SALISBURY NHS FOUNDATION TRUST
TRUST BOARD

MONDAY 7 DECEMBER 2015, 1.30 PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
1.30pm	**1**	**APOLOGIES FOR ABSENCE –**			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES**			
		Meeting held on 5 October 2015			1
	4	**MATTERS ARISING**			
1.35pm	**5**	**CHIEF EXECUTIVE**			
		Chief Executive's Report	PH	SFT 3714	9
1.45pm	**6**	**STAFF**			
		1. Workforce Performance Report to include Safer Staffing and Skill Mix	AK/LW	SFT 3715	11
2.00 pm	**7**	**PATIENT CARE**			
		1. Quality Indicator Report to 31 October (Month 7)	CB/LW	SFT 3716	29
		2. Skill Mix Review	LW	SFT 3717	37
2.30 pm	**8.**	**PERFORMANCE AND PLANNING**			
		1. Finance & Performance Committee Minutes 28 September & 26 October 2015	NM	SFT 3718	49
		2. Finance and Contracting Report 31 October (Month 7)	MC	SFT 3719	57
		3. Progress against Targets and Performance Indicators to 31 October 2015	AH	SFT 3720	67
		4. Update on Strategic Planning	LA	-	-
		5. Report of Director of Infection Prevention Control	LW	SFT 3721	73

3.20 pm	**9**	**PAPERS FOR NOTING OR APPROVAL**			
		1. Minutes from Clinical Governance Committee 24 September and 22 October 2015	LB	SFT 3723	133
		2. Minutes from Audit Committee 12 October 2015	PK	SFT 3724	155
		3. Staff Survey Results Update	AK	SFT 3726	159
		4. Assurance Framework	LW	SFT 3727	163
3.50 pm	**10**	**ANY OTHER URGENT BUSINESS**	NM		
	11	**QUESTIONS FROM THE PUBLIC**	NM		
	12	**NEXT MEETING**			

The next ordinary meeting will be held on Monday 8 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 5 October 2015

Board Members Present:	Dr N Marsden	Chairman
	Dr C Blanshard	Medical Director
	Dr L Brown	Non-Executive Director
	Mr M Cassells	Deputy Chief Executive
	Mr A Freemantle	Non-Executive Director
	Mr A Hyett	Chief Operating Officer
	Mr P Kemp	Non-Executive Director
	Mrs A Kingscott	Director of Human Resources and Organisational Development
	Mr S Long	Non-Executive Director
	Right Revd Dame S Mullally	Non-Executive Director
	Ms L Wilkinson	Director of Nursing
Corporate Directors Present:	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 J Noeken	Appointed Governor
	Mr M Mounde	Public Governor
	Mrs J Sanders	Public Governor
	Dr A Lack	Lead Governor
	Sir R Jack	Public Governor
	Dr E Robertson	Public Governor
	Dr J Lisle	Public Governor
	Dr R Bolton	Anaesthetic Registrar
	Mrs S Mortlock	Thames Valley & Wessex Leadership Academy
	Ms A Jennings	Thames Valley & Wessex Leadership Academy
Apologies:	Mr P Hill	Chief Executive
	Mr I Downie	Non-Executive Director

ACTION

2115/00 DECLARATIONS OF INTEREST AND FIT AND PROPER/GOOD CHARACTER

Members of the Board were reminded that they have a duty to declare any impairment to Fit and Proper and being of good character as well as to avoid any conflict of interest and to declare any interests arising from the discussion. No member present declared any such interest or impairment.

2116/00 MINUTES

Patient Experience and Feedback

The Chairman read part of a letter from a patient who had requested that his praise for the hospital be shared publicly with the Board.

The minutes of the meeting of the Board held on 3 August 2015 were accepted as a correct record with an amendment to the top of page three under 2104/01 to insert the word supervisory in relation to the Band 7 Senior Sister posts.

2117/00 CHIEF EXECUTIVE'S REPORT - SFT 3696 – PRESENTED BY MC

The Board received the Chief Executive's Report.

Malcolm Cassells highlighted the ongoing work in relation to the Adult Community Services bid, the 2015 patient led assessment of the care environment (PLACE result), work towards the Care Quality Care Commission inspection in December, the recent Quality in Care Programme award for the Trust's VTE and Anti-coagulation Service and the Trust's Annual General Meeting 2015 which had been positive and well supported.

The Trust had at the end of September been visited by Monitor and feedback was expected in Monitor's routine quarterly feedback report.

Directors also reflected on the Board's annual hospital food tasting, work towards the information requirements of the Care Quality Commission and the Dementia Friends training that had taken place at the Board Seminar Day in September.

2118/00 STAFF

2118/01 Workforce Performance Report including Safer Staffing and Skill Mix SFT 3697 - Presented by AK & LW

The Board received the Workforce Performance Report for Month 5 and AK highlighted the following principal points -

- The Trust continued to use bank and agency to fill vacancies and actions continued to recruit nurses in particular from newly qualified and overseas.
- The Safer Staffing Board would consider the Department of Health's Staffing Toolkit.
- Agency spend continued to be reduced but there was an overspend on staffing costs of £677,000.
- The Trust was close to its target for staff sickness of 3%.

It was noted that the National Staff Survey would shortly be launching, conducted by the Picker Institute.

On mandatory training there was concern about compliance with infection control requirements and it was noted that this was a mixture of online and classroom sessions and there was sometimes difficulties in capturing completed training activity. On non-medical appraisals AK reminded the Board that staff reported through surveys a high level of compliance with this requirement but that the system required all steps including second manager sign off to have been completed before it would report an employee as compliant. The target of 85% compliance would be reviewed at the end of 2015/16.

On Safer Staffing, LW reported that the Trust continued to operate within the expected percentages. The areas flagged red, NICU and Radnor had been discussed previously and reflected changes in the patient mix and small numbers of health care assistance in the figures.

There some staffing issues in Maternity. There were some staff sickness and vacancies in the Spinal Unit (Avon and Tamar Wards).

It was noted that there was a twice daily bed meeting held by nursing managers that provided an action summary of the status of the hospital and was escalated as necessary.

On the Skill Mix Review LW reminded the Board of the actions agreed at the August meeting and reported that resources had been identified for an additional staff member at weekends on Redlynch and Pitton for a pilot. Work continued on a wider bed reconfiguration.

The Board noted the Workforce Report.

2119/00 PATIENT CARE

2119/01 Quality Indicator Report to 31 August 2015 (Month 5) – SFT 3698 - Presented by CB and LW

The Board received the Quality Indicator Report for August. Christine Blanshard reported a new Serious Incident Investigation involving a misplaced nasal gastric tube. The incident was considered to be a never event and it was confirmed that the Duty of Candour had been exercised.

It was noted that the mortality rate had reached 109 which was just above the expected range. The Clinical Governance Committee had discussed the situation and it was considered that the current report reflected a peak in mortalities from pneumonia conditions experienced in January. There was growing emphasis on reviewing rates of avoidable death and the Trust's position was that there were very low rates of avoidable deaths found on a recent audit.

There had been a reduction in patients arriving in the stroke Unit within 24 hours – one of these had been diagnosed with a stroke as an inpatient. There had been 33 strokes in August in one week. On Fractured Neck of Femur, six patients had missed the target of which two did not in the end have surgery.

It was noted that the Trust's infection control measure for C-Diff was on trajectory. The Trust continued to manage DSSA breaches, ensuring that patients were in the right place at the right time and managing within constraints in the Acute Medical Unit.

The Board noted the Quality Indicator Report.

2119/02 Customer Care Report – SFT 3699 – Presented by LW

The Board received the Quarter One Customer Care Report and Lorna Wilkinson highlighted the following principal points –

- In Quarter One there had been a rise of in complaints, some of which may relate to episodes of care occurring in Quarter Four when the Trust was especially busy.
- Key themes in the complaints related to appointments, delays, and in Ophthalmology where the Trust was challenged by high levels of patient demand.
- There was an Appointments Transformation Programme currently active.
- The rate of complaints of 0.1% of episodes remained static.

- RTF and Friends and Family feedback continued to feature noise, response to call bells and it was noted that responses were being monitored more closely and that the noise at night campaign was continuing.
- There had been no new Ombudsman cases raised in Quarter One; one previous complaint had been not upheld.

It was suggested by Steve Long that patient stories might be of help in helping staff to address this issue and it was agreed to discuss this further at the Clinical Governance Committee. It was also noted that on Friends and Family Test, of 8,000 recorded responses less that 19 individuals were unlikely to recommend the hospital.

The Board noted the Customer Care Report.

2120/00 PERFORMANCE AND PLANNING

2120/01 Finance & Performance Committee Minutes 27 July and 24 August 2015 – SFT 3700 – Presented by NM

The Board received for information the minutes of the Finance and Performance Committee held on 27 July and 24 August which had focused on the Trust's community services bid, performance targets and on Replica 3D.

The Board noted the Finance and Performance Committee Minutes.

2120/02 Finance and Contracting Report to 31 August 2015 – SFT 3701 – Presented by MC

The Board received the Month 5 Finance and Contracting Report and it was noted that an in month deficit of £968,000 had been recorded. The Trust's year to date position was close to plan at £3.9m deficit. Further savings needed to be identified to address this. Additional activity had helped the position. Non-elective activity continued to be above plan which suggests that QUIP and Better Care Fund initiatives were not addressing this sufficiently.

There had been a good reduction in agency use.

The Trust was on plan on its capital schemes and working capital and cash balances were somewhat behind plan due to phasing.

Wiltshire CCG were indicating that they were in financial difficulty and where coming to the attention of NHS England. Discussions of this would continue.

It was noted that the proportion of green rated cost improvement programme schemes was increasing and that 2016/17 schemes were being developed.

The Board noted the Finance and Contracting Report.

2120/03 Progress against Targets and Performance Indicators to 31 August – SFT 3702 – presented by AH

The Board received the Month 5 report. AH reported that the Trust was reviewing its capacity in trauma to improve patient flow and to reduce adverse effects on elective activity.

The Trust continued to deliver the A & E Four Hour Target, having delivered it in August, September and for all of Quarter 2. Work continued to improve emergency flow. Ambulance handovers were flagging as red and work was underway to improve the triage of patients being delivered by ambulance.

Referral to Treatment targets had been delivered and diagnostics were on trajectory. The Cancelled Operations Standard had been delivered in August. On Cancer Targets there were some red areas in the two week pathways and these would continue to be reviewed with Southampton hospital.

Delayed Transfers of Care were flagged red and it was noted that winter Better Care Fund initiatives particularly around discharge was underway. Unusually patient discharges in Dorset had become an issue of late.

The Board noted the Operational Performance Report.

2120/04 Update on Strategic Planning – Presented by LA

Laurence Arnold informed the Board that discussions with Monitor on capital plans and demand and capacity had taken place. Planning for 2016/17 was getting underway. The Board was likely to see the first outputs of this in January in line with published commissioning intentions and other national frameworks. The Trust was printing the strategy on a page to hand out to all staff.

2120/05 Capital Development Report – SFT 3703 – Presented by LA

It was noted that the Electronic Patient Record project had been launched.

Work was on-going to upgrade the bathrooms on Laverstock Ward and the refurbishment of the Surgical Assessment Unit. A tender for the building of the Breast Care Unit was being issued. Laminar Flow had been installed in Theatre 5.

The Board would be considering the full business case including readiness review at the December meeting.

The Board noted the Capital Development Report.

2121/00 PAPERS FOR NOTING OR APPROVAL

2121/01 Minutes of Clinical Governance Committee 23 July 2015 – SFT 3704 – Presented by LB

The Board received for information the confirmed minutes of the 23 July Clinical Governance Committee.

2121/02 Draft Minutes from Public Section of Council of Governors 20 July 2015 – SFT 3705 – Presented by NM

NM highlighted the Governor's discussion of the Adult Community Services bid, presentation on the accounts from the external auditor and the formation of a range of governor committees.

The Board noted the draft minutes of the Council of Governors.

2121/03 Risk Management Annual Report 2014/15 – SFT 3706 – Presented by LW

The Board received the Annual Report on Risk Management and it was noted that Internal Audit had provided substantial assurance in relation to Serious Incidents Management and Risk Management. The rollout of Datix Web had increased reporting rates to a high standard. There was good progress on the implementation of the Duty of Candour, building on existing approaches and culture which had been extended to moderate events in line with the new requirements.

Challenges included reducing falls that had resulted in injury and continuing to improve risk registers from departmental to corporate level.

The Board noted the Annual Report.

2121/04 Risk Management Strategy 2015/16 – SFT 3707 – Presented by LW

The Board received the Risk Management Strategy 2015/16 which contained only minor updates. The report was approved.

2121/05 Maternity and Neonatal Risk Management Strategy – SFT 3708 – Presented by LW

The Board received the Maternity and Neonatal Risk Management Strategy and it was noted that this had been considered in detail by a number of sub groups. Minor changes had been enacted around the role of the anti-natal manager. The existing supervisor of midwives role would continue despite legislative changes in this connection.

The Board approved the Maternity and Neonatal Risk Management Strategy.

2121/06 Maternity and Neonatal Risk Management Annual Report – SFT 3709 – Presented by LW

The Board received for information the Annual Report.

2121/07 Management Letter 2014/15 – SFT 3710 – Presented by MC

The Board received for information the Management Letter considered by the Council of Governors at its July meeting.

2122/00 ANY OTHER URGENT BUSINESS

No matters were raised.

2123/00 QUESTIONS FROM THE PUBLIC

In relation to a question from Sir Raymond Jack, Laurence Arnold confirmed that the Site Programme Management Board on 21st October would be considering the tenders received for Springs Entrance and what aspects of the work if any could go forward and this would be considered by the Finance Committee at its 26 October meeting.

In relation to a question about the Friends and Family Test responses in relation the Children's Ward, Lorna Wilkinson undertook to provide further information to Alastair Lack. LW

2124/00 DATE OF NEXT MEETING

7 December 2015 at 1.30 pm.

CHIEF EXECUTIVE REPORT

MAIN ISSUES:

JUNIOR DOCTORS INDUSTRIAL ACTION

Like other NHS hospitals we are prepared for events that can cause disruption to services and have contingency plans to cover industrial action. Our highest priority is to provide excellent and safe services to our patients and in preparation for the industrial action the Trust received excellent support from its staff. At the time of writing the Trust planned for a minimal number of cancellations. We advised patients that unless they are directly contacted by the hospital, they should attend their outpatient appointment as usual and told them that we would notify patients if we have to cancel their operation or procedure. These messages were shared with the media and publicised both externally and internally within the hospital.

CQC INSPECTION

We welcomed the team from the Care Quality Commission (CQC) on site as part of their four-day inspection between 1-4 December, which touches on most aspects of the hospital and its work. On completion the Trust can expect a further unannounced visit in the days following the initial inspection and we expect to see the report around three months later. We will then have to display our ratings throughout the hospital and on our website.

ADULT COMMUNITY SERVICES

On 9 November 2015 the Trust submitted a bid, with its partners at Great Western Hospital Swindon and Royal United Hospital Bath, for the five year contract for adult community services in Wiltshire. This follows a significant effort across the three organisations and comes after the Board formally decided at its meeting in October, with the governors in attendance, to submit a bid. The Trust's aim in wanting to deliver these services in partnership with other hospital providers in Wiltshire is to create a new and improved model for community services which focuses on providing an outstanding experience for patients in the community, in the hospital and for GP practices. We expect to hear the results of the tender exercise by mid-December.

NEW HOSPICE AT HOME SERVICE

The Salisbury Hospice charity has announced its support for a new Hospice at Home service. This service will provide nursing care in the community for patients within the last two weeks of life, with the aim of keeping people at home if this is their wish. The £1.M pound cost of 'Hospice at Home' will be spread over three years. It is hoped that one aspect of the service will be to act as crisis intervention, preventing any unnecessary admissions to an acute hospital, hospice or alternative care setting. The Salisbury Hospice charity is working to a six month schedule to get the 'Hospice at Home service up and running.

SAFEGUARDING ADULTS CHAMPIONS

All NHS organisations have a duty to identify and protect patients who may be at risk of abuse, neglect or exploitation and we are introducing champions in all wards and departments who will promote awareness and help embed best practice around

safeguarding adults arrangements. A nurse from each ward and department has put themselves forward and we are holding regular workshops so that they have the knowledge and skills aimed at developing them in their new roles.

TRUST SIGNS UP TO NATIONAL DEMENTIA PATIENTS SUPPORT CAMPAIGN

The Trust has signed up to the national *Stay With Me* campaign and we are one of the first hospitals to be awarded the John's Campaign Certificate. This recognises hospitals that have stated publicly that they welcome carers of patients with dementia whenever they need them, including overnight if necessary. This is another example of our commitment to provide the very best care and support for all our patients and campaigners have described our hospital as "being in the forefront of a real change in the way vulnerable people are supported in hospital". They have also asked us to congratulate our staff and pass on their gratitude.

VOLUNTEERS NEEDED TO ACT AS WARD COMPANIONS FOR DEMENTIA PATIENTS

We are looking for new volunteers who can give up some of their free time to provide companionship to patients with dementia to support them in hospital. This will differ from our Engage programme, where volunteers increase social interaction for patients through quizzes, discussion groups and memory games. The new ward companions will act as "friends", sitting with patients, talking and giving them company during their hospital stay.

RECENT AWARDS

Congratulations to Pamela Permalloo-Bass, Head of Equality and Diversity who has won the NHS Leader of Inclusivity of the Year category at the Thames Valley and Wessex Leadership Awards. Pamela's award recognises the outstanding contribution that she has made to equality and diversity issues across the Trust and in the local community and the impact that has had on staff. Well done to Colette Martindale, Directorate Senior Nurse for CSFS who was a finalist for the Coach/Mentor of the year award at the same event, acknowledging her outstanding commitment and leadership in supporting staff at Salisbury District Hospital. Well done also to physiotherapist Gill Hibberd who has been highly commended in the Shine Awards by NHS Health Education Wessex. The award recognises the way in which she led the therapy service review at Salisbury District Hospital, highlighting leadership, collaboration and belief in the need for change to improve patient care.

STRIVING FOR EXELLENCE AWARDS

We are looking forward to our Striving for Excellence Awards. There is a tremendous amount of good work that takes place across the hospital each year and this is an excellent opportunity to share best practice and recognise the enormous contribution our staff make to the hospital and our local community. We will be publicising their efforts through the local media and our own dedicated newsletter.

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 Workforce Performance Report
M7 (October) 2015-16

SFT3715

Presented for : Information

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

Author : Victoria Downing-Burn, Deputy Director of HR (interim) and Mark Geraghty, Head of Workforce Information and Planning

Key points
The Trust Board is asked to consider this report, the detail of the metrics and updates, and the return to green actions.

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

Strategic Aims

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

Values

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

1. Summary
This report provides a more detailed assessment of the workforce numbers including vacancies and the actions and intentions to improve the variances.

The metrics is summarised against four categories, with the narrative focusing on three key areas for improvement*:

- *Workforce Numbers: numbers and vacancies
- *Workforce Quality: temporary workforce and safer staffing
- Workforce Health: absence, starters and turnover and reasons for turnover, Staff FFT
- *Workforce Compliance: appraisal, training

2. Performance

Please refer to the charts in the document for monthly data (October 2015) and trends over the previous five months (May – September 2015).

Workforce Numbers

2.1 Staff in Post – RED and GREEN

The total number of staff in post is 2773 against a plan of 2942. Within the gap of 169, 111 are registered nurses. This gap is largely closed through the use of variable staffing, reducing the gap by 106.

2.2 Vacancies and variable staffing – RED and GREEN

The overall vacancy rate for the Trust is 5.8% (5.7% in the previous month), which is green, against a plan of 5%.

Within Registered Nursing the vacancy rate is 13% rated as RED against a plan of 10%, showing no change since the previous month. When variable staffing (use of temporary agency / bank staff) is included the nursing vacancy rate is 0.6%.

2.3 Workforce costs and quality – AMBER/RED

The total work force spend is above plan by 1.5%, with variable staffing representing c11% of the total spend against a plan of 6.8% (see chart 1). Nursing Bank spend has seen a small increase on the previous month, and total bank spend has reduced.

Agency spend continues to increase against plan with nursing agency showing an increase on the previous month while medical agency spend has shown a decline, to below previous levels.

The recent Monitor consultation, due to be implemented on 23 November, will bring into force the requirement to work within capped rates for agency staffing for all workforce groups. Representatives from HR, Finance and Procurement – and under the leadership of the Director of HR and OD – are working on monitoring the use of agency under the existing agreed Crown Commercial Contracts to satisfy the national reporting requirements.

2.4 Return to Green 2.1 – 2.3

On-going recruitment to the Nursing and Medical workforce is a key strategy to improve the supply of labour and reduce the demand for variable staffing. Previous reports have highlighted the recruitment activity particularly relating to nurses, and this is captured in Section 5. Recent activity includes:

- A Nurse Open day held in October at the hospital, which attracted 11 people and we made 5 successful offers. Following feedback from the attendees we have placed a rolling advert for nursing staff.
- Rolling Open-Advert, has led to 6 successful offers made.
- Next planned Open Day is 27 February 2016.

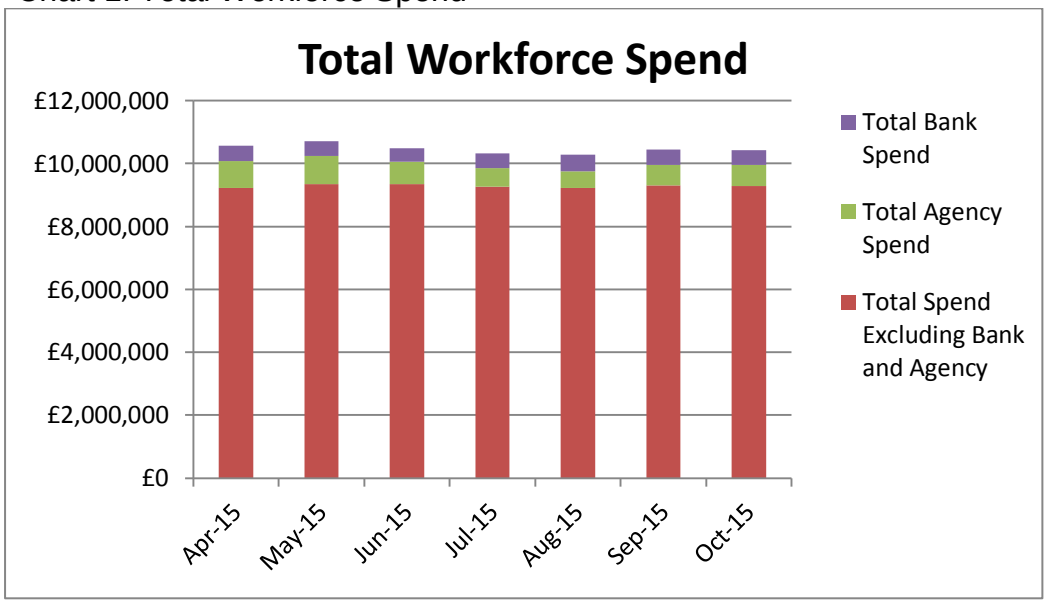
- The Trust is also attending the 'British Forces Resettlement Services' Conferences in Jan and Sept 2016 to promote the Trust and recruit personnel returning from Germany.
- Attendance at the Acute and General Medical Conference in November, with the contact details of c200 people captured. These are being followed up with emails, as well as direct contacts to those interested in current vacant posts.
- ***Apprenticeships.*** Another area that the Trust has promoted in supporting the workforce issues has been the employment of Apprentices[1].

  Apprenticeships are work-based training programmes designed around the needs of the Trust, which lead to nationally recognised qualifications. Apprenticeships are aimed at attracting new talent, re-skilling existing staff and tackling skills shortages. The trust receives a grant / funding to employ the apprentices and support their education.

  Salisbury NHS Foundation Trust currently employs around 40 apprentices, in area such as Theatres, Pathology Laboratory, Education, Day Nursery, Pharmacy, Clinic Admin, IT and Wards.

  Apprenticeships being studied for include Health Pathology Support, Clinical Health Care, Business and Administration, Customer Service and Team Leading.

Chart 1: Total Workforce Spend



Workforce Quality

2.5 Efficiency of staff deployment

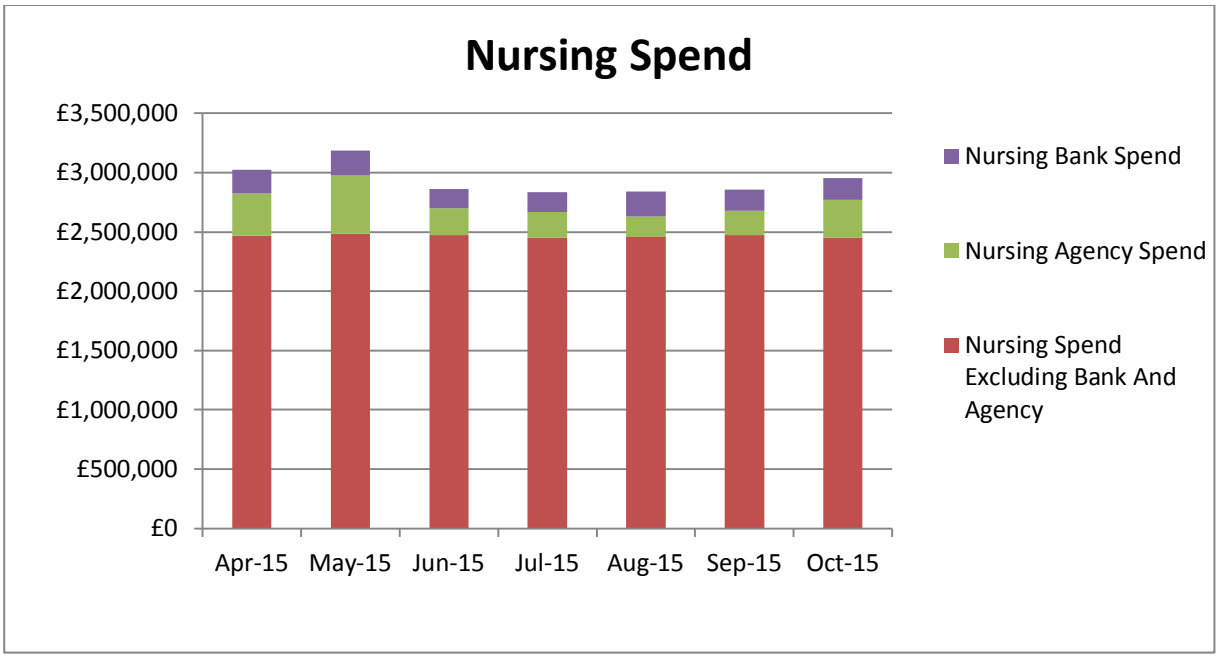
Although the shift fill hours for nursing Bank has shown an improvement in the seventh month of the year (2015-16), the overall % fill rate is below target at 64%. . The Trust is seeking to move to a position where the uptake of bank shifts is the

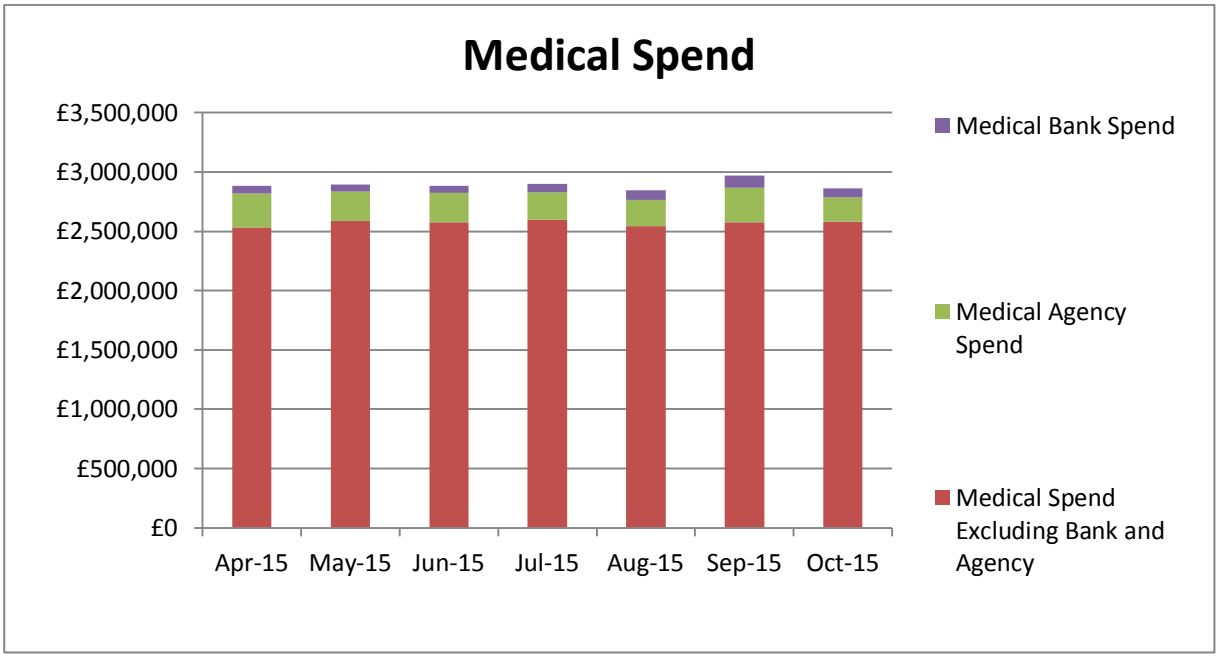
[1] www.nhsemployers.org/apprenticeships

major proportion of variable staffing where required, with agency usage at a minimum.

Next steps

- Monitoring of use of bank and agency to be continued, and promoting our bank.
- All agency requests (excluding ward based nursing) to be scrutinised by the Workforce Vacancy Review panel





2.6 Safer staffing – appendix 1

Appended to this report is the 'Safer Staffing NQB Report – October 2015' which provides a further analysis of the nursing staffing levels across the Trust including a

full breakdown of the percentage of filled shifts (day and nights). The report also provides an assessment of Red and Amber areas and mitigations.

2.7 Monitor - Agency Caps

Monitor and the NHS Trust Development Authority (TDA) have implemented a cap on the amount of money that trusts can pay per hour for agency staff working for the NHS[2]. This took effect from 23 November 2015.

The cap applies to all NHS trusts and NHS foundation trusts employing agency staff. This covers all staff groups, including: nursing, medical, all other clinical and other non-clinical agency staff. The price caps do not apply to substantive/permanent staff, bank staff.

The Trust undertook preparatory work during the consultation period to establish, within nursing supply, which agencies are currently used would conform to the capped rates. Further work has also begun to complete the same data set for the other staff areas.

The Trust currently operates existing Crown Commercial Contracts with some areas of staffing supply.

Existing controls for the use of agency include: Nursing Agency: 'Authorisation Requirements for Booking Agency' form requiring DSN /Deputy / Director of Nursing sign off; Medical: Locum Request Form requiring Directorate Manager and Clinical Director sign off; and Workforce Control Panel for all other agency requests requiring Executive sign off.

Trusts are expected to only use agencies under the capped rates, with a tolerance of 30% of total agency spend permitted above cap as 'break-glass' / clinical exceptions / patient safety reasons. Trusts are required to submit weekly data to confirm usage of agencies and any above cap spend.

The Procurement, Finance and HR teams are working to ensure compliance with the reporting requirements and to manage the potential for over cap 'overrides'.

Workforce Health

2.8 sickness and turnover – GREEN / AMBER

The percentage of Sickness with no reason recorded has increased this month. Directorate teams have been encouraged to report at first point of contact.

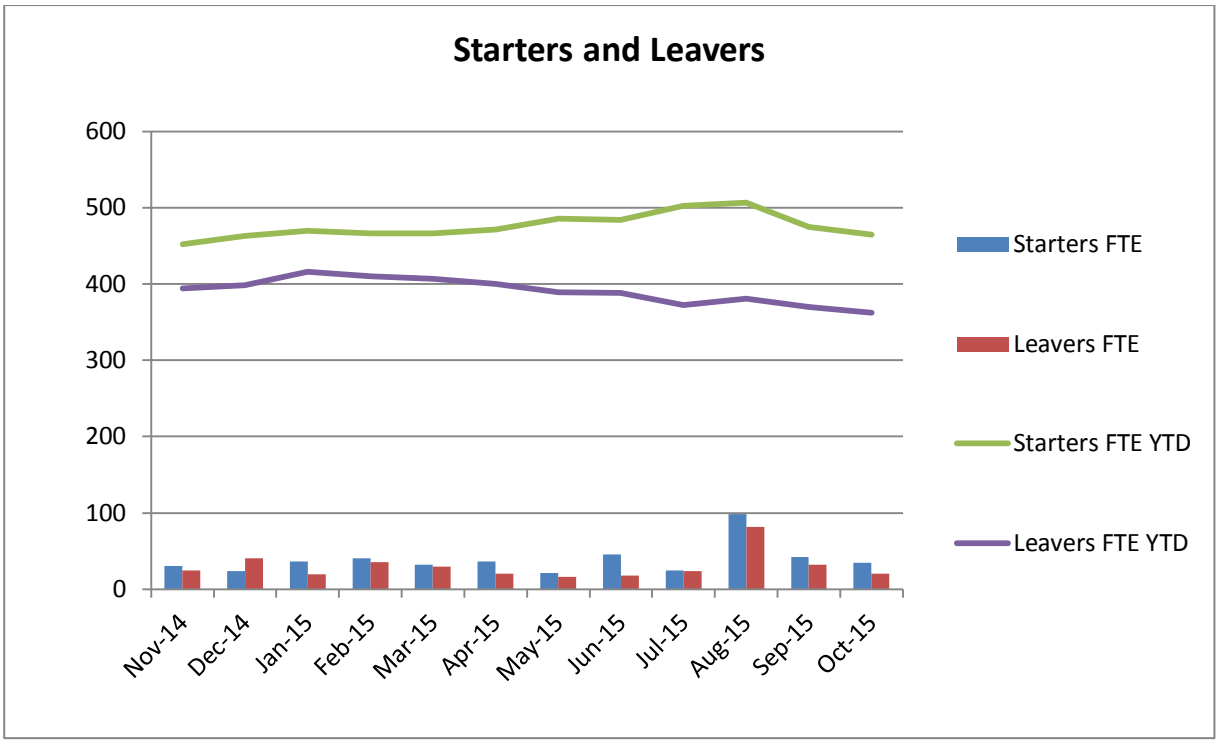
The employee self-service function on the Electronic Staff Record (ESR) is being considered.

2

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478691/Agency_letter_to_trusts_post_consultation_final.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478695/Price_caps_for_agency_staff_rules_final.pdf

Trust turnover (which excludes medical staff on rotation) is 9.7%, down on the previous month (10.1%), against a target of 8.5%. Nurse turnover is 8.1%, which is lower than the trust average.

A review of retention rates and reasons for leaving has been undertaken to understand retention opportunities.



2.9 Friends and Family Test – GREEN

Data in quarter 2 has shown a decrease in the number of staff who are stating that they would recommend the Trust as somewhere to work. Feedback attributes this to:

- 'Lack of pay rise' / 'low pay', although it is acknowledged that this is not a Trust issue
- The 'financial' issues are starting to take effect
- Access to and the cost of parking

These comments were provided by a small number of staff, with a total of 30 comments relating to issues highlighted above out of 222 responses (13%).

Workforce Compliance

2.10 Appraisal rates – RED/AMBER

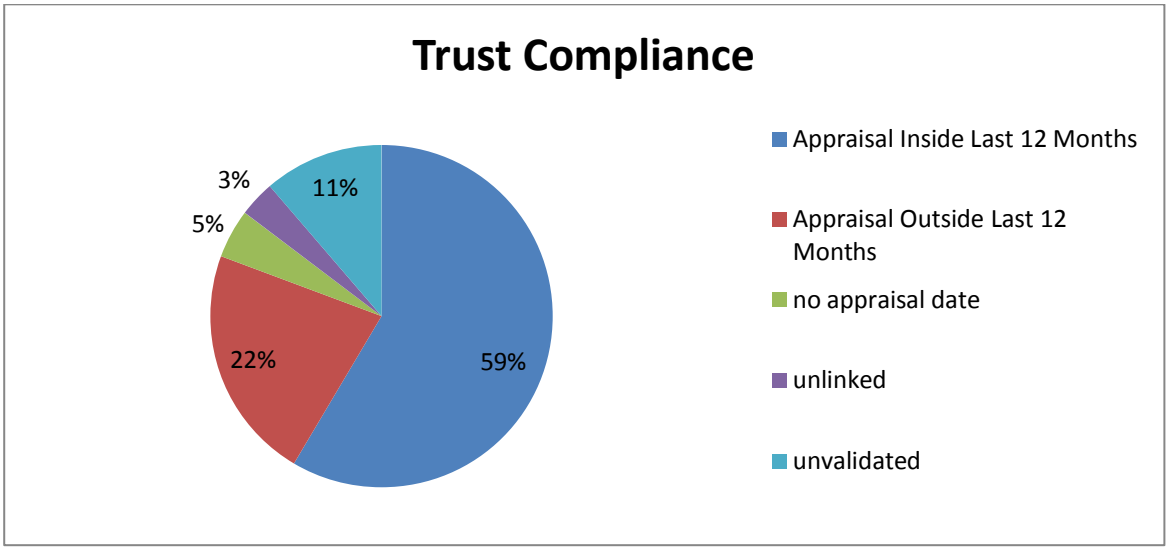
Non-medical appraisal rate: 59%, and shows a decrease from the previous month. Medical appraisal rate: 92%. Significant work has been undertaken to ensure that all appraisal data is appropriately recorded and 'signed off'.

Return to Green
System generated emails will go to all staff who are not in the 'appraisal inside last 12 months' reminding them to progress their appraisal record.

Phase 2 of the development of the appraisal tool (SpIda) now in the testing phase with a planned go live date of January 2016. This will include a function for nurse and midwife revalidation.

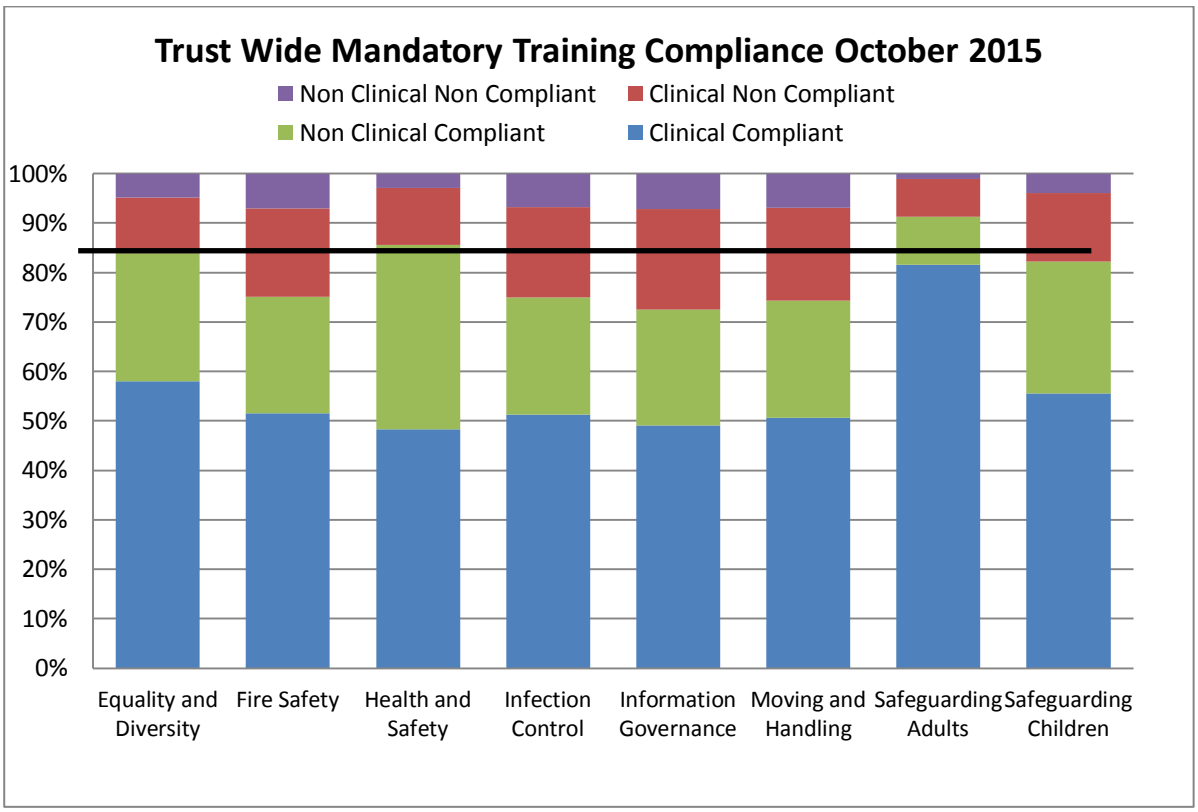
Training on the new system will need to be undertaken from the beginning of January led by the HR team.

As noted in the chart below, the data from the system identifies a number of staff who sitting in categories other than 'appraisal inside last 12 months'.



2.11 Statutory and Mandatory Training – AMBER/RED

Compliance with training is reported as amber at 81.1% which varies between each of the core topics as demonstrated by the table below.



Note: Information Governance
The recorded figure of compliance provided by the IG team and submitted as part of the IG Toolkit is 94.3%.

Return to Green

- Trust staff have been reminded of the requirement to be compliant with statutory and mandatory training.
- Line managers are required to confirm compliance with training for pay progression through the SpIda appraisal system.

3. Communication and Involvement
The workforce metrics are available for all staff groups, Directorates and wards/departments throughout the Trust. Work continues to integrate qualitative intelligence with the metrics to better inform performance management discussions. Directorates are provided with rankings on key measures, enabling managers to understand how their performance compares with their peers.

