SALISBURY NHS FOUNDATION TRUST

TRUST BOARD

MONDAY 6 JUNE 2016, 1.30 PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
1.30pm	**1**	**APOLOGIES FOR ABSENCE**			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES** Joint meeting with Council of Governors 29 February Public Board Meeting held on 4 April 2016			1
	4	**MATTERS ARISING**			
1.35pm	**5**	**CHIEF EXECUTIVE**			
		1. Chief Executive's Report	PH	SFT 3770	11
1.45pm	**6**	**STAFF**			
		1. Workforce Performance Report to include Nurse Staffing	AK/LW	SFT 3771	15
		2. Voluntary Services Annual Report	AK	SFT 3772	29
2.00pm	**7**	**PATIENT CARE**			
		1. Quality Indicator Report to 30 April (month 1)	CB/LW	SFT 3773	37
		2. Report of Director of Infection Prevention & Control	LW	SFT 3774	45
		3. CQC Action Plan and Progress Report	LW	SFT 3775	89
2.30pm	**8**	**PERFORMANCE AND PLANNING**			
		1. Finance & Performance Committee Minutes 21 March and 25 April 2016	NM	SFT 3776	93
		2. Financial Performance to 30 April (month 1)	MC	SFT 3777	101
		3. Progress against Targets and Performance Indicators to 30 April (month 1)	AH	SFT 3778	109
		4. Update on Strategic Planning and Programme Management	LA	SFT 3779	113
		5. Capital Development Report	LA	SFT 3780	123

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

1.	Audit Committee Minutes - 14 March 2016	PK	SFT 3781	135
2.	Clinical Governance Committee minutes - 25 February, 24 March 2016	LB	SFT 3782	139
3.	Council of Governors Committee Part I Minutes – 16 May 2016	NM	SFT 3783	153
4.	JBD Minutes Evidencing Presentation of Assurance Framework and Risk Register	PH	SFT 3784	157

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

11 **QUESTIONS FROM THE PUBLIC**

12 **NEXT MEETING**

The next public meeting will be held on Monday 8 August 2016, 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 Joint Meeting of Council of Governors and Board of Directors Held on 29 February 2016 In the Boardroom, Salisbury District Hospital

PRESENT

Directors:
Nick Marsden (Chairman)
Ian Downie
Lydia Brown
Paul Kemp
Peter Hill
Malcolm Cassells
Christine Blanshard
Laurence Arnold

Governors:
Colette Martindale (Deputy Lead Governor)
Raymond Jack
Lynn Taylor
Jan Sanders
Isabel McLellan
Ross Britton
John Parker
Shaun Fountain
Jenny Lisle
Pearl James
Jonathan Wright
Lucinda Herklots
Sharan White

APOLOGIES:
Nick Alward
Christine White
Mary Monnington
Alastair Lack
Beth Robertson
Andy Hyett
Lorna Wilkinson
Steve Long

Meeting note - there were not enough governors present to form a quorum, so the Council's actions are subject to ratification.

1. MONITOR PLAN 2016/17 including Quality Account

In support of the requirement to consult on this, the draft plan for 2016/17 was received; it was due for final submission to Monitor on 12 April 2016. The plan took account of the NHS Planning Guidance for 2016/17 and was based on Monitor guidance and included chapters on financial planning, workforce and quality.

The plan highlighted a number of initiatives being undertaken in the year, including the electronic patient record, setting up of Wiltshire Health & Care and the delivery of an unprecedented savings plan. The Trust's vision and principal objectives were unchanged, and were based on Choice, Staff, Value and Care.

The quality account priorities (goals) for 2016/17 had been the subject of consultation and were as follows:

1. Continue to keep patients safe from avoidable harm
2. Ensure patients have an outstanding experience of care
3. Actively work with our community partners, patients and cares to prevent ill-health and manage long-term conditions
4. Provide patients with high quality care seven days a week
5. Provide co-ordinated care across the whole health and care

community

Principal risks included a possible financial deficit in 2016/17, failure to deliver key performance targets and a failure to cascade learning from complaints and incidents to achieve sustainable change. Mitigations were in place for each risk area.

It remained the Trust's intention to continue to deliver high quality care.

The report was noted.

2. UPDATING THE CONSTITUTION

A report was received, circulated seven days before the meeting setting out proposals for the revision of the Trust's Constitution and the standing orders and rules that comprised it. A detailed report on non-executive director tenure describing among other factors the guidance in the Code of Governance as provided.

The following additional paragraph was approved by the Board, and approved subject to ratification by the Council.

> 37.3 The Chairman and other non-executive directors may be appointed for initial terms of up to 4 years, which may be renewed by the Council for a further term of up to 4 years, and may be renewed thereafter for such term, if any, as will bring the total length of service to 8 years. Where a director has served 8 years, his appointment may be renewed for a further year provided that exceptional circumstances exist in relation to the renewal.

The following other approvals were given:

Council of Governors Standing Orders	
11.3 composition of nominations committees for selecting non-executive directors (Page 55)	**Omit** in square brackets: • the Chairman [who will chair the committee]
Consolidation: Agreed by the Council of Governors in July 2014 (Page 61)	**NEW -** 21. Amendment of Standing Orders 21.1 Paragraph 20.1 of the Trust's Constitution provides that the standing orders of the Council may be amended as provided in the standing orders. 21.2 The Standing Orders of the Council of Governors may be amended at a meeting of the Council by a vote of the majority of governors (not a majority of governors present, but a majority of the governors). 21.3 No such vote shall be taken unless the proposed amendment has been included in an agenda for the meeting circulated to governors not less than 7 days before the meeting (for example, for a meeting on 27 January no later than 20 January). But the Council may vote to make an amendment the substance of which has been so included

	but which has been altered at the meeting.
Annex 4 Council composition Re Military Governor (page 26)	**Add:** "6. There shall be one governor appointed by the Commander of 1 Artillery Brigade or the Officer holding a position nearest to that position to represent local army interests."
Trust board standing orders – for information	
Para 16.2 –board committees (page 75)	**Omit** the requirement to appoint the local ACCEA, staff appeals, senior medical appointments committee
Para 25.4 (page 79)	Statement of Internal Control: now Annual Governance Statement
Annex 9 (Page 83)	**Add**: All board appointments are subject to compliance with the Health & Social Care 2008 (Regulated Activities) 2014
For information	
Annex 5 Model Election Rules	To replace with the latest published set, which permit various forms of electronic (rather than restricted to postal) voting.

SALISBURY NHS FOUNDATION TRUST

Minutes of the meeting of Salisbury NHS Foundation Trust Board Held on Monday 4 April 2016

Board Members Present:	Dr N Marsden	Chairman
	Mr P Hill	Chief Executive
	Dr C Blanshard	Medical Director
	Dr L Brown	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
	Mr I Downie	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
	Ms L Wilkinson	Director of Nursing
Corporate Directors Present:	Mr L Arnold	Director of Corporate Development
In Attendance:	Mr P Butler	Head of Communications
	Mr D Seabrooke	Secretary to the Board
	Mr P Lefever	Wiltshire Healthwatch
	Mr M Mounde	Public Governor
	Sir R Jack	Public Governor
	Dr A Lack	Lead Governor
	Dr B Robertson	Public Governor
	Mrs L Taylor	Public Governor
	Mr & Mrs Gould	Volunteers
	Elizabeth Kendal	Salisbury Journal

ACTION

2161/00 DECLARATIONS OF INTEREST AND FIT AND PROPER/GOOD CHARACTER

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

2162/00 MINUTES 8 FEBRUARY 2016

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

2163/00 CHIEF EXECUTIVE'S REPORT - SFT 3750 – PRESENTED BY PH

The Board received the Chief Executive's Report and the following principal points were highlighted by PH –

Care Quality Commission (CQC Report)
It was noted that the Quality Summit was scheduled for Wednesday 6 April and the publication of the completed report was expected by the end of the week.

Openness and Transparency
It was noted that the Trust had been rated as outstanding and was ranked fifth in the country in the recently published Learning From Mistakes league table published by NHS Improvement.

Patient Safety Collaborative
Two teams won awards in the Wessex Patient Safety Collaborative – the Transfer of Care Team and the Sepsis Team won two of the eight awards available.

Staff Survey 2015
The Trust had performed among the best in 25 of the 32 key findings. Past actions and responses had included the introduction of 24 hour site security and there would be further analysis of the findings of the survey. The good morale and engagement that the survey findings described were linked to good patient care. The Trust continued to flag average on questions relating to bullying and harassment and this was being discussed further.

NHS Leadership Academy Awards
It was noted that the Trust's Head of Equality and Diversity Pamela Permalloo-Bass had won the National Leader of Inclusivity of the year in the recent national awards.

Freedom to Speak Up Guardian
It was noted that Public Governor Isabel McClellan had been appointed as the Freedom to Speak Up Guardian and she was contactable via email and was holding monthly drop in clinics in the hospital.

Save 7 Campaign
The Trust had launched the Save 7 Campaign encouraging every employee to save £7 a week by reviewing and changing the way they work.

Junior Doctors Industrial Action
The next round of action being the withdrawal of all but emergency care was on 6 and 7 April. Junior Doctors had planned a further round of action for 26 and 27 April during which all care would be withdrawn between 8 am and 5 pm. Plans were being put in place to manage the effect on patients arising from this action.

The Board noted the Chief Executive's Report.

2164/00 STAFF

2164/01 Workforce Performance Report including Nurse Staffing - SFT 3751 - Presented by AK & LW

The Board received the Workforce Performance Report.

It was noted that the Trust's overall vacancy rate was 5.3% and the Trust continued to use variable staffing to fill rotas. There was extensive use of bank staff but there continued to be a challenge to fill all shifts. Agency was the next stage and these arrangements were now subject to caps nationally. There was a vacancy rate of 12% for nursing and midwifery which reduced to -1.6% when temporary staff and agency staff were factored in. In month 11 half of agency shifts for nursing were 'break glass' shifts within the guidance.

Negotiations with the provider agencies were continuing as it was expected that more shifts would be filled against the caps being introduced from 1 April. There was concern that the overall control total set by Monitor posed a potential threat to the Trust's payment of £6.3m under the Sustainability and Transformation fund.

Overseas recruitment continued and it was noted that the International Language Standard Two had been introduced and there was concern that this would be difficult for some EU recruits to attain. The government had recently confirmed that nurses would remain on the shortage occupation list albeit with restrictions attached.

In relation to the Nurse Staffing Report it was noted that Radnor and NICU continued to adopt a flexible approach to staffing in relation to variable demand. The current model was based on the rostas and were resulting in these areas flagging as red. Additional nurse staffing had been introduced in the Spinal Unit to ensure ventilated patients were continually monitored.

The Board noted the Nurse Staffing Report.

2165/00 PATIENT CARE

2165/01 Quality Indicator Report to 29 February 2016 (Month 11) – SFT 3752 - Presented by CB and LW

The Board received the Quality Indicator Report for February.

It was noted that two new Serious Incident Inquiries had started in February. A Never Event which had not resulted in serious harm was also declared.

The HSMR (Hospital Standardised Mortality Rate) was at 110 to November 2015 and was higher than expected. Mortality governance was being strengthened in line with recent NHS England guidance with more emphasis on analysing avoidable mortality.

A reduction in patients with fractured hip operated on within 36 hours of admission was due to theatre capacity. A business case was due to be approved that would separate out Orthopaedic and Trauma lists.

The SSNAP Audit for stroke services for Quarter 3 was a grade C on a scale of A-E.

There had been no new MRSA cases and the Trust had 15 attributed C-Diff cases to 31 March 2016. There had been a good reduction in the number of single sex accommodation breaches although there had been an increase in bed capacity and a reduction in the number of multiple patient moves.

The Board noted the Quality Report.

2165/02 Customer Care Report – Quarter 3 – SFT 3753 – Presented by LW

The Board received the Customer Care Report for Quarter 3. The Trust continued to receive complaints at a rate of 0.08% in relation to completed episodes. The figure for compliments was 0.8%. There had been 66 new complaints received which was similar to Quarter 2 although slightly down on the previous year. The 25 day turnaround of complaints was improving, as was more personal contacts with complainants. There had been one PHSO case not upheld in the Quarter. Complaints in relation to appointments arose from a range of issues and learning was always being

reviewed and implemented.
In terms of the reporting methodology it was suggested that complaints and compliments could not be offset.

The Board noted the Customer Care Report.

2166/00 PERFORMANCE AND PLANNING

2166/01 Finance & Performance Committee Minutes 30 November and 21 December 2015 – SFT 3754 – Presented by NM

The Board received the confirmed minutes of the Finance and Performance Committee for 25 January and 29 February 2016. The Committee had held a useful discussion with the Chairman and Managing Director of the Laundry company and was working with its representatives on Replica 3D to resolve that company's issues.

The Board noted the Finance and Performance Committee minutes.

2166/02 Finance and Contracting Report to 29 February 2016 – SFT 3755 – Presented by MC

The Board received the Finance and Contracting Report. The Trust had a year to date deficit of £7.4m which was an adverse variance of the year to date plan of £611,000. CIP savings were less than planned but were in part off set by over performance on income due to reductions in activity by QIPP schemes not being delivered. The Trust's position was off-set by changes in depreciation to the value of £800,000. There had been an increase in delayed transfers of care. The Trust's position was made more challenging because of the use of agency staff in relation to escalation beds that had been opened during the month.

Trust was working to finalise the year end positions with Wiltshire and West Hampshire CCGs. The latter discussion had been escalated to CEO level. Work was also underway to sign 2016/17 contracts including aligning activity projections for the year. Crucial information from the specialised commissioner had only just been received and was currently being analysed. The Trust would be submitting its final plans to Monitor by 11 April.

The Trust was on target to deliver the £6m deficit for 2015/16 that it had originally targeted.

The Board noted the Finance and Performance Report.

2166/03 Progress Against Targets and Performance Indicators to 29 February – SFT 3756 – presented by AH

The Board received the Targets and Performance Indicators Report. AH reported that the Referral to Treatment and Cancer target had been delivered. The Emergency Department target for month 11 had not been delivered. New bed capacity had been opened and patients with greater acuity had been presenting. There had been some ambulance handover breaches due to patient flow issues. However the Trust was ranked best in region for the lack of ambulance delays by South West Ambulance Trust.

There was good informal networking among hospitals in the locality. Formal executive level authorisation was required for any diverts.

The Board noted the Targets and Indicators Report.

2166/04 Statement on Major Incident Preparedness – SFT 3757 - Presented by AH

It was noted that providers had been required to make a public statement to the Board in relation to major incident preparedness.

Andy Hyett confirmed to the Board that a suitable policy was in place, which had been subjected to exercises and also that a business continuity plan was in place. The processes continued to be revised.

The Board noted the declaration.

2166/05 Financial Estimates 2016/17 – SFT 3758 – Presented by MC

The Board received the Base Estimates 2016/17 report explaining the base estimates to enable budgets to be set for the 2016/17 year in accordance with the Trust's standing orders.

It was noted that in order to receive sustainability and transformation funding of £6.3m through the year the Trust was required to deliver an income and expenditure control total surplus of £1.8m which would require savings totalling £9.5m (4.5%) This was considered to be a significant risk.

Changes to the Tariff made more cash available, thought to be £2.2m. The assumption was that the laundry and other subsidiary companies would be neutral in the estimates.

There was a national increase in employer contributions to pensions of around £1 billion nationally. The assumed impact of cost pressures on cash is £1.5m when compared to 2015/16. Non-recurring resilience support of £0.9m was received in 2015/16 to support emergency care during winter. Although the CCG had indicated that it will continue to support schemes there had been no confirmation of funding so far. As noted previously QIPP was at this stage unclear and activity assumptions with commissioners had yet to be aligned.

It was noted that savings arising from the Carter Report were still being explored although MC did not accept the final figure published by Carter in relation to the trust.

The Board approved the Financial Estimates 2016/17.

2167/00 PAPERS FOR NOTING OR APPROVAL

2167/01 Audit Committee Minutes – 12 October 2015 – SFT 3759 – Presented by PK

The Board received for information the confirmed minutes of the October 2015 meeting of the Audit Committee.

2167/02 Minutes from Clinical Governance Committee – 28 January 2016 – SFT 3760 – Presented by LB

The Board received for information the confirmed minutes of the 28 January 2016 meeting of the Clinical Governance Committee.

2167/03 JBD Minutes Evidencing Presentation of Assurance Framework and Risk Register – SFT 3761 – Presented by PH

The Board received for information a minute extract describing the review of the Risk Register and Assurance Framework by the Joint Board of Directors.

2167/04 National Out-patient and Emergency Department Survey Results – SFT 3762

This item was withdrawn.

2167/05 Staff Survey Results 2015 – SFT 3763 – Presented by AK

The Board received the Staff Survey results which as noted in the Chief Executive's report indicated that 25 of 32 key areas of the Trust had been placed in the top 20% of Trusts in the survey. No indicators were in the bottom 20% and there was a small number in the average band. The Executive Workforce Committee would continue to work through actions and would bring a report back to the Board in December.

The Board noted the Staff Survey Results 2015.

2167/06 Minutes from Council of Governors 22 February 2016 – SFT 3764 – Presented by NM

The Board received for information the minutes of the Council of Governors held on 22 February 2016.

2167/07 Annual Plan 2016/17 – SFT 3765 – Presented by LA

LA informed the Board that comments from NHS Improvement had been received in relation to the draft submission made earlier in the year. The submission deadline for the report was 11 March 2016. Governors had been consulted on the draft at the joint meeting held on 29 February and it had been reviewed by the Governor's Strategy Committee. The plan would form the first year of the Wiltshire Sustainability and Transformation Plan which was due for submission by June.

