will be published on our website.

The Trust will be required to produce a delivery plan alongside this document to detail how the pledges are to be achieved; this will underpin our safety programme over the next 3 years and the work undertaken as part of the Wessex Patient Safety Collaborative.

Proposed Action:

Seek Board ratification of the Sign up to Safety pledges

Links to Assurance Framework/ Strategic Plan:

Care - We will treat our patients with care, kindness and compassion and keep them safe from avoidable harm
BAF Risk 2.2

Appendices: none

SIGN UP PACK

Welcome to Sign up to Safety

Listen, Learn, Act

Listening to patients, carers and staff, **learning** from what they say when things go wrong and take **action** to improve patients' safety.

Our vision is for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. This means taking all the activities and programmes that each of our organisations undertake and aligning them with this single common purpose. Sign up to Safety has an ambition of halving avoidable harm in the NHS over the next three years and saving 6,000 lives as a result

As Chief Executive or leader of your organisation, we invite you sign up to the campaign by setting out what your organisation will do to strengthen patient safety by

- Describing the actions your organisation will undertake in response to the five Sign up to Safety pledges (see page 3 and 4) and agree to publish this on your organisation's website for staff, patients and the public to see. You may like to share and compare your ideas before you publish – this support will be available to you.
- Committing to turn your proposed actions into a safety improvement plan which will show how your organisation intends to save lives and reduce harm for patients over the next 3 years. Again, support will be available, if you wish to access it, to assist in the description of these plans.
- Within your safety improvement plan you will be asked to identify the patient safety improvement areas you will focus on. You will be supported to identify 2 or more areas from a national menu of high priority issues and 2 or more from your own local priorities.

To officially sign up your organisation to the campaign, please complete the following sign up form and return via email to england.signuptosafety@nhs.net or post to Sign up to Safety, Skipton House, Area 2B, 80 London Road, London SE1 6LH

SIGN UP FORM

Organisation name:

In signing up, we commit to strengthening our patient safety by:

- Describing the actions (on the following pages) we will undertake in response to the five campaign pledges
- Committing to turn these actions into a safety improvement plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years.
- Identify the patient safety improvement areas we will focus on within the safety plans.
- Engage our local community, patients and staff to ensure that the focus of our plan reflects what is important to our community
- Make public our plan and update regularly on our progress against it.

Chief Executive Sponsor:

Name Signature Date

Please tell who will be the key contact in your organisation for Sign up to Safety:

Title:		First name:		Last name:	
Email:				Job title:	

The five Sign up to Safety pledges

1. Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally. ***We will***
2. Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are. ***We will***

3. Honesty. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong. ***We will***
4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use. ***We will***

5. Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

We will

FREQUENTLY ASKED QUESTIONS

1. **What is Sign up to Safety?**

   Sign up to Safety is a campaign that aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. The ambition is to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result. By signing up to the campaign organisations commit to listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.

2. **What does Sign up to Safety mean?**

   This campaign and its mission are bigger and much more important than any individual's or organisations' programmes or activities. We want to establish and deliver a single vision for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. This means taking all the activities and programmes that organisations currently own and aligning them with this single common purpose.

3. **What is different about Sign up to Safety from previous campaigns?**

   What is unique and fundamentally different is that this campaign is for everyone. It transcends organisational boundaries and will align the whole system to achieving our shared ambition. There will be no targets or 'performance management' from the centre – the energy, ideas and expertise will be found deep inside the NHS and within your organisation. The Chief Executives of NHS England, the Care Quality Commission (CQC), the NHS Trust Development Authority, Monitor, NHS Improving Quality (NHS IQ) and the NHS Litigation Authority (NHS LA) have all signed up to align their work with this campaign.

   The idea is to harness the talent and enthusiasm within organisations and connect this to others in our National Health Service.

4. **Who can sign up to the campaign?**

   Sign up to Safety is for everyone, everywhere. Whether you work in primary, secondary, or tertiary care; whether you work in acute, mental health, learning disabilities, ambulance, or community care settings;

whether you work in a national body or a general practice, Sign up to Safety applies to you.

5. **How is the campaign being organised and supported?**

A National Co-ordinating and Support Group has been established, chaired by **Sir David Dalton** who is supported by **Dr Suzette Woodward** as Campaign Director.

The following national organisations have committed to system wide support of Sign up to Safety:

- NHS England will provide expert clinical patient safety input to the development of improvement plans and framework for plan assessment. They will also play a key leadership role in the campaign and will ensure all their programmes of work described above are actively working to support the campaign.
- Monitor and the NHS Trust Development Authority will offer leadership and advice to trusts and foundation trusts who participate in Sign up to Safety and who will develop and own locally their improvement plans. They will also sign post to partner organisations for specific expertise where required.
- NHS Litigation Authority which indemnifies NHS organisations against the cost of claims, will review trusts' plans and if the plans are robust and will reduce claims, they will receive a financial incentive to support implementation of the plan. Any savings made in this way will be redirected into frontline care. This is just one way that we can tackle some of the financial costs of poor care. Any savings made in this way will be redirected into frontline care.
- The Care Quality Commission will support trusts signed up by reviewing their improvement plans for safety as part of its inspection programme. CQC will not offer a judgment on the plans themselves but consider them as a key source of evidence for Trusts to demonstrate how they are meeting the expectations of the five domains of safety and quality.
- The Department of Health will provide Government-level support to the campaign and work with the Sign up to Safety partners to ensure that the policy framework does all it can to support the campaign and the development of a culture of safer care.

6. **What support is available to organisations who sign up to the campaign?**

The National partners will work together with improvement experts to establish what a good improvement plan looks like and to support organisations to learn from each other in drawing up and delivering theirs. It is crucial that the leadership of the campaign is exercised locally but equally that this work is completely aligned with and mutually supportive of the work that is already underway or planned in relation to patient safety improvement.

In this first phase, an 'Alliance of Improvement Experts' will be asked to come together and offer provider organisations who sign up the opportunity to have improvement support and advice. The Improvement Alliance will also combine their sign up coaching with supporting the local patient safety collaborative to help enhance and align the activities of both. The level of advice and support will depend on what local organisations ask for, but the Improvement Alliance will act to bolster the development of these linked initiatives where they can, transferring skills to collaboratives and provider organisations, as well as supporting the development of the Patient Safety Fellows Programme.

Over time we expect that the Campaign will be self-supporting as capacity is created locally to harness enthusiasm and develop capability, not least through the developing patient safety collaboratives.

At the outset of the campaign a National Co-ordinating and Support Group will be established chaired by Sir David Dalton, with NHS England leadership provided by Dr Mike Durkin. The CQC, Monitor, the NHS LA and TDA will be part of the Group alongside representation from professional bodies, patient groups and improvement experts. The Group will encourage organisations to commit to the campaign and will listen to what they need for support. The Group will also work to ensure the alignment with and support the establishment of related system activities including the patient safety collaborative programme, the Patient Safety Fellows Programme and the core development and support activity of the Trust development Authority and Monitor already in place. It is crucial that this campaign is seen as bringing the activity of the whole system together with a common and urgent single purpose.

7. How should organisations get patients, families and carers involved in Sign up to Safety

We strongly encourage organisations that sign up to be actively engaging with patients in a meaningful and productive way. Patients, their families and carers have a vital role in patient safety and their perception of safety and opinions on where improvement can be made should form part of the development of the improvement plans. Their opinions are one of the most powerful influencers of other people and their choices and their voice a powerful force for change if listened to and learned from. This could be through a patient suggestion scheme, inviting patient representatives to be part of committees or forums to develop the plans, holding consultation events etc. More suggestions on including patients in the campaign are available on the website and case studies will be added as more and more organisations sign up to the campaign.

8. **How does Sign up to Safety align with other patient safety programmes and initiatives?**

The following linked initiatives to improve patient safety will be aligned with the campaign so that the whole system supports involvement.

Patient Safety collaboratives – These are regionally based safety improvement networks led by Academic Health Science Networks that will work across whole local systems and all health care sectors, to deliver locally designed safety improvement programmes drawing on recognised evidence based methods. They will begin their work later in the year. Organisations that sign up to safety can commit to join their local collaborative as part of their plan (although they are open to all organisations).

Patient safety Fellows – work is underway to create a group of 5,000 respected, enthusiastic and effective safety improvers who will become the backbone of patient safety improvement over the coming decade, making an active contribution to improving safety. The group will launch later this year and organisations who participate in Sign up to Safety are involved in the collaboratives will benefit from the expertise of the fellows and can also support their own staff to become fellows.

New National Reporting and Learning System (NRLS) – work is underway to review and re-commission the NRLS. We already have the world's most comprehensive incident reporting system and this will be developed further to make incident reporting as easy, effective and rewarding as possible, so that learning and improvement continue to grow across the system.

SAFE team – A new Safety Action for England team will be developed to provide short-term support to individual trusts in the area of patient safety. SAFE will provide trusts with a clinical and managerial resource to help to develop organisational and staff capabilities to help improve the delivery of safe treatment and care. SAFE will be piloted later this year and could help support signed up organisations, and others, who

require additional help.

Safety website – A new set of hospital patient safety data is now available on NHS Choices enabling trusts to be compared against each indicator. Putting key safety information into the public domain supporting transparency and helping patients to make informed choices about their care and exercise their right to challenge their local healthcare providers on safety issues. Organisations that have signed up to safety can use this public data to inform their plans and conversations with their local communities.

Trust Board meeting **SFT 3602**

FINANCE & PERFORMANCE COMMITTEE – MINUTES OF 20 OCTOBER 2014

Date: 8 December 2014

Report from: Nick Marsden, Chairman

Executive Summary:
The committee approved the Trust's quarter 2 governance return to Monitor. It has resumed monthly monitoring of CQUINs in view of commissioner challenges.

Proposed Action:
To note the minutes of the 20 October meeting of Finance & Performance

Links to Assurance Framework/ Strategic Plan:
2014 risk assurance framework 4.2 and 4.3 – budgetary control, savings targets, efficiency
Value – achieving financial targets including cost improvement programmes

Appendices:
Approved minutes of Finance & Performance Committee – 20 October 2014

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance and Performance Committee

Held on 20 October 2014

Present:	Dr N Marsden	Chairman
	Dr L Brown	Non-Executive Director
	Mr A Freemantle	Non-Executive Director
	Ms K Hannam	Chief Operating Officer
	Mr P Hill	Chief Executive
	Mr L Arnold	Director of Corporate Development
	Mr M Cassells	Director of Finance and Procurement
Apologies:	Mr I Downie	Non-Executive Director
In Attendance:	Mr D Seabrooke	Head of Corporate Governance
	Mrs K Stovin-Bradford (for item 6)	Business Relations Manager
	Mrs C Gorzanski (for item 7)	Head of Clinical Effectiveness
	Mrs L Wilkinson (for item 7)	Director of Nursing
	Mrs F Hill (for item 8)	Head of Risk Management

1. MINUTES – 22 SEPTEMBER 2014

The minutes of the meeting held on 22 September 2014 were agreed as a correct record.

2. MATTERS ARISING

It was noted that the Board, at its meeting on 6 October had agreed a revision to the Terms of Reference to include operational performance monitoring and a change to the committee's name.

It was noted that Dorset County Hospital NHS FT did not award a Pathology Contract following the completion of the tendering process. Informal discussions may take place regarding whether support can be given from SFT.

3. FINANCE REPORT TO 30 SEPTEMBER 2014 (MONTH 6)

The Committee received the Finance Report and it was noted that the Trust's position had deteriorated somewhat and that the stated position only appeared more favourable due to the effect of the treatment of donated assets. Results from Salisbury Trading and Odstock Medical had been shown on a break even basis.

There was increasing challenge on CQUIN from Commissioners and it was agreed that monthly monitoring of progress on CQUIN should be re-instated.

In-patient elective activity was down but day cases were up. Non-elective activity was up. The capital plan was £2.95m spent against a plan for the year of £11.98m.

There was concern that the £7m invested this year by Wiltshire CCG in the Better Care Fund did not appear to be helping SFT as there continued to be a lack of local community services and community bed provision causing significant DTOC numbers.

The Risk Assurance Framework remained 4 and the forecast out turn at this stage remained in accordance with plan.

The Committee noted the Finance Report.

4. TRANSFORMATION AND COST IMPROVEMENT

The Committee received at the meeting a copy of the Month 6 Report to be presented to the Programme Steering Group. It was noted that transformation

plans in Month 6 were £458,000 against the phased plan of £685,000. On an unphased basis the savings achieved are 54% of the required level. Directorate savings were 83% achieved against plan. Savings delivered were 41% recurring at this stage.

The Patient Flow and Out-Patients Projects had been risk areas for the Trust. The Trust was engaging with others in the south west and was receiving support from NHS Elect.

Work was underway on understanding delays arising from internal factors and it was noted that the hospital was in full escalation. There were thought to be about 70 patients with a length of stay of over 28 days of whom around half were considered to be fit to leave the hospital.

The Chairman requested an improved understanding of the position and year end forecast for cost improvement and excess income at the next meeting of the Committee.

The Committee noted the Report.

5. OPERATIONAL PERFORMANCE – MONTH 6

It was noted that the meetings of the Committee in the remainder of 2014 were set too early for a written report of the preceding month to be prepared. Dates in 2015 were set to fall later in the month.

There were concerns about the flow from A & E into the hospital with performance currently just above the 95% target which left no contingency as winter approached. Overall the Trust was achieving 18 weeks RTT Targets but with some concerns at specialty level.

6. GP REFERALS/MARKET INTELLIGENCE

The Committee received the Market Intelligence Report. It was noted that Public Health Dorset was looking to tender its Community, Contraception and Sexual Health Service and the Trust was engaging in this process against

commercial competition.

LA had attended a provider engagement event on the proposed Wiltshire Adult Community Service procurement. A competitive dialogue process was expected to start in early 2015 with the new service to start in April 2016.

The Committee noted the Market Intelligence Report.

7. CQUIN – QUARTERLY UPDATE

The Committee received the Quarterly update report on CQUINs.

The following principal points were made –

- On the three national CQUINs it was thought that the Friends and Family Test in A & E requirement would be met by the year end; the new Pressure Ulcers Indicator was determined by the median performance in the last five months of the year.
- On the Wiltshire/Dorset CQUINs there was concern that recently received information from the CCG was indicating that payments were being refused because of minor delays and minor errors in some information provided.
- Work on End of Life and Sepsis 6 was being stepped up.
- On the West Hampshire CQUINs the outpatient follow-up project was thought to be green now.
- On the National CQUINs it was noted that the new dashboards were not in place yet but background information was being collected.
- A challenging month on chemotherapy wastage had been reported due to the presence of particles in the solution. Further investigation is required as to how this has happened.

It was agreed that monthly monitoring would continue for CQUIN.

The Committee noted the report.

8. ASSURANCE FRAMEWORK/RISK REGISTER QUARTERLY REVIEW

The Committee received the Quarterly Report. There was a new gap in control around the achievement of savings plans targets in 2014/15 and it was suggested that the positive assurance around contracts with commissioners should be modified in view of the discussions around contract challenges.

9. MY TRUSTY UPDATE

The Committee received a Report giving an update on sales and marketing of the My Trusty Range. It was noted that product development and sales had been separated following the recruitment of sales agents for the UK and overseas. Discussions continued with leading retailers.

The Committee noted the report and confirmed support for the initiatives.

10. MONITOR GOVERNANCE RETURN – QUARTER 2

The Committee received the Quarter 2 return for targets and indicators.

It was agreed that the following position be reported to Monitor on C-diff attributed cases; 13, cases under review 5, total C-diff 8.

The Committee approved the Quarter 2 report for submission.

11. DATE OF NEXT MEETING

Monday 24 November 2014 at 9.30 am in the Boardroom.

SALISBURY NHS FOUNDATION TRUST **SFT 3603**

TRUST BOARD

PERFORMANCE TO 31 OCTOBER 2014

1. SUMMARY

This paper reports the financial and contracting position to 31st October 2014. It is summarised in the dashboard in appendix A.

The Trust's Income & Expenditure (I&E) position after seven months was a deficit of £368k (after adjusting for donated asset income of £432k), an adverse variance against the plan of £501k.

The main reasons for the adverse variance were:

- Cost Improvement Plans (CIPs) being behind plan by £188k.
- Agency pay spend being higher than planned.
- Non-pay adverse variances have been partly offset by over-performance income on CCG contracts and an increase in other revenues.

Summary of Key Financial Information	YTD (Cumulative)			
	Plan £000s	Actual £000s	Variance £000s	Variance %
Income	111,479	117,150	(5,671)	-5.1%
Expenditure	102,261	108,712	6,451	6.3%
EBITDA	**9,218**	**8,438**	**780**	**8.5%**
Finance Costs	8,635	8,374	(261)	-3.0%
I+E Surplus / (Deficit) including donated asset income	**583**	**64**	**519**	**89.0%**
Donated Asset Income Adjustment	450	432	**18**	**4.0%**
I+E Surplus excluding donated asset income	**133**	**-368**	**501**	**376.7%**
Favourable variance in brackets				

Under Monitor's Continuity of Service rating the Trust continues to score 4 which is the maximum.

It should not be expected that the over-performance on income will continue and therefore focus on delivery of CIPs is essential to ensure the financial target surplus for the year is achieved.

Income is ahead of plan but this has not resulted in in an improved bottom-line position due to larger increases in expenditure.

The Trust is performing well on all NHS contracts. Challenges are relatively limited however one of the main areas is in respect of day attenders and provision has been made for this. In

addition work is underway to review the cause of re-admissions to establish whether the 17% reduction currently applied is accurate.

Work is being undertaken to ensure full CQUIN payments are obtained. Discussions are ongoing on the various schemes with the commissioners and good progress is being made.

The Trust's cash position at 31 October 2014 was £14.11m, which was an increase on the September figure of £12.79m. During the month Wiltshire CCG paid £1m in respect of over-performance in the first quarter of the year. Income has been accrued for activity above contracted levels undertaken in the second quarter.

The local CCGs and NHS England have confirmed extra funding of £1.6m from the recently announced additional national money for the NHS. This will support winter pressure initiatives and the likely increase in emergency attendances and admissions.

The Trust's forecast remains unchanged at surplus of £0.8m excluding donated assets which is in accordance with plan. The outturn will be very dependent on savings being achieved.

A review of the Directorates forecast position has been undertaken with clinical and finance managers in November.

2. SALES

NHS activity revenue was ahead of plan by £1,779k due to continuing activity over-performance and un-delivered Commissioner's Quality, Innovation, Productivity & Prevention (QIPP) schemes. The Trust's main Commissioner (Wiltshire CCG) has recently approved the quarter 1 Commissioning for Quality Innovation (CQUIN) payment in full. All known penalties and fines relating to contract performance to date have been included. (see also Appendix B and D)

Contract Activity Performance 2014/15 (to 31 Oct 2014)	Actual	Actual	Trust Plan Plan	Commissioner's Plan	Actual Variance	Trust Plan Variance	Commissioner's Variance
	2013-14	2014-15	2014-15	2014-15	13/14 v 14/15	2014-15	2014-15
Elective inpatients	3,638	3,543	3,702	3,647	-95	-159	-104
Elective PSDs/day attenders	15,975	16,571	15,690	15,489	596	881	1,082
Non Elective Activity	14,545	14,988	14,613	14,474	443	375	514
Outpatient initial attendances	35,709	37,688	37,388	37,388	1,979	300	300
Outpatient follow-up attendances	71,039	67,617	70,001	70,001	-3,422	-2,384	-2,384
Outpatient procedures	20,887	21,477	23,709	23,709	590	-2,232	-2,232
A&E attendances	26,004	26,844	25,738	25,738	840	1,106	1,106

Other clinical activities income and other operating income were ahead of plan by £1,869k and £1.622k respectively, and this relates to clinical and non-clinical services provided to other NHS organisations, Road Traffic Accident (RTA) and overseas patient income.

3. COST OF SALES

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 total for all Directorates was an overspend position of £1,553k. The position is summarised below:

Directorates	In Month			Year to Date (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Medicine	3,344	3,443	99	22,522	22,916	394
Musculo Skeletal	2,654	2,660	6	18,202	18,254	52
Surgery	2,876	2,931	55	20,091	20,282	191
Clinical Support & Family Services	2,668	2,717	49	19,736	20,185	449
Facilities	383	367	(16)	2,696	2,658	(38)
Other Directorates	1,725	1,913	188	14,113	14,618	505
TOTAL	**13,650**	**14,031**	**381**	**97,360**	**98,913**	**1,553**

At the end of Month 7 nursing and healthcare assistants budgets were underspent by £210k, compared to £73k underspend last month. In Month 7 £71k was spent on specialing patients compared to £67k in Month 6, the main areas that have used specialing were Winterslow Ward and the Burns Unit.

The year to date spend was £25,414k on nurses and healthcare assistants compared to £25,095k for the same period last year, an increase of £319k.

The use of Agency staff for nursing and healthcare assistants was £1,607k compared to £2,156k for last year a decrease of £549k. Work continues to reduce agency spend further.

At the end of Month 7, Medical budgets were overspent by £346k, compared to £223k at the end of month 6.

The year to date spend on medical staff is £19,416k compared to £19,195k for the same period last year, an increase of £221k.

The use of Agency staff for consultants and staff grades is £1,023k, compared to £350k for the same period last year, an increase of £673k.

The agency cost for doctors in training was £774k, compared to £693 for the same period last year, an increase of £81k.

The Medical Director and HR, are currently in discussion with various agencies to explore obtaining medical staff from overseas.

4. COST IMPROVEMENT PLANS

The total cost improvement savings target for the year is £9.0m which includes revenue generation and expenditure reduction schemes. Monitor requires revenue generation and expenditure reduction to be separately reported. It should be noted that the £9.0m included £1m for a reduction in agency spend which was to reduce overspending rather than baseline budgets.

The Trust has achieved savings of £2,709k against a phased planned target of £2,897k a shortfall of £188k (6.5%). The majority of the shortfall relates to slippage on transformation schemes. On a straight line basis the Trust is £2,541k below where it should be.

It is recognised the CIP Programme is significantly back loaded which increases the average monthly savings run rate required to achieve the planned target. Considerable work is needed to ensure the planned savings are achieved.

5. STATEMENT OF FINANCIAL POSITION (see Appendix E)

a. Non-Current Assets

Property, Plant and Equipment increased in the month by £677k, mainly as a result of expenditure on the capital programme rising from £2.95m at September 2014 to £4.37m at October 2014.

b. Current Assets

Trade and other payables rose from £15.21m to £17.17m as a result of an increase in amounts owed to suppliers and the October accrual for the Public Dividend Capital. The latter is payable in two instalments each year. The next payment is due in March 2015 and will cover the period from 1 October 2014 to 31 March 2015.

c. Cash

The Trust's cash position at 31 October 2014 was £14.11m, which was an increase on the September figure of £12.79m. During the month Wiltshire CCG paid a September dated invoice for £1m in respect of over-performance in the first quarter of the year.

Cash is monitored on a daily basis and surplus cash is invested in the National Loan Fund scheme.

6. CAPITAL EXPENDITURE

Expenditure for the year to 31 October 2014 was £4,365k, leaving a further £7,687k to be spent for the year. Details are shown in Appendix C.

The Capital Programme plan has been revised for the year to £12,052k. All schemes continue to be reviewed to ensure expenditure profiles are understood. There is likely to be slippage on the Capital Programme in 2014-15.

7. FINANCIAL RISKS

The Trust's key financial risks for 2014-15 can be summarised as follows:

- Deliver the CIP target – the greatest financial challenge;
- Meet contractual obligations and avoid penalties such as for CDiff;
- Delivery of CQUIN targets;

- Manage budgets effectively particularly in respect of: nursing agency and 'specialing' costs, and locum doctors and additional payments to doctors;

- Match capacity to demand in the most cost effective way in order to avoid losing work to local competitors.

8. OTHER ISSUES

- The funding for resilience and ED support work of £1.6m has been agreed with NHSE and local Commissioners and will be paid in December;

- The Wiltshire CCG has supported the Better Care Fund (BCF) by £7m however the Trust continues to struggle with high numbers of Delayed Transfer of Care (DTOCs) and lack of local community service provision in terms of staffing, social worker input, and beds. It is not clear what the investment in the BCF has or will achieve;

- Discussions are taking place with Wiltshire CCG regarding the possible provision of step up/down beds on the hospital site but in the short term we do not have bed capacity and therefore this may be a development which could happen on the south of the site over the next two years.

9. CONCLUSIONS

The deficit after seven months of the financial year was £368k representing an adverse variance against the plan of £501k. Delivery of CIPs is behind plan and must improve to achieve the financial plan surplus of £0.8m. Nevertheless the achievement of the plan is considered to be realistic.

10. RECOMMENDATIONS

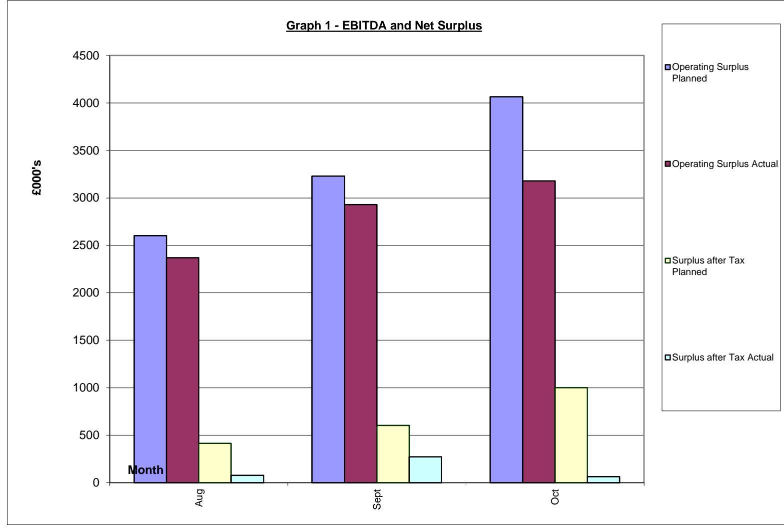
The Trust Board is asked to note the report.