4. Recommendation
The Board is asked to note the current position.

5. Supporting Information
The following documents are attached as appendices:

1. Metrics
2. Safer Staffing NQB Report – October 2015.
3. Recruitment Activity Summary

Recruitment Activity Summary
1. We are using Twitter and Facebook to advertise vacancies weekly

2. We are using LinkedIn, Twitter and Facebook for specified vacancies
3. We have created a Trust ‘postcard’ used to advertise and increase membership of our social media sites (for the public and staff, including new recruits during induction)
4. We are continuing the Refer a Friend Scheme
5. We have used ‘Salisbury Staff Stories’ via facebook and LinkedIn www.linkedin.com/company/salisbury-nhs-foundation-trust/insights
6. The Relocation Expenses Policy has been updated to extend the scope of the policy, including hard to recruit to posts
7. There was Nurse and HR attendance at Salisbury Job Fair during September
8. We had a tailored radio campaign with Heart Radio during September, with limited response from this and no follow up campaigns planned
9. We advertised on Heart Radio Website (Hampshire, Dorset, Somerset and Wiltshire)
10. Advertising on the Trust courier vans launched, with a competition for ‘sightings’ being arranged
11. Further training is being undertaken in the Employment Service Team (recruitment) to realise more benefits from NHS Jobs

Alison Kingscott
Director of HR and OD - November 2015

Staff In Post (SiP) numbers	*Target*	Oct-15	Trend	*Plan*
Total substantive Staff in Post (FTE)	= 95% of funded establishment (see vacancy rate RAG rating criteria below)	2,773		2,942
Total substantive SiP - Registered Nurses (FTE)	= 92% of funded establishment (see vacancy rate RAG rating criteria below)	738		849
Total registered nurses including variable staffing	See plan	844		849

Vacancies	*Target*	Oct-15	Trend	*Plan*
All Vacancies - excluding variable staffing (%)	<5% = green, 6% to 10% = amber, >10% = red	5.8%		5.0%
Registered Nursing Vacancies - excluding variable staffing (%)	<10% = green, 10% to 12% = amber, >12% = red	13.0%		10.0%
Registered Nursing Vacancies - including variable staffing (%)	<=4% = green, 5% to 6% = amber, >6% = red	0.6%		0.0%

Workforce Costs and Quality	*Target*	Oct-15	Trend	*Plan*
Total Workforce spend vs. plan (YTD % above/below plan)	Plan ±<1% = green, plan ±1 to 5% = amber, plan ±>5% = red	1.5%		£41,392,414
Variable Staffing spend as proportion of total workforce spend	Reduction	10.9%		6.8%
Bank Spend Total	Upward trend	£467,692		
Nursing Bank Spend (All Nursing)	Upward trend	£320,500		
Medical Locum Bank Spend	Upward trend	£73,711		
Agency Spend Total	Reduction	£669,500		
Nursing Agency Spend (All Nursing)	Reduction	£396,810		
Medical Agency Spend	Reduction	£208,134		

Workforce Quality

Efficiency of Staff Deployment	*Target*	Oct-15	Trend	*Plan*
Bank Shift Fill Rate % - All Nursing	Upward Trend	63.7%		85.0%
Bank Shift Fill Hours - All Nursing	Upward Trend	17,116		22,841
Agency Shift Fill Rate % - All Nursing	Reducing	28.4%		
Agency Shift Fill Hours - All Nursing	Reducing	7,637		

Safer Staffing	Target	Sep-15	Trend	*Plan*
Actual Staffing Levels - Nursing Assistants % of planned	No target	99.1%		
Actual Staffing Levels - Registered Nurses % of planned	No target	94.7%		
Actual Skill Mix % Qualified	No target	62.0%		

Workforce Health

Sickness Absence	*Target*	Oct-15	Trend	*Plan*
Overall Sickness Absence Rate (12m rolling average %)	<=3.1% = green, 3.2% to 4% = amber, >4% = red (2.87% target).	3.1%		3.0%
Short Term Sickness (12m rolling average %)	No target	1.4%		1.4%
Long Term Sickness (12m rolling average %)	No target	1.7%		1.6%
Average number of working days lost per FTE (in previous 12 months)	<=6.1 = green, 6.2 to 8.6 = amber, >8.6% = red	6.7		6.8%
Financial cost of sickness in last 12 months	<=3.1% = green, 3.1% to 4% = amber, >4% = red	£3,765,760		£3,673,950
% of Sickness Absence with no reason recorded	<=5% = green, 5% to 15% = amber, >15% = red	18.3%		<=5%
Turnover	*Target*	Oct-15	Trend	*Plan*
Staff Turnover rolling 12 months % (Excluding Rotational Medical Staff)	7-10% = green, 10% -12% = amber, >12% = red. (8.5% target)	9.7%		9.9%
Registered Nurse Turnover rolling 12 months %	7-10% = green, 10% -12% = amber, >12% = red. (8.5% target)	8.1%		8.2%
Starters % rolling 12 months (Excluding Rotational Medical Staff)	No target	12.8%		12.9%
Registered Nurse Starters rolling 12 months	No target	8.9%		9.2%
Staff Friends and Family Test	Target	Q2 2015/16	Trend	*Forecast Out Turn*
% of Staff agreeing they would recommend the hospital as a place to receive treatment	Awaiting publication of 2015/16 National Results	89.6%		92.6%
% of Staff agreeing they would recommend the hospital as a place to work	Awaiting publication of 2015/16 National Results	67.6%		80.8%

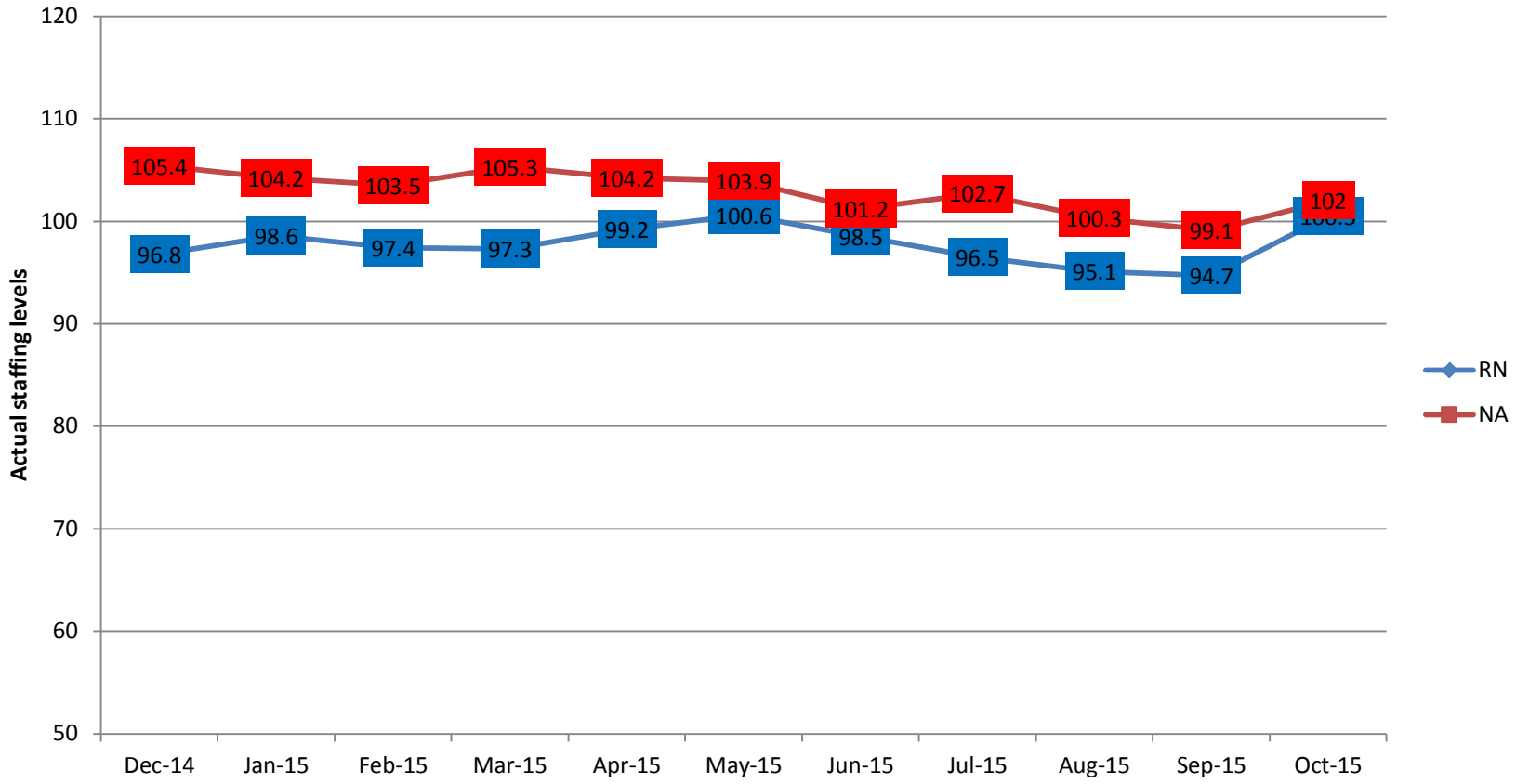
Workforce Compliance

Appraisal rates (excludes Medical Staff)	*Target*	Oct-15	Trend	*Plan*
Appraisal rates for Non Medical Staff	>85% = green, 75% to 85% = amber, <75% = red	61.0%		85.0%
Appraisal rates for Medical Staff	>85% = green, 75% to 85% = amber, <75% = red	92.0%		90.3%
Statutory and Mandatory Training - All Staff	*Target*	Nov-15	Trend	*Plan*
Overall Statutory and Mandatory Training Compliance	>85% = green, 75% to 85% = amber, <75% = red	81.1%		85.0%
Equality and Diversity	>85% = green, 75% to 85% = amber, <75% = red	83.9%		85.0%
Fire Safety	>85% = green, 75% to 85% = amber, <75% = red	75.1%		85.0%
Health and Safety Overview	>85% = green, 75% to 85% = amber, <75% = red	85.5%		85.0%
Infection Prevention and Control (including hand hygiene)	>85% = green, 75% to 85% = amber, <75% = red	75.0%		85.0%
Information Governance	>85% = green, 75% to 85% = amber, <75% = red			
Moving and Handling	>85% = green, 75% to 85% = amber, <75% = red	74.3%		85.0%
Safeguarding Adults	>85% = green, 75% to 85% = amber, <75% = red	91.3%		85.0%
Safeguarding Children Level 1 and 2	>85% = green, 75% to 85% = amber, <75% = red	82.2%		85.0%

Safe Staffing NQB Report – October 2015

Monthly Comparisons – Actual Staffing Levels

Registered Nurses			Nursing Assistants			Combined			Actual Skill Mix	
P	A	%	P	A	%	P	A	%		
56145.9	56434.28	100.5%	33917.1	34594.47	102%	90063	91028.75	101%	62	38



Overview of Nurse Staffing Hours – October2015

	RN	NA
Total Planned hours (day shift)	33775.44	22620.6
Total Actual hours (day shift)	33730.28	23025.22
Percentage	**99.9%**	**101.8%**
Total Planned hours (night shift)	22370.5	11296.5
Total Actual hours (night shift)	22704	11569.25
Percentage	**101.5%**	**102.4%**

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	**13229.98**	**13763.48**	**104.0%**	**9998.75**	**11023.51**	**110.2%**
Durrington Ward	1068	1073	100.5%	868.5	1145	131.8%
Emergency Department	356.5	356.5	100.0%	356.5	356.5	100.0%
Farley Ward	1772.5	1854.25	104.6%	1542.5	1516	98.3%
Hospice	879.5	905.5	103.0%	637.5	810.5	127.1%
Pembroke Ward	855.5	858	100.3%	394.75	395.25	100.1%
Pitton Ward	1402.5	1652.25	117.8%	1142.5	1250.5	109.5%
Redlynch Ward	1467.98	1480.98	100.9%	1142	1161.5	101.7%
Tisbury Ward	2034.5	1906.5	93.7%	712	712	100.0%
Whiteparish Ward	1630	1825	112.0%	1091	939.76	86.1%
Winterslow Suite	1763	1851.5	105.0%	2111.5	2736.5	129.6%
Surgery	**6393.5**	**6503.17**	**101.7%**	**3105.5**	**2709.51**	**87.2%**
Britford Ward	2189.5	2142	97.8%	1242.5	1202.76	96.8%
Downton Ward	1363	1357.67	99.6%	1045	1050.75	100.6%
Radnor	2841	3003.5	105.7%	818	456	55.7%
Clinical Support	**4624.5**	**4191**	**90.6%**	**2101.25**	**1639.42**	**78.0%**
Maternity	2663.5	2248.25	84.4%	1347.25	1119.17	83.1%
NICU	1098.5	1028.5	93.6%	397.5	208.5	52.5%
Sarum Ward	862.5	914.25	106.0%	356.5	311.75	87.4%
Musculo-Skeletal	**9527.46**	**9272.63**	**97.3%**	**7415.1**	**7652.78**	**103.2%**
Amesbury Suite	1893.5	1892.64	100.0%	1547.5	1563.97	101.1%
Avon Ward	1429.69	1428.95	99.9%	1556.57	1877.88	120.6%
Burns Unit	1471	1459	99.2%	554.75	510.5	92.0%
Chilmark Suite	1498.75	1599.17	106.7%	1139.75	1044.28	91.6%
Laverstock Ward	1910.68	1682	88.0%	1092.25	1040.67	95.3%
Tamar Ward	1323.84	1210.87	91.5%	1524.28	1615.48	106.0%
Grand Total	**33775.44**	**33730.28**	**99.9%**	**22620.6**	**23025.22**	**101.8%**

Nursing Hours by Night Shifts

	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**9500.5**	**9847**	**103.6%**	**5053**	**5472.75**	**108.3%**
Emergency Department	356.5	356.5	100.0%	356.5	356.5	100.0%
Farley Ward	1069.5	1115.5	104.3%	713	690	96.8%
Hospice	589	591	100.3%	418.5	444	106.1%
Pembroke Ward	713	719	100.8%	0	0	0
Pitton Ward	1069.5	1312	122.7%	713	770.5	108.1%
Redlynch Ward	1069.5	1081	101.1%	356.5	345	96.8%
Tisbury Ward	1425	1429	100.3%	356.5	373.25	104.7%
Whiteparish Ward	1426	1449	101.6%	356.5	331.5	93.0%
Winterslow Suite	1069.5	1069.5	100.0%	1069.5	1403	131.2%
Durrington Ward	713	724.5	101.6%	713	759	106.5%
Surgery	**4402**	**4686.25**	**106.5%**	**1150**	**1238.5**	**107.7%**
Britford Ward	930	933	100.3%	620	631	101.8%
Downton Ward	620	640	103.2%	530	550	103.8%
Radnor	2852	3113.25	109.2%	0	57.5	0
Clinical Support	**4600**	**4214.25**	**91.6%**	**1460.5**	**1134**	**77.6%**
Maternity	2495.5	2171.75	87.0%	1069.5	1007.5	94.2%
NICU	1035	1007.5	97.3%	345	46	13.3%
Sarum Ward	1069.5	1035	96.8%	46	80.5	175.0%
Musculo-Skeletal	**3868**	**3956.5**	**102.3%**	**3633**	**3724**	**102.5%**
Amesbury Suite	589	589	100.0%	883.5	883.5	100.0%
Avon Ward	620	660.75	106.6%	930	920	98.9%
Burns Unit	620	617.25	99.6%	310	310	100.0%
Chilmark Suite	589	617.5	104.8%	589.5	542	91.9%
Laverstock Ward	830	830.5	100.1%	310	320	103.2%
Tamar Ward	620	641.5	103.5%	610	748.5	122.7%
Grand Total	**22370.5**	**22704**	**101.5%**	**11296.5**	**11569.25**	**102.4%**

Overview of Areas with Red/Amber

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	**Radnor**	56%		√	Day	Small numbers of NA's used to support the team. Not covered each shift which is not always clinically indicated but the data collection model used cannot reflect this flexibility as planned establishment has to be entered into the system as a standard daily amount.
Red	**NICU**	52%		√	Day	Small number of MA's used with an increase of 30% since September
Red	**NICU**	13%		√	Night	Small number of MA's used but a decrease of 19% since September demonstrates that demand for night staffing support cover has not been as high
Amber	**Laverstock**	88%	√		Day	Staffing levels assessed daily .
Amber	**Maternity**	87%	√		Night	3% increase since September. Escalation protocol used and each shift assessed against a risk assessment to ensure 1:1 care in labour maintained.
Amber	**Maternity**	84%	√		Day	Increase of 6% since September . Staff vacancies exist whilst recruitment to increased establishment continues.
Amber	**Maternity**	83%		√	Day	Change from Red to Amber . This reflects flexible rostering of reducing NA night cover by 19% leaving a higher proportion of RN cover at night and increase in 18% support for day shifts (since September) to meet patient demand and available skills
Amber	**Sarum**	87%		√	Day	2% reduction. Staffing levels assessed daily against patient acuity
Amber	**Whiteparish**	86%		√	Day	Staffing levels assessed against patient acuity each shift., ongoing recruitment into vacancies.

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

Mitigation of Risk

Fewer wards are flagging red/amber against our internal measures this month reflected in staffing levels for both NA and RN at 100% for both Night and Day

- Specialist areas such as Radnor (ICU), and NICU continue to flag where staffing is used flexibly according to patient numbers and acuity which cannot be reflected accurately on this tool.
- High level of NA nights staffing on Sarum noted due to flexible rostering where an NA has been assigned to support night shift needs for 3 shifts dramatically increasing the percentage
- Each shift risk assessed for staffing needs by senior nurse and adjusted accordingly.
  - Maternity are actively recruiting into an increased establishment
  - Appropriate 1:1 or 1:2 ratios maintained on all shifts in critical care areas
- All shifts are assessed daily by Directorate Senior Nurses to ensure they are safe .

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
- Shifts that are difficult to cover (nights and weekends) are prioritised.
- If all of the above measures have been taken there may be a requirement that staff on training days are brought back to work clinically as required and / or Sisters on supervisory shifts work clinically.
- Additional NAs rostered to support unfilled RN shifts
- CCOT team support wards where acuity of patients high

Trust Board meeting **SFT 3716**

Quality indicator report – October 2015

Date: 23 November 2015

Report from: Dr Christine Blanshard, Medical Director
Presented by: Dr Christine Blanshard, Medical Director

Executive Summary:

- 2 MSSA bacteraemias.
- 1 case of Trust apportioned reportable C Difficile. The Trust is slightly below trajectory at the end of M7.
- 1 never event. The previous never event commissioned in August 15 is being put forward to the CCG for downgrade.
- 3 new serious incident inquiries which includes the never event.
- An increase in the crude mortality rate in October with an upward trend in admissions. SHMI is 107 to March 2015 is as expected. HSMR is 107 to July 15 and is as expected having peaked in May 15. A recent discussion paper indicated a 0.9% rate of avoidable deaths at SFT compared to 3.6% nationally. This has been discussed in detail at the CGC and with the commissioners.
- An increase in grade 2 pressure ulcers reported during the month. The Tissue Viability Specialist Nurse is leading cluster reviews.
- Safety Thermometer – 96% of 'new harm free care' and a decline to 90% of 'all harm free care' of patients admitted to hospital with a harm.
- There were 2 falls in October, both resulted in catastrophic harm with subdural haemorrhages. Both are subject to a serious incident inquiry.
- In October, there was good performance in stroke care of patients receiving a CT scan within 12 hours and spending 90% of their time on the stroke unit. However, there was a decline to 80% of patients reaching the stroke unit within 4 hours. This affected 5 patients – 4 related to bed capacity and 1 patient arriving minutes after the 4 hours from ED.
- High risk TIA referrals being seen within 24 hours was at 75%. This affected 5 patients – for 1 patient there was no available clinic due to consultant leave, for 2 patients the investigations were not completed until after 24 hours, for 1 patient the referral from ED was not sent until the following day and in the other patient the referral was not forwarded by the GP until 6.5 hours later. The patient was contacted the following morning but was unable to attend the clinic until the afternoon. The GPs have assisted with improvements by reinforcing the need for immediate electronic referral whilst the patient is still in the surgery.
- Escalation bed capacity has increased as has the number of multiple patient ward moves, as demand for hospital care has also increased.
- In October there were 4 mixed sex accommodation breaches affecting 27 patients, all on AMU. A remedial action plan is in place. This includes a policy, patient information, and RCA process, and is under constant review with the commissioners.
- Real time feedback from patients about whether they were treated with care and compassion and rating the quality of the care they received remains above the 14/15 average. FFT response rates for inpatients remained constant and Maternity Services improved. ED remained below the local target. Day cases and outpatient response rates remain at a low level.

Proposed Action:

1. **To note the report**

Links to Assurance Framework/ Strategic Plan:
CQC registration

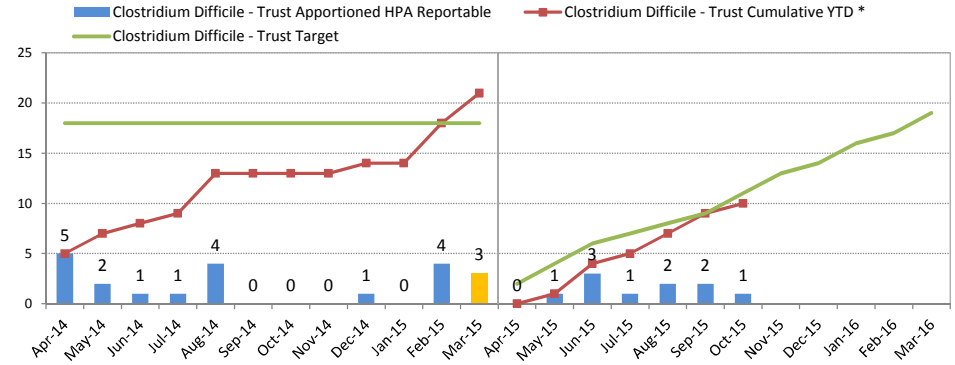
Appendices:
Trust quality indicator report – October 2015
Supporting Information

Trust Quality Indicators - October 2015

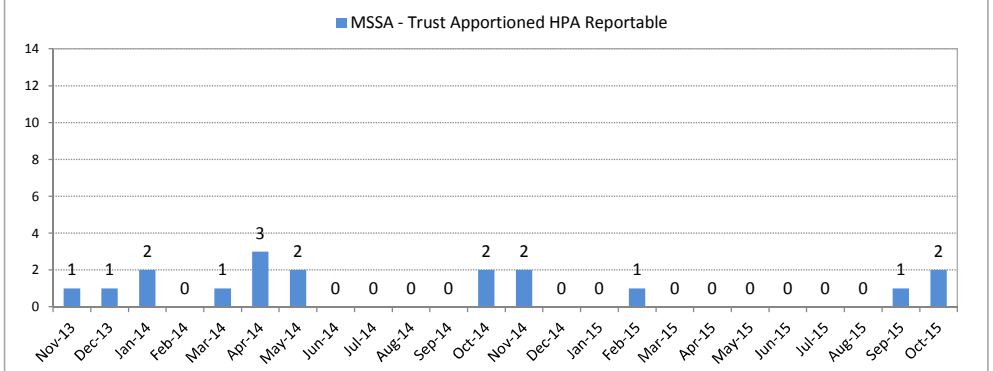
Infection Control	2014-15	2015-16 YTD
MRSA (Trust Apportioned)	1 (+1)	0

Trust Incidents	2014-15	2015-16 YTD
Never Events	2	2
Serious Incidents Requiring Investigation	30	13

Clostridium Difficile - Trust Apportioned



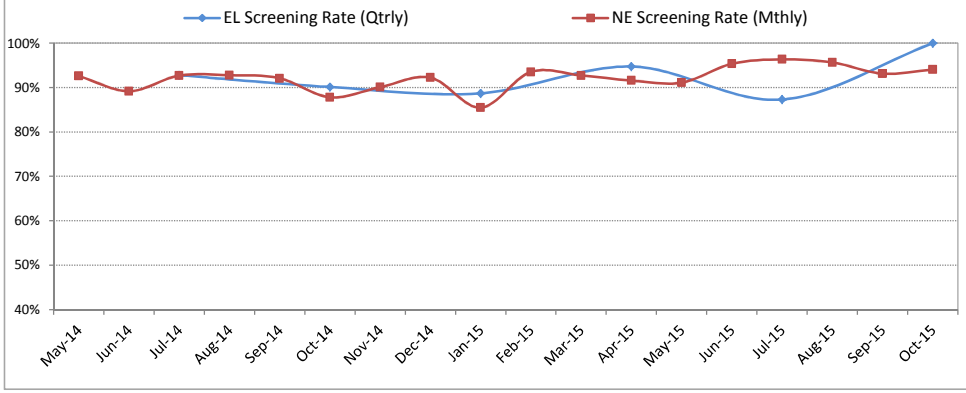
MSSA - Trust Apportioned



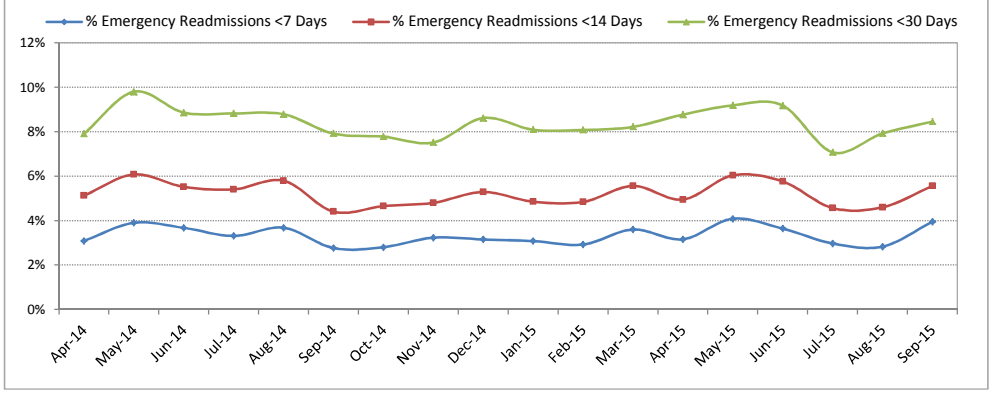
* Clostridium Difficile – Trust cumulative YTD includes only those cases with identified lapses in care

In March 2015 there were 2 additional cases of Clostridium Difficile that were removed from the trajectory following a CCG review. No lapses in care were found.

MRSA Screening



Emergency Readmissions within 7, 14 & 30 days of Discharge



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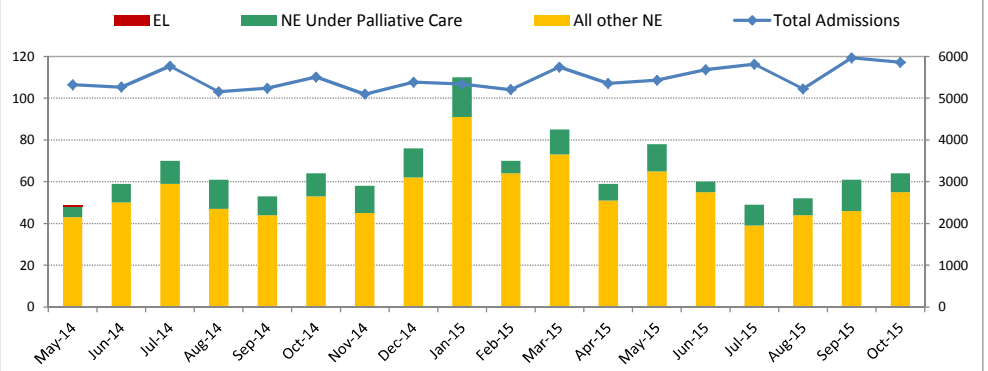
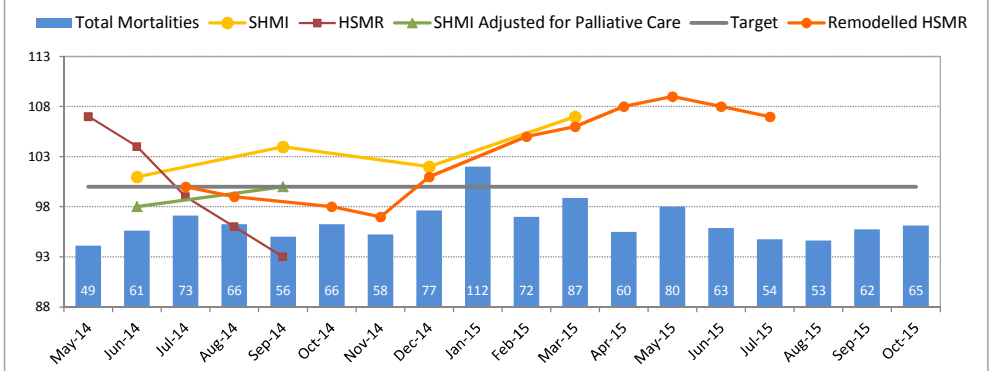
Trust Quality Indicators - October 2015

Quality Measures

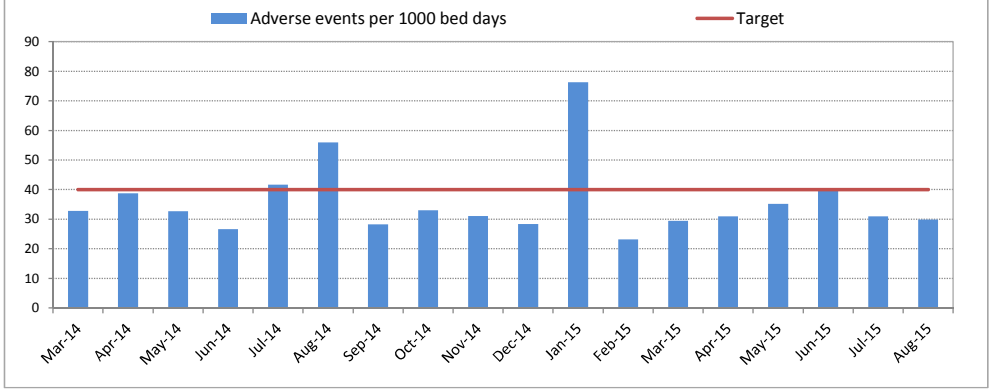
Hospital Mortalities



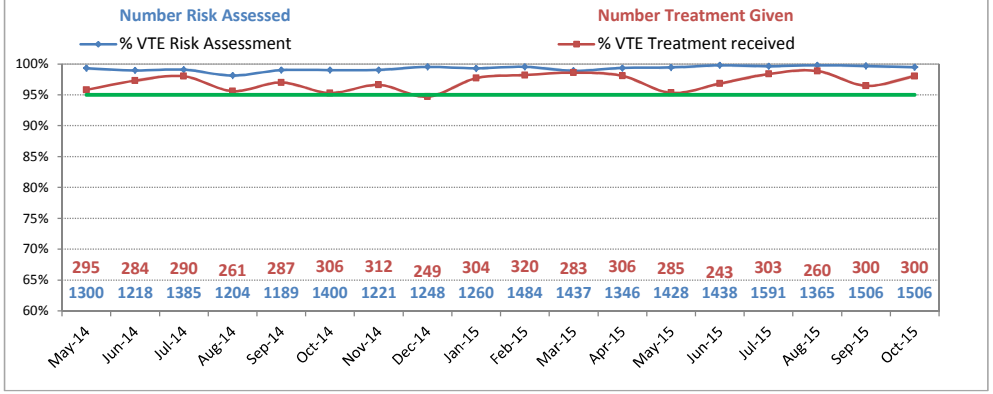
HSMR and SHMI



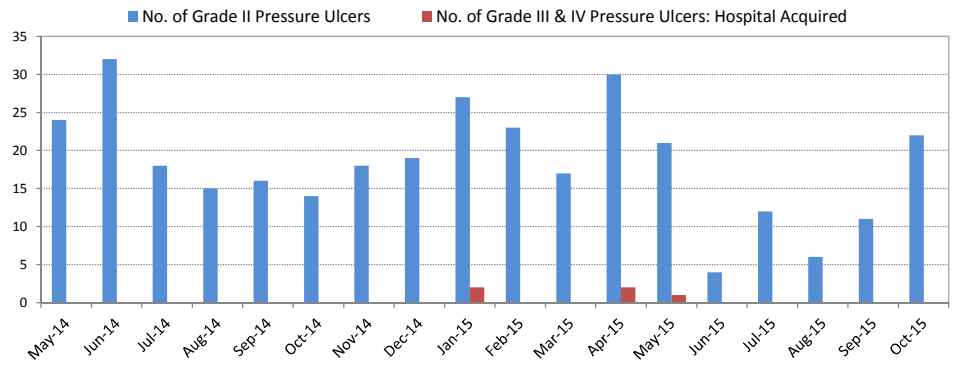
Global Trigger Tool



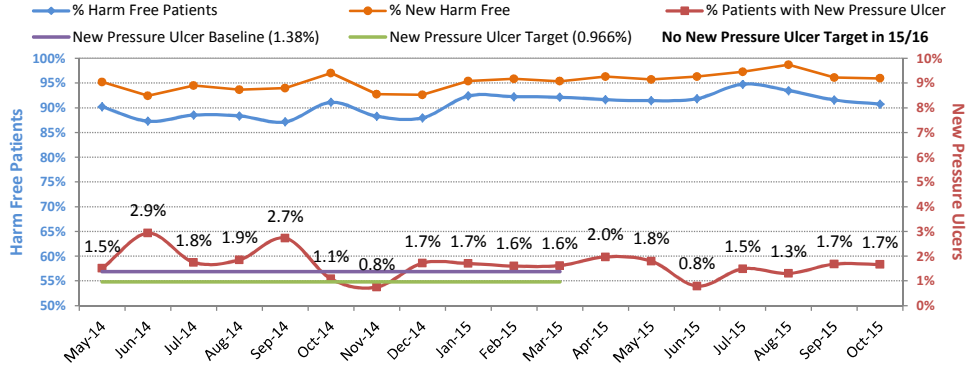
Venous Thrombous Embolism: Risk Assessment & Prophylaxis



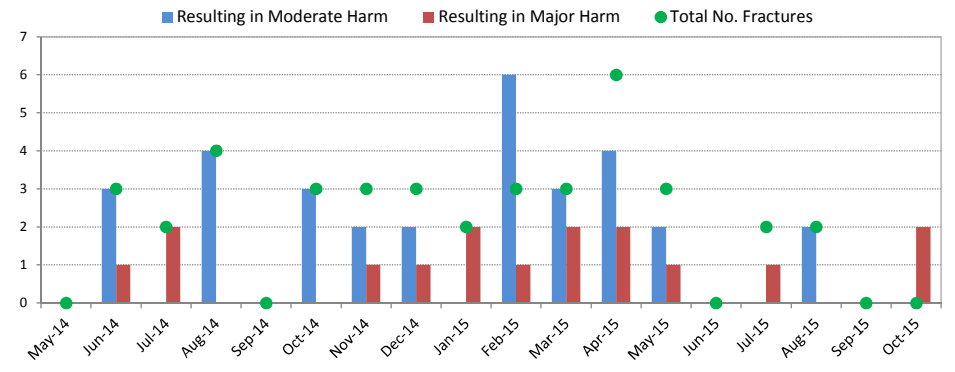
Pressure Ulcers - Total Number per Month



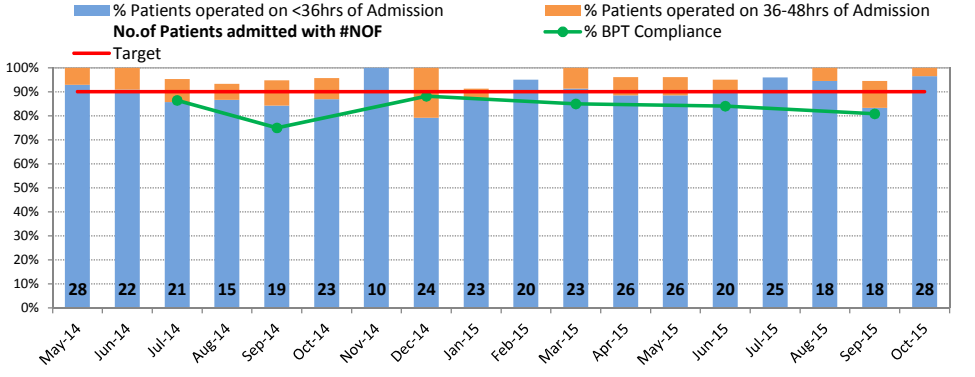
Safety Thermometer - One Day Snapshot per Month



Patient Falls in Hospital Resulting in Moderate Harm or Fracture / Major Harm



Fracture Neck of Femur operated on within 36 hours



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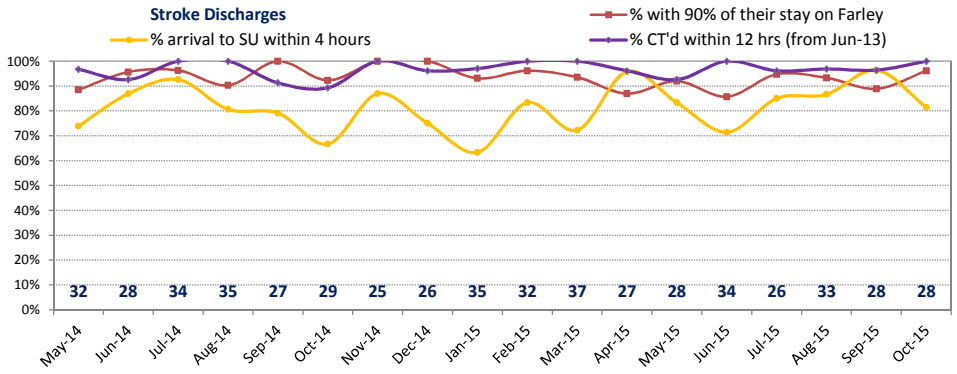
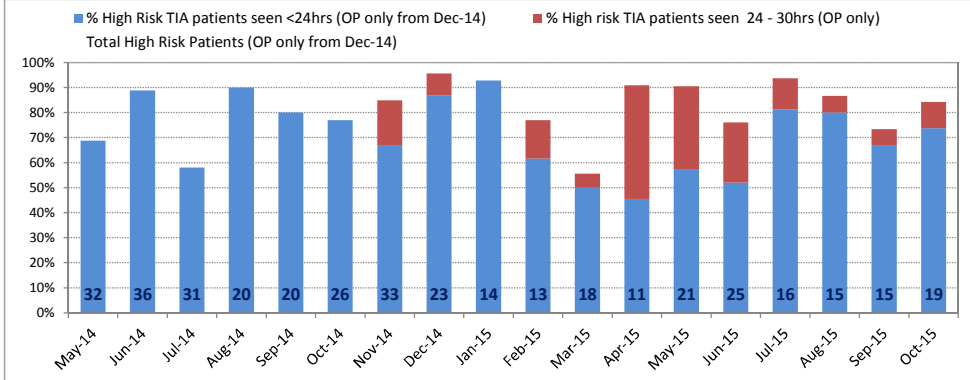
Trust Quality Indicators - October 2015

Quality Measures

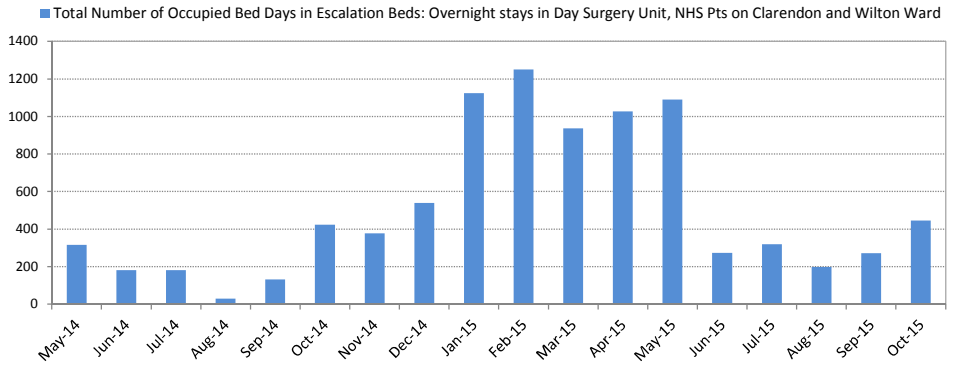
Stroke Care



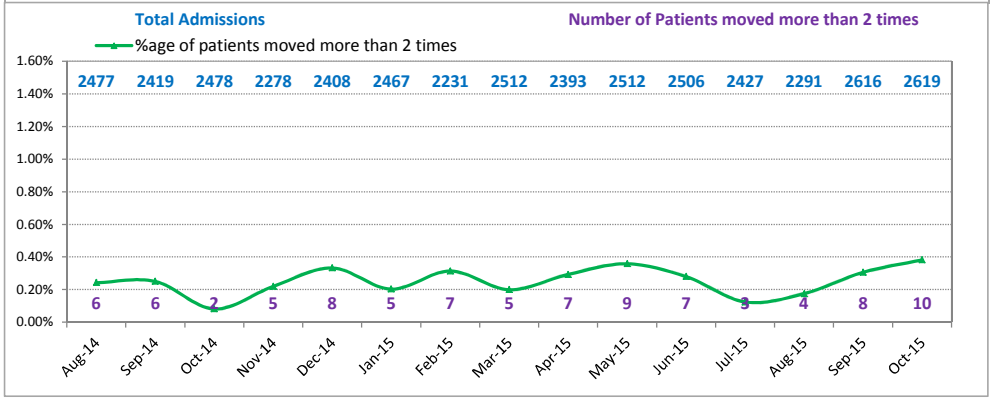
TIA Referrals



Escalation Bed Days

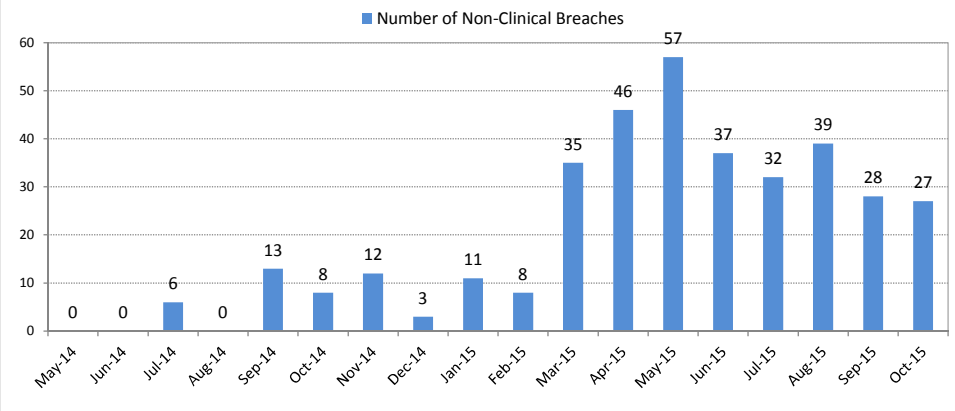


Patients moving multiple times during their Inpatient Stay

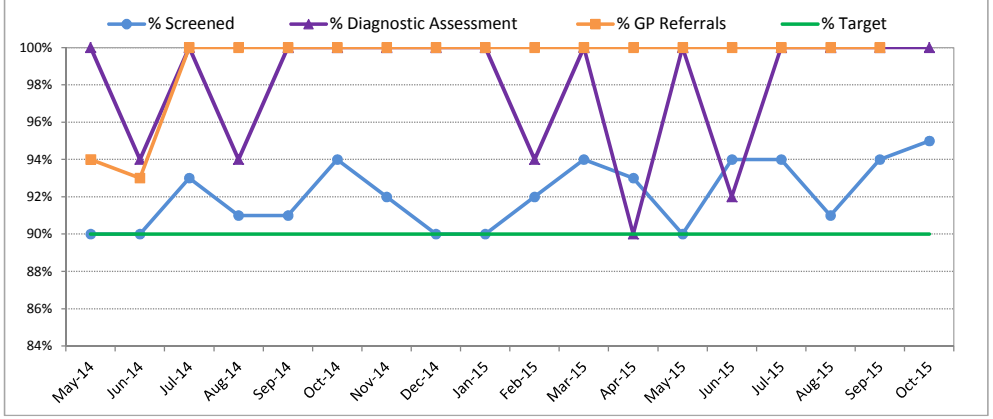


Please note, from Sep-14 escalation bed capactity is Winterslow 8 beds, Wilton 12 beds and DSU if it stays open at night. Breamore ward opened from 1st January 2015 with a further 27 escalation beds and closed on 29th May 2015. From 1st April 2015 Wilton closed for escalation beds.

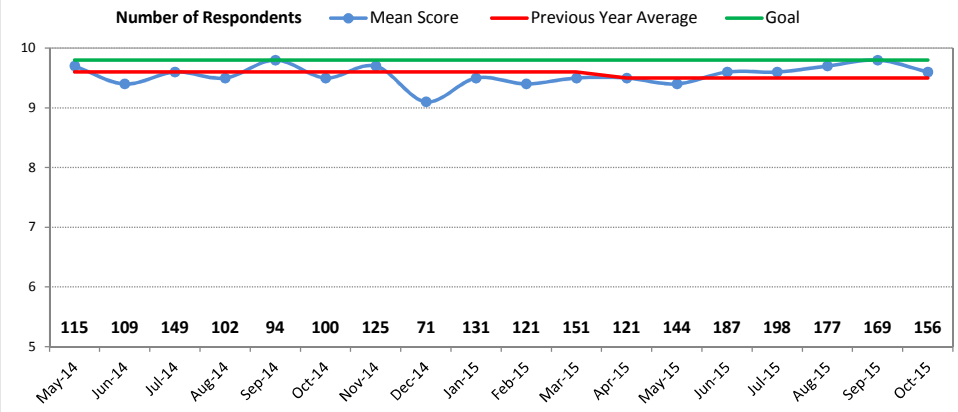
Delivering Same Sex Accommodation



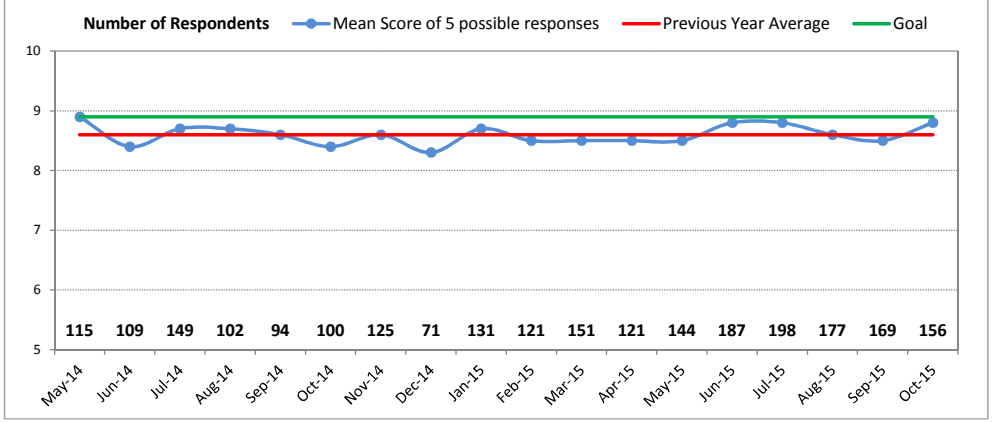
Dementia Audit of Patients Aged 75+



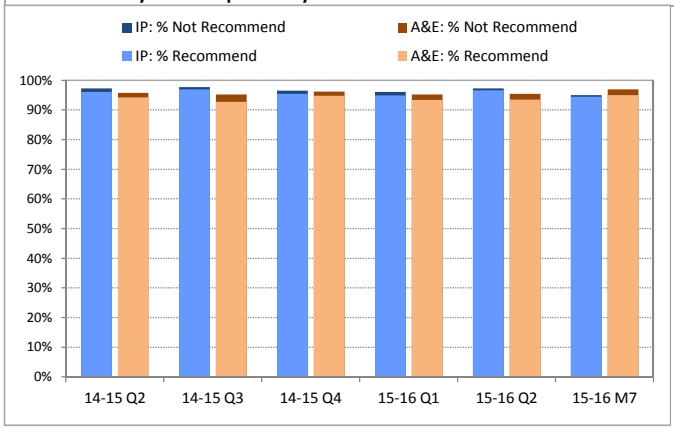
Real Time Feedback: Are you being treated with care and compassion?

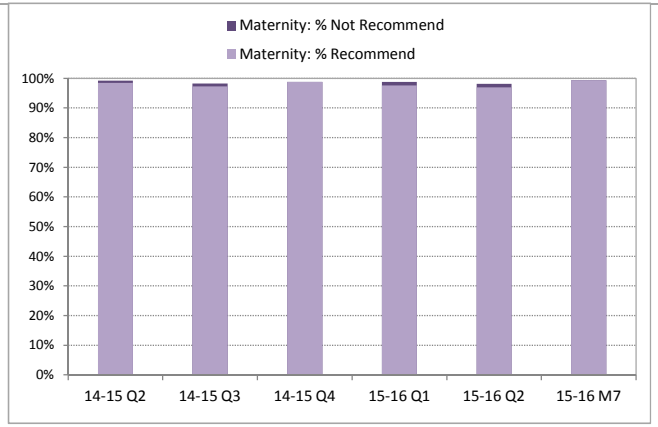


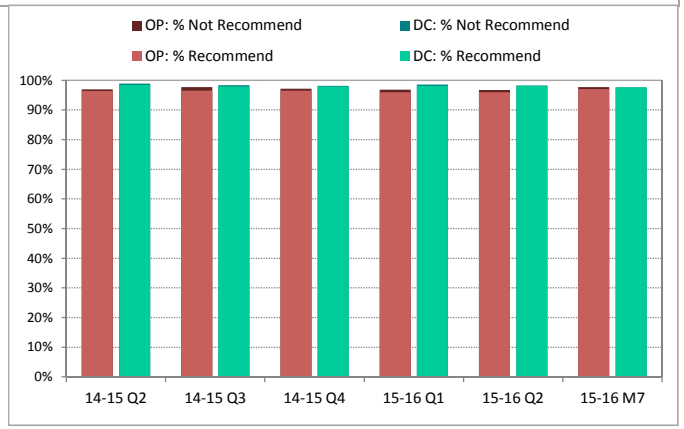
Real Time Feedback: Overall how would you rate the quality of care you received?



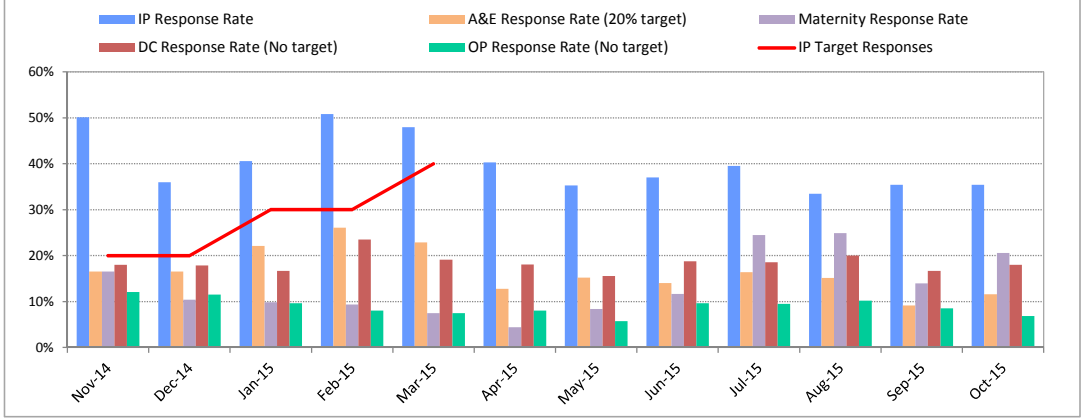
Friends & Family Test: Responses by Area



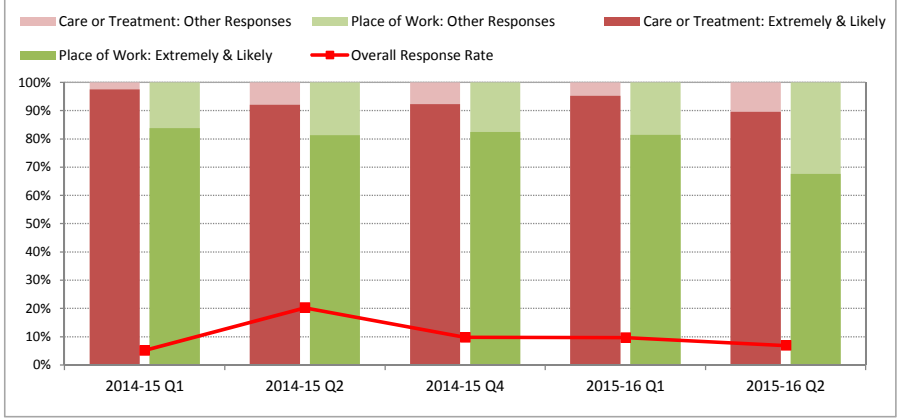




Friends & Family Test: Response Rates (%) by Area



Friends & Family Test: Staff (% Responses)



From October 2014 the Net Promoter Score (NPS) is no longer being used as a headline score.
The new score measures the % Recommended (Likely + Extremely Likely) and the % Not Recommended (Unlikely + Extremely Unlikely) to show the pecentage of responses that would or wouldn't recommend the Trust.
Don't Know and Neither Likely or Unlikely responses are excluded from this measure.