The Board approved the report.

2168/00 ANY OTHER URGENT BUSINESS

No matters were raised.

2169/00 QUESTIONS FROM THE PUBLIC

In relation to a question from Beth Robertson, Lydia Brown indicated that the Clinical Governance Committee had had a video patient's story at its February meeting. It had not been possible to complete the patient's story planned in January.

In relation to the Customer Care Report, Alastair Lack highlighted the Salisbury Foundation Trust page on NHS Choices which had a number of patient comments on it but no Trust responses as most queries and responses were posted on the Salisbury District Hospital page. It was also noted that an intranet page was included in the report which Governors

would not be able to access.

2170/00 DATE OF NEXT MEETING

The next ordinary meeting of the Board would be held on Monday 6 June 2016 at 1.30 pm in the Board Room.

CHIEF EXECUTIVE REPORT

MAIN ISSUES:

CARE QUALITY COMMISSION (CQC) REPORT

As publicised extensively in the local and regional media, the Care Quality Commission (CQC) identified a number of examples of outstanding areas of practice and aspects for improvement in its report of the Trust and all agencies met to discuss plans for improvements or actions from the report in a Quality Summit on April 6. As part of our ongoing staff communications I held four open sessions which gave staff an overview of the findings and how the actions from the report will be taken forward. In terms of staff engagement on the action plan itself, we held a number of internal workshops around each of the nine core services and these proved very successful and influenced our overall Trust-wide action plan which has now been submitted to the Care Quality Commission (CQC), NHS improvement and NHS England. Further details of our action plan and progress will be covered later in this Trust Board.

ADULT COMMUNITY SERVICES IN WILTSHIRE

As covered before in my reports to the Board we worked closely with other acute providers in Bath and Swindon last year to set up Wiltshire Health & Care to provide adult community services across Wiltshire and we are in the final stages of the implementation of the contract which will start on 1 July 2016. The aim is that this will provide more “joined up care” and expand the amount of care being offered in the community through a five year contract with Wiltshire CCG.

SUSTAINABILITY AND TRANSFORMATION PLAN

We are engaged in discussions with other organisations across our STP footprint (Bath, Swindon and Wiltshire) regarding the development of the plan, which will support the Five Year Forward View. The next checkpoint submission date for information to be provided to NHS England is due at the end of June and the group is on course to meet this deadline.

NURSE RECRUITMENT DRIVE

As part of our ongoing nurse recruitment campaign we have offered 73 nurses from the Philippines positions at the Trust following an interview and selection process carried out by a team of four, including specialist nursing staff and a Human Resources Manager. The nurses are scheduled to start arriving in November and December following further clinical and English language tests, as part of their Nursing and Midwifery Council registration process. They are experienced nurses and will have the skills required for the areas we currently find difficult to recruit to such as theatres, elderly care the spinal unit. Once here, they will have to complete a further examination as part of their registration. The Philippines is not on the Government’s restricted list of countries for nurse recruitment to the UK.

NHS PRIDE AND PASSION ON INTERNATIONAL NURSES DAY

In May our staff highlighted the enormous contribution nurses have made to the hospital and the NHS over the years as part of International Nurses’ Day. Poster displays highlighting the innovation, quality of care and professionalism of nursing staff across all wards and departments were on level four of the hospital, with

historical photographs showing how services, practices and patient care has developed over the years. International Nurses Day was set up to coincide with the birthday of Florence Nightingale who laid the foundations for modern day nursing and her commitment, care and compassion strikes a chord with the six key themes that we adhere to now and our own values and behaviours that are key to all our staff here in Salisbury.

CARER'S WEEK

Over the last couple of years we have introduced a number of initiatives to support carers in hospital and we are proud to support Carers' Week, which is taking place between the 6 and 12 June. We will be holding a special Carers' Café tea party with homemade cakes and an information stand in Spring's Restaurant on June 9. Carers Week is an annual campaign which raises awareness of caring and the challenges that all carers face. It is also an opportunity to acknowledge the tremendous support that carers give to family, friends or people that need their help and also the significant contribution that they make to our society.

SAVE 7 CAMPAIGN

Since we launched our Save 7 campaign to increase staff awareness and involvement in our current financial situation we have had a fantastic response from our staff. Thirty members of staff have already volunteered to become Save 7 Champions in their areas with staff taking away ideas to investigate within their own teams. Since its launch, over100 money saving ideas have been received and recent examples cover savings and more efficient practices in both clinical and non clinical areas. Staff now have access to a Save 7 intranet toolkit which is a central resource for us to share staff ideas, celebrate staff successes and provide communication and engagement materials.

SALISBURY TEAM AWARDED RESEARCH GRANT

Our clinical scientists and specialist staff have been awarded an initial £244,000 grant to lead new research that will look at whether Functional Electrical Stimulation (FES) could improve co-ordination and movement for patients with Parkinson's disease. The work, which will be done using equipment and services from our FES company Odstock Medical Ltd, will test a new device that aims to improve walking for people who have Parkinson's disease as they often have difficulty in walking. FES is used to stimulate underactive muscles, by applying small electrical impulses to their nerves, enabling them to walk more effectively. Over 22 weeks they will measure the changes in walking speed, falls, quality of life and symptoms. Information gathered from this study will be used to design a full research project and apply for an additional grant.

APPPOINTMENT NON EXECUTIVE DIRECTORS

This is a challenging period for the NHS and it is essential that the Board has a wide range of skills and knowledge to take us forward successfully in the future. We have appointed five new Non Executive Directors who will bring a wide range of public and private sector knowledge and experience to the Trust Board. Kirsty Mathews who is a former Chief Executive of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust and Tania Baker who is a Non Executive Director at HPA, a joint venture company which arranges treatment for its medical insurers have already joined the Board. Dr Michael Von Bertele OBE, Professor Jane Reid, Kirsty Matthews

and Dr Michael Marsh will join in the autumn, replacing Steve Long, Ian Downie and Lydia Brown who will have completed their term of office.

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 M1 (April) 2016-17

Presented for : Information

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

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

Previous Committees : Executive Workforce Committee 31 May 2016.

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

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	✓

NOTE: This report is one of two reports provided for M1. Appendix 3 provides a SAMPLE document for initial consideration, as it provides yearly comparators.

1. Summary

- This report provides a description of the activities within the Return to Green areas of Amber and Red on the Workforce Metrics (appendix 1).
- The Workforce Metrics (Appendix 1) have agreed levels of tolerance for each metric, agreed by Trust Executives on an annual basis.
- The Metrics are RAG-rated against these agreed tolerances.
- The Return to Green analysis below is based on areas where there has been a trend of amber or red.
- It is important to note that workforce figures for M1 are still being finalised following the close down of 2015/16. An update will be provided at the Board

2. SFT Workforce Numbers, Vacancies and use of Temporary Staff

Summary
The workforce metrics for M1 are showing Amber and Red, and work is being undertaken to clarify the budget and establishment positions.

2.1. The Total Workforce planned number has increased since M12, with the actual numbers of FTE against the plan FTE rated as Amber, with a gap of 244 FTE.

2.2 The trend over the past five months has seen a relatively stable level of staffing trust wide c.2790 FTE.

2.3 There is significant recruitment activity for registered nurses occurring including:

- International recruitment, with a recent trip to the Philippines in May resulting in over 70 job offers. These nurses are scheduled to join the Trust over the next 12 months, starting in Q3 of 2016-17.
- New starters from recent EU recruitment due in June.
- Further EU recruitment via skype interviews conducted in the last month
- An open advert for newly qualified nurses on NHS jobs http://www.jobs.nhs.uk/xi/vacancy/daeba2d83ede3b94d5754e434d3094dc/?vac_ref=914163885

2.5 The Safer Staffing report shows the expected ratios for Registered nurses: Nursing Assistants (60:40%).

2.6 Gaps in the medical workforce is being addressed through the Medical Workforce Transformation Group and includes:

- A review of rates of pay for bank staff
- New promotional recruitment information and conference attendance

2.7 The Trust aims to use bank staff to support the substantive workforce. The fill rates of shifts and hours for nursing vary month by month, and the trend has been a fill rate of c60-70%.

2.8 In the past five months the demand for bank hours has increased from a low of 25,400 (M9) to a high of 35,500 (M12). To encourage the uptake of bank shifts the Trust has adopted some incentives for staff.

2.9 In Month 1, of the agency shifts for nursing, 76% were break glass shifts (as per the Monitor guidance), with the Monitor tolerance at 30%. For the same period, the percentage of medical agency shifts over the Monitor cap was 100%. Work is ongoing with the agencies.

2.10 Recruitment to substantive posts and making bank assignments more attractive are the key actions being undertaken to reduce the use of agencies.

3. Workforce Health and Compliance

Summary
There have been significant improvements in the rates of non-medical appraisals.

3.1 Sickness rates are at 3.2% against a stretch target of 3.0%. Sickness rates for each Directorate have been set for 2016-17, with a reducing trajectory.

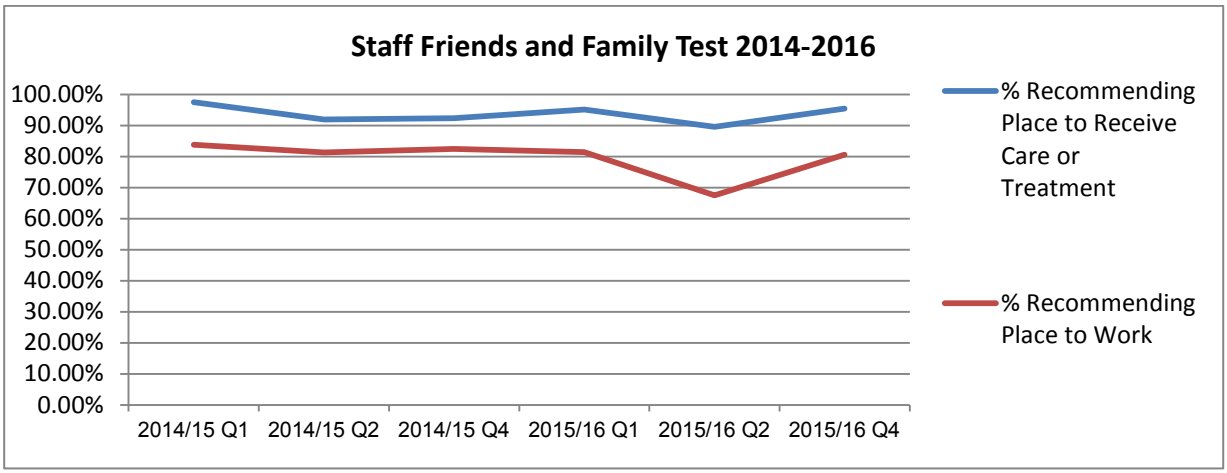
3.2 More than 50% of all Trust areas were below their target for sickness absence in M1.

3.3 Staff appraisal rates have increased from 59% M12 (2015-16) to 71% M1. This has been the result of dedicated support to managers and increased number of appraisals being completed. Recent additional reporting has allowed managers to review the individual staff records and chase up non-compliance at an individual level. Maintaining and improving this position is subject to an Improvement Plan and is overseen by a Steering Group.

3.4 Mandatory and Statutory Training overall compliance is 82.9%. The figure for Safeguarding Adults is not available this month, due to unresolved data processing issues. There is an Improvement Plan for MAST which is overseen by a Steering Group, chaired by the Director of HR & OD.

3.5 The Staff Friends and Family Test Q4 results: the results put the Trust in the top 20% of Trusts.

% Recommending Place to Receive Care or Treatment	95.5%
% Recommending Place to Work	80.6%



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

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

1. Metrics
2. Safer Staffing NQB Report – April 2016
3. SAMPLE M1 Report (landscape orientation)

Alison Kingscott, May 2016

Workforce Numbers

Staff In Post (SiP) numbers	*Target*	Apr-16	Trend	*Plan*
Total substantive Staff in Post (FTE)	= 95% of funded establishment (see vacancy rate RAG rating criteria below)	2,798		3,042
Total substantive SiP - Registered Nurses (FTE)	= 92% of funded establishment (see vacancy rate RAG rating criteria below)	741		894
Total registered nurses including variable staffing	See plan	849		894

Vacancies	*Target*	Apr-16	Trend	*Plan*
All Vacancies - excluding variable staffing (%)	<6% = green, 6% to 10% = amber, >10% = red	8.0%		5.0%
Registered Nursing Vacancies - excluding variable staffing (%)	<10% = green, 10% to 12% = amber, >12% = red	17.2%		10.0%
Registered Nursing Vacancies - including variable staffing (%)	<5% = green, 5% to 6% = amber, >6% = red	5.0%		0.0%

Workforce Costs and Quality	*Target*	Apr-16	Trend	*Plan*
Total Workforce spend vs. plan (YTD % above/below plan)	Reflects vacancy targets	1.4%		£10,780,153
Variable Staffing spend as proportion of total workforce spend	Reflects vacancy targets	12.7%		6.8%
Bank Spend Total	Upward trend	£877,659		
Nursing Bank Spend (All Nursing)	Upward trend	£712,760		
Medical Locum Bank Spend	Upward trend	£84,172		
Agency Spend Total	Reduction	£506,773		
Nursing Agency Spend (All Nursing)	Reduction	£232,945		
Medical Agency Spend	Reduction	£188,517		

Workforce Quality

Efficiency of Staff Deployment	*Target*	Apr-16	Trend	*Plan*
Temporary Shifts Requested	Upward Trend	3,745		
Bank Shift Fill Rate % - All Nursing	Upward Trend	60.1%		85.0%
Bank Shift Fill Hours - All Nursing	Upward Trend	19,485		27,558
Agency Shift Fill Rate % - All Nursing	Reducing	26.6%		
Agency Shift Fill Hours - All Nursing	Reducing	8,621		

Safer Staffing - April 16 to follow	Target	Mar-16	Trend	*Plan*
Actual Staffing Levels - Nursing Assistants % of planned	No target	103.4%		
Actual Staffing Levels - Registered Nurses % of planned	No target	100.0%		
Actual Skill Mix % Qualified	No target	62.0%		

Red
Amber
Green

Workforce Health

Sickness Absence	*Target*	Apr-16	Trend	*Plan*
Overall Sickness Absence Rate (12m rolling average %)	<=3.1% = green, 3.2% to 4% = amber, >4% = red (2.87% target).	3.2%		3.0%
Short Term Sickness (12m rolling average %)	No target	1.5%		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)	<=6.8 = green, 6.9 to 8.6 = amber, >8.6% = red	6.9		6.5
Financial cost of sickness in last 12 months	<=3.1% = green, 3.1% to 4% = amber, >4% = red	£3,874,737		£3,673,950
Turnover	*Target*	Apr-16	Trend	*Plan*
Staff Turnover rolling 12 months % (Excluding Rotational Medical Staff)	7-10% = green, 10% -12% = amber, >12% = red. (8.5% target)	9.7%		8.5%
Registered Nurse Turnover rolling 12 months %	7-10% = green, 10% -12% = amber, >12% = red. (8.5% target)	8.6%		8.5%
Starters % rolling 12 months (Excluding Rotational Medical Staff)	No target	12.9%		13.2%
Registered Nurse Starters rolling 12 months	No target	9.2%		9.5%
Staff Friends and Family Test	*Target*	Q3 2015/16	Trend	*Forecast Out Turn*
% of Staff agreeing they would recommend the hospital as a place to receive treatment	Top 20% of Trusts Nationally (77%)	84.8%		92.7%
% of Staff agreeing they would recommend the hospital as a place to work	Top 20% of Trusts Nationally (71%)	72.5%		80.9%