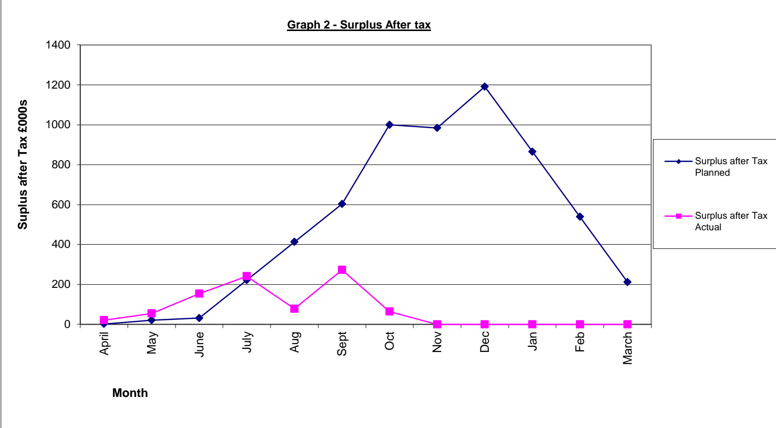
Malcolm Cassells

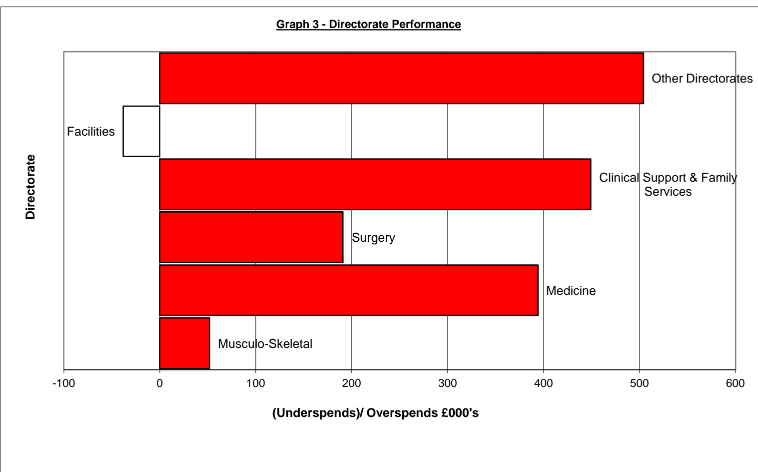
Director of Finance and Procurement

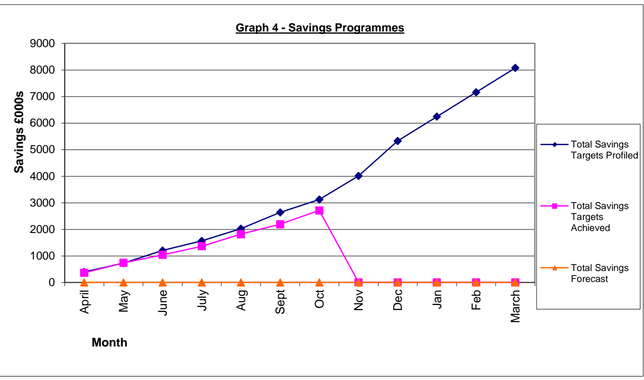
30 November 2014

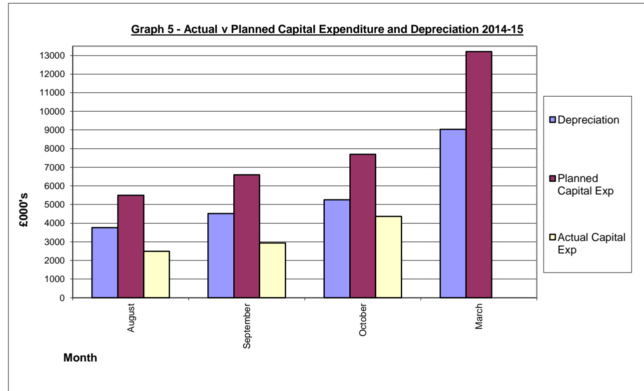
APPENDIX A - FINANCIAL PERFORMANCE DASHBOARD - to 31 OCTOBER 2014

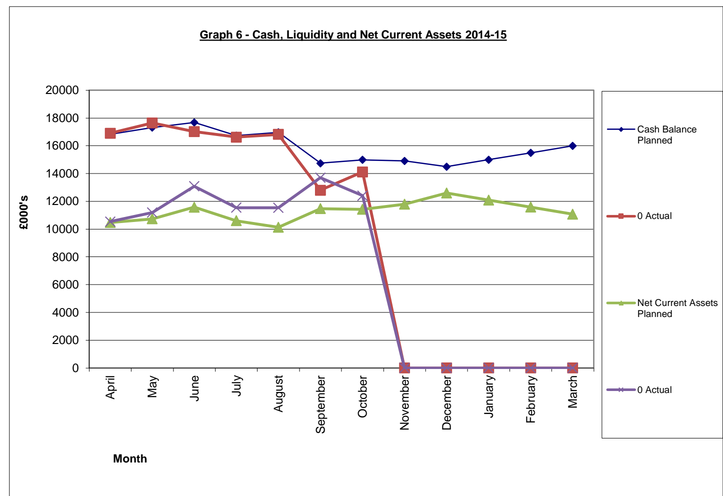












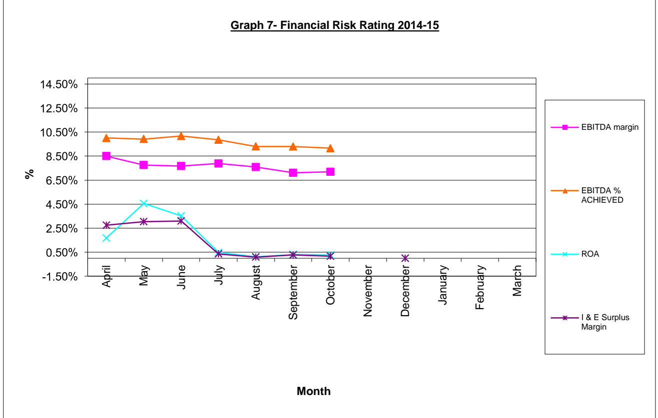


Table 2 New FRR

Ratio	Description	Planned Risk Score	Actual			Rating	Risk Ratings Weight
Capital Service Capacity	Revenue Avaliable for Debt Service Divided by Capital Service Costs	4	8538.00 / 3245.00	=	2.63	3	50%
Liquidity	cash for liquidity purposes/operating expenses * no. of days in period	4	9159.00 / 108712.00	=	17.69	4	50%
Total Weighted Score		4.0				3.5	100%

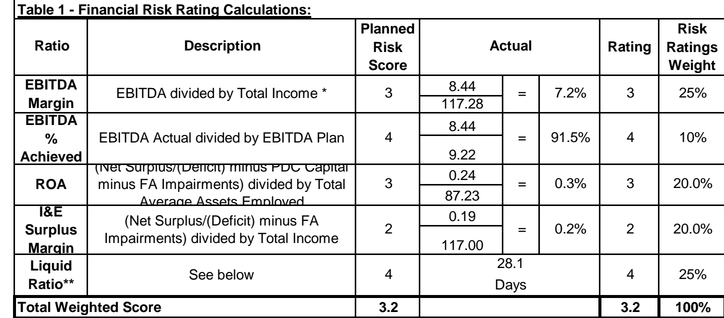
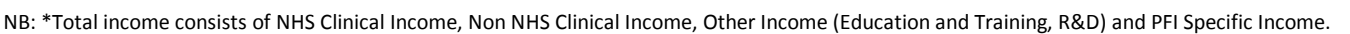


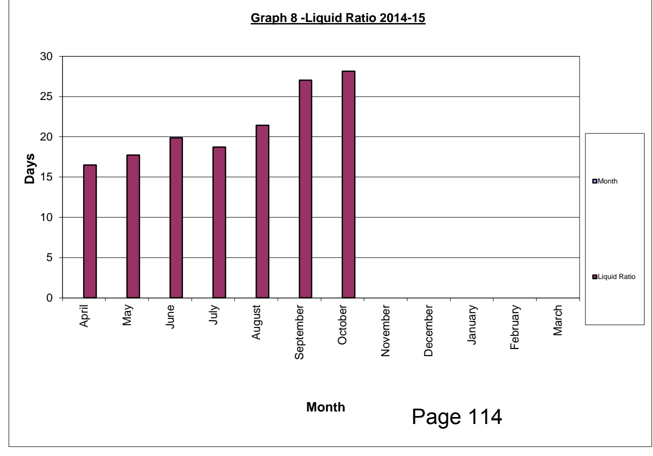
Table 1 - Financial Risk Rating Calculations:

Ratio	Description	Planned Risk Score	Actual			Rating	Risk Ratings Weight
EBITDA Margin	EBITDA divided by Total Income *	3	8.44 / 117.28	=	7.2%	3	25%
EBITDA % Achieved	EBITDA Actual divided by EBITDA Plan	4	8.44 / 9.22	=	91.5%	4	10%
ROA	(Net Surplus/(Deficit) minus PDC Capital minus FA Impairments) divided by Total Average Assets Employed	3	0.24 / 87.23	=	0.3%	3	20.0%
I&E Surplus Margin	(Net Surplus/(Deficit) minus FA Impairments) divided by Total Income	2	0.19 / 117.00	=	0.2%	2	20.0%
Liquid Ratio**	See below	4	28.1 Days			4	25%
Total Weighted Score		3.2				3.2	100%



NB: *Total income consists of NHS Clinical Income, Non NHS Clinical Income, Other Income (Education and Training, R&D) and PFI Specific Income.

NB: The liquidity ratio is defined as cash plus trade debtors plus unused working capital facility minus (trade creditors plus other creditors plus accruals) expressed in number of days operating expenses that could be covered.



APPENDIX B - ACTIVITY & INCOME

ACTIVITY	Year to date - October 2014								
	PLANNED SAME DAY			ELECTIVE IN-PATIENT			NON-ELECTIVE IN-PATIENT		
	Plan Spells	Actual Spells	Variance Spells	Plan Spells	Actual Spells	Variance Spells	Plan Spells	Actual Spells	Variance Spells
Clinical Commissioning Groups (CCGs)									
Wiltshire	8,924	9,629	(705)	2,004	1,988	16	6,930	9,951	(3,021)
Dorset	1,713	1,822	(109)	518	538	(20)	1,347	1,763	(416)
West Hampshire	1,207	1,302	(95)	377	374	3	1,166	1,363	(197)
Other CCGs	214	208	6	208	182	26	298	310	(12)
TOTAL CCGs	**12,058**	**12,961**	**(903)**	**3,107**	**3,082**	**25**	**9,741**	**13,387**	**(3,646)**
NHS England (NHSE)									
Specialist Commissioning	2,326	2,484	(158)	180	196	(16)	219	284	(65)
Dental	487	590	(103)	82	75	7	86	82	4
Military	397	383	14	137	116	21	687	820	(133)
Offender Health	27	26	1	5	2	3	36	39	(3)
TOTAL NHS England	**3,237**	**3,483**	**(246)**	**404**	**389**	**15**	**1,028**	**1,225**	**(197)**
Non Contracted Activity	99	127	(28)	90	72	18	317	376	(59)
Balance to Trust Annual Plan	93	0	93	45	0	45	3,389	0	3,389
Total Activity	**15,487**	**16,571**	**(1,084)**	**3,646**	**3,543**	**103**	**14,475**	**14,988**	**(513)**

INCOME	Year to Date (Income)		
	Plan £000s	Actual £000s	Variance £000s
Elective inpatients	11,605	11,033	572
Day cases/day attenders	11,910	12,447	(537)
Non Elective Inpatients	30,168	29,813	355
	16,695	15,291	1,404
A&E	2,779	3,017	(238)
Direct Access	3,907	4,731	(824)
Drugs	6,325	7,908	(1,583)
Critical Care	3,640	3,055	585
Maternity	5,210	5,249	(39)
Other	4,844	6,197	(1,353)
CQUIN	1,942	2,063	(121)
TOTAL NHS CLINICAL INCOME	**99,025**	**100,804**	**(1,779)**

Excludes Emergency Winter Monies and £150k worth of MRET reinvestment

APPENDIX C - CAPITAL EXPENDITURE

Project Name	14/15 Board Approved + 13/14 final slippage - 13/14 b/fwd	Adjustments to final Plan	Slippage to 2015/16	Revised Plan	Spend to 31st October 2014	(Under) / Over spent on Project	Outstanding Spend 2014/15
	£	£	£	£	£	£	£
Donated Assets							
Benson Suite - Donated	16,138	0	0	16,138	5,895		10,242
NICU / Parents Accommodation - Donated Assets	15,769	0	0	15,769	0		15,769
Small Donated Additions	0	67,385	0	67,385	67,385		(0)
Spinal Refurb ADL Bathroom (LoF contribution)	0	10,792	0	10,792	0		10,792
Donated Assets - Totals	**31,907**	**78,177**	**0**	**110,083**	**73,280**	**0**	**36,803**
Phase 3 Building Schemes							
CT Scanner Building and Enabling	149,470	165,530	0	315,000	167,677		147,323
Helter Skelter Storage	150,000	0	0	150,000	0		150,000
Laundry Buildings	56,636	0	0	56,636	6,432		50,204
Maternity - DoH Grant	30,367	0	0	30,367	56,749	26,382	(52,764)
Radnor Ward Development	1,168,000	60,000	0	1,228,000	382,621		845,379
Springs entrance development	1,389,924	30,000	(1,000,000)	419,924	91,361		328,563
Ward changes - Dementia Patient Care	627,156	0	0	627,156	578,197		48,959
Building Schemes - Totals	**3,571,553**	**255,530**	**(1,000,000)**	**2,827,083**	**1,283,037**	**26,382**	**1,517,664**
Building and Works							
Accommodation - Langley House Kitchen Upgrade	29,000	0	0	29,000	14,701		14,299
Accommodation - Replacement glazing units	3,023	0	0	3,023	2,062		961
Accommodation & Leisure Centre Boilers	75,928	(5,300)	0	70,628	69,461		1,167
Accommodation key security	7,000	0	0	7,000	0		7,000
AGSS Overhaul & Med Gas Racking	15,000	(15,000)	0	0	0		0
AHU replacement yr 3 (2014/15) of 7	420,593	3,034	0	423,627	209,630		213,997
Asbestos management	22,217	0	0	22,217	3,995		18,222
BMS upgrade 3rd year of 3 - invest to save	42,679	0	0	42,679	0		42,679
Catering boiling pan replacement	3,153	0	0	3,153	0	(3,153)	6,306
Catering Dishwasher	126,000	0	0	126,000	0		126,000
Catering - Oven Replacement	0	22,000	0	22,000	14,679		7,321
Catering refrigeration upgrade	27,427	(17,427)	0	10,000	0		10,000
Catering Replacement Cooking Equipment	9,175	0	0	9,175	0	(9,175)	18,350
Catheter Suite - Rebalance of Heating System	20,000	0	0	20,000	0		20,000
Central Clinical Notes Preparation	0	9,800	0	9,800	0		9,800
Childrens OPD Audiology Soundproof Room	72,043	0	0	72,043	50,384		21,659
Decentralisation of Boilers	0	263,200	0	263,200	269,741	6,541	(13,082)
DSU Replacement Insulation to Air Handling System	8,600	0	0	8,600	0		8,600
DSU Roof Repairs	0	20,000	0	20,000	0		20,000
DSU Theatres - Flooring	1,882	0	0	1,882	0		1,882
Ductwork & Fire Damper Cleaning Whole Site 2nd year of 2	189,508	0	(80,000)	109,508	5,553		103,955
ED Data Centre Ventilation	40,000	0	0	40,000	1,047		38,953
Education Centre Reception DDA Compliance	8,000	0	0	8,000	5,446		2,554
Electricity at Work Regulations Compliance - Year 3 (2013/14) of 3	133,505	0	(30,000)	103,505	73,193		30,313
Endoscopy Ensuite Enema Room	30,000	0	0	30,000	29,439		561
Eye clinic expansion	4,377	0	0	4,377	0		4,377
Fertility Air Conditioning	12,000	5,000	0	17,000	16,614		386
Finance fire alarm system upgrade	21,600	0	0	21,600	0		21,600
Finance Office Refurbishment	(1,899)	1,899	0	0	0		0
Fire alarms - detection & prevention equip - various	5,548	10,000	0	15,548	10,074		5,475
Fire compartmentation SDH north - remedial works	58,013	(10,000)	0	48,013	0		48,013
Fire Suppression to Transformer Rooms	41,628	0	0	41,628	16,767		24,861
Gas mains test	7,000	0	0	7,000	7,848	848	(1,696)
Genetics Air Conditioning	11,000	(5,000)	0	6,000	2,365		3,635
Hedgerows - Public WC's Refurbishment	2,598	(2,598)	0	(0)	0		(0)
Hedgerows extension	14,935	(14,935)	0	0	0		0
Hot Water Pipes - SDH Various Areas	165,990	(140,000)	0	25,990	0		25,990
IVF lab. Ventilation system modifications	854	0	0	854	0		854
Legionella risks	85	0	0	85	0		85
Level 2 Flooring	98,721	(68,721)	0	30,000	0		30,000
Level 4 Bedspace Power Sockets	69,460	(7,000)	0	62,460	850		61,610
LIfts overhaul - year 3 (2014/15) of 3	156,298	25,000	(50,000)	131,298	120,142		11,156
Main Entrance L3 Upgrade	54,556	20,000	0	74,556	62,354		12,202
Main Theatres 4th Laminar Flow System	185,000	0	(185,000)	0	0		0
Maternity Obstetric Theatre Refurbishment	78,000	0	0	78,000	0		78,000
Maternity Post Natal Upgrade	122,000	0	0	122,000	0		122,000
Maternity Relocation - Enabling	1,622	0	0	1,622	0		1,622
Mattress Laundering	2,521	0	0	2,521	0		2,521
MDMC Infusion Device Analyser	8,000	0	0	8,000	7,824		176
Medical Air (Dryers) SDH North	4,120	0	0	4,120	0		4,120
Medical Gas Hoses 1st year of 2 (2014/15)	66,000	15,000	(40,000)	41,000	0		41,000
Medical Gas System	3,456	0	0	3,456	0	(3,456)	6,912
Microbiology - Category 3 Room	58,164	(13,034)	(3,600)	41,530	41,530		(0)
Mortuary electrical installation compliance	11,673	7,000	0	18,673	12,221	0	6,453
Mortuary Refrigeration	15,901	0	0	15,901	10,109	(5,792)	11,584
Noise Reduction & Facilities Equipment	29,488	0	0	29,488	0		29,488
Nurse Call System Upgrade - SDH North & Maternity - 2nd year of 2	173,397	0	(75,000)	98,397	39,076		59,321
Occupational Health Replacement Boilers	1,068	0	0	1,068	0		1,068
Oral Surgery - Theatre 9 (plus more dental chairs)	44,659	(44,538)	0	120	120		0
Pathology & Histopathology OSNA Room (4.5.20) Air Conditioning	4,973	0	0	4,973	0		4,973
Piped medical gas system safety valves replacement	3,683	0	0	3,683	0	(3,683)	7,366
Procurement Out of Hours Bay	5,642	0	0	5,642	6,919	1,277	(2,554)
Productive Operating Theatres	27,415	0	0	27,415	8,873		18,542
Public & Staff WCs L5,L4,L3	84,000	2,598	0	86,598	0		86,598
Public Spaces Fund	18,404	0	0	18,404	224		18,180
Radiology Recovery Area Improvements	60,000	(10,000)	0	50,000	42,572		7,428
Relocation of Liquid Oxygen VIE Plant	28,148	0	0	28,148	0		28,148
Rheumatology temperature control	17,079	0	0	17,079	0		17,079
Roads and paving repairs	160,949	0	0	160,949	0		160,949
Roof Repairs - Various	20,866	0	0	20,866	28,098	7,232	(14,464)
SDH Main Chillers Replacement	26,812	0	0	26,812	1,767		25,046
SDU X 2 Washers	100,000	52,000	0	152,000	0		152,000
Security Improvements 2013/14	35,431	0	0	35,431	18,025		17,406
Server Rooms - Air Conditioning	41,522	0	0	41,522	0		41,522
Shower Cubicle Drainage Improvements	30,000	0	0	30,000	0		30,000
Site Signage 2013/14	3,580	0	0	3,580	689		2,892
Spinal treatment centre refurbishment	189,935	0	0	189,935	10,925		179,010
Spinal Unit - wheelchair cleaning and storage	3,370	0	0	3,370	3,818	448	(896)
Spinal Unit Double Glazing 1st yeat of 2 (2014/15)	60,000	0	0	60,000	0		60,000
Spinal Unit Fire Escape	17,000	0	0	17,000	0		17,000
Spinal X-ray booking facilities and doors	28,677	0	0	28,677	26,642		2,035
Theatres 1 - 10 Replacement Taps	4,051	0	0	4,051	3,256		794
Walls - repairs to failing walls	8,000	0	0	8,000	0		8,000
Wessex Rehab Windows and Cladding	11,466	0	0	11,466	0		11,466
Wilton Ward Winter Pressures 13/14 (Block 79)	33,924	0	0	33,924	0		33,924
Building Projects/Building and Works Totals	**3,837,494**	**102,978**	**(463,600)**	**3,476,871**	**1,249,032**	**(8,913)**	**2,236,753**

Project Name	14/15 Board Approved + 13/14 final slippage - 13/14 b/fwd £	Adjustments to final Plan £	Slippage to 2015/16 £	Revised Plan £	Spend to 31st October 2014 £	(Under) / Over spent on Project £	Outstanding Spend 2014/15 £
Information Technology							
Abdominal Aortic Aneurysm (AAA) Project	(0)	0	0	(0)	0		(0)
ACS Licences	12,000	0	0	12,000	0		12,000
AD Upgrade to 2008	28,827	4,461	0	33,288	33,288		0
Allocate' Roster System	39,168	0	0	39,168	39,000		168
Auditbase link to iPM	20,000	0	0	20,000	0		20,000
Backup Tape Library Replacement	52,000	0	0	52,000	11,513		40,487
Blood Tracking	17,491	0	0	17,491	0		17,491
Blood Tracking Phases 1 - 3	337,177	0	0	337,177	0		337,177
BMS Network Upgrade	31,955	0	0	31,955	0		31,955
Brocade Switch Replacement	7,513	0	0	7,513	1,069		6,444
Clikview Reporting System	80,000	0	0	80,000	0		80,000
Clinical Coding Encoder	23,692	0	0	23,692	8,788		14,904
Community Midwifery system trial	35,748	0	0	35,748	0		35,748
Connectivity Upgrade for Warminster & Shaftesbury	42,000	0	0	42,000	0		42,000
COSD - Cancer Database	24,000	0	0	24,000	20,000		4,000
Dell Kace Push Software	1,437	0	0	1,437	267		1,170
Desktop PC Windows 7 Upgrade	12,472	0	0	12,472	2,354		10,118
Diabetic Retinopathy Screening	1,621	0	0	1,621	2,630		(1,009)
EDCR-Changes to improve air flow and balance	9,500	0	0	9,500	0		9,500
Edge Security replacement	0	3,050	0	3,050	0		3,050
Electronic Letters	24,160	0	0	24,160	3,017		21,143
EPMA (Yr 2 (2014/15) of 7)	152,438	0	0	152,438	51,053		101,385
Estates Management Information System	5,000	6,000	0	11,000	5,463		5,537
Exchange 2010 Upgrade	23,301	(5,000)	0	18,301	16,351		1,949
Genetics High Spec Analysis Equipment & Software	86,000	0	0	86,000	0		86,000
Histopathology Hardware	20,000	0	0	20,000	2,235		17,765
Inhouse development team - applications, databases and Dashboards (subject to bus case)	92,176	0	(92,176)	0	0		0
iPad Security	22,000	0	0	22,000	21,840		160
Lab Medicine-Tpath to Nxt Gen	0	0	0	0	0		0
Maternity PC & Screens Replacement	22,000	0	0	22,000	724		21,276
Mobile Computing	76,332	0	0	76,332	23,366		52,966
Moorefield's Eye Hospital Software	27,000	(27,000)	0	0	0		0
Network Load Balancers	36,000	(2,511)	0	33,489	7,069		26,420
Network Upgrade Consultancy	91,500	0	0	91,500	0		91,500
Neurophysiology Project	4,446	0	0	4,446	0		4,446
Nexus 5 Expansion	49,000	0	0	49,000	455		48,545
Open Eyes System	40,152	27,000	0	67,152	1,738		65,413
Order Comms (includes System Admin Bid & Sexual Health Bid)	22,889	0	0	22,889	7,624		15,265
PACS Reprocurement	78,940	(2,169)	0	76,771	5,435		71,337
Palliative Care EPR	4,437	35,000	0	39,437	0		39,437
PAS 2016 Replacement - Consultancy Costs	70,000	0	0	70,000	37,324		32,676
Patient Observations Monitoring and Decision Support/Early Warning System/POET	267,383	0	0	267,383	69,983		197,400
Patient Tracking	1,253	0	0	1,253	1,015		238
Radiologists 'on-call' Laptops	12,000	2,169	0	14,169	14,168	(1)	2
Radiology - OrderComms	71,257	0	0	71,257	2,219		69,038
Radiology Replacement PC's	10,000	0	0	10,000	0		10,000
RAM Asset Maintenance Module	1	0	0	0	2,639	2,639	(5,278)
Results System in GP Practices 'Review' System	30,000	0	0	30,000	10,322		19,678
RIS patient self check in	7,848	0	0	7,848	6,250		1,598
SBAR for PAS	0	100,000	0	100,000	4,455		95,545
SBAR re NACS Update to ED Symphony	0	7,500	0	7,500	0		7,500
Scanned Health Rtecords	7,418	0	0	7,418	5,100		2,318
SDU Quality System	0	12,600	0	12,600	5,126		7,474
SLAM	805	0	0	805	0		805
Sophos Renewal	0	0	0	0	0		0
Telecomms Voice Over IP - invest to save	16,397	0	0	16,397	0		16,397
Telepath enhancements	46,365	0	0	46,365	8,000		38,365
Telepath to NexGen (Phase 3 of 4 2014/15)	75,000	(75,000)	0	0	0		0
Theatre management system - balance	1,496	0	0	1,496	0		1,496
Upgrade of low spec equipment (680 machines)	0	71,340	0	71,340	36,747		34,593
UPS Replacement Programme	26,036	0	0	26,036	6,357		19,679
UPSs - Room based for Computer Rooms	27,000	0	0	27,000	5,850		21,150
VMWare Upgrade	20,000	0	0	20,000	170		19,830
Wireless Expansion	2,710	0	0	2,710	128		2,582
Information Technology Totals	**2,347,341**	**157,440**	**(92,176)**	**2,412,604**	**481,133**	**2,638**	**1,928,833**
Medical Devices							
Anaesthetic Machines	100,000	0	0	100,000	0		100,000
B-Braun Review of Theatre Instruments	300,000	0	(200,000)	100,000	42,389		57,611
BED replacement programme - 2nd (2014/15) yr of 4	193,885	0	0	193,885	193,231		653
Birthing Beds x8	60,000	0	0	60,000	60,000		0
Clinical Radiology 2 x Ultrasound	160,000	0	0	160,000	0		160,000
DSU Operating Theatre Lights	110,000	0	0	110,000	68,169		41,831
ED Trolleys x 20	0	66,347	0	66,347	0		66,347
Fertility - Time Lapse Imaging (Primo Vision) x 2 Cameras	0	74,802	0	74,802	74,854	52	(104)
Fluoroscopy Loop System in Room 7	0	9,750	0	9,750	9,570	(180)	360
Foetal Heart Monitors X 6	7,531	0	0	7,531	0		7,531
ICSI Rig	0	0	0	0	0		0
Laparoscopic instrumentation	53,902	0	0	53,902	0		53,902
Laser Holmium Yag Machine - Urology	50,000	42,085	0	92,085	92,085		0
Maternity Theatre Equipment	63,000	0	0	63,000	54,631		8,369
Medical Equipment < £50k 12/13	73,800	(66,347)	0	7,453	35,286	27,833	(55,666)
Medical Equipment < £50k 13/14	115,234	0	0	115,234	3,033		112,201
Medical Equipment <£50k 14/15	350,000	5,580	0	355,580	150,886		204,694
Orthodontics & Oral Surgery Cone Beam CT Scanner	110,000	0	0	110,000	0		110,000
Patient monitoring and stations 2nd phase of 2	55,392	0	0	55,392	46,125		9,267
Patient trolleys x 14 + 1 Radiology	69,000	0	0	69,000	66,517		2,483
Replacement Mattresses (x 15)	0	30,000	0	30,000	4,963		25,037
Retinal Screening Equipment	0	38,981	0	38,981	34,596	(4,385)	8,770
Revenue Grouped Items 2013/14	25,525	(17,794)	0	7,731	7,731		(0)
Revenue Grouped Items 2014/15	100,000	17,794	0	117,794	44,914		72,880
Rigid hysteroscopes x 4 plus stack	39,842	0	0	39,842	19,048		20,794
Scopes	0	0	0	0	0		0
Spinal Bed	0	9,600	0	9,600	0		9,600
Vascular Unit Ultrasound Machine	90,000	0	0	90,000	0		90,000
Ventillators Programme - 1st year of 5 (2014/15)	60,000	0	0	60,000	0		60,000
Zimmer Meshers & Dermatones	4,382	0	0	4,382	0	(4,382)	8,764
Medical Equipment Totals	**2,191,493**	**210,798**	**(200,000)**	**2,202,291**	**1,008,030**	**18,938**	**1,175,323**
Other							
Bed Stacking - Feasibility	0	3,000	0	3,000	0		3,000
Car Park Machinery	30,000	(30,000)	0	0	0		0
Catering Trolley Replacement x20	4,652	0	0	4,652	0		4,652
Drinking Water Stations	700	0	0	700	0		700
Efficiency schemes	338,370	(135,400)	0	202,970	1,037		201,933
Endoscope Vacuum Pack System	0	35,000	0	35,000	0		35,000
Finance systems 2011/2012	40,170	0	0	40,170	0		40,170
Fire Safety Training Equipment	820	0	0	820	0		820
Forklift Truck Replacement - Procurement	17,500	0	0	17,500	17,465		35
LED Lighting	81,675	0	0	81,675	14,608		67,066
Microfibre Cleaning	44,000	(44,000)	0	0	0		0
Outpatient Kiosks	198,000	0	0	198,000	79,191		118,809
Phhotovoltaic's / Solarthermal PV	49,276	6,007	0	55,283	42,059		13,224
Project costs 2013/14	14,715	0	0	14,715	11,964		2,751
Staff Accommodation Fire Door Closers	0	16,000	0	16,000	15,685		315
Telecoms Trunk Lines	0	10,000	0	10,000	0		10,000
TRV's (details to be taken to CapCG Oct mtng)	17,500	(17,500)	0	0	0		0
Voltage Optimization	94,705	(6,007)	0	88,698	88,699		(0)
Ward Waste Bins	141,839	0	0	141,839	0		141,839
Other Totals	**1,073,921**	**(162,900)**	**0**	**911,021**	**270,707**	**0**	**640,313**
TRUST TOTALS	**13,053,709**	**642,023**	**(1,755,776)**	**11,939,954**	**4,365,219**	**39,045**	**7,535,690**
Outside of Trust Sourced Funding							
Laundry Equipment	112,500	0	0	112,500	0	112,500	0
TOTAL CAPITAL PROGRAMME	**13,166,209**	**642,023**	**(1,755,776)**	**12,052,454**	**4,365,219**	**151,545**	**7,535,690**