Trust Board meeting **SFT 3717**

Six Monthly Skill Mix Review to Trust Board

Date: December 2015

Report from: Lorna Wilkinson, Director of Nursing

Presented by: Lorna Wilkinson, Director of Nursing

Executive Summary:

The fourth skill mix review has been completed and is being presented to the Trust Board to allow for a discussion on the findings, and to agree a way forward on recommendations.

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

This review covers the Emergency Department and Maternity as well as the inpatient ward areas. All of these areas have been subject to a detailed skill mix review using a defined approach to ensure consistency for comparison, which included a range of information; triangulating the ward staffing levels against nurse sensitive indicators, NICE standards, quality indicator / outcome data, HR indicators, and financial information. Professional judgement was ensured as each review has been undertaken by the Directorate Senior Nurse and Ward Sister with a DSN from outside the Directorate to add objectivity and provide initial challenge. The Director of Nursing and/or Deputy Director of Nursing attended each meeting.

Proposed Action:

The Board are asked to:

- Discuss and agree any areas for investment from this skill mix review paper with full impact analysis to be included in next skill mix review due June 2016
- Support the actions listed in 5.1 with reported outcomes incorporated into next skill mix review due June 2016
- Support the analysis work from the Safecare tool across the ward areas to inform future skill mix requirements
- Support the continuation of recruitment and retention activities

Trust Board December 2015

Title Six Monthly Skill Mix Review – September 2015

Meeting Date

Sponsoring Executive Lorna Wilkinson – Director of Nursing

Author Denise Major – Directorate Senior Nurse

1. Background

The government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry 'Hard Truths – The Journey to Putting Patients First' (DH 2013), was published in November 2013. In its executive summary the report highlights the importance of safe staffing and refers to the National Quality Board published guidance *'How to ensure the right people, with the right skills, are in the right place at the right time'* which clarifies the expectation on all NHS bodies to ensure that every ward and every shift have the right number of nursing staff on duty to ensure that patients receive safe care. It requires Boards to take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.

There are 10 expectations within the NQB guidance with three key reporting elements that each Trust is required to have in place:

- The clear display of information at ward level about the nurses, midwives and care staff present on each ward on each shift. ✓
- The publication of ward level information on staffing requirements and if these are being achieved on a ward by ward, shift by shift basis through the publication of planned versus actual nursing and midwifery staffing levels. ✓
- The completion of a detailed skill mix review which is presented to Board every 6months. ✓

Following the detailed skill mix reviews that have taken place in September 2015, this report provides an assessment of the current nurse staffing provision on wards at Salisbury NHS Foundation Trust (SFT) as assessed locally and against national guidance and validated tools. This results in recommendations where additional investment is identified as well as highlighting early indications of future investment which might become apparent with predicted service change.

2. Previous Investment

During 2014/15 there was investment into ward based nurse staffing as a result of the 2 skill mix reviews totalling £917 000. This included the move to supervisory status for all ward leaders. It is therefore important to note that these Band 7 staff are not included in any of the ratios cited in this paper.

Following the April 2015 skill mix review there has been investment in the following:

- ED additional staffing and band 6 cover 24/7 (£183,753) funded via resilience monies.
- Maternity - 5 band 6 Registered Midwives (£187, 000) in June 2015.

- Increase in Registered Nurse weekend cover on Redlynch and Pitton Wards was agreed at the October Trust Board on a six month pilot with full evaluation to follow (£8,862 to cover duration of the pilot)
- 5 Band 5 midwives as the second stage of the midwifery workforce plan (£177,245)

3. General Wards:

3.1 Ratio of RNs to Patients:
There has been no change since the April 2015 skill mix review to the RN ratios and wards remain compliant with the NICE guidance recommendation that day shift ratios in general wards should not exceed 1:8.

Night shifts have a higher ratio of RN to patients and range from 1:5-1:16. These ratios reflect the patient case mix on these wards. The one ward with a night time ratio of 1:16 (elective orthopaedics) is currently under review to explore use of twilight shifts with a trial commencing on the next roster in December 2015.

3.2 Ratio of RN to Nursing Assistant (NA)
The ratios of RN:NA are listed in appendix B and remain consistent with the previous skill mix review. This continues to differ as expected from ward to ward depending on case mix of patients. The wards range from 80:20 to 50:50, however there are 2 wards that fall below 50% RNs**;** Avon (46:54) and Tamar (45:55). Both of these wards are within the Spinal Injuries Rehabilitation Unit and have a higher number of band 3 positions than other ward areas. The band 3 nursing assistants have specific competencies and have an important role in supporting patient care. This is exemplified by respiratory competencies where the band 3 can support a registered nurse with acute care needs. It is the increase in the number of band 3s however, that has reduced the ratio of RN:NA.

In areas where we are developing the Band 4 roles (such as elderly care) this can have a negative impact on the ratio even where it adds to the continuity of ward staffing and enhancement of skills. There is work nationally to review the role of the band 4 and future skill mix reviews may include a 3 way split of nurse ratio recognising the positive impact of the band 4 role.

3.3 Care Contact Time
The Clinical Directorates with the Director of Nursing are to further define target areas to evaluate the use of care contact time. Previously the Trust has carried out some initial work on this in evaluating a Band 1 ward assistant role, which demonstrated how much direct care contact time could be reinvested into nursing time. There is further work with expansion of band 4 roles within elderly care and spinal injuries. The evaluation of care contact time in conjunction with analysis of safe care data is to be agreed.

3.4 Skill Mix Review Methodology:
All inpatient wards have been subject to a detailed skill mix review during September 2015. The reviews were undertaken using a defined approach to ensure consistency for comparison which included a range of information; triangulating the ward staffing levels against nurse sensitive indicators, NICE standards, quality indicator / outcome data, HR indicators, and financial information. Professional judgement was ensured as each review has been undertaken by the Directorate Senior Nurse (DSN) and Ward Sister for that area with the Director and/or Deputy Director of Nursing and the DSN for Musculoskeletal Services from outside the Directorate to add objectivity and provide challenge.

3.5 Findings:
Initial analysis and findings of the skill mix reviews are included in Appendix B. The budgeted RN:Patient staffing ratio is demonstrated by shift alongside the RN:NA ratio. The Supervisory Ward Sister/Charge Nurse role is in addition to these ratios.

3.5.1 There is one area where immediate agreement for funding has been identified:

- **Amesbury** – The late shift was uplifted following the skill mix review in 2014 to improve the RN:patient ratio. However, the night shift remains at 1:16 and themes via RTF and Friends and Family identify lateness of medications and noise at night as themes. A pilot will take place in December 2015 for 2 twilight shifts per week. If successful and rolled out for 7 days a week this would cost £3,162

3.5.2 There are also areas to note, where further investment may be required in future skill mix reviews but this is dependent on further analysis and will be reported in June 2016.

- **Whiteparish** – There are potential changes to the Whiteparish template which is subject to a business case within the Medical Directorate. A further skill mix review will be required once the outcome of the case has been agreed and incorporating the Nunton Day Unit.
- **Downton** – continue to support staffing on Clarendon (private patients unit). The provision of private and amenity beds is being reviewed and the outcome of this will identify future staffing requirements.
- **Avon Ward** – The current establishment has been identified as insufficient since 2012. National staffing levels are not available although benchmarking with a similar Unit has identified a lower band 5 ratio in Salisbury. This is off-set however by the use of highly skilled band 3 nurses in Salisbury, not utilised in the comparative site. Using professional judgement, an increase of 1.35WTE band 3 and 1.47WTE band 2 is required at a cost of £70,000. This is based on the model of 17 beds (4 beds have been closed since August 2014) and reflects the current expenditure of the staffing increase in 2012. The requirement for band 1 and band 4 roles within spinal services is to be analysed in conjunction with the safe care data.
- **Winterslow** – Work is currently underway to reduce the band 5 establishment by 4WTE and replace with band 4s (trainees in post) as we have continued to experience vacancies in this area. A previous trial of Band 1 assistants resulted in positive feedback from staff and patients and this is being revisited in light of the above.
- **Radnor** – layout of the new unit means that when side rooms are all in use there is the need for a 'runner' overnight – recommend this as a band 2. Further analysis is required on this regarding occupancy and activity in order to inform any decision going forward.
- **Redlynch** – the ward has seen the number of patients requiring a 1:1 special increase. In the first 6 months of 2015/16 a total of £18,695 has been spent on B2 night specialling (this is based on the cost of a bank nurse versus agency). The increase for a substantive uplift of a band 2 at night would require 2.55WTE with a cost of £61,273.
- **Britford** – current staffing levels satisfactory but a review of skill mix will be undertaken once the SAU refurbishment is completed.
- **Durrington** – review of skill mix against the requirements of delivering a fully functioning RACE model to be undertaken.
- **Burns** – review of safe care data and analyse evidence for band 2 early at the weekend.
- **Whiteparish** staffing reduces by 1 at the weekend which historically has reflected lower medical takes on these days, ongoing analysis of this is required using Safe Care data.

- **Laverstock –** were utilising a band 4 to provide additional cover on the late shifts to support additional activity. This received positive feedback from staff who felt that the late shift was more efficient and post- operative care more timely and there was less impact on the night shift. This was staffed by using the hours from band 4 staff completing long day shifts. This has currently ceased on Laverstock as it can no longer be managed within budget. Analysis of safe-care data will be used for the skill mix review in April 2016 alongside criteria for evidencing the impact of this additional shift prior to further recommendation.
- **Tamar –** when the vacancy factor has been reduced a pilot of a twilight band 3 to take place and review of band 1-4 workforce with Avon
- **Sarum -** Prior to November 2014 Sarum skill mix at night was 2 RNs and 1 NA. Last winter Sarum ward piloted a trial of 3 registered nurses at night with no nursing assistant and it was agreed that this could continue as it was managed within budget. In the past year there have been no diversions of children to other hospitals, no ward closures and no specials. Higher dependency children can be managed with 3 RNs at night. There have been no incidents of delays to giving medication or IVs which was a regular issue in the past. There have been occasions when the third nurse has been able to support paediatric resuscitation in ED. The third nurse allows for greater flexibility and the ward can increase capacity to 18 if required as long as the dependency allows for this. Further evidence is required to fully analyse the day shifts, currently the staffing is variable based on planned activity of day of the week. To increase to 3 RNs across every day would require 1.45WTE at a cost of £51,401.

4. Emergency Department

The Emergency department were provided with an uplift in staffing from the June 2015 skill mix review with the addition of a second resuscitation/majors nurse (at Band 5 level), and the provision of 24/7 Band 6 cover. This was funded through use of resilience monies on a non- recurrent basis. The recommendation is that this staffing uplift is now funded recurrently.

Feedback from both nursing and medical staff has been extremely positive with noted improvements in the ability to take necessary breaks in the working day, time to complete necessary observations and documentation, and ensure key communication with patients and their relatives. The department has continued to see excellent feedback via Friends and Family and complaints have reduced in regard to nursing staff.

Strategic discussions are taking place regarding the second stage of the nursing skill mix review in the Emergency Department which proposed an additional Band 5 to run the minors and Paediatric area, (pending a successful capital bid to combine the two areas).

5. Recommendations:

The Board is asked to note the findings of the report and agree the areas for action:

5.1 Investment

- Amesbury – support of the twilight shift cover (£3,162)
- ED – to recurringly fund the uplift in band 5 and band 6 nursing (£183,753) which is currently funded via resilience monies to 31st March 2016.

5.2 Trust Board Actions:

- Support the analysis work from the Safecare tool across the ward areas to inform future skill mix requirements
- Support the continuation of recruitment and retention activities

Appendix A – Efficient Use of Nursing Workforce

1. Allocate Electronic-Rostering and Safe Care Module:

In order to enhance rostering efficiency and understanding of patient acuity and dependency the Trust has been implementing the Allocate E-Rostering system and SafeCare Module, utilising the Shelford tool as endorsed by NICE.

1.1 Headroom

Headroom remains a debate nationally and is being considered within the Workforce Efficiency project. The existing 19% headroom is below the average requirements for wards as demonstrated through our e-rostering system. This continues to impact on the use of bank and agency and the ability to manage the 1% study leave allowance. National information regarding headroom will be available in 2016 on the publication of the 'Model Hospital' work by Lord Carter.

1.2 E-Rostering Performance

The Safer Staffing Steering Group (SSSG) is focussing on efficiency of rostering through the reporting and review of KPIs generated through the Allocate system via Roster Perform. This data has become available from April 2015 and is presented by the DSN for each clinical directorate every month. This will include maternity service moving forward. Outcomes from the Workforce Efficiency Collaborative are also presented at this group.

1.3 Safe Care Module

Analysis by Allocate for 4 wards using safe-care has been completed and the Trust is waiting receipt of this data. Following review of the current use of the Shelford Tool (the dependency and acuity tool within safe-care) it has been agreed at the SSSG that DSNs will have agreed the detail for individual wards by November 2015. This will allow the analysis of data at ward level rather than to be used as comparative acuity data across wards and departments. This data is planned to be utilised more evidently within the skill mix reviews during April 2016 as well as any data available regarding NHPPD.

2. Lord Carter – Productivity and Efficiency Programme

2.1 Workforce Efficiency Collaborative

In 2015 SFT became 1 of an initial 22 Trusts to participate in the Lord Cater Workforce Efficiency programme. Lord Carter and his team visited the Trust to review the early data in July 2015.

Under the auspices of this programme SFT are fully participating in the Workforce Efficiency Collaborative which is a collective of Trusts undertaking focussed work on specific areas of the nursing workforce including roster management and use of nursing specials. The project group at SFT includes a Directorate Senior Nurse, Allocate Lead, HR Manager, Data Analyst and 2 Ward Sisters. The project for SFT is to improve the efficiency of the roster practices and ensure that substantive staff availability is utilised effectively whilst also balancing appropriate working patterns. This includes a balance of net hours, annual leave allocation and flexible working agreements as well as roster building and publishing processes. The turnover of staff is also measured to identify if roster practices have any impact on staff recruitment and retention. Additional shifts required and use of agency are also reviewed.

A comprehensive data set has been collected and submitted monthly, since August, to the Department of Health with an updated project plan. There are also monthly teleconferences and web-ex with the other participants and a monthly tele-call with the Lead Nurse for the Workforce Collaborative who is part of Lord Carter's team. The 2nd collaborative meeting took place on 29th October, 2015. The project team will review the scope for further roll out to other wards over the next few months.

2.2 Nursing Hours Per Patient Day (NHPPD)

SFT are also 1 of 3 Trusts participating in a further programme linked to the Workforce Efficiency Collaborative to define the use of NHPPD. NHPPD is a systematic nursing workload monitoring and measuring system that provides a guide to the number of nurses (registered and non registered) required for service provision within a specific clinical area. The NHPPD model is not designed as a rigid, mandatory determinant of staffing but relies on clinical judgement to assess adequate staffing to deliver care on a daily basis. The model is used to calculate the number of direct nursing hours required to provide patient care and as a framework to establish a nursing roster. This model has been used in the USA and Australia for some time and it is hoped this will be used in further skill mix reviews alongside professional judgement and existing guidance.

The involvement in this project by SFT has resulted in funding of £40k by the Department of Health for SFT to implement the mobile technology required to effectively use the Safecare tool that is currently being used across the ward areas. The use of this via a tablet will allow a view of staffing across the Trust whilst indicating areas of high acuity and areas using nurse specials.

3 <u>Recruitment and Retention</u>:

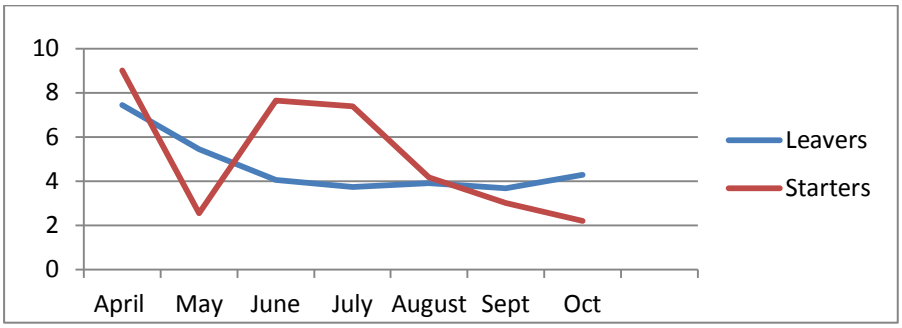
Vacancy numbers have remained high in some areas despite successful recruitment programmes overseas and locally. During the summer the Trust undertook a radio campaign targeted in the North of England towards people who might be considering relocation. This was followed up with an open day on Saturday 3rd October where interviews were completed on the day. The open day was also advertised locally and within the RCN Bulletin. From this 6 job offers have been made with a further 5 pending interview. A further open day is planned for February 2016 as well as open days for student nurses.

Overseas recruitment has continued with further recruitment in Italy planned for December 2015 and in the new year. During October a number of Skype interviews have taken place with nurses interviewed across Europe. This has resulted in 24 successful candidates who have accepted positions and will start between November 2015 and January 2016. The Trust is also considering non EU recruitment following the temporary inclusion of nurses on the occupational shortage list. This is due to be reviewed nationally in February 2016.

The first cohort (4) of Return to Practice students commenced in the Trust in September 2015 and recruitment to a February intake is currently taking place.

The new Clinical Educator posts commenced in September 2015. These roles support nursing staff in practice – this includes those on the preceptorship programme, overseas recruits, return to practice, and those working towards the Care Certificate. Work continues with the development of band 4 roles particularly within elderly medicine and spinal services where RN recruitment is challenging.

Starters and Leavers



Maternity leave remains high and also impacts the bank and agency spend alongside the vacancy factor. Recruiting to fixed terms contracts to cover maternity is anecdotally less successful than in previous years. The Directorates have predicted 26WTE members of nursing staff will be on maternity leave spanning the period September 2015 – March 2016 (Medicine 12 WTE, Surgery 8 WTE and MSK 6 WTE).

4. Reducing Agency Spend

The Trust did respond to the Monitor Agency Rules published in September 2015 and as a result has ensured that all agencies sourced are within the recognised frameworks given. The only exception to this is through the use of an off framework agency for specialist area (ITU) where executive approval is required on a case by case basis.

Reports on percentage agency spend are routinely reviewed at Programme Steering group.

The Trust has responded to the Monitor consultation on capping agency rates. At the time of writing this report the outcome of this consultation is awaited.

Appendix B
Six Monthly Skill Mix Review September 2015

Ward	RN: Patient Ratio (Early)	RN: Patient Ratio (Late)	RN: Patient Ratio (Night)	% RN : HCA (based on establishment)	Comments / Recommendations
Whiteparish	1:5 (1:6)	1:5 (1:6)	1:5.6 (lower with twilight)	72:28	Review with Nunton following decision on the business case for changing the current footprint
Tisbury	1:4.5/2.5	1:4.5/2.5	1:5.75	75:25	Nil
Pitton	1:6.75	1:6.75	1:7.6	59:41	
Redlynch	1:6.75	1:6.75	1:7.6	57:43	Review increase on night shift to 2 NAs 2.55WTE £61, 273 in order to reduce spend on 1:1
Farley	1:6	1:6	1:10	57:43	Nil
Durrington	1:7	1:7	1:10.5	55:45	Full implementation of RACE model will require further skill mix review
Winterslow 40	1:8	1:8	1:13.3	49:51	Require further analysis of Band 4 roles and potential introduction of Band 1 ward support.
Pembroke	1:5	1:5	1:5	81:19	Nil
Hospice	1:5	1:5	1:5	60:40	Nil
Amesbury	1:6	1:8	1:16	53: 47	Pilot of twilight from December at cost £3,162 for 1 year
Chilmark	1:6 (8)	1:8	1:12	57:43	Review safe care data for late shift
Burns	1:4.6 (1:3 Paed)	1:5.6 (1:3 Paed)	1:8.5	80:20	Evidence and safe care analysis for band 2 on weekend early
Laverstock	1:5.2	1:8.6	1:8.6	65:35	Review evidence for continuing increased band 4 on late
Avon	1:4.25	1:5.6	1:10.5	43:57	Match recurrent funding with agreed establishment in place since 2012. Review of band 4 and band 1 roles. Analysis of safe care data to support current use of additional shifts.

Tamar	1:7	1:7	1:10.5	47:53	Consider pilot of twilight using late band 3 (not supported with current vacancy) and review of band 1 to 4 roles
Britford	1.5	1:5	1:10	63:37	Review of skill mix on completion of changes to SAU template
Downton	1:6.75	1:9	1:13	65:35	Requirement to backfill Clarendon with no additional WTE within establishment requires review.
DSU ward	1:7	1:7	N/A	50:50	Include headroom in-line with ward areas
Sarum	1.8 (5)	1.8	1.5	73:27	Analyse safe care data to review increase band 5 to cover the day by 1.45WTE £51,401
ED					Recurring funding to be agreed for the staffing uplift in phase 1 of the skill mix review from April 2015. Strategic discussions on paeds area in progress
Radnor	ICS Levels of care 1:1 or 1:2				Evidence collection for Band 2 runner at night

Numbers in brackets denotes weekends

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance and Performance Committee
Held on 28th September 2015

SFT3718

Present:	Dr N Marsden	Chairman
	Mr P Hill	Chief Executive
	Mr A Hyett	Chief Operating Officer
	Dr L Brown	Non-Executive Director
	Mr I Downie	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
	Mr L Arnold	Director of Corporate Development
	Mr A Freemantle	Non-Executive Director
In Attendance:	Mr P Kemp	Non-Executive Director
	Mrs H Ball	Minute Taker

Apologies: None

1. MINUTES of 24 August 2015

The minutes of the meeting of the committee held on 24 August 2015 were agreed as a correct record.

2. MATTERS ARISING

No matters arising as cash position will be discussed in Finance paper.

3. FINANCE REPORT TO 31ST AUGUST 2015 (M5)

The committee received the finance report. It was noted that we have moved closer to plan but are also relying on increased savings during the second part of the financial year and that excess activity is expected to be paid for. It was also noted that the in-month deficit was £968k.

The visit of Monitor was discussed and the likelihood that they will focus on the delivery of the plan and how realistic the savings are. Broadly the Trust is on course to deliver the plan but there are concerns about the Wiltshire CCG financial position. MC commented that we may have to add resources to the Contracts team if the CCG starts to challenge payments at a more transactional level.

It was noted that a letter from CCG regarding their need for a recovery plan to avoid special measures was received last week. It was predicted that over-performance will increase as there was no sign of activity management having any great effect.

LB enquired after staff morale in Finance. MC confirmed that staff always rise to the challenge and are well aware of the current position. However the range of demands was exceptional and some resourcing may be necessary for a period.

There was discussion around CCG contract challenges. MC confirmed that he is happy to go to arbitration if necessary; however, only minor challenges have been raised so far.

CIP's remain a significant challenge and pressure continues to be applied to all Directorates and Departments to deliver savings and identify new ones.

The activity variations from plan across the different service areas was noted

It was noted that the overspending in Directorates was mainly due to undelivered savings and the excess costs of using agency. It was noted that nursing agency spend has improved, although nursing budgets remain overspent. There has been a reduction in specialing and a tightening up on Nursing. The committee was concerned about the agency and locum costs of doctors and the use of agency in some clinical support areas.

Following a request from the committee, MC highlighted the Cash Statement which identifies the routine use of cash separately from the £6m loan. It was noted the cash position is monitored on a daily basis and the committee welcomed the additional clarity.

Capital expenditure and the potential effect of the new tariff for 2016/17 were noted. If the new tariff were to be implemented it would make most Cardiology services financially unviable.

The risk and forecast outcome for the year 2015/16 was noted.

4. REPLICA 3D UPDATE

LB gave an update on the current situation and confirmed a Board meeting involving a telephone conversation with Craig Rochford, Replica 3DM Board member, had taken place. LB had written to CR to ask him to confirm our understanding of the comments he had made, and no response was received. It was noted that Replica owes SFT circa. £85k plus the £50k original working capital start-up money. It was also noted that without the support of SFT the Company would be trading whilst insolvent and this would place MC and LB as nominated Directors in a difficult position. It was noted that SFT is the only creditor. Accordingly the committee ratified the current position.

Several options were considered by the Committee including forced closure and SFT offering a nominal amount for other shareholdings, but a decision was made to continue for the next two months given the potential time impact on key individuals and the fact that the current monthly losses are small. LB and ID will compose a potential letter to the shareholders and ID will speak with Craig Rochford on behalf of SFT to determine exactly what his plans are. ID to liaise with MC and LB regarding this.

5. TRANSFORMATION AND COST IMPROVEMENT

The committee received the PMO report for Month 5 and AH confirmed there is currently £1.2m of unidentified savings. The teams are also working on a set of criteria to establish the meaning of Red/Amber/Green schemes.

AH & MC have implemented three measures;

- Revenue spend against budget;
- CIP delivery against target;
- Income delivery against plan.

Income: A number of CIP's are attached to three types:

- Selling capacity to Southampton
- Over activity due to transfer from other Trusts
- Over performance against Contract.

All Directorates are looking at savings for next financial year. Facilities have identified 50% and CS&FS have identified 30%.

There was discussion around bringing some schemes forward to this financial year. AH confirmed that conversations were taking place to identify the feasibility of this. AH reassured PK that systems were already in place to monitor Amber and Red schemes to ensure they become Green as quickly as possible. Some schemes are also dependant on Income.

6. OPERATIONAL PERFORMANCE (MONTH 5)

Targets:
ED continues to deliver 95% each month. However, September is a challenge and the delivery of the month standard is at risk.
ED continues to provide good patient flow and good schemes.

RTT: Delivering against three measures.

Cancer: Workload is currently high and targets remain quarterly. The data for this current month is as yet not complete. Therefore, next month will report previous month full information.

August delivered 99.1% for Diagnostics and striving to deliver within 4 weeks in line with Trust stretch target.

Modelling using IMAS tool is now complete.

It was also noted that:

- MRI is at full capacity.
- Endoscopy does not have sufficient capacity
- IMAS working with SFT and currently testing in Orthopaedics and Colorectal.

AF queried the Ambulance Breaches. AH confirmed that the numbers were low and whilst showing Red for the year, it was currently Green and continuing to look at improvements.

PK queried the 62 day wait in relation to Lung. AH confirmed that this was mainly due to the constraints in capacity and that some patients are not available to come in on a two week wait.

PK also queried the NHS DToC. AH stated that numbers had dropped but were now increasing once more. AH has a meeting this afternoon with CCG to discuss improvements. AH is concerned how the “system” will react, rather than how “SFT” will react.

LB confirmed that AH continues to do a good job.

7. CAPITAL DEVELOPMENT REPORT

Springs Main Entrance Development:
LA confirmed there are 5 high quality tenders under consideration. It was agreed to discuss further at the next meeting and perhaps to investigate charity donation funding.

Single Sign On:
Whilst there had been a delay, it is envisaged that the rollout for the outpatient desktop will take place in October.

Patient Observation and Escalation Tool - POET:
Solutions are still required in some areas. However, this has gone live on Laverstock and Nurse feed-back is very positive.

Electronic Discharge Summaries:
Programme has been very positive and will soon be rolled out to all wards.
MC confirmed there may be issues around funding but have applied to CCG. Also regarding the link with Pharmacy, it takes longer to complete on-line than on paper.

During discussions, LB confirmed that North Bristol were having issues with Lorenzo. LA confirmed that our new Head of Information Services was already in direct contact with Bristol as they are approx. 3 – 6 months ahead of us.

8. AULT COMMUNITY SERVICES - BUSINESS CASE

LA circulated a draft report to the committee and highlighted the three options available to the Trust.

The contract value is £40m each year. There followed discussion regarding the figures, cost savings, reliability and benefits to the Trust. Concerns were raised around some Trusts that may undergo regulatory intervention and how this would affect the continuation of the Bid or Contract.

The committee decided that the only option was to put in a Compliant Bid, as no other option would be accepted by CCG or Monitor.

LA will circulate the bid as soon as possible.

9. ANY OTHER BUSINESS

Maternity Funding:
Maternity Funding: Discussions are currently taking place between SFT, GWH, Wiltshire CCG and RUH regarding the Maternity funding process. The CCG agreed that RUH could have a block contract for maternity services which is contrary to PbR and means that a patient undergoing out-patient appointments at SFT having previously been seen at RUH would not be paid for. SFT is owed £100k for 2014/15 and the sum in 2015/16 is likely to be greater than this. GWH are currently owed £400k for last year and UHB are owed about £500k. SFT, and UHB have formally objected the proposal to give RUH a block in 2015/16 which it is understood would have to be ratified by Monitor.

Laundry:
MC was pleased to announce that STL have been awarded the Laundry Contract for UHS subject to the standstill period.

Meeting ended at 11.50am

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance and Performance Committee
Held on 26 October 2015

Present:	Dr N Marsden	Chairman
	Dr L Brown	Non-Executive Director
	Mr I Downie	Non-Executive Director
	Mr A Freemantle	Non-Executive Director
	Mr P Hill	Chief Executive
	Mr M Cassells	Director of Finance and Procurement
In Attendance:	Mr D Seabrooke	Head of Corporate Governance
	Ms L Wilkinson	Director of Nursing (for item 2)
	Mr R Drag	Procurement Manager (for item 10)
	Mr R Webb	Associate Director of Procurement (for item 10)
Apologies	Mr L Arnold	Director of Corporate Development
	Mr A Hyett	Chief Operating Officer

1. MINUTES – 28 SEPTEMBER 2015

The minutes of the meeting of the committee held on 28 September 2015 were agreed as a correct record.

It was noted that nursing spend in theatres had increased and that nurse recruitment efforts were continuing for example Skype interviews with EU candidates and the Trust attending job fairs.

2. C QUIN – QUARTERLY UPDATE

Lorna Wilkinson attended for this item and the Committee received the Quarter 2 update which reported that all C QUIN targets were on track. The CCGs would be determining their own view of this position in the coming weeks. The most challenging target moving into Quarter 3 was for Sepsis Screening.

3. FINANCE AND CONTRACTING REPORT TO 30 SEPTEMBER (MONTH 6)

The Committee received the Finance and Contracting Report to 30 September and MC reported that there was a deficit at Month 6 of £3.9m which was slightly better than planned. It was noted that agency spend would increase with escalation beds in the coming months. The Medicine Directorate was behind plan due to agency costs and the Surgery Directorate because of a CIP shortfall.

Length of stay was key to reducing a range of costs. The Trust was somewhat behind plan on cash and somewhat ahead on capital spending. The principal concern on contracts was with Wiltshire CCG. Commissioning Intentions Letters had been received for 2016/17 and the Trust was responding to these including requesting specific narrative around the future for a hospital for South Wiltshire.

The Trust would continue to make use of day surgery facilities to enable collective throughput in the month ahead.

The Trust was self-assessing as a Financial Risk Rating Level 2 which would be a position shared with many Trusts nationally.

A proposed estates revaluation was likely to reduce the total asset value of the site which would increase rates of depreciation and reduce business rates liability. It did not however generate any cash. It was noted that Salisbury Trading had won the Southampton Hospitals laundry business.

The Committee noted the Finance Report.

4. REPLICA 3D UPDATE

It was noted that a small profit had been made in the preceding month and the Committee agreed to continue to monitor the company's performance.

5. TRANSFORMATION AND COST IMPROVEMENT

The Committee received the PMO report. The Trust was still short of identifying the whole £8m saving requirement for 2015/16. The PMO was being strengthened from November and there would be greater focus on the Outpatients and Theatres schemes. Generally schemes were moving from the Red and Amber to the Green category. The Committee received details of the CIP classification scheme.

It was noted that £3m of schemes for 2016/17 had been identified.

6. OPERATIONAL PERFORMANCE

The Committee received the Operational Performance Report or Month 6. The Trust had not met in September three of the Cancer Targets. Symptomatic Breast Cancer – 2 Week Waits had not been met year to date. Focus continued on achieving the A & E Target.

The Committee noted the Performance Report.

7. MONITOR QUARTER 2 REPORT

The Committee received the draft Targets and Indicators Tab for the Quarter 2 report to Monitor. The validation process for the cancer quarterly outturns would continue until after the date of the submission of the Quarter 2 return. At present the Trust would be indicating it had not met the Systematic Breast Cancer Two Week Wait Target in Quarter 2.

The Committee approved the Quarter 2 return.

8. ADULT COMMUNITY SERVICES

PH reported that the tender request had been received with a return deadline in November.

9. ASSURANCE FRAMEWORKS/RISK REGISTER QUARTERLY REVIEW

The Committee received the Assurance Framework and Risk Register. It was agreed to strengthen risks on the Assurance Register Framework around commissioner overspends.

The Risk owners in relation to high level risks shown on the action plan were requested to complete their actions were necessary.

The Committee approved the Quarterly Review.

10. GS1 BUSINESS CASE

Rob Drag and Rob Webb attended for this item. It was noted that the Trust had been shortlisted by the Department of Health and the business case in support of the bid was required to be submitted by 13 November. The Department was being invited to give a £1.6m grant in support of costs assessed at £1.8m with the difference being spent on some items of hardware. Ian Downie undertook to review the business case in more detail and provide further feedback.

The Committee recommended to the Board that the business case be approved.

11. ANY OTHER BUSINESS

MC reported that due to changes in the government banking service a new bank account with RBS would need to be opened for use from 7 December. The Committee recommended to the Board that this account be approved.

12. DATE OF NEXT MEETING

30 November 2015 at 9.30 am

Trust Board

FINANCE & CONTRACTING REPORT TO 31st October 2015

1. Introduction

This paper outlines the main drivers behind the SFT Group consolidated financial position for the period ending 31st October 2015.

The Income & Expenditure (I&E) position was a Year-to-Date (YTD) deficit of £4,820k (before adjusting for donated income of £248k), a favourable variance against the YTD plan of £428k due to phasing, but nevertheless an in-month deficit of £603k. This level of in-month deficit is really concerning at this time of year.

The main reasons for the YTD position were:

- Expenditure on agency was £882k above plan.
- CIPs savings being less than planned by £946k (24.1%).
- This has been offset by over-performance on income of £481k mainly on CCG contracts due to reductions in activity for QIPP schemes not being delivered.

The over-performance income from CCG contracts is mitigating the overspending. However, this needs to be treated with some caution as to its sustainability, and therefore it is important CIP projects deliver.

Summary of Key Financial Information	YTD (Cumulative to October)				Forecast Outturn		
	Plan £000s	Actual £000s	Var £000s	Var %	Plan £000s	Revised £000s	Var £000s
Income	117,016	117,497	481	0.4%	202,873	203,687	814
Expenditure	113,345	113,283	62	0.1%	193,339	193,960	(621)
EBITDA	**3,671**	**4,214**	**543**	**14.8%**	**9,534**	**9,727**	**193**
Finance Costs	8,919	9,034	(115)	(1.3%)	15,534	15,727	(193)
I+E Surplus /(Deficit) excl donated asset income	**-5,248**	**-4,820**	**428**	**8.2%**	**-6,000**	**-6,000**	**0**
Donated Asset Income Adjustment	200	248	**48**	24.0%	500	500	**0**
I+E position including donated asset income	**-5,048**	**-4,572**	**476**	**9.4%**	**-5,500**	**-5,500**	**0**
Adverse variance in brackets							

There were small in-month favourable variances for income and expenditure, and there were no individual material variances to report. There was an exercise undertaken to review account code mapping to expenditure categories which had an impact on the in-month variances for some expenditure lines.

2. Sales

NHS activity revenue was £101,218k which was £1,205k greater than plan. Excluded pass-through drugs under-performance was £214k and was offset by a similar underspend on expenditure. The over-performance against the Plan was mainly driven by QIPP schemes, which were to deliver a reduction of activity, not being achieved. The performance on NHS clinical activity can be summarised as follows:-

Contract Activity Performance 2015/16 (October 2015)	Actual 2014-15	Actual 2015-16	Plan 2015-16	Year on Year Variance	Plan Variance
Elective inpatients	3,523	3,269	3,670	-254	-401
Elective PSDs/day attenders	12,452	13,234	13,746	782	-512
Regular Day Attenders	4,128	4,784	4,175	656	609
Non Elective Inpatient	14,926	15,405	14,047	479	1,358
Outpatient initial attendances	39,040	39,415	39,197	375	218
Outpatient follow-up attendanc	68,286	65,484	66,315	-2,802	-831
Outpatient procedures	21,479	21,181	20,848	-298	333
A&E attendances	26,844	26,718	25,460	-126	1,258
Favourable Variances are shown as +ve					

- Day Cases were up by 782 when compared to last year. The areas of under-performance were Colorectal Surgery, Ophthalmology and Cardiology but these have been offset by over-performance in Plastics and Gastroenterology.

- Elective spells were down by 401 against plan and year on year comparison by 254, with notable reductions against General Surgery, Urology, T&O and Plastics. Activity is expected to increase in the coming months to meet contractual requirements. These tend to be the more profitable areas of work.

- Non-Elective activity has over-performed by 1,358 spells against plan and 479 when compared to last year. There is significant over-performance against West Hampshire and Dorset CCGs where we have restraints on income. The causes are being investigated to put a case for funding to the CCGs. The areas of non-elective over-performance were General Surgery, T&O, A&E, Medicine and Paediatrics.

- Overall Outpatients attendances were down by 280 against plan, most notably follow-up attendances where commissioning intentions are to drive down this number.

- A&E activity was up against the Plan but is slightly down when compared to last year.

3. Cost of Sales including indirect costs

The total for all Directorates was an YTD overspend position of £2,819k and a Forecast overspend variance of £4,696k. The position is summarised below:

Directorates	In Month			Year to Date (Cumulative)			Forecast
	Plan	Actual	Var	Plan	Actual	Var	Var
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Medicine	3,335	3,464	(129)	22,995	23,828	(833)	(1,469)
Musculo Skeletal	2,376	2,458	(82)	16,475	17,177	(702)	(1,329)
Surgery	2,833	3,099	(266)	19,522	20,687	(1,165)	(1,934)
CSFS	3,123	3,167	(44)	21,412	21,712	(300)	(549)
Facilities	333	325	8	2,479	2,416	63	85
Corporate	1,757	1,738	19	12,609	12,491	118	500
TOTAL	**13,757**	**14,251**	**(494)**	**95,492**	**98,311**	**(2,819)**	**(4,696)**
Adverse variance in brackets							

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 following summarises the directorate positions:

- **Medicine -** The Year to Date (YTD) overspend of £833k was mainly attributable to the cost of agency staff due to continuing high level of nursing vacancies on wards. This will be monitored very closely by the Directorate Management Team. The Forecast is an adverse variance of £1,469k of which includes CIP under-performance of £142k.

- **Musculo-Skeletal -** The YTD overspend of £702k was mainly due to charges of £243k for LLP (private contractor), the high use of temporary staff due to vacancies and the shortfall in CIPs of £310k resulting from a delay in the start-up of savings schemes. The Forecast is an adverse variance of £1,329k of which includes CIP under-performance of £122k.

- **Surgery -** The YTD overspend of £1,165k was due to a shortfall on CIPs of £617k mainly relating to unidentified schemes and the additional cost of agency staff due to nursing vacancies. The Forecast is an adverse variance of £1,934k of which includes CIP under-performance of £1,224k.

- **Clinical Support & Family Services -** The YTD overspend of £300k was due to underperformance on CIPs as a result of unidentified schemes. The Forecast is an adverse variance of £549k of which includes CIP under-performance of £717k.

- **Facilities -** The Directorate's YTD underspend was £63k and they have over-achieved its savings target. The Forecast is a favourable variance of £85k of which assumes achievement of CIP target.

- **Corporate services -** The YTD underspend of £118k represents an in-month favourable variance of £19k which includes a shortfall on CIP of £124k. The Forecast is a favourable variance of £500k.

4. Cost Improvement Plan

The total cost improvement savings target for the year is £8.0m which includes revenue Income Generation (IG) schemes of £2.1m.

The Trust has achieved savings and income generation of £2,980k against a plan target of £3,926k an adverse variance £946k. It is recognised the CIP programme is back loaded and therefore on a straight line basis the Trust would be £1,687k below where it should be.

At the time of preparing this report, unidentified schemes amount to £1,101k (13.8%) compared with last month at £1,114k. Clinical Directorates & Corporate Services continue to work on developing schemes and finalising the deliverability of key project milestones and the monthly phasing of savings. Considerable work is required to identify sizable change projects that will release significant savings especially in order to make inroads into the planned deficit of £6m.

The COO will report separately about the CIP progress and the discussions which have taken place as part of the Carter review.

5. Statement of Financial Position

Overall the working capital position (current asset less liabilities) was ahead of plan by £442k due to borrowing being less than plan. The cash balance at 31st October 2015 was £13,211k which is behind plan by £688k due to a number of prepayments and bulk purchases of stock, the latter to secure improved prices. The plan also assumed the receipt of £359k of Public Dividend Capital, which was not received until early November 2015.

The Trust's insurance premiums are paid to the NHS Litigation Authority in ten instalments commencing April 2015 but cover the whole of 2015-16. Part of each instalment is treated as a prepayment, which will be released to expenditure in the last two months of the year.

6. Capital Expenditure

Expenditure was £4,737k which was behind plan by £320k. The current programme indicates planned expenditure of £14,024k, although efforts are on-going to reduce capital expenditure by slipping some of these schemes into next year where possible provided there is no direct impact on patient care.

The Trust has been contacted by Monitor with regard to the potential to defer capital spend in order to support the national position. It is understood such deferrals would be attributed to the Trust as revenue and could therefore help the bottom line. It is unclear as to the impact on cash. We are awaiting details regarding this initiative.

7. 2015-16 Contracts

The Trust has responded to the Wiltshire CCG challenge file for month 6 and the Informatics team have been working closely with the Commissioning Support Unit (CSU) to assist them with cross-referencing our SUS submission to allow the CSU to exclude cancer related procedures. The newly formed joint Finance and Information Group (FIG) met this month and highlighted some areas in the challenge process that needed improving. A Task and Finish Group has been established to review the challenge and fines process.

The Trust received five Performance Notices (one for each month) from Wiltshire CCG relating to fines for not achieving various contractual quality standards. The Trust responded by issuing an excusing notice to ask for the Performance Notices to be withdrawn. The Trust is aware of the pressures on the CCG from NHS England (NHSE) regarding the formal management of provider contracts. The situation was further clarified at this month's Contract Performance meeting whereby future letters would be worded appropriately and a more pragmatic approach to remedial action plans was confirmed.

Wiltshire CCG is looking at expanding the list of Interventions Not Normally Funded (INNF) to support their financial recovery plans and discussions are ongoing between the CCG's Director of Acute Commissioning and the Trust's Chief Operating Officer. This could impact on income during the latter part of the year.

Activity levels for Dorset and West Hampshire CCGs were significantly above plan and further work is ongoing to identify the changes to patient referrals from last year. Both contracts have financial cap and collar agreements around under and over-performance whereby the Trust does not receive full tariff for activity above plan. Provisional findings suggest that the impact of the roadworks into Bournemouth has had a material effect on the number of patients both elective and non-elective coming to the Trust. The current levels of over-performance for the main acute contracts were Wiltshire CCG £434k above plan, Dorset CCG £922k above plan and West Hampshire £602k above plan.

NHSE specialised services commissioners have released a new Information Reporting (IR) Algorithm which all Providers have been asked to apply to their 2014-15 out turn activity to show the movement between commissioners if these new rules were to be implemented. This also contains an updated list of drugs to be commissioned by NHSE and a new list of High Cost Devices. This impact assessment is to be submitted by the 20th November and NHSE will make a final decision as to how they wish to proceed at the end of December. The impact of these rules is yet to be fully understood but there is an expectation that funding will transfer between commissioners.

8. Risks and Forecast Outcome for 2015/16

The Trust's key financial risks can be summarised as follows:

- Deliver the CIP target of £8m; this is the greatest financial challenge;
- Developing CIPs for future years;
- Contractual challenges from CCGs;
- Meet contractual obligations and avoid penalties;
- Delivery of CQUIN targets;
- Unplanned growth of non-elective activity which has a detrimental impact on elective work;
- Match capacity to demand in the most cost effective way in order to avoid losing work to local competitors.
- Impact of junior doctor's industrial action.

The forecast scenarios used to calculate the outturn position have been updated this month using the YTD actual outturn and in addition for Scenario 1 and 2 including £100k charge for contractual fines.

- Scenario 1: The forecast outturn deficit continues to be £6m or £5.5m net after allowing for donated assets, which is in accordance with our approved plan.
- Scenario 2: The forecast outturn deficit would be £6,642k net which is above plan by £1,142k.
- Scenario 3: has been calculated using a straight-line methodology and the forecast outturn deficit would be £8,383k which is above plan by £2,883k.

The forecast outturn scenarios have been calculated using the following assumptions:

- Growth in activity continues in line with monthly planning trajectories until the year end and CQUIN is delivered in full. However, this does not take into account an escalation of contractual fines and penalties or address any challenges from NHSE for payment of high cost drugs.
- Resilience funding has been allocated to the Directorates and assumes costs will be managed accordingly.
- All Electronic Patient Record (EPR) project costs are capitalised
- Strategic projects (Adult Community Services tender bid, Genomic and joint venture Pathology projects) spend is capped at £400k.
- Inflation pressures are zero to allow the inflationary contingency reserve to offset Directorate budget overspending.
- The minimum assumed CIP and Income Generation delivery is £5.5m but there needs to be continued drive to improve delivery of schemes.

9. Other Issues

Wiltshire CCG has issued a financial recovery plan covering a range of initiatives to reduce their expenditure by £4.8m. The full impact is being assessed but the indications are that most do not impact heavily on SFT. However there may be increased fining driven by NHSE and challenges around CQUIN may also increase.

There has been a significant increase in demands for information by Monitor and this is proving time consuming given the other pressures on staff.

We are finalising a contract with specialist building and estate valuers which we expect to drive a reduction in the values of our buildings and a reduction in depreciation. The

approach applies the concept of a ‘modern equivalent asset’ in a more robust way. There is unlikely to be a big cash saving but the bottom line should be improved. The work, when it commences, will take roughly four weeks and is therefore fairly urgent.