Workforce Compliance

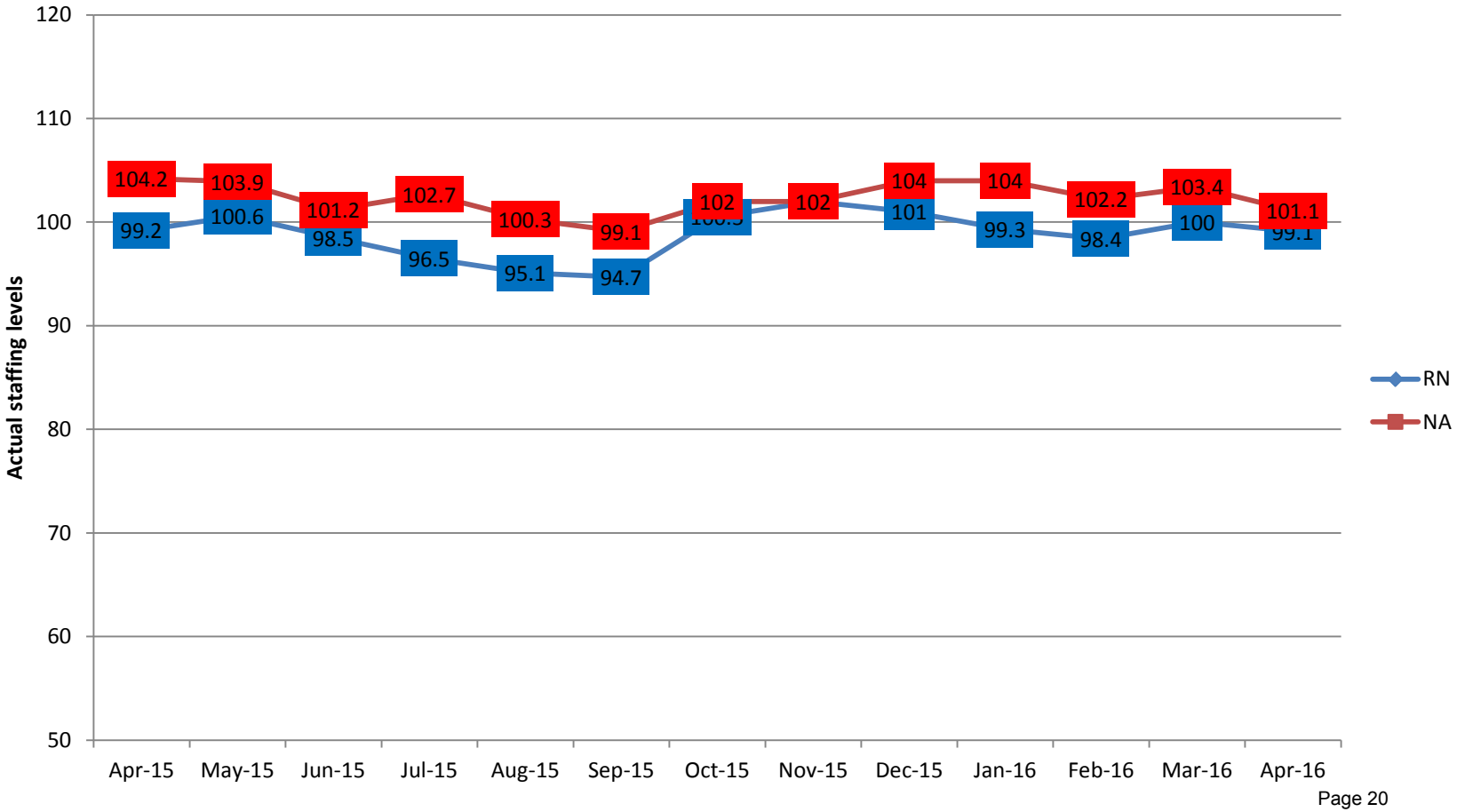
Appraisal rates (excludes Medical Staff)	*Target*	May-16	Trend	*Plan*
Appraisal rates for Non Medical Staff	>85% = green, 75% to 85% = amber, <75% = red	71.0%		85.0%
Appraisal rates for Medical Staff	>85% = green, 75% to 85% = amber, <75% = red	95.0%		95.0%
Statutory and Mandatory Training - All Staff	*Target*	May-16	Trend	*Plan*
Overall Statutory and Mandatory Training Compliance	>85% = green, 75% to 85% = amber, <75% = red	82.9%		85.0%
Equality and Diversity	>85% = green, 75% to 85% = amber, <75% = red	87.3%		85.0%
Fire Safety	>85% = green, 75% to 85% = amber, <75% = red	83.3%		85.0%
Health and Safety Overview	>85% = green, 75% to 85% = amber, <75% = red	87.1%		85.0%
Infection Prevention and Control (including hand hygiene)	>85% = green, 75% to 85% = amber, <75% = red	78.3%		85.0%
Information Governance	>85% = green, 75% to 85% = amber, <75% = red			
Moving and Handling	>85% = green, 75% to 85% = amber, <75% = red	78.7%		85.0%
Safeguarding Adults *	>85% = green, 75% to 85% = amber, <75% = red			85.0%
Safeguarding Children Level 1 and 2	>85% = green, 75% to 85% = amber, <75% = red	83.0%		85.0%

*The figure is not available this month.

Safe Staffing NQB Report – April 2016

Monthly Comparisons – Actual Staffing Levels

Registered Nurses			Nursing Assistants			Combined			Actual Skill Mix	
P	A	%	P	A	%	P	A	%		
56938.6	56433.8	99.1	34010.3	34389.7	101.1	90948.9	90823.5	99.9	62	38



Overview of Nurse Staffing Hours – April 2016

	RN	NA
Total Planned hours (day shift)	34141.1	22538.3
Total Actual hours (day shift)	33442.2	22623.2
Percentage	**97.9%**	**100.4%**
Total Planned hours (night shift)	22797.5	11472
Total Actual hours (night shift)	22991.6	11766.5
Percentage	**100.8%**	**102.6%**

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	**13897.50**	**14117.50**	**101.6%**	**10599.50**	**11184.97**	**105.5%**
Breamore Ward	965.50	1084.50	112.3%	854.50	923.00	108.0%
Durrington Ward	961.50	1020.00	106.1%	811.25	1080.92	133.2%
Emergency Department	345.00	345.00	100.0%	345.00	345.00	100.0%
Farley Ward	1790.00	1760.50	98.4%	1453.50	1508.50	103.8%
Hospice	874.50	880.00	100.6%	639.50	648.00	101.3%
Pembroke Ward	835.00	839.25	100.5%	378.50	373.00	98.5%
Pitton Ward	1474.00	1416.50	96.1%	1161.00	1078.30	92.9%
Redlynch Ward	1448.00	1390.00	96.0%	1157.50	1107.00	95.6%
Tisbury Ward	1943.00	1803.50	92.8%	683.50	661.50	96.8%
Whiteparish Ward	1520.50	1951.00	128.3%	1083.75	850.25	78.5%
Winterslow Suite	1740.50	1627.25	93.5%	2031.50	2609.50	128.5%
Surgery	**6308.00**	**6154.75**	**97.6%**	**3006.00**	**2542.25**	**84.6%**
Britford Ward	2114.50	2345.75	110.9%	1214.50	1152.50	94.9%
Downton Ward	1322.00	1310.00	99.1%	980.00	986.75	100.7%
Radnor	2871.50	2499.00	87.0%	811.50	403.00	49.7%
Clinical Support	**4937.75**	**4443.75**	**90.0%**	**1972.75**	**1555.50**	**78.8%**
Maternity	2561.25	2410.00	94.1%	1303.25	1119.75	85.9%
NICU	1350.00	1035.25	76.7%	324.50	77.50	23.9%
Sarum Ward	1026.50	998.50	97.3%	345.00	358.25	103.8%
Musculo-Skeletal	**8997.80**	**8726.20**	**97.0%**	**6960.00**	**7340.50**	**105.5%**
Amesbury Suite	1447.63	1428.75	98.7%	1374.00	1328.00	96.7%
Avon Ward	1388.58	1313.87	94.6%	1470.83	1852.67	126.0%
Burns Unit	1436.25	1485.25	103.4%	524.75	618.00	117.8%
Chilmark Suite	1529.00	1625.25	106.3%	1098.50	1033.50	94.1%
Laverstock Ward	1870.00	1654.75	88.5%	1025.00	1035.25	101.0%
Tamar Ward	1326.33	1218.33	91.9%	1466.92	1473.08	100.4%
Grand Total	**34141.05**	**33442.20**	**98.0%**	**22538.25**	**22623.22**	**100.4%**

Nursing Hours by Night Shifts

	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**9862.00**	**9976.00**	**101.2%**	**5576.00**	**6001.50**	**107.6%**
Breamore Ward	690.00	724.50	105.0%	690.00	648.50	94.0%
Durrington Ward	690.00	655.50	95.0%	690.00	747.50	108.3%
Emergency Department	345.00	345.00	100.0%	345.00	345.00	100.0%
Farley Ward	1035.00	1058.00	102.2%	690.00	834.75	121.0%
Hospice	570.00	571.00	100.2%	401.00	397.00	99.0%
Pembroke Ward	690.00	687.50	99.6%	0.00	0.00	0.00
Pitton Ward	1035.00	1023.00	98.8%	690.00	655.50	95.0%
Redlynch Ward	1035.00	1035.00	100.0%	345.00	529.00	153.3%
Tisbury Ward	1357.00	1345.50	99.2%	345.00	322.00	93.3%
Whiteparish Ward	1380.00	1473.00	106.7%	345.00	333.50	96.7%
Winterslow Suite	1035.00	1058.00	102.2%	1035.00	1188.75	114.9%
Surgery	**4259.50**	**4241.92**	**99.6%**	**1110.00**	**1131.50**	**101.9%**
Britford Ward	900.00	1262.00	140.2%	600.00	589.50	98.3%
Downton Ward	599.50	610.67	101.9%	510.00	520.00	102.0%
Radnor	2760.00	2369.25	85.8%	0.00	22.00	0.00
Clinical Support	**4471.00**	**4341.67**	**97.1%**	**1426.00**	**1119.75**	**78.5%**
Maternity	2401.00	2349.42	97.9%	1035.00	947.25	91.5%
NICU	1035.00	967.75	93.5%	345.00	92.00	26.7%
Sarum Ward	1035.00	1024.50	99.0%	46.00	80.50	175.0%
Musculo-Skeletal	**4205.00**	**4432.00**	**105.4%**	**3360.00**	**3513.75**	**104.6%**
Amesbury Suite	1035.00	1020.75	98.6%	690.00	701.50	101.7%
Avon Ward	600.00	829.00	138.2%	900.00	872.00	96.9%
Burns Unit	600.00	670.25	111.7%	300.00	419.75	139.9%
Chilmark Suite	570.00	598.50	105.0%	570.00	560.50	98.3%
Laverstock Ward	810.00	744.50	91.9%	300.00	370.00	123.3%
Tamar Ward	590.00	569.00	96.4%	600.00	590.00	98.3%
Grand Total	**22797.50**	**22991.58**	**100.9%**	**11472.00**	**11766.50**	**102.6%**

Overview of Areas with Red/Amber

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	**Radnor**	50%		√	Days	Down 8% from March . Review underway to align budgeted staffing template & the process of recording unrequired NA shifts for reporting purposes.
Red	**NICU**	24%		√	Days	Current establishment allows for between 2 and 3 registered nurses on per shift. Use of MAs to support registered nurses within a flexible fashion depending on patient demand.
Red	**NICU**	27%		√	Nights	25% reduction on NA staff at night compared to March. Awaiting agreed budgeted staffing template to enable accurate recording of unrequired NA shifts
Red	**NICU**	77%	√		Days	Unchanged since March
Red	**Whiteparish**	78%		√	Days	A reduction from 106% on March
Amber	**Laverstock**	88%	√		Days	At 93% in March demonstrating a 5% reduction in RN cover. Unfilled late shifts are left uncovered rather than use temporary staff when judged to be safe.
Amber	**Maternity**	86%		√	Days	A reduction in 7% compared to March
Amber	**Radnor**	87%	√		Days	This evidences a 4% reduction in levels since March
Amber	**Radnor**	86%	√		Nights	A 13% reduction in RN staffing levels at night from March

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

Overview of Overstaffed Areas >115%

Ward	%	RN	NA	Shift	Comments
Britford	140 %	√		Night	Reflects extra staffing requirements through SAU refurbishment. This has been corrected within the roster template to reflect staffing levels for the refurbished SAU accurately from 18th July 2016 roster period
Sarum	175 %		√	Night	A 100% reduction on last month's very high establishment of 215%. A Nursing Assistant is used rather than an RN. Professional judgement used to determine the ward was safe to do this in terms of acuity and dependency at the time of the decision making. No requests for Thornbury.
Avon	119 %		√	Day	Use of competent band 3 staff to cover RN gaps where appropriate on a flexible basis with a 6% increase on March
Avon	138 %	√		Night	A 12% increase ensuring ventilated patients receive 'line of sight' care as per CQC requirements. This figure will further reduce in later reports as the increased budgeted staffing levels are reflected within the rosters
Durrington	133 %		√	Day	A 6% increase in NA day cover . Vacant RN shifts are being covered with actin g up NA staff & 24 hour 1:1 care for a patient.
Burns	118 %		√	Day	An increase of 2% compared to last month.
Burns	140 %		√	Night	An 8% decrease in overstaffing at this grade compared to last month
Winterslow	115 %		√	Night	A reduction of 17% on March
Winterslow	128 %		√	Day	The first reduction in overstaffing since the last 2 months with a 13% decrease
Whiteparish	128 %	√		Day	1% increase on March
Redlynch	153 %		√	Night	An 8% increase
Farley	121%		√	Night	An increase of 26%
Laverstock	123%		√	Night	There was a 20% increase of NA numbers . This was for only 2nights where NA cover supported unfilled RN shifts. This was based on professional judgement and patient safety.

Mitigation of Risk
for Red/Amber

The overall Trust levels remains consistent with actual fill rates of RN 99 % & NA 101%.

A review of the budgeted roster templates with the number of shifts for NA staff on Radnor ,NICU & Maternity is being undertaken as the small numbers of staff rostered easily result in a Red/Amber trigger.

When completed , a formal process with training will be put in place where shifts can be accurately managed to reflect flexible staffing needs & reporting figures accurately. There is nothing to indicate in quality indicator data of an adverse impact in month.

Maternity are undertaking active recruitment to the increase in the areas and duties for their Maternity Assistants as the same number of staff are currently spread “more thinly” within the unit . This is also reflecting within the lower staffing numbers.

Over-Staffing

Although the demographic of wards has changed, there been an overall decrease in the levels of over-staffing Trust wide for April.

- Avon continues to flag as new staffing levels are not yet reflected within the rosters.
- Britford will continue to flag until the SAU changes align with roster production

Rationale for Overstaffed Units

Sarum**:-** A reduction of 100% on last month's figure . Staffing levels are based on robust clinical assessments

Burns :- NA cover for days was increased with a reduction in night cover to compensate for this change.

Winterslow :- An overall reduction of overstaffing on both day and night shifts compared to last month.

Durrington :- NA staff with appropriate skills are acting up in vacant RN shifts subject to scrutiny

Whiteparish:- RN with supernumary status

Redlynch:- Additional duties to cover required specials

Farley:- Additional duties to cover required specials

Laverstock:- Only 2 nights of NA cover acting up for unfilled RN shifts based on clinical judgement provides a 20% increase in the figures

Actions taken to mitigate risk

Actions required remain unchanged:-

Over-staffing is only used to support high patient acuity & dependency & where appropriate, using unregistered staff. All are subject to scrutiny by the DSNs

- Staffing levels are flexed according to patient acuity and dependency levels. These are assessed by the nurse-in-charge of individual wards.
- The skills set of staff is carefully accounted for when deciding on the band of staff needed. Safety is a priority with careful consideration to cost efficiency.
- Additional NAs are rostered to support unfilled RN shifts as demonstrated
- All shifts are assessed on a shift by shift basis.
- Staff are moved across wards by Directorate Senior Nurses and Clinical Site Team as required. This ensures safe levels of care are maintained whilst trying to reduce reliance on expensive temporary staff
- Staffing levels are reduced when beds empty/ procedure lists reduced whilst maintaining appropriate staffing ratios
- Shifts that are difficult to cover (nights and weekends) are prioritised.
- If all of the above measures have been taken there may be a requirement that staff on training days are brought back to work clinically as required and / or Sisters on supervisory shifts work clinically.
- CCOT team support wards where acuity of patients high.

VOLUNTARY SERVICES DEPARTMENT ANNUAL REPORT

PURPOSE: To bring to the Board an Annual Report detailing the nature and extent of volunteering within the Trust in the year 2015/16.

This report is provided to highlight some of the invaluable activities undertaken by individual volunteers and the voluntary organisations registered with the Department.

MAIN ISSUES: As at 31st March 2016, 693 volunteers were registered with the Voluntary Services Department. The volunteers continue to give a large number of hours of their time to complement and enhance a variety of services to our patients across the hospital. This service is extremely well received by staff, patients and visitors, and reflects the strength of feeling and support for Salisbury NHS Foundation Trust by many members of the local community. Volunteers gave assistance in two ways: either directly, or indirectly as a member of a voluntary group or local branch of a national voluntary organisation.

Voluntary Services continues to work alongside the Human Resources Department enabling it to be involved with issues around the Trust and to keep up to date regarding changes to recruitment procedures. Josie Kennedy, Administrator is currently on maternity leave, Jo Jarvis, Manager, has ensured that standards have been maintained during this time.

Within the past year we lost of the services provided by the Royal Voluntary Services (formally the WRVS) due to the reduction of volunteer numbers, and the viability of the service they offered. This has been a great loss to some patients who are bed-bound.

Applications. In the twelve months to 31st March 2015, 191 applicants applied to be a volunteer, 39 applicants who returned their form later changed their mind or were refused a placement due to either health checks or Disclosure & Barring checks. 127 new applicants started during the year and 25 applicants are currently completing their recruitment paperwork.

Trust Membership. All volunteers are given the opportunity to join the Foundation membership, which increases steadily year on year. The number stands currently at 214 members who are volunteers. Many volunteers have joined the membership as a member of the public rather than as a volunteer so we understand the real number of members who are also volunteers is higher.

Volunteer Governor. Pearl James was elected as governor from 1 June 2015. She has been very enthusiastic in her role, and has played a pivotal role in encouraging volunteers to wear the polo shirt. She is not afraid of facing challenges head on, and offers valued support to Voluntary Services and all the volunteers.

Volunteers Trust Inductions. Tuesday 5th April 2016 saw the first Volunteers Trust Induction (VTI). All new volunteers will be required to attend a VTI and these will be held 4 times a year on a different day of the week at varying times of the day to enable working, retired and school pupils an opportunity to attend. It is a full session lasting 2.5 hours and includes a welcome from either the Chief Executive or Chairman, Alison Kingscott, Director of Human Resources and Operation Development talked about the importance of the Trust Values and Behaviours,

together with sessions on Safeguarding Adults and Children, Health & Safety, Information Governance and Infection Control to name a few. Feedback from our first Induction was very positive with very few amendments required for future and subsequent sessions. Our longer serving volunteers are also currently invited to attend to enable them to feel included, updated and informed on the Trusts current position.