APPENDIX D - STATEMENT OF COMPREHENSIVE INCOME

Actual Year 2013/14 £M		ANNUAL PLAN 2014/15 £M	Plan October YTD £m	Actual October YTD £m	Variance October YTD £m
	OPERATING INCOME				
	NHS Clinical Revenue				
18.086	Tariff revenue	19.494	11.391	10.919	(0.472)
0.096	Non-Tariff revenue	0.107	0.062	0.114	0.052
18.182	**Elective activity revenue, Total**	**19.601**	**11.453**	**11.033**	**(0.420)**
	Elective day case patients (Same day)				
15.177	Tariff revenue	15.460	9.034	10.159	1.125
0.894	Non-Tariff revenue	1.209	0.705	0.674	(0.031)
16.071	**Elective Day Case activity revenue, Total**	**16.669**	**9.739**	**10.833**	**1.094**
	Non-Elective patients				
47.150	Tariff revenue	40.178	23.524	23.186	(0.338)
14.362	Non-Tariff revenue	10.874	6.343	6.627	0.284
61.512	**Non-Elective activity revenue, Total**	**51.052**	**29.867**	**29.813**	**(0.054)**
	Outpatients				
23.688	Tariff revenue	25.675	15.003	13.738	(1.265)
1.440	Non-Tariff revenue	2.577	1.503	1.553	0.050
25.128	**Outpatients activity revenue, Total**	**28.252**	**16.506**	**15.291**	**(1.215)**
	A&E				
4.759	Tariff revenue	4.694	2.748	3.017	0.269
0.000	Non-Tariff revenue	0.000	0.000	0.000	0.000
4.759	**A&E activity revenue, Total**	**4.694**	**2.748**	**3.017**	**0.269**
	Other NHS activity				
0.000	Direct access & Op, all services	2.760	1.610	2.356	0.746
0.000	Unbundled chemotherapy delivery	0.888	0.518	0.623	0.105
0.000	Unbundled external beam radiotherapy	0.000	0.000	0.000	0.000
0.000	Maternity Pathway tariff	8.800	5.133	5.249	0.116
1.438	Other tariff revenue	0.258	0.178	0.114	(0.064)
1.438	**Tariff revenue, Total**	**12.706**	**7.439**	**8.342**	**0.903**
0.000	CQUIN revenue	3.280	1.913	2.063	0.150
0.000	Diagnostic tests & Imaging revenue outside tariff	3.852	2.247	2.375	0.128
0.000	Critical care (outside tariff) Adult, Neonate, Paediatric	6.160	3.593	3.055	(0.538)
0.000	High cost drugs revenue from commissioners	10.704	6.244	7.908	1.664
0.000	Other drugs revenue (all types all bands including Chemotherapy)	0.000	0.000	0.000	0.000
33.335	Other non-tariff revenue	12.469	7.274	7.074	(0.200)
33.335	**Non-Tariff revenue, Total**	**36.465**	**21.271**	**22.475**	**1.204**
34.773	**Other NHS activity revenue, Total**	**49.171**	**28.710**	**30.817**	**2.107**
110.298	Total NHS Tariff income	118.207	69.139	69.361	0.222
50.127	Total NHS Non-Tariff income	51.232	29.886	31.443	1.557
160.425	**NHS Clinical Revenue, Total**	**169.439**	**99.025**	**100.804**	**1.779**
	Non Mandatory/Non protected revenue				
1.807	Private patient revenue	0.740	0.430	1.028	0.598
4.502	Other Non Mandatory/Non protected clinical revenue	3.700	2.158	3.429	1.271
6.309	**Non Mandatory/Non protected revenue, Total**	**4.440**	**2.588**	**4.457**	**1.869**
	Other Operating Revenue				
0.743	Research and development revenue	0.726	0.424	0.500	0.077
4.796	Education and training revenue	5.100	2.975	3.318	0.343
1.042	Donations& Grants received of PPE & intangibles	1.200	0.000	0.000	0.000
1.128	Parking revenue	1.280	0.747	0.795	0.048
0.848	Catering revenue	0.850	0.500	0.522	0.022
1.210	Accommodation revenue	1.280	0.747	0.766	0.019
1.682	Revenue from non-patient services to other bodies	5.960	3.277	4.420	1.143
5.244	Misc. other operating revenue	1.280	0.747	1.136	0.389
16.693	**Other Operating revenue, Total**	**17.676**	**9.415**	**11.457**	**1.622**
183.427	**Operating Revenue, IFRS, Total**	**191.555**	**111.029**	**116.718**	**5.689**

Actual Year 2013/14 £M		ANNUAL PLAN 2014/15 £M	Plan October YTD £m	Actual October YTD £m	Variance October YTD £m
	OPERATING EXPENSES				
	Raw Materials and Consumables Used				
-14.273	Drugs	-16.350	-9.558	-9.669	(0.111)
-17.185	Clinical supplies	-18.068	-10.562	-12.064	(1.502)
-17.090	Non-clinical supplies	-19.806	-11.553	-11.843	(0.290)
-48.548	**Raw Materials and Consumables Used, Total**	**-54.223**	**-31.674**	**-33.576**	**(1.902)**
-2.745	**Cost of Secondary Commissioning of mandatory services**	**0.000**	**0.000**	**-2.157**	**(2.157)**
	Employee Expenses [was "Pay"]				
-110.124	Employee expenses, permanent staff	-111.963	-65.664	-66.933	(1.269)
-4.441	Employee expenses, agency & contract staff	-6.334	-3.820	-4.658	(0.838)
-114.565	**Employee Expenses, Total**	**-118.297**	**-69.484**	**-71.591**	**(2.107)**
-0.550	Research & Development expense	-0.400	-0.233	-0.214	0.019
-0.392	Education and training expense	-0.300	-0.175	-0.157	0.018
-0.358	Consultancy expense	0.000	0.000	-0.293	(0.293)
0.000	Misc. other Operating expenses	-0.671	-0.391	-0.429	(0.038)
0.184	(Increase)/decrease in Provisions, Current and Non-Current, net	0.000	0.000		0.000
0.260	(Increase)/decrease in Impairment of receivables, Current and Non-Current, net	0.200	0.267	0.229	(0.038)
-0.921	PFI unitary payment	-0.975	-0.569	-0.524	0.045
-167.635	**Operating Expenses within EBITDA, Total**	**-174.666**	**-102.260**	**-108.712**	**(6.452)**
	Depreciation and Amortisation				
-7.605	Depreciation and Amortisation - owned assets	-8.560	-4.993	-4.674	0.319
-0.306	Depreciation and Amortisation - donated assets	-0.435	-0.203	-0.230	(0.027)
-7.911	**Depreciation and Amortisation - owned assets**	**-8.995**	**-5.197**	**-4.904**	**0.293**
-0.062	Depreciation and Amortisation - assets held under finance leases	-0.060	-0.035	-0.036	(0.001)
-0.523	Depreciation and Amortisation - PFI assets	-0.580	-0.338	-0.318	0.020
-8.496	**Depreciation and Amortisation, Total**	**-9.635**	**-5.570**	**-5.258**	**0.312**
-0.795	Impairment (Losses) / Reversals net (on non-PFI assets)	0.000	0.000	0.000	0.000
-9.291	**Operating Expenses excluded from EBITDA, Total**	**-9.635**	**-5.570**	**-5.258**	**0.312**
-176.926	**Operating Expenses IFRS, Total**	**-184.301**	**-107.830**	**-113.970**	**(6.140)**
6.501	**Surplus (Deficit) from Operations**	**7.254**	**3.198**	**2.748**	**(0.450)**
	Non Operating				
	Non-Operating income				
	Finance Income [for non-financial activities]				
0.219	Interest Income	0.068	0.040	0.039	(0.001)
0.219	**Finance Income [for non-financial activities], Total**	**0.068**	**0.040**	**0.039**	**(0.001)**
	Other Non-Operating income				
-0.001	Gain/(loss) on asset disposals	0.000	0.000	0.000	0.000
	Income of NHS Charitable funds (if consolidated)	0.000	0.000	0.090	0.090
0.218	**Non-Operating income, Total**	**0.068**	**0.040**	**0.129**	**(0.001)**
	Non-Operating expenses				
	Interest Expense				
-0.065	Interest Expense on Non-commercial borrowings	-0.006	-0.006	-0.005	0.001
-0.036	Interest Expense on Finance leases (non-PFI)	-0.025	-0.015	-0.011	0.004
-1.732	Interest Expense on PFI leases & liabilities	-1.913	-1.116	-1.013	0.103
-1.833	**Interest Expense, Total**	**-1.944**	**-1.137**	**-1.029**	**0.108**
-3.254	PDC dividend expense	-3.372	-1.967	-2.216	(0.249)
-5.087	**Finance Costs [for non-financial activities], Total**	**-5.316**	**-3.104**	**-3.245**	**(0.141)**
-5.087	**Non-Operating expenses, Total**	**-5.316**	**-3.104**	**-3.245**	**(0.141)**
1.632	**Surplus (Deficit) before Tax**	**2.006**	**0.133**	**-0.368**	**(0.591)**
0.000	Income Tax (expense)/ refund	0.000	0.000	0.000	0.000
1.632	**Surplus (Deficit) After Tax**	**2.006**	**0.133**	**-0.368**	**(0.591)**
0.000	Profit/(loss) from discontinued Operations, Net of Tax	0.000	0.000	0.000	0.000
1.632	**Surplus (Deficit) After Tax from Continuing Operations**	**2.006**	**0.133**	**-0.368**	**(0.591)**

Income is reported as positive figure / Actual Expenditure as a negative

APPENDIX E - STATEMENT OF FINANCIAL POSITION

	Actual at 41,729.000 £m	Plan 41,943.000 £m	Actual 41,943.000 £m
Assets			
Assets, Non-Current			
Intangible Assets, Net, Purchased or created	1.934	1.137	1.681
Intangible Assets, Net	**1.934**	**1.137**	**1.681**
Property, Plant and Equipment, Net, Donated or granted	2.875	3.071	3.014
Property, Plant and Equipment, Net, Purchased or constructed	109.807	111.256	109.557
Property, Plant and Equipment, Net	**112.682**	**114.327**	**112.571**
On balance sheet PFI assets, Non-Current			
PFI: Property, Plant and Equipment, Net	21.363	21.201	21.044
On balance sheet PFI assets, Non-Current, Total	**21.363**	**21.201**	**21.044**
Assets, Non-Current, Total	**135.979**	**136.665**	**135.296**
Assets, Current			
Inventories	**3.140**	**2.883**	**3.243**
Trade and Other Receivables, Current			
NHS Trade Receivables, Current, Gross	3.862	3.567	5.457
Non NHS Trade Receivables, Current, Gross	1.601	1.467	2.130
Other related party receivables, Gross	0.593	0.450	1.031
Other Receivables, Current, Gross	5.064	3.467	3.476
Impairment of Receivables, Current (for bad & doubtful debts)	-0.989	-0.733	-0.760
Trade and Other Receivables, Net, Current, Total	**10.131**	**8.217**	**11.334**
Prepayments, Current, Total	**1.107**	**1.933**	**2.205**
Cash and Cash Equivalents			
Cash with Government Banking Service	16.778	14.692	13.776
Cash with commercial banks and in hand	0.554	0.300	0.335
Cash and Cash Equivalents, Total	**17.332**	**14.992**	**14.111**
Assets, Current, Total	**31.710**	**28.025**	**30.893**
ASSETS, TOTAL	**167.689**	**164.690**	**166.189**
Liabilities			
Liabilities, Current			
Interest-Bearing Borrowings, Current			
Loans, non-commercial, Current (DH, FTFF, NLF, etc)	-0.819	-0.074	-0.074
Interest-Bearing Borrowings, Current, Total	**-0.819**	**-0.074**	**-0.074**
Provisions, Current	**-0.561**	**-0.583**	**-0.561**
Trade and Other Payables, Current			
Trade Payables, Current	-5.499	-4.733	-6.398
Other Payables, Current	-7.883	-7.557	-7.851
Capital Payables, Current	-1.413	-0.400	-0.638
Trade and Other Payables, Current, Total	**-14.795**	**-12.690**	**-14.887**
Other Financial Liabilities, Current			
Accruals, Current	-0.689	-0.350	-0.380
Payments on Account	-1.879	-1.933	-1.583
Finance Leases, Current	-0.098	-0.103	-0.102
PFI leases, Current	-0.598	-0.585	-0.587
PDC dividend payable, Current	-0.138	-0.281	-0.317
Other Financial Liabilities, Current, Total	**-3.402**	**-3.252**	**-2.969**
Liabilities, Current, Total	**-19.577**	**-16.600**	**-18.491**
NET CURRENT ASSETS (LIABILITIES)	**12.133**	**11.425**	**12.402**
Liabilities, Non-Current			
Interest-Bearing Borrowings, Non-Current			
Loans, Non-Current, non-commercial (DH, FTFF, NLF, etc)	-0.037	0.000	0.000
Interest-Bearing Borrowings, Non-Current, Total	**-0.037**	**0.000**	**0.000**
Provisions, Non-Current	**-0.369**	**-0.350**	**-0.315**
Other Financial Liabilities, Non-Current			
Finance Leases, Non-current	-0.190	-0.129	-0.129
PFI leases, Non-Current	-19.704	-19.380	-19.378
Derivatives and embedded derivatives liabilities, non-current			
Other Financial Liabilities, Non-Current			
Other Financial Liabilities, Non-Current, Total	**-19.894**	**-19.509**	**-19.507**
Liabilities, Non-Current, Total	**-20.300**	**-19.859**	**-19.822**
TOTAL ASSETS EMPLOYED	**127.812**	**128.231**	**127.876**
Taxpayers' and Others' Equity			
Non Controlling interest (was Minority Interest)	**0.056**	**0.062**	**0.056**
Taxpayers Equity			
Public dividend capital	53.339	53.839	53.339
Retained Earnings (Accumulated Losses)	15.965	15.878	16.029
Other Reserves			
Revaluation Reserve	58.452	58.452	58.452
TAXPAYERS EQUITY, TOTAL	**127.756**	**128.169**	**127.820**
TOTAL ASSETS EMPLOYED	**127.812**	**128.231**	**127.876**

Trust Board meeting

SFT 3604

PROGRESS AGAINST TARGETS AND PERFORMANCE INDICATORS TO 31 OCTOBER

Date: 8 December 2014

Report from: **Kate Hannam** **Presented by: Laurence Arnold**

Executive Summary: This details the Trust performance as at October 2014.

Proposed Action: To note the report

Links to Assurance Framework/ Strategic Plan:

Appendices:

Supporting Information

AGENDA ITEM

TRUST PERFORMANCE REPORT TO END OF OCTOBER 2014

PURPOSE: To provide summary information to the Trust Board on performance with regard to key activity and quality indicators.

MAIN ISSUES:

This report sets out the Trust's recent performance against a number of key indicators.

MONITOR

1. **A&E –** the acuity of patients presenting to ED in particular out of hours, in conjunction with the significant challenges in terms of managing delayed transfers of care, resulted in the target of patients being managed within 95th percentile during October – i.e. 4 hour wait (92.3%) not being achieved. The daily review of performance has resulted in a number of changes to the way patient flow is managed with the need for early escalation for senior review and involvement, coupled with increased escalation with partner agencies to support on-going management of our patients.

2. **Cancer 2 week waits** – the target of 93% of patients being seen within 2 weeks of referral was not achieved in October (92.3%). A detailed review of this by the cancer manager and WTAG highlighted the significant increase in demand across all specialties (expect to see on average 450 patients and 608 were seen in October). That level of demand combined with issues with patients choosing to attend outside of the 2ww deadline caused the breach issues.

3. **Cancer 62 day target** – the target of 90% of patients being seen within 62 days was not achieved in October due to one patient breaching this target. A detailed review of this pathway highlighted issues with annual leave and delays in securing scanning to be the main contributory factors and plans have been put into place to minimise the risk of this happening again.

PATIENT CHOICE

4. **Diagnostics** – whilst all national targets have been achieved in October, the target of no patients waiting in excess of 4 weeks was not achieved with 88.6% of patients being seen within 4 weeks. As in previous months, demand rises continue to exceed capacity despite additional lists being arranged within CT and MRI. Detailed work undertaken by the directorate to manage the ultrasound demand has however resulted in a further reduction in the backlog of patients waiting in excess of 4 weeks

from 450 in August to 290 in September and 235 in October (despite a 5% growth since last year), and also a reduction in the MRI backlog from 119 in September to 73 in October (despite growth in referrals) and work continues to further reduce the backlog in these areas. Endoscopy continues to remain under pressure and the directorate management teams are finalising a service review to identify and implement long term solutions to manage the capacity shortfall and variability caused by urgent patients requiring endoscopy diagnostics in addition to increasing demand.

PARTNERSHIP WORKING

5. **Delayed transfers of care (DTOC)** – the number of DTOCs remains a constant focus of the patient flow team and workstreams established as part of the Better Care Fund and '100 day challenge' continue to review systems and processes to understand the bottlenecks to improvement and potential solutions to improve the experience for our patients**.**

STAFF

6. **Appraisal rates** – the overall Trust position at the end of October is 57%. High level analysis of the data suggests the impact of the new electronic appraisal system (SpIda) remains an issue on the impact on the figures, with delays in second sign off of managers and not all staff having transferred across to the system. This is being actively pursued by the HR advisors and additional training is being delivered to support appraisers in the process.

7. **Statutory Mandatory Training** – movement on performance in this area has been slower than expected. Reviews at performance meetings have highlighted a contributory factor is the reliability of the data for some of the modules reporting within this area. Further work is being undertaken during October to understand the reporting issues in conjunction with assurance from Directorates from manual records of the performance in some areas.

VALUE AND EFFECTIVENESS

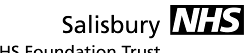
8. **Daycase rates for selected procedures** – further work is being undertaken by the Surgical DMT to understand the reasons for a drop in performance in this indicator. Ensuring full utilisation of day surgery in accordance with best practice is an area of focus for the theatre transformation programme.

ACTION REQUIRED BY THE BOARD: To note the Trust's performance.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:
Board Performance Report, October 2014

AUTHOR: KATE HANNAM
TITLE: CHIEF OPERATING OFFICER

Trust Board Performance Report - October 2014



Monitor Assurance

Metric Name	Indicative Monthly Volume	Target Source	Ceiling	Oct-14	YTD	Benchmark	Trend
Infection control – Clostridium difficile	5,800 discharges	Contract	18 cases (deminimis volume 12)	0	13		
Infection control - MRSA	5,800 discharges	Contract	0 cases (deminimis volume 6) *	0	1 (+1) **		

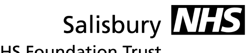
Metric Name	Indicative Monthly Volume	Target Source	Target	Sep-14	Quarter 3 to date	Benchmark	Trend
Patients treated within 18 weeks requiring admission	1,000 patients	Contract	90% treated within 18 weeks	95.8%	93.9%	92%	
Patients treated within 18 weeks not requiring admission	3,500 patients	Contract	95% treated within 18 weeks	98.3%	98.0%	97%	
Proportion of patients waiting less that 18 weeks for first treatment	10,300 patients	Contract	92% still waiting within 18 weeks	96.2%	N/A	95%	
Zero tolerance RTT waits > 52 weeks		Contract	Zero	0	0		

Metric Name	Indicative Monthly Volume	Target Source	Target	Oct-14	YTD	Benchmark	Trend
All Cancer two week waits	450 patients	Contract	93% patients within 2 weeks	92.3%	94.5%	95.4%	
Symptomatic Breast Cancer - two week waits	85 patients	Contract	93% patients within 2 weeks	95.7%	94.5%		
31 day wait standard	110 patients	Contract	96% patients within 31 days	97.9%	97.8%	97.9%	
31 day subsequent treatment : Surgery	20 patients	Contract	94% patients within 31 days	100.0%	99.3%		
31 day subsequent treatment : Drug	20 patients	Contract	98% patients within 31 days	100.0%	100.0%		
62 day wait standard	50 patients	Contract	85% patients within 62 days	93.4%	90.1%	87.0%	
62 day screening patients	4 patients	Contract	90% patients within 62 days	77.8%	94.3%		
62 day patients waiting first definitive treatment after Consultant upgrade	3 patients	Contract	85% patients within 62 days	0 Patients (Sep-14)	100% (Sep-14)		

A&E - Time in A&E department	3,600 patients	Contract	95% patients leave within 4 hours of arrival	94.3%	95.2%	94%	

Quarterly Governance risk rate	Green: No evident concerns

Trust Board Performance Report - October 2014



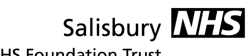
Salisbury NHS Foundation Trust

Patient Choice

Metric Name	Indicative Monthly Volume	Target source	Target	Oct-14	YTD	Benchmark	Trend
Patients waiting less than 4 weeks for diagnostics	1,800 patients	Trust	98% of Diagnostic Waiting List <= 4 weeks	88.6%	85.9%	81%	
Patients waiting less than 6 weeks for diagnostics	1,800 patients	Contract	100% of Diagnostic Waiting list < 6 weeks	100.0%	99.97%	99%	
Friends and Family - % patients with feedback	1,400 discharges	Contract	15% patients offer feedback by end of Q1, 20% or more by end of Q4	49.2%	45.8%	N/A	
Friends and Family - % likely to recommend Hospital	1,400 discharges			97.5%	96.4%	N/A	
A&E Clinical Target 1 - Effectiveness of Care - unplanned reattendance rate	3,600 patients	Contract	<5% ED attendances to have unplanned return	2.0%	2.3%	7.2%	
A&E Clinical Target 2 - Left without being seen	3,600 patients	Contract	<5% patients to leave ED without being seen by clinician	1.5%	1.5%	2.7%	
A&E Clinical Target 3 - 95th Percentile time in A&E	3,600 patients	Contract	95th percentile ED wait to be less than 4 hours	04:33	04:10	04:11	
A&E Clinical Target 4 - Time to initial assessment	3,600 patients	Contract	95th percentile ED time to initial assessment < 15 minutes	00:07	00:08	benchmark data not fit for purpose	
A&E Clinical Target 5 - Time to treatment	3,600 patients	Contract	Median time to treatment in ED < 60 minutes	48	56	benchmark data not fit for purpose	
Ambulance Handover Breaches	970 arrivals by ambulance	Contract	Patients waiting > 20 minutes for Ambulance Handover	4	29		
Trolley Waits in A&E		Contract	Patients waiting > 12 hours on a trolley	0	0		
GUM % Offered appt within 48 hours	340 patients	Contract	100% patients offered appt within 48 hours initial referral	100%	100%	100%	
GUM % Accepted appt within 48 hours	340 patients	Contract	80% patients seen within 48 hours initial referral	83.5%	85.1%	89%	
Cancelled operations on the day of surgery	2,100 elective admissions (incl. daycase)	Trust	< 0.7% elective patients cancelled	0.8%	0.8%	0.77%	
Cancelled operations rebooked within 28 days	20 cancellations per month	Contract	100% patients rebooked within 28 days of cancelled surgery	100.0%	100.0%	96%	

Metric Name	Indicative Monthly Volume	Target source	Target	Aug-14	2013-14	Benchmark	Trend
Market Share: NHS Wiltshire - Elective		Strategy		35.0%	29.1%		
Market Share: NHS Wiltshire - Non-Elective		Strategy		36.0%	35.3%		
Market Share: Core Practices - Elective **		Strategy	Increase market share from 52% to 55% over 5 years	58.6%	52.0%		
Market Share: Core Practices - Non-Elective **		Strategy		66.8%	64.5%		

Trust Board Performance Report - October 2014

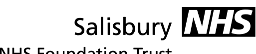


Partnership working

Metric Name	Indicative Monthly Volume	Target source	Target	Oct-14	YTD	Benchmark	Trend
Delayed Transfers of Care - NHS				14	N/A		
Delayed Transfers of Care - Social Services			4 DTOCs based on 3 Wilts SS delays and ~1 other	9	N/A		
Outpatient Follow Up rates	15,000 attendances	Contract	Aspire for Follow up -New Rate <=1:1.6	1.55	1.59		

Staff

Metric Name	Indicative Monthly Volume	Target source	Target	Oct-14	YTD	Benchmark	Trend
Staff absence rate		Strategy	2.87% absence rate	2.98%	3.14%		
Staff turnover	2731 FTE	Strategy	12% over 12 months as a cumulative figure	N/A	4.92%		
Appraisal rates		Strategy	90% of Appraisals completed (rolling 12 months compliance rate)	57.0%	N/A		
Statutory and Mandatory Training levels		Strategy	100% of Training completed (rolling 12 month compliance rate)	65.1%	N/A		
Registered Nurses Vacancy Factor		Strategy	10%	9.3%	7.3%		
Nursing Support Vacancy Factor		Strategy	10%	8.6%	8.5%		
Trustwide Vacancy Factor		Strategy	10%	-0.6%	3.7%		
Bank Spend		Strategy	To be determined	£504,930	£3,328,855		
Agency Spend		Strategy	To be determined	£685,243	£4,229,382		

Salisbury 
NHS Foundation Trust

Value and Effectiveness

Metric Name	Indicative Monthly Volume	Target source	Target	Oct-14	YTD	Benchmark	Trend
Elective Medical Length of Stay	40 Medical G&A overnight stays	Trust	3.48 days	3.1	4.2	Benchmark data not fit for purpose	
Non-Elective Medical Length of Stay	900 Medical G&A overnight stays	Trust	7.78 days	8.4	7.4	15.7	
Elective Surgical Length of Stay	480 Surgical G&A overnight stays	Trust	2.19 days	2.7	2.7	3.5	
Non-Elective Surgical Length of Stay	750 Surgical G&A overnight stays	Trust	3.15 days	3.1	3.5	3.0	
Hip replacements discharged within 5 days	25 patients	Trust	60% patients discharged within 5 days	60.0%	69.2%		
Knee replacements discharged within 5 days	24 patients	Trust	60% patients discharged within 5 days	69.0%	62.7%		
Coding - % coded within 1 week of discharge	5,800 discharges	Trust		70.4%	40.0%		
Coding - % coded within 5 days of month end	5,800 discharges	Trust		89.9%	70.0%		
NHS no. coverage	230,000 patients	Contract	95% of patients with activity in last 3 years to have validated NHS no.	98.1%	97.8%		
1st Outpatient DNA rate	5,500 appointments	Contract	No more than 7.5% patients to not attend 1st outpatient appointment	5.7%	5.7%	7.0%	
Elective Theatre Utilisation - Main Theatres	530 cases	Trust	Data recently obtained from new theatre system, no target set at this point	91.5%	94.7%		
Elective Theatre Utilisation - Day Surgery	860 cases	Trust	Data recently obtained from new theatre system, no target set at this point	87.5%	83.7%		
Non-elective Theatre Utilisation - Main Theatres	370 cases	Trust	Data recently obtained from new theatre system, no target set at this point	41.3%	43.1%		
Daycase Rates for selected procedures	350 patients	Trust	80% of selected elective surgical cases to be treated as daycase	78.0%	81.7%	81.2%	
Continuity of Service Risk Rating (CoSRR)	4. No compliance issues						

Cells with black dotted outlines indicate provisional data

*Please note: MRSA is no longer monitored by Monitor

**** Please note, the MRSA figures are showing as 1 (+1) because one of these cases was not a true bacteraemia but rather a contaminant and the patient was not unwell**

TRUST BOARD PAPER

PROPOSED CAPITAL PROGRAMME FOR 2015/16

PURPOSE OF PAPER:

The enclosed document is the draft Capital Programme for 2015/16. As in recent years the Programme is highly constrained reflecting the financial position of SFT. The Capital Control Group together with its representative sub-committees has considered the detailed schemes in constructing the Programme for 2015/16. The Joint Board of Directors has reviewed the Programme. As in previous years a high priority has been given to schemes affecting health and safety of staff and patients, and the broad criteria used in prioritising are shown against the schemes in the Programme.

The position is very challenging given the overall financial outlook and if money had been available there are schemes that would have been nice to do. However it is necessary to conserve cash as much as possible and the schemes included particularly focus on those which are essential to continue services safely, or offer a good return in terms of operational benefits or finance.

Schemes in the 2014/15 Capital Programme which are not complete by the end of the financial year will be included in the 2015/16 Capital Programme together with the relevant resources. Some known slippage is already included as well as an uncommitted balance from 2014/15.