10. Conclusions

After seven months of the financial year the Trust is showing a deficit of £4,820k (before adjusting for donated income of £248k), a favourable variance against the YTD plan of £428k. It is important that the Trust continues to achieve savings, manage budgets tightly and undertake more profitable elective work.

Using the new risk rating, introduced by Monitor, the Trust score is 2. The score of 2 is the maximum the Trust can achieve due to a rating of 1 for the I&E deficit position and capital servicing capacity.

11. Recommendation

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

Malcolm Cassells
Director of Finance and Procurement
30 November 2015

Appendix 1 - SUMMARY STATEMENT OF COMPREHENSIVE INCOME

	In month			YTD (Cumulative)			Forecast - Scenario 1		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Operating Income									
NHS Clinical Income	13,355	13,514	159	91,288	92,707	1,419	158,378	160,821	2,443
High cost drugs income	1,417	1,403	(14)	8,725	8,511	(214)	15,159	14,788	(371)
Other Clinical Income	649	681	32	4,683	3,999	(684)	8,000	6,798	(1,202)
Research & Development & Education	561	572	11	3,818	3,811	(7)	6,518	6,515	(3)
Other (Excluding Donated Asset income)	1,225	1,089	(136)	8,502	8,469	(33)	14,818	14,765	(53)
TOTAL INCOME	**17,207**	**17,259**	**52**	**117,016**	**117,497**	**481**	**202,873**	**203,687**	**814**
Operating Expenditure									
Pay - In post	9,796	9,877	(81)	68,978	69,312	(334)	117,780	118,561	(781)
Pay- Agency & Locums	687	772	(85)	4,894	5,776	(882)	8,301	10,247	(1,946)
Drugs	1,747	1,693	54	10,800	10,560	240	18,696	18,281	415
Clinical Supplies	1,743	1,865	(122)	11,915	11,188	727	19,905	18,731	1,174
Non-Clinical Supplies	1,182	232	950	6,800	6,472	328	11,561	11,020	541
Other (incl PFI unitary charge)	1,438	2,140	(702)	9,958	9,975	(17)	17,096	17,120	(24)
TOTAL EXPENDITURE	**16,593**	**16,579**	**14**	**113,345**	**113,283**	**62**	**193,339**	**193,960**	**(621)**
EBITDA (Earnings Before Interest, Tax, Depreciation & Amortisation)	**614**	**680**	**66**	**3,671**	**4,214**	**543**	**9,534**	**9,727**	**193**
Financing Costs	1,303	1,283	20	8,919	9,034	(115)	15,534	15,727	(193)
SURPLUS / (DEFICIT) excluding DONATED ASSET INCOME	**-689**	**-603**	**86**	**-5,248**	**-4,820**	**428**	**-6,000**	**-6,000**	**0**
Donated Asset Income	0	0	0	200	248	48	500	500	0
SURPLUS / (DEFICIT)	**-689**	**-603**	**86**	**-5,048**	**-4,572**	**476**	**-5,500**	**-5,500**	**0**

Appendix 2 - CAPITAL EXPENDITURE

Project Name	15/16 Board Approved + 14/15 final slippage - 14/15 b/fwd £	Adjustments to final Plan £	Revised Plan £	Spend to 31st Oct 2015 £	Under/(Over) spent on Project £
Donated Assets					
Bariatric Bed	11,140	0	11,140	0	
Clinical Radiology 2 x Ultrasound	137,008	0	137,008	0	
Dermatology UV Light	15,300	0	15,300	0	
Durrington Upgrade (Charitable Contribution to Decant Ward Project)		0	0	0	
Fluoroscopy Room 8 - Charitable Contribution	0	330,000	330,000	0	
O&G Bladderscanner	6,985	0	6,985	0	
Orthodontics & Oral Surgery Cone Beam CT Scanner	110,000	0	110,000	0	
Small Donated Additions	-0	237,625	237,625	237,625	
Spinal Refurb ADL Bathroom (LoF contribution)	10,792	0	10,792	10,792	
Spinal Unit Ultrasound	35,542	0	35,542	0	
Vascular Unit Ultrasound Machine	65,475	0	65,475	0	
Donated Assets - Totals	**392,241**	**567,625**	**959,866**	**248,417**	**0**
Phase 3 Building Schemes					
Breast Unit enabling	50,000	0	50,000	8,833	
CT Scanner Building and Enabling	11,822	0	11,822	1,746	
Laverstock Ward (Decant Ward Project)	500,000	-420,000	80,000	17,594	
SAU Refurb (Decant Ward Project)	0	280,000	280,000	0	
Helter Skelter Storage	150,000	-149,350	650	650	
Maternity development 1st (2015/16)year of 2	500,000	0	500,000	5,471	
Radnor Ward Development	164,191	-73,585	90,606	53,682	
SDU Development	0	50,000	50,000	2,000	
Springs entrance development	1,310,252	-1,000,000	310,252	62,347	
Ward changes - Dementia Patient Care	10,112	-6,000	4,112	805	
Building Schemes - Totals	**2,696,378**	**-319,935**	**1,377,443**	**153,128**	**0**
Building and Works					
Accommodation - Langley House Kitchen Upgrade	3,461	-3,461	-0	0	
Accommodation key security	7,000	0	7,000	0	
Accommodation replacement of kitchens and bathrooms	150,000	-16,539	133,461	12,388	
AHU replacement yr 3 (2014/15) of 7	352,559	800	353,359	340,693	
Asbestos management	18,222	0	18,222	5,576	
Avon House Boiler Replacement	-0	20,000	20,000	0	
BMS upgrade 3rd year of 3 - invest to save	42,642	0	42,642	59	
Boiler house demolition	-0	0	-0	0	
Car park 8 machinery replacement - [? Part insurance claim]	96,000	0	96,000	85,929	
Catering Dishwasher	126,000	0	126,000	6,268	
Catering oven	17,000	0	17,000	14,406	
Catering refrigeration upgrade	9,560	0	9,560	0	9,560
Catering thaw cabinet	8,000	0	8,000	7,987	13
Catheter Suite - Rebalance of Heating System	18,400	0	18,400	0	
Central booking relocation - block 79 (Wilton ward)	100,000	0	100,000	0	
Central Clinical Notes Preparation	617	0	617	5,497	(4,881)
DSU Replacement Insulation to Air Handling System	8,600	-8,600	0	0	
DSU Roof Repairs	58,856	-20,000	38,856	19,340	
DSU Theatres - Flooring	1,882	0	1,882	0	1,882
Ductwork & Fire Damper Cleaning Whole Site Year 3 of 3	188,865	0	188,865	50,234	
ED Data Centre Ventilation	78,999	40,000	118,999	0	
Electricity at Work Regulations Compliance	82,744	0	82,744	(8,753)	
Estates health and safety	10,000	0	10,000	5,275	
Eye clinic expansion	4,292	0	4,292	0	
Finance fire alarm system upgrade	21,600	-21,600	0	0	
Fire alarms - detection & prevention equip - various	4,487	0	4,487	0	
Fire compartmentation SDH north - remedial works	28,407	0	28,407	0	
Flooring Replacement (including Stairwells)	67,744	0	67,744	18,078	
General laboratory replacement autoclave	60,000	0	60,000	50	
Genetics Modular cold room	26,000	0	26,000	15,388	
Glanville Roof	0	7,200	7,200	5,976	
Grovely Roof Repairs	30,000	0	30,000	0	
Hillcote Sale Costs	0	0	0	0	
Hospice and Finance Fire Alarms	30,000	21,600	51,600	0	
Lab Medicine Cold Room & Pathology Reception and Office	36,000	56,000	92,000	33,423	
League of Friends - Bungalow 2 Refurb	0	0	0	0	
Level 4 Bedspace Power Sockets	61,610	0	61,610	0	
Lightning Conductor	0	12,000	12,000	0	
Lifts overhaul - year 3 (2014/15) of 3	66,379	0	66,379	6,180	
Main boiler burners	60,000	0	60,000	53,761	
Main Entrance L3 Upgrade	10,076	0	10,076	4,090	
Main operating theatres recovery area	56,000	0	56,000	35,185	
Main Theatres 4th Laminar Flow System	185,000	0	185,000	137,409	
Mamo Enabling	0	40,000	40,000	0	
Maternity Obstetric Theatre Refurbishment	78,000	-19,000	59,000	17,089	
Maternity Post Natal Upgrade	121,550	15,000	136,550	116,859	
Maternity Relocation - Enabling	1,622	0	1,622	1,349	
Mattress Laundering	2,521	0	2,521	0	
Medical Gas Hoses 2nd year of 2 (2015/16)	147,000	-117,000	30,000	0	
Microbiology - Category 3 Room	2,025	0	2,025	0	2,025
Mortuary washer disinfector	10,000	0	10,000	0	
Noise Reduction & Facilities Equipment	26,368	0	26,368	0	
Nurse Call System Upgrade - SDH North & Maternity - 2nd year of 2	133,167	0	133,167	0	
OHSS replacement windows	27,000	0	27,000	0	
Old GUM Clinic Demolition	13,998	0	13,998	2,038	
Orthotics Move and Radiology Bowel Screening Relocation	33,315	0	33,315	37,163	(3,848)
Pathology - air tube upgrade	36,000	0	36,000	0	
Pathology - conversion of computer room to office	12,000	-12,000	-0	0	
Pathology Reception	44,000	-44,000	0	0	
Pedestrian crossings	66,000	-66,000	0	0	
Portering bed movers	23,000	8,000	31,000	0	
Powered Door Curtains Level 2	30,000	0	30,000	0	
Productive Operating Theatres	18,542	0	18,542	0	
Public & Staff WCs L5,L4,L3	86,598	0	86,598	0	
Public Spaces Fund	13,425	0	13,425	984	
Radiology Recovery Area Improvements	603	0	603	225	
Roads and paving repairs	160,169	66,000	226,169	0	
Sarum Kitchen Ventilation	0	7,800	7,800	0	
Sarum Ward Playdeck	0	0	0	7,200	(7,200)
SDH North Drain Survey	15,000	0	15,000	7,200	
SDU Washers	148,605	0	148,605	15,870	
Security Improvements	48,921	0	48,921	24,125	
Server Rooms - Air Conditioning	16,890	0	16,890	0	
Shower Cubicle Drainage Improvements	30,000	0	30,000	0	
Site Signage	2,462	10,128	12,590	173	
Spinal Boiler Replacement & Associated Pipework	-0	37,400	37,400	0	
Spinal treatment centre refurbishment	169,286	52,000	221,286	139,283	
Spinal Unit Doors and Locks	-0	35,000	35,000	20,722	
Spinal Unit Double Glazing 2nd year of 2 (2015/16)	60,000	-60,000	0	0	
Spinal Unit Fire Escape	27,000	-27,000	0	0	
Springs servery upgrade - floor and freezers only	75,000	0	75,000	0	
Taps & IPS panels - sitewide	60,000	911	60,911	8,398	
Theatres 1 - 10 Replacement Taps	911	-911	0	0	
Theatres - Male Changing Facilities	0	25,000	25,000	98	
Walls - repairs to failing walls	8,000	0	8,000	0	
Water tanks access - main tanks only	30,000	0	30,000	0	
Wessex Rehab Windows and Cladding	11,466	0	11,466	0	
Wilton Ward Winter Pressures 13/14 (Block 79)	10,000	0	10,000	0	
Building Projects/Building and Works Totals	**3,927,446**	**38,728**	**3,966,174**	**1,253,216**	**(2,449)**

Appendix 2 - CAPITAL EXPENDITURE

Project Name	15/16 Board Approved + 14/15 final slippage - 14/15 b/fwd	Adjustments to final Plan	Revised Plan	Spend to 31st Oct 2015	Under/(Over) spent on Project
Information Technology					
Alternative to Microsoft products - review	50,000	0	50,000	0	
Aruba expansion	34,000	12,690	46,690	52,503	(5,813)
Baby Tagging - RFID	66,000	-37,000	29,000	24,772	
Backup Tape Library Replacement	470	1,949	2,419	3,309	(889)
Bighand 2015 AMS Renewal	0	0	0	0	
Blood Tracking	8,891	0	8,891	0	
Blood Tracking Phases 1 - 3	225,439	-108,200	117,239	32,628	
BMS Network Upgrade	16,596	0	16,596	3,134	
Brocade Switch Replacement	5,004	0	5,004	0	
Catering Cash Register Replacement	0	13,000	13,000	0	
Clinical Coding Encoder	13,168	0	13,168	0	
Cohort system - Occupational Health	44,000	0	44,000	42,180	
Community Midwifery system trial	35,748	0	35,748	0	
Connectivity Upgrade for Warminster & Shaftesbury	42,000	0	42,000	0	
EDCR-Changes to improve air flow and balance	3,468	-1,949	1,519	0	
Edge Security replacement	651	-651	-0	0	
Electronic Letters	20,148	0	20,148	4,994	
EPMA (Yr 2 (2014/15) of 7)	47,011	41,000	88,011	86,849	
EPR	0	350,000	350,000	98,560	
Estates - Oracle software interface	24,000	0	24,000	0	
Exchange 2010 Upgrade	1,949	0	1,949	0	
Genetics - software upgrade	101,000	0	101,000	82,037	
Genetics High Spec Analysis Equipment & Software	57,691	-30,000	27,691	0	
Histopathology Hardware	13,384	0	13,384	2,611	
IBD register	10,000	0	10,000	0	
Inhouse development team - applications, databases and Dashboards (subject to bu	92,176	0	92,176	47,022	
iPad Security	160	0	160	138	
Maintenance renewal - estimate	650,000	0	650,000	499,046	
Microsoft Licensing - being challenged	500,000	0	500,000	503,720	(3,720)
Mobile Computing	19,151	0	19,151	2,995	
Mortuary module	52,000	0	52,000	0	
Network - unsupportable equipment	52,000	0	52,000	0	
Network Load Balancers	12,690	-12,690	0	0	
Network Upgrade Consultancy	68,910	0	68,910	26,689	
Neurophysiology Project	726	-726	-0	0	
Nexus 5 Expansion	7,809	0	7,809	4,982	
Ophthalmology System	153,938	0	153,938	7,687	
Order Comms – additional development	41,000	-41,000	0	0	
Order Comms (includes System Admin Bid & Sexual Health Bid)	15,265	0	15,265	0	
PACS Reprocurement	68,308	0	68,308	960	
Palliative Care EPR	39,437	0	39,437	0	
PAS 2016 Replacement - Consultancy Costs	7,606	1,970	9,576	5,950	
Patient Observations Monitoring and Decision Support/Early Warning System/POET	32,029	0	32,029	30,635	
Patient Tracking	238	-238	-0	0	
Radiology - OrderComms	46,602	0	46,602	0	
Radiology Replacement PC's	522	-306	216	286	(70)
RAM Asset Maintenance Module	2,999	0	2,999	1,361	1,638
Replace 6509x3 network hubs	350,000	0	350,000	18,423	
Reporting System	80,000	0	80,000	68,910	
Results System in GP Practices 'Review' System	19,678	0	19,678	0	
SBAR Cardiology DICOM Migration	0	47,000	47,000	4,960	
SBAR for PAS	38,447	0	38,447	16,634	
SBAR re NACS Update to ED Symphony	7,500	0	7,500	0	
SBAR re UPS Replacement (formerly UPS Replacement - Room based for Computer	21,150	0	21,150	0	
Scanned Health Rtecords	2,292	0	2,292	0	
Scriptlogic licenses and upgrade	67,000	-67,000	0	0	
SDU Quality System	1,727	0	1,727	2,917	(1,189)
SLAM	805	0	805	0	805
Telecomms Voice Over IP - invest to save (non clinical areas - subject to a telephony	167,000	0	167,000	23,321	
Telepath enhancements	8,245	0	8,245	0	
Telepath to CSCLims (Phase 3 / Year 3 of 4 2015/16)	75,000	0	75,000	0	
Therapy information system	45,000	0	45,000	0	
Tray Tracking	71,000	0	71,000	71,886	(886)
Upgrade of low spec equipment (680 machines)	265	-49	216	251	(35)
UPS Replacement Programme	24,202	0	24,202	1,298	
VMWare Upgrade	20,000	0	20,000	20,000	
Whiteboards	200,000	0	200,000	8,551	
Wireless Expansion and Coverage	122,582	0	122,582	0	
Information Technology Totals	**4,006,077**	**167,800**	**4,173,877**	**1,802,198**	**(10,159)**
Medical Devices					
Anaesthetic Machines	1,931	0	1,931	0	
Anaesthetic monitors x2 - DSU	26,000	0	26,000	28,317	(2,317)
Arthroscopy telescope/sheath replacement - DSU	58,000	0	58,000	0	
Bariatric Bed (2016/17 bfwd)	0	12,654	12,654	0	
Bariatric Equipment	1,054	13,700	14,754	12,774	
B-Braun Review of Theatre Instruments	704,237	0	704,237	37,685	
BED replacement programme - 3rd (2015/16) yr of 4	158,047	0	158,047	124,284	
Biologics Service		60,000	60,000	60,000	
Bowel Scope Programme	-29,000	41,000	12,000	0	
DSU Operating Theatre Lights	40,755	0	40,755	0	
ED Trolleys x 20	15,726	-15,726	0	0	
DSU Powered Patient Trolleys	0	40,000	40,000	0	
Fluoroscopy x-ray machine - radiology room 8	330,000	-263,500	66,500	0	
Foetal Heart Monitors X 6	7,531	-7,531	0	0	
General x-ray machine - Westbury - radiology	99,000	0	99,000	0	
Grouped Items 2014/15	6,543	-6,300	243	0	
Grouped Items 2015/16	100,000	21,814	121,814	93,780	
Histpathology Kit	0	39,026	39,026	35,030	
Maquet Repairs Table/Lights	0	6,730	6,730	5,257	
Maternity Theatre Equipment	7,014	19,000	26,014	0	
Medical Equipment < £50k 13/14	21,433	-21,433	0	0	
Medical Equipment <£50k 14/15	152,429	-26,067	126,362	40,118	
Medical Equipment <£50k 15/16	384,262	-80,800	303,462	209,599	
Medical Equipment <£50k 16/17	0	34,712	34,712	0	
O&G Ultrasound	11,734	0	11,734	0	
Patient monitoring and stations 2nd phase of 2	9,267	0	9,267	0	
Patient trolleys x 14 + 1 Radiology	2,483	-2,483	-0	0	
Pitton Monitoring	0	16,500	16,500	16,485	
Power tools replacement/upgrade - theatres/DSU/oral surgery	200,000	0	200,000	199,995	
Radiology Room 2 Replacement	0	228,000	228,000	0	
Refrigerated Centrifuge	0	6,556	6,556	4,713	
Replacement Mattresses (x 15)	557	0	557	0	
Rigid hysteroscopes x 4 plus stack	4,115	0	4,115	554	
Scopes x7 endoscopy	150,000	103,920	253,920	253,920	
Spinal Hoists	0	35,000	35,000	0	
Static and Pressure Relieving Mattresses	0	69,000	69,000	40,162	
Thermometery Data Loggers	29,958	-17,000	12,958	0	
Urology Laser Scope	-11,928	28,000	16,072	16,369	(298)
Ventillators Programme - 1st year of 5 (2014/15)	2,400	0	2,400	0	
Videoscopes x2 - main theatres	50,000	0	50,000	0	
Medical Equipment Totals	**2,533,547**	**334,772**	**2,868,319**	**1,179,044**	**(2,615)**
Other					
Bed Stacking	98,200	0	98,200	4,800	
Car Park White Lining Site Wide	0	23,072	23,072	0	
Catering Trolley Replacement x20	3,902	0	3,902	0	
Demand Response Generator Conversion	360,000	-180,000	180,000	0	
Drinking Water Stations	700	0	700	0	
DSU Truck	434	0	434	0	
Efficiency schemes	160,570	-138,400	22,170	0	
Endoscope Vacuum Pack System	1,120	0	1,120	2,394	(1,275)
Finance systems 2011/2012	40,000	0	40,000	0	
Fire Safety Training Equipment	820	0	820	0	
LED Lighting	52,555	0	52,555	15,257	
Lightning Repairs	0	0	0	39,914	(39,914)
Mortuary Temporary Storage	230	0	230	0	
Outpatient Kiosks	74,338	0	74,338	2,809	
Phhotovoltaic's / Solarthermal PV	23,744	0	23,744	0	
Procurement Storage Raching Investment	0	11,400	11,400	10,872	
Procurement Tug 2015/16	0	9,940	9,940	0	
Project costs 2013/14	14,029	0	14,029	0	
Staff Accommodation Fire Door Closers	315	0	315	0	
Telecoms Trunk Lines	10,000	0	10,000	1,720	
Theatres Storage and Trolleys	0	51,420	51,420	23,702	
Ward Waste Bins	60,643	0	60,643	0	
Other Totals	**901,599**	**-222,568**	**679,031**	**101,468**	**(41,189)**
Trust Totals	**14,457,289**	**-432,578**	**14,024,711**	**4,737,470**	**(56,412)**
Likely slippage on Trusts schemes 2015/16	0	-1,030,849	-1,030,849		
Trust Totals	**14,457,289**	**-1,463,427**	**12,993,862**	**4,737,470**	**(56,412)**

Trust Board meeting
SFT

SFT3720

MONTH 7 OPERATIONAL PERFORMANCE REPORT

Date: 30th November 2015

Report from: **Andy Hyett, Chief Operating Officer**

Presented by: **Andy Hyett, Chief Operating Officer**

Executive Summary:

The trust delivered all Infection Control, Referral to Treatment, and Cancer performance standards for month 7. The trust failed to deliver the ED standard reporting 94.5% for month 7.

Emergency Pathway

The trust failed to deliver the ED standard in Month 7 and reported 0.5% below the national standard. During this period escalation capacity was opened to manage emergency flow and clinical teams in ED and AMU reported an increase in the acuity of patients presenting.

A number of actions have been introduced including operational standards in ED and across the trust and daily operational planning meetings with ED and operational teams.

At the time of writing this report the ED standard has been delivered for the previous 2 weeks.

RTT

All RTT standards were delivered in September at trust level. The greatest risk to continued deliver of these standards is any change in referral pathways as a result of performance challenges at neighbouring providers.

Extensive work is currently taking place in Orthopaedics and Ophthalmology to ensure capacity meets demand.

Diagnostic

The trust has now cleared the backlog of endoscopy referrals and is compliant with the diagnostic standard. The trust is continuing to work to decrease diagnostic

waiting times further.

Cancelled Operations

The trust is working hard to decrease the number of cancelled operations and will be trialling additional trauma lists from mid November. This should also improve pre procedure length of stay for non elective surgical procedures.

Unfortunately elective procedures have also been cancelled as a direct result of the impact of high medical admissions. All attempts are being made to limit this impact and where required patients are being notified as early as possible.

Cancer

All cancer standards were delivered in Month 7. The trust continues to work closely with GPs to minimise the number of breaches due to patient availability. A business case has been approved to increase capacity for Breast referrals which will allow earlier appointments and greater patient choice.

Links to Assurance Framework/ Strategic Plan:

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

Appendices: Appendix 1. Trust Board Performance Report – October 2015

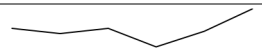
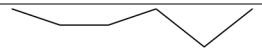
Trust Board Performance Report - October 2015

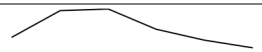
Salisbury NHS
NHS Foundation Trust

Monitor Assurance

Metric Name	Indicative Monthly Volume	Target Source	Ceiling	Oct-15	YTD	Benchmark	Trend
Infection control – Clostridium difficile	5,800 discharges	Contract	19 cases (deminimis volume 12)	1	10		
Infection control - MRSA	5,800 discharges	Contract	0 cases (deminimis volume 6) *	0	0		

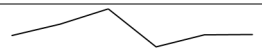
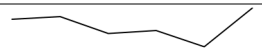
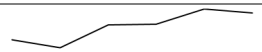
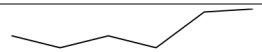
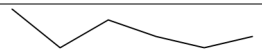
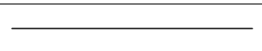
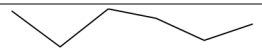
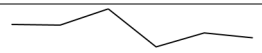
Metric Name	Indicative Monthly Volume	Target Source	Target	Oct-15	Quarter 3 to date	Benchmark	Trend
Patients treated within 18 weeks requiring admission	1,000 patients	Contract	90% treated within 18 weeks	90.06%	90.0%	92%	
Patients treated within 18 weeks not requiring admission	3,500 patients	Contract	95% treated within 18 weeks	96.2%	96.2%	97%	
Proportion of patients waiting less that 18 weeks for first treatment	10,300 patients	Contract	92% still waiting within 18 weeks	93.1%	N/A	95%	
Zero tolerance RTT waits > 52 weeks		Contract	Zero	0	0		

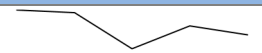
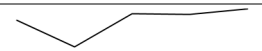
Metric Name	Indicative Monthly Volume	Target Source	Target	Oct-15	YTD	Benchmark	Trend
All Cancer two week waits	450 patients	Contract	93% patients within 2 weeks	93.6%	93.8%	95.4%	
Symptomatic Breast Cancer - two week waits	85 patients	Contract	93% patients within 2 weeks	98.4%	94.1%		
31 day wait standard	110 patients	Contract	96% patients within 31 days	100.0%	99.4%	97.9%	
31 day subsequent treatment : Surgery	20 patients	Contract	94% patients within 31 days	100.0%	100.0%		
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	92.9%	90.4%	87.0%	
62 day screening patients	4 patients	Contract	90% patients within 62 days	100.0%	100.0%		
62 day patients waiting first definitive treatment after Consultant upgrade	3 patients	Contract	85% patients within 62 days	100% (Jun-15)	100% (to Jun-15)		

A&E - Time in A&E department	3,600 patients	Contract	95% patients leave within 4 hours of arrival	94.5%	96.0%	94%	

Quarterly Governance risk rate	Green: No evident concerns

Patient Choice

Metric Name	Indicative Monthly Volume	Target source	Target	Oct-15	YTD	Benchmark	Trend
Patients waiting less than 6 weeks for diagnostics	1,800 patients	Contract	100% of Diagnostic Waiting list < 6 weeks	99.7%	97.8%	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	35.4%	36.6%	N/A	
Friends and Family - % likely to recommend Hospital	1,400 discharges			94.4%	95.5%	N/A	
A&E Clinical Target 1 - Effectiveness of Care - unplanned reattendance rate	3,600 patients	Contract	<5% ED attendances to have unplanned return	2.6%	2.4%	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	1.7%	1.3%	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	04:24	04:01	04:11	
A&E Clinical Target 4 - Time to initial assessment	3,600 patients	Contract	95th percentile ED time to initial assessment < 15 minutes	00:28	00:12	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	60	52	benchmark data not fit for purpose	
Ambulance Handover Breaches	970 arrivals by ambulance	Contract	Patients waiting > 20 minutes for Ambulance Handover	4	32		
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%	100.00%	100%	
GUM % Accepted appt within 48 hours	340 patients	Contract	80% patients seen within 48 hours initial referral	79.7%	79.7%	89%	
Cancelled operations on the day of surgery	2,100 elective admissions (incl. daycase)	Trust	< 0.7% elective patients cancelled	0.73%	0.95%	0.77%	
Cancelled operations rebooked within 28 days	20 cancellations per month	Contract	100% patients rebooked within 28 days of cancelled surgery	84.2%	94.4%	96%	

Metric Name	Indicative Monthly Volume	Target source	Target	Jul-15	YTD	Benchmark	Trend
Market Share: NHS Wiltshire - Elective		Strategy		30.2%	30.0%		
Market Share: NHS Wiltshire - Non-Elective		Strategy		35.1%	35.5%		
Market Share: Core Practices - Elective		Strategy	Increase market share from 52% to 55% over 5 years	54.3%	53.1%		
Market Share: Core Practices - Non-Elective		Strategy		63.1%	64.1%		

Trust Board Performance Report - October 2015

Salisbury NHS
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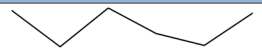
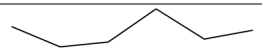
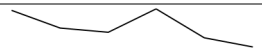
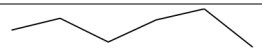
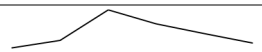
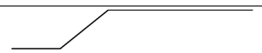
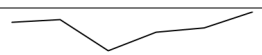
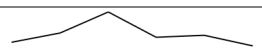
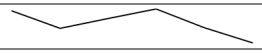
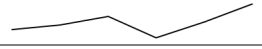
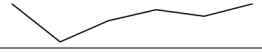
Partnership working

Metric Name	Indicative Monthly Volume	Target source	Target	Oct-15	YTD	Benchmark	Trend
Delayed Transfers of Care - NHS				13	N/A		
Delayed Transfers of Care - Social Services			4 DTOCs based on 3 Wilts SS delays and ~1 other	12	N/A		
Outpatient Follow Up rates	15,000 attendances	Contract	Aspire for Follow up -New Rate <=1:1.6	1.55	1.50		

Value and Effectiveness

Metric Name	Indicative Monthly Volume	Target source	Target	Oct-15	YTD	Benchmark	Trend
Elective Medical Length of Stay	40 Medical G&A overnight stays	Trust	3.48 days	5.7	4.5	Benchmark data not fit for purpose	
Non-Elective Medical Length of Stay	900 Medical G&A overnight stays	Trust	7.78 days	6.4	7.2	15.7	
Elective Surgical Length of Stay	480 Surgical G&A overnight stays	Trust	2.19 days	2.9	2.6	3.5	
Non-Elective Surgical Length of Stay	750 Surgical G&A overnight stays	Trust	3.15 days	3.5	3.5	3.0	
Hip replacements discharged within 5 days	25 patients	Trust	60% patients discharged within 5 days	60.7%	72.8%		
Knee replacements discharged within 5 days	24 patients	Trust	60% patients discharged within 5 days	63.2%	76.0%		
Coding - % coded within 1 week of discharge	5,800 discharges	Trust		48.0%	49.6%		
Coding - % coded within 5 days of month end	5,800 discharges	Trust		81.8%	84.3%		
NHS no. coverage	230,000 patients	Contract	95% of patients with activity in last 3 years to have validated NHS no.	98.3%	98.3%		
1st Outpatient DNA rate	5,500 appointments	Contract	No more than 7.5% patients to not attend 1st outpatient appointment	6.2%	5.8%	7.0%	
Elective Theatre Utilisation - Main Theatres	530 cases	Trust	Data recently obtained from new theatre system, no target set at this point	95.4%	96.8%		
Elective Theatre Utilisation - Day Surgery	860 cases	Trust	Data recently obtained from new theatre system, no target set at this point	77.2%	83.5%		
Non-elective Theatre Utilisation - Main Theatres	370 cases	Trust	Data recently obtained from new theatre system, no target set at this point	54.4%	48.0%		
Daycase Rates for selected procedures	350 patients	Trust	80% of selected elective surgical cases to be treated as daycase	84.8%	83.4%	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

Salisbury NHS
NHS Foundation Trust

PAPER: SFT 3721

DIRECTOR OF INFECTION PREVENTION AND CONTROL REPORT

PURPOSE: The Director of Infection Prevention and Control (DIPC) six monthly report, together with the monthly Quality Indicator (QInd) Report, are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of this DIPC Report is to inform the Trust Board of the progress made against the 2015/16 Annual Action Plan to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

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

HCAI management

During quarters 1 and 2 of 2015/16 there have been no outbreaks.

Mandatory surveillance update
- **MRSA bacteraemia cases –** There have been 0 MRSA bacteraemia cases identified during the reported period.
- **MSSA bacteraemia cases –** There has been 1 hospital apportioned case during the reporting period. This is a decrease on the previous year.
- **Clostridium Difficile –** at the end of Q2 the Trust has reported 9 cases of hospital apportioned reportable cases against a year end trajectory of 19.
- **Surgical Site Infection Surveillance (SSIS) –** During Q1 surgical site infection surveillance was carried out for patients undergoing hip replacement surgery with no reported infections.

Audit
- **Antimicrobial stewardship audits** – during 2015/16, all scheduled antibiotic audits have been completed and show a continued improvement in compliance with standards.
- **Hand hygiene –** During Q1 and Q2, hand hygiene compliance audits have continued to completed across the clinical directorates. The audit tool captures all of the '5 moments for hand hygiene'. The identified poor compliance area continues to be predominantly missed opportunity number 5, which relates to contact with patient surroundings. The results have been fedback to the relevant Clinical Leaders and DSNs with actions identified, and additional education and support provided for staff groups

Education and Training:
- **Mandatory training.** Compliance remains low across both areas assessed. Executives continue to pursue this issue through the Directorate Performance meetings and the Infection Control Nurses have increased availability of the drop in hand hygiene sessions for staff. This continues to be a focus through Q3 and Q4

Cleaning services
The Trust participated in the National PLACE assessment during Q1. A total of 10 wards and ED were visited, 4 food assessments were undertaken, 2 outpatient areas as well as external spaces and communal areas were also assessed as required under the PLACE criteria. The Results were published nationally in August 2015 showing improvements across all areas and above national average figures.

In addition, the report summarises progress in relation to education, training and innovations, and outlines the updated positions for the decontamination strategy and water safety management.

ACTION REQUIRED BY THE BOARD:

The Board is asked to:

1. Note the report and how the contents relate to Board assurance.

2. Minute/document that the Board continues to acknowledge their collective responsibility as described above and detailed within the DIPC report.

ATTACHMENT AVAILABLE TO VIEW ON WEBSITE:

The DIPC Six Monthly Report for Quarter 1 and Quarter 2 2015/16

AUTHOR: Lorna Wilkinson

TITLE: Director of Nursing & Director of Infection Prevention & Control

Salisbury NHS
NHS Foundation Trust

Director of Infection Prevention & Control (DIPC)

6 Monthly Report for Quarter 1 and 2 2015/16

Lorna Wilkinson
DIPC

November 2015
(Final)

Contents

Appendices

1. Introduction

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

The DIPC annual 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.

The purpose of the DIPC Report is to inform the Trust Board of the progress made against the 2015/16 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".

2. Overview and Action Plan

The work towards achieving the objectives of the Annual Action Plan 2015/16 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 (IPCT) provides a liaison and telephone consultation service for all inpatient and outpatient services, with arrangements for service cover by an Infection Control Nurse (ICN) during declared Norovirus outbreaks.

The IPCT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (w.t.e) Infection Control Nurses (ICNs) and secretary (0.61 w.t.e) (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, which is achieved through the following actions:

- Agree an annual infection control programme and monitor its implementation.
- Oversee the implementation of infection control policies and procedures.

- Monitor and review the incidence of HCAI.
- Develop and review information regarding infection prevention and control.
- Monitor the activities of the IPCT.
- 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 2015/16 is £160K comprising:

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

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 a serious incident investigation (SII). 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 NHS England for patient safety domain (Serious Incident Framework: Supporting learning to prevent recurrence, March 2015), 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 2015/16, the Trust has had no declared outbreaks of the following: Clostridium difficile (C.difficile); 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 9.

The ICNs have continued to provide ward teams with infection control advice, support and education as part of the daily visits undertaken to inpatient areas. The management of patients admitted with suspected and known alert organisms has been discussed, and risk assessments undertaken based on the individual patient's clinical presentation, past medical history and other risk factors. The ICNs have continued to be involved in undertaking these assessments in conjunction with staff, based on the level of care and intervention the patient may require. The Isolation Risk Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway has been promoted to further aid the risk assessment process.

The availability of sideroom facilities across the Trust site for isolation nursing can be limited, and it has been recognised that there are patients with alert organisms that can be safely managed either within cohort bays, or be isolation nursed in a bedspace. The ICNs continue to review patients nursed in siderooms on a daily basis to identify those who would be most suitable to move out, to accommodate higher risk patients. This information is cascaded to both the ward nursing and medical teams and the Clinical Site Coordinators, with additional written documentation provided to support staff in the ongoing management of these patients.

Areas that the IPCT have been particularly involved with include:

6.1.1 Carbapenemase Producing Enterobacteriaceae (CPE)
Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of humans and animals. However, these organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. CPE is the name given to those strains of the bacteria that have developed the ability to destroy Carbapenem antibiotics, used to treat infections when other antibiotics have failed. CPE infections can still be treated; however the treatment options are more difficult and may rely on the use of older antibiotics.

Following the increase in the number of cases of CPE infection identified at other regional hospitals, advice has been given to the ward nurses by the ICNs in relation to the safe transfer of patients to the Trust from other countries or UK hospitals with a known higher prevalence of CPE. In addition, the ICNs have circulated information relating to the management of all patient admissions, including the transfer of patients from other Trusts. When patients are admitted to the Trust and trigger CPE screening, they are isolated appropriately within sideroom facilities, and provided with the relevant patient information.

As previously reported a patient on Radnor Ward, the Intensive Therapy Unit (ITU) was identified to be a likely CPE positive on 31st March 2015 and was isolated in a sideroom facility on the ward until transferred to another Trust for ongoing care. Patient contacts were identified for enhanced screening for CPE, and from this a second patient was identified with likely CPE, and was moved to a sideroom for isolation nursing. Multidisciplinary meetings were held during April 2015 to discuss the management of these patients and the implications for the ward. A further meeting was held on 24th April 2015, attended by key personnel, to agree the management of Carbapenem Resistant Enterobacteriaceae (CRE) on Radnor Ward, in line with the Department of Health (DH) toolkit, this included screening processes for all patients and compliance with strict infection control practices and environmental cleaning.

It has subsequently been confirmed that these patients were not found to be CPE positive from further testing.

6.1.2 Clostridium difficile (C.difficile)
There were no declared outbreaks or periods of increased incidence (PII) of C.difficile during quarters 1 and 2 of 2015/16.

The management of patients identified to be previously or newly identified as C.difficile positive has presented additional challenges. These patients need to be assessed on admission, with regards to the requirement for isolation nursing. Staff are advised about the potential risk of relapse of infection, and the need for prompt assessment of symptoms by the clinicians. In addition, the requirement for the appropriate sampling for these patients has been highlighted by the ICNs, and the completion of the Trust Diarrhoea Pathway (which supports the Trust algorithm for the management of inpatients with diarrhoea), further promoted.

6.1.3 Influenza

During quarter 1 of 2015/16, patients continued to be admitted to the Trust with respiratory and 'flu-like' symptoms. Where there has been a high suspicion of influenza, patients have been isolated within sideroom facilities on admission; whereas when the suspicion has been considered to be low, patients have been managed within the bay setting. In both situations, patient contacts have been identified for follow up. When a positive influenza result has been reported, the relevant clinicians have been contacted to assess the need for antiviral prophylaxis, as per PHE guidance. Through clinical visits, the ICNs continued to provide support and guidance to staff groups within the ward teams in the ongoing management of identified patients, and included the wearing of PPE and respiratory protection.

There have been 5 cases of cases of influenza B identified during quarter 1 and no cases identified during quarter 2.

6.1.4 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 quarter 1, there were 2 unrelated cases of invasive Group A streptococcal infection identified for patients admitted to the Trust.

During quarter 2, the ICNs were notified by the Laboratory of 4 cases of invasive Group A streptococcus, identified from patients admitted to the Trust. Of these, 2 cases were confirmed at different times during July 2015 for patients identified to be related household contacts. Patients identified with invasive Group A streptococcus are isolated within sideroom facilities, and ongoing management advice is provided by the IPCT.

6.1.5 MRSA

During quarters 1 and 2 of 2015/16, there has been no requirement for the ICNs to close beds as a direct result of MRSA. Patients have been admitted to the Trust who are known to be MRSA positive, or identified to be positive on or after admission. The Trust continues to screen patients for MRSA in accordance with national guidelines, with screening either undertaken prior to admission (for planned or elective admissions) or immediately following admission to the Trust (emergency admissions).

Patients identified to be MRSA positive have either been isolated within sideroom facilities, or isolation nursed within bedspaces, according to the risk assessments undertaken. The ICNs have supported ward staff in the safe management of patients who are known to have been previously MRSA positive, reinforcing the use of alerts on the inpatient management system (iPMs) to indicate when a patient has been MRSA positive.

6.1.6 Norovirus

There were no declared outbreaks of Norovirus during quarters 1 and 2 of 2015/16, 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.

Where patients developed symptoms after admission, the appropriate infection control measures were implemented, and environmental cleaning completed. During quarters 1 and 2, the level of diarrhoea and vomiting activity necessitated the closure of 26 bays (with 2 ward closures) in clinical areas across the medical, musculoskeletal and clinical support and family services directorates at different times. This was to ensure the safe management of patients and continued service provision. (Of note: A number of these closures were implemented by the ICNs when cases of C.difficile were identified. It is established practice that any affected bays are closed to admissions, following the identification and isolation of patients with C.difficile, until the required level of environmental and equipment cleaning has been completed by Housekeeping).

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/wards 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.

6.1.7 Staphylococcus aureus Scalded Skin Syndrome (SSSS)

Staphylococcal scalded skin syndrome (also known as Pemphigus neonatorum or Ritter's disease, or Localized bullous impetigo) is a dermatological condition caused by Staphylococcus aureus (S.aureus) bacteria. This germ produces a toxin that causes the outer layer of the skin to be shed. When a toxin producing type of S.aureus infects the skin, it can cause easily torn blisters to appear at the site of infection. This condition is known as the bullous (blistering) type of impetigo. The toxin is removed by the immune system and the kidneys. If either is not working properly, the toxin can circulate in the blood and can then affect most of the body’s surface. The skin then resembles a scald or burn, which is why this condition is called staphylococcal scalded skin syndrome. The toxin can also cause the upper layer of the skin detach and to peel and crust.

In young children, especially newborns, the immune system and kidneys are not fully developed, and this explains why they are most commonly affected. SSSS is rare in adults, but can affect those with kidney failure and immune deficiency, as well as those on immune suppressant drugs or undergoing chemotherapy. In most cases, SSSS is cured completely with no visible difference or lasting effects to the skin, especially when treatment (with oral antibiotics) starts early. The skin needs gentle cleansing and soothing creams or dressings, which may include antibiotics or antiseptics.

During September 2015, the Deputy ICD/Consultant Microbiologist worked closely with the neonatal unit team to undertake a thorough investigation of a suspected cluster of SSSS involving four premature babies on the Neonatal Unit. One baby was confirmed to have SSSS, and the contact and screening of all patients was appropriately managed. SSSS was not confirmed in the other 3 babies and all four babies made a full recovery.

6.1.8 Tuberculosis

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 Occupational Health (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 quarter 2, a case of Tuberculosis was identified for a patient initially admitted to the Intensive Therapy Unit (ITU) within the surgical directorate, and then appropriately transferred to a sideroom facility on Pitton Ward (medical directorate). The patient was confirmed to have Tuberculosis in two sites. A separate meeting was held to review the case management and ensure that patient and staff contact follow up was undertaken. This was led by the Respiratory Department, with the involvement of the IP&CT, OH Department, and other agencies to ensure the required follow up and implementation of any ongoing actions.

6.1.9 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.

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

Patients previously VRE positive require isolation in a sideroom facility on admission, wherever possible, and risk assessments have been undertaken to identify those patients suitable to be safely managed within bays. The ICNs have supported staff in this process, which is dependant on a number of factors including the number of positive sites, presentation of the patient and their urinary and faecal continence. Although currently there is no plan to cohort VRE positive patients, this may be a consideration for the future.

Strict isolation precautions are instigated to minimise the risk of environmental contamination, and additional written information has been provided for both the patients and staff. Twice daily environmental cleaning by Housekeeping is undertaken for sideroom facilities occupied by VRE positive patients, with deep cleaning and GLOSAIR disinfection undertaken when the room is vacated. The ICNs continue to provide support and education for all ward teams relating to all aspects of patient management for these cases.

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 2015/16 are the following:

- Hip replacement surgery was completed in quarter 1 (2015/16).
- During quarter 2 (2015/16), 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 an agreed timeframe (which had been extended at the request for the Senior ICN). Of the 83 hip replacement procedures recorded, there were no infections identified.
- This can be compared to the category of hip replacement surgery completed during the same period for 2014/15, where a total of 75 hip replacement procedures were recorded with 1 superficial surgical site infection and 1 deep infection was identified, and gives an infection rate of 2.66%.

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

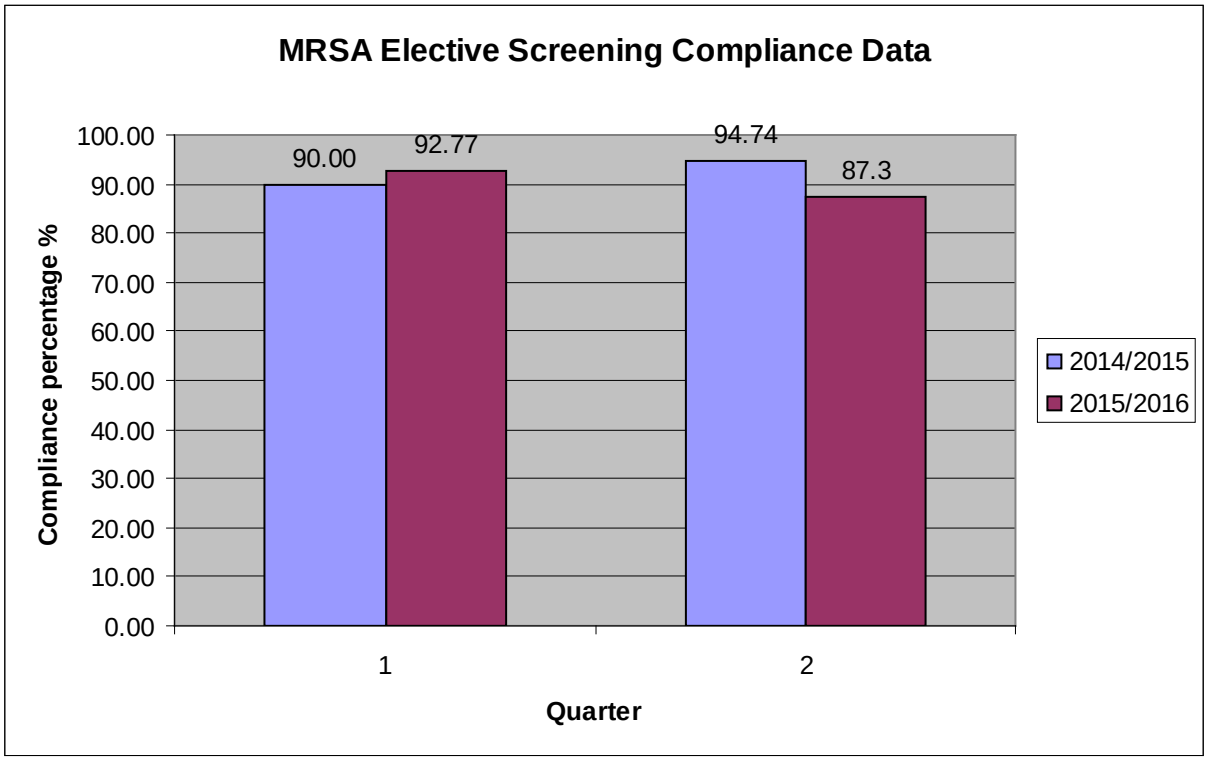
6.2.2 Methicillin Resistant Staphylococcus aureus (MRSA)

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).