Staff Awards. Volunteers are included in the annual Staff Awards. The winner can be either an individual or a team of volunteers. The judging panel consisting of Alistair Lack (Lead Governor), Pearl James (Volunteer Governor) and Nick Marsden (Chairman) decided on the winners. It was a hard decision for the panel to make but they finally came up with one winner and three highly commended.

Jane Middleton was the overall winner. Jane has volunteered at the Hospice since 1994 and has been an energetic and caring volunteer. She has been dedicated to the wellbeing of others in a variety of ways such as running bakery sessions and opening up her garden for patients, carers and staff to enjoy. Highly Commended was awarded to Teresa Kennedy. Teresa has helped the Chaplaincy team for the past 14 years, giving her time freely alongside patients and their families in times of crisis. Keith Nobel also received a Highly Commended for his work with the Toybox Day Nursery. Keith secures donations to help him fund the beautiful flowers he provides to the nursery, making their outside space colourful and enjoyable. He attends every day to water the plants including weekends. Finally Angie Wescomb received a High Commended for her work with the Sterilisation and Disinfection Unit Previously the SDU Quality and Training Manager Angie continued as a volunteer offering guidance and support whilst dealing with a challenging medical condition.

Work Experience. We provide placements to pupils aged 14 and 15 in non-clinical areas, whilst those aged 16 and over can apply for clinical placements. We also provide placements to mature students who are contemplating a career change. All applicants attend an interview with the VSM Manager together with a member of staff from their placement of choice. If successful a 5 day (Monday – Friday) placement is offered. Placements become very competitive as several applicants are seeking the same placement at the same time.

We provided placements for 95 students in over 30 locations around the Trust. We would like to say ‘Thank You’ to all the wards and departments who agree to take Work Experience students.

The Physiotherapy team needed to find a way to work smarter but still offer the same opportunity to work experience students. Working together a ‘Study Day’ was created. This provided students with a full day of talks, simulated tasks using the SIM man and followed by observational time with a physiotherapist and patient in a clinical setting. The trial session took place in November 2015 with further sessions to take place twice a year (next session is June 2016). Previously only one student a month for 10 months of the year would have secured a placement, but now they can accommodate 20 students a year (10 at each study day) doubling the number of placements in two days work. This has enabled the team to manage staffing better and give value to the students attending.

Careers & Further Education Fairs. The VSM has continued to attended careers fairs held within local schools, giving the opportunity to provide students with information regarding a career in the NHS and also on how to become actively involved through work experience and volunteering.

Volunteers Day. The Volunteer’s Day was held on Wednesday 10th June 2015. Volunteers were also invited to the Volunteers Christmas Party in December. We

gave volunteers the opportunity to bring a guest, whether that was their partner, friend or neighbour, which did lead to recruiting a few extra volunteers. These events give the Trust a chance to say 'Thank you' to all the volunteers and an opportunity for the volunteers to meet with other like minded people who help us.

The next volunteer's day is to be held on Friday 10th June 2016, from 2.00pm – 4.00pm for afternoon tea in the Boardroom. Board members would be very welcome to attend to meet some of our volunteers.

Achievements
We have received a Silver Award from Health Education Wessex for the quality of work experience we offer students at Salisbury District Hospital. Our assessment, which was carried out in conjunction with Fair Train, covered induction, health and safety, safeguarding and equality training, as well as the placement itself.

Future Plans
It is important that we improve on the service we already provide to departments, and with the public offering their time we need to ensure that we make the most of their skills.

With the new Volunteers Trust Induction now in place, we will continue this work by ensuring that volunteers have a robust 'departmental' induction. This will ensure that volunteers have the department explained fully, ensuring they know where important but basic items are, such as the toilet, where to hang their coat. We would also like to work with wards and departments to ensure that volunteers roles are clearly defined enabling everyone to know exactly what their purpose is and that full training is given whether that be 'on the job' or classroom based.

Leading on from this we hope to have a 'volunteer mentor' in every ward giving new volunteers a friendly face to make contact with in their early days of volunteering.

Conclusion
Voluntary Services Department is fortunate to have the full support of the Chairman and the Board members, and we would like to thank them for their support.

The number of volunteers currently registered with the Trust stands at 680.

The dedicated work and support the volunteers give can only go on with the support they receive by the Trust and the staff within it. I would like to offer my thanks to all the staff and I would like to personally thank all the volunteers, both individual and those attached to voluntary organisations for their commitment and tireless support for the Trust.

ACTION REQUIRED BY THE BOARD:

1. To note the report.
2. Approve its wider circulation and distribution.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

- Voluntary Services Snapshot April 2016

AUTHOR: Jo Jarvis
TITLE: Voluntary Services Manager

VOLUNTARY SERVICES DEPARTMENT
SALISBURY DISTRICT HOSPITAL

The following provide details of placements and locations within the Trust where Volunteers assist patients, visitors and staff.

The Volunteers

Our Volunteers gave assistance in two ways: either directly, or indirectly as a member of a voluntary group or local branch of a national voluntary organisation.

Direct Voluntary Staff

Direct volunteers enhance the services provided to patients, visitors and staff by providing help to particular wards or departments. There are many ways of offering voluntary help and many different areas to work in, for example, ward work, helping out at an out-patients department, and guiding patients and visitors around the hospital. Volunteers also offer help to one-off projects. There are volunteers in approximately 30 different locations within the Trust.

Other Volunteers and Voluntary Organisations

The groups that are active within the Trust cover all types of work, including ArtCare, Radio Odstock, Floral Societies, Pets as Therapy, the League of Friends, the RVS and the 'Stars' appeal..

These bodies play a vital part in the everyday functioning of the Trust, and of course are an essential lifeline to patients and visitors alike.

Their Services

The following gives a brief outline of the various services provided by both our individual volunteers and those members of the voluntary groups involved in Trust departments during the past year.

ArtCare

ArtCare have 8 volunteers who are professional artists who give their time to offer patients the opportunity to 'have a go' at art in hospital. They will be increasing their number of volunteers who will help with their new 'history of Salisbury District Hospital' project.

Audiology

Audiology has a volunteer who is able to help in the office and to change batteries and carry out minor cleaning to hearing aids received in the post.

Changing Faces

A volunteer, who is a highly trained individual, provides therapeutic hand care and cosmetic camouflage to patients. This service is greatly appreciated by the patients within plastic surgery.

Pets as Therapy (PAT)

Pets within the hospital make a huge difference to every patient they visit. They provide, and open up channels of communication between patients. Staff and visitors also like to offer 'affection' to

the pets. We currently have just 4 dogs who visits patients with their owner and we are currently recruiting new owners/pets.

Cancer Services

Cancer Services currently has 2 volunteers who help the department by locating, collecting and preparing patients notes ready for the MDT teams. This process can be very time consuming and their help is invaluable to the team.

Catering

The catering team continue to provide placements for 2 volunteers one of which has learning disabilities. They carry out basic but still important roles and we have seen them flourish.

Children's Day Nursery

The nursery provides placements to volunteers to help them gain experience either to assist with college courses or due to being unemployed and not being experienced enough to secure them employment.

Chaplaincy Visitors

The Chaplaincy is supported by 26 volunteers who are able to offer comfort, prayers and other spiritual support to patients at their bedside.

Clinical Psychology

The Clinical Psychology department have 70 volunteers who help with the delivery of their 'Engage' project. They have been providing our patients with stimulation and interaction through memory puzzles, discussion groups and reading. More cognitive stimulation and social interaction can help alleviate some of the problems that older people could face when they leave familiar surroundings to come into hospital and provide a more interesting and therapeutic environment for them. Tora Mathias-Jones who was the lead on this project left until August 2015, Antoinette Broomfield took this role on but is due to leave as she is moving from the area.

Christmas Carols/Father Christmas

Choirs/bands visited the hospital to entertain the patients, visitors and staff on the run up to Christmas. Their visits are a pleasure and bring a smile to everyone's face.

Father Christmas visited the hospital together with Mrs Christmas and their two elves. They came on Christmas Eve and supplied gifts to patients on, Burns Unit, Sarum, Maternity, and NICU, Laverstock and Radnor Ward. A special gift was left for the first born baby on Christmas Day, and every patient, visitor and sibling were presented with gifts. Reeves the bakers in Salisbury donated large Christmas cakes which were left with each of the wards.

Discharge Lounge

Volunteers provide refreshments for the patients whilst they wait to go home, as well as collecting prescriptions and getting lunch for them if necessary.

Floral Societies

Seven local floral groups provide us with a beautiful floral arrangement each week in the Chapel. Patients, visitors and staff welcome and appreciate these delightful floral arrangements.

Fundraising

Dave Cates, the Director of Fundraising together with his team of administrators continue to receive support from approximately 31 volunteers who work tirelessly raising funds. The Stars Appeal is attracting great interest and volunteers are embracing the campaigns with great vigour.

Horatio's Garden Friends

'Horatio's Garden at the Spinal Unit, 80 volunteers help maintain the garden. In addition volunteers also provide patients on the unit with someone to sit and chat to, play games, read, and to help patients with gardening tasks. Volunteers have received wheelchair and bed moving training enabling them to take patients from the unit out to the garden. Activities are planned for the coming summer to ensure that the garden will be a social area for people to meet.

Hospice/Palliative Care

The Hospice has approx. 100 volunteers who offer a vast array of support to patients, visitors and staff. They also support the Day Centre and fundraising events. Dorothy Harker, the coordinator of volunteers at the Hospice left this role in September 2015 and we have welcomed Elaine Willman to this role. Elaine has worked well with Voluntary Services to ensure their volunteers receive appropriate training specific to their needs, and that recruitment is carried out correctly in a timely manner.

Hospital Guides/Self Check-In

This service always receives positive feedback from members of the public. We have a team of 20 dedicated and fit volunteers who assist our patients and visitors who enter the hospital by either directing them to the location of their appointment or to help them use the Self-Check-in screens. It has been known for them at times to help staff, and save them from getting lost!

Library Services (Staff)

The Library volunteers provide an excellent service helping to shelve books, photocopy and undertake other varied tasks within the staff library.

Lung Exercise and Education Programme (LEEP)

LEEP has a volunteer who assists the team by attending the courses for patients with severe respiratory issues. She provides careful encouragement and praise during the structured exercise sessions to the patients and that well earned 'cup of tea' at the end.

Pharmacy

Pharmacy has 2 volunteers who assist them. They help to 'serve' the customers on the front desk and also help with the stock deliveries and returns. Volunteers will also deliver urgent stock to wards.

Readership Panel

Our readership panel volunteers provide an invaluable service by reading the information leaflets that are designed to be given to patients, making sure they are understandable and jargon free. The panel is made up of ex-patients, current patients and other interested parties and have all taken a course on 'plain English'.

Radio Odstock

Radio Odstock have 17 volunteers providing live and recorded programmes to our patients. They are currently looking at ways of improving their listening numbers and bringing their service more up to date.

Recycling

A team of 20 volunteers collect all unwanted furniture, equipment and office sundries such as desks, filing cabinets, folders, and box files. They repair some items to enable them to be reused; items that are beyond repair are dismantled, parts which have a scrap value are sold rather than being disposed of.

Salisbury Hospital League of Friends (LoF)

The League of Friends continues to support the Trust. Their traditional sweets continue to be a hit with everyone. They have again been able to provide the Trust with the funds required for additional equipment for a number of projects.

Schools in the Community Volunteers

We received applications from sixth form students from various public and private schools within our local area who wish to volunteer. Many of the pupils have expressed a wish to pursue a career in healthcare, and attend once a week during term time to gain experience working within our Trust. Pupils are always polite and committed to their placement, staff and patients are always pleased to have their company.

Spinal Unit

There is a close working team of 12 volunteers who provide an integral service to the patients and staff on the Unit. Volunteers very often become a befriender to patients as they can be some distance from their home and their relatives, and provide an important service at mealtimes feeding patients or preparing/cutting their food.

Trade Unions & Staff Associations

We continue to have a good relationship with the Trust's Trade Union and Staff Association representatives, who are very supportive of the department's work.

Ward Helpers

A large proportion of our volunteers provide support to our patients during their stay in hospital. The volunteers provide a friendly face to the patients and staff throughout the ward, offering conversation, refreshments, assistance at mealtimes, and non-clinical 'tender loving care'.

Wessex Rehabilitation Unit

Wessex Rehab has 9 volunteers who help patients using the workshop. They create a number of products which they sell, and are able to produce wine racks, house name/number plaques and stools, and engraving to a range of materials. They are also able to produce specially commissioned items, and have produced a number of staff badges and door signs for the Trust.

Trust Board meeting **SFT 3773**

Quality indicator report – April 2016

Date: 23 May 2016

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

Executive Summary:

- 2 cases of Trust apportioned C Difficile.
- A decline in the elective MRSA screening rate. Directorates are investigating each case.
- 4 new serious incident inquiries commissioned in April.
- A decrease in the crude mortality rate in April 16 associated with a decrease in admissions. SHMI is 109 and 104 adjusted for palliative care to September 2015. HSMR decreased to 109 in January 16 and is higher than expected.
- The number of grade 2 pressure ulcers remain static. Share and learn meetings on-going. Two grade 3 pressure ulcers, one was a particularly complex patient. Full investigations underway.
- Safety Thermometer – 96% 'new harm free care'.
- There were 2 falls, 1 resulting in major harm (fractured elbow requiring internal fixation) and 1 moderate harm (head injury).
- CT scan within 12 hours was sustained at 100% for stroke patients. An improvement in patients spending 90% of their time on the stroke unit. Patients arriving on the unit within 4 hours declined due to bed pressures but mostwho breached the target arrived minutes after the 4 hours.
- A significant reduction in high risk TIA patients being seen within 24 hours due to clinic availability (industrial action and consultant leave). However, 90% were seen within 30 hours.
- Escalation bed capacity remains at a high level with a significant number of delayed transfer of care and 'green to go' patients. Ward moves remain at a low level.
- In April 16 there were no non-clinical mixed sex accommodation breaches.
- Real time feedback improved in April for patients rating the quality of their care. The Friends and Family test response rate for inpatients and ED declined as did the Maternity Services response rate. Day case response rates improved but outpatient response rates remained consistent with previous months. Q4 staff FFT showed an improvement in recommending the hospital as a place to work and to receive care and treatment.

Proposed Action:

1. **To note the report**

Links to Assurance Framework/ Strategic Plan:
CQC registration

Appendices:
Trust quality indicator report – April 2016

Supporting Information

Salisbury NHS
NHS Foundation Trust

Trust Quality Indicators - April 2016

Quality Measures

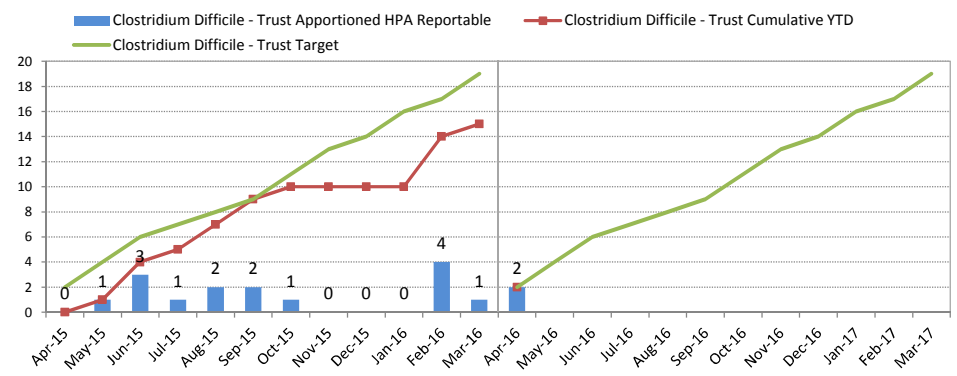
Infection Control	2015-16 YTD	2016-17 YTD
MRSA (Trust Apportioned)	0	0

Trust Incidents	2015-16 YTD	2016-17 YTD
Never Events	2**	0
Serious Incidents Requiring Investigation	28***	4

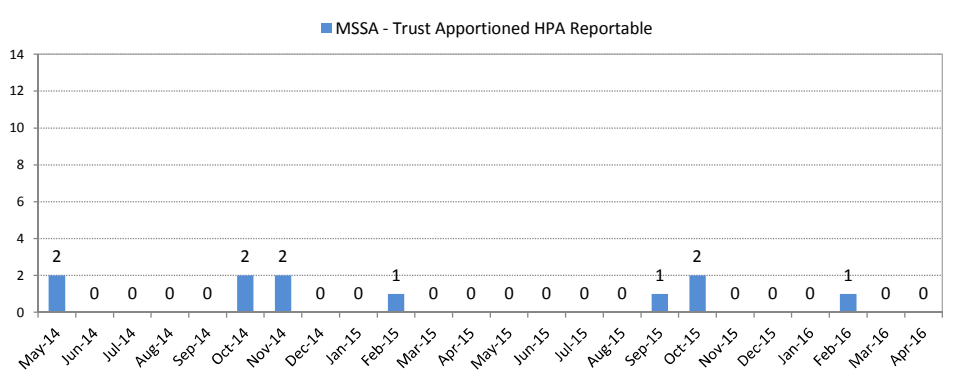
** A formal agreement was reached with the CCG to downgrade a third never event as it did not meet the definition.