EXECUTIVE SUMMARY:

a. Total resources being made available are £8.5m plus slippage from 2014/15. As a Foundation Trust the prime source of cash for capital schemes is the depreciation of assets.
b. No assumption has been made for 2015/16 regarding charitable support to the Programme however a number of medical equipment items have not been included and will seek support from the Trustees during the year.
c. The proposed expenditure is in line with the forecast resources but there is a small uncommitted sum of £98k plus a sum of £200k to support invest to save schemes.
d. It is important to review the notes at the bottom of the table as these highlight schemes not yet included in the Programme. Some of these will need to be undertaken during the year.
e. Of importance is the exclusion of any costs of the Electronic Patient Record which could cost in excess of £8m. A separate case will be made to the Board in due course but the expectation is that this will be funded from a loan supported by savings which should accrue. Similarly cases will be made for a new SDU facility and laundry despatch centre on the south of the site and these will be funded from loans subject to approval of their business cases. Clearly the use of loans will affect funds availability in future years.
f. A total of £2.3m has been earmarked for medical equipment. In addition there will be additional equipment items in radiology which will need to be replaced as a result of flooding on level 4 and these should be funded from expected insurance payments.
g. Expenditure on IT is becoming an increasing pressure on the Programme as we seek more efficient ways of doing things.
h. Provision has been made for the first year of the maternity development which will take place over two years. Allowance has also been made for upgrading another ward.
i. Once the Programme for 2015/16 is agreed some schemes, as indicated, will be brought forward into the current financial year due to operational urgency.

RECOMMENDATIONS

The Trust Board is asked to consider the 2015/16 Capital Programme and approve it.

Malcolm Cassells
Director of Finance and Procurement
30 November 2014

DRAFT CAPITAL PROGRAMME 2015-16											
				CRITERIA							
	2015-16	2015-16	b/f	CRITERIA							
	£000	£000		Delivery of good quality Patient Focused Care							PFC
SOURCE OF FUNDS				Improvement in Effectiveness							IE
Depreciation	8,000			Maintain Service Capability							MSC
Uncommitted 2014-15	583			Developments & New/Protect Income Streams							DNIS
less Salix loan	-37			Hospital Infrastructure							HI
Slippage from 2014-15	1,751			Safety and Legality							S
AVAILABLE FUNDS	**10,297**	**10,297**		Ecology							ECO
				Efficiency and cost saving							EFF
APPLICATION OF FUNDS											
				PFC	IE	MSC	DNIS	HI	SL	ECO	EFF
STRATEGIC AND ON-GOING SCHEMES											
Breast Unit enabling	50			#							
Downton upgrade	500			#							
Maternity development 1st year of 2	500			#		#					
Slippage from 2014-15	1,751	2,801									
MEDICAL EQUIPMENT <£50K											
Activac therapy pumps x6 - main theatres	30					#					
Antivibration table x2 and microscope shield x2 - fertility	19			#	#	#					
Blood gas analyser - respiratory	15					#					
CO2 efficient endoscopic insufflator x2 - endoscopy	16					#					
ECG machine - cardiac investigation unit	7					#					
Electro-surgical unit with endocut x2 - endoscopy	30					#					
FESS telescopes - DSU	27					#					
Fetal monitors and transducers - maternity	48					#					
Fuid warming cabinets x3 - urology	15					#			#		
Laser scopes for prostate surgery - urology	28					#					
Morcellator - urology	30					#					
MRX defibrilators x4 (one without pacing) - main theatres/DS	28					#			#		
Operating light - mobile - main theatres/ DSU	11					#					
Operating theatre lights - obstetric theatre - mobile	11					#					
Ophthalmology laser	30				#	#					
Powered theatre trolleys x5 (13 requested) - DSU	45					#					
Wi fi stack system and associated kit - endoscopy	41					#					
Grouped items	100	531				#					
MEDICAL EQUIPMENT >£50K											
Anaesthetic monitors x2 - DSU	26					#					
Arthroscopy telescope/sheath replacement - DSU	58					#					
Replacement beds 130 beds plus accessories - yr 3 of 4	204			#		#			#		
Fluoroscopy x-ray machine - radiology room 8	330		b/f			#					
General x-ray machine - Westbury - radiology	99			#			#				
Instrument replacement - theatres trustwide	500					#			#		
Power tools replacement/upgrade - theatres/DSU/oral surger	200					#					
Scopes x7 endoscopy	150					#					
Slim colonoscopes - endoscopy	133					#					
Ultrasound machine - O&G - radiology	70		b/f			#					
Videoscopes x2 - main theatres	50	1,821				#					
BUILDING AND WORKS SCHEMES - high priority											
AHU yr 3 of 7	280			#					#		
Bed stacking solution	100		b/f		#						#
Catering oven	17					#					
Catering thaw cabinet	8					#					
Central booking relocation - block 79 (Wilton ward)	100				#						
Demand response generator conversion (invest to save)	180		b/f							#	#
DSU powered truck replacement	8					#					
Estates health and safety	10								#		
Hospice fire alarm	30								#		
Inspection and testing remedial works	36								#		
Medical gas hoses yr2 of 2	66								#		
Modular cold room for genetics	26				#						#
Mortuary washer disinfector	10								#		
Owlswood houses x2 blocked cavities	30				#		#				
Pathology - air tube upgrade	36					#					
Pedestrian crossings	66								#		
Renewal of floors on stairwells	50			#				#	#		
SDU washers	150				#	#					#
Taps & IPS panels - sitewide	60	1,262							#		
BUILDING AND WORKS SCHEMES - medium priority											
Accommodation replacement of kitchens and bathrooms	150						#	#			
Boiler house demolition	0							#			

Car park 8 machinery replacement - [? Part insurance claim]	96		b/f				#				
Demolish old GUM clinic	50		b/f	#	#		#	#			#
Drain survey SDH north	15		b/f			#		#			
Duct work and fire damper yr3 of 3	50							#			
General laboratory replacement autoclave	60					#					
Main boiler burners	30					#		#			
Main operating theatres recovery area	56			#							#
OHSS replacement windows	27							#			
Orthotics move and bowel screening admin	35		b/f				#				#
Pathology - conversion of computer room to office	12										#
Portering bed movers	23					#					
Powered door curtains level 2	15		b/f						#	#	#
Security doors and CCTV	70								#		
Spinal unit fire escape removal assessment	10							#	#		
Springs servery upgrade - floor and freezers only	75					#			#		
Water tanks access - main tanks only	30	804				#			#		
INFORMATICS SCHEMES											
Alternative to Microsoft products - review	50										#
Baby Tagging - RFID	66								#		
Big Hand	50		b/f		#	#					
Cohort system - Occupational Health	44						#				
Estates - Oracle software interface	24										#
Finance - workflow	40										#
Genetics - software upgrade	101					#					
IBD register	10			#		#					
Mortuary module	52										#
Open eyes phase II	120			#	#						#
Order Comms – additional development	41										#
Telepath to CSCLims (Phase 3)	75										#
Therapy information system	45				#						#
Tray Tracking System	71								#		
Aruba expansion	34										#
Maintenance renewal - estimate	650					#					
Microsoft Licensing - being challenged	500					#					
Network consultancy	25					#		#			
Network - unsupportable equipment	52					#		#			
Replace 6509x3 network hubs	350					#		#			
Scriptlogic licenses	38					#					
Scriptlogic upgrade	29					#					
UPS replacement	24					#					
VOIP - non clinical areas - subject to a telephony strategy	167				#						#
Wireless coverage	120	2,778			#						#
OTHER											
Project costs	12										
Invest to save	200	212									#
TOTAL	**10,208**	**10,208**									
UNCOMMITTED FUNDS		**89**									
Other issues:											

Replacement of damaged stereotactic machine - mammography and Room 2 machine as a result of flood damage is not shown.
Funding expected from insurance and will then be added to programme
The laundry despatch centre assumes loan funding and is not included
Spinal Unit schemes will be considered as a package together with their underspent 2014-15 schemes
The development of an Electronic Patient Record is assumed to be fully funded through a loan of say £8m
The EPR should deliver an EPMA, mobile working apps, and other application which are therefore not included
The potential SDU development with a joint venture partner is excluded and would require loan funding
The effect of loan finance on future years needs to be borne in mind
A number of schemes are urgent and will be brought forward as shown
Some items of medical equipment may be supported by charitable funds in due course

SFT 3607

Trust Board meeting
ASSURANCE FRAMEWORK UPDATE

Date: 8 December 2014

Report from: Lorna Wilkinson, Director of Nursing

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 September 2014. Trust Board members agreed the principal risks for inclusion in the 2014/15 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 2014/15 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: None

ASSURANCE FRAMEWORK 2014-15

Trust Board December 2014

Corporate Objectives and Key to Care Quality Commission Outcomes

Corporate Objectives – Service Plan 2014/15 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 choosing to be treated elsewhere, the local population losing trust in SFT as a provider of high quality care and intervention by regulators
Meeting both internal and external targets
1.2 (i) Market share falls resulting in a fall in income to the Trust and indicative of local patients and GPs' dissatisfaction with the service provided.
(ii) Centralisation of services – resulting in services not being provided on the SFT site at odds with the strategic objective of providing a comprehensive range of services.
(iii) Services put out to tender which would reduce the Trust's overall income and may have a negative impact on other services provided by the Trust
1.3 Failure to listen and act on feedback provided by patients and key stakeholders resulting 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

AF 2 - Care - We will treat our patients with care, kindness and compassion and keep them safe from avoidable harm
Linked Risks
2.1 Poor compliance with infection prevention practice and policy leading to:

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

2.2 Failure to comply with internal and external expectations on quality of care

- 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 Failure to protect the most vulnerable if safeguarding policies and procedures for children, young people, and adults are not applied appropriately.
2.4 Failure of the organisation to have robust governance processes which provide positive assurance and maintain the Trusts excellent reputation.

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 deliver excellence for all patients if individuals and teams of staff do not feel valued, safe and have the right skills to complete their job.
3.2 Failure to deliver excellence for all patients if the workforce is not appropriately skilled and staffed to the right levels.

AF 4 - Value - We will be innovative in the use of our resources to deliver efficient and effective care
Linked Risks
4.1 Informatics Strategy - for the Trust to develop as an effective provider of modern, dependable health care it requires the provision of an effective, reliable IT infrastructure which provides high quality information to staff about their patients as and when they need it.
4.2 Failure to secure all income potentially due under contracts whilst avoid fines will impact on the Trust's financial position and potentially undermine the financial viability of the Trust.
4.3 Failure to contain expenditure with budgets and achieve agreed efficiency savings will impact on the Trust's financial position and potentially undermine the financial viability of the Trust.
4.4 The failure to undertake robust capacity and demand planning which reflects the capacity requirements in terms of workforce, beds, finances and assets (theatres etc) against predicted levels of demand, could result in the failure of the Trust to meets its regulatory operational targets in terms of waiting times, failure to meet contractual requirements and failure to secure sufficient income to meet the requirements of the Trust at financial balance

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 can gain independent evidence that our controls/systems, on which we are placing reliance, are effective.	We have evidence that shows 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 choosing to be treated elsewhere, the local population losing trust in SFT as a provider of high quality care and 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 Recently updated Access Policy Central booking – consistent approach to delivery of key waiting list targets Winter pressures plan – maintaining performance at times of increased emergency demand	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. Commissioner engagement on performance issues	Strong track record of delivery Green governance rating from Monitor. Reflected in 'light touch' approach. CQC banding Limited issues raised by commissioners in terms of performance Strong benchmarking across a range of indicators.	a) Some (sub)specialty issues for RTT, resulting from increasing demand and capacity constraints b) ED performance risk for Q3 c) Impact of other organisations' performance on Trust's ability to deliver d) Ensuring good knowledge of Access Policy rules for key staff	
Actions Agreed 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) b) Robust plan developed for improved ED performance in last weeks of the quarter using winter funding and determine impact this will have c) Close liaison with other organisations' in the local health economy through the Operational Resilience Board and Urgent Care Network d) 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					**By Who:** COO/Head of Information/DM's DM Medicine Head of Op/DM Medicine Central Booking Manager / Head of Training	**By When:** March '15 End Nov '14 Ongoing February '14	**Date Completed:**

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	Market share falls resulting in a fall in income to the Trust and indicative of local patients and GPs' dissatisfaction with the service provided.	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)	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	Market share relatively stable. SFT reputation amongst both patients and GPs NHS Choices feedback and Friends and Family ratings across a range of settings (ED, maternity, cancer services, inpatients)	a) Orthopaedic market share falling b) Waiting times rising (eg ortho, urology, ophthalmology) c) Greater engagement of primary and secondary care clinicians - role of Primary Care Forum	d) Time lag in Dr Foster data (only source of market share information)
	Centralisation of services – resulting in services not being provided on the SFT site at odds with the strategic objective of providing a comprehensive range of services.		Engagement with commissioners – local and specialist	Specialist services designation process	Large degree of compliance with designation. Strong relationships with commissioners High quality outcomes proven	e) Spinal services – time to admit to unit and outpatient wait times. f) Service specifications driven by specialist centres and focused on inputs, not outcomes.	g) Need robust data on outcomes
	Services put out to tender which would reduce the Trust's overall income and may have a negative impact on other services provided by the Trust		Finance and Performance Committee	Success rate of bidding for tenders Process established for determining whether SFT will submit tenders – informed decision making.	Good quality tenders submitted. Purchasing authority feedback Rational decision made not to bid for Dorchester pathology – a service that was ultimately not let. High degree of commissioner satisfaction with performance of SFT services.	h) Expertise and support for major tenders may be required.	

Actions Against Gaps in Control/Assurance:	By Who:	By When:	Date Completed:
a) Task and finish group established to reduce waiting times in orthopaedics in light of capacity difficulties	COO/DM(MSK)	Mar '15	
b) Demand and capacity work required for most challenged specialties (see AF1, 1.1 above)	COO/Head of Information/DM's	Mar '15	
c) Revised approach to PCF involving joint meeting between Sarum Exec and Clinical Directors to be established with agreed terms of reference. To establish reviews of key pathways.	COO	Jan/Feb '15	
d) Review contract with Dr Foster re lack of data	Head of Informatics	Feb '15	
e) Spinal services review – key recommendations	MD/COO	???	
f) Engage with specialist commissioners to ensure designation reflects outcomes	CEO/MD/DoF	Ongoing	
g) SFT to collect outcomes data to reflect quality of specialist services being provided – review service by service	MD/COO	Ongoing	
h) Commission external tender support on an 'as and when required' basis	DofCD	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 provided by patients and key stakeholders resulting 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 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 Customer Care reports to CGC and Trust Board Implementation of learning from incidents in all clinical areas	Patient survey action plans resulting from annual reports Customer care reports Directorate level action plans and learning as a result of complaints NHS Choices Complaints workshop completed in Oct 14 to review current systems against post Francis learning and recommendations (includes Clwyd/hart report) as well as Patients Association Standards Serious Incident and Clinical Review investigations and recommendations	Continued compliance with response rate for FFT as well as positive net promoter score as reported on NHS Choices Positive feedback from the Ombudsman on individual complaints management of cases brought before them.	Actions resulting from Oct 14 Complaints workshop have identified improvements to be made in: • resolution at a local level • improving the personal response and contact in the first few days of a complaint being made • structured and transparent sharing of lessons learnt Feedback from mock CQC report (Sept 14) – not all staff able to describe any lessons learned	
Actions Against Gaps in Control/Assurance:					**By Who:**	**By When:**	**Date Completed:**
1. Action plan agreed and disseminated as a result of the complaints workshop and monitored by DoN					HH/LW	Nov 14	20/11/14

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	Poor compliance with infection prevention practice and policy leading 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 Safety workstream on HAI reduction methods such as introduction of care bundles for lines and devices. 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 2014) Monthly hand hygiene audits showing reliable practice across a number of areas.	a) HAI rates for C-Difficile and MRSA currently over trajectory for 14/15 at mid year. Reporting 13 against a target of 18 c-dif cases and 1 MRSA bacteraemia. b) Variability practice across clinical areas c) Some staff not able to describe infection control measures, observations of past practice – Mock CQC inspection report. d) Availability of weekend cleaning services	e) Emerging risk of the ebola crisis and how it will impact upon the NHS – although small risk for SFT – state of readiness to be tested.

Actions Against Gaps in Control/Assurance:	By Who:	By When:	Date Completed:
a) Clostridium Difficile action plan in place which has had overview from external partners and is being monitored monthly via the Infection Control Working Group	DoN/Infection Control Dr and Senior Nurse	Dec 14	
Root cause analysis completed for all cases. Action plan in place and monitored by the Infection Prevention and Control Committee.	DoN/Infection Control Dr and Senior Nurse	Ongoing	
b) Individual area feedback following CQC mock inspection	Exec Directors	Nov 14	Nov 14
Action plan in place following observational visits which are specific to each area	Ward and dept leaders	Dec 14	
c)			
d)			
e) Internal group established working on Trust readiness with robust and detailed actions including training of staff to deal with scenarios	DoN	Oct 14	Oct 14 established and work ongoing
Maintaining links with Public Health England and Regional networks as information becomes available	Infection Control Doctors/Emergency Planning Lead	Oct 14 and ongoing	Oct 14 established and work ongoing

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	Failure to comply with internal and external expectations on quality of care • 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	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 Review of SFT Organsiational 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	Positive CQC follow up visit Oct 2013 with compliance declared across all standards. Risk rating band 6 (lowest risk) Dec 14 Mid year Quality account report shows good progress across priority areas NRLS benchmarked report on incident data shows the Trust has increased reporting rates whilst reducing severity of events (healthy safety culture) HSMR/SHMI within expected limits		
Actions Against Gaps in Control/Assurance:					**By Who:**	**By When:**	**Date Completed:**

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	Failure to protect the most vulnerable if safeguarding policies and procedures for children, young people, and adults are not applied appropriately.	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	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 (Oct 2013) continues to demonstrate good level of understanding and knowledge of individual staff responsibility to safeguard children Improving uptake of safeguarding training Action plan achieved following CQC inspection of Wiltshire Council Safeguarding Children	i) Comprehensive review of TNA in response to Intercollegiate document (2014) underway ii) Changes to DOLS following Supreme Court judgement resulting in risk of increased requests for authorisations and potential for holding patients unlawfully due to inability for LA to complete timely assessment. iii) Safeguarding Adult and MCA lead absence with unsuccessful attempt to secure temporary cover	iv) MLE continues to provide inaccurate data on training compliance. v) Variability of safeguarding (adult) and MCA knowledge across depts..

			Supervision: Coordinated by Lead Nurse for safeguarding Children and offered individually, group and ad hoc as per policy. Safeguarding schedule of NHS contract				

Actions Against Gaps in Control/Assurance:	**By Who:**	**By When:**	**Date Completed:**
i) TNA to be completed and ratified through Integrated Safeguarding Committee	JM	Dec 14	Sept 14
ii) Monitoring via tracker sheets within Directorates and incident reporting	DSNs	Sept 14	Sept 14
Regular follow up with Local Authority	RB/FH	Sept 14	Nov 14
Development of local information, escalation, and documentation proforma	FH/GC	Dec 14	
Continue to work with LA on this issue	GC	Ongoing	
iii) Alternative Directorate cover to be agreed temporarily via an in house solution	LW	Nov 14	
iv) Continue to work with the education dept to solve issue of merging old and new information	JM	Jan 15	
v) Commission of MCA training with structured programme of specific depts to attend	FH/JO	Jan 15	
Mock CQC action plan to target areas for support	LW	Dec 14	

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
Safe Effective Caring Responsive Well Led	Failure of the organisation to have robust governance processes which provide positive assurance and maintain the Trusts excellent reputation.	Joint Board of Directors Chief Executive Officer	Monthly reporting to Trust Board on quality, performance, finance and staffing Trust Board programme of business reviewing all areas Assurance Framework and Risk Register Process Internal and external audit review Detailed review by Board Committees Raising concerns policy to enable staff to report concerns	NED challenge at Board Data quality review Board effectiveness reviews and development Critical review by Council of Governors Regular review by CGC, JBD and Finance and Performance Committees Reports to Audit Committee Executive Walkrounds to triangulate performance and quality. Reports at board, dip sampling of complaints records Regular upward reporting of activities to Trust Board Regulatory feedback – Monitor, CQC, HSE Whistleblowing survey	Effective Board Meetings 'Clean' external audit review opinion Absence of regulatory concerns – HSE, Monitor, CQC Positive response to 'whistleblowing' survey – High reporting rate	a) Limited assurance internal audit reports	b) Last board effectiveness review completed in 2011 c) Testing governance processes at team / directorate level

Actions Against Gaps in Control/Assurance:	**By Who:**	**By When:**	**Date Completed:**
a) Action plans against limited assurance audits b) monitoring of progress with Strategy Development c) Monitoring through Directorate Performance (3:3) meetings			

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

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 deliver excellence for all patients if individuals and teams of staff do not feel valued, safe and have the right skills to complete their job.	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. Leadership and Talent Strategy with Executive Sponsorship progress monitored through EWC. NHSLA inspections/visits Staff Survey Results Staff Friends and Family Test Equality Delivery Scheme Public Sector Equality Duty Compliance Annual Staff Survey H&S Committee receive reports on all staff related incidents with actions taken and recorded.	Staff turnover average 15%. Staff sickness at 3.1%. Staff Survey 2013 results show that staff would recommend the Trust as somewhere to work, and somewhere to receive care, where they experience support from managers and feel engaged (all higher than national average). Staff Friends and Family Test results are very positive in Q1&2, combined score of 87.6% favourable. Sickness level at a low level: <3% Staff Health and Wellbeing established: shapeup@salisbury, including Stress workshops and access to RMN 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.	Further assurances that staff are engaged with the new values and behaviours. 90% Staff to be compliant with statutory and mandatory training. (stretch target 100%) 90% Staff to be compliant with Appraisal (stretch target 100%)	The Executive Workforce Committee does not have a direct line of accountability to the Trust Board. Minutes of this meeting are provided to JBD.

Actions Against Gaps in Control/Assurance:	**By Who:**	**By When:**	**Date Completed:**
Monitoring of the Values and Behaviours Action Plan through the Exec Workforce Committee	AK (JO/VDB/JH)	April 2015	
Monitoring of training and appraisal rates via OMB (Deputy Director) and Exe Workforce Committee	AK	April 2015	

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 (March 2014, annually thereafter)	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. Proactive management of sickness/absence by Directorate Managers with HR support. Workforce Issues are part of the discussions (and are minuted) at Directorate 3:3s including: staffing and or skill shortages related to business as usual and change projects, Annual Staff Survey. CQC audits/visits Annual review of workforce and training needs through Health Education Wessex	Staff Survey 2013 results show that staff would recommend the Trust as somewhere to work, and somewhere to receive care, where they experience support from managers and feel engaged (all higher than national average) Staff sickness at 3.1% Skill mix review of ward based nursing completed and signed off by Trust Board, updated during 10/14 Workforce reviews are an accepted part of requirements of managers Salisbury Organisational Trigger Tool assesses workforce planning needs as one of its measures Service planning processes for 2014 onwards commenced and will include Directorate workforce plans.	Ability of the Trust to maintain Safe Staffing requires constant review of workforce plans Workforce plans that describe the size and make-up of the whole workforce over the next few years are an ongoing requirement	The Executive Workforce Committee does not have a direct line of accountability to the Trust Board.
Actions Against Gaps in Control/Assurance: Develop an action plan for the delivery of the Trust's identified workforce priorities that relate to the Trust's workforce capacity and capability					**By Who:** AK	**By When:** March 2015	**Date Completed:**

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	Informatics Strategy - for the Trust to develop as an effective provider of modern, dependable health care it requires the provision of an effective, reliable IT infrastructure which provides high quality information to staff about their patients as and when they need it.	Joint Board of Directors Director of Corporate Development	The Trust Board ratify the Informatics Strategy and any significant changes to it.	The Executive Board also receive an annual stocktake report that gives a full update of all aspects of its progress.			
			Informatics Strategy Steering Group (ISSG) chaired by the Chief Execs and attended by many of the Executive Board members along with the IT Clinical Lead meets every 2 months.	This group review the progress of core projects that form the foundation of the strategy along with Informatics main risks and potential future developments.	Often these meetings generate further exploratory work that allows more scrutiny into specific projects or strategic themes. This group also advises on some organisational approaches to mitigate risks associated with some projects.	a) Decisions made are not sufficiently widely advertised.	
			Informatics Priority Group (IPG) which consists of the Informatics Managers, the IT Clinical lead and the Director of Corporate Development meets every month	This group review the existing workload and prioritise work packages accordingly. The results of this process are reviewed at ISSG.	This group review Requests for Change (RFC's) that generate new projects or have a heavy impact on the Informatics resources. They prioritise or drop projects to ensure that the delivery against the core Trust and Informatics Strategic direction is maintained.	b) Sometimes departments within the Trust initiate IT related work without the knowledge of IT which subsequently has an impact on the Informatics team resources.	d) Often the full picture of resource impact of works and how the projects interlink is not reviewed.
			Capital Control Group which is chaired by the Finance Director and attended by several executive board member and representatives from various departments and meets monthly	This group review applications/business cases for funding of major projects and upgrades including IT related systems.	This group review applications for new systems and also review the expenditure against annual profile for capital projects including IT.	c) Need to ensure adequate sign off of inhouse developed software solutions, including assessment for compliance with Clinical Risk and IG standards.	

			Project management boards (PMBs) exist for the top Informatics strategically aligned projects and they meet regularly	PMB's have Senior Responsible Owners assigned who tend to be Senior clinical or Executive leads	PMB's review progress of specific projects and review the Risks and Issues logs related to their associated work. These often produce flags which are then fed into both the IPG and ISSG updates	e) Due to the pressure of work for clinicians it is often difficult to get suitable time scheduled in for their involvement in IT related projects. This could lead to an increase in clinical risk. Also need for Clinical Risk sign off of Trust developed systems	
			Regular audits are completed by an external organisation.	TIAA provide audit reviews on the process of delivery with regard to elements of the Strategy and report these to the Audit committee which includes members of the Governors and executive Board.	The TIAA audit team review and assess functional aspects of the Informatics delivery mechanisms such as the departmental change process, compliance with the Information Governance toolkit and the approach to developing software products.		f) There are only a limited number of audits that are commissioned per year (IG is always reviewed annually) meaning that some functions or process may not be audited for a number of years.

Actions Against Gaps in Control/Assurance:	**By Who**	**By When**	**Date Completed:**
a) Ensure feedback is given to departments who present cases for Informatics resources	DoI	April '15	
b) Ensure that the implications of additional, immediate demands on Informatics time is made clear to the organisation by highlighting to ISSG, or Executive Team	DoI/DoCD	Ongoing	
c) Sign of inhouse developments is established which all work to which ensures adequate checks have been made in relation to clinical risk, IG risk as well as compliance against user brief and Trust infrastructure	DoI/Project Managers/IG	Feb '15	
d) Develop a clear critical path and resource map for the delivery of the Informatics priorities as set out within the Trust Informatics Strategy	DoI	April '15	
e) Ensure projects realistically assess need for clinical engagement and options for resourcing this are found. Clinical Lead for Informatics to undertake Clinical Risk training	Informatics and Directorates/ Clinical Lead	Ongoing and Feb '15	
f) Seek alternatives to external audit and establish case.	DoI	April '15	

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 all income potentially due under contracts whilst avoid fines will impact on the Trust's financial position and potentially 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 Committee Clinical Quality Review Group Monthly Directorate performance review meetings SLA Task & Finish Group Use of standard NHS SLA contract & timetable for contract negotiations	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 contracts signed with key NHS Commissioners 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	Development of informatics & finance systems to ensure the availability of relevant, accurate and timely activity and performance information Lack of KPIs at Directorate level	CCG challenges & delivery of CQUIN Contract Breaches resulting in penalties Readmissions avoidance

Actions Against Gaps in Control/Assurance:	By who:	By When:	Date Completed:
1. Agree Directorate KPIs	COO	31.3.15	
2. Agree CQUIN delivery plan	LW/COO	Annually by e.o.y.	
3. Review of informatics requirements for the Trust	LA / MC	31.3.15	
4. Evaluate new performance reporting tools. (i.e. CIVICA, QLIKVIEW)	LA / MC	31.3.15	
5. Avoidance of readmissions	COO	On-going	
6. Avoidance of contractual breaches (e.g RTT, A&E waits, Cancelled operations, Infection control etc.)	COO	0n-going	

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 expenditure with budgets and achieve agreed efficiency savings will impact on the Trust's financial position and potentially undermine the financial viability of the Trust.	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 Established Cost Improvement plans (CIPs) Programme Steering Group External Audit of Annual Accounts Benchmarking Reference costs	Monthly performance reports to Trust Board & Finance Committee Audit reports Monitor's Continuity Services Risk Rating (CoSR) Monitor's financial performance reports	Achievement of financial plan Achievement of CIPs target 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	Tracking & delivery of CIPs Financial & Activity reporting reflects best practice in the NHS Development of 3 year CIPs plan Development of forecasting capabilities & system Development of Service Line Reporting (SLR)	Delivery of recurrent CIPs Accuracy of financial plans and forecasting at Directorate level Non-Finance management training programme Usability of SLR

Actions Agreed:	By Who:	By When:	Date Completed:
1. Evaluate new performance reporting tools. (i.e. CIVICA, QLIKVIEW)	LA / MC	31.3.15	
2. Refresh of performance reporting to the organisation	MC	31.3.15	
3. Development of robust savings plan	COO/MC	Annually by e.o.y.	
4. Confirm planning & budget setting guidance 2015/16	MC	31.3.15	
5. Develop 3 year savings	CE/COO/MC	Annually by May	
6. Develop non-financial management training programme	MC	31.3.15	
7. Development plan for SLR	MC	31.12.14	

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	The failure to undertake robust capacity and demand planning which reflects the capacity requirements in terms of workforce, beds, finances and assets (theatres etc) against predicted levels of demand, could result in the failure of the Trust to meets its regulatory operational targets in terms of waiting times, failure to meet contractual requirements and failure to secure sufficient income to meet the requirements of the Trust at financial balance	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 is also reviewed at 3:3 monthly meetings.	The achievement of all regulatory and internal targets regarding performance will provide assurance that the balance is correct in terms of matching capacity and demand within the resources available.	The use of predictive tools which utilise known demand to forecast capacity issues in the future needs to be systematically embedded. This will ensure resources are used as efficiently and effectively as possible. Review at DMT level of activity performance compared to contracted levels at specialty level.	IST tool will provide assurance of the ongoing balance of demand and capacity. Contractual performance - income and activity meeting expected budgeted levels.
Action Agreed: 1) Robust demand and capacity modelling at specialty level to inform contractual round 2) Full implementation of the IST model 3) Activity reports with drill down facility provided at Directorate and specialty level					**By Who:** DMT and contract team Informatics and DMs Informatics	**By When:**	**Date Completed:**

Trust Board meeting **SFT 3608**

ESTATES STRATEGY UPDATE

Date: 8 December 2014

Report from: Laurence Arnold, Director of Corporate Development

Executive Summary:
This annual update on the Trust's Estates Strategy (2010-15) provides information on progress towards achieving the objectives set out in the 2010 document and describes some of the key priorities for the next few years to continue to make progress with developing an estate that can meet the needs of our patients and of our staff.