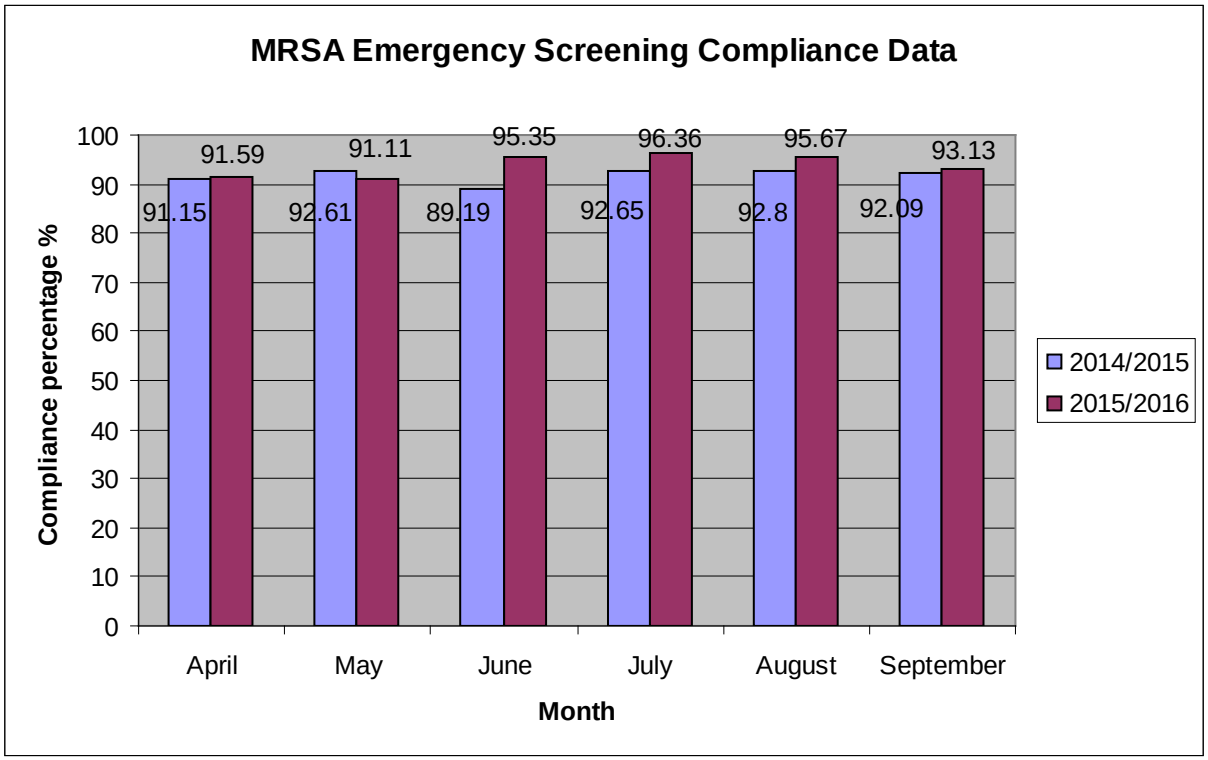
Tables 1 and 2 relate to the overall compliance for both elective admission and emergency admission screening audit figures, for April 2015 to September 2015, with figures provided for April 2014 to September 2014 for comparison.

Table 1



(*Table 1)*

Table 2



(*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.

Table 3
Breakdown of total number of Trust cases recorded April 2015 – September 2015.
The figures in brackets show the number of cases recorded April 2014 – September 2014.

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

(Table 3)

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

The Trust's MRSA target for 2015/16 is zero Trust apportioned cases. Post Infection Review (PIR) investigations were undertaken by the relevant Clinical Commissioning Groups (CCGs) for the non Trust apportioned cases identified during August 2014, with the involvement of the Senior ICN with this process. Both cases were assigned to the relevant CCGs and were not linked.

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.

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.

Table 4
Breakdown of reportable cases recorded for inpatients April 2015 – September 2015
The figures in brackets show the number of reportable cases recorded April 2014 – September 2014

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**0 (6)**	**1 (2)**	**3 (1)**	**2 (2)**	**3 (5)**	**3 (0)**							**12 (16)**
Non Trust apportioned cases	0 (1)	0 (0)	0 (0)	1 (1)	1 (1)	1 (0)							3 (3)
Trust apportioned cases	0 (5)	1 (2)	3 (1)	1 (1)	2 (4)	2 (0)							9 (13)

(Table 4)

Table 5
Breakdown of total number of reportable Trust C.difficile cases recorded April 2015 – September 2015
The figures in brackets show the number of reportable cases recorded April 2014 – September 2014

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Inpatients	**0 (6)**	**1 (2)**	**3 (1)**	**2 (2)**	**3 (5)**	**3 (0)**							**12 (16)**
Community Hospitals	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)							0 (0)
General Practitioners (GPs)	4 (3)	1 (0)	1 (3)	0 (1)	2 (1)	3 (3)							11 (11)
Residential/Nursing Home	0 (0)	0 (0)	0 (0)	1 (0)	0 (0)	0 (0)							1 (0)
Other (e.g. Coroner, Private Hospital, Day Attender, A&E, Outpatient)	1 (0)	1 (0)	0 (0)	1 (0)	0 (1)	0 (0)							3 (1)
Total	**5 (9)**	**3 (2)**	**4 (4)**	**4 (3)**	**5 (7)**	**6 (3)**							**27 (28)**

(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 2015/16 is no more than 19 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 Antimicrobial Pharmacist or 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 High Impact Intervention (HII) C.difficile audit tool, whilst the patient remains 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, 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 other key members. The membership of this group has been reviewed, and a Gastroenterologist and Dietician will be involved as required.

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.

The Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either 'Trust apportioned' or 'non Trust apportioned'.

Table 6
MSSA Bacteraemias figures recorded for blood cultures from inpatients, and blood cultures taken in outpatient areas and the Emergency Department, from April 2015 – September 2015
The figures in brackets show the number of cases recorded from April 2014 – September 2014

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**3 (4)**	**2 (3)**	**1 (5)**	**2 (2)**	**2 (3)**	**6 (2)**							**16 (19)**
Non Trust apportioned cases	3 (1)	2 (1)	1 (5)	2 (2)	2 (3)	5 (2)							15 (14)
Trust apportioned cases	0 (3)	0 (2)	0 (0)	0 (0)	0 (0)	1 (0)							1 (5)

(Table 6)

During 2015/16, there has been 1 Trust apportioned case 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 this Trust apportioned case. Updates on progress on identified actions is monitored by the Directorate Senior Nurse (DSN).

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'.

Table 7
E.coli Bacteraemias figures recorded for blood cultures from inpatients, and blood cultures taken in outpatient areas and the Emergency Department, from April 2015 – September 2015 The figures in brackets show the total number of cases recorded from April 2014 – September 2014

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**6 (13)**	**9 (3)**	**10 (7)**	**11 (9)**	**12 (14)**	**7 (9)**							**55 (55)**
Non Trust apportioned cases	6 (9)	7 (3)	8 (5)	10 (7)	9 (10)	6 (5)							46 (39)
Trust apportioned cases	0 (4)	2 (0)	2 (2)	1 (2)	3 (4)	1 (4)							9 (16)

(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 9 Trust apportioned cases identified during quarters 1 and 2 of 2015/16, two were determined as likely HCAI related, two cases as possibly HCAI related, for one case it was unknown if it was HCAI related, and the final four cases were determined as not likely 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. Where concern is highlighted by the Microbiologist

for an individual case, further investigation is undertaken. For these Trust apportioned cases, no further follow up was identified.

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 has continued to implement this toolkit across the inpatient and outpatient clinical areas.

Following the increase in the number of cases of CPE infection identified at other regional hospitals, advice continues to be provided by the ICNs in relation to the safe transfer of patients to the Trust from other countries or UK hospitals with a known higher prevalence of CPE. In addition, the ICNs have recirculated information relating to the management of all patient admissions, including the transfer of patients from other Trusts. When patients are admitted to the Trust and trigger CPE screening, they are isolated appropriately within sideroom facilities, and provided with the relevant patient information.

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 Matrons Monitoring Group (MMG) meetings.

In additional support of this practice, a 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 >85%, 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 for quarters 1 and 2 of 2015/16, 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.
- Audit delegated to a staff member(s) unfamiliar with the audit process

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 this action has provided evidence to strengthen the feedback process for the directorates to action.

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

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

For quarters 1 and 2 of 2015/16, the overall compliance rate from external auditing of 9 inpatient clinical areas was 69.3%. This is a slight decrease on the previously reported overall compliance of 71% for quarters 1 and 2 of 2014/15.

Detailed analysis was undertaken to identify the key areas of non-compliance, which was predominantly staff missing moment number 5, handwashing after contact with patient surroundings. The results were reported via the DIPC and challenged by the IPCC members with feedback provided to the clinical leaders and DSNs to address the shortfall in practice. Additional education and support has been provided by the IPC team to staff groups and focusing on the audit findings. Extra hand hygiene assessment sessions have been undertaken as demonstrated by the tables below:

Quarter 1 (1st April 2015 – 30th June 2015)

Number of hand hygiene sessions held using a UVLB	**Number of attendees**	**Who led the session**
7	333	ICNs
7	61	ICNs
20	289	ICLPs
TOTAL	**683**	

Quarter 2 (1st July 2015 – 31st October 2015)

Number of hand hygiene sessions held using a UVLB	**Number of attendees**	**Who led the session**
7	431	ICNs
7	123	ICNs *
20	378	ICLPs
TOTAL	**932**	

* This was a scheduled teaching session undertaken by the ICNS.

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 2015/16, 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.
- BBE policy and Uniform and Workwear guidance
    - Reaudit was completed during quarter 3 (2014/15), with data collection undertaken by the ICLPs and Clinical Leaders across the clinical inpatient and outpatient areas for clinical staff wearing a uniform. A total of 374 observations of staff members were recorded across the directorates.
    - Achieved 100% compliance with no sleeve or garment being worn below the elbow.
    - Achieved 96.8% compliance with wearing no wrist watch or wrist jewellery, where 12 staff were identified to be non compliant.
    - In addition, the other main theme of non compliance related to jewellery, with 70 staff found to be wearing earrings that did not adhere to the uniform policy.
    - In response to feedback from previous audits, the ICNs undertook additional data collection of clinicians not wearing a uniform, to audit solely against the BBE requirements. 117 observations were recorded, with 100% compliance achieved with no sleeve or garment being worn below the elbow, and 100% compliance achieved with no nail varnish or false nails being worn. Achieved 99.15% compliance for both wearing no wrist watch or wrist jewellery, and wearing no ring with stones. For both cases, 1 staff member was identified to be non compliant.
    - A further breakdown of the results for clinical staff wearing a uniform were provided for each directorate. The aim of providing this information was to enable the directorates to further target and improve their compliance levels.
    - The findings from the reaudit will be utilised in line with current evidence based research and best practice guidance within the revision of the Trust BBE and uniform policies and workwear guidance. The report was approved by the IPCWG during quarter 4 (2014/15), and presented to the IPCC in quarter 1 (2015/16).
- Observation of Practice Audits
    - The ICNs continue to undertake additional observational audits of staff practices within clinical areas, as part of the initial 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 during 2014/15) 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. In addition, the Trust has identified the requirement to ensure that patient pillows are fit for purpose and therefore require a mechanism for monitoring. The matter was discussed at the MMG meetings to determine a suitable solution. A similar process to that employed to monitor mattress quality is not achievable for pillows. However guidance for staff to ensure pillows remain fit for purpose and are replaced when required is available in the linen policy. Work is underway via MMG to ensure ward staff are conversant with this guidance.

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

8.1 Innovations

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

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

9. Antibiotic Prescribing *(information for this section has been provided by 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. Membership of the ARG has been expanded (in 2015) to include a Medical Consultant as an Antibiotic champion, and nursing representation from the Nurse Consultant in Critical Care. This membership review has enabled the formation of new ideas to improve awareness of antibiotic stewardship challenges across the Trust.

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 for 2015/16 include:

9.1 Guideline development/review

The following guidelines are currently being reviewed:

- Burns (draft policy completed, taken to ARG June15, July 15. Discussion with Plastic Surgeons - agreed. Appendix re children's doses (LP)- Pending
- Plastics. Completed, taken to ARG June15. Presented to Plastic Surgeons - Agreed.
- Endocarditis (Treatment) JH. Reviewed by ET. Discussed at ARG August 2015. Completed. For discussion at DTC November 2015.

Guidelines recently completed and approved:

- Paediatric Antibiotic Policy
- Abdominal Sepsis
- Work Plan for 2015/16
- Endocarditis (Prophylaxis)

Guidelines under development:

- Antifungal guidelines (PR (lead)/SH/DR/JC)

Future Guidelines for review:

- Urinary Sepsis/Pyelonephritis
- Gentamicin Conventional Multiple Dosing

- Sepsis of Unknown Origin / Septic Shock

9.2 Regular Antimicrobial Stewardship Audits

The rolling programme of antibiotic stewardship audit, commenced in 2009, continues and has been rolled out until March 2016. The aim is to audit one ward every fortnight, to provide a snapshot of antimicrobial prescribing practice within our trust

The audits take 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 designed for our use by Consultant Microbiologist (S Cotterill). The spreadsheet yields a percentage performance score for the ward in question.

Feedback has previously been provided by the ward pharmacists. It is hoped in the future the auditing pharmacist can provide feedback to the ward sister as soon as the data has been entered into the spreadsheet. The microbiologists also hope to feedback to the medical/ surgical clinicians at the time of the audit and through pharmacy department.

Overall, results have shown that general areas for attention are the documentation of the indication for antibiotic prescribing and the specification of a course length/review date. Compliance with both of these standards it was hoped would improve 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.

9.2.1 Recent Audit Results:

Throughout the year, for each quarter 2015/2016, the target will be to visit 2 wards per month. For the first quarter, this target has been met. In summary, performance in these audits has improved compared to the first quarter.

Table 8 Average Quarterly Score

Quarter :	1	2	3	4
Average %age	94.3%	92.6%	-	-

The first quarter average percentage score is very high, and compares favourably with the same period last year (81.3%). The improvement may well be attributed to the raft of measures we now have in place to inform all clinical staff of the results attained for the ward concerned.

Similarly, quarter 2, the average percentage scores continues to stay well above the 80% threshold. The two areas of weakness remain constant, the stop / review date, and recording indication on the chart and in the notes.

We will aim to review the rolling programme, to ensure wards visited during the year are done so in accordance with clinical need. Priority will be given to wards who either scored poorly in the antibiotic audit, or where concerns have been highlighted with regard to infection control (e.g. clostridium difficile).

Point prevalence audit
The regional Annual Antibiotic Point Prevalence Audit is conducted in February of the year. 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.

This year, the results were published on April 15th 2015. Below is a comparative summary:

Table 9 Annual Antibiotic Point Prevalence Audit results

	Salisbury District Hospital	Regional average %
Dose appropriate	99.04%	98.8%
Course length	73.68 %	73.44%
Indication on chart	85%	71.98%
Indication in notes	10.53%	23%
Comply with guidelines	93.78%	86.84%

In all areas scored, Salisbury scored higher than the regional average with the exception of the reporting of indication in the notes. However, this is misleading as for the purposes of the audit, the priority was indication on the chart. The 10.53 % represents those patients for whom there was not an indication recorded on the chart; those notes were then scanned by the auditors for a note entry with this regard. Course length/review date had improved on the two previous years 69.2% (2014) . 71.9% (2013). Compliance with guidelines, significantly exceeded the regional average. The nexy audit is due February 2016.

9.3 Clostridium difficile
Inclusion of Fidaxomicin within trust treatment guidelines: In line with the Public health ‘Updated guidance on the management and treatment of Clostridium difficile infection’, the trust algorithm has been amended to include Fidaxomicin.

Antibiotic Treatment Review Sheet: This has been updated to improve the information collected and the time taken. The ‘pharmacist comment’ has been replaced by a medicines management section covering four specific areas: past antibiotics, PPI/H2 antagonist , Antimotility medicine, Antibiotic Allergy. It is hoped that this will efficiently collect the information both in time taken by the ward pharmacist and the IP&CT to analyse. The antibiotic therapy received by the patient is reviewed by a pharmacist and links with community teams as necessary. A designated Senior Pharmacist attends the multidisciplinary ward rounds on a weekly basis. This is undertaken by a Consultant Microbiologist together with a members of the IP&CT. This provides an opportunity to review the treatment and management of inpatient C.difficile cases, and also use the forum to discuss any concerns. In addition, the group will liaise with the appropriate clinician/nursing staff for the patient if required, and an entry is made within the healthcare records.

9.4 Consultant Microbiologist Ward Round
Commenced in August 2013, this ward round has been implemented with a senior pharmacist and a consultant microbiologist leading the initiative to review those prescriptions that fall outside certain parameters including age of patient, fall outside of guidance, antibiotic used and course length. fall This has been found to be a very useful initiative but the service has suffered from a lack of availability of consultant microbiologist time in recent months. We hope in the future that microbiologist cover may be fully available for this service. It is hoped that other team members will also participate to maintain a weekly ward round

9.5 Antibiotic Awareness
As part of the European Antibiotic Awareness Day 18th November, we annually plan a campaign to raise awareness of the need to use antibiotics responsibly.
Last year we introduced 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, Dispensary Patient Waiting area, Education and training notice boards.

- Broadcast /Cascade brief - via Patrick Butler .

- Screensaver - detailing the principles of the' start smart then focus' initiative.

- Display in Dispensary patient waiting area

- This year, in addition to the above, we intend to:

- Utilize the plasma screens in patient waiting areas to promote key messages

- Advertise the event on the hospital website (with links – from the 3rd November)

- Press release- via Patrick Butler

9.6 Datix reports
Datix reports involving antibiotics are highlighted monthly at the ARG to identify any concerning trends (lead, ET)

9.7 ICID
The ARG continually works to ensure policies on ICID are easily accessible and up to date. Recently we have been working with the ICID team to refine the way in which the Antimicrobial team are alerted to any policies approaching their review date with a new system involving a generic ARG mailbox being set up. The driver for this is that on a number of occasions key guidelines have been automatically removed from ICID. This is seen as a clinical risk as clinicians are increasingly using ICID as a reference source for local policies. Additional members have been added to the ARG mailbox to help ensure this does not happen. ARG chair to review mailbox prior to meeting.

9.8 Defined daily doses
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.

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 support 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 during quarters 1 and 2 of 2015/16. At the request of the Trust Board the figures presented in Appendix 7 also reflect the percentage of staff in each directorate who have completed the CBL package on the MLE during the relevant quarter.

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 (for new starters, medical students, pre-registration nursing students and foundation course nursing assistants)
- Volunteer Co-ordinators
- 'Hospital at Night' Team and Clinical Site Coordinators
- Temporary Nurse and Administration Bank

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 for the medical directorate, specifically for the implementation of the diarrhoea care pathway.

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. These have 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. Sessions have been held to focus on the management of influenza and Ebola through PPE workshops, and also covered the management of CPE.

Opportunities continue to be provided for clinical staff to shadow the ICNs, by both new starters to the Trust, newly promoted (Band 6 and 7) 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. This has proved a useful exercise.

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.

Additional infection control support has been provided to nursing staff and allied health professionals in the inpatient areas. In particular this has been with junior staff members who were taking charge of a clinical area (under supervision of the relevant clinical leader/senior staff member).

The infection prevention and control CBL package is accessible for all staff on the MLE via the Trust intranet site. Feedback had been received by the ICNs that aspects of the package were not working, e.g. web links. The Senior ICN raised the issue with the Education Department Manager. The package was requested to be provided to enable the ICNs to update information. However, this is not possible and the Senior ICN was informed that alternative infection control packages are being sourced by the Education Department.

11. Water Safety Management *(information for this section has been provided by Neville Edwards, Person Responsible for Water and Interim Head of Estates)*

This section summarises the water safety management precautions that the Trust has taken over quarters 1 & 2 of 2015/16. 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 part 2.

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 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 part 2 was carried out by the Water Safety Group during 2014 but no changes were made to the policy. A further audit carried out in October 2015 identified some necessary changes to the policy and it will go to the Water Safety Group in February for approval

The Trust Water Safety Group (WSG) has been active during 2015/16 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, and Interserve, and the Trust's independent advisor will be attending future meetings. An audit was undertaken by the Water Hygiene Centre in October, which identified some areas of improvement. An action plan is being implemented to address these issues.

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 Routine water sampling results (Legionella)

The annual Legionella sampling commenced in July 2015, 168 separate outlets have been sampled to date. All positive samples are being managed in line with the Trust Water Safety policy, the table below lists the outlet which are being sample in line with the policy and in cases where the levels recorded have exceeded the 1000 cfu/l threshold a meeting has been called and an action plan agreed to mitigate any risks to patients and staff.

Table 10 Routine water sampling results (Legionella)

Description	Room No	Asset	Datix	At 12th Nov
ED Minors – GJ15	Room 5	WHB	89374	<20
ED Minors – GJ 17	Room 4	WHB	89374	<20
ED Minors – GJ 19	Room 1	WHB		<20
ED Paeds – GJ 21	Room 3	WHB	88592	<20
ED Paeds – GJ 23	Room 2	WHB		<20
ED Paeds – GJ 25	Room 1	WHB		<20
ED Paeds – GJ 27	3:1:72	WHB		<20
Energy Centre – GJ 48		Hot	88594	<20
Blood Bank	3:14:38	Hot	88703	<20
Lab Rest Room	3:14:24	Hot	88703	<20
Pathology A/Clave – GJ 68	3:14:19	Hot	88703	<20

Block 70 – GJ 101		Cold		<20
Hospice – GJ 124		Cold	89003	40
Hospice – GJ 125		WHB	89003	100
Level 3 Paeds – GJ 127		Cold	89108	<20
Level 2 Paeds – GJ 128	3:06:38	WHB	89108	<20
Telephone R/room – GJ 130	3:05:14	Hot	89109	560
Staff W/C – GJ 137	3:16:29	WHB	89110	<20
Rehab W/shop – GJ 147		WHB	89950	200
Cath Labs - GJ	4:0:10		89951	200
Winterslow	2:10:77		90229	420
Pembroke	2:10:28		88755	20
Amesbury	4:10:232		88757	1186

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 Routine water sampling results (Pseudomonas)
PPM 1 (six monthly) completed June 15. No significant counts were identified.

PPM 2 (six monthly) delayed.

Flushing
The flushing of all outlets across the hospital continues with compliance for the months August, September and October at 86%, 76% and 72% respectively.

Table 11 shows the ETS flushing schedule which continues. Areas in Bold are collection only of daily flushing sheet.

Table 11

Ward/Block	Ward/Block	Ward/Block
B5 Spinal x-rayB81	Pre Op Assessment	B65 Breamore.
B27 Rehab centre	B85 Glanville Centre	B69 Day Assessment Unit-Antenatal Clinic
B59 Diabetic Clinic	B91 O&G	**B77 N.I.C.U.**
B99 Spinal unit (lower floor) & Clarendon	B99 Spinal Unit(Ground Floor) **Avon**	B84 & B87 Day & Baby Nurserys.xls
B79 B4 Post Natal	2.2 Durrington & Farley	Block 15
B86 Hospice & palliative care	B93 Day Surgery Unit (ground floor)	Block 79
B93 Day Surgery Unit (first floor)	B5 Fertility Clinic	B62 G.U.M
B8 Dialysis Unit	B35 Clinical Psyche Orthotics	B78 B3 Wards
B67 + 68 Post Natal Unit	B76 B5 & Obstetrics	3.13 Physiotherapy

3.1 Emergency Department	3.3 Outpatients	4.12 Redlynch & Pitton
4.0 Cardiac Cath Lab	4.2 **Radnor** & Laverstock	3.02 Radiology
2.1 Nunton Unit	3.0 Fracture Clinic	4.1 Whiteparish & Tisbury
3.4 Eye Clinic	3.16 Respiratory Dept	3.6 Paed Children's Unit
4.4 Anaesthetics & Paeds	4.13 Downton & **Britford**	4.6 Paed Children's unit
3.14 Pathology & Genetics.	4.14 Pathology & Genetics.	Amesbury suite
3.15 Pathology & Genetics.	4.15 Pathology & Genetics.	Chilmark Suite
Main Theatres 4.3	Main Theatres 4.4	Endoscopy
Medical Photo	MRI	**Pembroke Suite**
Plastic and Oral Surgery	Speech Therapy	Winterslow suite
Burns unit	Dermatology	Maxillofacial Lab
Medical Records	P.O.P main corridor	**Pembroke Ward**
Plastic Treatment	Wessex Laser Centre	Benson Suite

11.3 Copper/Silver Ionisation Plant

No recorded issues. Regular maintenance continues on the Silver/Copper ionisation plant serving the Spinal and Central areas of the hospital supporting the overall management of Legionella.

11.4 Events

SFT is continuing to support PHE who are 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, until autumn 2015. 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 has been invited to attend the WSG meetings to discuss the results and outcomes of the Legionella testing project to date with the WSG members, but has been unable to attend recent meetings.

11.5 Independent advice

Interserve continues to provide independent technical support to the Trust with regard to water management. A training day was organised in January for all Responsible Persons and Deputies, which resulted in the attendees being awarded a City and Guilds standard certificate for the Control of Legionella in Water Systems. Interserve presented the findings of their Risk Assessment and Management Scheme Review on 7th April, and whilst it was noted that significant progress has been made, further work is required on:

i. Updating of the Water Safety Policy,
ii. Record keeping to be available in a central point
iii. Training updates are required for all staff as appropriate to their roles
iv. Procedure notes for the operation and maintenance of some specific plant are required.
v. Some areas required their water systems to be upgraded to current standards e.g. Avon/Wylye/Bourne Houses
vi. Dead legs and flexible hoses to be removed routinely when identified.

A supplementary audit was carried out by the Water Hygiene Centre in October, and the findings have been put into an action plan to resolve.

The contract with Interserve runs until November 2015, and we will work with Procurement to tender for this work to secure this advice for the next 3 years.

11.6 Drain Blockages

Drain blockages in 2014-15 were running at an average of 2 major blockages per day. The problem was due to a number of factors:

1. Disposal of inappropriate material down the drains
2. Lack of understanding of what should not be disposed of down the drains
3. Technical issues with the drainage systems, e.g. poor design
4. Inadequate sealing around showers and WCs

These issues have been addressed by a number of measures:

1. Producing printed matter to identify the correct way to dispose of waste items
2. Carrying out staff awareness sessions to explain what is able to be flushed away
3. Surveying the drains and modifying them as required to remove any restrictions
4. Ensuring that all holes where drains pass through floor slabs are fully sealed, and that all shower areas are fully sealed

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

Decontamination Lead continues to attend and brief, the Theatre Risk Group and the Endoscopy Clinical Group. The Trust Decontamination Group has quarterly meetings, with formal feedback to the IPCWG and IPCC.

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.

12.1 Ensure fully compliant decontamination practice - on going Trust-wide.

Tray Tracking -. The first stage of the implementation has experienced significant delays. IT has had issues with the upgrade and continued support for the wireless printers. Second stage is to roll this out in MTD and DSU linking with TMan system, this will enable tray tracking to Theatre locations and Patients. Third stage is to implement electronic tracking and tracing for flexible Endoscopes.

Instrumentation issues – Inventory audits have taken place to identify capital requirements.
Ophthalmic instruments have been identified as high risk and are being replaced as priority.

Holes in tray wraps are an ongoing issue, SDU and MTD working closely to provide a permanent solution. Main causes are storage and handling in user locations and transportation. To resolve the issues of holes in tray wraps, MTD and SDU are addressing two main areas.

- Capital bid has been accepted to replace theatre racking and SDU trolleys. This is has been brought forward and the installation of the racking is took place August 2015. The Trolleys are expected October 2015.
- A number of orthopaedic trays identified which would benefit from being containerised. Procurement is currently in the process of sourcing containers for orthopaedic sets.

New Urology Instrumentation has been ordered and the urgent instrumentation list from May 2015 has been compiled. Due to the large amount of devices required this is going out for tender.

Trust is reviewing new cystoscopes using single use sheaths as working channel. It is thought that 2-3 of these could replace the 18 currently in use and reduce cost and time of SDU processing.

Decontamination Audit plan –

Q1 Audits conducted in Spinal unit, Respiratory and Radiology. Action plans are in place and review Audits required

Q2 Audits conducted in ED, ICU and ENT OPD. Action plans are in place and review Audits required. A review audit was conducted of the Spinal unit, good progress had been made against actions from previous audit.

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 ENT OPD and lists in O&G.

12.3 Maintain a fully complaint SDU until at least 2017.
The SDU, here in Salisbury, continues to maintain its compliance and accreditation to the latest European Standards in Sterile Services. SDU has received its first surveillance audit from BSI. SDU successfully closed the 4 minor corrective actions from the previous audit; BSI identified 2 minor corrective actions. A full recertification Audit was conducted 20th October 2015. SDU successfully closed the 2 minor corrective actions from the previous audit; BSI identified 4 minor corrective actions. This resulted in the SDU being recertified for accreditation to ISO13485:2003, 9001:2008 and 93/42/EEC medical Device Directive until January 2019.

12.4 Look at marketing the Salisbury SDU services to increase the external customer base.

- The SDU continues with the Army, Royal Marines and the Navy contracts, this contract expired in May 2015, however, the MOD has a two year extension option within this contract. Procurement is starting talks with the MOD about further continuation.
- The Wiltshire Community Health contract for its South Wiltshire Podiatry Tray Service continues to progress but continues to be under review.
- SDU continues to expand its decontamination contract with an external independent health care provider BMI. This contract has been renewed for a further 12 months and is due to expire 1st September 2016.
- SDU is currently in talks to build new fully compliant purpose built unit on Trust site. This would be with a view to increase external custom and expand the service.

The Decontamination Committee continues to examine the following headings.

a) Decontamination Equipment within the Trust - Update
The Decontamination committee examines, and raises the profile of equipment around the Trust such as Bedpan Washers, Mortuary Washing Machine, EWDs, Cabinet Washer Disinfectors, and Autoclaves in SDU and Path Lab.

b) Data and Test Results from Decontamination Equipment used within the Trust.
Test results and PPM schedules for Trust decontamination equipment are discussed, and minutes recorded, within the Decontamination Meetings.

c) Choice Framework Documents, (CFPP)

The Decontamination Committee will also be making recommendations on other Choice Framework Documents 01 -01 “Management and Decontamination of Surgical Instruments used in acute care” and “Choice Framework for local Policy and Procedures 01-06: Reprocessing of flexible endoscopes: management and decontamination”.

The SDU is now audited to compliance with CfPP 01-01. The first Audit for this was June 2015. This was also the first audit for the new eQMS, as above this was a successful audit resulting in

two minor corrective actions, an improvement from the previous 4 from the last audit. Followed by a successful recertification audit in October 2015.

13. Cleaning Services *(information for this section has been provided by Michelle Sadler, General Manager Facilities)*

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.

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

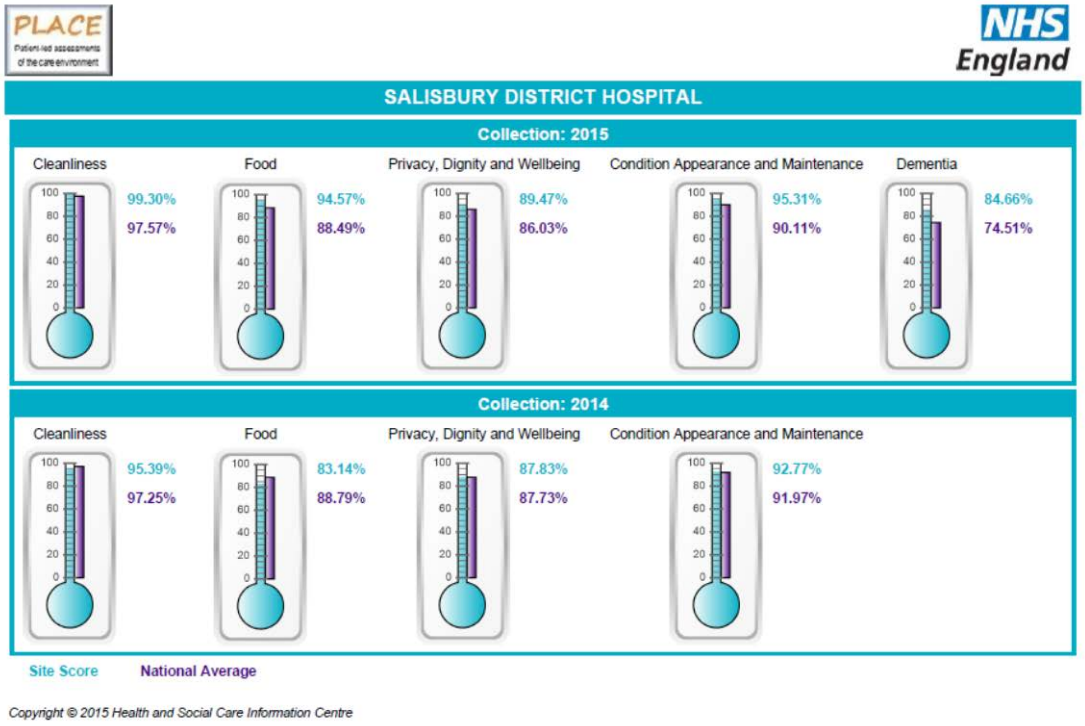
There is a plan to undertake 50 internal PLACE assessments between September 2015 and March 2016. To date, these assessments actively engage with and receive good support from Governors and Volunteers and our local Health watch representatives. An action plan is produced and progress reported and monitored 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 PLACE audits are also helping inform and drive the capital bids and decorating programmes. We continue to input the results within the PLACE LITE tool linked to The Health and Social Care Information Centre. Results will be reported annually using this tool at the MMG

13.2 National PLACE

The Trust participated in the National PLACE assessment on April 28th 2015. A total of 10 wards and ED were visited, 4 food assessments undertaken, 2 outpatient areas as well as external spaces and communal areas were also assessed as required under the PLACE criteria. The Results were published nationally in August 2015 showing improvements across all areas and above national average figures.

Below are the scores for both the 2014 PLACE and 2015 PLACE audit showing the Trust site score against the national average and the improvements made over the course of the year.

2014/2015 PLACE results



When PLACE audit findings demonstrate a shortfall in cleaning, corrective action is taken on the same day for very high risk areas and within 1 day for high risk areas.

Table 12 demonstrates the additional cleaning activity across the Trust.

Table 12

Area of Focus	KPI	Apr – 15	May – 15	Jun – 15	Jul - 15	Aug – 15	Sep – 15
Departmental Data	Post Infection cleans	373	417	416	366	385	457
	Enhanced cleaning hrs	109.75	50.75	34.50	10.25	26	31.75
Cleaning	Total audits	117	99	96	115	94	95
	Passes	52	38	46	46	37	34
	Qualified Passes	65	61	50	69	57	61
	Fails	0	0	0	0	0	0

13.3 Terminal enhanced and doubles cleaning

The table below illustrates the additional cleaning undertaken in clinical areas between April 2015 and September 2015.

Table 13 Terminal enhanced and doubles cleaning

Month/Year	2014/15	2014/15	2015/16	2015/16	2015/16
	Number of terminal cleans	Enhanced cleaning hours	Number of terminal cleans	Enhanced cleaning hours	Double cleans in hours
April	326	77.25	373	109.75	47
May	287	100.75	471	50.75	79
June	389	178.50	416	34.50	103.25
July	360	200.75	366	10.25	70.5
August	321	73.50	385	26	63.25
September	329	80.00	457	31.75	64.25
Year to date total	**2012**	**710.75**	**2468**	**263**	**427.25**

13.4 Deep clean programme/rapid response team

The Deep Clean/decorating programme started in April 2015 and is well under way (a Deep Clean program is attached). The demand on the GLOSAIR 400 room decontamination system remains high as tabled below.

Table 13 GLOSAIR 400 room decontamination

APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
28	16	31	28	26	50

13.5 Housekeeping resource

The Head of Facilities and Facilities General Manager are further developing a resource paper previously submitted to the Executive Directors. This paper reviews the current cleaning resources and funding available to meet the demands on the service and ensure national cleaning standards and infection control needs are met.

13.6 Improvement Work Projects

Housekeeping management team are leading on the opportunity of implementing bsi. Standard cleaning specification (PAS 5748:2014) across the trust and the potential outcome/impact to the service this may have.

Housekeeping General Manager is an active part of a Department of Health working group - Improve Cleaning Efficiency forming part of the Lord Carter Program.

14. Summary

This 6 monthly Report has provided the Trust Board with evidence of the measures in place that make a significant contribution to improving infection prevention and control practices across the Trust.

The Report has detailed the continuing progress against the Action Plan for 2015/16 in reducing HCAI rates for the Trust and the key priorities include:

- Continued focus on the reduction of all reportable Trust apportioned cases for C.difficile infection 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 2015/16

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

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

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

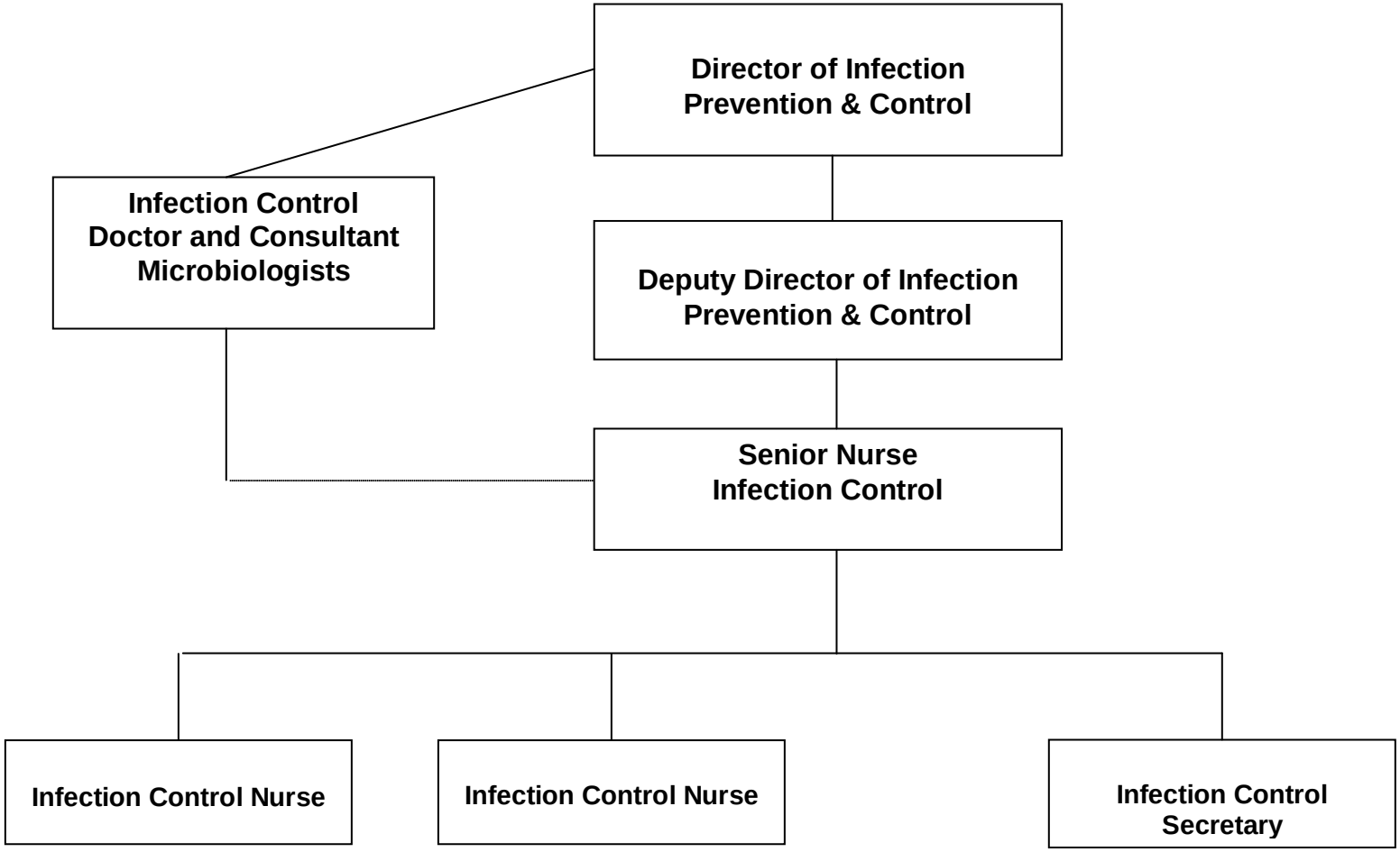
Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	In place
Isolation of patients	JH	In place
Safe handling and disposal of sharps	PK/GL	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	HL	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)	CM	In place
Disinfection policy	MS	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)	JD	In place
Infection control measures for ventilated patients	MF	In place
Tuberculosis	JH	In place
Legionellosis risk management policy and procedures, including pseudomonas	NE	In place
Strategic Cleaning Plan & Operational Policy	MS	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	NE	In place
Waste Management Policy	PJ	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	RW	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

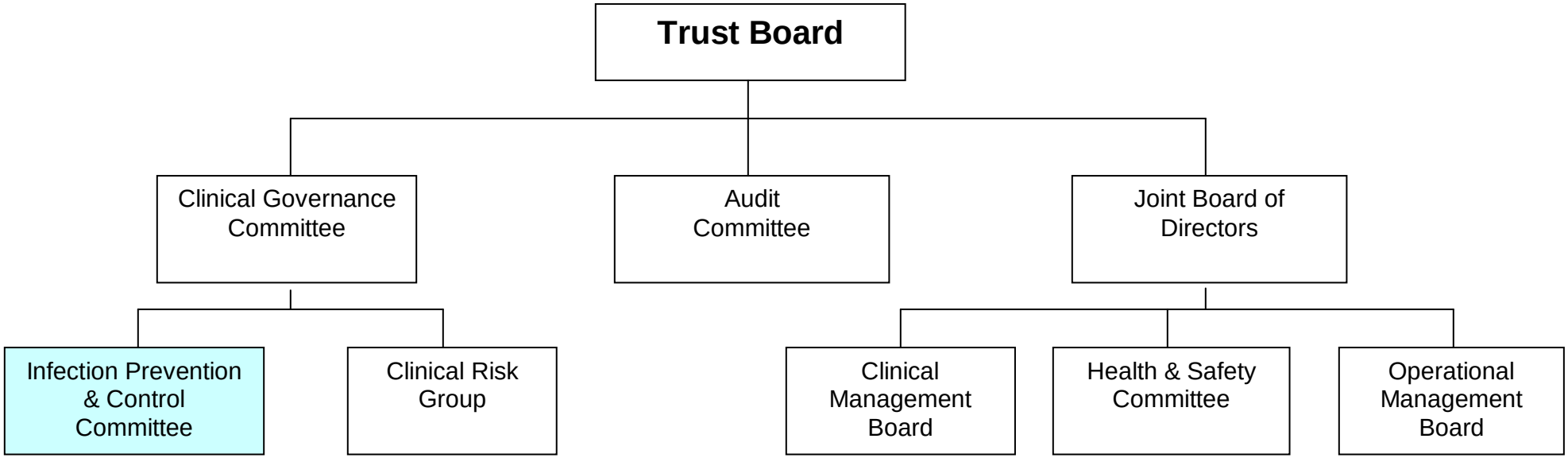
DIPC	Lorna Wilkinson, Director of Infection Prevention & Control
DDIPC	Karen Littlewood, Deputy DIPC (July 2015 onwards)
RW	Robert Warburton
JH	Julian Hemming, Consultant Microbiologist & Infection Control Doctor
SC	Stephen Cotterill, Consultant Microbiologist
PR	Paul Russell, Consultant Microbiologist
IR	Ian Robinson, Head of Facilities
NE	Neville Edwards
DSNs	Directorate Senior Nurses
CM	Colette Martindale, DSN for Clinical Support & Family Services
PK	Paul Knight, Health & Safety Manager, OH Department
GL	Geoff Lucas, Safety Advisor, OH Department
HL	Heidi Lewis, Manager OH Department
SH	Simon Howe, Antimicrobial Pharmacist
JD	Jacqui Dalley, Neonatal Unit Sister
MF	Maria Ford, Nurse Consultant in Critical Care
PJ	Paul Jackson, Energy and Waste Manager, Facilities
AK	Alison Kingscott, Director of Human Resources
MS	Michelle Sadler, Facilities Manager
ET	Emma Taylor, Principal Pharmacist

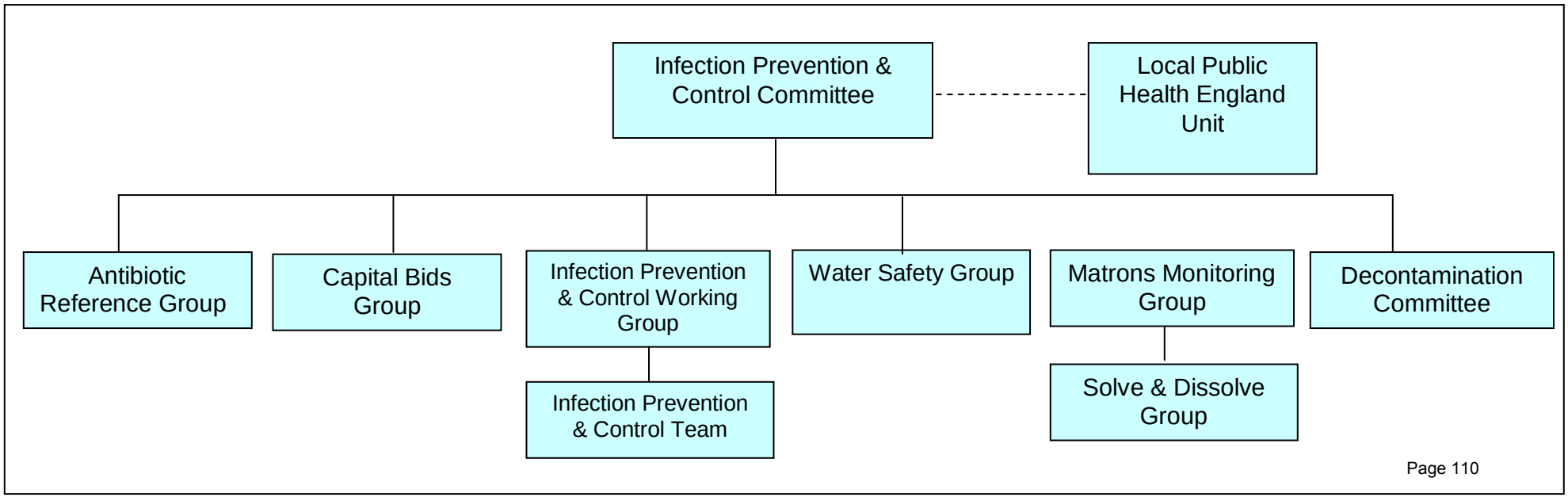
Infection Prevention & Control Team



Appendix 3

Trust Reporting Structure





Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Clinical Support & Family Services Quarter 1 (April to June 2015)