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

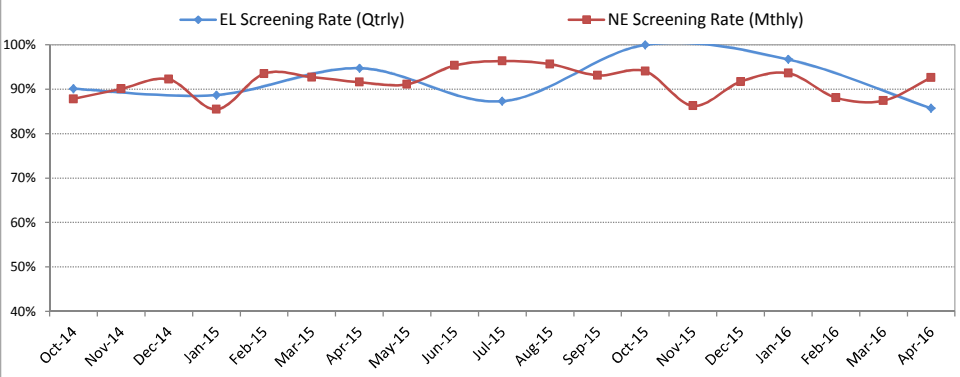
Clostridium Difficile - Trust Apportioned



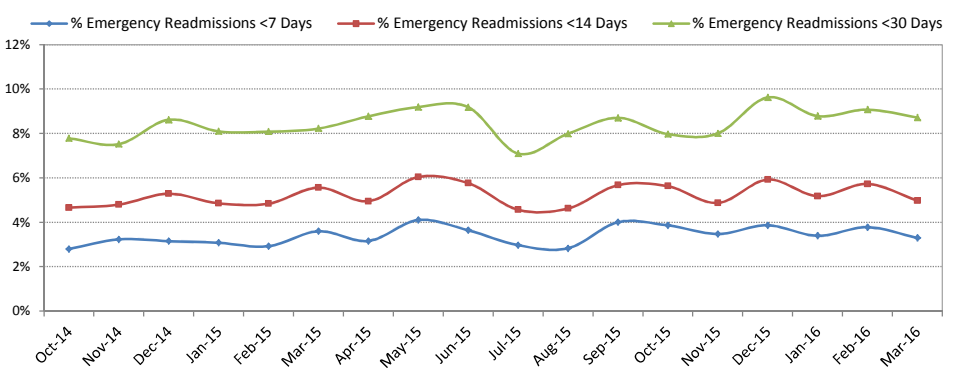
MSSA - Trust Apportioned



MRSA Screening



Emergency Readmissions within 7, 14 & 30 days of Discharge

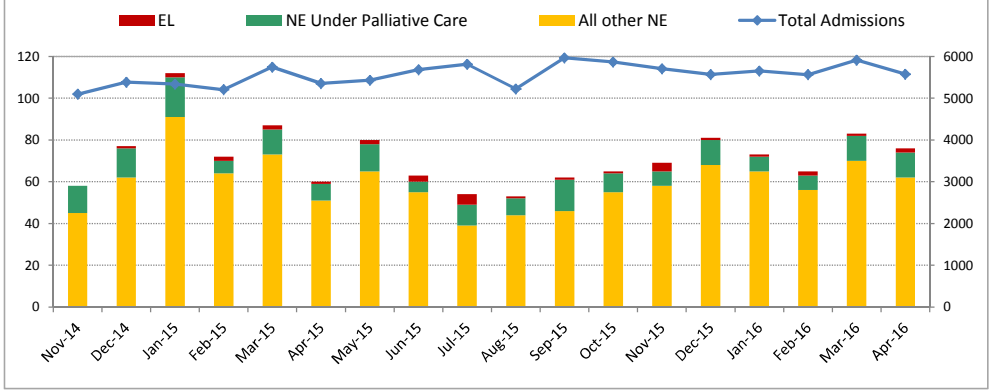


Salisbury NHS
NHS Foundation Trust

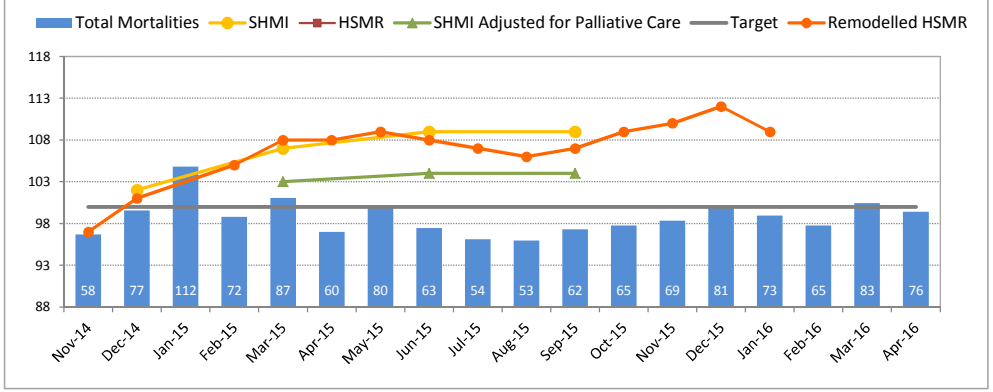
Trust Quality Indicators - April 2016

Quality Measures

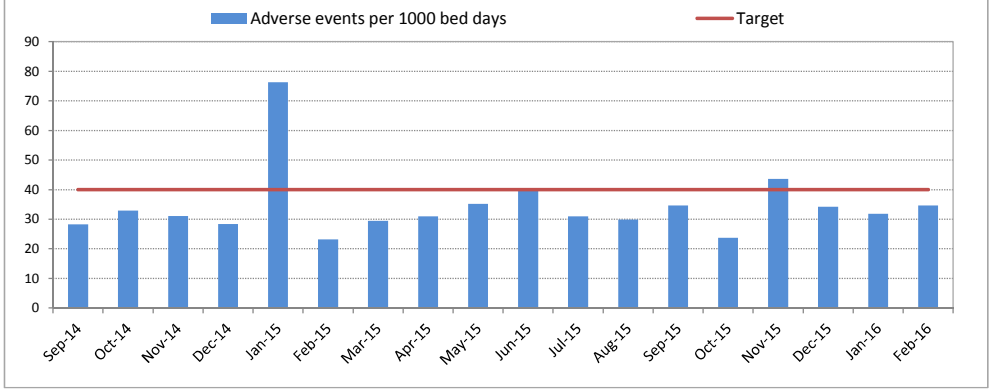
Hospital Mortalities



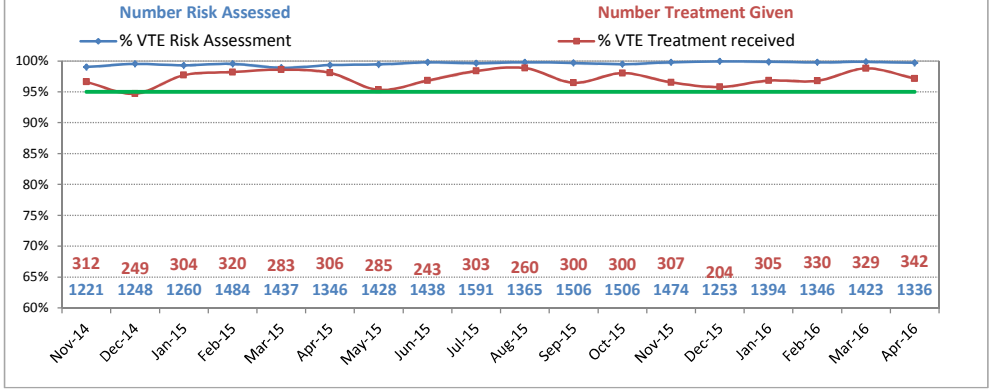
HSMR and SHMI



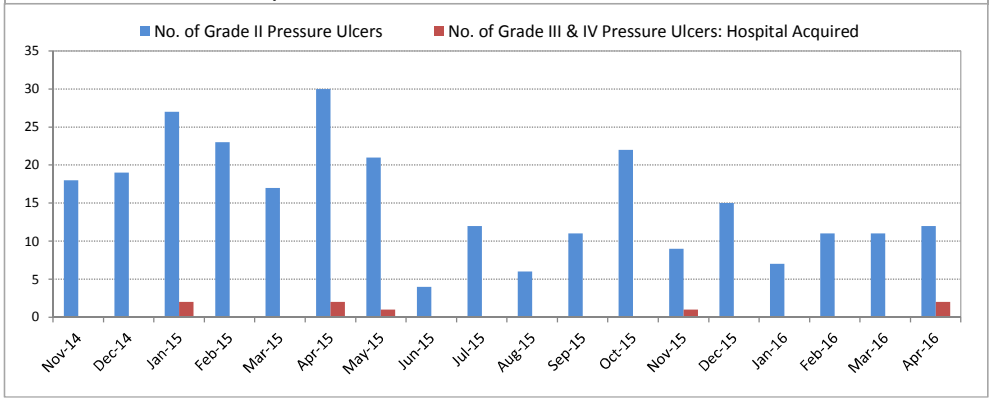
Global Trigger Tool



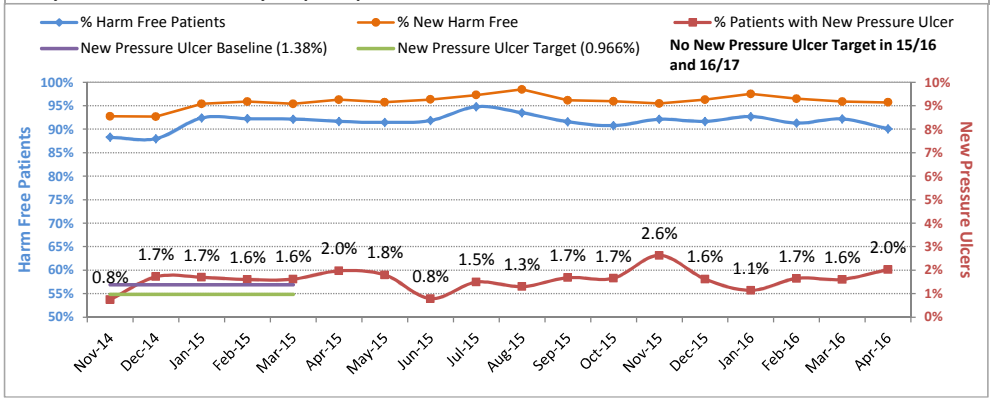
Venous Thrombous Embolism: Risk Assessment & Prophylaxis



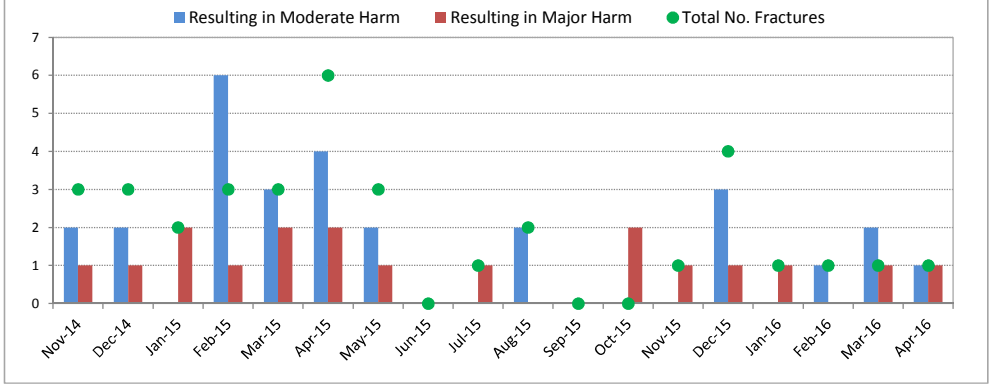
Pressure Ulcers - Total Number per Month



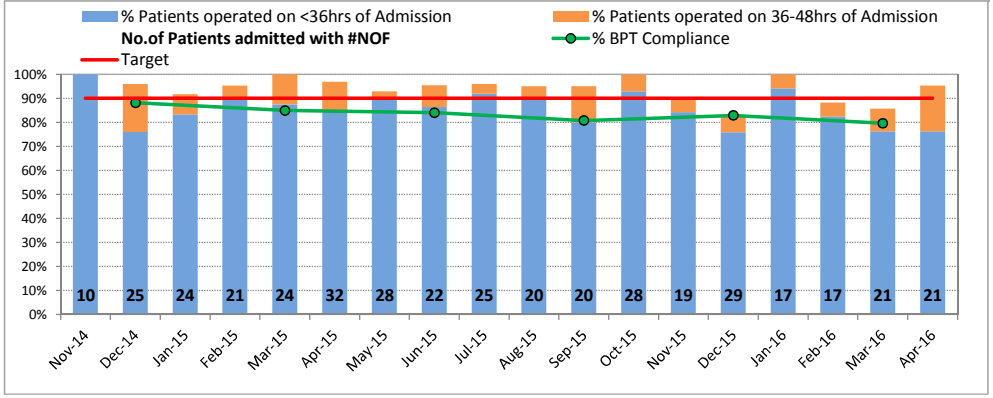
Safety Thermometer - One Day Snapshot per Month



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

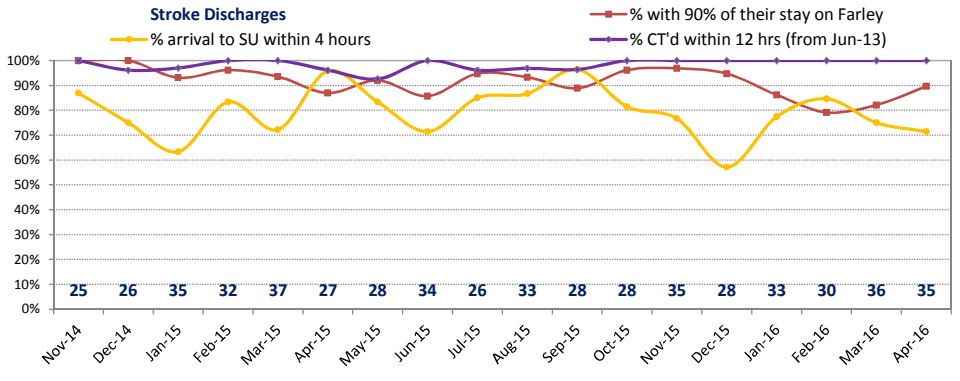


Fracture Neck of Femur operated on within 36 hours (Revised following TIAA Audit)

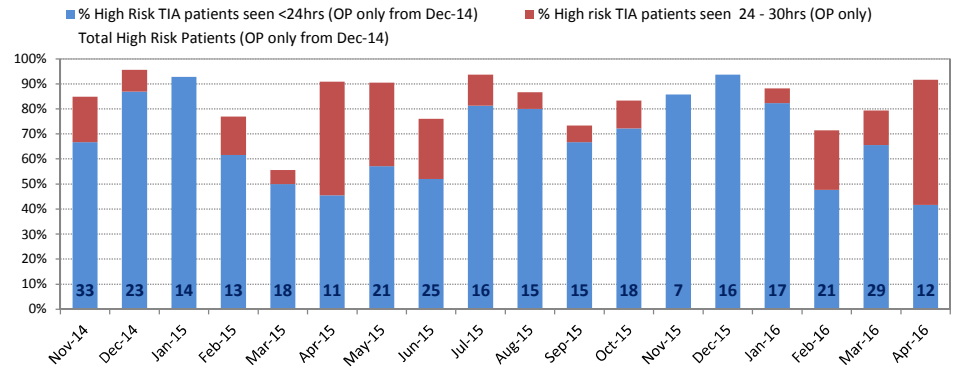


Please note, due to the time it takes to complete Clinical Coding, the current months Fracture Neck of Femur data will be subject to change over the following months.