The document describes the major initiatives, many of them predicted in the Strategy, which have been undertaken and those that are in the pipeline either to take forward or to consider the feasibility of undertaking.

The paper describes the impact these initiatives have begun to have both in terms of key estate quality indicators and in terms of the important issue of improving our energy efficiency and the contribution SFT can make to environmental concerns.

Proposed Action:

To note the update
To note the intention to substantially update the Estates Strategy in 2015, whilst noting the future developments proposed which are consistent with the draft capital programme (see SFT 3606)

Links to Assurance Framework/ Strategic Plan:

Choice - maintaining a high quality environment which attracts patient to choose to be treated at SFT

Appendices: Appendix A describes key estate performance indicators

Supporting Information

Estates Strategy 2010-15 - Update on Progress and Future Plans

1. Introduction

This annual update on the Trust's Estates Strategy (2010-15) provides information on progress towards achieving the objectives set out in the 2010 document and describes some of the key priorities for the next few years to continue to make progress with developing an estate that can meet the needs of our patients and of our staff. The overall Estates Strategy will be fundamentally reviewed and refreshed during 2015 to reflect the changes envisaged as a result of external factors and also the needs of individual services and the overall Trust strategic direction.

2. The Existing Estate

2.1. Introduction

The Trust owns two freehold properties; both are operational and are based in Salisbury. The property details are summarised below:

Estate Code	Trust Property	Site Area (ha)	Building *GIA (m^2)
RNZ 02	Salisbury District Hospital, Odstock Road, Salisbury SP2 8BJ	21.17	95,899
RNZ 13	Hillcote, 22 Manor Road, Salisbury SP1 1JS	0.18	739
	Totals	21.35	96,638

*GIA = Gross Internal Area

The full asset valuation as at March 2014 (Trust Land and Buildings) was £100.6m (including £21m for the PFI building). The Trust Charitable Fund property assets comprise a further £4.7m

The open market value is estimated as no greater than the net book value due to planning restrictions on the use of the site. The Salisbury District Local Plan does not allow for developments on the site other than for health related purposes.

The Charitable Fund also owns properties in Salisbury and Alderbury which are leased to the Foundation Trust for staff accommodation.

Hillcote, Manor Road, Salisbury

Hillcote (pictured opposite) is a large Edwardian building located close to Salisbury City centre. Great Western Hospital provide residential care for children with severe learning difficulties under a lease. The building is owned and maintained by SFT and is in reasonable good order for its age. AWP have confirmed that from June 2015 they will no longer provide services from Hillcote and therefore the facility will be available for SFT use or disposal.

Salisbury District Hospital (SDH), Salisbury

From this point forward, this Strategy concentrates on the SDH site for the detailed analysis of the Foundation Trust's estate. The SDH site covers an area of 21 hectares, and has buildings with a total floor area in use of 95,899m2. The hospital stands on open down land south of the City of Salisbury. The hospital can be divided into three distinct areas.

SDH North area is the modern Phase 1 and 2 developments totalling approximately 51,200m2 of floor space. Phase 1 was completed in January 1993 and is based on the Nucleus cruciform design with a hospital street on 5 levels. Phase 2 (top right) opened in May 2006. SDH North houses most of the acute inpatient wards, A&E, main theatres, diagnostic services, burns and plastics services and the main outpatient departments

SDH North viewed from the South

SDH Central is predominately 1940s, single storey, flat roofed accommodation. Nearly 4,000m2 of these wartime structures still house some clinical services, including intensive care unit (NICU), the maternity services and pre op assessment. SDH Central also includes the Day Surgery Unit (DSU), a satellite radiology department and the Spinal Unit. The Spinal Unit is a traditional pitched roof building (top centre) opened in the early 1980s and the DSU (white building) is of modular construction built in 1993 which was subsequently extended in 1999 and again in 2003.

S

DH Central Viewed from the West

SDH South comprises a mixture of largely single storey buildings. Many of the wartime buildings are now empty and taken out of use, awaiting demolition. Some of the more recent, substantive buildings are the Salisbury Hospice, (centre right) Wessex Rehabilitation Centre, Court Close staff residential houses, Medical Engineering and Science Centre and administrative offices (foreground right).

SDH South Viewed from the West

2.2. Recent Estate Developments

The Strategy is now nearly four years into the normal five year cycle of estate planning and progress is being made on the following main redevelopment and estate management targets. This section sets out the more recent capital developments completed and operational at SDH, improving the levels of care and helping to deliver quality of care in an estate fit for purpose.

- **Land sale**

  The final parcel of Trust land at Wilton Road in Salisbury known as Llangarren was sold in 2011.

- **SDH redevelopment projects**

  The refurbishment of the Emergency Department and the creation of the new two storey Paediatrics Department in the main Phase 1 building were completed in March and June 2011 respectively. The Paediatric scheme was successful in the national Building Better Health Care awards where the Unit won a category in recognition of its unique child-friendly design and bright and sensitive internal decoration. This reflects the key planned improvements strategy (p 22) *"… committed to designing, maintaining and improving the environmental standards across all sites and areas within the Trust remit".* These schemes have set the benchmark for design standards for future schemes.

- **Maternity services**

  A scheme to transfer antenatal and postnatal services into the former Pembroke ward and suite buildings was completed in November 2011. This scheme has better equipped the department to manage an increasing birth rate, centralise maternity services on one side of the SDH Central corridor and provided one central entrance point for Maternity. A new scheme, funded through the Stars Appeal, to provide a dedicated baby bereavement unit (the Benson Suite) was also completed in March 2013.

- **NICU relocation and Parent's Accommodation**

  NICU was relocated to the former Wilton ward in May 2012 creating transitional care beds with an improved environment and privacy, along with the creation of more single rooms. New parent's accommodation provided in the vacated NICU building funded through the Stars Appeal has seen the opening of four ensuite bedrooms in October 2012.

- **Clinical Psychology**

  A project to relocate the Clinical Psychology department within the former children's unit (Block 74) was completed in June 2013.

- **Spinal Outpatients department**

  The refurbishment of the Spinal outpatient based service in a dedicated facility with new patient hoists and an expanded clinical treatment space was opened in September 2012.

- **Urology OPD**

  Refurbishment of the former children's accommodation (Blocks 70, 72 & 74) saw the creation of a new Urology OPD department including the creation of offices for Ophthalmology and ENT Admin staff (thus relieving space pressures in key clinical areas of the main Phase 1 building). This scheme completed in June 2013

- **Private Patients Unit**

  A new four bedded facility was opened in 2011 on the lower ground floor of the Spinal Injuries Unit. An improved pedestrian access has also been provided giving a direct route from the main visitor car park.

- **Transport**

  A partnership between the Trust and Wiltshire Council has seen a significant improvement to the cycle and pedestrian footpath between the main entrances on the Odstock Road. In recognition of full funding by the Council, a slither of hospital land has been dedicated to the Highways Authority so that they can carry out future maintenance. Double yellow lines now prevent parking all along the Odstock Road beyond Entrance B to the south.

- **Reuse of existing spaces**

  Two recent projects showing a diverse use of the existing spaces on site. The Horatio Garden project has seen the creation of a rehabilitation garden for patients of the Spinal Treatment Centre in memory of Horatio Chapple, which was opened in September 2012. In the main entrance to the hospital at level 3, the Trust has leased space to WH Smith as a commercial venture.

- **Redlynch and Pitton wards**

  Both these wards were upgraded during 2013/14 to provide facilities that were designed with the needs of patients with cognitive impairment, especially dementia, firmly to the fore. More light was brought into the wards, the décor was freshened up with new toilet and shower facilities installed. Communal areas have been created to allow patients space to wander and to gather and interact with other patients and staff. The new facilities have been a great success and have garnered much praise from patients, visitors and staff.

2.3. Environmental Management Projects and initiatives

The Trust has been investing for the future by carrying out a series of sustainability and energy management projects and initiatives. The major schemes have included the replacement of some heating boilers, with efficient condensing units and the installation of efficient LED lighting in the main hospital corridors.

The replacement of the main cooling equipment has been carried out to ensure that the hospital can provide a suitable clinical environment in a cost effective and energy efficient way. Investment has been made in renewable technology with the installation of solar thermal and photo electric arrays on the roof of the buildings; these will provide both power and heating to help further reduce the carbon footprint.

2.4. Key Estate Indicators

The full detail of the estate's current (March 2013) condition is contained within Appendix A. The following section represents some key headlines from that more detailed information. Given that the latest information is from March 2013, it is worth noting that with the improvements recently made to Pitton and Redlynch wards and those underway in Radnor, the figures will improve substantially.

Almost 90% of the Trust's estate is in (Estatecode) condition B or better. It is worth noting that condition B is the standard which the PFI partner is contractually obliged to maintain the PFI building. Whilst the majority of the estate is in that condition, in SDH Central that figure falls closer to 80%. By 2015, the Estate Strategy set a target that this site-wide figure would be 91% - it is expected that this figure will be achieved with further improvements made in SDH Central.

There are no statutory standards which the Trust is not complying with, however maintaining the corridors in a fit state for access in the event of a fire remains a constant issue which requires regular review and operational attention.

Almost 80% of the estate is suited for the services provided, but approximately 25% of SDH Central does not pass that particular test. The site is well used, with very little underutilised space particularly in the main clinical areas. And, on the whole, the accommodation is of a good quality – some 65% being of excellent or acceptable quality (compared to an Estates Strategy target of 61%). However that leaves a substantial floor area which will require further capital investment, some of which has already begun (phase 1, SDH North) or is planned (SDH Central).

2.5. Headlines on Progress Against Key Estate Indicators

The updated data for March 2013 shows that the Trust is making steady progress towards delivering the key indicators and targets it set for the delivery of estates strategy:

Indicator	At Dec 2009	Plan At Dec 2015	Actual At March 2013	Status
Percentage of estate at estatecode B – **physical condition**	88.3%	91.1%	88.7%	
Percentage of estate at estatecode B – **functional suitability**	73.4%	76.1%	78.4%	
Percentage of estate at estatecode B – **quality of environment**	57.8%	61.3%	64.1%	
NHS Energy Efficiency	B (58 GJ/100 cu m)	A	A (50 GJ/100 cu m)	

With a year of the strategy still to go, and given the improvements made since early 2013, the expectation is that there will have been sufficient improvements made to the estate to ensure all these elements will be delivered by the end of 2015.

3. Service Strategies and Impact on Estate Need

3.1. Current Service Profile

Salisbury provides a broad portfolio of acute district general hospital (DGH) services to our local population of around 230,000 to patients in Wiltshire, Dorset and Hampshire. Alongside these services we deliver a focused portfolio of highly regarded tertiary services, such as burns and plastic surgery, and the Wessex Genetics Laboratory, to a wider catchment of about 3 million. The Duke of Cornwall Spinal Unit covers the whole of Southern England from Kent to Cornwall and up to London, comprising an area of some 11 million population.

The population of Wiltshire is projected to increase by 6.6% (33,000 in numbers) between 2011 and 2021 (source Joint Strategic Assessment (JSA) based on ONS projections from the 2011 Census). Projected increases in the population is are greatest in the areas to the periphery of SFT's catchment area – growth in Warminster and Westbury, Trowbridge and Devizes will have most impact on SFT.

Wiltshire's population is heavily weighted towards older age groups (2011 - 19.5% 65 years+ compared to England average of 16.7%), and this is projected to increase over the next 10 years (2021 – 22.6% 65 years+ compared to England average of 19.1%). This represents a 32% increase in the number of people over 65 in Wiltshire over this 10-year period.

The Trust serves a considerable proportion of the secondary health care needs of the army population stationed at Tidworth, Bulford and Larkhill and this population is due to increase as 4,000 military personnel and their families (10,000 in total) are repatriated from bases in Germany in the next 2-4 years, with the biggest expansion beginning in 2018. This is likely to have the most significant impact on maternity, paediatric and musculoskeletal and trauma services provided by the Trust. This population has an increased percentage of ethnic minorities compared to the rest of the Trust's catchment.

3.2. National Context

The recent publication of the *Five Year Forward View* has rearticulated some broad directions of travel for healthcare over the next five years, stressing the changes needed to manage the increasing demands predicted.

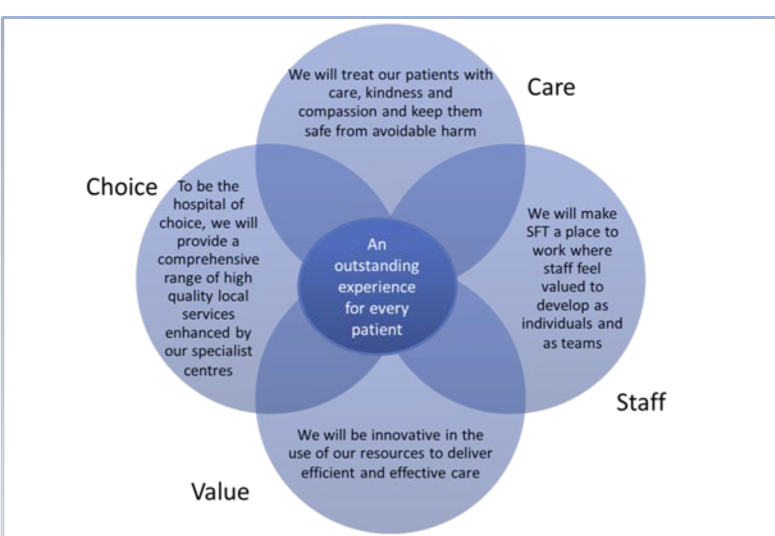
One of the key themes that will impact upon the Trust's estate is the expectation that with care provided closer to home, the number of acute beds required on this site will reduce. Once a sustained drop in demand is apparent and the need for escalation beds reduces, the Trust can effectively plan for how it will change its estate plans and find alternative uses for the freed up estate.

3.3. The Trust Vision and Key Strategic Goals

Salisbury NHS Foundation Trust's vision is to offer:

> An outstanding experience for every patient

The strategy has identified four strategic goals to move the organisation forward in achieving the vision described above:



For all of these four goals a high quality estate and a superior standard of facilities is vital. Facilities play an important part in patients choosing to attend this hospital and to come back. We can only care for patients in an environment that promotes safe and high quality care and it is clear that the environment has an important role to play in patients' recovery. We want to provide our staff with facilities which offer a pleasant environment to work in. And our estate must contribute to the Trust being an

effective, value for money organisation – energy efficiency being just one way in which that contribution is already being made.

The Board has recognised the important role that the environment plays in delivering on the strategy by reiterating in its Statement of Intent that it would:
"invest in the adoption of high quality design to make substantial improvements to the ward areas, especially for the elderly and for users of our maternity services."

4. The Next Development Phase for the Estate

The funding is not available for large-scale capital schemes given the levels of NHS funding predicted over the coming year and in it's five year strategic plan submitted to Monitor in June 2014, the forecast levels of capital for building works were restricted in light of the funds available and competing priorities for maintenance, replacement equipment and information technology:

Capital Programmes for 2014/15 to 2018/19 (check final version)

	2014-15 £000	2015-16 £000	2016-17 £000	2017-18 £000	2018-19 £000
New Build	4,036	2,250	1,000	1,000	1,000
Maintenance	3,867	3,463	3,160	3,160	3,160
Equipment	2,547	2,300	2,500	2,500	2,500
Information Technology	2,375	2,550	2,200	2,200	2,200
Gross	**12,825**	**10,563**	**8,860**	**8,860**	**8,860**
Less Grants and Deductions	1,400	600	300	300	300
Net Total	**11,675**	**9,963**	**8,560**	**8,560**	**8,560**

Given this, the Trust will need to focus on how it can secure the best return on this investment, in the main by the imaginative re-use of existing accommodation.

Within these constraints, the major capital schemes highlighted within the Trust's strategic plan of 2014 include the following:

Maternity Developments - Maternity services at Salisbury are predicted to experience growth in the birth rate as a result of the garrison changes as somewhere in the region of 4,000 serving personnel and 6,000 dependents return to the UK and locate within the service's catchment area over the next 2-3 years. At the same time the service is provided from buildings which have limited flexibility to expand and which have a relied on a number of injections of funds to maintain the patient environment for facilities which are now more than fifty years old. Over the lifetime of this strategy further investment in the maternity infrastructure is required to enable the service to meet the projected increase in workload, but also to enhance the environment offered to local women and their partners and increase the degree of choice of how and where their babies are delivered, including the development of a low risk birthing unit. It is expected that this will require a phased development plan, beginning with a major expansion starting in 2015/16. A business case will come to Board in the first quarter of 2015.

Phase 1 improvements – the Phase 1 building of SDH North is now more than twenty years old and in increasing need of refurbishment. The success of the Redlynch and Pitton developments have shown

the improvements which can be made within the constraints of the existing infrastructure to deliver facilities of the highest standard which meet the needs of the patients using them. Over this period, the Trust will look to refurbish all the wards in Phase 1. Many of them will build on the lessons learnt from making the environment appropriate for the needs of the elderly, including the cognitively impaired, but that approach will not be relevant for all the wards. A programme of refurbishments will be developed, but the anticipation that the next ward to undergo this work will be Downton during the summer of 2015.

Level 2 - Springs Entrance – a project is already underway to secure an improved entrance at level 2 for the increased number of patients accessing the hospital site from the main public car parks. The current entrance was not designed to accommodate the volume of footfall now experienced. The intention is to improve access from the car parks, shield off the patient and visitor entrance from the industrial area around the laundry and catering service areas and to create an entrance which is welcoming and makes a statement to the public. The entrance will house some key reception functions and could potentially offer some retail space. The project has not progressed as hoped, largely due to issues with fire regulations building close to another building. Final plans are being drawn up, planning permission being sought and it is intended that work on site will begin in the summer.

Use of SDH South - a scheme is underway to secure a potential joint venture partnership to exploit the opportunities offered by approximately 2 hectares of space on SDH South which is currently not effectively used. It is intended that the Trust will determine a preferred partner for this development in early 2015. That partner will assist in the overall strategic planning of this site and will contribute to future iterations of this Estates Strategy as well as assisting SFT to bring partners on to the site to develop innovative schemes to generate a revenue stream for the Trust.

Breast Unit - It is proposed that the outpatient and diagnostic treatments and examinations for patients who are referred with suspected breast cancer should be brought together in one dedicated unit. It is proposed that this is achieved through combining the Breast unit with the current Gynaecology OPD facility with some additional build and the purchase of the necessary diagnostic equipment (ultrasound). Such a scheme will have considerable benefits for the experience of the patients using that service enabling their care to be provided from a purpose-built environment tailored to their needs and sensitivities.

Improvements to the Spinal Unit - with infrastructure which is now thirty years old, the Duke of Cornwall Spinal Unit is also in need of focused attention. The recent improvements by Horatio Garden and the proposed extension which will allow patients to enjoy the garden from inside, there are good examples of what can be achieved with the building. There are a number of projects which have separate budgets which could be combined to achieve more. A distinct condition survey of the Spinal Unit was undertaken in October 2014 and this will form the basis for an improvement plan for the unit which will evolve over the next 12 to 18 months.

Other projects which are still at the feasibility stage include:

Sterilisation and Disinfection Unit (SDU) – the Trust is currently reviewing the opportunity to move SDU from its current location to one on the SDH South site. An expanded unit would enable the Trust to bid for additional sterilisation work from other hospitals as well as freeing up space in SDH North. A store for laundry linen would be included which would free up space in the main building which would be used to improve the laundry's productivity.

Campus Project – the Trust is contributing to a project looking at the use of the public sector estate across Wiltshire, particularly focussed on the market towns. The aim is to generate savings by public

sector bodies working together more effectively in the use of their collective estates. This also might generate opportunities for the use of the SDH South estate.

Step down unit – another possibility for the local community to develop on the SFT site (possibly in SDH South) is an intermediate care unit for patients who no longer require acute care but who are not ready for a care package in the community. This unit would have a strong emphasis on rehabilitation to promote patients' independence and therefore could link with the wider rehabilitation agenda (see below).

Expanded emergency assessment unit – to improve how we manage emergency admissions with a particular focus on reducing the numbers of patients admitted as urgent. To achieve this, we believe we need to develop an enlarged emergency assessment unit which allow a cohesive, fast-moving service focused on rapid patient assessment and discharge planning, with efficient and effective collaboration between primary and secondary care clinicians. Making this facility appropriate for the needs of elderly patients would be a requirement.

Day Surgery Unit (DSU) – the success of DSU is clear to see with a very effective and popular facility undertaking more than 10,000 operations a year. There is undoubtedly potential to expand the proportion of work which goes through the facility. In 2015 the plan is to move much of the administration out the unit so that the facility can be expanded clinically, either with additional theatre space or with a bedded 24-hour unit. Feasibility plans will follow from capacity and demand analysis.

The SDH Central Boiler area – with the move to more devolved boiling systems this central facility is no longer required. The space the building occupies is in a prime location close to DSU and to the Spinal Unit car park. A cost of about £150k has been estimated to demolish the building. Plans and opportunities for how this space might be used will be considered over the next twelve months.

Rehabilitation Unit – there are opportunities from the development of rehabilitation services for the Trust in a number of areas. With Wessex Rehabilitation Unit and the Spinal Unit there are good clinical linkages which would support a development which could require capital investment to unlock.

Private Patient Unit – private patient activity is an area that the Trust has identified as a potential opportunity to expand income. The current facility is undersized to make a substantial contribution and the Trust will need to determine whether it allocates additional funds to expand the private patient offering it makes.

Anaesthetic department – this department is expanding in terms of medical workforce and is in a key location close to theatres. There are no firm plans to move the department to a less central location, but it would be expected to feature in future plans.

Hillcote – a decision is required on the future use or disposal of the Hillcote site. Professional advice is currently being sought.

4.1. Energy Management - Future Priorities and Targets

As stated, the Trust is working towards the achievement of the NHS Sustainable Development Unit targets of carbon reduction, which in line with the Climate Change Act 2008 gives an ambitious aspiration for the health and care system to achieve a 34% reduction by 2020 in carbon dioxide equivalent emissions from building energy use and the travel and procurement of goods and services.

To achieve this target the Trust has developed a Sustainable Development Strategy and Management Plan (SDMP) to improve the sustainability of the Trust's operations by establishing clear objectives and

targets. This will provide the basis for long term improvements in sustainability within the Trust. The Sustainability Working Group will undertake regular reviews of the SDMP to ensure that the Trust's commitments to sustainable development are being fully integrated into all areas.

Future initiatives to improve the Trust's energy efficiency will include:

Traffic management - The Trust has plans to reduce traffic impacts and promote public transport and active travel which is supported by information and incentive schemes. On-site car parking is managed through the use of enforcement measures by the Trust.

Minimising waste - The Trust has as active campaign to recycle unused or unwanted office equipment and furniture through a scheme run by volunteers. This has proved very popular with staff and has directly reduced the level of waste from the site that goes to landfill. The Trust has avoided the cost of buying new equipment, by sorting waste and using suitable recycling operators and is looking at options for reducing the amount of waste which is transported offsite.

Energy and water usage - The Trust has made use of specific funding set aside internally and government backed loans to invest in energy efficient equipment. These schemes include low energy lighting LED, high efficiency condensing boilers, highly efficient coolers and renewable energy through PV and solar thermal arrays. These measure together with the introduction of a managed electrical demand process should allow the Trust to exit the CRC framework releasing a significant financial benefit whilst generating income from it's stand-by power assets.

Community Engagement - The Trust developed a community engagement action plan with clear social, economic and environmental objectives. The Trust continues to work in partnership with other bodies and links in with local government and climate change adaptation teams where required to ensure a coordinated approach to environmental management. The Trust has gathered views on sustainable development. In addition, local volunteers have been very successful with a groundbreaking initiative for the NHS, by forming a voluntary equipment recycling and reclamation project. This initiative links in with the site waste management group to reuse and recycle as much equipment as we can.

Design - Work to minimise whole life costs of building and refurbishment projects through design will continue, with work to produce design briefs that encourage low carbon, low environmental impact proposals from suppliers and partners.

5. Conclusion

The Trust has faced a considerable challenge over the period of this strategy in consolidating the development of the estate at a time of financial restraint. A combination of success at bidding for external funds, the generosity of the local public in supporting the Stars Appeal, the considered reuse of existing accommodation and a robust approach to cost control and effective project management has meant that a significant number of schemes have been delivered and limited funds have been used effectively. There remains a lot that can still be done. SFT is fortunate to have substantial land at its disposal and there remain considerable opportunities to harness those opportunities to improve further the environment we deliver our services to our patients.

During 2015 there will be a major reworking of the Estates Strategy to plan for the next five years and be clear about how we will develop an estate that meets future needs, is well integrated with other organisations' planning.

Appendix A - The Existing Estate

A.1. Introduction

As part of the appraisal of its current position, the Trust carries out work to analyse its land and property and their utilisation in accordance with EstateCode. This includes considering the 'six-facet approach' comprising:

- The physical condition of the buildings and engineering installations;
- Compliance with fire, statutory and non-statutory requirements;
- The environmental management of the buildings and engineering systems;
- The functional suitability of the estate for its current use;
- The utilisation of existing space;
- Quality

The prime purpose of carrying out land and property appraisal is to help in the operational and strategic tasks of estate management. The detail of the analysis is 'high level' (i.e. on a block by block basis) and considered sufficient for general management, identifying "black spots", investment priorities and opportunities for rationalisation.

The estate strategy document is reviewed and updated annually. The Estates and Facilities annual returns (ERIC data) also ensure that information is collected each financial year and submitted to the DoH for Performance Monitoring and Benchmarking. This system of data collection is currently under development and should continue to prove to be more informative in the future.

A.2. Physical condition and age

The physical condition of the estate is a product of the age, use, design, construction and maintenance of the assets that make up the estate. Assets have an economic life varying from 5 years for equipment, up to 60 years for the structure of a building. Engineering services and replaceable elements like roofs, windows, and floors generally have economic lives of 10 – 20 years.

Some parts of the SDH estate have gone beyond their economic life e.g. lifts, boilers, switchgear, flooring due to elements that are obsolescent. Spare parts to repair them have to be specially made. Assets can be worked beyond their economic life but will incur an increased frequency of maintenance and emergency breakdown repairs at additional cost.

The categories for physical condition are as follows:

A as new and can be expected to perform adequately over half its expected shelf life
B sound, operationally safe and exhibits only minor deterioration
C operational but major repair or replacement will be needed soon, that is, within three years for building and one year for engineering elements
D runs a serious risk of imminent breakdown
X (added to C or D) impossible to improve without replacement.

Below shows the results of the physical condition survey at SDH.

Almost 89% of the SDH estate is condition B or better.