Clinical Support & Family Services	April					May					June				
	Nurses	**Drs**	**AHP**	**Other**	**TOTAL**	**Nurses**	**Drs**	**AHP**	**Other**	**TOTAL**	**Nurses**	**Drs**	**AHP**	**Other**	**TOTAL**
Sarum Ward	(8/8) 100%	(8/8) 100%	(1/2) 50%	____	**(17/18) 94.44%**	X	X	X	X	**X**	(8/8) 100%	(4/4) 100%	(4/4) 100%	____	**(16/16) 100%**
Children's Outpatients	(7/7) 100%	(6/7)* 85.71%	(3/3) 100%	(1/1)* 100%	**(17/18)* 94.44%**	(3/3)* 100%	(7/8) 87.5%	(8/8) 100%	____	**(18/19)* 94.74%**	(8/8) 100%	(8/8) 100%	(5/5) 100%	(3/3) 100%	**(24/24) 100%**
Beatrice Labour Ward (Including DAU)	(8/8) 100%	(6/7) 85.71%	(4/4) 100%	(1/1)* 100%	**(19/20)* 95%**	(22/23) 95.65%	(8/9) 88.88%	(0/1) 0%	(6/6) 100%	**(36/39) 92.31%**	(7/7)* 100%	(6/6)* 100%	(1/2) 50%	(5/5)* 100%	**(19/20)* 95%**
Beatrice Postnatal	(8/8) 100%	(8/8) 100%	*	(4/4) 100%	**(20/20) 100%**	(8/8) 100%	(8/8) 100%	(4/4) 100%	(3/4) 75%	**(23/24)* 95.83%**	(8/8) 100%	(8/8) 100%	____ *	(4/4) 100%	**(20/20)* 100%**
Neonatal Unit (NNU)	(16/16) 100%	(4/4) 100%	____	____	**(20/20) 100%**	(13/13) 100%	(5/5) 100%	____	(2/2) 100%	**(20/20) 100%**	(16/16) 100%	(4/4) 100%	____	____	**(20/20) 100%**
Gynae Clinic	(8/8) 100%	(4/4) 100%	____	(8/8) 100%	**(20/20) 100%**	(6/6) 100%	(8/8) 100%	(4/4) 100%	(2/2) 100%	**(20/20) 100%**	(8/8) 100%	(8/8) 100%	(4/4) 100%	____	**(20/20) 100%**
Sexual Health (GUM)	(8/8) 100%	(7/7) 100%	____	____	**(15/15) 100%**	(7/7) 100%	(6/6) 100%	____	____	**(13/13) 100%**	(12/12) 100%	(9/9) 100%	____	____	**(21/21) 100%**
Salisbury Fertility Clinic	(8/8) 100%	(4/4) 100%	(8/8) 100%	____	**(20/20) 100%**	(6/6) 100%	(8/8) 100%	(8/8) 100%	____	**(20/20) 100%**	(8/8) 100%	(8/8) 100%	(8/8) 100%	____	**(24/24) 100%**
Radiology	____	____	(17/18)* 94.44%	____	**(17/18) 94.44%**	(4/4) 100%	(2/2) 100%	(15/16) 93.75%	____	**(21/22) 95.45%**	(2/2) 100%	(19/19)* 100%	____	____	**(21/21)* 100%**
Endoscopy Unit	(8/8) 100%	(8/8) 100%	____	____	**(16/16) 100%**	(8/8) 100%	(8/8) 100%	____	(1/1) 100%	**(17/17) 100%**	(8/8) 100%	(8/8) 100%	____	(2/2) 100%	**(18/18) 100%**

X = depicts audit not completed by the clinical area
***** **=** A number of incomplete entries have been recorded for these areas and any incomplete entries are not included in the compliance score
Results in **blue** received after deadline
Number of observations are shown in brackets, e.g. 16/20 = correct hand hygiene behaviour was observed in 16 out of the 20 observations

KEY:	No return X	< 85%	86% - 100%

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Clinical Support & Family Services Quarter 2 (July – September 2015)

Clinical Support & Family Services	July					August					September				
	Nurses	Drs	AHP	Other	TOTAL	Nurses	Drs	AHP	Other	TOTAL	Nurses	Drs	AHP	Other	TOTAL
Sarum Ward	(8/8) 100%	(4/5) 80%	____	(1/1)* 100%	**(13/14)* 92.86%**	(8/8) 100%	(3/3)* 100%	____	(1/2) 50%	**(12/13)* 92.31%**	(15/16) 93.75%	(15/15)* 100%	(2/2) 100%	(2/2) 100%	**(34/35)* 97.14%**
Children's Outpatients Department	(6/6) 100%	(6/6) 100%	(11/11) 100%	(3/3) 100%	**(26/26) 100%**	(7/7) 100%	(7/7) 100%	(12/12) 100%	____	**(21/21) 100%**	(6/6) 100%	(5/5) 100%	(5/5) 100%	(3/3) 100%	**(19/19) 100%**
Beatrice Labour Ward (Including DAU)	(8/8) 100%	(6/7) 85.71%	(4/4)* 100%	(1/1)* 100%	**(19/20)* 95%**	(6/7)* 85.71%	(8/8) 100%	____	(2/3) 66.66%	**(16/18)* 88.88%**	(6/7)* 85.71%	(6/6) 100%	(3/3) 100%	(3/3) 100%	**(18/19)* 94.74%**
Beatrice Postnatal	(8/8) 100%	(7/8) 87.5%	____ *	(4/4) 100%	**(19/20)* 95%**	(8/8) 100%	(7/8) 87.5%	____	(4/4) 100%	**(19/20) 95%**	(11/13) 84.62%	(0/1) 0%	(0/1) 0%	(3/5) 60%	**(14/20) 70%**
Neonatal Unit (NNU)	(12/12) 100%	(4/4)* 100%	____	(3/3)* 100%	**(19/19)* 100%**	(12/12) 100%	(4/4) 100%	____	(4/4) 100%	**(20/20) 100%**	(12/12) 100%	(8/8) 100%	____	____	**(20/20) 100%**
Gynae Clinic	(8/8) 100%	____	(4/4) 100%	(8/8) 100%	**(20/20) 100%**	(8/8) 100%	(8/8) 100%	(2/2) 100%	(2/2) 100%	**(20/20) 100%**	(8/8) 100%	(8/8) 100%	(4/4) 100%	____	**(20/20) 100%**
Sexual Health (GUM)	(13/13) 100%	(7/7) 100%	____	____	**(20/20) 100%**	(7/7) 100%	(8/8) 100%	____	____	**(15/15) 100%**	(11/11) 100%	(9/9) 100%	____	____	**(20/20) 100%**
Salisbury Fertility Clinic	(8/8) 100%	(8/8) 100%	(8/8) 100%	____	**(24/24) 100%**	(8/8) 100%	(8/8) 100%	(8/8) 100%	____	**(24/24) 100%**	(8/8) 100%	(8/8) 100%	(8/8) 100%	____	**(24/24) 100%**
Radiology	X	X	X	X	**X**	____	____	(15/16) 93.75%	(3/3)* 100%	**(18/19)* 94.74%**	____	____	(14/18) 77.77%	(1/2) 50%	**(15/20) 75%**
Endoscopy Unit	(8/8) 100%	(8/8) 1005	____	____	**(16/16) 100%**	(8/8) 100%	(8/8) 100%	____	(2/2) 100%	**(18/18) 100%**	(8/8) 100%	(8/8) 100%	(2/2) 100%	____	**(18/18) 100%**

X = depicts audit not completed by the clinical area
***** **=** A number of incomplete entries have been recorded for these areas and any incomplete entries are not included in the compliance score
Results in **blue** received after deadline
Number of observations are shown in brackets, e.g. 16/20 = correct hand hygiene behaviour was observed in 16 out of the 20 observations

KEY:	No return X	< 85%	86% - 100%

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Medicine Quarter 1 (April – June 2015)

Medicine	April					May					June				
	Nurses	Drs	AHP	Other	TOTAL	Nurses	Drs	AHP	Other	TOTAL	Nurses	Drs	AHP	Other	TOTAL
Whiteparish AMU	(8/8) 100%	(5/6) 83.33%	(3/3) 100%	(3/3) 100%	**(19/20) 95%**	(8/8) 100%	(5/5) 100%	(1/1) 100%	(2/2) 100%	**(16/16) 100%**	(8/8) 100%	(4/4) 100%	(5/5) 100%	(3/3) 100%	**(20/20) 100%**
Tisbury CCU	(8/8) 100%	(3/3) 100%	(3/3) 100%	(2/2) 100%	**(16/16) 100%**	(7/7) 100%	(7/7) 100%	(2/2)* 100%	(2/2) 100%	**(18/18)* 100%**	(7/7) 100%	(3/3) 100%	(5/5) 100%	(5/5) 100%	**(20/20) 100%**
Pitton Ward	(8/8) 100%	(4/6) 66.67%	(4/4) 100%	(1/3) 33.33%	**(17/21) 80.95%**	(7/8) 87.5%	(3/7) 42.86%	(3/3) 100%	(0/2) 0%	**(13/20) 65%**	(7/7) 100%	(5/8) 62.5%	(1/3) 33.33%	(0/1) 0%	**(13/19) 68.42%**
Redlynch Ward	(8/8) 100%	(3/4) 75%	(6/6) 100%	(3/3) 100%	**(20/21) 95.2%**	(8/8) 100%	(5/5) 100%	(4/4) 100%	(3/4) 75%	**(20/21) 95.24%**	(9/10) 90%	(3/4) 75%	(4/4) 100%	(2/2) 100%	**(18/20) 90%**
Farley Ward	(7/7) 100%	(7/7) 100%	(3/3) * 100%	(2/2) 100%	**(19/19)* 100%**	(8/8) 100%	(4/5) 80%	(6/6) 100%	(2/2) 100%	**(20/21) 95.24%**	(7/8) 87.5%	(5/5) 100%	(5/5) 100%	(2/2) 100%	**(19/20) 95%**
Winterslow Suite	(8/8) 100%	(5/5) 100%	(4/4) 100%	(3/3) 100%	**(20/20) 100%**	(8/8) 100%	(5/5) 100%	(4/4) 100%	(2/2)* 100%	**(19/10)* 100%**	(7/8) 87.5%	(3/3) 100%	(5/6) 83.33%	(3/3) 100%	**(18/20) 90%**
Durrington Ward	(8/8) 100%	(4/4) 100%	(6/6) 100%	(2/2) 100%	**(20/20) 100%**	(8/8) 100%	(7/8) 87.5%	(8/8) 100%	*	**(23/24)* 95.83%**	(8/8) 100%	(6/6) 100%	(3/4) 75%	(2/2) 100%	**(19/20) 95%**
Pembroke Ward	(6/6) 100%	(5/5) 100%	(6/6) 100%	(5/5) 100%	**(22/22) 100%**	(8/8) 100%	(4/4) 100%	(5/5) 100%	(5/5) 100%	**(22/22) 100%**	(8/8) 100%	(3/3) 100%	(4/5) 80%	(2/4) 50%	**(17/20) 85%**
Pembroke Suite	(8/8) 100%	(4/4) 100%	____	____	**(12/12) 100%**	(8/8) 100%	(2/2) 100%	____	____	**(10/10) 100%**	(8/8) 100%	(2/2) 100%	____	____	**(10/10) 100%**
Hospice	(5/5) 100%	(4/4) 100%	(4/4) 100%	(2/2) 100%	**(15/15) 100%**	(5/5) 100%	(2/2) 100%	(3/3) 100%	(3/3) 100%	**(13/13) 100%**	(8/8) 100%	(2/2) 100%	____	(5/5) 100%	**(15/15) 100%**
Emergency Department	(6/8) 75%	(5/8) 62.5%	(6/8) 75%	(3/6)** 50%	**(20/30)** 66.67%**	(7/7) 100%	(4/5) 80%	(2/3) 66.66	(3/5) 60%	**(16/20) 80%**	(6/8) 75%	(6/6) 100%	(4/7) 57.14%	(2/5)** 40%	**(18/26)** 69.23%**
Cardiac Suite/Cath Lab	(8/8) 100%	(5/6) 83.33%	(5/5) 100%	(1/1) 100%	**(19/20) 95%**	(8/8) 100%	(6/6) 100%	(6/6) 100%	____	**(20/20) 100%**	(6/8) 75%	(6/6) 100%	(5/5) 100%	____	**(17/19) 89.47%**
Nunton Discharge Lounge	X	X	X	X	**X**	(8/8) 100%	(5/5) 100%	(3/3) 100%	(7/7) 100%	**(23/23) 100%**	(8/8) 100%	(5/5) 100%	(4/4) 100%	(4/4) 100%	**(21/21) 100%**
Escalation Area (Breamore Ward)	(8/8) 100%	(5/5) 100%	(2/2) 100%	(5/5) 100%	**(20/20) 100%**	(8/8) 100%	(7/7) 100%	(5/5) 100%	(1/1) 100%	**(21/21) 100%**	**CLOSED**				

X = depicts audit not completed by the clinical area

*** =** A number of incomplete entries have been recorded for these areas and any incomplete entries are not included in the compliance score

Results in **blue** received after deadline

Number of observations are shown in brackets, e.g. 16/20 = correct hand hygiene behaviour was observed in 16 out of the 20 observations

** = overall audit compliance for the Emergency Department has been lower due to the inclusion of Ambulance staff visiting the department. The low compliance scores for this individual staff group have been fedback to the relevant organisation by the Lead Nurse, with identified actions for improvement.

KEY:	No return X	<85%	86% - 100%

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Medicine Quarter 2 (July – September 2015)

Medicine	July					August					September				
	Nurses	**Drs**	**AHP**	**Other**	**TOTAL**	**Nurses**	**Drs**	**AHP**	**Other**	**TOTAL**	**Nurses**	**Drs**	**AHP**	**Other**	**TOTAL**
Whiteparish AMU	(7/8) 87.5%	(2/4) 50%	(1/3)* 33.33%	(1/2) 50%	**(11/17) 64.71%**	(6/7)* 85.71%	(3/5)* 60%	(3/3) 100%	(1/3) 33.33%	**(13/18)* 72.22%**	(8/8) 100%	(7/7) 100%	(4/4) 100%	(2/2) 100%	**(21/21) 100%**
Tisbury CCU	(11/13) 84.62%	(1/3) 33.33%	(1/2) 50%	(2/2) 100%	**(15/20) 75%**	(10/11) 90.91%	(5/7)* 71.43%	(1/1)* 100%	____	**(16/19)* 84.21%**	(8/8) 100%	(3/3) 100%	(5/5)* 100%	(2/3) 66.66%	**(18/19)* 94.74%**
Pitton Ward	(5/7)* 71.43%	(3/3) 100%	(5/5)* 100%	(0/1) 0%	**(13/16)* 81.25%**	(7/8) 87.5%	(4/5) 80%	(3/3) 100%	(4/4) 100%	**(18/20) 90%**	(6/8) 75%	(3/6) 50%	(3/3) 100%	(1/3) 33.33%	**(13/20) 65%**
Redlynch Ward	(6/8) 75%	(3/5) 60%	(1/3)* 33.33%	(1/3) 33.33%	**(11/19)* 57.89%**	(6/9) 66.67%	(1/2) 50%	(7/9) 77.78%	____	**(14/20) 70%**	(5/8) 62.5%	(3/5) 60%	(4/4) 100%	(2/2) 100%	**(14/19) 73.68%**
Farley Ward	(8/8) 100%	(4/5) 80%	(6/6) 100%	(2/2) 100%	**(20/21) 95.24%**	(7/8) 87.5%	(6/8) 75%	(5/8) 75%	(7/7)* 100%	**(26/31)* 83.87%**	(7/8) 87.5%	(5/6) 83.33%	(4/4) 100%	(2/4) 50%	**(18/22) 81.81%**
Winterslow Suite	(5/6)* 83.33%	(5/5) 100%	(2/2)* 100%	(2/2)* 100%	**(14/15)* 93.33%**	(7/7)* 100%	(4/6)* 66.67%	(8/8) 100%	(5/5)* 100%	**(24/26) 92.31%**	(7/8) 87.5%	(4/8) 50%	(5/5) 100%	(5/5) 100%	**(21/26) 80.76%**
Durrington Ward	(8/8) 100%	(1/1) 100%	(7/8) 87.5%	(2/3) 66.66%	**(18/20) 90%**	(7/8) 87.5%	(4/4) 100%	(5/5) 100%	(2/3) 66.67%	**(18/20) 90%**	(7/8) 87.5%	(5/6) 83.33%	(5/5) 100%	(2/2) 100%	**(19/21) 90.48%**
Pembroke Ward	(8/8) 100%	(6/6) 100%	(2/2) 100%	(4/4) 100%	**(20/20) 100%**	(7/7) 100%	(6/6) 100%	(1/1) 100%	(7/7) 100%	**(21/21) 100%**	(13/13) 100%	(7/7) 100%	(4/4) 100%	(5/6) 83.33%	**(29/30) 96.66%**
Pembroke Suite	(8/8) 100%	(3/3) 100%	____	____	**(11/11) 100%**	(8/8) 100%	(2/2) 100%	(4/4) 100%	(2/2) 100%	**(16/16) 100%**	(8/8) 100%	____	(2/2) 100%	____	**(10/10) 100%**
Hospice	(7/7)* 100%	(4/4) 100%	(4/4) 100%	(3/3) 100%	**(18/18)* 100%**	(8/8) 100%	(2/2) 100%	____	(3/3) 100%	**(13/13) 100%**	(6/6) 100%	(4/4) 100%	(2/2) 100%	(4/4) 100%	**(16/16) 100%**
Emergency Department	(6/6)* 100%	(4/5) 80%	(4/5) 80%	(2/3) 66.66%	**(16/19)* 84.21%**	(6/7) 85.71%	(3/6)* 50%	(1/2) 50%	(3/5)* 60%	**(13/20)* 65%**	(7/8) 87.5%	(3/4)* 75%	(2/3) 66.66%	(3/6) 50%	**(15/21)* 71.43%**
Cardiac Suite/Cath Lab	(8/8) 100%	(8/8) 100%	(2/2) 100%	(2/2) 100%	**(20/20) 100%**	(8/8) 100%	(6/6) 100%	(4/4)* 100%	(2/2) 100%	**(20/20)* 100%**	(8/8) 100%	(6/6) 100%	(4/4)* 100%	(1/1) 100%	**(19/19)* 100%**
Nunton Discharge Lounge	(8/8) 100%	(8/8) 100%	(5/5) 100%	(5/5) 100%	**(26/26) 100%**	(8/8) 100%	(6/6) 100%	(4/4) 100%	(5/5) 100%	**(23/23) 100%**	(8/8) 100%	(7/7) 100%	(3/3) 100%	(5/5) 100%	**(23/23) 100%**
Escalation Area (Breamore Ward)	CLOSED					CLOSED					CLOSED				

X = depicts audit not completed by the clinical area

*** =** A number of incomplete entries have been recorded for these areas and any incomplete entries are not included in the compliance score

Results in **blue** received after deadline

Number of observations are shown in brackets, e.g. 16/20 = correct hand hygiene behaviour was observed in 16 out of the 20 observations

KEY:	**No return X**	**< 85%**	**86% - 100%**

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Musculoskeletal Quarter 1 (April – June 2015)

Musculoskeletal	April					May					June				
	Nurses	Drs	AHP	Other	TOTAL	Nurses	Drs	AHP	Other	TOTAL	Nurses	Drs	AHP	Other	TOTAL
Amesbury Suite	(8/8) 100%	(7/7)* 100%	(8/8) 100%	(7/7)* 100%	**(30/30)* 100%**	(8/8) 100%	(7/7)* 100%	(8/8) 100%	(7/7)* 100%	**(30/30) 100%**	(8/8) 100%	(7/8) 87.5%	(8/8) 100%	(8/8) 100%	**(31/32) 96.88%**
Chilmark Suite	(8/8) 100%	(4/5) 80%	(5/5) 100%	(1/1)* 100%	**(18/19)* 94.74%**	(8/8) 100%	(3/5) 60%	(4/4) 100%	____	**(15/17) 88.24%**	(8/8) 100%	(3/3) 100%	(2/3) 66.66%	(3/3) 100%	**(16/17) 94.12%**
Laverstock Ward	(7/7) 100%	(6/7) 85.71%	(4/4) 100%	(1/2) 50%	**(18/20) 90%**	(18/20)* 90%	(17/21) 80.95%	(7/7) 100%	(5/11)* 45.45%	**(47/59)^ 79.66%**	X	X	X	X	**X**
Burns Unit	(7/8) 87.5%	(3/4) 75%	(5/5) 100%	(3/3) 100%	**(18/20) 90%**	(8/8) 100%	(5/6) 83.33%	(4/4) 100%	(1/2) 50%	**(18/20) 90%**	(6/6) 100%	(7/7) 100%	(5/5) 100%	(0/2) 0%	**(18/20) 90%**
Avon Ward	(8/8) 100%	(5/5) 100%	(5/6) 83.33%	(1/1) 100%	**(19/20) 95%**	(8/8) 100%	(4/4) 100%	(8/8) 100%	____	**(20/20) 100%**	X	X	X	X	**X**
Tamar Ward	(8/8) 100%	(0/2) 0%	(7/7) 100%	(2/3) 66.66%	**(17/20) 85%**	(8/8) 100%	(4/4) 100%	(4/4) 100%	(5/5) 100%	**(21/21) 100%**	(7/7) 100%	(7/7) 100%	(6/6) 100%	(6/6) 100%	**(26/26) 100%**
Spinal OPD (SPOD)	X	X	X	X	**X**	(3/4) 75%	(2/8) 25%	____	____	**(5/12) 41.66%**	(2/6) 33.33%	(2/7)* 28.57%	(1/6) 16.66%	____	**(5/19) 26.32%**
Orthopaedic OPD	(8/8) 100%	(6/8) 75%	(6/8) 75%	(5/8) 62.5%	**(25/32) 78.12%**	(8/8) 100%	(8/8) 100%	(7/8) 87.5%	(4/8) 50%	**(27/32) 84.38%**	(6/7)* 85.7%	(8/8) 100%	(8/8) 100%	(2/8) 25%	**(24/31)* 77.42%**
Plastic OPD	(13/14) 92.85%	(12/12)* 100%	____	____	**(25/26)* 96.15%**	(16/16) 100%	(11/12)* 91.66%	____	____	**(27/28)* 96.43%**	(10/12)* 83.33%	(9/10)* 90%	____	____	**(19/22) 86.36%**
Oral Surgery OPD	X	X	X	X	**X**	(10/10) 100%	(10/10) 100%	____	____	**(20/20) 100%**	(10/10) 100%	(10/10) 100%	____	____	**(20/20) 100%**
Rheumatology	X	X	X	X	**X**	X	X	X	X	**X**	(10/10) 100%	(10/10) 100%	____	____	**(20/20) 100%**
Wessex Laser Centre	(19/20) 95%	____	____	____	**(19/20) 95%**	(19/20) 95%	____	____	____	**(19/20) 95%**	(8/8) 100%	(8/8) 100%	(4/4) 100%	____	**(20/20) 100%**
Burns/Plastics Therapists	(6/6) 100%	(5/7) 71.43%	____	____	**(11/13) 84.62%**	(8/8) 100%	(4/4) 100%	(8/8) 100%	____	**(20/20) 100%**	(5/5) 100%	(8/8) 100%	(8/8) 100%	____	**(21/21) 100%**
Dermatology Department	(8/8) 100%	(7/7) 100%	____	____	**(15/15) 100%**	(8/8) 100%	(8/8) 100%	____	____	**(16/16) 100%**	(11/11) 100%	(8/8)* 100%	____	____	**(19/19)* 100%**

X = depicts audit not completed by the clinical area

*** =** A number of incomplete entries have been recorded for these areas and any incomplete entries are not included in the compliance score

Results in **blue** received after deadline

Number of observations are shown in brackets, e.g. 16/20 = correct hand hygiene behaviour was observed in 16 out of the 20 observations

^ = extra audits were undertaken by Laverstock Ward, following the identification of a positive C.difficile case in May 2015

KEY:	No return X	< 85%	86% - 100%

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Musculoskeletal Quarter 2 (July – September 2015)

Musculoskeletal	July					August					September				
	Nurses	Drs	AHP	Other	TOTAL	Nurses	Drs	AHP	Other	TOTAL	Nurses	Drs	AHP	Other	TOTAL
Amesbury Suite	(8/8) 100%	(7/7)* 100%	(8/8) 100%	(7/7)* 100%	**(30/30)* 100%**	X	X	X	X	**X**	(6/8) 75%	(8/8) 100%	(8/8) 100%	(8/8) 100%	**(30/32) 93.75%**
Chilmark Suite	(8/8) 100%	(5/5) 100%	(5/5) 100%	(1/2) 50%	**(19/20) 95%**	(8/8) 100%	(4/4) 100%	(4/4) 100%	(2/2) 100%	**(18/18) 100%**	(7/7) 100%	(5/5) 100%	(5/5) 100%	(1/2) 50%	**(18/19) 94.74%**
Laverstock Ward	(7/7)* 100%	(5/5)* 100%	(2/3)* 66.66%	(1/6) 16.66%	**(15/21)* 71.43%**	(7/7) 100%	(5/6) 83.33%	(6/6) 100%	(5/5)* 100%	**(23/24)* 95.83%**	(5/5)* 100%	(6/6) 100%	(5/5) 100%	(5/5) 100%	**(21/21)* 100%**
Burns Unit	(8/8) 100%	(6/6) 100%	(2/2) 100%	(4/4) 100%	**(20/20) 100%**	(5/6) 83.33%	(4/4) 100%	(7/7) 100%	(2/2)* 100%	**(18/19)* 94.74%**	(7/7) 100%	(7/7) 100%	(3/4) 75%	(1/3) 33.33%	**(18/21) 85.71%**
Avon Ward	(8/8) 100%	(3/3) 100%	(1/1) 100%	(8/8) 100%	**(20/20) 100%**	(8/8) 100%	(3/6) 50%	(5/5) 100%	(4/4) 100%	**(20/23) 86.96%**	(7/8) 87.5%	(4/5) 80%	(6/6) 100%	____	**(17/19) 89.47%**
Tamar Ward	(8/8) 100%	(3/3) 100%	(6/6) 100%	(3/3)* 100%	**(20/20)* 100%**	(5/6) 83.33%	(8/8) 100%	(4/4) 100%	(3/3) 100%	**(20/21) 95.24%**	(8/8) 100%	(7/8) 87.5%	(5/5) 100%	(3/4) 75%	**(23/25) 92%**
Spinal OPD (SPOD)	(7/7) 100%	(0/2) 0%	____	____	**(7/9) 77.77%**	(6/6) 100%	(0/5) 0%	(1/8) 12.5%	(0/1) 0%	**(7/20)^ 35%**	____	(2/3) 66.66%	____	____	**(2/3) 66.66%**
Orthopaedic OPD	(8/8) 100%	(8/8) 100%	(8/8) 100%	(8/8) 100%	**(32/32) 100%**	(8/8) 100%	(8/8) 100%	(8/8) 100%	(7/8) 87.5%	**(31/32) 96.88%**	(8/8) 100%	(8/8) 100%	(8/8) 100%	(8/8) 100%	**(32/32) 100%**
Plastic OPD	X	X	X	X	**X**	(13/13) 100%	(14/14)* 100%	____	____	**(27/27)* 100%**	(8/8) 100%	(6/6)* 100%	(5/5)* 100%	____	**(19/19)* 100%**
Oral Surgery OPD	(10/10) 100%	(10/10) 100%	____	____	**(20/20) 100%**	(10/10) 100%	(10/10) 100%	____	____	**(20/20) 100%**	(10/10) 100%	(10/10) 100%	____	____	**(20/20) 100%**
Rheumatology	(9/9)* 100%	(10/10) 100%	____	____	**(19/19)* 100%**	(9/9) 100%	(10/10) 100%	____	____	**(19/19) 100%**	X	X	X	X	**X**
Wessex Laser Centre	(8/8) 100%	(7/8) 87.5%	(4/4) 100%	____	**(19/20) 95%**	(8/8) 100%	(8/8) 100%	(4/4) 100%	____	**(20/20) 100%**	X	X	X	X	**X**
Burns/Plastics Therapists	X	X	X	X	**X**	X	X	X	X	**X**	X	X	X	X	**X**
Dermatology Department	(16/16) 100%	(8/8) 100%	____	____	**(24/24) 100%**	X	X	X	X	**X**	X	X	X	X	**X**
Wessex Rehab	Commenced auditing September 2015										____	(1/1) 100%	(18/19) 94.74%	____	**(19/20) 95%**

X = depicts audit not completed by the clinical area

*** =** A number of incomplete entries have been recorded for these areas and any incomplete entries are not included in the compliance score. Results in **blue** received after deadline

Number of observations are shown in brackets, e.g. 16/20 = correct hand hygiene behaviour was observed in 16 out of the 20 observations

^ = Audit undertaken for videourodynamics procedure in Spinal Xray (staffed by Spinal OPD staff). Actions being implemented by the Lead Nurse.

KEY:	No return X	Upto 85%	86% - 100%

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Surgery Quarter 1 (April – June 2015)

Surgery	April					May					June				
	Nurses	**Drs**	**AHP**	**Other**	**TOTAL**	**Nurses**	**Drs**	**AHP**	**Other**	**TOTAL**	**Nurses**	**Drs**	**AHP**	**Other**	**TOTAL**
Britford Ward	(8/8) 100%	(8/8) 100%	(3/3) 100%	*	**(19/19)* 100%**	(8/8) 100%	(12/15) 80%	____	(3/3) 100%	**(23/26) 88.46%**	(7/7) 100%	(7/8) 87.5%	(3/3)* 100%	____	**(17/18)* 94.44%**
Downton Ward	(8/8) 100%	(8/8) 100%	(3/4) 75%	____	**(19/20) 95%**	(8/8) 100%	(8/8) 100%	(6/6) 100%	*	**(22/22)* 100%**	(8/8) 100%	(8/8) 100%	(5/5)* 100%	(1/1) 100%	**(22/22)* 100%**
Radnor Ward (ITU)	(8/8) 100%	(6/8) 75%	(6/6) 100%	(4/4) 100%	**(24/26) 92.31%**	(8/8) 100%	(8/8) 100%	(2/2) 100%	(2/2) 100%	**(20/20) 100%**	(8/8) 100%	(8/8) 100%	(4/5) 80%	(3/3) 100%	**(23/24) 95.83%**
Vascular/Diabetes OPD	(8/8) 100%	(6/6) 100%	(8/8) 100%	____	**(22/22) 100%**	(13/13) 100%	____	(16/10) 100%	____	**(29/29) 100%**	(8/8) 100%	____	(8/8) 100%	(6/6) 100%	**(22/22) 100%**
Medical/Surgical OPD	(8/8) 100%	(8/8) 100%	(2/2) 100%	(2/2) 100%	**(20/20) 100%**	(8/8) 100%	(8/8) 100%	(2/2) 100%	(2/2) 100%	**(20/20) 100%**	(8/8) 100%	(8/8) 100%	(1/1) 100%	(2/2)* 100%	**(19/19)* 100%**
ENT Department	(12/12) 100%	(8/8) 100%	____	____	**(20/20) 100%**	(12/12) 100%	(11/11) 100%	____	(2/2) 100%	**(25/25) 100%**	(14/14) 100%	(8/8) 100%	____	____	**(22/22) 100%**
Ophthalmology Clinic	(8/8) 100%	(8/8) 100%	(8/8) 100%	____	**(24/24) 100%**	(8/8) 100%	(8/8) 100%	(8/8) 100%	____	**(24/24) 100%**	(8/8) 100%	(8/8) 100%	(8/8) 100%	____	**(24/24) 100%**
Main Theatres/Recovery	(8/8) 100%	(8/8) 100%	(2/2) 100%	(3/3) 100%	**(21/21) 100%**	(6/6) 100%	(7/8) 85.7%	____	(5/5) 100%	**(18/19) 94.74%**	(8/8) 100%	(8/8) 100%	____	(4/4) 100%	**(20/20) 100%**
Surgical Admissions Lounge (SAL)	(15/15) 100%	(6/6) 100%	____	____	**(21/21) 100%**	(16/16) 100%	(4/4) 100%	____	____	**(20/20) 100%**	(16/16) 100%	(4/4) 100%	____	____	**(20/20) 100%**
Day Surgery Unit (DSU)	(7/7)* 100%	(5/6) 83.33%	(2/2) 100%	(4/4) 100%	**(18/19) 94.74%**	(8/8) 100%	(3/5)* 60%	(2/3) 66.66%	(3/3) 100%	**(16/19) 84.21%**	(6/7)* 85.71%	(5/6) 83.33%	(4/5) 80%	(2/2)* 100%	**(17/20)* 85%**
Pre-operative Assessment (POAU)	(41/41) 100%	____	____	____	**(41/41) 100%**	(24/24) 100%	(4/4) 100%	____	(6/8) 75%	**(34/36) 94.44%**	(39/39)* 100%	(1/1)* 100%	____	____	**(40/40)* 100%**
Clarendon Suite	X	X	X	X	**X**	An incomplete audit for May was received and unable to be calculated				**X ***	X	X	X	X	**X**

X = depicts audit not completed by the clinical area
***** **=** A number of incomplete entries have been recorded for these areas and any incomplete entries are not included in the compliance score
Results in **blue** received after deadline
Number of observations are shown in brackets, e.g. 16/20 = correct hand hygiene behaviour was observed in 16 out of the 20 observations

KEY:	No return X	< 85%	86% - 100%

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Surgery Quarter 2 (July – September 2015)

Surgery	July					August					September				
	Nurses	Drs	AHP	Other	TOTAL	Nurses	Drs	AHP	Other	TOTAL	Nurses	Drs	AHP	Other	TOTAL
Britford Ward	(8/8) 100%	(5/7)* 71.43%	(4/4) 100%	____	**(17/19)* 89.47%**	(8/8) 100%	(7/8) 87.5%	(2/2) 100%	____	**(17/18) 94.44%**	(8/8) 100%	(2/8) 25%	____	(1/1) 100%	**(11/17) 64.71%**
Downton Ward	(8/8) 100%	(4/7) 57.14%	(4/4) 100%	(3/3) 100%	**(19/22) 86.36%**	X	X	X	X	**X**	X	X	X	X	**X**
Radnor Ward (ITU)	(3/3)* 100%	(7/7) 100%	(5/5) 100%	(4/4) 100%	**(19/19)* 100%**	(7/8) 87.5%	(6/6)* 100%	(5/5) 100%	(4/4) 100%	**(22/23)* 95.65%**	(16/16) 100%	(14/14) 100%	(6/6) 100%	(7/8)* 87.5%	**(43/44)* 97.72%**
Vascular/Diabetes OPD	(8/8) 100%	(6/6) 100%	(7/7)* 100%	____	**(21/21)* 100%**	(14/14) 100%	____	(13/13) 100%	(8/8) 100%	**(35/35) 100%^**	(8/8) 100%	(6/8) 75%	(8/8) 100%	(0/2) 0%	**(24/26) 92.31%**
Medical/Surgical OPD	(16/16) 100%	(14/16)* 87.5%	(12/12) 100%	(9/11) 81.81%	**(51/55)* 92.72%**	(16/16) 100%	(10/12) 83.33%	(3/3) 100%	(2/2) 100%	**(31/33) 93.94%^**	(8/8) 100%	(8/8) 100%	(3/3) 100%	(0/2) 0%	**(19/21) 90.48%**
ENT Department	(14/14) 100%	(8/8) 100%	____	____	**(22/22) 100%**	____*	(0/3) 0%	____	____	**(0/3)* 0%**	(6/8) 75%	(5/8) 62.5%	____	____	**(11/16) 68.75%**
Ophthalmology Clinic	(8/8) 100%	(8/8) 100%	(8/8) 100%	____	**(24/24) 100%**	X	X	X	X	**X**	(12/12) 100%	(2/2) 100%	(5/5)* 100%	____	**(19/19)* 100%**
Main Theatres/Recovery	(8/8) 100%	(6/6) 100%	(2/2) 100%	(4/4) 100%	**(20/20) 100%**	(8/8) 100%	(8/8) 83.33%	(4/4) 100%	____	**(20/20) 100%**	X	X	X	X	**X**
						(5/8) 62.5%	(0/3)* 0%	(0/1) 0%	(0/2) 0%	**(5/14)* 35.71%**	X	X	X	X	**X**
						(8/8) 100%	(2/4) 50%	____	(3/3) 100%	**(13/15) 86.60%**	X	X	X	X	**X**
Surgical Admissions Lounge (SAL)	(16/16) 100%	(4/4) 100%	____	____	**(20/20) 100%**	(16/16) 100%	(4/4) 100%	____	____	**(20/20) 100%**	X	X	X	X	**X**
Day Surgery Unit (DSU)	(7/7)* 100%	(4/6) 66.66%	(2/2) 100%	(3/3)* 100%	**(16/18)* 88.88%**	(7/8) 87.5%	(6/8) 75%	(0/2) 0%	(2/2) 100%	**(15/20) 75%**	(16/16) 100%	(7/11) 63.63%	(4/5) 80%	(1/2) 50%	**(28/34) 82.35%**
Pre-operative Assessment (POAU)	(24/24) 100%	____	____	____	**(24/24) 100%**	(22/23)* 95.65%	(7/8) 87.5%	____	(2/4) 50%	**(31/35)* 88.57%**	(7/14)* 50%	(5/7)* 71.43%	____	(1/3)* 33.33%	**(13/24)* 54.17%**
Clarendon Suite	(8/8) 100%	(6/6) 100%	____	(1/2)* 50%	**(15/16)* 93.75%**	X	X	X	X	**X**	(5/5) 100%	(3/3) 100%	(1/1) 100%	____	**(9/9) 100%**

X = depicts audit not completed by the clinical area

***** **=** A number of incomplete entries have been recorded for these areas and any incomplete entries are not included in the compliance score

Results in **blue** received after deadline

Number of observations are shown in brackets, e.g. 16/20 = correct hand hygiene behaviour was observed in 16 out of the 20 observations

^ = 2 audits were completed for this areas.

KEY:	No return X	< 85%	86% - 100%

Appendix 5

Report accessed from the Managed Learning Environment, and outlines the directorate compliance rates for the Hand Hygiene Assessments completed for Quarter 1 of 2015/16 (data accessed 16th July 2015)

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Hand Hygiene Assessment 122014	Balance Sheet (Direct)	10	41	51	20%
	Capital (Directorate)	4	3	7	57%
	Clinical Support & Family Services (Direct)	514	348	862	60%
	Corporate Directorate (Direct)	289	151	440	66%
	Facilities Directorate (Direct)	282	92	374	75%
	Finance - Charitable Funds (Direct)	1	3	4	25%
	Medical Directorate (Direct)	1	4	5	20%
	Medicine Directorate (Direct)	346	324	670	52%
	Musculo-Skeletal (Direct)	304	184	488	62%
	Nursing Directorate (Direct)	0	2	2	%
	Odstock Medical (Direct)	4	15	19	21%
	Quality Directorate (Direct)	176	308	484	36%
	Replica 3DM (Direct)	0	2	2	%
	Surgery (Direct)	336	326	662	51%
	SW Hub (Direct)	0	5	5	%
	Top (Direct)	0	1	1	%
		10	89	99	10%
Hand Hygiene Assessment 122014		**2277**	**1898**	**4175**	55%

Appendix 5

Report accessed from the Managed Learning Environment, and outlines the directorate compliance rates for the Hand Hygiene Assessments completed for Quarter 2 of 2015/16 (data accessed 1st October 2015)

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Hand Hygiene Assessment 122014	Balance Sheet (Direct)	10	44	54	19%
	Capital (Directorate)	10		10	100%
	Clinical Support & Family Services (Direct)	517	370	887	58%
	Corporate Directorate (Direct)	322	107	429	75%
	Facilities Directorate (Direct)	267	106	373	72%
	Finance - Charitable Funds (Direct)	2	3	5	40%
	Medical Directorate (Direct)	5	1	6	83%
	Medicine Directorate (Direct)	309	344	653	47%
	Musculo-Skeletal (Direct)	260	229	489	53%
	Nursing Directorate (Direct)	0	3	3	%
	Odstock Medical (Direct)	7	12	19	37%
	Quality Directorate (Direct)	184	314	498	37%
	Replica 3DM (Direct)	0	2	2	%
	Surgery (Direct)	323	354	677	48%
	SW Hub (Direct)	0	5	5	%
	Top (Direct)	1	1	2	50%
		9	89	98	9%
Hand Hygiene Assessment 122014		**2226**	**1984**	**4210**	53%

Appendix 6

Infection Prevention & Control Annual Audit & Policy Review Programme 2015/16

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

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 IPCT.
5	Prudent use of antibiotics.	Antibiotic prescribing & usage.	Action Plan agreed & monitored by the Antibiotic Reference Group (ARG).	Chief Pharmacist & Antimicrobial Pharmacist.
6	Management & organisation – • Policy, guideline & information development & review programme (review dates according to ICID or SDH intranet site).	Pt information leaflet - Acinetobacter.	Review January 2018.	ICNs.
		Microbiology Alerts Policy.	Under review 2015.	Stephen Cotterill.
		Aseptic technique.	Under review 2015.	ICNs.
		Central Line	Under Review 2015.	Sarah Clark.
		Clostridium difficile Policy.	Review May 2017.	ICD.
		Pt information leaflet - C.difficile.	Review February 2017.	ICNs.
		Contractors/Procurement information leaflet – infection prevention in hospital.	Review June 2018.	ICNs.
		Creutzfeldt Jacob Disease (CJD) Policy.	Review February 2016.	Decontamination Lead & ICD.
		Decontamination Policy.	Review July 2018.	Decontamination Lead.
		Pt information leaflet - ESBL.	Review May 2017.	ICNs.
		Glove Usage Policy & Chart.	Under Review 2015.	ICNs.
		Pt information leaflet - Group A Strep (GAS).	Under Review 2015.	ICNs.
		Staff information leaflet - Hand Hygiene.	Review January 2018.	ICNs.
		Infection Control Policy.	Review May 2016.	ICNs.
		Infection Prevention & Control Practice in the Operating Department.	Review September 2017.	Lucinda Pluck.
		Inpatients with diarrhoea algorithm.	Review September 2017.	ICNs.
		Isolation Policy (including diarrhoeal infections & other alert organisms).	Review June 2017.	ICD.
		Hand Hygiene Policy.	Review March 2016.	ICNs.
		Pt information leaflet - Invasive GAS Disease.	Under Review 2015.	ICNs.

No	Aim	Audit	When by/How	Person(s) responsible/main author
6	Continued	Linen Management Policy.	Under Review 2015.	ICNs.
		Legionellosis Management & Water Safety Policy.	Under Review 2015.	Neville Edwards.
		Clinical Management of MRSA Policy.	Review February 2016.	ICD.
		Pt information leaflet - MRSA.	Review January 2018.	ICNs.
		Pt information leaflet - MRSA Contact Bay.	Review August 2016.	ICNs.
		Pt information leaflet - MRSA Screening.	Review July 2018.	ICNs.
		Outbreak Management Policy.	Review May 2016.	IPCT.
		Outbreak Management of Norovirus Policy.	Review May 2016	IPCT.
		Pt information leaflet – Norovirus.	Review March 2016.	ICNs.
		Pt information leaflet – 'Now that I am in Isolation – some practical advice'.	Review October 2016.	ICNs.
		Prevention of Occupational Exposure to Blood Borne Virus Policy.	Review October 2016.	ICNs.
		Prevention of Spread of Carbapenem Resistant Organisms Policy.	Under Review 2015.	ICD.
		Pt information leaflets – CPE C3 – Colonised. C4 – Carrier. C5 – Contact.	Review August 2017.	ICNs.
		Peripheral Venous Cannulation Policy.	Under Review 2015.	ICNs.
		Pt information leaflet – Having a 'drip' (peripheral venous cannula)	Review March 2016.	ICNs.
		Standard Precautions Policy.	Under Review 2015.	ICNs.
		Surveillance Policy.	Review March 2016.	ICNs.
		Taking Blood Cultures Policy – Adults.	Review July 2017.	ICNs.
		Tuberculosis Infection Control Policy.	Review December 2017.	ICD.
		Ebola and other Viral Haemorrhagic Fevers Policy.	Review August 2017.	ICD
		Management of VRE Policy.	Under development 2015.	ICD.
		Pt information leaflet – new leaflet for VRE devised.	Awaiting final approval.	ICNs.