Stroke Care



TIA Referrals



SSNAP Case Ascertainment Audit

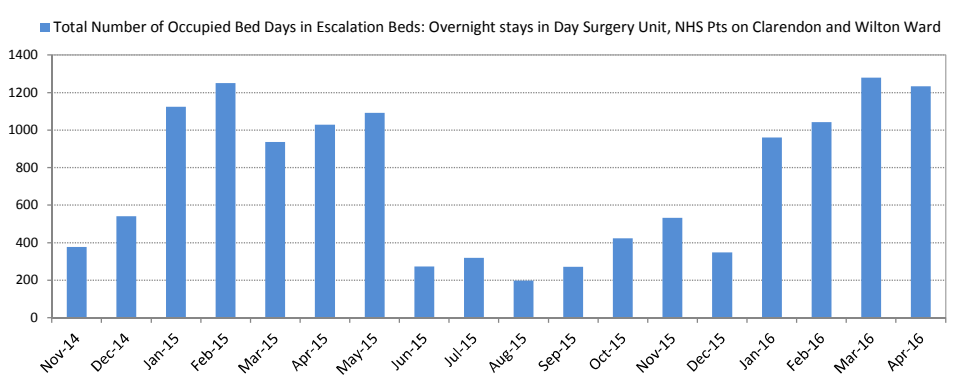
Highest level = Grade A

Lowest level = Grade E

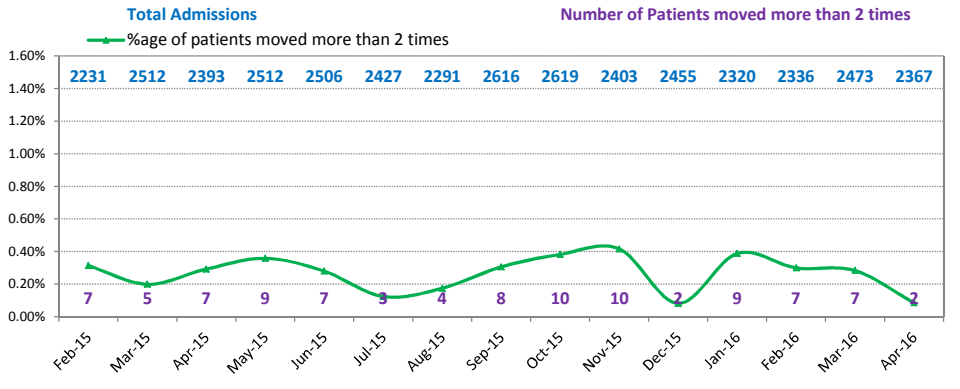
(These Grades are measured quarterly)

	Q1	Q2	Q3	Q4
2014-15	B	D	C	C
2015-16	D	C	C	
2016-17				

Escalation Bed Days

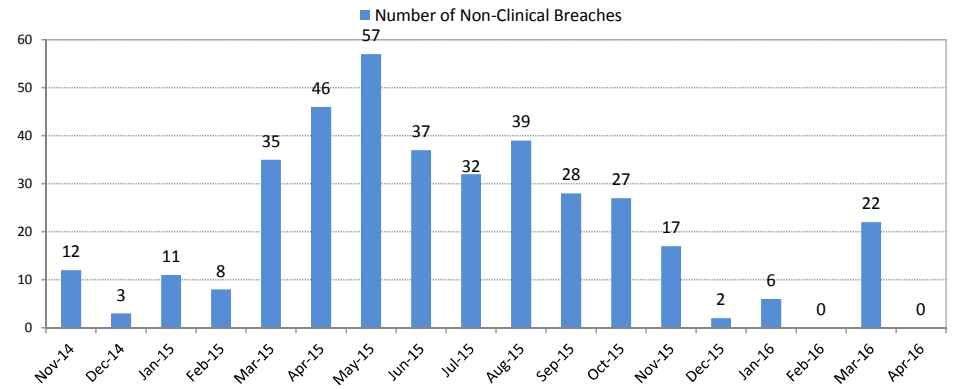


Patients moving multiple times during their Inpatient Stay

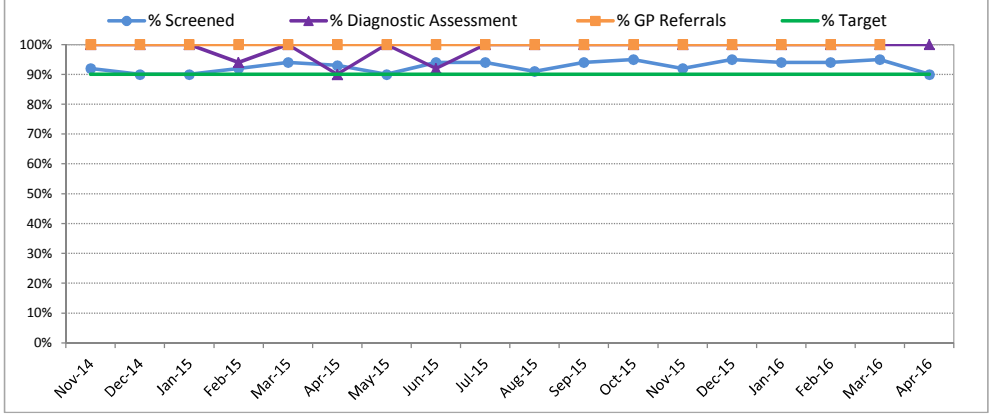


Please note, from Sep-14 escalation bed capactity is Winterslow 8 beds, Wilton 12 beds and DSU if it stays open at night. Breamore ward opened from 1st January 2015 with a further 27 escalation beds and closed on 29th May 2015. From 1st April 2015 Wilton closed for escalation beds. On 4th January 2016 Breamore Ward opened as a planned winter escalation ward.

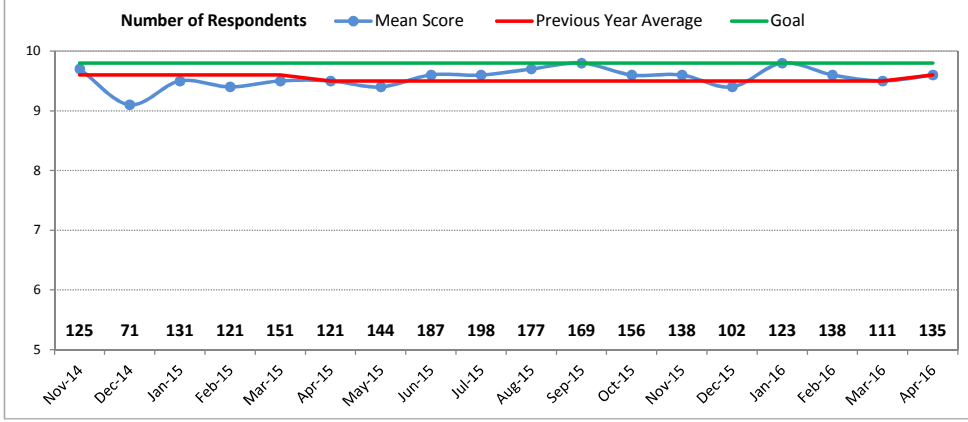
Delivering Same Sex Accommodation



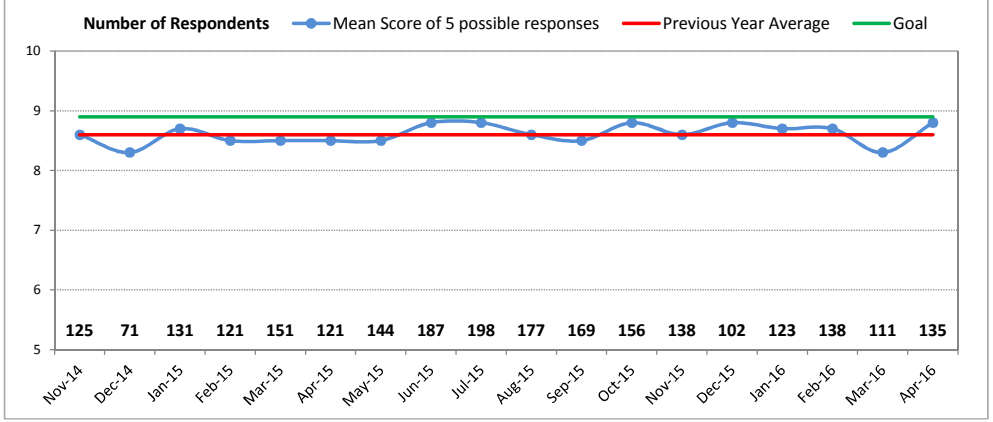
Dementia Audit of Patients Aged 75+



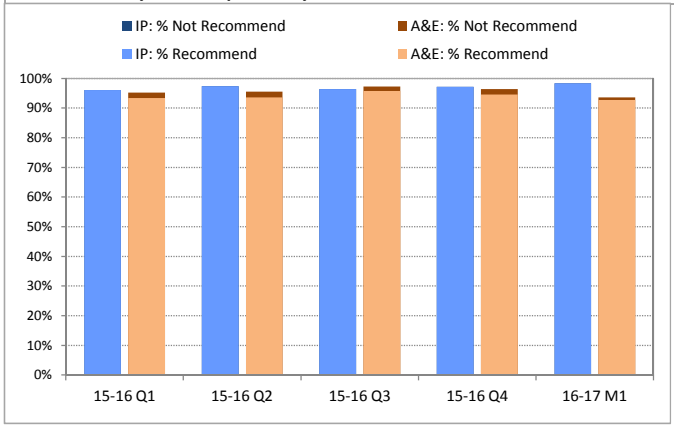
Real Time Feedback: Are you being treated with care and compassion?

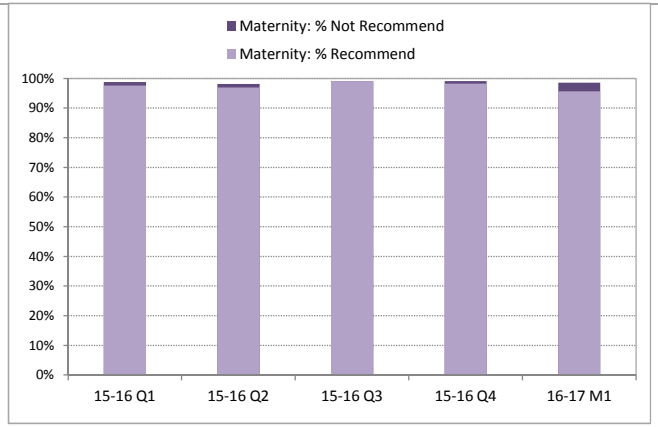


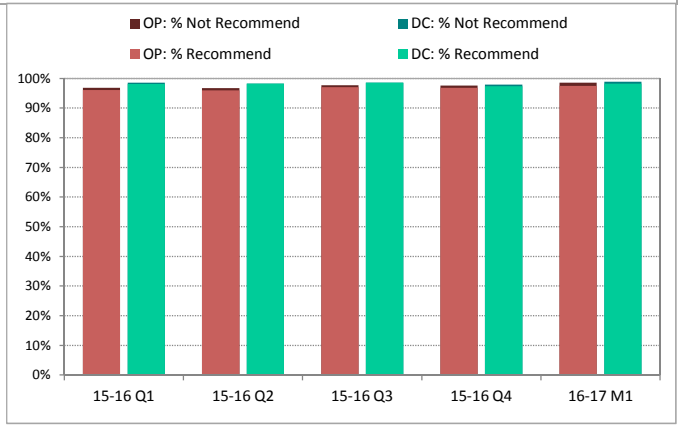
Real Time Feedback: Overall how would you rate the quality of care you received?



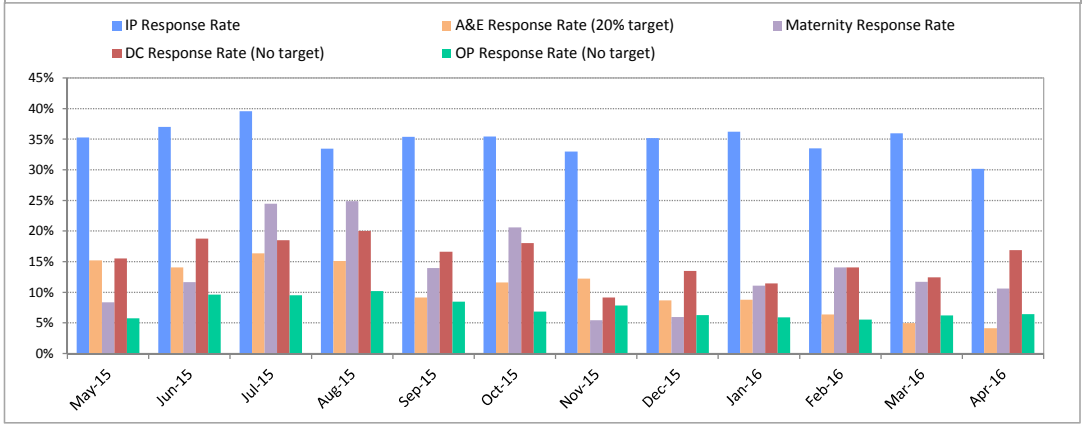
Friends & Family Test: Responses by Area



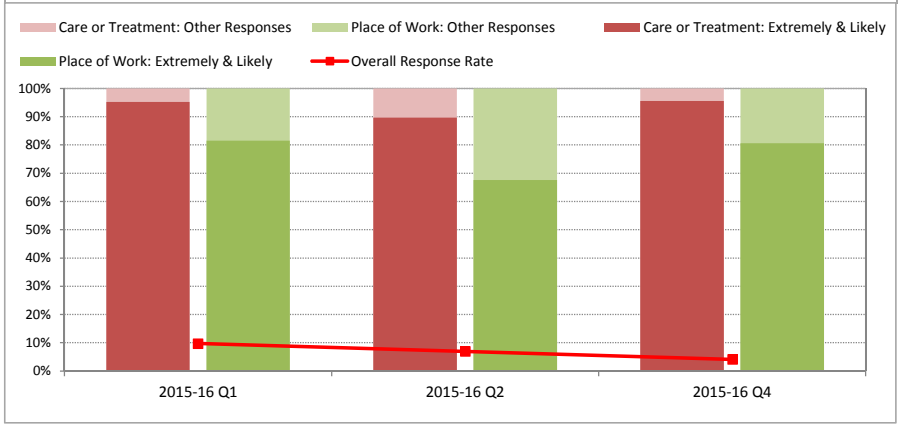




Friends & Family Test: Response Rates (%) by Area



Friends & Family Test: Staff (% Responses)



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

Salisbury NHS
NHS Foundation Trust

PAPER: SFT 3774

DIRECTOR OF INFECTION PREVENTION AND CONTROL REPORT

PURPOSE: The Director of Infection Prevention and Control (DIPC) annual 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 2015/16, there have been two outbreaks of Norovirus (November 2015 and March 2016).

Mandatory surveillance update

- **MRSA bacteraemia cases –** There have been no MRSA bacteraemia cases identified during the reported period.
- **MSSA bacteraemia cases –** There have been 4 Trust apportioned cases during the reporting period, which is a decrease on the previous year.
- **Clostridium difficile –** There have been 15 Trust apportioned C.difficile cases 2015/16, which did not exceed the target set for the Trust by NHS England of no more than 19 cases.
- **Surgical Site Infection Surveillance (SSIS) –** During quarter 1, 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 2015/16, hand hygiene compliance audits have continued to be completed across the clinical directorates. The audit tool captures all of the '5 moments for hand hygiene'. The identified poor compliance area continues to be predominantly missed opportunity number 5, which relates to contact with patient surroundings. The results have been fedback to the relevant Clinical Leaders and DSNs with actions identified, and additional education and support provided for staff groups.

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 has continued to be a focus through quarters 3 and 4 of 2015/16.

Cleaning services
The Trust participated in the National PLACE assessment during quarter 1. A total of 10 wards and Emergency Department 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 for the Trust and above national average figures.

In addition, the report summarises progress in relation to further 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 Annual Report 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)

Annual Report 2015/16

Lorna Wilkinson
DIPC

May 2016

Contents Page

1. Introduction

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

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

The purpose of the DIPC report is to inform the Trust Board of the progress made against the 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 Trust achieving the standards identified in 'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (2010), to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

2. Governance Arrangements

The work to achieve the objectives of the Annual Action Plan 2015/16 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and the Clinical Governance Committee (CGC) which completes the governance arrangements (Appendix 2).

3. Infection Control Arrangements

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

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

4. Budget Allocation for Infection Prevention and Control Nursing team

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

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

5. Assurance Activity

The IPCC

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

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

6. HCAI Management and Statistics

6.1 HCAI

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

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

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

During 2015/16, the Trust has had no declared outbreaks of:

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

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

The availability of sideroom facilities across the Trust site to isolate infected patients can be limited at times when demands on capacity are high. Patients with alert organisms can be safely managed

either within cohort bays, or isolation nursed in a bed space. The ICNs continue to review patients nursed in siderooms on a daily basis to prioritise high risk patients. Information and guidance is communicated to the ward nursing and medical teams and the Clinical Site Coordinators, with additional written documentation provided to support staff in the ongoing management of these patients.

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

6.2 Carbapenemase Producing Enterobacteriaceae (CPE)

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

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

6.3 Clostridium difficile (C.difficile)

During quarters 3 and 4 of 2015/16, there were two periods of increased incidence (PII) of C.difficile, within the medical and surgical directorate. Stool samples were sent to the External Reference Laboratory for ribotyping with no links identified. Trust policy was followed and the appropriate patient management completed.

The IPCT provide advice to staff to enable them to effectively manage patients identified to be previously or newly identified as C.difficile positive.

6.4 Influenza

During 2015/16, patients were admitted to the Trust with respiratory and ‘flu-like’ symptoms. When required patients were isolated within sideroom facilities on admission; some patients were managed within the bay setting. In both situations, patient contacts were identified for follow up. When a positive influenza result is confirmed appropriate antiviral prophylaxis is provided, as per PHE guidance. The IPCT provide support and guidance to staff groups within the ward teams in the ongoing management of identified patients, including use of personal protective equipment (PPE). During quarter 4, there was an increase in the presentation of patients to the Trust with ‘flu-like’ symptoms.

6.5 Invasive Group A Streptococcus (iGAS)

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

During quarter 2, there were 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 were isolated within sideroom facilities, and ongoing management advice was provided by the IPCT.

6.6 MRSA

During quarters 3 and 4 of 2015/16, 2 bays on separate medical wards were closed as a direct result of MRSA. The management of these bays was in accordance with Trust policy.

The Trust continues to screen patients for MRSA in accordance with national guidelines, with screening either undertaken prior to admission (for planned or elective admissions) or immediately following admission to the Trust (emergency admissions).

6.7 Norovirus

The Trust has experienced a fairly consistent level of activity associated with patients experiencing diarrhoea and vomiting. This included patients 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.

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. Closure ensured the safe management of patients and continued service provision.

During quarters 3 and 4 of 2015/16, the level of diarrhoea and vomiting activity continued with the closure of 22 bays in clinical areas across the medical and surgical directorates at different times. In addition, there were further bay closures as a result of the two separate declared outbreaks of Norovirus within the medical directorate. This resulted in 3 ward closures during November 2015 and 2 ward closures during March 2016. The Trust Norovirus Outbreak management policy was followed with the appropriate internal and external personnel involved.