PHYSICAL CONDITION SURVEY SDH				At March 2013		
Category	A	B	C	D	DX	Total m^2
SDH North	13,772	39,184	-	-		52,956
SDH Central	755	27,592	5,626	36	649	34,658
SDH South	593	4,440	4,612	-	20	9,665
Totals	**15,120**	**71,216**	**10,238**	**36**	**669**	**97,279**
% of floor area	15.5	73.2	10.5	0.0	0.7	**100**

Below shows that approximately 15,689m2 (equating to 16%) of the current SDH accommodation by floor area is over 40 years old, predominantly in SDH Central.

AGE OF BUILDINGS SDH				At March 2013	
Years	**North**	**Central**	**South**	**Total m^2**	**%**
pre 1948	-	11,630	4,059	15,689	16.4
1948-54	-	78	-	78	0.1
1955-64	-	36	-	36	0.0
1965-74	-	862	1,388	2,250	2.3
1975-84	-	11,727	1,514	13,241	13.8
1985-94	36,435	7,539	1,730	45,704	47.7
1995-04	2,470	2,806	974	6,250	6.5
2005+	12,328	-	-	12,328	12.9
Totals	**51,233**	**34,678**	**9,665**	**95,576**	**100**

A.3. Statutory and non-statutory requirements

There are a wide range of statutory standards relating to hospitals (the most important of which are Health & Safety at Work and Firecode), and a number of non-statutory standards required by the Department of Health such as Health Technical Memoranda and Health Building Notes.

Fire - There are no outstanding problems in patient areas, although the Trust has experienced difficulties with maintaining clear access in some of its corridor areas. A programme of local replacement and updating of fire safety systems is in hand to complement new technology.

Safety and Statutory - Health and safety continues to feature as a priority in the Trust's capital programme to ensure on-going compliance. Sometimes standards are mandatory for existing and new buildings, becoming more stringent over time. An example is the Asbestos Regulations. The Trust is under a constant and ever changing pressure to ensure its buildings do not present a hazard to its patients, staff, visitors and the contractors it employs.

Disability Discrimination - The Disability Discrimination Act 1995 (HSC 1998/156) at Section 21 makes it unlawful for people who provide goods, facilities or services to the public to discriminate against disabled people.

The Trust has taken all reasonable action in accordance with the Act to change practices and policies to remove physical barriers or offer alternative methods of access for disabled people to use hospital services.

A.4. Environmental management strategy on Sustainability

It is recognised that the NHS has a role to play in reducing the UK's carbon dioxide emissions. The running of Salisbury NHS Foundation Trust involves many activities which can have an impact on the environment. These include the use of energy and water, the production and handling of waste and the use of natural resources. The Trust continues to investigate ways in which their environmental impact can be reduced.

Energy efficiency is an important factor in determining the overall efficiency of a property and its performance as an asset. The Trust measures a number of key indicators to assist with the monitoring of environmental performance such as utility usage and waste generation. Key indicators are measured and reported within the Trust through regular reports and to the Department of Health through ERIC returns.

The NHS targets for the healthcare estate are 35-55 GJ (Gigajoules) per 100 cubic metres.

The NHS categories for energy efficiency are as follows:

A 33 – 55 GJ/100 cu m

B 56 – 65 GJ/100 cu m

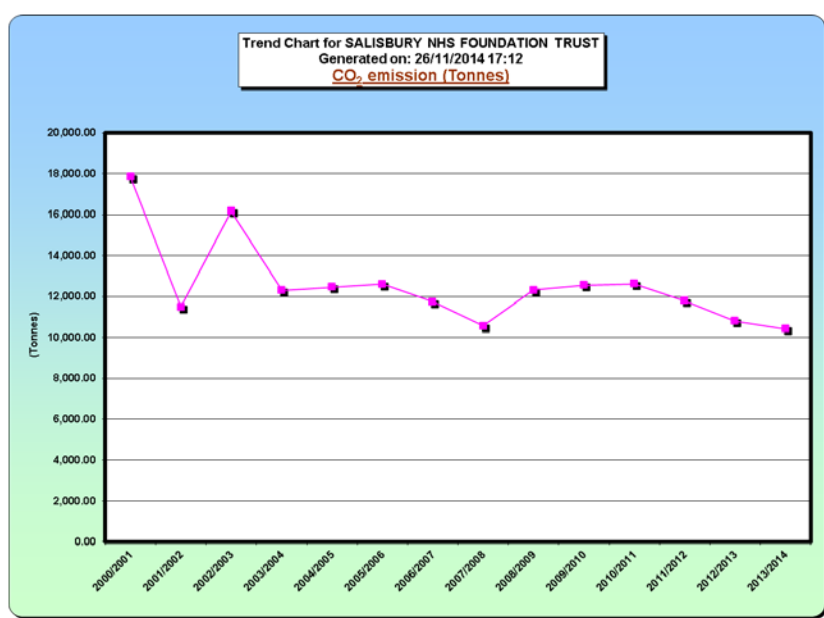
C 66 – 75 GJ/100 cu m

D 76 – 100 GJ/100 cu m

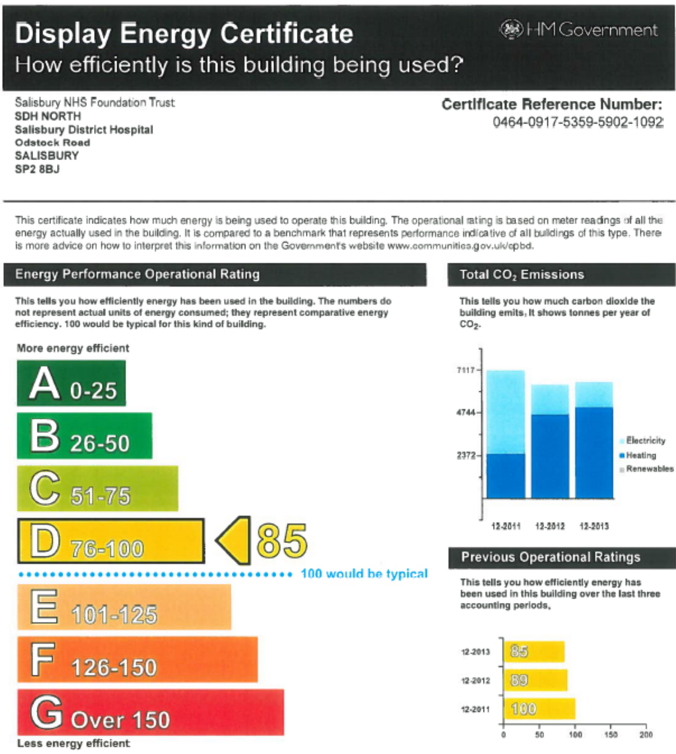
X (added to C or D) indicates improvement to a performance level of B is either impossible or uneconomic.

Current ratings show the Trust as a good performer. With the recent building upgrades and energy efficiency schemes fully operational and some of the older buildings at SDH South closed or demolished, the current rating for the whole of SDH averages out at A (50.51 GJ/100 cu m. The South and Central areas are lower rated at C while the residential accommodation is A, with SDH North at A.

The size of the Trust also means that it participates in the National Carbon Reduction Commitment (CRC) scheme. The reports generated for this scheme allow the Environment Agency (EA) to monitor the absolute carbon generated by the organisation and the change year on year to a "footprint" year. The NHS Sustainable Development Unit (SDU) has also set targets for the NHS of a 10% reduction in carbon emissions by 2015 from a 2007 baseline. The Trust has achieved this target reduction in 2014 and is now working towards a more challenging target of a 34% reduction from the 1990 baseline.



The Trust will continue to develop more accurate key performance indicators with the progression of environmental management and improved sustainability initiatives. The Trust continues to ensure compliance with the Building Performance Directive and ensure that updated Display Energy Certificates (DEC) are in place.



Display Energy Certificate

How efficiently is this building being used?

HM Government

Salisbury NHS Foundation Trust
SDH NORTH
Salisbury District Hospital
Odstock Road
SALISBURY
SP2 8BJ

Certificate Reference Number:
0464-0917-5359-5902-1092

This certificate indicates how much energy is being used to operate this building. The operational rating is based on meter readings of all the energy actually used in the building. It is compared to a benchmark that represents performance indicative of all buildings of this type. There is more advice on how to interpret this information on the Government's website www.communities.gov.uk/epbd.

Energy Performance Operational Rating

This tells you how efficiently energy has been used in the building. The numbers do not represent actual units of energy consumed; they represent comparative energy efficiency. 100 would be typical for this kind of building.

More energy efficient

A 0-25
B 26-50
C 51-75
D 76-100 — 85
100 would be typical
E 101-125
F 126-150
G Over 150

Less energy efficient

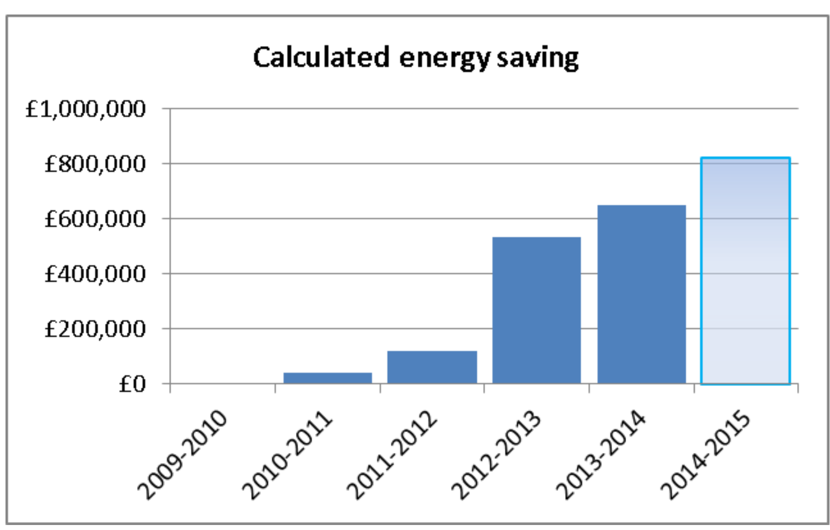
Total CO_2 Emissions

This tells you how much carbon dioxide the building emits. It shows tonnes per year of CO_2.

Previous Operational Ratings

This tells you how efficiently energy has been used in this building over the last three accounting periods.

Period	Rating
12-2013	85
12-2012	89
12-2011	100



A.5. Functional suitability

The functional suitability analysis describes how effectively a site, building or part of a building supports the delivery of a specified service. The three elements assessed are internal space relationships, support facilities and location.

It should be noted that the extent of the survey concentrates on clinical areas and covers 70% of the existing floor space (omitting staff housing, leisure centre, development areas, plant rooms and SDH North link corridors).

The ratings used for **functional suitability** are:

- **A** very satisfactory, no change needed
- **B** satisfactory, minor change needed
- **C** not satisfactory, major change needed
- **D** unacceptable in its present condition
- **X** supplementary rating added to D to indicate that nothing but a total rebuild will suffice.

FUNCTIONAL SUITABILITY SURVEY SDH				**At March 2013**		
Category	A	B	C	D	DX	**Total m²**
SDH North	12,355	21,274	3,387	1,308	-	**38,324**
SDH Central	1,720	15,450	2,687	2,298	1,471	**23,626**
SDH South	974	3,258	2,907	1,094	-	**8,232**
Totals	**15,049**	**39,982**	**8,981**	**4,700**	**1,471**	**70,183**
% of floor area	21.4	57.0	12.8	6.7	2.1	**100**

The functional suitability assessment concluded:

- the configuration and condition of the oldest wards in SDH Central are becoming unsuitable for the delivery of healthcare in the 21st century
- replacement is required to bring these wards up to an acceptable standard throughout
- some mechanical and electrical services are outdated, likely to suffer increased problems and need radical overhaul if not replaced as part of a rebuilding programme
- the repair of the existing buildings in the central site would in most cases be an unsatisfactory compromise in terms of efficient provision of healthcare in accordance with patients' reasonable

expectations as to comfort, amenity and access to support services. This is particularly so in SDH Central, the Maternity wards and Neonatal Intensive Care unit, whilst have recently undergone some extensive refurbishment, are still housed in 1940's buildings.

Externally at SDH there remains the poor functional relationship of the helipad (built with the Spinal Unit) to the Accident and Emergency department and Burns Unit. Emergencies to all departments have to involve ambulances standing by for patient transfer. However following an extensive survey in 2013, the report concluded that the creation of a helipad close to SDH North would be both difficult (in planning terms) and expensive to construct.

A.6. Space utilisation

The space utilisation analysis indicates under or over utilised capital assets. However, these spaces may be difficult to release because of their disparate nature and physical barriers to their rationalisation. Under-use of space represents a waste in terms of property overhead costs (i.e. cost of lighting, heating, maintenance, cleaning, capital charges, rates, etc). Overused space may impede the effective delivery of healthcare.

It should be noted that the extent of the survey concentrates on clinical areas and covers 70% of the existing floor space (omitting staff housing, leisure centre, development areas, plant rooms and SDH North link corridors).

The ratings used for space utilisation are:

E empty
U underused
F fully used
O overcrowded

SPACE UTILISATION SURVEY SDH				**At March 2013**	
Category	E	U	F	O	**Total m^2**
SDH North	-	-	37,682	642	**38,324**
SDH Central	923	54	20,200	1,052	**22,229**
SDH South	-	1,009	7,224	-	**8,233**
					-
Totals	**923**	**1,063**	**65,106**	**1,694**	**68,786**
% of floor area	1.3	1.5	94.7	2.5	**100**

A.7. Quality

This facet assesses the quality of the Trust estate taking account of three elements - amenity, comfort engineering and design:

- Amenity (function) - whether the estate offers an attractive and pleasing area for patients and staff (for example in terms of privacy, dignity, comfort, working conditions, signposting)?
- Comfort engineering - whether the estate offers an acceptable environment (for example is it well lit, adequately heated and cooled, noise and odour free)?
- Design (appearance) – whether the estate is attractively designed both internally and externally (for example in terms of good colour schemes, well furnished, enhanced by art, plants, landscaping, views etc)?

It should be noted that the extent of the survey concentrates on clinical areas and covers 70% of the existing floor space (omitting staff housing, leisure centre, development areas, plant rooms and SDH North link corridors).

The ratings used for quality are:

A a facility of excellent quality
B a facility requiring general maintenance investment only
C a less than acceptable facility requiring capital investment
D a very poor facility requiring major capital investment or replacement
X supplementary rating added to D indicates that nothing but a total rebuild will suffice

QUALITY SURVEY SDH						**At March 2013**
Category	A	B	C	D	DX	**Total m^2**
SDH North	11,177	16,267	9,572	1,308	-	**38,324**
SDH Central	579	12,377	5,779	1,625	1,815	**22,175**
SDH South	-	3,688	2,880	571	1,094	**8,233**
Totals	**11,756**	**32,332**	**18,231**	**3,504**	**2,909**	**68,732**
% of floor area	17.1	47.0	26.5	5.1	4.2	**100**

This facet should emphasise the 'feel good' factor of the hospital environment. On a site such as the SDH, the vast difference in the quality of the estate can only lead to superficial and subjective ratings. However, measured against many other acute hospital sites, SDH does benefit from a wonderful rural setting that must promote a feeling of wellbeing for patients, visitors and staff. This has been demonstrated with the Phase 2 development.

The Trust widely uses 'Art in Hospital' on all sizes of schemes from new build through to refurbishment projects. Success has been seen on recent refurbishment projects up to 2013 which included relocating the Children services to SDH north. Special efforts are made to tidy up some of the older corridors, improve wayfinding and making entrances more welcoming. The Trust has complied with the law to ban smoking in public buildings and has smoking shelters placed at strategic locations around the site. These however are not attractive features.

The quality assessment concluded:

- the problems associated with heat gain in SDH North (Phase 1) building remain prevalent
- SDH Central corridor is category DX as limited improvements can be made to improve the quality of this environment
- refurbishment of the former clinical accommodation on SDH South to offices has enabled better working environment for staff and visitor

Trust Board meeting
STRATEGIC PLAN 2014-15 MID-YEAR REVIEW **SFT 3609**

Date: 8 December 2014

Report Presented by: Laurence Arnold, Director of Corporate Development

Executive Summary:
The mid-year review provides the Trust Board with an update on progress with;

- Compliance with regulatory requirements
- Building on our strategy and improving services in line with the strategy focussing on;
    1. Choice
    2. Care
    3. Our Staff
    4. Value
- Infrastructure developments

Proposed Action:
The Board is asked to note this report

Links to Assurance Framework/ Strategic Plan:
This is the mid-year review of year 1 of the Strategic Plan 2014-19

Appendices:
None

Supporting Information

Strategic Plan 2014-15 –Mid Year Review

1. Introduction

The purpose of this document is to provide an update to the Board on progress made towards achieving and implementing the key priorities which Salisbury NHS Foundation Trust (SFT) identified in the Annual Plan which was submitted to Monitor in May 2014. This document is an overall summary and is not intended to repeat the information which is sent to the board from a range of other sources.

2. Regulatory Requirements

2.1. Trust Governance

The Trust is required to report on a number of regulatory requirements in its quarterly report to Monitor:

Compliance with CQC registration: The Trust remains compliant. The CQC published the finalised new inspection methodology for acute trusts in September 2014 and a scheduled inspection under this new methodology is expected in 2015. The Trust continues to be placed at the low-risk end of the CQC's bandings. The Trust held a Mock Inspection in September 2014 and action plans arising from the reported findings have been developed where required. The exercise has informed our thinking on re-shaping our preparations and self-assurance in relation to these requirements. A set of proposals to maintain and demonstrate compliance with the required standards is being discussed by the Executive.

Monitor Licence and Risk Assurance Framework: The Licence requires the Trust to deliver commissioner requested services; ensure its on-going good governance, access to required resources, to report to Monitor where required and to avoid anti-competitive or obstructive behaviour. This is being achieved and the Trust maintains the delivery of robust governance. The Trust continues to achieve a Continuity of Service rating of 4 (range 1-4, with 4 being the highest), and this is monitored by the Finance Committee on behalf of the Board. The Trust shows a green rating in both quarter 1 and 2 under the Risk Assurance Framework with no exception reports. Action plans are in place to ensure this position is maintained.

Achievement of financial targets: Meeting the cost improvement and income generation targets will be challenging. However, the Programme Management Office overseen by the Chief Operating Officer are working to achieve these and there is transparent reporting of progress to the Finance Committee.

2.2. Compliance with the NHS Constitution

National standards for referral to treatment times within 18 weeks, have been achieved for all specialties during the first half of the year, and benchmarking shows the Trust is performing well in comparison to other Trusts.

The Trust has complied with the cancer two week waiting times for both quarters during the first half of the year, and there is on-going work to ensure this is maintained in light of increased demand arising from a series of public health campaigns to increase the public's awareness of the early signs of cancer.

3. Strategic Direction

The 5 year strategic plan (2015-19) was approved by the Trust Board in March 2014 and submitted to monitor in June 2014. The Trust's vision is to provide "An outstanding experience for every patient", and the strategy identifies four strategic goals as a vehicle to achieve the vision.

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

3.1. Trust's Strategy

The Trust's strategic vision has been shared with staff throughout the organisation; different formats of the strategy document are being produced to promote awareness. The Chief Executive delivered several well-attended presentations updating our staff on the challenges faced by the NHS and how the Trust's 5 year strategy has been informed by those challenges and changes. The Trust Board has, through designated "away days" agreed and contributed to the Trust's strategy. Engagement of the clinical directors enables information to be cascaded to clinical colleagues, as did presentations which have been given at lead clinician workshops to ensure they have the opportunity to participate in discussions about the Trust's strategy – another follows in early February. The Board has received presentations from five clinical services (genetics, plastic surgery, stroke, urology and maternity) on the key issues facing those services and their development plans. The success of last years "Board to Board" meeting was repeated this year between SFT and Wiltshire CCG where both organisations shared their respective strategies, reflecting on a high degree of consistency and agreement within the local health economy.

3.2. Trust Values and Behaviours

The Trust's values and behaviours were approved by the Board in April 2014. Positive promotion of the values has included the Living the Values award included in this year's Striving for Excellence Awards, through the internet and the intranet pages. Values based recruitment has been embedded in the recruitment policy as well as within the staff appraisal system (SPIDA).

3.3. Nursing Strategy

In response to the Trust's vision of offering "an outstanding experience to every patient", and to consider the implications of the Francis and Keogh reports, the Nurses, Midwives and Allied Health Professionals developed a strategy during 2013 designed to ensure that patients, their families and carers receive compassionate, high quality care at all times. The strategy was officially launched on in October 2013. One year on the new Director of Nursing is in the process of meeting with all ward and department leaders to discuss how the strategy has been put into practice, what difference it has made, and each area's priorities going forwards in order to build on this work. These meetings have established that progress has been made in all areas with some high quality pieces of work completed. This will be celebrated through a second Pride In Practice Event in March 2015 where departments will present their work and the next stage of the Strategy will be launched.

3.4. Planning Beyond this Year

The importance of longer term planning is ever more apparent. The Trust's Strategy covers a 5 year period and will be updated to ensure that it continues to be a live and relevant framework around which developments can be planned. The directorates are currently working on their service plans to cover 2015/16 and 2016/17 and a session is to be held in early February with the clinical leads and department heads focused on developing services plans which are consistent with the Trust strategy. An important element of this planning session will be to consider the implications of the Five Year Forward View and particularly what this heralds for community services in Wiltshire.

The Programme Management Office is leading the development of a three year cost improvement programme. Major transformation projects are being developed and will be implemented over the medium term, including areas such as: patient flow, outpatients, theatres, corporate departments, and reducing agency spend.

3.5. Specialist services

An important element of the Trust's Strategic Direction relates to the development of specialist services to complement the DGH element of the Trust's business. It has been essential to build relations with the new commissioners who are now the second largest commissioner in terms of financial value. In addition the Trust has maintained links with the relevant clinical networks (many of them located in Wessex) and with the Academic Health Science Network (AHSN).

SFT is working closely with other organisations to ensure that SFT's role in the provision of specialist services is maintained and enhanced. For example SFT is currently recruiting to two posts to ensure that plastic surgeon presence is substantively and consistently provided at University Hospital Southampton (UHS) to provide a reconstructive service to the major trauma centre. SFT is similarly working closely with UHS to develop plans to respond to the changing way in which laboratory genetics services will be provided.

4. Service Developments and Approach to Quality

This section is set out under the four strands of the Trust's Strategy, and includes a summary of progress made towards achieving the priorities set out in the Quality Account. A comprehensive mid-year review of the Trust's Quality Account has been undertaken and the progress update report has been presented to and approved by the Clinical Governance Committee.

4.1. Choice

During the first half of the financial year, the upward trend in GP referrals has continued resulting in an increase in market share within our core local GP practices.

To encourage patients living on the periphery of the Trust's catchment area, clinics have been established in Westbury, Warminster and Ringwood with the aim of increasing market share in these areas. A review of the utilisation of these clinics is planned, along with visits to key GP practices with clinicians. The x-ray service at Shaftesbury is now a walk-in service rather than booked appointments and due to the success of this model, other peripheral x-ray services and the GP x-ray clinic at SFT will follow suit. Promoting the Pathology service with a view to increasing the number of practices who send their samples for testing at SFT is also underway.

Local competitors have continued to promote NHS activity, and are attractive to patients as the waiting times for first outpatient appointments are shorter than those at the Trust. This has been particularly concerning in orthopaedics. However, since April 2014, there is cautious optimism that this trend has started to reverse, with the number of referrals received by SFT for this specialty increasing month on month with a small increase in market share. Demand and capacity work undertaken for orthopaedics has identified the need for separate trauma lists, and the full plan should be implemented by March 2015. Similar capacity and demand work is planned for other specialties during 2015.

Electronic Discharge Summaries (EDS) can now be sent from all in-patient wards, and feedback from GPs has been very positive. Work continues on the project to allow GPs to see all pathology results electronically and a successful project by junior doctors to reduce prescribing errors out of hours has prompted the roll out of access to GP records in A&E, MAU and SAU.

Substantive recruitment of two plastic surgeons is underway and will further consolidate our commitment to the trauma network and allow involvement of the plastic surgeons in the care and recovery of patients with skin cancer.

The therapy review was undertaken to ensure that the therapy delivered to our patients was high quality, affordable, responsive and patient centred. The new model benefits from clear lines of reporting, defined responsibilities and the ability to measure the impact therapy input has on the patient's length of stay. The newly appointed Therapy Lead will take up the post early in the New Year.

A service review of the Spinal Unit has begun using external facilitators from Wiltshire County Council with a view to developing the service further. At the same time early conversations with local and national commissioners have begun looking at a step down facility whilst safeguarding ventilated beds.

The cleft lip and palate specialist service continues to meet the commissioner's specification, jointly working with Oxford.

The RACE (Rapid Assessment & Care of the Elderly) model of elderly care has been introduced on Durrington ward, and initiatives such as 'Home for Lunch' are being rolled out. The electronic consultant to consultant referral of inpatients was successfully implemented for key services in August with roll out to the rest of the Trust on schedule. This project was highly commended in the recent Striving for Excellence Awards.

Updating and improving care pathways continues through collaborative work with the Sarum Executive of Wiltshire CCG. The diabetes pathway is nearing completion and work on the heart failure pathway has begun.

Development of the plan for expanding the maternity unit is underway to ensure that the service can continue to serve an increasing population.

Real time feedback continues to be collected by volunteers and governors and from April outpatients and patients attending for a day case procedure have been asked if they would recommend these areas to friends and family if they needed similar care or treatment. Of those who responded 97% said they would be 'likely' or 'extremely likely' to recommend the hospital. Friends and family feedback now also includes a quarterly question to staff– for the first quarter 98% of staff who responded said they were 'likely' or 'extremely likely' to recommend Salisbury District Hospital to their friends and family if they required treatment.

4.2. Care

Good progress has been made towards the six key objectives.

A strong focus on the public health agenda and aiming to reduce the number of people dying from preventable conditions has been embraced by the Trust. Over 22,800 inpatients and outpatients have been asked if they smoke, all of those who indicated they would like to give up were given information and 77% were also given support. Within the maternity service there has been some success in encouraging mothers to stop smoking during their pregnancy

Over three quarters of patients presenting at ED were asked about their drinking and of these 3% were found to be drinking at harmful levels – these patients were all referred to GP services and followed up by the nurse specialist.

Initiatives to reduce obesity and promote healthy lifestyles including the counter weight programme and Shape up at Salisbury are on-going.

The phasing out of the Liverpool Care Pathway is complete and the new Medical and Nursing Personalised Care Plans are being trialled by the Hospice. The trial will be reported to CMB in March 2015 with a view to Trust wide roll out. The conversation project which supports patients to make decisions about their end of life care has been welcomed by patients and their families.

Work to encourage and support patients to self-manage long term conditions have included courses and one to one input to make care plans and this is on-going. A booklet 'understanding and managing the symptoms of dementia' was produced using feedback from carers and has been well received.

Challenges remain around on-going collaborative working with Wiltshire Council to resolve waiting times for neuro-rehabilitation for patients who have suffered a stroke. As planned, there is an upward trend in the number of patients fast-tracked to Wessex Rehab after a major traumatic injury.

Real time feedback shows a sustained picture for patient experience and all reporting, including safe-staffing numbers are being collated and published as required.

The KPI's that monitor how patients are kept safe from avoidable harm are showing progress; for example HSMR is as expected, there has been a reduction in the number of pressure ulcers and falls. Safeguarding training continues to be a high priority and robust plans are in place to achieve infection control targets.

4.3. Staff

The four values and behaviours approved by the Board are now embedded throughout the recruitment policy, included in Induction for staff and form part of the appraisal system. Staff sessions are planned and managers are being encouraged to use values and behaviours when talking to staff about underperformance and it is hoped that this will lead to more positive outcomes; mediation rather than formal processes.

To understand and address bullying across the organisation, analysis of bullying complaints had been planned. During the first half of the financial year, the low number of complaints has made the

analysis difficult. Therefore results from the staff survey and a benchmarking exercise against other Trusts will be completed.

Developing the workforce to ensure the organisation benefits from high quality leaders has begun following a comprehensive consultation exercise to define a Medical Leadership Framework. This will support enhanced medical engagement and succession planning for Lead Clinicians, Clinical Directors and Medical Director.

The Health and Wellbeing strategy has been developed and staff participation is increasing. The recent appointment of a mental health nurse will further increase the range of services available to staff.

Plans are moving forward on a workplace learning project, the Education Quality Assurance Group are developing protocols to ensure health and safety, clinical outcomes and patient experience outcomes are all taken into account.

4.4. Value

The Trust's strategic plan sets out a number of initiative and tasks to enhance the efficiency of the services we provide and to expand the Trust's income base. Each month, the Trust Board receives the Financial Performance report showing the Trust's financial position and key financial metrics and provides a commentary on Trust activity and other significant influences on the Trust's financial position. The Finance Committee receives reports on the Trust's Transformation and Cost Improvement projects as well as significant opportunities to expand our activities and income. The Transformation and Cost Improvement projects each have their own Boards reporting up to the Programme Steering Group, meeting monthly and chaired by the Chief Executive.