Appendix 7

Report accessed from the Managed Learning Environment, and outlines the directorate compliance rates for the Infection Control CBL Package for Quarter 1 of 2015/16 (data accessed 16th July 2015)

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Infection Control 122014	Balance Sheet (Direct)	30	21	51	59%
	Capital (Directorate)	7		7	100%
	Clinical Support & Family Services (Direct)	714	148	862	83%
	Corporate Directorate (Direct)	369	71	440	84%
	Facilities Directorate (Direct)	344	30	374	92%
	Finance - Charitable Funds (Direct)	2	2	4	50%
	Medical Directorate (Direct)	4	1	5	80%
	Medicine Directorate (Direct)	531	139	670	79%
	Musculo-Skeletal (Direct)	410	78	488	84%
	Nursing Directorate (Direct)	0	2	2	%
	Odstock Medical (Direct)	15	4	19	79%
	Quality Directorate (Direct)	389	95	484	80%
	Replica 3DM (Direct)	1	1	2	50%
	Surgery (Direct)	560	102	662	85%
	SW Hub (Direct)	0	5	5	%
	Top (Direct)	0	1	1	%
		9	90	99	9%
Infection Control 122014		**3385**	**790**	**4175**	81%

Appendix 7

Report accessed from the Managed Learning Environment, and outlines the directorate compliance rates for the Infection Control CBL Package for Quarter 2 of 2015/16 (data accessed 1st October 2015)

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
	Balance Sheet (Direct)	31	23	54	57%
Infection Control 122014	Capital (Directorate)	9	1	10	90%
	Clinical Support & Family Services (Direct)	724	163	887	82%
	Corporate Directorate (Direct)	340	89	429	79%
	Facilities Directorate (Direct)	334	39	373	90%
	Finance - Charitable Funds (Direct)	3	2	5	60%
	Medical Directorate (Direct)	5	1	6	83%
	Medicine Directorate (Direct)	520	133	653	80%
	Musculo-Skeletal (Direct)	400	89	489	82%
	Nursing Directorate (Direct)	0	3	3	%
	Odstock Medical (Direct)	14	5	19	74%
	Quality Directorate (Direct)	407	91	498	82%
	Replica 3DM (Direct)	1	1	2	50%
	Surgery (Direct)	575	102	677	85%
	SW Hub (Direct)	0	5	5	%
	Top (Direct)	1	1	2	50%
		8	90	98	8%
		3372	**838**	**4210**	80%

Appendix 8

Topics covered at the ICLP monthly meetings during quarters 1 and 2 of 2015/16 have included the following:

- C.difficile (discussed at each meeting during the quarter):
    - Notification of the number of inpatient Trust apportioned cases identified during each month with confirmation of the Trust target of no more than 19 Trust apportioned reportable C.difficile cases for 2015/16.
    - Reporting that for 2014/15, for the total of 23 Trust apportioned reportable C.difficile cases that were identified, 5 cases had been selected for submission to the Appeals Panel for the relevant Clinical Commissioning Group (CCG). Of these, explanation that 2 cases were successful and therefore the final count was 21 Trust apportioned reportable C.difficile cases for 2014/15.
    - Definitions for Trust and non Trust apportioned inpatient C.difficile cases were clarified, in addition to covering the required isolation precautions.
- Notification that the target of zero had been set for Trust apportioned MRSA bacteraemia cases during 2015/16. Notification of the 2 non Trust apportioned MRSA bacteraemia cases identified during August 2015, and explanation of the Post Infection Review process undertaken by the relevant CCG, with participation by the Trust.
- Explanation that MSSA and E.coli bacteraemia cases identified will continue to be reported to PHE in line with national mandatory reporting requirements, with no targets having been set.
- The management of patients with suspected infective or confirmed infective diarrhoea, either when admitted with symptoms or developing symptoms during admission. This included discussion:
    - To follow the Trust algorithm for the management of inpatients with diarrhoea, with the emphasis that patients must be isolated in a sideroom facility, with ensuite bathroom or designated commode when an infective cause for symptoms is suspected.
    - Required isolation signage and documentation, a stool chart and Isolation Risk Assessment Tool.
    - The wearing of Personal Protective Equipment (PPE) disposable plastic apron and gloves, with hands to be washed with soap and water on removal of PPE for all care episodes.
    - Where patients have been moved to a sideroom from a bay, required actions to terminal clean the bedspace and any bathroom used by the patient.
    - Explanation that the Diarrhoea Pathway had been implemented across all clinical inpatient areas, to reinforce the decision making process for the assessment of patients with symptoms of diarrhoea, and requires completion by nursing staff and clinicians.
- Reinforcing the actions to be completed when a C.difficile positive result is identified for a patient being nursed in a bay:
    - The immediate isolation of the patient in a sideroom facility on the ward (if not already taken place). Closing the bay and commencing isolation precautions, with terminal cleaning of the bedspace and any bathroom used by the positive patient.
    - Informing the clinicians of the result, to enable a patient review to determine whether treatment is indicated, and that any prescribed treatment to commence without delay.
    - Ensuring that the patient has been informed of the result and is provided with the C.difficile information leaflet, with a record of this discussion made in the patient's healthcare records.
    - Confirmation that the bay must remain closed until the required deep cleaning and GLOSAIR disinfection of the bay can be undertaken.
    - Discussion of the bay management if any of the patients develop symptoms of diarrhoea, where the bay stays closed under isolation precautions, until resolution of

symptoms with clinician reviews where appropriate. Deep cleaning and GLOSAIR disinfection of the bay to be completed before the bay can reopen.
    - High Impact Interventions (HII) C.difficile audits to be completed on every shift for the C.difficile positive patient.
- Ongoing management of current C.difficile positive patients, and the management of patients known to be previously C.difficile when admitted to the Trust.
- Introduction of the diarrhoea care pathway, including the development and initial trial on a medical ward leading to roll out across the medical directorate. Explanation that the pathway aims to reinforce the decision making process for the assessment of patients with symptoms of diarrhoea, and requires completion by nursing staff and clinicians.
- Use of Actichlor (Chlorine based disinfectant) and decontamination processes. Updated information for the safe use of Actichlor explained, and highlighted action required by the ICLPs to ensure eye protection/safety goggles available in the dirty utility/decontamination rooms. Correct decontamination of equipment, specifically mattress and clinical trolleys, discussed and reinforced the safe use of Actichlor solution.
- Presentation of the formal report from reaudit of the Bare Below the Elbow and Uniform Workwear policy.
- Use of the microbiology alerts on the inpatient management system (iPMs), what they are and how staff can access this information to guide risk assessment and appropriate patient management.
- Notification of the Trust participation in the skin care intervention in nursing (SCIN) trial, a research project lead by Guys and St Thomas' NHS Foundation Trust to undertake a study of nurses at high risk of developing dermatitis.
- Updates regarding the level of diarrhoea and vomiting activity, the number of patients admitted with symptoms or developing symptoms during their admission process, and resulting bay closures.
- Water Safety Management – Attendance by Terry Cropp (Estates Technical Services - ETS) to discuss water safety and in particular Legionella:
    - Flushing of clinical and non-clinical areas.
    - Communication process for any raised counts identified and required actions.
    - Trust Legionellosis and Water Safety Risk Management Policy.
    - Agenda item at Matrons Monitoring Group (MMG) as part of ETS reporting.
- Universal sanitising wipes update – Attendance by the Gamma Healthcare Representative to provide an educational update on correct uses of the wipes.
- Level 3 face mask fit testing – Reminder issued of the requirement for clinical staff to be fit tested by the identified trainers across each of the clinical directorates.
- Induction for new starters – Explanation that the Infection Prevention and Control induction forms had been revised to include separate forms for clinical and non clinical staff members. Implementation by the ICLPs requested to include existing staff members in addition to new starters.
- MLE update for infection control CBL – Awaiting a nationally set package with plan that staff will need to undertake an annual refresher.
- Hand hygiene assessment recording issues ongoing.
- UVLB training – Agenda item at meeting. MLE compliance rates for directorates and emphasised role of ICLPs with this training.
- Care Quality Commission (CQC) – Covered at the meetings in August and September 2015, with initial discussion of the dates notified to the Trust for the planned inspection. Presentation and more detailed discussion for CQC inspection preparation work covering :
    - Priorities – Trust, strategy and quality
    - How safe is our service
    - Evidence – Areas for potential observations and questioning of staff during the visit and examples for ICLPs and Line Managers to consider in preparation.
- Highlighting the Trust Pride in Practice Nursing, Midwifery and Allied Health Professionals Strategy 2015 to 2018.

- MRSA Screening – Reminder for the taking of a full MRSA screen and the required sites for screening. Included reinforcing the Trust Clinical Management of MRSA Policy.
- Updates regarding the level of diarrhoea and vomiting activity, the number of patients admitted with symptoms or developing symptoms during their admission process, and resulting bays and ward closure. This also included increased levels reported in the local community.
- Hand hygiene audits – continued education and support made available to the ICLPs with the audit process. Further discussion prompted by ICLP feedback and clarification of reporting process for monthly results and dissemination via clinical leaders and Matrons Monitoring Group.
- Reminder for the ICLPs to undertake refresher training with the ICNs, to enable continued use of the UV light box to undertake hand hygiene assessments in their areas/departments.
- Responding and advising on specific clinical related issues, in addition to the various concerns identified by the ICLPs.
- Reminders for the different 'drop-in' education sessions facilitated by the ICNs.

Appendix 9

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 2015/16, the ICNs have not been informed of any cases of multi drug resistant Acinetobacter for inpatients.

- **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.

Please refer to page 5 of main report.

- **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 2015/16, the ICNs have not been informed of any cases of chickenpox for inpatients.

- **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.

There were no declared outbreaks of E.coli during quarters 1 and 2 of 2015/16.

- **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.

There were no declared outbreaks of pertussis during quarters 1 and 2 of 2015/16.

- **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 2015/16.

- **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 2015/16.

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 2015/16.

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.

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 24th September 2015, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair), Christine Blanshard, Claire Gorzanski, Hazel Hardyman, Peter Hill, Jan Sanders, Karen Littlewood.

Lydia Brown welcomed Ian Downie to the Committee although he was unable to attend today. Thanks were given to Paul Kemp who will no longer be part of this committee as he will be attending other committees in the future.

In attendance:

	Item
Kate Williams	Minute taker
Stuart Verdin, Jo Baden-Fuller, Fran Williamson	CGC0908
Katrina Glaister	CGC0909
Sue Dowding	CGC0911
Fenella Hill	CGC0923
Emma Taylor	CGC0924

CGC0901 Apologies:

Andy Hyett, Lorna Wilkinson, Sarah Mullally, Hollie Foreman, Sally Tomlin, Steve Long.

CGC0902 – Minutes of the meeting held on 23rd July 2015

All suggested amendments were considered and approved after which the minutes of the last meeting were agreed as an accurate record.

CGC003 – Action Tracker

No comments.

CGC0904 – Matters arising – Raising concerns Policy Update – Christine Blanshard, Claire Gorzanski

Raising Concerns Survey 2015

Overall, there was a higher response rate than the survey in 2014. Over half of the respondents were front-line staff. More staff knew about the policy and who to talk to about any type of concern that affected patients, visitors or staff. In the majority of cases this was the line manager.

There were more staff who had no concerns to raise and less staff who felt they needed to raise a concern and did so. However, there remained a small number of people who felt unable to raise concerns, even though they had them because they believed that nothing would be done, fear of victimisation, not wanting to cause trouble or past experience of raising a concern.

More staff were satisfied with the way their concern was dealt with. The main issue for staff who were dissatisfied with the way their concern was dealt with was because they felt they had not been listened to or taken seriously.

Additional support staff would like to have in place to help them raise concerns:
1) An anonymous telephone helpline to leave a message
2) A nominated person to provide support and
3) Training to raise awareness of the policy, the conduct of investigations and giving feedback.

Actions from the survey and actions from the Freedom to Speak Up report are combined below:

CGz reported that the results of this survey were encouraging and better than the last one.

Freedom to Speak Up report

The Freedom to Speak up review was established in response to continuing disquiet about the way NHS organisations deal with concerns raised by NHS staff and the treatment of some of those who have spoken up. This was first highlighted in the report into the failings at The Mid Staffordshire NHS Foundation Trust Public Inquiry.

The review is a detailed description of the views of staff, employers, unions and national bodies. It also includes the outcomes of research and international comparisons that were undertaken. The report details good practice and also reveals some shocking treatment of staff. To address this, the report covers how organisations can create the right culture, how concerns should be handled and what is needed to make improvements to ensure that NHS staff feel safe to raise concerns, that they will be listened to and their concerns will be acted upon. To do this we must have the right culture in the Trust.

Of the 22 principles and actions for acute Trusts, SFT are compliant with 15 recommendations, partially compliant with 6 recommendations and non compliant with 1 recommendation.

Key actions for the Trust are:

1. Appoint a Freedom to Speak Up Guardian – Chief Executive
2. Nominate a non-executive director to receive reports and report to the Board – Chief Executive
3. Decide on who the nominated manager in each department should be to receive reports of concerns – Nominate Executive Director.
4. Update the Raising Concerns policy – Head of Clinical Effectiveness by 30/9/15.
5. Update the Bullying and Harassment policy in respect of improving dignity at work through support workers – Deputy Director of Human Resources by 31/3/16.
6. Develop, train and publicise the Dignity at Work Ambassadors - Deputy Director of Human Resources by Resources by 31/3/16.
7. Establish and provide a support system for nurse revalidation – Director of Nursing and Directorate Senior Nurse for MSK by 31/3/16.
8. Review the joint curriculum for training staff in raising concerns when published by NHSE and HEE - Head of Clinical Effectiveness, Deputy Director of Human Resources, Head of Learning.
9. Consider using ‘Speaking in Confidence’ survey to supplement the staff survey to understand key themes - Deputy Director of Human Resources by 31/12/15.
10. Review actions required when NHSE have published guidance on support current and former employees finding alternative employment - Deputy Director of Human Resources.
11. To include a section on raising concerns in the Quality Account 15/16 describing the number of reports and outcomes – Head of Clinical Effectiveness by 30/4/16
12. To publish the second Whistleblowing survey report. Head of Clinical Effectiveness by 30/9/15.

CGz reported that a key item for this organisation will be the appointment of an independent ‘Freedom to Speak Up’ Guardian. This person will report directly to the Chief Executive and to an independent officer at the CQC. The position will be supported by Dignity at Work ambassadors who will be highly visible and someone that staff can approach to talk to them. The ambassador will be able to listen, signpost and report. All will receive training to enable reporting to be made to them.

LB asked if we were currently appointing a Guardian to which PH responded that yes, this was being done and it was essential we had the right person in this role.

AC commented that currently, if an incident report is made, no response is received and it is more likely that a response will be forthcoming to an email. CB added that it is well recognised that it is positive to give feedback that action has been taken. KL suggested that it would be a good idea to empower ward staff to give feedback and in that way we are collectively dealing with any issues.

CGC0905 – Matters arising –Learning Disabilities report and work plan 15/16 – Karen Littlewood

KL reported that the Action Plan has been refreshed. We are also going to refresh membership of the Learning Disabilities group to include Sandy Woodbridge and Jo Jones. We need to tie things together and ensure that different departments join up effectively.

Gill Cobham introduced a 'flagging system' on PIMS to ensure patients with a learning disability were recognised and records could be audited. We have good outcomes. The hospital passport is being used in 50% of cases. There is evidence that staff had gone above and beyond their duties in order to help patients. However, there does not appear to be a lot of guidance for staff in this area.

We plan to re-launch the hospital passport with a workshop scheduled in January. We aim to nominate some champions. We have some fantastic support from organisations such as MENCAP and SWAN but we need to make sure that we are all working to the same agendas.

PH commented that there is a real need for this and he is delighted that it is being rejuvenated.

CGC0906 – Matters arising – Nursing revalidation (verbal update) – Karen Littlewood

KL reported that this is all on track. The Band 7/ 6's are being shown how to support staff. A sticking point is that the necessary IT programme is a bolt on to SPIDA and this is proving to be an issue.

CB commented that for medical revalidation the Trust purchased a system externally for their needs.

CGC0907 – Matters arising – Spinal Unit Leadership (verbal update) – Christine Blanshard

CB reported that Wendy is continuing to make improvements; there were 22 recommendations and all but 5 are completed. There are some outstanding actions with plans in place to progress these. Patient Real -Time feedback has shown some negativity especially in the area of communication recently.

KL commented that in response to some negative feedback regarding a member of staff and care given we are going to increase the presence of medical staff. Lorna Wilkinson is going to put in intensive support.

LB noted that this does need to come back to the Clinical Governance Committee but it is good to see that any concerns are being attended to quickly. CB felt that it was disappointing that issues are returning. PH commented that we need to continue to build on the good work that has been done. KL noted that we had a patient who suffered a pressure ulcer on the ward as we could not discharge them – care packages need to be organised more promptly.

PH reported that we have learnt that all patients need the same level of care, regardless of the level of their injuries.

STRATEGY

CGC908 – Core Service presentation – Maternity and Gynaecology – Stuart Verdin, Jo Baden-Fuller, Fran Williamson

This presentation was made in two parts to reflect the clear distinctions between the Maternity and Gynaecology Services.

SV reported that the Gynaecology Department have a responsibility to provide care for all elective and emergency gynaecology patients throughout the Trust. This includes subspecialty services in colposcopy, infertility and reproductive medicine, gynae-oncology, vulval skin disease and early pregnancy assessment.

The Trust does not currently operate a termination of pregnancy service, other than for pregnancies with known abnormalities.

The department has a dedicated "women only" outpatient facility which now incorporates a wide range of clinics, including colposcopy and out patient hysteroscopy treatment rooms and an early pregnancy assessment service. The team also provide peripheral clinics in 4 different locations.

There are theatre lists both in DSU (30/month) and main theatres (11 /month) with inpatients cared for on Britford ward.

SV reported that the Gynaecology department is very proud of their clinical space. They have developed a welcoming and comforting area for women and the feedback received is that patients like the department. There has also been incredible feedback from patients who have received

comfort as they undergo procedures for cancer and other issues and who receive constant communication throughout. We are very proud of the whole team.

JB-F gave a presentation to the committee regarding Obstetrics and Maternity services.

The service annually has 2500 mothers delivering from Wiltshire, Hampshire and Dorset. The department have approximately 100 audits ongoing at any time to ensure the safety of patients. The clinical guidelines are reviewed and updated every three years, or sooner. Supervisors of Midwives are in place and receive additional training. However, after the Kirkup Report, Supervision may be disbanded which causes concerns.

Datix reporting is encouraging. The team are proactive – for example there was a recent increase in stillbirths and this was investigated to see if there were any trends. With regard to Obstetrics the data is not generally published but this is improving. The service has produced a Dashboard which records items such as VBACS and home births, and sets the levels for this hospital higher than national levels.

We were approached by the SHINE project with regard to the BMI of expectant mothers. SHINE organised for patients to be given Slimming World vouchers and other advice which we see as a good innovation.

The team are effective in sharing their learning through challenging practise – they have meetings and debates and challenge each other. They risk assess, particularly with regard to mothers who are older. Midwives and Anaesthetists have undertaken training together.

FW reported that Real-Time Feedback and the Friends and Family / Inpatient Survey showed that the service is deemed to be better performing than others.

The Trust now has an Obstetric Theatre.

There has been a significant reduction in complaints in the last few years.

In terms of responsiveness, the service has a high home birth rate and 24 hour access for women. They fully support women in their choices and women are cared for in the right place by the right staff.

They have a huge team and work well with Obstetrics.

Concerns include financial restraints and staff feeling stressed – we are working with HR and focus groups in order to deal with this. The junior doctors find that the rota is punishing and in February we will be losing 2 ½ posts.

The team are proud of the Benson Suite which has been set up for bereaved women and the refurbishment of the department. The unit has never closed in the last 10 years – this is due to team work. There is visible management and amazing feedback, as a team they all work well together.

PH commented that it is so important that we never close our doors. There are some concerns regarding the Obstetric Theatre and these need to be addressed. PH asked whether, within the CQC domain, the staff know what the Trust is about and how they fit into that? SV responded that currently there are strategies so that individuals know where the department is going but before the CQC we need to make our position in the organisation clear. PH noted that the team provide a fantastic service.

KL commented that our clinical skills are good but for the CQC we need to be able to demonstrate social interventions being reported with regarding to early intervention and safeguarding. CB added that screening for ante natal depression and other issues need to be reported and demonstrated.

LB thanked SV, JB-F and FW for their presentations and said that they should be proud of the work they are doing.

CGC0909 - Patient Story – Katrina Glaister, SD

SD was referred by her GP to the Gynaecology Department. She felt very welcome at the first appointment and was seen 4 weeks later at the Fertility Department where she was assessed to see if she was suitable for funding. The nurses there were also very welcoming and remembered SD on each visit. After SD was assessed as being suitable for funding she had an appointment with Mr Fountain who explained all the processes to SD and her partner. SD was surprised to discover that she could start the process the following month. The embryologist contacted her throughout and communication was brilliant – SD has been back to show her little boy to the staff.

SD had two community midwives – Sharon, then Paula who were both fully supportive in her decision to have a home birth and assisted with her birth plans. In the event it became necessary to be admitted to hospital and the midwife treated this very sensitively. SD trusted the advice given to her. On arrival at the maternity ward at 3am, Paula stayed with SD to get her settled. The staff on the maternity ward were brilliant. SD was upset that she needed to have an emergency caesarean section but the nurses were all very kind. In Theatre, there was one negative moment when a theatre member was rude to a midwife who wanted to stay with SD against his wishes. SD did not feel as relaxed and comfortable with the Registrar as she had with the midwives.

When SD's son was born he was taken to NICU as he was not breathing well, and SD's partner was able to accompany the baby and take photographs for her. The staff there were subsequently able to assist SD with breastfeeding. Due to her spinal block, SD needed to stay on the ward – a midwife noticed that she was missing her son and arranged for him to be brought up from NICU for an hour so she was able to cuddle him. The midwives would come at any time to help her with breastfeeding. In total, SD's baby needed to remain in NICU for 5 days and during that time SD was kept updated at all times.

In summary, SD felt that the whole process had flowed – she had not had to repeat information as everything was passed on between the departments. SD felt very looked after by each department and would not have changed a thing. SD feels it was a really good experience.

LB thanked SD for coming to the meeting and speaking to the committee, it brought her experience to life.

LB noted that in the throws of an emotional experience the patient was clearly able to pick up the vibes of the people caring for them. KL commented that there is a heightened awareness of the negatives – the one incident where the Theatre member was rude – and this message needs to be got across to staff. PH commented that this is something which he addresses in all inductions with members of staff.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC0910 – Update on the Francis Report – Claire Gorzanski

In September 2015, of the 90 recommendations applicable to the Trust, SFT consider we are now compliant with 85 recommendations and partially compliant with 5 recommendations.

There are two main actions needed to complete the 5 recommendations:

1. Work has been undertaken to learn from the themes arising from patient experience feedback but further work is required to triangulate the themes with incidents and litigation cases.

2. Ensure all patients on all wards have a bed board in place with their name, and the consultant, nurse, therapist caring for them along with any special instructions.

CGz reported that we are improving our learning. The bed boards are on the action tracker for January 2016. There are newer versions of the customer care report which includes themes. This is the final report.

The committee agreed this was the final report and that the outstanding actions should be followed up in the quarterly customer care report and action tracker.

CGC0911 – Dementia Strategy Mid Year Report – Karen Littlewood

The focus for the past 6 months has been to sustain and maintain positive practice.

1. Achieve the 3 requirements for National Dementia CQUINs,

2. Actively participate in the development of the Wiltshire Dementia Strategy

3. Working collaboratively with the End of life steering group to enable good end of life care for patients with dementia.

4. Continue to improve the knowledge, understanding and skills of the workforce.

5. Completion of the 2nd Outpatient local Charter Mark Audit

KL reported that Sandy Woodbridge is leading in this and it all seems to be very good except for dementia CQUIN data collection. CGz responded that she was surprised to hear this as it is all on track for delivery. KL noted that administrative support is needed and she will action this. CB commented that this should not fail.

KL reported that Sandy has been doing great work with the staff and attitudes are changing. Staff can obtain a 'dementia friend' badge. Sandy has been very enthused about safeguarding and learning disabilities. The Carer's Café needs to be better advertised to encourage more people to attend.

KL commented that she is not sure that the relevant information is being captured accurately with regard to the Dementia Quality Indicator.

LB noted that on the last paragraph of page 6 of the report it is stated that Dr Carroll is not able to support the dementia round. CB reassured the Committee that Dr Carroll is returning from leave and will be able to resume her dementia rounds.

AC stated that with regard to the Carer's Café – these are currently held in the afternoon but it would be better to hold them in the mornings so that the carers are not visiting with their friends and relatives when the café is taking place.

CGC0912 – End of Life Care Biannual Report – Dr Felicity Morgan

End of Life Care is now a core component of the CQC inspection, this process will be informed by the NICE End of Life Quality Standards and the "5 Priorities of Care". Significant progress has been made in the last 6 months, most notably with the recruitment of the 2 end of life care facilitators, however there remains more that could be done to further improve end of life care within SFT. There is a clear need to roll out the new Personalised Care Framework (PCF) throughout the Trust, however this needs to be done as a planned process with a robust education programme to support it. There is also an urgent need to secure ongoing funding for the specialist palliative care CNS 7 day working and to work with Salisbury Specialist Palliative Care Service) and the CCG on projects such as hospice@home, 72 hour rapid response and EPACCs.

FM reported to the committee that there were concerns regarding 7 day working. Specialist palliative care across the Trust is funded to March 2016. The 72 hour rapid response is moving forward.

The personalised care frame work was piloted on Redlynch Ward and now is being tested on Farley Ward. There has been wonderful engagement with this and audits and revamps have been ongoing. There is an ambitious roll-out for completion by January 2016. Intensive training is needed for all staff and the results have been universally positive. There will be an extraordinary meeting of the Hospice user group in November. The Hospice Charity will be utilising one million pounds over the next three years and is in a much better place than previously.

LB asked what is going wrong with the Rapid Discharge process to which FM replied that as a team, a discharge in 24 hours can be achieved but only if the family are able to provide care.

LB asked for this to be scheduled as a Hot Topic halfway through next year. **KW (completed)**

CGC0913 – ED Survey 2014 – CQC Benchmark Report and Local Action Plans – Hazel Hardyman

SFT participated in the fifth national Accident and Emergency Department survey between May and September 2014.

The benchmark results and action plan were presented to the Clinical Management Board on 25th March 2015.

HH reported that work on all the actions is now complete and efforts are ongoing to maintain the level of service.

The Clinical Governance Committee were assured.

CGC0914 – Q1 Complaints Report – Hazel Hardyman

87 complaints were received in quarter 1 compared to 74 complaints in quarter 4 (2014-15) and 79 complaints for the same period in the previous year.

The main issues from complaints are:

- Clinical treatment (29), 2 less than Q4 (31) - sub-themes were 12 unsatisfactory treatment across 9 different specialties, 6 delays in receiving treatment which has decreased this quarter by 2, 3 correct diagnosis not made, 3 further complications, 2 inappropriate treatment, 2 treatment unavailable and 1 lack of communication. The Emergency Department received the highest number of complaints (5) about clinical treatment (2 discharges, 1 staffing levels leading to delays, 1 unsatisfactory treatment and 1 diagnosis not made). There were no themes.
- Appointments (18), 7 more than in Q4 (11) – sub-themes were 5 appointment dates cancelled, 4 appointment dates required (across 4 different specialties), 4 appointment system delays, 3 appointment procedures, 1 postponed and 1 unsatisfactory outcome.
- Staff attitude (15), 3 more than in Q4 (12) – 11 related to medical staff, 3 nursing staff, and 1 administrative across 15 different areas. There were 12 complaints for the same period last Year.

The main issues from real time feedback were:

- noise
- call bells
- cleaning

The main area of concern from the Friends and Family Test was:

- waiting times in the Emergency Department and Outpatients

HH reported that there were spikes in Quarters 1 and 2, but there is no real indication as to why this would be. There are no special themes running through. HH reported the results of the Real -Time and Friends and Family test feedback to the Committee. LB noted that our 25 day response rate is poor and asked if this was just an anomaly. HH responded that this does happen occasionally due to various complexities and was not a cause for concern.

KL commented that we are not being smart enough to nip some of these in the bud and that we need to support staff to do this. AC stated that everyone should be able to deal with issues, not just line managers.

CGC0915 – Complaints Dip Sampling Report – Hazel Hardyman

The dip sampling exercise suggested that there is a need to formalise arrangements between SFT and CCG's where a complaint concerns action by both organisations, specifically in relation to the discharge process. The need for good and timely communication with relatives as part of the discharge process was also highlighted.

HH reported on concerns regarding the discharge of patients. AC commented that communications with relatives in this matter are made more difficult as there is very little notice regarding care packages. KL stated that it is important to let people know what is going on even if definitive information is not available. PH agreed that it is important – we should not wait for small missing parts of information, we should go ahead and write to patients with the information that we have and then write again once any additional information becomes available.

HH will be visiting other organisations to see how they deal with their complaints and will feedback to the committee on this. The committee noted the report. **HH**

CGC0916 – Annual Complaints Survey results – Hazel Hardyman

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

245 complainants were sent an introductory letter and a questionnaire. To facilitate return of the questionnaire, a pre-paid envelope was also included. The letters were posted at the end of each complaints quarter. No reminders were sent.

80 questionnaires were returned in total (32.6% response rate), which was slightly lower than the previous year (36.6%).

HH reported that approximately 56% of respondents are happy with how complaints are handled. Following a complaints workshop last October we now have an intranet page.

Priorities for 2015 / 2016 – Healthwatch Report. We have revised our questionnaire as a result of this. We have formalised dip sampling. A meeting will be held soon to see how we run training in the future.

CB commented that this report was discussed at the Clinical Management Board meeting and something that had come from that was that it was not possible to see actions that have arisen in direct response to criticisms. CB asked if information about how to complain should be put onto Friends and Family test questionnaires to which HH responded that leaftlets, business cards and posters are all available which give this information.

JS commented that, as a governor, she is able to pass on a form for complaints and spread the message for complaints.

CB stated that it was also important to keep people informed about the progress of a complaint.

HH reported that a 6 month audit of moderate – high complaints is to be undertaken.

ASSURING CLINICAL EFFECTIVENESS

CGC0917 – Quality Indicator Report – Christine Blanshard, Claire Gorzanski

No MRSA or MSSA bacteraemias for 6 months. The elective MRSA screening rate declined and the relevant Directorates have investigated this with the clinical leads to gain improvement.

- 2 cases of hospital apportioned C Difficile for the month means the Trust remains within trajectory.
- 1 new serious incident inquiry – a never event.
- A decrease in the re-admission rate to July 15.
- A decrease in the crude mortality rate in August 15. SHMI is 102 to December 2014 is as expected. HSMR is 109 to May 15 and is higher than expected. Red flag mortality groups continue to be investigated for evidence of avoidability and learning points are disseminated for improvement actions.
- A decrease in grade 2 pressure ulcers with a downward trend since April. Cluster reviews ongoing.
- Safety Thermometer - an upward trend to 98% of ‘new harm free care’ and a slight decline to 94% of ‘all harm free care’ of patients admitted to hospital with a harm.
- There were two falls which resulted in two fractures - a fractured wrist and a fractured elbow, both managed conservatively. RCAs undertaken with a Trust wide falls action plan in place.
- 87% of patients arrived on the stroke unit within 4 hours. One patient had a stroke as an inpatient but the stroke team were not informed and two patients waited for a bed. CT scan

within 12 hours sustained at 97%. A slight decrease in patients spending 90% of their time on the stroke unit with 1 patient moved prior to discharge to accommodate a new stroke patient and 1 inpatient that the stroke team were not informed about contributed to the delay

- High risk TIA referrals being seen within 24 hours was sustained at 80% in August. 2 patients were not seen within the time frame as a referral was not sent to the single point of access and the other waited for the completion of investigations, missed by 30 minutes. The CCG have assisted with improvements by raising patient level issues with individual GP practices.

- Escalation bed capacity remained at a low level as did multiple patient ward moves.

- In August there were 7 mixed sex accommodation breaches affecting 39 patients mainly on AMU (38) and 1 patient waiting to be transferred out of Radnor for more than 12 hours. There were no breaches in the last 2 weeks of August. The CCG undertook a second walk round in AMU to advise on improvements, such as more bathroom screens, consent documentation and quick screens in the bays. A recovery plan has been submitted to the CCG and NHSE.

- Real time feedback was as expected. FFT response rates for inpatients dipped and Maternity Services sustained their improvement from July. ED remained below the local target. Day cases and outpatient response rates have improved a little.

CB reported that there has been a steady rise in HMSR and is now higher than expected. There was a peak of crude deaths in January and also March and it is a hangover from that. We looked at March in more detail with regard to the contributors to the peak in mortality. From January to the end of May it was noted that elderly patients admitted as emergencies were from two general practises that had higher than expected rates. There is a gap in services to elderly patients in rural areas. Patients suffering with cellulitis are generally found to have other underlying causes. The BMJ has published a paper regarding mortality reviews and case notes reviews. There has now been a shift in thinking. Avoidable deaths account for 3.6% of hospital deaths rather than 5% as previously thought. HMSR has low correlation to quality of care, although it is still useful reviewing quality issues.

303 cases were reviewed and of these there was one strongly avoidable death and a few were possibly avoidable. There is a high rate of avoidable admissions – patients could be supported at home better.

LB commented that this was a great analysis and asked where this would lead. It shows if we can keep people at home it will have knock on effects for hospital. CB stated that Hospice @ Home should help. It is vital to keep 7 day palliative care. KL noted that this was raised at the Wiltshire CCG – we need to get into that forum to start to deal with this.

CGC0918 – Internal Audit programme six-monthly update – Christine Blanshard, Claire Gorzanski

- In 2014/15 one audit has one outstanding action which is due for completion by 30 October 2015.

- In 2015/16 the external KPMG audit of the indicators in the Quality Report had 7 recommendations, 3 have been fully completed and the other 4 are partially completed with a plan to move to full compliance by March 2016.

The committee noted the report.

CGC0919 - Monitor Quality Governance Framework Annual Self-Assessment – Christine Blanshard, Claire Gorzanski

- The report is structured around the Quality Governance Framework and the work needed to ensure compliance with the NHS Outcomes Framework in 15/16.

- The Quality Strategy and Quality Account are the key drivers for improvement. The quality priorities in 15/16 reflect the needs of patients and other key stakeholders.

- The paper serves to give the Board assurance that effective arrangements are in place to continuously monitor and improve the quality of care, and areas that require improvement are effectively addressed.

LB commented that this was very useful.

The committee noted the report.

CGC0920 - National Clinical Audit Update – Christine Blanshard, Claire Gorzanski

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

Actions from 22 reports published in previous reporting areas are progressing satisfactorily.

The committee noted the report.

CGC0921 – Biannual Report on National Reviews, National Confidential Enquiries, External Agency Visits and National Clinical Audits February 2015 – July 2015

National Reviews

Four reports were published between February and July 2015. Action plans have been developed as appropriate.

Recommendations from five reports are outstanding from previous reporting periods.

National Confidential Enquiries

One report was published between February and July 2015. An overview of the report and its findings will be presented to the Clinical Management Board in October 2015.

The Trust is partially compliant with 12 recommendations from four reports in the previous reporting periods.

External Visits

A total of 5 visits took place between February and July 2015. Action plans have been developed where necessary.

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

The committee noted the report.

CGC0922 – Q1 Research and Development Report for noting – Christine Blanshard

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

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

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

CB reported that we are doing really well, we have just got our 900th patient recruited into a trial.

The committee noted the report.

ASSURING SAFETY

CGC0923 – Risk Report Card Q1 – Fenella Hill

- 1713 incidents reported over the quarter
- No incidents categorised as catastrophic
- 4 incidents categorised as major
- 3 major incidents due to fracture within the quarter
- No new 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
- No new Local Reviews commissioned within the quarter

The Committee noted the report.

GC0924 – Medication Safety mid-year Report – Emma Taylor

The report identifies 6 key medicines safety indicators and uses the RAG rating system to provide an assessment of each indicator and sets out plans to address any areas of concern.

ET reported that we are doing well for the CQC as evidenced in the report. The medicine safety group is focusing more on the administration of high risk medication – they have just completed work in relation to insulin.

KL and LW are working together to look at systemic failures regarding missed doses.

The committee agreed that the format of this report looked good.

CB commented that it has previously been discussed that information regarding a prescribing error needs to be fed back to the doctor. ET responded that she has been working with Adam Hughes so that feedback is possible. The name of the prescriber is to be put on a medication error report – this will start next month.

PH requested that feedback regarding missed doses is heard by the Clinical Governance Committee within the next few months.

ST/ET

CGC0925 – Risk Annual Report – Fenella Hill

The Risk Management Annual Report focuses on the progress that has been made against the strategic goals as set out in the Risk Management Strategy (2014), the lessons that have been learnt as a result of incident reviews undertaken, changes within the risk (particularly incident reporting) processes over the 2014/15 year and ongoing progress against agreed key performance indicators.

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

The report concludes with the future developments that will be driven forward in 2015/16 to ensure the implementation of the Risk Management Strategy.

FHi reported that there has been a 1.5% increase in reporting in 2014/2015 which is seen as a positive. NRLS reports changed slightly – it looked as if we had dipped, but this is increasing again now. The new version of Datix has a feedback function and this should roll out in the next couple of weeks. CB asked if this would require feedback from a manager to which FHi responded that it was an automatic feedback mechanism.

PAPERS FOR NOTING

CGC0926	Clinical Management Board meeting minutes (July, August 2015)	Noted
CGC0927	Information Governance Group meeting minutes (June)	Not available
CGC0928	Clinical Risk Group meeting minutes (June/July)	Noted
CGC0929	Integrated Safeguarding Committee (April 2015)	Noted
CGC0930	CQC Inspection Steering Group meeting minutes (July 2015)	Noted
CGC0931	Supervision of Midwives Assurance meeting minutes (July 2015)	Noted

CGC0731 - ANY OTHER BUSINESS

Safeguarding – Karen Littlewood

KL sought permission to review our safeguarding policy and requested an extension of the old policy to the 1st January 2016. Our policies are out of date. Gill Cobham has been tasked with this but is currently on leave. In her absence, KL has been working with Jo Jones and Rebekah Benson to complete service improvement plans. There will be a workshop in November when work will be undertaken with IT to improve security in transfers.

CB commented that it is less than ideal which was agreed by KL.

The committee approved the request.

Potential Strike Action – Angela Clarke

AC asked the committee to be aware that strike action is being suggested with regard to the new junior doctor contract that is being proposed by the Government.

October Agenda Item

Mixed Sex Accommodations to be put on the agenda for the Clinical Governance Committee meeting in October **KW (Completed)**

NEXT MEETING
2015 dates will be Thursdays, 10am-12pm in the Boardroom - 22nd October, 26th November. No meetings in April, August or December.

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 22nd October 2015, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair), Christine Blanshard, Claire Gorzanski, Peter Hill, Jan Sanders, Karen Littlewood, Andy Hyett, Hollie Foreman, Sally Tomlin, Steve Long, Mark Stabb, Angela Clarke.

Lydia Brown welcomed Ian Downie to the Committee.

In attendance:

	Item
Kate Williams	Minute taker
Carl Taylor, Mandy Cooper	CGC1008

CGC1001 Apologies:

Lorna Wilkinson, Hazel Hardyman, Maria Ford

CGC1002 – Minutes of the meeting held on 24th September 2015

One amendment was made and agreed after which the minutes of the last meeting were agreed as an accurate record.

CGC1003 – Action Tracker

No comments.

CGC1004 – Matters arising – Terms of Reference for the Clinical Governance Committee – Lydia Brown

- Addition of the Care Quality Commission preparedness steering group minutes
- Addition of monitor the progress of an announced or unannounced Care Quality Commission inspection action plan.
- Minor word changes in the monitoring function of the Committee

LB suggested an additional change to the Terms of Reference, asking the Committee to consider making the Governor, who is currently an observer, a full member of the Committee so that she may obtain papers and make contributions. LB suggested that any new Governor should undergo an induction process and asked that CGz attends to this.

ID asked if the Governor, as a full member of the Committee, would be covered by insurance to which PH responded that we would need to check the position on this. **PH**

CGC1005 – Matters arising – Reporting Schedule – Lydia Brown

The schedule was considered by the Committee and it was agreed that any suggestions for the 'Hot Topic' item should be sent to CGz before the year end. CB asked for the Seven Day Service Plan to be added as a Hot Topic.

CGC1006 – Matters arising – Effectiveness of the Committee and Attendance Monitoring – Lydia Brown

- The review period totalled nine meetings held between September 2014 and July 2015.
- The paper gives the Board assurance that the Clinical Governance Committee is effective in complying with its duties as set out in its terms of reference.

The Committee were asked to complete the included survey – responses will be collated and the results will be reported back. This will give documentary evidence of the Committee's review. **CGz**

CGC1007 – Matters arising – Clinical Governance Committee dates for 2016

January	28th
February	25th
March	24th
April	No meeting
May	19th
June	23rd
July	21st
August	No meeting
September	22nd
October	20th
November	24th
December	No meeting

CGz noted that the meeting date in May is earlier than usual to accommodate Quality Account reporting deadlines.

AC informed the Committee that she will be on Maternity Leave from March for one year.

STRATEGY

CGC1008 – Core Service presentation – Children and Young People's Services – Carl Taylor, Mandy Cooper

CT gave an update on the document ' Department of Child Heath – Report to the Clinical Governance Committee'.

The Document
This document is a constantly updated 'conversation'. The aim is to regularly update the information, building on the initial 2014 document.

The Department
Salisbury NHS Foundation Trust serves a population of approximately 45,000 children under 18 years with approximately 2500 deliveries per year**.**

Children and Young People's Services have a responsibility to provide oversight for the entire patient journey through the Trust and the department will provide outreach support for any child in the Trust. The Children & Young Peoples Quality & Safety Board, chaired by the Chair of Governors has the remit of overviewing all children seen throughout the Trust.

Children and Young People's Services have made an active decision to become a predominantly consultant delivered service, ensuring maintenance of a balance between acute and chronic services. Strong collaborative links with Southampton Children's Hospital are fostered to ensure a high quality local service for the population with rapid access to specialised services.

The focus has been predominately on ensuring the delivery of safe, effective care for neonates, acute and general paediatrics. This has highlighted discrepancies in the commissioning of services generally considered 'Community Paediatrics'. The team support the CCG in ensuring the commissioning of an equitable community child health service across Wiltshire. Virgin Care have recently (14/10/15) been awarded the contract for Community Paediatric Services. The team will need to forge strong links with this new provider.

CT reported in respect of the community paediatric service that from the staffing point of view, the main concern was with regard to where the jobs would be – there is uncertainty in some areas / services as to where the positions will be. There is going to be both structure and staff reorganisation.

Since the last report, there have been data changes regarding admissions to Sarum Ward – admission numbers have decreased. There is a high volume of admissions which last for less than 24 hours and the question must be asked as to the necessity of admission in the first instance. The data shows that the majority of admissions are for children under the age of 2.

Looking at data over the last 2 years of total daily activity and the staffing / nursing levels there are no peaks. An increase is expected as winter months approach.

The team would like to open the day unit for 7 days a week throughout the year but currently this only happens through the winter months.

A lot of children are sent home after being observed at play over time – the advantage is that there is not a 4 hour limit, unlike the Emergency Department. Admissions to Sarum Ward do not show a great deal of change month on month but the patients' illnesses are more severe in the winter months.

Jim Baird and Chris Anderson have driven the Risk / Clinical Governance meetings. CT would like to ensure that the minutes of these meetings are sent out more quickly but there is currently no administrative support.

MC gave an example of a situation in which a vulnerable family were supported by the team and a new consultant was very impressed. The consultant completed a 'favourable event' report which has been introduced and which gave positive feedback to the staff. This is a balance to the 'adverse events' reporting. The reports are put into a folder and are available for all staff to read.

CT reported that the Safeguarding Nurse will be leaving soon – this position will need to be filled. KL stated that interviews will be taking place on 2nd November.

CT is working with IT with regard to the Doctor Foster peer review system. Children and Young People's Services are effective, Consultant Led with MDT teamwork and do this well.

MC reported that in respect of staffing levels and having looked at staff ratios, the team does not have enough nurses. They are doing some work on acuity. Every day the team is at least one nurse down. The team are working to get evidence of low staff levels.

CT reported that the Paediatric Early Warning Score and the Sepsis Screening Tool are both used to aid responsiveness. CT is working on producing a dashboard.

ID asked if the team completed peer reviews to which CT responded yes, using Doctor Foster. Consultants from Southampton Hospital run clinics here although their peer reviews are not recorded. MC stated that the team work closely with many departments including oncology / epilepsy / diabetes.

CT reported that there is an expected rise in births from 2,500 to 3,000 per annum so the service will need to be able to deal with this in the future.

In summary, there have been no major changes since the last report to the Clinical Governance Committee, but there are concerns regarding staffing levels which were picked up in the mock CQC inspection. PH noted that this was the case but that actions were subsequently taken. KL stated that it would be helpful to get a tool to map this as more work needs to be done in order to make decisions to increase the numbers of staff. CT noted that looking at the numbers during the day might not reflect the true picture of patient numbers. KL stated that the challenge is the crude levels we use to record numbers but we will ultimately achieve the numbers that are needed. CT stated that the service are using locums which needs to be managed effectively as this is a national problem.

PH stated that the fragmentation of the service with the introduction of Virgin Care is concerning as it was a very well integrated service before from a patient pathway point of view. PH has expressed his concerns about this as there are potential safeguarding issues regarding communications between the different services. We need to make this work.

Children and Young People's Services rated themselves as good for caring, effective, responsive and well, but in need of improvement in the Safe domain due to staffing.

SL commented that the self-assessment seems rather harsh to which CT responded that the CQC will make an assessment. SL noted that more peer reviews would be helpful for this reason.

CGz thanked CT and MC for their very comprehensive report and asked if everyone on the team had access to this to which CT responded that, with the Committee's agreement the document will be sent out to all the staff. AC asked that it be forwarded to the junior doctors as they sometimes have good ideas. AH stated that it was clear that the team works in a very multidisciplinary way and

they should be proud of their achievements. PH commented that P16 of the report needs to be re-worded to be more positive before sharing amongst the staff. KL offered to assist in this.

LB thanked CT and MC for their presentation. PH noted that this was a very good service. CB commented that the 'favourable event' reporting is a good initiative but has concerns that MC feels that the service is unsafe in terms of staffing. KL reported that they are working through the concerns and as yet there is no evidence to support the idea that the service is unsafe. AH commented that there is equally no evidence to support opening the day unit for 7 days a week throughout the year. ID questioned the short stays of many patients and AH reported that this has been raised – it might be that it is the right clinical pathway but it needs to be looked at. KL commented that it can be the case that patients are admitted as parents / carers are too anxious to look after the child at home and we need to be able to provide telephone support to help those people.

CGC1009 – Hot Topic – Nursing Documentation Audit – Maria Ford

This item was deferred to the Clinical Governance Committee meeting in May 2016.

CGC1010 – Spinal Unit Leadership – verbal update – Christine Blanshard

CB, LW and Alison Kingscott went to a meeting on 12th October for feedback on progress in the last 18 months. It was very well attended. This is still a work in progress. We had feedback from Alison regarding the leadership of the team, she has reported that they are very open and willing to work together. One ward is receiving intensive leadership support. KL worked a morning on Tamar ward and found it to be excellent but noted that the leadership needs to be strengthened.

LB noted that it appears that we are moving in the right direction. KL confirmed that lots of work is being done. LB stated that it is important that the Committee continue to receive regular reports on this.

CGC1011 – Nursing, Midwifery and AHP Strategy Update – Karen Littlewood

- The Nursing, Midwifery and AHP Strategy was approved by the Clinical Governance Committee. This was a revised document with changes made following feedback from staff.
- The Strategy has since been widely disseminated and printed in a A5 leaflet with copies for all staff
- The report provides key headlines on progress with the agreed 2015/16 priorities
- All action areas are making progress although work may not be completed hence most areas currently amber
- Individual team and department progress against the Strategy will be celebrated once again through a Pride in Practice event in April/May 2016

KL reported that everything is moving forward, with some more advanced than others. There is a reduced agency spend although it has peaked this month. There is a lot of evidence and we need to use this to learn from patient experience. There is a workshop planned with the DMT's focusing on 1 or 2 actions. We are on track to deliver.

CB noted that we have agreed to defer the 'Hi my name is' campaign. KL responded that this should be achievable and we need to consider the right time to launch it. PH asked if we could achieve this outcome without using this campaign.

<u>ASSURING A QUALITY PATIENT EXPERIENCE</u>

CGC1011A – Mixed Sex Accommodation – Karen Littlewood

KW reported that the mandate from the Department of Health in 2011 is that we should avoid mixed sex accommodation. We need to provide guidance regarding information for patients. We were having a lot of breaches per month particularly on Whiteparish ward. An Action Plan was drawn up and there has been lots of effort to reduce this. In September there were 28 breaches and in October there were 2 breaches to date. We have started root cause analysis which is sharpening our minds and developing good integrated working.

AC commented that this is working really well on Whiteparish but the other wards are now breaching here and there – we need to educate the other wards. KL agreed that mixed sex cannot

be used as an option at all. We need to support staff to deal with this. Fixed screens have been ordered.

LB noted that we are moving in the right direction with this.

ASSURING CLINICAL EFFECTIVENESS

CGC1012 – Quality Indicator Report including DSSA (for discussion) – Christine Blanshard

- 1 MSSA and no MRSA bacteraemias in Q2. The elective MRSA screening rate declined and the Directorates have investigated this with the clinical leads to gain improvement.