6.8 Staphylococcus aureus Scalded Skin Syndrome (SSSS)

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.

6.9 Tuberculosis

During quarter 2, a case of Tuberculosis was identified for a patient initially admitted to Radnor Ward (ITU) within the surgical directorate, and then appropriately transferred to a sideroom facility on Pitton Ward (medical directorate). A case management review was undertaken to ensure that patient and staff contact follow up was undertaken. This was led by the Respiratory Department, with the involvement of the IPCT, Occupational Health (OH) Department, and other agencies to ensure appropriate follow up and implementation actions.

6.10 Vancomycin Resistant Enterococcus (VRE)

During 2015/16, new cases of VRE have been identified, with a number of patients also identified to be VRE positive either in the community, or on admission to the Trust. When inpatient cases have been identified, required actions were agreed following discussion with a Consultant Microbiologist. These have included strict isolation precautions, the completion of additional environmental and equipment cleaning, and where indicated screening of identified patient contacts, with the continuation of antibiotic stewardship.

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

7. Mandatory Surveillance

7.1 Surgical Site Infection Surveillance (SSIS)

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

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

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

The Trust complies with this annual requirement to undertake SSIS, and the surveillance category completed for 2015/16 was for hip replacement surgery.

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 the agreed timeframe. Of the 83 hip replacement procedures recorded, there were no infections identified compared to 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 identified.

A formal report outlining progress with SSIS is presented at the IPCC and disseminated to relevant Trust personnel.

7.2 Methicillin Resistant Staphylococcus aureus (MRSA)

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

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

Tables 1 and 2 below relate to the overall compliance for both elective admission and emergency admission screening audit figures, for 1 April 2015 to 31 March 2016, figures are provided for April 2014 to March 2015 for comparison.

Table 1: MRSA Compliance Data- Elective Admission

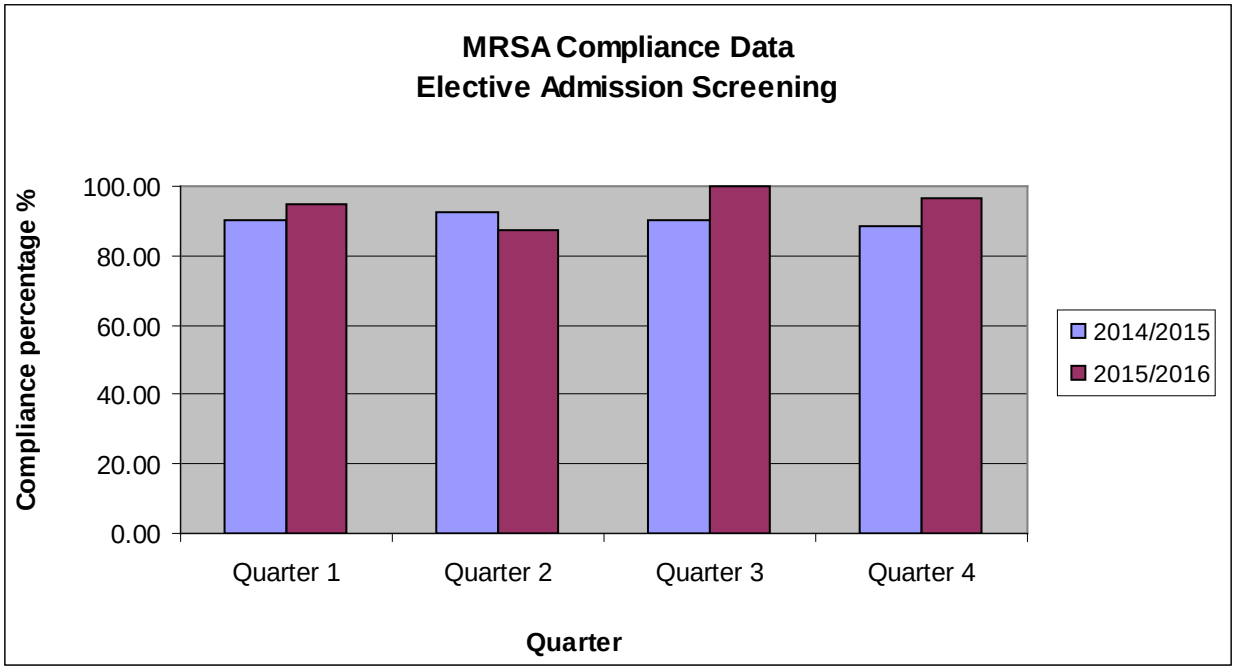
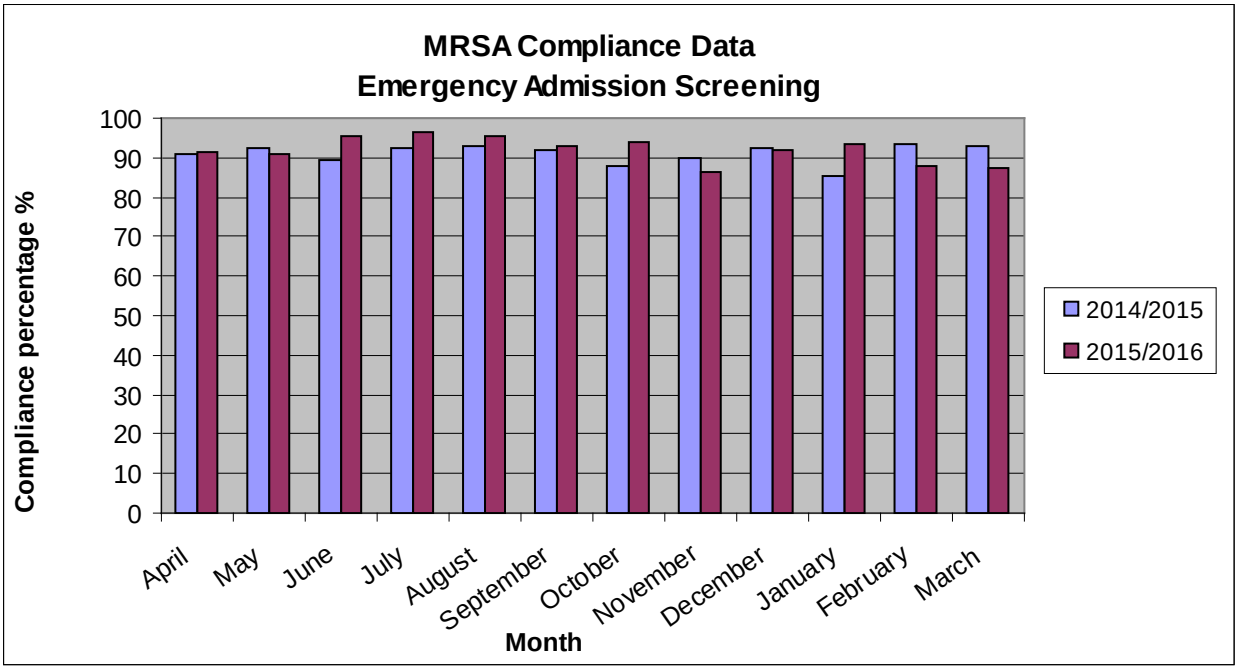


Table 2: MRSA Compliance Data- Emergency Admissions



The Trust continues to report mandatory surveillance in line with PHE requirements onto the national HCAI Data Capture System. The Trust adheres to the classification of cases in accordance with the set definitions. This is applicable to MRSA bacteraemia cases and C.difficile cases, and differs from previous classification reporting formats. Results are provided in the summary below, and include the definitions of 'Trust apportioned' cases and 'non-Trust apportioned' cases.

MRSA Bacteraemia Trust apportioned cases include patients that are –

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

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

Table 3: Breakdown of total number of Trust cases recorded April 2015 to March 2016
The figures in brackets show the number of cases recorded April 2014 to March 2015

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**0 (0)**	**0 (1)**	**0 (0)**	**0 (1)**	**2 (0)**	**0 (1*)**	**0 (0)**	**0 (0)**	**0 (2)**	**0 (0)**	**0 (0)**	**0 (0)**	**2 (5)**
Non Trust apportioned cases	0 (0)	0 (1)	0 (0)	0 (0)	2 (0)	0 (0)	0 (0)	0 (0)	0 (2)	0 (0)	0 (0)	0 (0)	2 (3)
Trust apportioned cases	0 (0)	0 (0)	0 (0)	0 (1)	0 (0)	0 (1^{1})	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (2)

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

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

7.3 Clostridium difficile

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

7.4 Monitoring and diagnostic C.difficile testing

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

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

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

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

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

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

Table 4: Breakdown of reportable cases recorded for all inpatients April 2015 to March 2016
The figures in brackets show the number of inpatient reportable cases April 2014 to March 2015

	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)**	**2 (0)**	**0 (1)**	**1 (2)**	**1 (1)**	**4 (4)**	**1 (5)**	**21 (29)**
Non Trust apportioned cases	0 (1)	0 (0)	0 (0)	1 (1)	1 (1)	1 (0)	1 (0)	0 (1)	1 (1)	1 (1)	0 (0)	0 (0)	6 (6)
Trust apportioned cases	0 (5)	1 (2)	3 (1)	1 (1)	2 (4)	2 (0)	1 (0)	0 (0)	0 (1)	0 (0)	4 (4)	1 (5)	15 (23)

Table 5: Breakdown of total number of reportable C.difficile cases recorded April 2015 to March 2016
The figures in brackets show the total number of reportable cases recorded April 2014 to March 2015

	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)**	**2 (0)**	**0 (1)**	**1 (2)**	**1 (1)**	**4 (4)**	**1 (5)**	**21 (29)**
Community Hospitals	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
General Practitioners (GPs)	4 (3)	1 (0)	1 (3)	0 (1)	2 (1)	3 (3)	1 (3)	1 (2)	1 (1)	0 (1)	1 (0)	1 (0)	16 (18)
Residential/Nursing Home	0 (0)	0 (0)	0 (0)	1 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (0)
Other (e.g. Coroner, Private Hospital, Day Attender, A&E, Outpatient)	1 (0)	1 (0)	0 (0)	1 (0)	0 (1)	0 (0)	0 (0)	0 (0)	0 (1)	0 (0)	0 (0)	0 (0)	3 (2)
Total	**5 (9)**	**3 (2)**	**4 (4)**	**4 (3)**	**5 (7)**	**6 (3)**	**3 (3)**	**1 (3)**	**2 (4)**	**1 (2)**	**5 (4)**	**2 (5)**	**41 (49)**

Table 5 reflects the number of positive episodes. In a single patient, a positive test occurring after a previous positive test is considered a new episode after 28 days.
The Trust's reported 15 Trust apportioned C.difficile cases in for 2015/16 which did not exceed the target set for the Trust by NHSE of 19. For each inpatient episode, an infection control incident investigation is completed. This process is led by the ICNs, with the increased involvement of staff in the relevant clinical area and the Antimicrobial Pharmacist (or area Pharmacist), to complete the required documentation.

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

Multidisciplinary C.difficile ward rounds have continued, with the involvement of the ICD and/or Consultant Microbiologist, ICNs and Antimicrobial Pharmacist. Attendees can include the DIPC, Deputy DIPC and Medical Director. These rounds provide an opportunity to formally review and assess the patient's progress and management in relation to C.difficile. The group members also ensure that information is shared with the ward teams and this is supported by an entry within the patient healthcare records. The membership of this group has been reviewed, and a Gastroenterologist and Dietician will be involved as required.

7.5 Methicillin Sensitive Staphylococcus aureus (MSSA)

The Trust continues to report MSSA bacteraemia cases via the HCAI Data Capture System. Currently, there is no national guidance for data definition of MSSA bacteraemia cases for targets to be set.

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 the Emergency Department April 2015 to March 2016
The figures in brackets show the number of cases recorded April 2014 to March 2015

	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)**	**5 (3*)**	**5 (3)**	**1 (4**)**	**5 (2)**	**3 (3)**	**1 (2)**	**36 (36)**
Non- Trust apportioned cases	3 (1)	2 (1)	1 (5)	2 (2)	2 (3)	5 (2)	3 (1)	5 (1)	1 (4)	5 (2)	2 (2)	1 (2)	32 (26)
Trust apportioned cases	0 (3)	0 (2)	0 (0)	0 (0)	0 (0)	1 (0)	2 (2)	0 (2)	0 (0)	0 (0)	1 (1)	0 (0)	4 (10)

* October 2014 – An additional MSSA bacteraemia case was identified from blood cultures taken whilst a patient was attending an outpatient clinic. The patient was later admitted to the Trust from the clinic environment.
** December 2014 – An additional MSSA bacteraemia case was identified from blood cultures taken from a post mortem sample. The person had not been admitted to the Trust.

During 2015/16, there have been 4 Trust apportioned cases identified. The ICNs undertake an infection control incident investigation for Trust apportioned inpatient cases, in conjunction with staff from the clinical area concerned. Emphasis has been placed on the need for continued monitoring of invasive devices by staff, adherence to the relevant Trust policies relating to the taking of blood cultures and skin disinfection/decontamination and maintaining the required care documentation.

The presence of an indwelling device was identified as a potential contributory factor i.e. central venous catheter (CVC), peripherally inserted central catheter (PICC) or peripheral vascular cannula (PVC), for two of the Trust apportioned cases. Update on progress with identified actions is monitored by the Directorate Senior Nurse (DSN).

7.6 Escherichia coli (E.coli)

The Trust continues to input data in accordance with current guidance from the DH and the PHE. Currently, there is no national guidance for data definition of E.coli bacteraemia cases for targets to be set. From 1st April 2012, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the E.coli bacteraemia cases recorded within the Trust. This allows the cases to be classified as either Trust apportioned or non-Trust apportioned.

Table 7: E.coli Bacteraemias figures recorded for blood cultures from inpatients and the Emergency Department April 2015 to March 2016
The figures in brackets show the total number of cases recorded from April 2014 to March 2015

	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)**	**8 (7)**	**6 (6)**	**9 (7)**	**9 (10)**	**8 (3)**	**12 (5)**	**107 (93)**
Non-Trust apportioned cases	6 (9)	7 (3)	8 (5)	10 (7)	9 (10)	6 (5)	5 (5)	4 (5)	8 (6)	8 (8)	6 (1)	9 (5)	86 (69)
Trust apportioned cases	0 (4)	2 (0)	2 (2)	1 (2)	3 (4)	1 (4)	3 (2)	2 (1)	1 (1)	1 (2)	2 (2)	3 (0)	21 (24)

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

Of the 21 Trust apportioned cases identified during 2015/16, three were determined as likely HCAI related, six cases as possibly HCAI related, for five cases it was not known if it was HCAI related, and the final seven cases were determined as not likely to be HCAI related. This data is entered onto the HCAI Data Capture site. Where concern is highlighted by the Microbiologist for an individual case, further investigation is undertaken. For these Trust apportioned cases, no further follow up was identified.

8. Hand Hygiene

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

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

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the directorates of measures implemented to improve non- compliance. This target is reflected in the clinical leaders and DSNs personal objectives, with ongoing work required by the DMTs to sustain improvements. To promote hand hygiene compliance the ICNs continuing to train and update the Infection Control Link Professionals (ICLPs) to undertake hand hygiene assessments for staff in

their own areas. This has proved successful in raising the profile of hand hygiene behaviour and compliance with BBE. It also provides an alternative opportunity for staff to complete their annual mandatory hand hygiene assessment. The directorates are encouraged to share successes within individual areas at the MMG meetings.

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

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

When compliance is poor the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results are now disseminated according to staff groups for each area. This action has provided evidence to strengthen the feedback process for the directorates to take the necessary action.

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

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

For 2015/16, the overall compliance rate from external auditing of 11 inpatient clinical areas was 70.63%. This is a slight decrease on the previously reported overall compliance of 71.8% from auditing of 10 inpatient clinical areas during 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 the IPCC and feedback was 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 focusing on the audit findings.

During quarter 3, the IPCWG members agreed a provisional 'Red, Amber and Green' rating for the hand hygiene compliance audits. This included actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised during quarter 4. The impact of these measures is being monitored by the IPCWG.

Extra hand hygiene assessment sessions have been undertaken as demonstrated by Table 8 below:

Table 8: Additional Hand Hygiene Sessions

2015/16 Month	Total number of hand hygiene sessions held using a UV light box	Total number of attendees
April	7	333
May	7	61
June	20	289
July	7	431
August	7	123
September	20	378
October	11	382
November	15	367
December	11	250
January	12	178
February	11	249
March	9	242
TOTAL	137	3283

9. Audit

In line with the requirements of the Health and Social Care Act 2008, a programme of infection prevention and control audits is illustrated in the annual audit programme (Appendix 4). The programme ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust.

The ICNs have been involved with the following audit work during 2015/16, including the follow up and outcomes from auditing against infection control policies. Reports are generated for each completed audit and resulting action plans approved by the IPCWG.