Transformation and Cost Improvement

The target for financial improvement through transformation and cost improvement projects in 2014/15 is £7.947 million. This is coupled with a target to reduce the costs of agency spend by £1 million against 2013/14 spend; thereby reducing historic overspends against budgets. This is consistent with our strategic ambition in year 1 of the 2014 -2019 strategy to make cost improvements of 4% of turnover. To the end of month 6, financial improvements of £2.19 million have been achieved, against the profiled budget target figure of £2.647 million. The financial benefits of the projects are heavily end loaded in the financial year, reflecting that many of the schemes would produce benefits gradually during the year as changes were made. The benefit realisation in the second half of the year must be twice that of the first half of the year if the overall target is to be achieved.

Successive Financial Performance reports have identified the achievement of the financial benefits from these projects as our greatest short term financial risk for the Trust hitting its financial targets during the year. There has been significant progress in the year, but it is unlikely that the projects will achieve the target. Of the financial improvements to the end of month 6, 41% are recurrent and 59% (including income increases) are non-recurrent.

In terms of agency spend, we have focussed on our nursing agency cost, and to month 6, our spend on nursing agency staff is running £630,000 lower than the first half of 2013/14. We have improved our IT systems to facilitate more bank staff shifts and will be looking to recruit nursing staff from Europe. Unfortunately, our overall agency spend has increased, being £380,000 above the same period in 2013/14, with particular pressures on medical staff and professional and technical scientific staff.

Our expectation for 2015/16 is that our financial improvement target should once again be 4% of turnover.

Market Share and Activity

The Trust has consistently reported that activity and income have been higher than plan. While this has imposed significant operational pressures on the Trust and has impacted some of the cost improvement projects (for example, it has been more difficult to reduce bed numbers), the increased income is a fundamental support to the Trust's financial position in 2014/15. To the end of month 6, the Financial Performance report shows £3 million of income above the Trust's plan.

The initial indications of our market share from our core constituency of referring GPs for the the year (to August month 5) are positive, with Salisbury receiving 56% of elective work compared with 52% in 2013/14 (and 50.8% in 2012/13).

Other Income Initiatives

The laundry business is likely to make a surplus and these funds will be covenanted back to the Trust. We are evaluating the possible benefits of investment in a larger Sterilisation and Disinfection Unit, with a business model similar to the laundry (although with the likely involvement of another organisation in a joint venture). In 2015/16, we are planning to have established a contract with Royal United Hospitals Bath for support diagnostic services.

We have established the operational manager post for the private patients unit focussing on the improvement of the patient experience and marketing our services in the Clarendon Suite.

Over the coming months, we will evaluate the implications of being part of the tender for Community Services for Wiltshire.

The generosity of the people of Salisbury and the success of our fund raising continues to support major Trust initiatives. We have recently purchased two CT scanners as a result of the 2013 STARS fundraising appeal and have already raised £300,000 of the target of £750,000 for the STARS Breast Cancer Unit appeal.

Other Value Initiatives

The Trust has continued to work on the best utilisation of our staff – both our greatest cost element and obviously our greatest asset. We have completed the consultation on changes to the medical leadership model and have drafted the Job Plan Policy. The SPIDA Appraisal system has been launched across the Trust.

The Trust is an active stakeholder in the projects supported by the Better Care Fund. Our main focus is on initiatives to reduce emergency admissions to the hospital and to speed up the patients move to a more appropriate care environment or home after the completion of their clinical care at Salisbury. We are in the early days of these initiatives and have not yet seen any substantial benefits for the Trust or our patients. We will continue to work with the other partners in the local health system to achieve the beneficial objectives of the initiatives.

In recent months, the Trust has begun to use social media platforms in a more systematic manner, establishing corporate Facebook and Twitter accounts, and putting recruitment videos on YouTube. We are using the platforms to communicate and advertise and will look at the value of LinkedIn for recruitment purposes.

Financial Metrics

Metric	Strategic Target	Current Position
Monitor Continuity of Services Risk Rating	4	4
EBITDA	At least 8% turnover	8% of turnover
As a minimum, achieve a surplus	Surplus	Small surplus
Working Capital/ Net Current Assets	Positive	Positive
Cost Improvement Programme	3% - 4% turnover	C3% of turnover

5. Developing the Trust's Infrastructure

5.1. Informatics

In August 2013, the Trust Board approved an update to the Trust's Informatics Strategy for the next three years. It sets out the key priorities and outline programme for the development of systems to harness the benefits of digital working. At the centre of the strategy is the need to develop a co-ordinated electronic patient record.

A number of key updates to core clinical systems have been undertaken in the first half of 2014/15:

- A major upgrade to the way that many staff access key systems has been introduced which speeds up logging in and the transition between different Trust systems. Single sign on (SSO) has been introduced on all inpatient wards, is currently being extended into outpatients and then will be deployed in ED and in maternity.
- Following the major change to the Trust's digital radiology system (PACS/RIS) in mid 2013 the focus this year has been on extending the range of providers with whom the Trust can share images.
- The Ordercomms project for the electronic requesting and viewing of laboratory medicine and radiological tests was completed early in 2014. The next phase, due to begin in January, is for GP electronic requesting.
- An electronic patient record system specifically for ophthalmology patients has been successfully implemented for the cataract pathway. Working with Moorfields, the system was introduced very successfully such that the whole patient pathway is now recorded electronically.
- Electronic discharge summaries, rather than difficult to read carbon copies, are now firmly established, with upwards of 90% being collated electronically. Many Wiltshire GPs now receive the discharge summaries directly into their primary care systems.
- A patient observation system is due to be piloted on an acute surgical ward during December. The system will allow nurses to record patients' observations, to be reminded to take observations and the system will calculate an early warning score. Along with a number of other projects this will see the widespread use of mobile technology by clinical staff on the wards.

- SFT is part of a Wiltshire wide collaborative looking at improving the sharing of data on patients across different parts of the public sector.
- The Trust has started the procurement of an electronic patient record which will replace the current iPM patient administration system and potentially a number of other systems, whilst integrating effectively with others. This procurement will complete in the middle of 2015.

5.2. Estates

Improvements to the estate have continued over 2014, with many of them building on projects started in 2013:

- Both Redlynch and Pitton wards were refurbished during 2014 at an overall cost of £1.3m making the environment more suited to patients with dementia and generally giving the wards a much needed update after 20 years of use. The feedback received from patients, visitors and staff has been extremely positive.
- After the success of the fundraising campaign in 2013, the Trust took delivery of two new CT scanners during 2014. The second of these two in particular will enable the Trust to expand the range of procedures which can be undertaken using this imaging modality.
- In September Radnor ward moved out to allow the intensive care ward to be expanded from an 8 to a 12-bedded unit. The building programme is on target and the ward will return to its new facilities in the first full week of January
- The Trust has continued its on-going infrastructure maintenance programme with the added benefit of replacing ageing stock with new, more energy efficient technology.
- The main entrance was upgraded in early 2014 and plans are almost complete for the redevelopment of the level 2 entrance.
- Following a successful bid for national funds, the hospice was upgraded and reopened in xxx.

6. Conclusion

This paper summarises the progress the Trust is making in achieving its corporate objectives in line with the plan submitted to Monitor in May. The picture is one of steady progress against a backdrop of significant strategic change and increasing financial challenge. The agenda remains considerable both in terms of what needs to be delivered and the changes on the horizon. The Trust has made significant advances in the first half of the year; the workload for the remainder of the year is considerable, particularly in ensuring a financial surplus can be delivered to ensure capital investments can be made in future years, whilst maintaining and improving on the quality of care provided to our patients.

Trust Board meeting **SFT 3610**

PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT, AUDIT REPORT

Date: 8 December 2014

Report from: Laurence Arnold, Director of Corporate Development

Presented by: Ian Robinson, Head of Facilities

Executive Summary:

In 2013 the NHS England, Patient Environment Action Team (PEAT) environmental assessments were replaced by Patient Led Assessments of the Care Environment (PLACE).

All Healthcare organisations with 10 or more in-patient NHS beds were asked to participate and were given six weeks' notice to complete the assessment.

The Trust undertook the PLACE assessment May, measuring patient food services, cleanliness, privacy and dignity and condition, appearance and maintenance, against criteria set out by NHS England.

This report includes an action plan to improve compliance against the PLACE food standards, developed by the Food and Nutrition Steering Group this has been shared with the Operational Management Board.

Actions to improve compliance with PLACE cleanliness standards have been included within a Housekeeping resource paper; the monitoring of cleanliness standards is being undertaken each month by the Matrons Monitoring Group.

The 2015 PLACE programme will be undertaken between March and June.

Proposed Action:

1. To note the report.
2. To note the attached (food services) action plan.

Links to Assurance Framework/ Strategic Plan:

Care / Choice – ensuring delivery of a high quality environment which meets patient expectations.

Supporting Information

Salisbury NHS Foundation Trust

Patient Led Assessment of the Care Environment (PLACE)

Introduction

In 2013 the Patient Environment Action Team (PEAT) programme was replaced by the Patient-Led Assessment of the Care Environment (PLACE) the key changes being:

1. Membership of assessment teams must meet specified criteria (patients representing 50% of each team)
2. A revised scoring process to include Fail (<80%), Qualified Pass (80-99%) and Pass (100%).
3. Revised assessment questions, with some weighting.

The focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported, remained unchanged.

2014 PLACE National Results

The average scores for each of the 4 domains of the assessment were as follows:

	2013 National Average	2013 Trust Score	2014 National Average	2014 Trust Score	Trust Variance 2013-2014
Cleanliness	95.75%	85.11%	97.25%	95.39%	+10.28%
Food and Hydration	85.41%	68.34%	88.79%	83.13%	+14.79%*
Privacy Dignity and Wellbeing	88.90%	88.90%	87.73%	87.83%	-1.07%*
Condition Appearance and Maintenance	88.78%	80.06%	91.97%	92.77%	+12.71%

**NHS England notes that due to changes in the assessment methodology and scoring, the 2014 results for Food and Hydration and Privacy Dignity and Wellbeing are not considered to be directly comparable with 2013.*

2014 Trust PLACE Assessment

A training event for Trust staff and patient assessors was held in April and the PLACE assessment was undertaken on Friday May 9th and Monday May 12th. The assessment teams were made up of 8 staff (including the Deputy Director of Nursing and Senior Sister Infection Control) and 8 patient representatives (including Health Watch and FT Governors).

In addition to public areas, entrances, car parks and external areas, the following 14 patient areas were assessed:

Children's Outpatients
Redlynch Ward*
Sarum Ward
Amesbury Ward
Britford Ward*
Whiteparish Assessment

Plastic OPD
Chilmark Ward*
Endoscopy
Radnor Ward
Labour Ward
Pembroke Suite
Pembroke Ward
Downton Ward

**Food Assessments were also undertaken on these areas.*

2015 PLACE Programme

We are advised that the 2015 National PLACE ASSESSMENT programme will be held between March and June, avoiding the Easter fortnight (w/c 30th March and 6th April).

It is anticipated that we will receive 6 weeks' notice of our assessment; we will be permitted to select the day or days within the week to conclude the assessment. The criteria for the PLACE assessment has not been published however we believe the following changes may apply.

Car Parking – It is likely that new questions will be added relating to the *NHS Principles* – these questions look at Pay on Exit schemes, and concessionary parking charges.

Food - Questions relating to the recommendations from the Hospital Food Standards Panel:-

- Existence of a Food and Drink Strategy
- Compliance with the 10 Key Characteristics of Good Nutritional Care
- Compliance with the British Dietetic Association's Nutrition and Hydration Digest
- Percentage of patients assessed using the Malnutrition Universal Screening Tool (MUST) or an equivalent.

External Areas - The section may extend to include availability, condition and appearance of external social spaces, the availability of seating, condition of surfaces, wheelchair accessibility, pathways and planting.

Public Areas – This section may extend to include handrails, seating of differing types/heights, and space for wheelchairs in reception areas, wheelchair accessible toilets and hearing loops at reception desks.

Dementia - This section is likely to be considerably expanded and become a scored element.

Conclusion

The Trust score for food and hydration increased significantly from 2013, however, remains the area requiring the greatest focus, the action plan developed reflects this and the actions required to deliver a positive response to each of the (2014 PLACE) food service questions.

The Trust undertook a though PLACE inspection, applying NHS England criteria without compromise. In comparing our outcome with other NHS organisations it is evident that standards are interpreted differently across organisations.

With pressures within the inpatient environment we recognise the need to ensure cleanliness standards within outpatient environments are maintained, these are being monitored and reported to the Matrons monthly meeting. At the time of the assessment, the inspection team noted lower cleanliness standards within outpatient areas.

The Patient Lead Assessor is required to provide a statement, on behalf of the patient assessors, that summarises their view of the Trusts performance.

A modernised hospital with good cleanliness overall, well maintained, where patients are treated with kindness, dignity and respect by staff under considerable pressure.

The food, cooked on site is extremely good. Served hot with thoughtfulness and a good choice of menu.

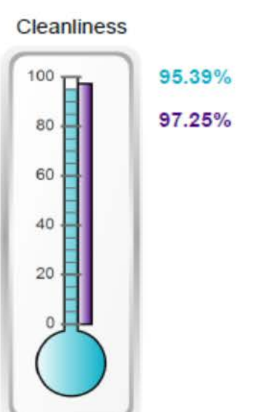
Ian Robinson
Head of Facilities
November 2014

SALISBURY DISTRICT HOSPITAL

SiteScore

National Average

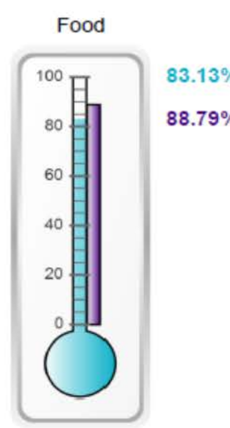
Cleanliness



95.39%

97.25%

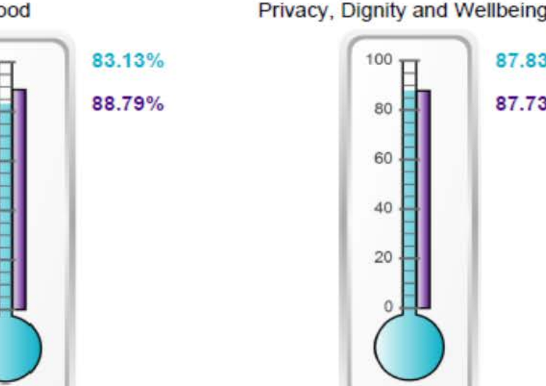
Food



83.13%

88.79%

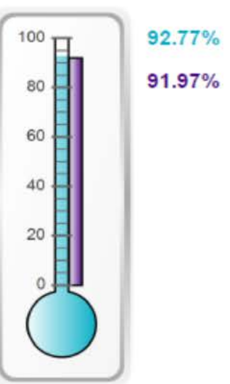
Privacy, Dignity and Wellbeing



87.83%

87.73%

Condition Appearance and Maintenance



92.77%

91.97%

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2014 PLACE Assessment

Specific Areas Requiring Improvement

Cleanliness – areas requiring improvement (mainly Out Patient Departments) -

1. High level dusting (curtain tracks – OPD, Children's OPD, Endoscopy)
2. TV's dusty (Plastics OPD, Children's OPD)
3. Clutter/tidiness (in doorways (Children's OPD)
4. Lack of alcohol gel at the bedside
5. Dirty Floor (Plastics OPD)
6. Dirty visitor chairs (Chilmark, Downton)
7. Dirty bedside fans (Downton)
8. Dusty Med Gas Equip (Plastics OPD)
9. Bed frames dusty (Endoscopy, Downton & OPD – Plastics)
10. Door frames dirty (OPD – Plastics)
11. Ventilation grills/under radiator covers (Endoscopy)
12. Dirty internal & external glazing (increase from one to two window cleans per year) (Chilmark, Endoscopy)
13. Old and rusty bins/lids do not close

Food – areas requiring improvement

1. Offer a location away from the bedside for patients to eat meals
2. Make chilled water consistently available (accessible) (capital bid)
3. Serve patient meals course by course
4. Prepare patients prior to meal service (Redlynch)
5. Provide patients with the opportunity to wash their hands prior to meal service (Britford)
6. Observe Protected Mealtimes (Redlynch & Britford)
7. Provide crockery that contrasts with tables and trays. (Chilmark)
8. Menu – consider select at the point of service
9. Provide a weekly booklet or menu with service information or consider Hospedia display
10. Breakfast – offer 2 hot food choices (add baked beans on toast to the menu)
11. Breakfast – increase preserves/spread from 3 to 4
12. Lunch – add choice of 2 sandwiches to the menu
13. Lunch – add salad and protein to menu
14. Supper – Need to increase the number of hot food choices from 2 to 4
15. Supper – Add salad and protein to menu
16. 24 hours – need to make fresh fruit (including fruit salad) available 24/7
17. 24 hours – make hot meals available to all wards.
18. Add a snack between breakfast & lunch
19. Add a snack between lunch and supper meals

PLACE ACTION PLAN (FOOD)

Food – areas requiring improvement
The following action plan has been produced to address the negative responses for the Food and Nutrition questions, in the 2014 PLACE audit.
A further review will be undertaken once the 2015 PLACE criteria are published.

	Review	**Action**	**Costs**	**Lead**	**Status**
A	Review compliance against the Government Buying Standards for Food and Catering Services.	Ensure we are fully compliant	-	IR/MS	
B	Review Patient Information around the provision of finger foods.	Promote the Finger Food menu	-	IR/MS	
C	Review to confirm packaging/tops are removed before food is served.	Confirm this is routinely undertaken and reflected in Trust policy.	-	IR/FH	
	Criteria not fully met in 2014	**Action**	**Costs**	**Lead**	**Status**
1.	Offer a location away from the bedside for patients to eat meals.	We have wards due to their layout that can achieve this standard; these wards will be selected for the 2015 audit.	-	IR/FH	
2.	Make chilled water consistently available (accessible) – *cannot be located within staff areas or requiring staff to provide access.*	Capital bid submitted for 22 mains fed floor standing chilled water coolers.	£16k	IR	
3.	Serve patient meals course by course	Consider a ward based trial to identify issues. **Unlikely the Trust will be able to comply with this standard.**	-	FH/IR	
4.	Prepare patients prior to meal service	Promote the Service Excellence Checklist.	-	FH/IR	
5.	Provide patients with the opportunity to wash their hands prior to meal service	Promote the Service Excellence Checklist Promote the use of hand wipes as an alternative.	-	FH	
6.	Observe Protected Mealtimes	Promote Protected Mealtimes.	-	MS/FH/IR	

	Review	Action	Costs	Lead	Status
		1. Re-issue the PMT poster 2. Consider articles and a Broadcast 3. Highlight good practice – Whiteparish & Winterslow trial. 4. Consider a PMT Floor sign or something that prompts.			
7.	Provide crockery that contrasts with tables and trays.	Current NHS crockery does contrast with tables – achieved. Roll out blue crockery (plates as a minimum, bowls if poss.) by December 31st 2014.	-	MS/PS	
8.	Menu – select at the point of service	Consider a ward based trial to identify issues. **Unlikely the Trust will be able to comply fully with this standard.**	-	PS/MS	
9.	Provide a weekly booklet or menu with service information	Develop a ward catering resource folder to include food service information that meets the PLACE standard & add text to menus – to be in place by 31/12/14.	£8k	MS/PS	
10.	Breakfast – offer 2 hot food choices	Consider pots of baked beans as an additional choice.	£3K	PS	
11.	Breakfast – increase preserves/spread from 3 to 4 (excluding unsaturated spreads and butter).	Achieved.	-	PS	
12.	Lunch – add choice of 2 sandwiches & two types of bread, to the menu.	Add choice of 2 sandwiches & two types of bread, to the menu.	-	PS	
13.	Lunch – add salad and protein to all lunch menus.	Achieved – no further action required.	-	-	
14.	Supper – Need to increase the number of hot food choices from 2 to 4	Increase the number of hot food choices from 2 to 4 by adding jacket potato & filling to menu & reduce sandwich choice from 4 to 2.	-	PS/MS	
15.	Supper – Add salad and protein to menu	Add salad and protein to menu	-	PS	

	Review	Action	Costs	Lead	Status
16.	24 hours – need to make fresh fruit (including fruit salad) available 24/7	Provide each ward kitchen with a washable fruit bowl to store spare fruit in. Provide fruit salad. Add the fruit bowl to each tea trolley.	-	PS/MS/FH	
17.	24 hours – make hot meals available to all wards	Advertise the frozen meals project; add text to catering resource folder. Meals accessed from Burns, Chilmark, Britford wards.	approx. £3k	MS/PS	
18.	Add a snack between breakfast & lunch	Remove evening snack from menu and add snacks to ward kitchen stocks. Add text to menus and ward catering folder. Promote on tea rounds.	-	IR/MS	
19.	Add a snack between lunch and supper meals	Remove evening snack from menu and add snacks to ward kitchen stocks. Add text to menus and ward catering folder. Promote on tea rounds.	-	IR/MS	
20.	Marks lost in the food assessments: Taste Texture Temperature	Consider – Staffing, menus, training and equipment.	-	PS/MS	
21.	**Other actions** A. Provide training for the 2015 PLACE food assessors B. Ensure a Trust lead is present at each of the 4 food assessments.			IR/MS/FH	

Trust Board meeting **SFT 3611**

ASSURANCE FRAMEWORK – REVIEW BY JOINT BOARD OF DIRECTORS

Date: 8 December 2014

Report from: Peter Hill, Chief Executive

Executive Summary:
The report is 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. 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).

Minute extract – 15 October JBD
The Board received the update on the Assurance Framework and Risk Register.

Three new positive assurances were noted around the mortality rate, Engage Project and the Friends and Family Test.

The Trust Board Workshop had reviewed the Assurance Framework and this would be reported back in a new form at the December meeting of the Trust Board.

Proposed Action:
That the board note the quarterly review of the Assurance Framework by JBD.

Links to Assurance Framework/ Strategic Plan:

The report is in support of the sections assurance framework overseen by JBD.

MINUTES OF THE CLINICAL GOVERNANCE COMMITTEE SFT 3612
held at 10am-12pm, Thursday 25th September 2014
in the Boardroom, Salisbury District Hospital

Present:

Nick Marsden (Chair), Peter Hill, Dr Christine Blanshard, Lorna Wilkinson, Claire Gorzanski, Emma Taylor, Kate Hannam, Steve Long, Nigel Atkinson, Malcolm Ace, Jan Sanders (Governor)

In attendance:	Item
Helena Eagles (Minute-taker)	
Jonathan Wright	CGC0903
Dr Carl Taylor, Mandy Cooper, Andrew Stagg, Colette Martindale	CGC0905 & 06
Hazel Hardyman	CGC0908
Gill Sheppard	CGC0909, 10 & 15
Fiona McCarthy, Dr Julian Hemming	CGC0911

Apologies:

Fenella Hill, Fiona Hyett, Lydia Brown, Sarah Mullally, Mark Stabb

Nick Marsden welcomed everyone to the Committee, particularly JS who is attending for the first time, and NM confirmed the meeting was quorate.

CGC0901 MINUTES OF THE MEETING HELD ON 24th July 2014

ET suggested amendments to the wording regarding C.difficile and antimicrobial prescribing on p.8 and p.9. These amendments were agreed by the Committee (post meeting note, amendments completed by HE).

Following these changes the Committee approved the minutes as an accurate record of the meeting.

CGC0902 MATTERS ARISING/ACTION TRACKER

May 2014 CGC0503 Frimley Park Visit – Core Services Presentations & Committee Membership

Covered under item CGC0904, the Core Services presentations are now up and running. Item complete.

July 2014 CGC0703 Raising Concerns Survey Update

CGz stated that Public Concern at Work are coming to SFT on 13th November to present at the Clinical Governance Half Day. Whistleblowing Top 10 Tips for Staff will be available as a handout. Item complete.

July 2014 CGC0710 Annual Customer Care Report 2013/14 and Complaints Survey

Covered under item CGC0903.

July 2014 CGC0712 Quality Indicator Report Q1 2014/15 including C.difficile action plan and MRSA bacteraemias

Covered under item CGC0911.

CGC0903 Quality Impact Assessment for the Cost Improvements / Transformation

JW explained that this process was formally introduced in April 2014 and the assessment looks at the benefits to patients against the quality indicators and patient safety. In this year there are 318 CIPs identified.

JW highlighted the tables in the report and explained the scoring process. Scores up to 10 are monitored through the Programme Support Group and scores over 12 are monitored at Joint Board of Directors.

CB – there has been a learning curve on Quality Impact Assessments and it is challenging to accurately score services and work out the potential quality impact. The process needs sufficient detail on each scheme and what is actually entailed.

NM asked what the check and balance system is as we need to be assured on this matter. LW stated that the effects need to be monitored over time. JW responded that the projects are on the monthly reporting schedule for PSG.

CB discussed the various levels in governance and how the process is managed. The schemes with a higher impact on quality are monitored at a higher level.

The Committee noted the report and were assured.

CGC0904 Committee Membership – junior doctor & nurse attending CGC

CGz introduced the paper and explained the review of the membership of the SFT CGC came about after CGz and LB attended Frimley Park's CGC. CGz then ran through the potential terms of reference for the attendance of a junior doctor and nurse and how this could be implemented.

Clare Page has already identified a possible junior doctor candidate but there was lengthy discussion about how best to recruit the junior doctor and nurse.

PH felt that there needs to be a selection process as this is a fantastic career development opportunity for a junior. There needs to be strict criteria.

NA supported this idea as a fair way to find a representative.

SL suggested that this could be part of the Talent Management programme and PH agreed it could and should be taken into account. One issue is that junior doctors move through the system and away from SFT. It may be a more appropriate way to identify a junior nurse.

CB stated that although this opportunity would have definite benefit for development this is not the primary purpose. The reason for suggesting that a junior doctor and nurse attend is down to the Keogh review and Francis report. If there is a selection process rather than a nomination we would want to select someone who is best placed to represent busy clinical areas.

PH agreed that SFT need a representative who can tell us what it is like on the frontline.

NM asked for the Committee's decision as to whether the representatives should be selected from a number of candidates as part of a formal process or recruited via nomination.

CB felt that the selection process may be more beneficial next time and PH suggested that a 1 year tenure would be more appropriate rather than a 2 year tenure. It was agreed that this is a good compromise.

CGz noted that there is a junior doctor at SFT who had been on Frimley Park's CGC and this paper was based on how the Committee works at Frimley Park Hospital.

Action: Seek nominations for both a junior doctor and junior nurse for the CGz and report back in October. **CGz**

STRATEGY

CGC0905 Patient Story (Children & Young People's Service)

CT presented a Powerpoint describing a multi-disciplinary process of a child protection case. The child originally presented to ED and then Paediatrics became involved and the child was admitted to Sarum Ward. A core discussion followed involving a Radiologist, Orthopaedic Surgeon and the named doctor and nurse for safeguarding.

CT discussed the assessment and diagnostic process and explained how the child protection process was initiated with involvement from Social Services and the Police.

The case was discussed regionally to ensure that SFT's care was correct and discussed internally so that learning points could be disseminated.

PH asked about the interaction with parents in the process and CT confirmed that as soon as a child protection issue is raised the parents are notified and Paediatrics are very up front about it.

CGz felt this was a very good story which demonstrates the complexity of the issue and provides assurance that all actions are followed up.

CM – there is a real emotional cost for staff involved in the process.

The Committee thanked CT for the informative and detailed presentation.

CGC0906 Directorate Report (Children & Young People's Service)

CT began by asking for responses to the report and CB responded that this is exactly the kind of report we want to see at this meeting.

Safe:

CT explained how the service works and discussed the high patient turnover which can be affected by cystic fibrosis patients. The peak patient age is children under one year, the majority of children seen are under 2 years old. The inpatient peak is in December and the Day Unit peak is in September.

CT highlighted the assurance and safety governance processes for the department which include clinical risk meetings, safeguarding meetings, clinical governance sessions, cleaning and infection control and staff development.

Any child who dies in the hospital aged under 18 has a child death review, most cases are not unexpected as the patients have serious health conditions. Occasionally there are unexpected deaths and there is a special system for these cases.

Paediatrics have their own pharmacist and the Electronic Prescribing System will start in

this department.

SFT does well with regard to Dr Foster data which is reviewed every year. Peer reviews have also taken place recently.

Effective:

This is a Consultant Led Service with a complex rota. Handovers are vital and are done up to 4 times per day. Consultants are present twice a day at the weekend.

SFT meets guidelines for clinical care well. The Royal College of Child Health put these guidelines in place with a view to closing small centres but SFT meets these guidelines and should exist.