- 2 cases of C Difficile in September. Total of 5 cases in Q2. At trajectory at the end of Q2. Full year target no greater than 19 cases.

- No new serious incident inquiries in September. 4 in total in Q2 including the previously reported never event.

- A decrease in the crude mortality rate in Q2 despite the highest admission rate in September in the last 18 months. SHMI is 102 to December 2014 is as expected. HSMR is 108 to June 15 and is higher than expected. A recent discussion paper indicated a 0.9% avoidability rate at SFT compared to 3.6% nationally. This has been discussed in detail at the CGC and with the commissioners.

- A significant decrease in grade 2 pressure ulcers in Q2.

- Safety Thermometer – a sustained trend of 96 - 98% of 'new harm free care' and a decline to 92% of 'all harm free care' of patients admitted to hospital with a harm.

- There were no falls in September resulting in fracture or major harm. In Q2 a total of 3 falls resulted in 4 fractures - a fractured wrist and a fractured elbow, both managed conservatively and one patient who had two fractures - a fractured hip requiring surgery and a fractured humerus. RCAs undertaken with a Trust wide falls action plan in place.

- In Q2 an improvement in the number of patients arriving on the stroke unit within 4 hours and having a CT scan within 12 hours sustained at 97%. A downward trend in patients spending 90% of their time on the stroke unit affected 6 patients in Q2. 3 inpatients were late referrals, 2 patients were moved prior to discharge to accommodate a new stroke patient and 1 patient was delayed because of bed capacity.

- High risk TIA referrals being seen within 24 hours was sustained at 80% in July and August but dipped in September. 2 patients were not seen within the time frame as a referral was not sent to the single point of access, 2 patients were delayed due to lack of clinic availability due to consultant leave and the other patient waited for completion of investigations, just over 24 hours. In Q2 the CCG have assisted with improvements by raising patient level issues with individual GP practices.

- Escalation bed capacity remained at a low level as did multiple patient ward moves.

- In September there were 5 mixed sex accommodation breaches affecting 28 patients mainly on AMU (27) and 1 patient waiting to be transferred out of Radnor for more than 12 hours. There were no breaches in the last 2 weeks of August. In Q2 there were 17 breaches affecting 99 patients, a decrease from Q1. In Q2 the CCG undertook a second walk round in AMU to advise on improvements and a remedial action plan was submitted to the CCG and NHSE.

- Real time feedback was as expected. FFT response rates for inpatients remained constant and Maternity Services dipped at the end of Q2. ED remained below the local target. Day cases and outpatient response rates remain at a low level.

CB reported that we had the highest number of admissions for September of 6,000 so has been very busy. There is a low rate of avoidable mortalities. We have struggled with Stroke targets with late referrals due to diagnosis on other wards. All the winter ailments are presenting now.

KL noted that with regard to the Quality Indicators – more bed moves have happened to avoid mixed sex accommodation breaches. There has been a small dip in patient feedback which we need to monitor.

SL commented that this hospital gets good support from the local community but can we do more? PH stated that there is an agreement that as from January we will have regular slots in the Salisbury Journal. AC noted that the strike ballot is on 5th November.

CGC1013 – CQC Intelligent Monitoring Repot 15/16 – Christine Blanshard

This report is currently unavailable.

CGC1014 - Consultant Treatment Outcomes – Christine Blanshard

- Consultant treatment outcomes are published on the NHS Choices website to make more information available to the public about how services and professionals are performing. The aim is to drive up standards and the quality of care and help people choose the treatment that best suits their needs.

- The results provide information about individual consultants in seven specialities from a range of operations and treatments to help patients make decisions about care. Data is drawn from national clinical audits and compares the clinical outcomes for each consultant against the national average.

- The data provides the number of times each consultant has performed a particular procedure and their mortality rate for those procedures. The data has been risk adjusted to ensure consultants who undertake particularly high risk patients or carry out the most complicated procedures do not appear to have unfairly high mortality rates.

- If a hospital or consultant is identified as an outlier this is investigated and action taken to improve data quality and/or patient care. Where results differ significantly from the national average, there may well be a good reason. Patients are encouraged to discuss this with their GP and/or surgeon.

- All surgeons practising at SFT who submitted data to the relevant national audits in the seven specialities have outcomes within the expected range.

CB stated that all our surgeons were within the expected range, some were very good.

PH noted that we have had questions raised overs some of our services and this will aid us to demonstrate outcomes.

CGC1015 – Sign up to Safety / Safety Thermometer – Lorna Wilkinson, Karen Littlewood

This item has been deferred to the Clinical Governance Committee in November

CGC1016 – Dr Foster Report and Mortality Reviews – Will Garrett

WG reported that under Dr Foster there are 2 different sets of alerts : Care alerts and Trust view.

Care Alerts:

From January 2014 - December 2014 there were 3 at risk areas in Dermatology, Musculo-Skeletal and Vascular.

In Dermatology, 2 deaths were reviewed neither of which were thought to be avoidable. In Musculo-Skeletal there were 12 deaths as against the expected 6.7. 10 have been reviewed, none of which were thought to be avoidable. These had been coded as pathological fractures and work is being done to ensure that injuries are coded as traumatic.

In Vascular there were 3 deaths against the 1.9 expected. 1 has been reviewed and was not thought to be avoidable.

Trust View:

The date range covers a year.

SII review – a report has been issued.

Urethral Catheterisation – Kate Chadwick and Maria Ford are auditing the 54 deaths. To date, 32 have been reviewed, none have been avoidable but there have been some learning points. It is

interesting to note that in 12 of the records no co-morbidity has been recorded and all 12 had significant co-morbidities which had not been documented properly. It is possible that patients are being moved before a clear initial diagnosis.

AC noted that clerking does not cover co-morbidity coding. A transfer between consultants needs to be done.

CGz commented that we have made significant progress in this respect. AC stated that new F1's and F2's should be taught to record well.

LB asked if the Committee could be assured that this is being resolved to which WG responded that coders can provide coding information and share it with consultants. An update will be given to the Committee. CB stated that it should be noted that in relation to the catheterisation figures the details were generally of patients over 80 years of age who died of pneumonia or other illnesses – their deaths were not caused by the catheterisation.

C0922 – Q1 Research and Development Report for noting – Christine Blanshard

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

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

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

CB reported that we are doing really well, we have just got our 900th patient recruited into a trial.

The committee noted the report.

ASSURING SAFETY

CGC1017 – Assurance Framework – Karen Littlewood

There have been no newly identified gaps in control or assurance since the Assurance Framework extract was last presented at the Clinical Governance Committee.

KL reported that SFT is in the best performing quartile for CDifficile. We have had an increase in diarrhoea this month so that may affect figures.

ADSN is working with the Safeguarding Adults Trust and providing bespoke training. KL will be mapping our processes. We have had positive feedback about safeguarding adults.

CGC1018 –SII/CR report Q2 – Karen Littlewood

Updates to outstanding recommendations:

- SII 161 All recommendations completed
- SII 144 Recommendations 1 and 2 completed
- SII 160 Recommendations 1,3,4, 6 and 8 completed
- SII 162 Recommendations 1-9 completed
- SII 166 All recommendations completed
- SII 167 Recommendations added to Trust wide action plan
- SII 168 Recommendations added to Trust wide action plan
- SII 170 All recommendations completed
- SII 171 All recommendations completed
- SII 172 Recommendation 1 completed

Reviews with outstanding recommendations:

- SII 144
- SII 160
- SII 162
- SII 172

New Recommendations since July 2015 CGC

- SII 144 (MSK)
- SII 160 (CS&FS)
- SII 162 (Surgery)
- SII 166 (CS&FS)
- SII 167 (MSK)
- SII 168 (MSK)
- SII 170 (Medicine)
- SII 171 (Medicine)
- SII 172 (Medicine)

Serious Incident Inquiry/Clinical Review for Closure

- SII 161
- SII 166
- SII 167
- SII 168
- SII 170
- SII 171

KL reported that we are on track. The Risk team are really good at following through before they are signed off. It is very positive. There is real rigour to ensure actions are taken. Regarding the maternal death, this is marked as amber as a paper was recently published relating to a second spinal which was given.

LB commented that the presentation makes it easy to see the progress and completion of items.

CGC1019 – Safeguarding Children Q1 – Karen Littlewood

KL reported that we have not had in-house training at level 3. Levels 1 and 2 are being completed but level 3 is now under much more scrutiny. We are currently setting up level 3 training and strategy. The Q2 report should answer the challenges.

AH asked if this was minuted through the CQRM to which KL responded it was.

LB noted that there was a lot of work happening with this.

KL stated that it is possible that we will need only one named nurse and more work needs to be done with Jane Murray regarding this. KL reported that we are using a package regarding the safeguarding of children which was originally produced by the provider of the named nurse in the community. It is positive that we have a named nurse who can respond to concerns immediately but we do need to look at capacity for training.

ID asked if new staff should have the correct training when they come into the hospital as there is currently no training within the hospital to which KL responded that it is a priority to look at.

CGC1019A – NPSA NRLS report – Karen Littlewood

During this reporting period, all patient safety incidents are uploaded to the NRLS from the Trust once the investigation is closed, this has been in effect since July 2005. From April 2011 all incidents have been submitted as open and are updated when they are closed. A summary is attached. Key items to note are:

- Patient accidents continue to be the top reported incident at SFT (21.8% against the cluster reporting 19.7%). Medication incident reporting continues to be positively high with the majority of medication incidents being reported by pharmacists (1.4% higher than other small acute organisations).

- Nationally 74.3% of reported incidents result in no harm, we reported 87.7% of incidents as resulting in no harm.

- Reporting rate per 1000 bed days shows the Trust to be in the middle 50% of the cluster group although our position within this cluster has risen since the last report. We are now reporting a rate of 33.58 incidents per 1000 bed days compared to 28.94 for

the previous 6 month reporting period. This increase is seen as a positive safety culture indicator.

- Incidents reported in 6 of the 6 months 1 October 2013 – 31 March 2014

KL stated our reporting has gone up – this is very positive and healthy. PH questioned whether the figures in the report reflected this as it seems to indicate that we are slightly below average. KL clarified that we are increasing our reporting against other Trusts. KL commented that reporting is done differently in different organisations. We are reporting slightly higher numbers of patient accidents and medication. ST stated that we are aware that we report things that others do not.

SL asked if figure 1 reflected all acutes plus other organisations to which KL responded that we do not know. There are lots of questions and it is difficult to derive quality from this type of report. ST noted that the important aspect we need to look at is what we are reporting and the learning we are taking from it.

PAPERS FOR NOTING

CGC1020	Clinical Management Board meeting minutes (September 2015)	Noted
CGC1021	Information Governance Group meeting minutes (August 2015	Not available
CGC1022	Clinical Risk Group meeting minutes (September 2015)	Noted
CGC1023	Infection Prevention & Control meeting minutes (July 2015)	Noted
CGC1024	Children & Young People's Quality and Safety Board meeting (July 2015)	Noted
CGC1025	CQC Inspection Steering Group meeting minutes (July 2015)	Noted
CGC1026	Supervision of Midwives Assurance meeting minutes (September 2015)	Noted

CGC0731 - ANY OTHER BUSINESS

CQC Inspection – Claire Gorzanski

Staff preparations are going well. Virginia from TIA has been visiting wards with positive feedback.

There will be up to 40 CQC inspectors. On the first day they will meet and PH will give a presentation. They will be arriving at the hospital that afternoon and will interview service leads at 4pm.

We are planning some innovative things ie a poster display of the work we are doing. We are serving them a patient lunch and Ian Robinson will be attending to present it.

The Striving for Excellence Awards will be on the same week and Inspectors have been invited to the presentations. There will be a 1950's tea party on one of the wards which they can attend. There is a public listening event which staff will be able to attend. Lots of the Committee members will be meeting with them.

JS reported that they will be meeting with the Governors on 23rd November. AH reported that in the two weeks that follow we will have an unannounced out of hours visit

NEXT MEETING
2015 date will be Thursday, 10am-12pm in the Boardroom - 26th November.

2016 dates will be Thursdays, 10am-12pm in the Boardroom – 28th January, 25th February, 24th March, 19th May, 23rd June, 21st July, 22nd September, 20th October, 24th November. No meetings in April, August or December.

SALISBURY NHS FOUNDATION TRUST
Minutes of the Audit Committee
Held on: 12 October 2015

SFT3724

Present: Mr P Kemp (Chairman and Non-Executive Director)
Mr I Downie (Non-Executive Director)
Mr A Freemantle (Non-Executive Director)

In Attendance: Mr J Oldroyd (KPMG)
Mr M Stabb (TIAA)
Mr D Seabrooke (Head of Corporate Governance)
Mr M Cassells (Director of Finance and Procurement)
Mr A Morley (Local Counter Fraud Specialist)
Mr A Hyett (Chief Operating Officer) for item 5
Mr L Arnold (Director of Corporate Development) for item 5
Mr N Edwards (Interim Head of Estates) for item 5

Apologies: Dr L Brown (Non-Executive Director)

ACTION

1. MINUTES

The minutes of the meeting of the committee held on 13 July 2015 were accepted as a correct record.

2. MATTERS ARISING

All issues flagged in the 13 July minutes were picked up in the reports.

3. EXTERNAL AUDIT – AUDIT PLAN 2015/16 AND PROGRESS REPORT/TECHNICAL UPDATE

The Committee received the External Audit Plan Update and Progress Report. The Report described the format of the Audit for 2015/16 including the Long Form Report recently introduced. The National Audit Office Code had replaced the Monitor Code and the implications of this were being assessed.

In relation to the Going Concern Test the Auditors would need to substantiate the Director's representations in this regard taking into account factors such as loan facilities to support the Trust's cash position. Better guidance from Monitor was needed and there needed to be a consistent approach adopted nationally.

It was noted also that Monitor were reviewing a range of audit files from across the sector in relation to the Audit of Foundation Trust Quality Accounts. Following the presentation of the 2014/15 Audit Letter to the Council of Governors KPMG had provided feedback in support of this to Monitor.

The Committee noted the External Audit Plan 2015/16 and the Technical Update.

4. INTERNAL AUDIT

The Committee received the Internal Audit Progress Report and Local Counter Fraud Specialist Report.

Internal Audit Progress Report

The Report highlighted progress with actions on patients' property and monies, consultants job planning – consultant interviews and smart card security arrangements.

It reported two finalised audits in relation to budgetary control and cost improvement programme and Estates compliance. In relation to Financial Control Andy Hyett, Chief Operating Officer reported that the financial forecasting of cost improvement programmes was being strengthened and this included further clarification on the Red/Amber/Green assessment of cost improvement schemes. Recommendation 7 would provide an assessment by 31 December of options for improving financial reporting.

In relation to Estates Compliance it was noted that actions were underway to ensure that the requirements for authorised engineers and authorised persons for the relevant statutory compliance areas were in place and documented.

Local Counter Fraud Progress Report

It was noted that Fraud Case numbered 13/0026 had gone to court and that in relation to 00170 a final stage warning had been issued to this employee. A police caution had been requested. On 00135 full recovery of parking fees and fines was expected following a full admission of scratch card fraud.

The findings of the staff survey on counter fraud and whistle blowing were highlighted, showing good awareness in the trust of the relevant procedures and how to access them. There had been an intelligence alert following concerns that CCGs had received fraudulent requests to amend bank details for providers.

In relation to the Counter Fraud Risk Assessment on row 1.2 it was noted that there was reasonable assurance from Internal Audit that shifts were being allocated accurately in relation to working hours of staff. In entry 1.6 it was noted that the authorisation of time sheets was checked.

In entry 2.5 there was found to be weak controls in relation to Disclosure and Baring checks and the Committee requested that the Director of Human Resources and Organisation Development clarify the Trust's policies and practices in this regard. **AK**

Internal Audit were picking up issues arising from row 3.5 – single tender waivers in estates, 5.4 authorising purchase orders, 5.5 appropriate use of corporate credit cards and on 10.1 it was noted that improved electronic conciliation and better control over the "reset" function would improve controls against car park machine fraud.

The Committee noted the Counter Fraud Report and the Internal Audit Update.

5. HALF YEAR REVIEW OF ASSURANCE FRAMEWORK

The Committee received a report setting out details of the review in March, April and July of the Assurance Framework by the three assuring committees and a description of the Trust Board Annual Review which was reporting back in December 2015.

The Committee noted the Report.

6. ISSUES/ACTIONS ARISING FROM THE AUDIT OF ACCOUNT

Issues/actions had been picked up in the report of the external auditor and further response from Monitor was awaited.

7. REVIEW OF EFFECTIVENESS

The Committee had retained this item on the Agenda and discussed the conduct of today's business. Concerns were expressed about the separation of the composition of the Finance & Performance Committee and the Audit Committee.

8. DATE OF NEXT MEETING

The next meeting of the Audit Committee will be on Monday 14 March 2016 at 10 am.

Salisbury NHS Foundation Trust

SFT 3726

Salisbury NHS Foundation Trust
Staff Survey 2014 Update on Progress
(November 2015)

Presented for: Information

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

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

Previous Committees: None

Key points

The Trust Board is asked to consider this report and the actions taken to date to address the areas for improvement within the 2014 Staff Survey.

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

Strategic Aims

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

Values

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

1. Summary and background

This report provides a summary of the key actions taken to date in addressing a number of themes in the 2014 Staff Survey. It follows previous reports to Trust Board and the Executive Workforce Committee.

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

2. Programme of work and progress

There were six key themes identified as areas for improvement from the 2014 survey, as presented to Board in April 2015, and they are summarised below with the actions taken to support staff and improve the experience at work.

Work programme

2.1 Percentage of staff experiencing discrimination at work in the last 12 months

This category was a new area for improvement the Trust where the results last year were statistically worse than in the previous year.

A detailed analysis of the staff survey data, and discussion at Executive Workforce Committee, identified the forms of discrimination staff are reporting, and the sources of the discrimination such as peers, managers, patients and / or relatives.

A key action identified from this deep dive was to hold a specifically targeted Listening into Action group for those members of staff who identify themselves as being from a Black or Minority Ethnic Group. The Head of Equality and Diversity held this session during October and is developing a plan to share with the Staff Survey Steering Group meeting in November.

Monitoring through the Equality and Diversity Group continue with other work streams, aimed at promoting diversity, are developed such as Women Leaders.

2.2 & 2.3 Percentage experiencing harassment, bullying or abuse from patients, relatives the public or staff in the last 12 months and Percentage experiencing physical violence from patients, relatives the public or staff in last 12 months.

Dignity at Work Ambassadors

Although the Trust results are modest in this area the rate of improvement has not been sufficiently positive over previous years. The Staff Survey Steering Group considered options available for improving the work experience of staff, and in reviewing other organisations where rates of bullying have significantly reduced in the past 12 months, a proposal to develop 'Dignity at Work Ambassadors' (DAWA) was put forward and supported by the Director of HR & OD and the Chief Executive. It was also agreed that the existing NED Bullying Advisor role would be captured within the cohort of new DAWA's bringing experience and strength to the team.

During the summer, a role profile was developed and shared with the Staff Survey Steering Group and staff side colleagues. Following feedback the profile was amended and volunteers sought from all aspects of the workforce including existing Diversity Leads, representatives from clinical groups and admin and clerical staff as well as the two NEDs. A group of fifteen volunteers met to discuss the role and agree the training requirements.

During September ACAS attended the group to provide training on 'Dignity at Work' and a DAWA resource pack has been developed and shared to support those in the role.

The profile of the Trust Dignity at Work Ambassadors was recently highlighted as part of an Autumn CEO message. An intranet page and screen savers has also been developed as part of the soft launch. DAWA individuals are attending existing meetings to promote the role and the support and guidance available.

The DAWA group will continue to meet with the support of the Deputy Director of HR and HR Advisor, and later this year the group will undertake some role-play as part of the development programme.

As the Trust has developed this role, the 'Speaking Out' recommendations have been issued and the Head of Clinical Effectiveness and Deputy Director of HR have supported the development of the Local Guardian role, and governance.

The Dignity at Work Ambassadors and the Local Guardian – when appointed - will work together to provide staff with support aiming to improve the work experience of staff.

Security Services
The in-house 24/7 security service has been operating since late Spring 2015 and anecdotal feedback has been that staff – particularly ward staff - feel more supported and secure as members of the security team are regularly present on wards.

Training
A Violence and Aggression working group was set up and an action plan drawn up. As a result of the working group, conflict training has been rolled out along with Protect training.

2.4 Percentage receiving job relevant training, learning or development in last 12 months

Workforce Metrics is shared with the Trust Board for regular monitoring of progress against plan. This Metric has also been recently adapted to provide directorate level data to support HR and Directorate Managers in identifying actions. Attention is focused on driving up the compliance through 3:3s; Safety walk rounds; and the generation of zero compliance reports.

The range of programmes and sessions available to staff both internal to the Trust and external remains extensive and promotion of learning and development opportunities is occurring through Operational Meetings including OMB.

Activity
September saw the first of our season of Masterclasses aimed at the leadership community in Salisbury and opened the debate about what 'Well Led' looks like in Salisbury.

Coaching remains a priority for staff wishing to develop. Our trained in-house coaches remain busy with 67 staff currently being supported (as at October 2015).

We use Insights and MBTI psychometrics to help improve team communication. So far this year we have run in-service training days for Maternity, IT, Facilities and Spinal Unit. Insights forms part of the band 5 nurse development programme; MBTI forms part of the Clinical Leaders programme and the DMT leadership programme. All sessions have received positive feedback from staff members.

2.5 Percentage suffering work related stress

The percentage of staff reporting stress as a reason for sickness absence has decreased from 14.49% in November 2014 to March 9.8% and 9.2% in October.

Examples of work supporting staff on the wider health and well-being agenda, includes:

- The Trust has a registered Mental Health Nurse. The post is funded for a 2 year period through the charitable funds. Uptake of RMN appointments, since being appointed in October 2014 has been a total of 86 staff (64 stress and anxiety and 22 work related stress cases).
- A total of 359 Physiotherapy appointments made in the last 6 months with 153 individuals receiving treatment (some of these have been seen at least 6 times).
- Attendance at a BP/Cholesterol and Weight Clinics average 15 per session and are over subscribed (on average we have been running 4/5 clinics per year).

2.6 Percentage appraised in the past 12 months

Since the previous report to Board when the recorded uptake of appraisals was 46%, the rate of appraisals is 61%. Greater access to detailed compliance rates, and regular promotion of 'sign off' via Broadcasts have been key activities in Q2.

The SpIda 2 Programme Management Board are overseeing the development of the appraisal two, and significant 'testing' is underway in advance of the launch due in January 2016. It is anticipated that the improvements in the functionality of the appraisal system will encourage more timely completion of appraisals.

Alison Kingscott
Director of HR & OD
May 2015

SFT 3727

Trust Board meeting
Assurance Framework Update

Date: 7 December 2015

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

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

The Trust Board carries out an annual review of the Assurance Framework process to ensure that the risks described are the most valid and the document remains fit for purpose to be managed and monitored via the Assurance Committees. The Assurance Framework was reviewed during a Trust Board workshop in September 2015. Trust Board members agreed the principal risks for inclusion in the 2015/16 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 2015/16 Assurance Framework risks.

Links to Assurance Framework/ Strategic Plan:

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

Appendices:
Board assurance Framework – Trust Board December 2015

Salisbury NHS
NHS Foundation Trust

ASSURANCE FRAMEWORK

Trust Board - December 2015

Corporate Objectives and Key to Care Quality Commission Outcomes

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

AF1 - Choice - To be the hospital of choice, we will provide a comprehensive range of high quality local services enhanced by our specialist centres
Linked Risks
1.1 Failure to deliver key performance targets would result in patients choosing to be treated elsewhere, the local population losing trust in SFT as a provider of high quality care and intervention by regulators. Recognising some targets are influenced by patient availability to attend in addition to SFT capacity e.g. cancer.
1.2 Reduced demand for Trust services would have a detrimental impact on the sustainability of individual services and a cumulative impact for the organisation.
1.3 Failure to listen and act on feedback 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
- Increased incidence of falls resulting in harm
- Increased incidences of mixed sex breaches
- 'Never Events' relating to perioperative care

2.3 Failure to protect the most vulnerable if safeguarding policies and procedures for children, young people, and adults are not applied appropriately.

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 achieve an outstanding experience for every patient because staff do not feel valued and able to contribute fully to work as a consequence due to low morale
3.2 Failure to achieve an outstanding experience for every patient, because 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 To meet the clinical needs of patients and the organisation, the Trust has procured an Electronic Patient Record (EPR). This will have a substantial impact over the next 18 months and has the potential to impact on other IT projects, requirements and cause substantial organisational disruption.

4.2 Failure to secure all income required to run the organisation whilst avoiding fines will impact on the Trust's financial position and potentially undermine the financial viability of the Trust.

- CCG challenges
- Shifting case mix
- Coding gaps
- CQUIN non delivery
- Contract breaches resulting in penalties
- Readmissions

4.3 Failure to contain cash and 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 Capacity and demand models need to reflect changing clinical practice and evidence operational management decisions to reflect the Clinical Services Strategy.

Care Quality Commission - Outcomes

SAFE
EFFECTIVE
CARING
RESPONSIVE
WELL LED

Assurance Framework Template Headings

Principal Objective – What the organisation aims to deliver

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

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

1.1

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Effective Responsive Well Led	Failure to deliver key performance targets would result in patients choosing to be treated elsewhere, the local population losing trust in SFT as a provider of high quality care and intervention by regulators. Recognising some targets are influenced by patient availability to attend in addition to SFT capacity e.g. cancer.	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 May 2015 Limited issues raised by commissioners in terms of performance Strong benchmarking across a range of indicators. Capacity and demand modelling highlighting future challenges. Delivery of the diagnostic recovery plan	a) Some (sub)specialty issues for RTT, resulting from increasing demand and capacity constraints b) Impact of other organisations' performance on Trust's ability to deliver c) Ensuring good knowledge of Access Policy rules for key staff d) Limited ability of IT systems to record waiting list position i.e. follow up appts e) Inability to recruit to specific clinical posts f) Effect of actions taken by neighbouring trusts to deliver their performance standards	

Actions Agreed	By Who:	By When:	Date Completed:
a) Undertake capacity and demand analyses for key specialties. Use additional workforce where absolutely necessary (eg impending consultant unavailability for sick leave, significant gaps in rotas)	COO/Head of Information/DM's	December 15	2 areas complete. Rolling to 2 more using new IMAS model
b) Close liaison with other organisations' in the local health economy through the Operational Resilience Board and Urgent Care Network	Head of Op/DM Medicine	Ongoing	
c) Training plan developed to sit alongside the Access Policy and clear resource on the Trust intranet to give staff an easy to access source of good practice re waiting times management	Central Booking Manager / Head of Training	February 16	In place – with COO attending
d) Manual systems in place to cross check. Close links between ops, information and development of EPR to ensure future systems capture this data	AH/LA	October 16	
e) Reviewing recruitment models specific to services	AH/CB/LW	March 16	
f) Continuous briefing to CCG of risks and mitigation where possible	AH	March 16	

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	Reduced demand for Trust services would have a detrimental impact on the sustainability of individual services and a cumulative impact for the organisation.	Joint Board of Directors Chief Operating Officer Director of Corporate Development	Finance and Performance Committee Waiting List Task Force Plus Waiting Times Action Group (WTAG) Engagement with commissioners – local and specialist Finance and Performance Committee	Market intelligence – foreseen and predicted changes in competitor activity and commissioning changes Review of market share by HRG Waiting times now and predicted in future. Marketing strategy – link to Trust Strategy Specialist services designation process Success rate of bidding for tenders Process established for determining whether SFT will submit tenders – informed decision making.	Market share relatively stable. SFT good reputation amongst both patients and GPs Positive NHS Choices feedback and Friends and Family ratings across a range of settings (ED, maternity, cancer services, inpatients) Large degree of compliance with designation. Strong relationships with commissioners High quality outcomes proven Good quality tenders submitted. Purchasing authority feedback High degree of commissioner satisfaction with performance of SFT services.	a) Orthopaedic market share stabilised but strategic opportunities by increasing market share b) Waiting times rising (eg orthopaedics, ophthalmology) c) Greater engagement of primary and secondary care clinicians via work on clinical pathways 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. h) Expertise and support for major tenders may be required. i) Community services being provided by a private organisation may have adverse impact on SFT performance	d) Time lag in Dr Foster data (only source of market share information) g) Need robust data on outcomes

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)	February 16	
Additional resource recruited to undertake orthopaedic review and develop strategy for future	COO/DM(MSK)	February 16	
b) Demand and capacity work required for most challenged specialties (see AF1, 1.1 above)	COO/Head of Information/DM's	December 15	
Options paper to board re future of Opthalmology service	AH	November 15	November 2015
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	December 15	
d) Review contract with Dr Foster re lack of data. Contract renewed for another year but timeliness issues remain.	Head of Informatics	March 16	
e) Spinal services review – key recommendations	MD/COO	December 15	
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	
i) Impact analysis carried out if community services no longer provided by NHS provider	DoCD	January 2016	

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 Feedback from mock CQC report (Sept 14) – not all staff able to describe lessons learned	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 – working with NHS Elect to provide bespoke training in complaints management and PPI 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 reviewed by CGC and Trust Board 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	Positive net promoter score as reported on NHS Choices Positive feedback from the Ombudsman on individual complaints management of cases brought before them.		a) Lack of evidence of direct learning from complaints

Actions Against Gaps in Control/Assurance:	**By Who:**	**By When:**	**Date Completed:**
a) Action plan agreed and disseminated as a result of the complaints workshop and monitored by DoN. Monitoring implementation of action plan through 1:1. KPI's being developed for Customer Care Report. Customer care facilitators developing robust action tracker and follow up which can then be disseminated more widely in order to evidence learning.	HH/LW HH/LW HH	Nov 14 03/15 January 15	20/11/14 04/15

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 • C. Diff rates exceeded trajectory in 14/15 due to PII in Feb/Mar of 9 cases (21 reported on a trajectory of 18).	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 2015) Monthly hand hygiene audits showing reliable practice across a number of areas. Q1 and Q2 HCAI data report from SW shows SFT in best performing quartile for rates of MRSA/MSSA/C.Diff National Joint Registry surgical site infection rates within expected range Improved PLACE scores across all categories placing Trust above average 2015	a) Variability in practice and evidence of learning across clinical areas b) Blood culture technique variable – 2 MRSA positive results over the last 2 years due to contaminants	

Actions Against Gaps in Control/Assurance:	By Who:	By When:	Date Completed:
a) Observational rounds in place across all directorates and led by DSN's b) Action plan in place to standardise blood culture technique	DSN's FMc/JH	July 15 July 15	In place 07/15 July 2015 –plan agreed IPCWG

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 • Increased incidence of falls resulting in harm • Increased incidences of mixed sex breaches • 'Never Events' relating to perioperative care	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 SFT Organisational Risk Tool (SORT) Contract Quality Reporting Meeting	Internal audit programme Internal reports to CGC and CMB CQC reports and risk rating via intelligent monitoring KQI report Quality Account NRLS reports Peer reviews National audit reports CPA/JAG and other externally led inspections of services Dr Foster data and HSMR/SHMI Survey results	Positive CQC follow up visit Oct 2013 with compliance declared across all standards. CQC Risk rating band 6 (lowest risk) May 15 End of year Quality account report shows good progress across priority areas Grade 2 pressure ulcer development reduced 9% in 2014/15 and subsequent downward trend for Q1 and Q2	a) Reliable assessment and application of preventative measures for patients who are at risk of falls, particularly those becoming more mobile and 'medically fit' for discharge b) Proactive management of single sex within a capacity challenged environment such as AMU c) Variation in perioperative practices regarding briefings and stop moment	d) HSMR higher than expected May 2015 (Dr Foster data)

Actions Against Gaps in Control/Assurance:	By Who:	By When:	Date Completed:
a) Renewed focus on falls as part of Safety Programme with linked KPIs			
• Compliance with intentional rounding – monthly monitoring	CG	January 16	
• Review of falls risk assessment – launch new documentation	MF/CG	December 2015	1st launch November 15
• Review of physiotherapist terminology	CG/Ward Leads	February 16	1st area June 15
b) Daily review by COO/DoN with clinical teams to 'unblock' downstream capacity issues	COO/DoN/All	May 15	May 15 - ongoing
• Visit and review other hospitals who have worked on this challenge in AMU	HB	July 15	July 15
• Exploration of longer term plan to meet AMU capacity requirements	COO	August 15	Aug 15 Bid requires further work
• Submit action plan to commissioners with short/medium/long term actions to resolve	LW	August 15	Aug 15 rejected by CCG – agreed Oct 15
c) Review of perioperative safety and gain assurance around embedding recommendations from never event reports Refresh of periop safety workstream with linked KPIs	LW/CB Liz Pickering	September 15	Workstream work in progress and ongoing
Link with OU Academic Surgical unit on joint working in reducing perioperative never events.	LW/DM	October 15	October 15
d) Review and analysis of mortality to be undertaken and presented to CGC	CB	Oct 15	October 15

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. 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.	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 (April 15) continues to demonstrate good level of understanding and knowledge of individual staff responsibility to safeguard children Action plan achieved following CQC inspection of Wiltshire Council Safeguarding Children	a) TNA in response to Intercollegiate document not yet robust b) Best Interests assessments not being carried out in a timely way by the LA	c) MLE continues to provide inaccurate data on training compliance. d) Variability of safeguarding (adult) and MCA knowledge across depts. e) Concerns raised by coroner regarding application of DoLS on the ICU

			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:**
a)	TNA to be completed and ratified through Integrated Safeguarding Committee				JM	July 15	Sept 15
	Scoping of additional training resource if required				JM	Sept 15	Sept 15
b)	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 and escalation processes				GC	Mar 15	Feb 15
	Review documentation proforma in use on ITU with a view to rolling out across Trust				GC	July 15	July/Aug testing
	Continue to work with LA on this issue				GC	Ongoing	Ongoing
c)	Continue to work with the education dept to solve issue of merging old and new information				JM	July 15	July 15
d)	Commission of MCA training with structured programme of specific depts to attend				FH/JO	Mar 15	Dec 14. Ongoing monitoring
	Ad hoc training sessions for clinical staff whilst regular teaching sessions arranged				GC	Dec 15	
	Mock CQC action plan to target areas for support				LW	Dec 14	Jan 15. Ongoing monitoring
e)	Review of DoLs processes within ICU undertaken				JG	September 2015	September 15

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 achieve an outstanding experience for every patient because staff do not feel valued and able to contribute fully to work as a consequence due to low morale.	Joint Board of Directors Director of Human Resources and Organisational Development	Strategic level EWC with Executive leadership of the workforce agenda. Emergent Leadership and Talent strategies. Trust Values and Behaviours. Equality and Diversity Steering Group Effective use of HR Policies such as Bullying and Harassment Policy; Flexible Working; Equal Opportunities Policy; Psychological Well-being and Effectiveness at Work. Staff Wellbeing Project http://intranet/website/staff/hr/shapeup/strategy/home.asp Risk assessments for significant staffing changes regularly reviewed by DSNs and reflected in Directorate risk registers and reported through 3:3's, to maintain appropriately skilled teams. Executive Walkround. Health and Safety Committee	Governance: EWC, OMB, JBD, Trust Board receive reports on: sickness absence; disciplinary and grievances data; stability/turnover; vacancy rates; safer staffing reports; Training and Development compliance (MLE); appraisal rates and the Staff Survey action plan. This provides evidence of progress in the two risk areas. Monthly Board Workforce Report Leadership and Talent Strategy with Executive Sponsorship progress monitored through EWC. Staff Survey Results Staff Friends and Family Test Equality Delivery Scheme Public Sector Equality Duty Compliance Annual Staff Survey H&S Committee receive reports on all staff related incidents with actions taken and recorded.	Staff turnover average 14.5% (11.3% excluding rotational medical staff). Staff sickness at 3.1%. Staff Survey 2014 results show that staff would recommend the Trust as somewhere to work and receive treatment, staff feel motivated at work, have good job satisfaction and experience good support from their immediate manager. Staff also report feeling engaged, putting us in the top 20% of acute trusts. Staff Friends and Family Test results are very positive with an aggregated 2014 score of 88% across both measures. Staff Health and Wellbeing established: shapeup@salisbury, including Stress workshops, access to RMN and physiotherapy support. Striving for Excellence Award nominations. Executive Walkround and Feedback. Values and Behaviour embedded in Induction, Recruitment and Appraisals, with work occurring at team level to translate the V&B into service settings. Health and Safety Annual Report. In top 100 places to work		a) Trust not reporting compliance levels in: -Appraisals (65%) -Training (range 74%-85%) b) Staff Survey shows there are more staff experiencing discrimination than last year.

Actions Against Gaps in Control/Assurance:	By Who:	By When:	Date Completed:
a) Development of Phase 2 of Trust Appraisal System: SpIda	AK (S Holt)	April 2016	
Cleansing of MLE data	AK (S Holt)	April 2016	
Introduction of E-assessments (rather than complete whole module if previously completed)	AK (S Holt)	April 2016	
b) Staff Survey Steering Group overseeing actions on discrimination	VDB	April 2016	

3.2

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Safe Caring Well Led	Failure to deliver excellence for all patients if the workforce is not appropriately skilled and staffed to the right levels.	Joint Board of Directors Director of Human Resources and Organisational Development	Strategic level EWC with Executive leadership of the workforce agenda. Emergent Leadership and Talent strategies to create a high performing workforce with effective succession plans. HR Policies including: Security of Employment, Attendance Management. Directorate 3:3 Staff Wellbeing Project http://intranet/website/staff/hr/shapeup/strategy/home.asp Organisational Change processes supported by HR policies and adoption of learned good practice. Workforce Redesign Group for the development and use of workforce planning and workforce redesign tools and monitoring Nursing skill mix review regularly reviewed and updated	Governance: EWC, OMB, JBD, Trust Board receive reports on: sickness absence; disciplinary and grievances data; stability/turnover; vacancy rates; safer staffing reports; Training and Development compliance (MLE); appraisal rates. Monthly Board Workforce Report Proactive management of sickness/absence by Directorate Managers with HR support. Workforce Issues are part of the discussions (and are minuted) at Directorate 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 Workforce planning given priority in 2015-16 Strategic Plans.	Staff Survey 2014 results show that staff would recommend the Trust as somewhere to work and receive treatment; staff feel motivated at work, have good job satisfaction and experience good support from their immediate manager. Staff also report feeling engaged, putting us in the top 20% of acute trusts. Staff sickness at 3.1%. Skill mix review of ward based nursing to be refreshed and updated in June 2015. Workforce reviews are being undertaken in all service areas including medical workforce Salisbury Organisational Trigger Tool assesses workforce planning needs as one of its measures Positive staff survey reports on appraisal uptake.		a) Staff survey reports that we are below average in staff receiving relevant training, learning or development. b) Trust not reporting compliance in: -Training (range 74%-85%) C) Difficulty in recruiting junior and senior medical staff in some specialities d) Vacancy gap in nursing staff of 13.3% (trust average vacancy rate c6%.
Actions Against Gaps in Control/Assurance: See 3.1 a) Nursing Workforce Governance and action plans to be reviewed b) Development of Phase 2 of Trust Appraisal System: SpIda c and d) Reviewing recruitment models specific to services including overseas recruitment initiatives and Non EU efforts. Nursing plan in place.					**By Who:** LW (VDB) AK (S Holt) AH/CB/LW	**By When:** April 16 April 16 March 16	**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	To meet the clinical needs of patients and the organisation, the Trust has procured an Electronic Patient Record (EPR). This will have a substantial impact over the next 18 months and has the potential to impact on other IT projects, requirements and cause substantial organisational disruption.	Joint Board of Directors Director of Corporate Development / Chief Operating Officer	Informatics Strategy Steering Group (ISSG) chaired by the Chief Execs and attended by many of the Executive Board members along with the IT Clinical Lead meets every month and will oversee the project. Project Management Board will manage the project according to Prince2 methodology. Experienced Programme Manager appointed. Appointed supplier with reasonable track record for delivering projects successfully.	Regular review of project progress against plans and objectives. Regular input from NED who is experienced in delivery of such projects. Business case following the accepted Monitor 5 case (strategic, commercial, financial, economic, management) format.	Experience of delivering a number of major, organisational wide projects, eg PACS, test requesting (ordercomms). Initial stages of the project have progressed smoothly with all timescales achieved and good progress made. Extremely strong engagement from Executive Directors (eg 5 present on ISSG, 2/3 on PMB)	a) Ensuring sufficient clinical engagement to provide input such that user expectations are known. b) Ensuring organisational wide commitment to the project at a time of much change. c) Delivering the benefits described in the business case. d) The Trust may not have sufficient resources with the right skills to implement the EPR. e) There may be delays to Payment By Results (PBR) data reporting around the time of implementation. f) Hospital wide infrastructure is unable to support the increased flows of information.	g) Project resource and process redesign conflicts with EPR, GS1, EDMS, e-whiteboard, POET etc all operating in the same period which will also coincide with winter pressures. This has the potential to impact on Clinician availability to provide required input.

Actions Against Gaps in Control/Assurance:	By Who	By When	Date Completed:
a) Ensure support from all Exec directors to the overall project and ensure sufficient resources included in the business case for backfill.	DoCD/DoI	December '15	
b) Ensure that importance of the EPR project is well known and that recognised by all as an organisational priority.	All Execs	Ongoing	
c) Recruit staff to the project focussed on benefits identification and realisation. PMO to take lead to combine with overall Trust service improvement function to ensure there is one co-ordinated transformation agenda for the Trust.	DoI/COO	Ongoing	
d) Clear workforce plan identified for the project and regularly reviewed at PMB and ISSG.	DoI	Ongoing	
e) Develop plans for the replacement of the data warehouse in good time to prepare for data switch over, communicate clearly to commissioners and Regulators the risk, but seek to have double running for at least 3 months before switchover. Proposal for data warehouse available by November '15.	DoCD	December'15	
f) Informatics to review infrastructure available in line with CSC requirements and ensure that infrastructure is adequate and to report back to PMB – incorporate as part of the full business case.	DoI	December '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 required to run the organisation whilst avoiding fines will impact on the Trust's financial position and potentially undermine the financial viability of the Trust. • CCG challenges • Shifting case mix • Coding gaps • CQUIN non delivery • Contract breaches resulting in penalties • Readmissions	Finance Committee Director of Finance	Contract monitoring systems in place Regular contract performance review meetings with key NHS Commissioners Monthly performance reports to Trust Board & Finance and Performance Committee Clinical Quality Review Group Monthly Directorate performance review meetings Use of standard NHS SLA contract & timetable for contract negotiations All contracts signed with key NHS Commissioners KPI's discussed at Directorate Performance Meetings	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 Q1 2015/16 All commissioners challenges are proactively managed Contingency in place to allow for potential penalties & fines Successful award of tendered contracts Monthly Un-coded activity < % of total monthly activity & all activity coded at SLAM freeze date	1. Insufficient development of informatics & finance systems to ensure the availability of relevant, accurate and timely activity and performance information 2. Proactive management of single sex within a capacity challenged environment such as AMU	

Actions Against Gaps in Control/Assurance:	**By who:**	**By When:**	**Date Completed:**
1. Review of informatics requirements for the Trust Evaluate new performance reporting tools. (i.e. CIVICA, QLIKVIEW)	LA / MC	December 2015	
2. Daily review by COO/DoN with clinical teams to 'unblock' downstream capacity issues	COO/DoN/All	July 15	July 2015
• Visit and review other hospitals who have worked on this challenge in AMU	HB	August 15	October 2015
• Exploration of longer term plan to meet AMU capacity requirements – Business plan and Capital Bid	COO	January 16	

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 cash and 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 Budget setting guidance/processes in place Established Cost Improvement plans (CIPs) Programme Steering Group External Audit of Annual Accounts Benchmarking Reference costs Workforce Committee monitoring agency spend	Monthly performance reports to Trust Board & Finance Committee Audit reports Monitor's Continuity Services Risk Rating (CoSR) Monitor's financial performance reports Monthly reporting of CIPs target to PSG, Trust Board and Finance and Performance Committee	Internal Audit reports – Low priority recommendations External Auditors unqualified opinion of Annual Accounts Achievement of CoSR of at least 3 out of 4 (4 being the lowest risk). Reference cost index <100	1. Tracking & delivery of CIPs and lack of development of 3 year CIPs plan 2. Forecasting capabilities & system needs refining 3. Development of Service Line Reporting (SLR) requires introduction of costing system 4. £8 million saving programme required and not fully identified 5. Non-Finance management training programme	1. Non delivery of recurrent CIPs 6. Accuracy of financial plans and forecasting at Directorate level 3. Usability of SLR

Actions Agreed:	**By Who:**	**By When:**	**Date Completed:**
1. Development of robust savings plan and rolling CiP plan with stretch targets. Extraordinary CiP meetings	MC/AH	30.06.15	November 2015
2. Upgrade business intelligence tools to support evaluation of new performance tools	MC/AJ	31.12.15	
3. Development plan for SLR	MC	30.09.15	SLR in place
4. Refresh planning & budget setting guidance 2016/17	MC	31.12.15	
5. Develop non-financial management training programme	MC	31.12.15	
6. Plan to introduce 'Return to Green' reports	AH	Immediate	November 15

4.4

CQC Outcome Link	Principal Risk	Reporting Committee and Executive Lead	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
Effective Responsive Well Led	Capacity and demand models need to reflect changing clinical practice and evidence operational management decisions to reflect the Clinical Services Strategy.	Joint Board of Directors Chief Operating Officer	Demand and capacity planning should be undertaken annually as part of the contractual round to ensure risks to delivery against commissioners intentions are identified at an early stage and mitigated. This work should be undertaken initially by the DMT and utilised by the COO and the finance and contract teams to negotiate annual contracts. Proactive reviews of demand and capacity should be an ongoing process which is undertaken by the DMTs and capacity flexed to meet known increases/changes in demand. The use of WTAG on a weekly basis to review waiting lists and any imbalances between capacity and demand, highlights areas for focus. Utilisation of IST model to consider real time forward view will support a more proactive approach.	The effectiveness of the management controls are reviewed as part of WTAG (weekly), WLTF (monthly and chaired by the chief executive) and also at JBD and finance committee and Trust Board through high level dashboards against regulatory and agreed efficiency and effectiveness targets. Externally, a commissioner report of our performance is produced which is reviewed at the monthly contractual meetings. Performance at Directorate level reviewed at 3:3 monthly meetings.	Achievement of all regulatory and internal targets regarding performance provides assurance that the balance is correct in terms of matching capacity and demand within the resources available.	a) Capacity and demand modelling too higher level. Informs contract setting and needs to be at operational level and recognise sub speciality of services.	b) IMAS tool not fully implemented and unable to provide assurance of the ongoing balance of demand and capacity. Contractual performance - income and activity meeting expected budgeted levels.
Action Agreed: a) Role out use of IMAS capacity and demand modelling tool b) Full implementation of the IMAS model					**By Who:** AH/DM's Informatics and DMs	**By When:** December 15 December 15	**Date Completed:**