Caring:

MC reported on the caring aspects and explained that the new unit has really helped with this matter. The unit is more pleasant for children and parents can be accommodated. The team tries to ensure continuity of care for complex cases.

Responsive:

CT reports that the department keeps up to date and responds to the changing needs of patients.

Well Led:

There is constant change with regard to community paediatrics and with the influx of Forces personnel into the area SFT could see 500 more patients per year in a few years time. This will impact on the department.

MC leads the nursing team very well.

Concerns:

Staffing is a concern as Paediatrics do not meet RCN guidelines but it feels like a safe service. CT believes that the CQC will bring up staffing levels in an inspection.

Guidelines on ICID are not always easy to find.

PH raised 2 issues:-

1) Children's Community Nurses.
   A tendering exercise is happening at present and PH is going to a meeting this afternoon where this item is on the agenda. CT explained that the role of these nurses and how they will be utilised will depend on how Wiltshire defines the role. The same goes for physiotherapy.

2) Prediction on increase in admissions due to Army personnel.
   PH asked CT whether he had any concerns about the survival of the service in comparison to the new Children's Hospital at Southampton. CT has no concerns as SFT already works together with Southampton and we have joint clinics with them. Only a small amount of care is referred to Southampton by SFT.

LW agreed that the unit is well-led and responsive and many services could learn from the Paediatric service. The transparency with parents is excellent.

Fiona Hyett has been working on some activity tools and the staffing concerns have been noted.

CM discussed an initiative which will be trialled in the winter where a night-time nursing assistant will replace by a third registered nurse on nights The workforce review and skill mix review have been done.

CM is very proud of the team and their flexible approach.

CB – there is ample evidence that this is a safe service. CB really likes the fact that this service has a real learning culture and has innovative ways to approach learning.

MC and CT agreed that the team work closely.

CGz – the report was very comprehensive and well supported with data. CGz asked for permission to share this report with others and CT agreed.

The Committee noted the content of the report.

CGC0907 End of Life Care Strategy Update (paper for noting)

Update on progress with End of Life Care projects in SFT:

1. Link Nurses
   Although the time period for the link nurse programme has now in theory expired, there are still some limited backfill monies available as there was great difficulty in getting link nurses released from their ward duties.

2. 7/7 Palliative Care CNS Hospital and Community NP The Palliative Care CNS team 23 month pilot of 7/7 working is in progress. This has funding until end of October 2015. The project continues to go well, with examples of patients being supported to stay at home and avoiding some weekend admissions

3. Dying Awareness
   The dying awareness event at the Guildhall in May, ”Fayre Dying” was very successful with many local organisations participating.

4. EoLC CQUIN
   This is looking at conversations with patients and families about ceilings of treatment, and communication with primary care when patients are nearing the end of their lives. Progress is being monitored at the weekly mortality reviews. There is now a fax proforma to assist with communication with primary care.

5. Documentation for Patients in the Last Days of Life
   Care planning documentation for the last days of life, modified from documentation currently being used in Poole, is currently being trailed in the Hospice. The hope is that it can then be rolled out within SFT, with the support of an End of Life Facilitator.

6. Business case for End of Life Care Facilitator.
   A business case has been prepared and has now been submitted to Christine Blanshard and Lorna Wilkinson.

LW advised the Committee that SFT has funded an EOLC Facilitator and this has been agreed in principle, subject to a detailed job description and governance arrangements being in places.

The Committee noted the content of the report.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC0908 Q1 Complaints Report

The main issues from complaints are:

- Clinical treatment (26) - sub-themes were unsatisfactory treatment, correct diagnosis not made, inappropriate treatment, further complications, surgery unsuccessful and consent to treatment. There were no themes.
- Staff attitude (12) - 11 of these related to nursing staff and 1 to medical staff. A theme was identified and appropriate action was undertaken whilst an investigation took place. Again, a high number of comments were received in praise of staff through Real Time Feedback and the Friends and Family Test.
- Communication (10) – sub-themes were lack of communication, insensitive communication and information not given. There were no themes.

HH – in Q1 there were 79 complaints compared to 92 last year. Staff attitude is the only theme and where this has been a problem it has been dealt with appropriately.

A number of factors meant that some complaints were not resolved within the timescale.

MSK and Surgery both had an Ombudsman case. MSK's was not upheld and SFT is awaiting the response for Surgery.

ET discussed complaints that come via Pharmacy. Sometimes the main point of the complaint is lost amongst technical information and is not answered.

SL agreed that from the complaints he has sampled some are too full of jargon and the tone of letters can be too confrontational.

ET will forward the pharmacy complaint to LW and SL will email LW the four complaints he sampled.

LW – a Complaints Workshop will be running at the start of October.

LW would like to see more use of telephone calls in the complaints process rather than just letter writing.

The Committee noted the report.

CGC0909 National Maternity Survey 2013 – Update on Action Plans

Four areas of work were identified. All actions have now been undertaken.

Managers and supervisors will continue to monitor these areas to ensure continued adherence. The results from real-time feedback and comments from the Friends and Family Test will be used to identify any future areas of concern and steps will be taken to address these as necessary.

LW and GS explained that this report came to the Clinical Management Board yesterday.

The four areas of work were:

1) NICU mothers and hospital meals – there is ongoing dialogue with Catering to resolve this issue
2) Poor discharge – work has been done and we continue to monitor. There has been a decrease in discharge incidents recently.
3) Quality of interaction schedule – this item is not formally in place but the

supervisors of midwives have set up their own programme.
4) Upgrades to bathrooms – the postnatal ward upgrades are mostly complete.

The survey is likely to be repeated in 2016.

CGC0910 Piloting New Approaches for National Surveys

The pilot survey received responses from 7,141 patients across all participating Trusts, a response rate of 49%. Due to the small number of Trusts taking part in the pilot, the decision was made to benchmark results against the 2013 national survey and all the Trusts that took part in that survey.

SFT scored 'about the same' as most other trusts in all 10 overall sections; its scores were almost identical to 2013.

SFT scored 'worse' than most other trusts for one question. In 2013 it scored 'about the same':-

- Did you ever share a sleeping area with patients of the opposite sex?

SFT scored 'better' than most other trusts for two questions. In 2013 it scored 'about the same':-

- Discharge delayed due to wait for medicines/to see doctor/for ambulance
- Length of delayed discharge

Compared to its own 2013 results, there was a statistically significant decrease in the 2014 Pilot results in two areas:-

- Did you ever share a sleeping area with patients of the opposite sex?
- Did you get enough help from staff to eat your meals?

There was a significant increase in three areas:-

- Did a member of staff say one thing and another say something different?
- After you used the call button, how long did it usually take before you got help?
- Were you given enough notice about when you were going to be discharged?

Conclusions of the Pilot
Several Trusts reported that the level of information received on a weekly basis was not practical and that most Trusts would wait until the end of the survey to look at their results and take any action necessary.

The format for the national inpatient survey 2014 will remain, i.e. only one wave of patients will be sampled. For Salisbury, this will be patients who had at least one overnight stay during the month of July 2014.

A decision has not yet been made by the CQC as to whether there will be any changes to the methodology for the surveys going forward.

LW – GS led this piece of work earlier this year.

GS – the survey run by Picker aimed to increase the sample size and run in two waves, rather than just one wave as always happened in the past. The two waves chosen were to survey in December and February but it would have been much more useful to have one wave in the winter and the other in the summer and avoid December altogether. This pilot was not done in-house but by Picker. Only a few Trusts took part so for the results SFT was only compared to the 2013 results. It has not been agreed whether a two wave system will be implemented in future, this year's survey is running on the old system of one wave.

CGz – GS is very experienced in running these surveys and was able to advise Picker.

CB & LW congratulated GS as this involved a lot of hard work.

NM felt that it was good that SFT has been able to have some influence in the process.

The Committee noted the report.

ASSURING CLINICAL EFFECTIVENESS

CGC0911 Quality Indicator Report inc DSSA, Action Plan for C.difficile and Ribotyping Report

- 4 cases of C Difficile.
- No MSSA bacteraemias for three months.
- 4 new serious incident inquiries.
- A decrease in the crude mortality rate. SHMI remains 108 to December 2013 and is as expected. HSMR has declined again and is 96 in April 14 and is as expected. There is the potential for an up to an 11 point rise in October 14 when figures are rebased. Sepsis Six care is the key improvement action being undertaken.
- A decrease in grade 2 pressure ulcers. One cluster identified.
- Safety Thermometer – 88% 'harm free care'.
- Three falls resulted in moderate harm, two of which were a fractured ankle and a wrist and one which was a complex dislocation of a finger. All three were managed by plaster cast.
- Fractured hip patients being operated on within 36hrs increased to over 90%.
- A decrease to 80% of patients moving to the stroke unit within 4 hours. Action is in place to ensure all staff are familiar with the referral pathway. A decrease in the percentage of patients spending 90% of their time on the stroke unit. A significant increase (95%) of high risk TIA referrals seen within 24 hours.
- Escalation bed capacity and ward moves remain low. No non-clinical same sex accommodation breaches.
- Real time feedback showed patients felt they were treated with care and compassion and rated the quality of care as good. The Friends and Family test response rates were sustained in inpatients, but fell to 15.5% in ED and decreased in the Maternity Services. A new measure of the Friends and Family test response rates for outpatients and day cases shows a response rate of 14.1%.
- Q1 staff FFT shows 97% of staff are extremely likely or likely to recommend the hospital as a place to receive care or treatment and 83% are extremely likely or likely to recommend the hospital as a place to work. In a Health Service Journal survey comments from our staff have placed the Trust in the top 100 best healthcare organisations in the country to work. The assessors said "There is an open and honest feel at Salisbury Foundation Trust and a genuine desire to give good quality care throughout all levels and departments of the organisation."

CB ran through the highlights on the Quality Indicator report. There have been no MSSA bacteraemias in the past 3 months but there was a never event in September. This is disappointing as the last never event was in 2012. This will be reported as a serious

incident inquiry.

HSMR was discussed – the figure will be rebased soon.

The last Global Trigger Tool was in June and SFT was well below target. The Golden Patient Initiative has been reinstated with regard to fractured neck of femur patients. This has resulted in improvements.

Stroke care – on the whole we are on target to achieve.

The criteria for patient moves will reduce from 3 moves to 2.

LW discussed C.difficile in August. SFT stands at a total of 13 out of an annual target of 18.

SFT is doing well with pressure ulcers, there have been no grade 3 ulcers since April and a decrease in the number of grade 2 ulcers.

LW continues to keep an eye on falls.

The Safety Thermometer was discussed. SFT has 88% harm free care against a national average of 93%. The 88% is a combination of old and new harms and indicates that community providers may have some trouble with reporting harms. SFT's hospital acquired harms are at the national average.

<u>Action Plan for C.difficile</u>

FM and LW discussed the Wiltshire CCG Critical Friend visit which resulted in the drawing up of the action plan which is reviewed monthly at the Infection Prevention and Control Working Group. Actions are progressing. This is the third version of the action plan which looks at 4 areas. FM is still working closely with hospital areas that have patients admitted with symptoms of C.difficile – time to isolation and sampling are key. All information will be in the policy, this is a good piece of work with input from pharmacy and clinicians.

ET and FM raised the matter of antimicrobial prescribing and the need for someone to help engage medics. **Action: LW/FM/ET to discuss outside this meeting and then CB will take this forward.** **LW/FM/ET**

FM – there is an ongoing issue trying to get involvement for multi-disciplinary C.difficile rounds.

Trials have taken place with different colour aprons to minimise cases of cross contamination across clinical areas and this has been a good exercise.

Acticlor Plus is being trialled on four wards and cleaning results will be reviewed.

Education – additional workshops are being put on and ward visits to support.

PH commented on staff attitude and asked how learning from root cause analyses is embedded. The Infection Control team are great but we need to make an effective connection across all areas.

LW reported that this has been raised regularly at the Matron's Monitoring Meeting and Nursing & Midwifery Forum. Problems have been fed back to ward leaders and the IC nurses are on the wards as a check and balance system, particularly on Redlynch and Pitton. The Infection Prevention & Control Working Group is very active, not just on C.difficile.

Ribotyping Report

JH explained that ribotyping is a way of looking at a particular strain of C.difficile and we can use it to compare what is prevalent in the community with the types seen in the hospital. It helps review the various strains seen in SFT so we can make comparisons to look for cross contamination.

It is a useful tool to help make analysis easier and decide whether there are any staff or environmental factors.

The predominant strains seen at SFT are not all cross contaminants.

Ribotyping is done in Bristol and the labs are overwhelmed with requests. Ribotyping can only be done under strict criteria.

In January – April 2014 SFT had 14 identifiable ribotypes and the predominant strains are what is prevalent in this region.

This test is used when we think there may be a potential link in cases and can help focus the infection prevention and control measures.

NM stated that LB and SM were keen for this as part of the assurance process.

NA asked whether there had been any cases in September and JH confirmed there have been no cases yet.

CB asked JH about cross-contamination and how long it can take for symptoms to develop. JH responded that this can depend on the patient, those on antibiotics will develop symptoms more quickly. Not everyone who has C.difficile shows symptoms.

The service is free at point of use but SFT has to have agreement before sending off samples for testing.

LW – the next tranche of data has come through and Infection Control will be looking at this in detail at IPCWG.

The Committee noted the report.

CGC0912 Internal Audit Programme Six Monthly Update

- In 2013/14 both outstanding audit recommendations have been completed.
- In 2014/15 three audits have been undertaken. Of the 9 recommendations, 8 have been completed and one partially completed.

CGz briefly ran through the content of the report. SFT has made good progress.

SL – CGz has really got to grips with the internal audit programme and NM commented that the report was of a much higher standard than those he had experienced in other organisations.

The Committee noted the report.

CGC0913 Monitor Quality Governance Framework (Annual Self-Assessment)

- The report is structured around the Quality Governance Framework and the work needed to ensure compliance with the NHS Outcomes Framework in 14/15.

- The Quality Strategy and Quality Account are the key drivers for improvement. The quality priorities in 14/15 reflect the needs of patients and other key stakeholders.

- The Board is assured that effective arrangements are in place to continuously monitor and improve the quality of care and areas highlighted that require improvement are effectively addressed.

CGz – this report discusses our self-assessment against Monitor's framework.

1) Strategy – looks at overall progress and the Quality Account is the driver.
2) Capabilities and Culture – clear leadership, good governance, good progress on embedding a culture of learning and improvement.
3) Structure and process – SFT's governance structure is robust.
4) Measurement – good data quality can be demonstrated and it is used to learn and improve.

CB – SFT regularly reviews the data we present to the various committees. Some information is externally monitored but others are only reported internally. SFT has a high contribution to national audits and this is another external governance measure.

SL suggested some of the data which is only monitored internally could be shared with other local Trusts for best practice.

CB – where we have shared our data the feedback has been good, such as with KPMG's positive opinion on the Quality Account.

The Committee noted the report.

CGC0914 Major Issues Report

The following matters were reported:-

1. GMC national training survey 2014
2. The Kings Fund Medical Engagement – a journey not an event
3. NICE Safe Staffing guideline published.
4. Local publication of staffing levels.
5. Transforming urgent and emergency care services in England a progress update.
6. NHS England – Understanding the new NHS.
7. DH Refreshing the NHS Outcomes Framework 2015 – 2016 consultation
8. NHS 5 year forward view (5YFV)
9. NHS England's Commitment to Carers May 2014.
10. The Care Act 2014 consultation
11. 'Sign up to Safety' is a new national patient safety
12. Duty of candour and Deprivation of Liberty after the Cheshire West Case
13. NHS Choices website.
14. Staff Friends and Family test results published.
15. Pitton ward refurbishment completed.
16. Expansion of the mobile chemotherapy unit areas visited.

CB summarised the report and discussed the NHS England guidance. The Department of Health has produced a new framework and there is a five year forward view with consultation on the Care Act.

SFT will join the Sign Up To Safety system with LW and CB as the leads In due course this item will come back to CGC.

The Mobile Chemotherapy Unit is now running 4 days per week.

We have seen an increase in DoLS reporting following the Clinical Governance Half Day presentation in June.

The Committee noted the report.

CGC0915 External Enquiries & External Agency Visits Biannual report

National Reviews

Three reports were published within the reporting period. These have been considered within the Trust and actions are being taken where appropriate to ensure best practice within SFT.

Actions from six reports published in preceding reporting periods are progressing satisfactorily.

National Confidential Enquiries

One report was published within the reporting period. An action plan has been developed to address non-compliant areas. Progress is being monitored through the Clinical Management Board.

Actions on 14 recommendations from five reports published in preceding reporting periods are progressing.

Difficulties have been experienced in recruiting a consultant geriatrician to address recommendations from “An Age Old Problem” published in November 2010 but the job plan is being re-worked to try to address this.

External Visits

Twelve visits took place within the reporting period. Actions are being taken to address areas of non-compliance.

Actions from six visits in preceding reporting periods are progressing satisfactorily.

National Clinical Audits

Thirteen reports were published within the reporting period. Actions in all areas are being monitored by the Clinical Management Board.

Actions from 5 reports published in previous reporting areas are progressing satisfactorily.

GS – there have been three reports in this period and actions have been taken where appropriate. Actions are outstanding from six reports.

Steps have been taken regarding the action for geriatrician cover.

LW and NM agreed that this is a very comprehensive report and is very good to read.

The Committee noted the report.

CGC0916 Mortality Working Group Report

Salisbury NHS Foundation Trust figures: (Including hospice)

SHMI
Jan 2013 – Dec 2013 = 107.61

HSMR
Jan 2013 - Dec 2013 = 114.7

Current HSMR = 92.7

Lessons learned:
1. Specific terminology used by clinicians in the notes determines how the case is coded and therefore how the Trust is paid. For example 'Working diagnosis' of malignancy can be coded while '?malignancy' can not be.
2. The Gastroenterologists now communicate the outcome of their MDT meeting to the GP as well as to the hospital team to enhance communication which is vital in end of life palliative situations. This is good practice which should be spread across the Trust.
3. There was evidence of a high quality caring approach in Salisbury with a nurse arranging for a terminally ill patient to see his dog in hospital.

CB reported that the reviews have been looking at individual clinical areas which have been red flagged. These can change as only small numbers of patients can mean a red flag goes on the system. The reviewers take a multidisciplinary approach when looking at the notes. Key learning points are disseminated.

A new respiratory physician has been appointed this week and they will be assisting with this work.

The mortality reviews do not identify many avoidable deaths per year.

41% of all deaths in the hospital now have notes reviewed. Information is disseminated weekly by email.

The Mortality Working Group is responsible for implementing measures to improve communication with primary care and there is an associated CQUIN.

The Committee noted the report.

CGC0917- Francis Report and Hard Truths the Journey to Putting Patients First action plan update

- The Francis report requires us to focus on listening to patients, being open, honest and truthful and acting with care and compassion. We have looked at all 290 recommendations and how they apply to us as a Trust. For 200 recommendations implementation is being led by other organisations. We consider that we are now compliant with 84 recommendations and partially compliant with 6 recommendations.

- Hard Truths the Journey to Putting Patients First provides the Government's detailed response to the 290 recommendations in the Francis Report and accepts all the recommendations either in part, in full or in principle. It sets out a five point plan to prioritise care, improve transparency and ensure that where poor care is detected, there is clear action and accountability. We are confident as a Trust that we have a sound governance process in place to prevent, detect and act on problems promptly.

- The Trust has made good progress in responding to the recommendations in the Francis Report and has continued to build and strengthen a culture of compassionate care, learning and improvement in the care we give our patients. The focus of our improvement work has been on:

- Working with patients to provide a positive experience of care
- Supporting a positive staff experience
- Building and strengthening leadership

TIAA Audit Report on Implementation of the Francis Recommendations

- TIAA surveyed 12 NHS organisations and although SFT was not one of them we felt it would be helpful to review ourselves against the key findings. The survey focused on seven key recommendations made in the Francis report: common values, fundamental standards, openness, transparency and candour, compassionate, caring and committed nursing, leadership, accurate, useful and relevant information and cultural change.

- Overall, it is pleasing to see that considerable work has been undertaken to assure the Committee that the recommendations made in the Francis report have been acted upon. Of the 9 key issues, the Trust considers it is compliant with six and partially compliant with three issues. In these areas, actions are already on-going to continue to improve.

CGz explained there were three elements to this report which are Key Areas such as working with patients and building leadership skills, the Hard Truths Report which was the government's response to ensuring each organisation has a governance structure in place and the TIAA Review of 12 other organisations and how they implemented the Francis recommendations.

The Committee noted the report.

CGC0918 Berwick Report Update

- The report was commissioned by the Government to examine ways of improving safety in hospital following the failings at Mid Staffordshire NHS Trust. The single most important change is to improve the culture in the NHS to become a system devoted to continual learning and improvement.

- The report sets out ten recommendations. Over the last year, the Trust has made substantial progress in improving the culture of learning and improvement throughout the organisation. Central to this has been continuing to put quality and safety at the heart of everything we do, to listen to our patients, develop our staff and be transparent to inform our learning.

- SFT's progress update is set out in the action plan in the appendix of the report.

CB – the report focuses on the culture of learning and development, putting safety at the heart of everything we do. It is gratifying to look at these 10 recommendations and demonstrate how we have taken actions against each one.

NM asked if SFT had any deficiencies and CB responded that SFT does not have any major gaps but will require ongoing assurance and vigilance.

LW – this is a good report.

The Committee noted the report.

ASSURING SAFETY

CGC0919 Risk Annual Report

Key Items to note are:

- Progress against the strategic goals as set out in the Risk Management Strategy (2013)
- Progress against the Annual Risk Management Plan 2013/14 (Appendix 1)
- Part Year progress report against the Annual Risk Management Plan 2014/15 (Appendix 2)
- Annual Report Card 2013/14

LW reported that DATIX web is now partially implemented, there is good progress on SIIs and reviews and this puts SFT in a good place with regards to Duty of Candour.

FHi is constantly looking to improve ways to develop any learning within SFT.

The 2014/15 priorities are detailed within the report.

The Committee noted the report.

CGC0920 Risk Report Card Q1

- 846 incidents reported over the quarter
- No incidents categorised as catastrophic
- 4 incidents categorised as major*
- 3 major incidents due to fractures within the quarter
- 0 Never Events reported within the quarter
- 1 new Clinical Review commissioned within the quarter
- No new Non-clinical Reviews commissioned within the quarter
- 6 new Serious Incident Inquiries commissioned within the quarter
- 2 new Local Reviews commissioned within the quarter

*Initial grading and subject to change following review.

LW ran through the report and highlighted the safeguarding process. This is reviewed monthly at the Clinical Risk Group which will take place this afternoon.

The Committee noted the report.

<u>PAPERS FOR NOTING</u>

The Committee noted the following:-

CGC0921 Clinical Risk Group, June, July 2014
CGC0922 Clinical Management Board, July, Aug 2014
CGC0923 Information Governance Group (no meeting until Sept 2014)
CGC0924 Integrated Safeguarding Committee (no meeting until Sept 2014)
CGC0925 Children & Young People's Quality & Safety Board, June 2014

CGC0926 ANY OTHER URGENT BUSINESS

None raised.

NEXT MEETING

ALL

Thursday 23rd October, 10am-12pm, Boardroom.

Trust Board meeting **SFT 3613**

AUDIT COMMITTEE – DRAFT MINUTES 13 OCTOBER 2014

Date: 8 December 2014

Report from: Nigel Atkinson, Chairman

Executive Summary:
The committee reviewed the external audit plan for 2014/15 and the identified areas of potential risk.

A limited assurance internal audit report was received on the development of IT systems and will be brought back to the 22 January meeting.

Proposed Action:

That the draft minutes be NOTED.

Links to Assurance Framework/ Strategic Plan:

AF risk 2.4 – failure to recognise and treat serious clinical or financial risks
Value : we will be innovative in the use of our resources ti deliver efficient and effective care

Appendices:

Draft minutes of Audit Committee - 13 October 2014

SALISBURY NHS FOUNDATION TRUST
Minutes of the Audit Committee
Held on: 13 October 2014

Present:	Mr N Atkinson (Chairman and Non-Executive Director)
	Dr L Brown (Non-Executive Director)
	Mr I Downie (Non-Executive Director)
	Mr A Freemantle (Non-Executive Director)
In Attendance:	Mr M Cassells (Director of Finance and Procurement)
	Mr J Brown (KPMG)
	Mrs C Griffiths (KPMG)
	Mr M Stabb (TIAA)
	Mr A Morley (TIAA/Local Counter Fraud Specialist)
	Dr N Marsden (Chairman, Observer)
	Mr D Seabrooke (Head of Corporate Governance)
	Mrs F Hill (Item 6)

Apologies

ACTION

1. MINUTES

The minutes of the meeting held on 14 July 2014 were agreed as a true record.

2. EXTERNAL AUDIT

The Committee received the progress and technical update and External Audit Plan 2014/15.

In the Audit Plan the scope of the audit included confirming that the whole of Government Accounts requirements were met and the mandated review of the Quality Report. Areas identified as significant risks in relation to the Financial Statements included the delivery of £9m cost improvement, going concern and working capital facility, provisioning of non NHS debtors and agreement of inter authority balances. It was noted that the Trust no longer maintained a standing working capital facility.

It was noted that Odstock Medical Limited and Salisbury Trading Limited were audited by Fletchers and that a high level view was taken by KPMG.

There was no change proposed in the Audit fee for 2014/15 but this would be reviewed in relation to changes that may be announced in relation to the Enhanced audit reporting requirement.

In the Progress Report/Technical Update, the joint letter from Monitor/NHS England and the Trust Development Authority and Monitor's assessment of the Quarter 1 performance of the Foundation Trust sector were highlighted. The Committee discussed whether there was any learning around this arising from other Trusts. It was also noted that KPMG through its regional and national networks was discussing the financial situation of the Foundation Trusts they serviced with Monitor.

The progress Report/Technical Update and External Audit Plan 2014/15 were noted.

3. INTERNAL AUDIT

The Committee received the Internal Audit Progress Report and Local Counter Fraud Progress Report.

The results of the audit review of the specification, development and implementations of IT systems was highlighted. This Limited Assurance Report was

based on the following audit outcomes:

- The Trust was not formally complying with the clinical risk management standards.
- There was a lack of documented policies and procedures for IT projects.
- Informatics Development Team procedures were not documented.

It was noted that the Information System Steering Group was discussing this issue, including the delivery of the Clinical Safety Officer Role highlighted in the report.

It was agreed that this would be discussed again at the next meeting of the Committee.

In relation to the compliance review of the Friends and Family Test it was noted that improvements had been made on the ability to receive entries relating to specific wards and within 48 hours of discharge for on-line responses.

A Substantial Assurance Report was presented for Health and Safety Management, with the issues of manual handling and loan workers highlighted.

DS

There was substantial assurance in relation to the management of Serious Incidents.

The Committee received an update on responses to previous audit recommendations.

In relation to Counter Fraud an update was given on on-going and closed cases since the last update. There were some instances of parking fraud, and one of working through an agency whilst on sick leave. In relation to SWRT/13/0026 it was noted that with police support, an interview under caution had now taken place. It remained the Trust's intention to recover eleven months' salary paid to the individual whilst another investigation was on-going.

The Committee noted the Internal Audit and Counter Fraud Report.

4. HALF YEAR REVIEW OF ASSURANCE FRAMEWORK

Fenella Hill attended for this item and the Committee received the Half Yearly Report on the Assurance Framework presented to the JBD, Clinical Governance Committee and Finance Committee during July. It was noted that the Board Assurance Framework had been discussed at the September Seminar Day and would be coming to the 8 December Board Meeting for discussion and sign off.

The regular review of risks was continuing and themes such as C-diff control, capacity to deliver IT projects, inconsistencies in safeguarding procedures were discussed in the Assurance Framework.

A number of newly identified positive assurances were highlighted.

The Committee noted the report.

5. REVIEW OF EFFECTIVENESS

The Committee received a report of a brief survey carried out in September looking at overall questions in relation to the Committee's arrangements, the way in which it carried out its work, its standing in the Trust and advice provided by the two sets of auditors. A number of narrative comments were also provided by the respondents. Broadly the survey indicated that committee members were happy with the support given to the Committee, the Committee's standing in the organisation, its approach to its work and its effectiveness in key result areas. Narrative comments included formal training, the role of quality assurance, the status of the Trust's subsidiary companies and the Committees role as Corporate Risk Assurance Committee able to add risks to the Trust's risk register.

It was agreed that KPMG and TIAA would liaise to provide a training and development session to the January meeting of the Committee. The Chairman of the Trust reminded the Committee that if members had concerns about the effectiveness of the Committee they could raise these with him privately if necessary.

The Committee noted the report.

MS/JB

6. DATE OF NEXT MEETINGS

Thursday 22 January 2015, Friday 22 May, Monday 13 July and Monday 12 October all at 10 am in the Boardroom.