- BBE policy and Uniform and Workwear guidance – audit 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.
- 2% Chlorhexidine Gluconate in 70% Alcohol Isopropyl Wipes – audit commenced at the end of quarter 3, with the data collection undertaken by the clinical leaders or the ICLPs.
- Handling & Disposal of Linen – audit during quarter 4, the data collection was undertaken by the clinical leaders and the ICLPs. This audit covers the inpatient areas and all outpatient areas where patient linen is used.
- MRSA Prescription Treatment & Monitoring Pathway, & Isolation Policy – audit data collection commenced by the ICNs during quarter 4 and will continue into quarter 1 (2016/17).
- Observation of Practice Audits – the ICNs continue to undertake additional observational audits of staff practices within clinical areas. Feedback is provided at the time of the audit to the nurse in charge, and where non-compliance has been identified this is addressed with the individual staff member. Feedback is provided to the relevant Clinical Leader. Practice observations have included application of standard precautions, isolation nursing precautions and linen management.

The monthly audit programme for the safe use of mattresses continues and is led by the Medical Devices Management Centre (MDMC), with six monthly reporting to the MMG. In addition, the Trust identified the requirement to ensure that patient pillows are fit for purpose and a mechanism for monitoring in place. Guidance for staff to ensure pillows remain fit for purpose and are replaced when required is available in the linen policy. Work is underway via MMG to ensure ward staff are conversant with this guidance.

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

10. Innovations

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

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

11. Antibiotic Prescribing

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

11.1 Audit

Fortnightly antimicrobial stewardship audits are undertaken to assist the Trust to take action to address the inappropriate use of high risk antibiotics implicated in Clostridium difficile. The audit is based on the Start Smart and Focus campaign and forms part of a local CQUIN, the benchmark for compliance with the following audit standards is 70%

- Documentation of stop/review date
- Indication
- Prescribing within policy
- Appropriate use of high risk antibiotics implicated in Clostridium difficile.

Table 9: Audit Results

Quarter	1	2	3	4
Average ward %	94.3%	92.6%	89.4%	92.4%

11.2 Point prevalence audit

The regional Annual Antibiotic Point Prevalence Audit was conducted in March 2016 and results are awaited although early indications are that the Trust performed well above average.

11.3 Antibiotic Awareness

As part of the European Antibiotic Awareness Day 18th November, the Trust engaged in the national campaign to raise awareness of the need to use antibiotics responsibly. These included

- Advertising the European antibiotic awareness day and key antibiotic messages throughout the hospital.
- Utilising public notice boards, infection control notice board, dispensary patient waiting area, education and training notice boards.
- Broadcast /Cascade brief
- Screensaver- detailing the principles of the' start smart then focus' initiative.
- Display in dispensary patient waiting area

11.4 Defined daily doses

The Trust has implemented the recommendations from Department of Health document 'C.difficile – how to deal with the problem'. A mechanism for capturing defined daily doses (DDD) data is now

in place. This allows the Trust to monitor drug usage and compare it to that of other Trusts. A recent report showed that the Trusts total antibiotic usage in DDD is very favourable compared to other Trusts in the South West.

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

Table 10: Cephalosporins vs ciprofloxacin vs clindamycin vs co-amoxiclav

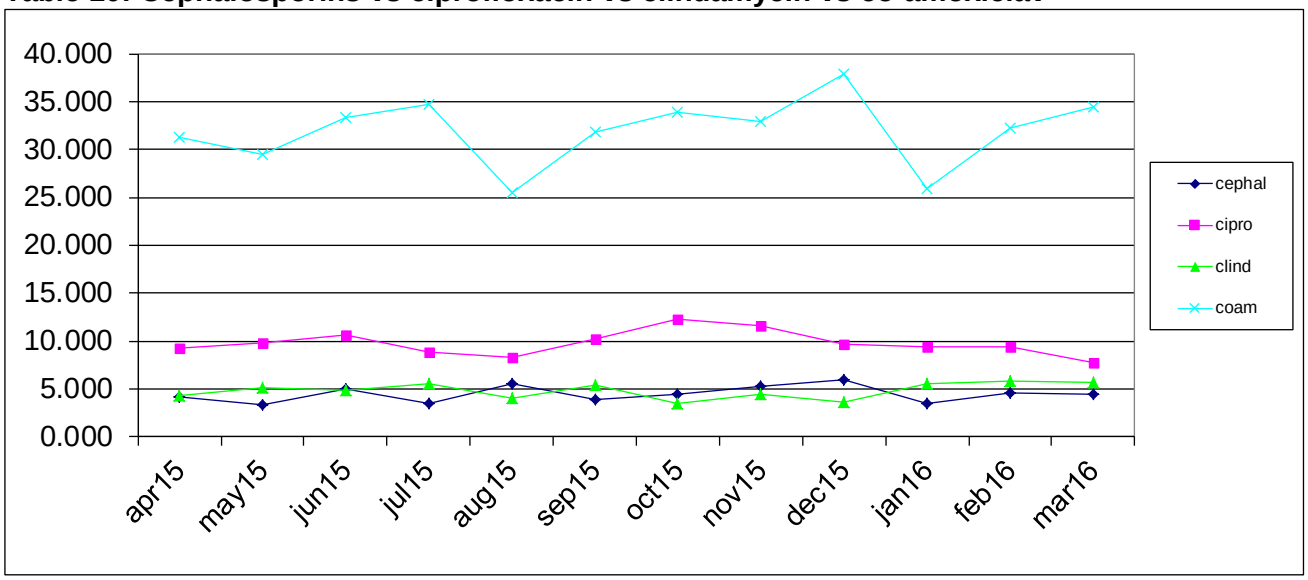


Table 11: Ceftazidime vs cefalexin vs cefaclor

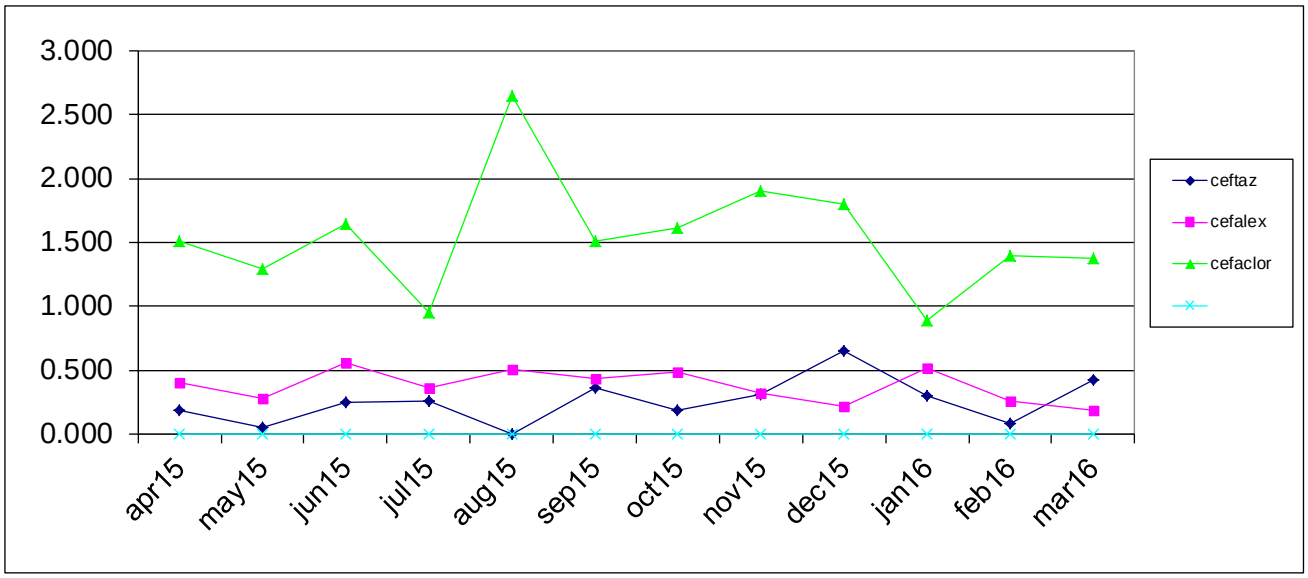


Table 12: Daptomycin vs vancomycin vs teicoplanin vs linezolid

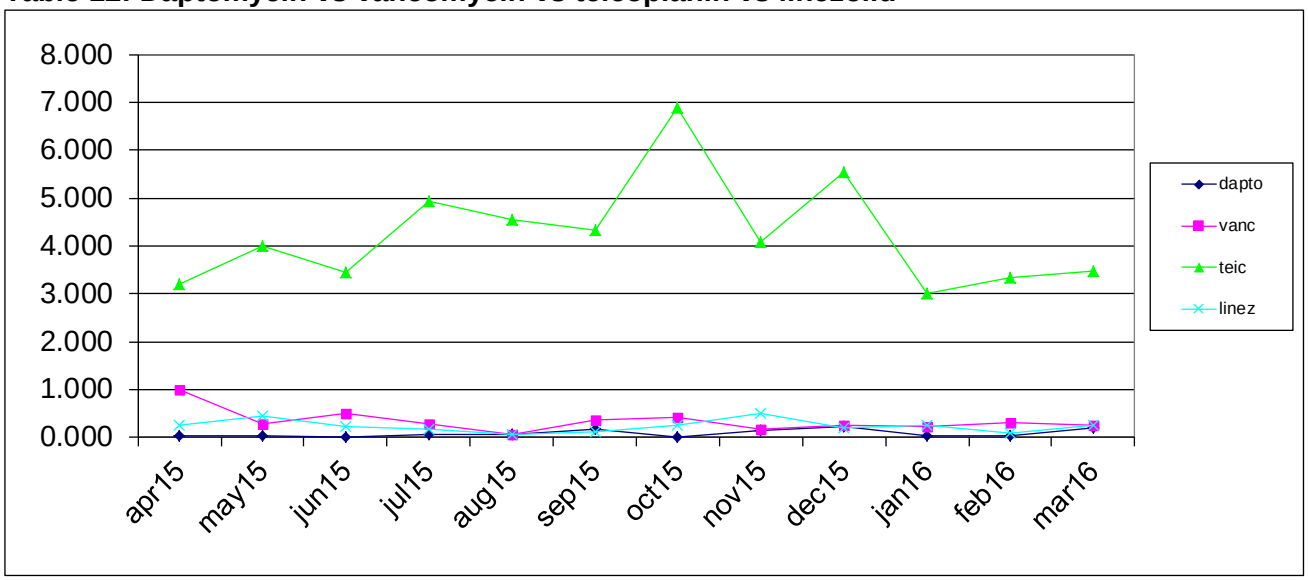


Table 13: Imipenem vs meropenem vs ertapenem vs piptaz

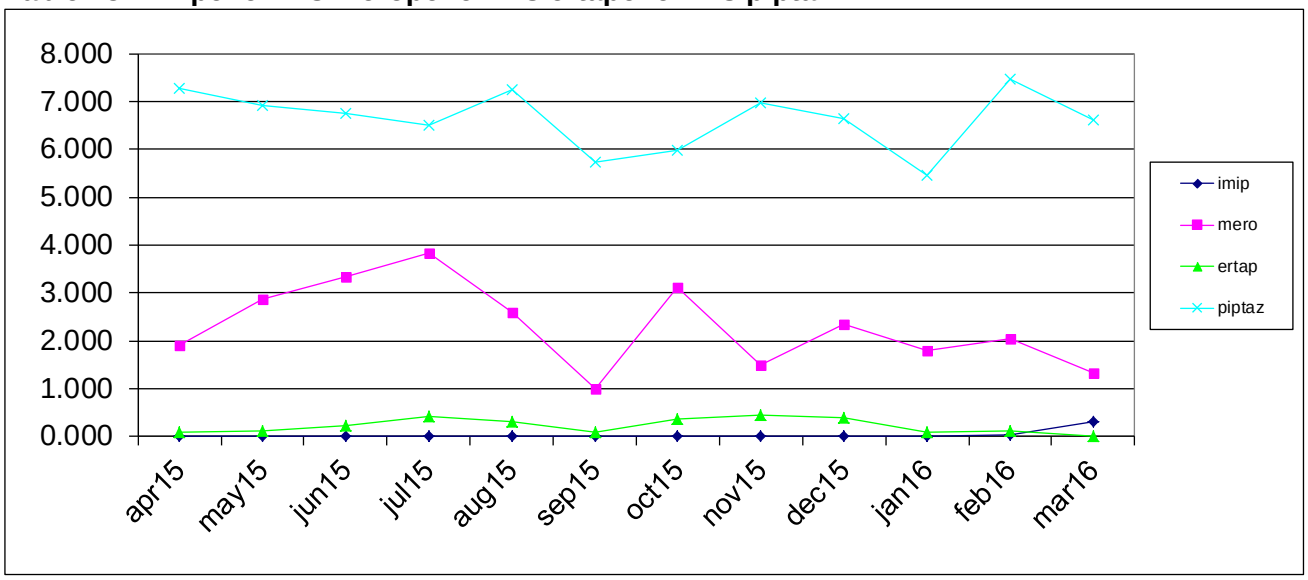


Table 14: Clindamycin vs clarithromycin vs doxycycline

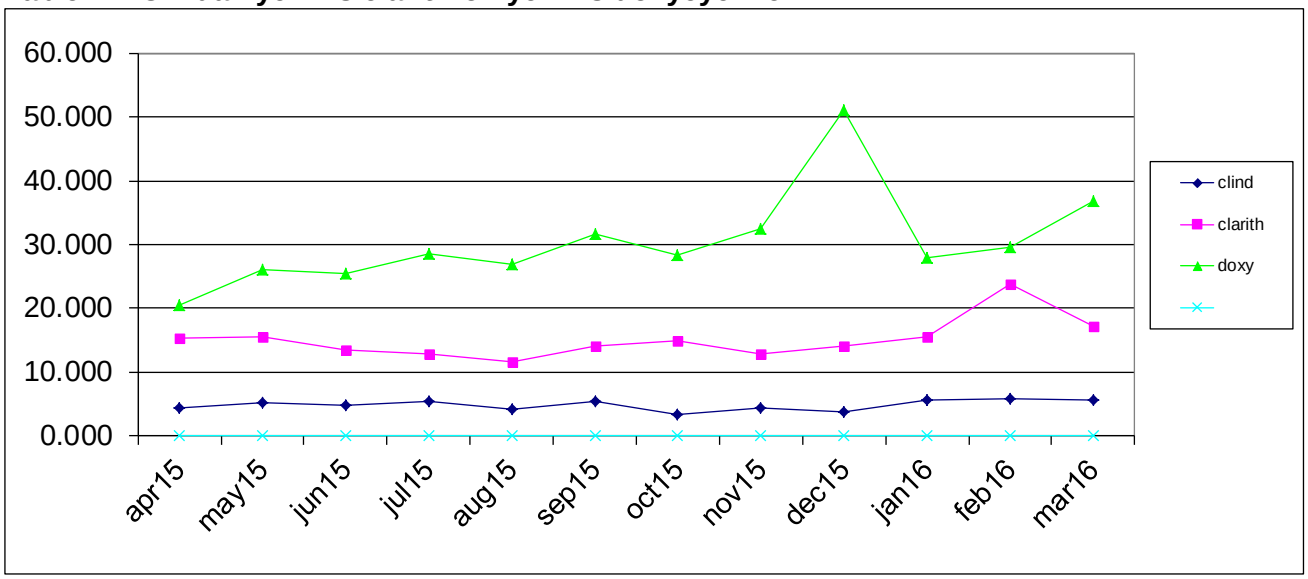
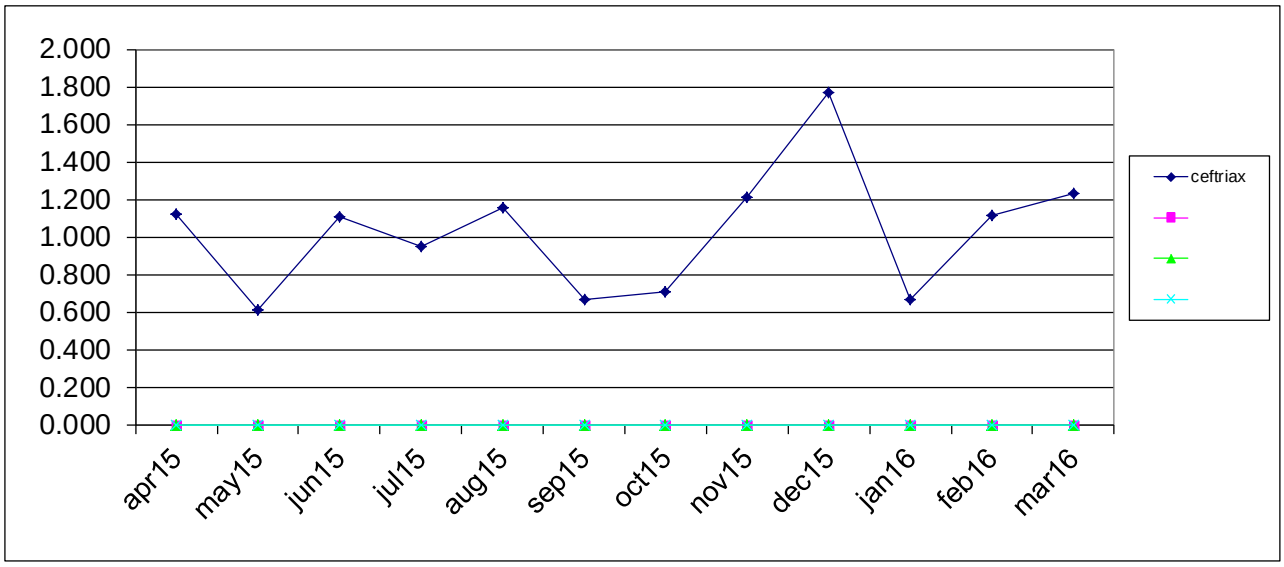


Table 15: Ceftriaxone



11.5 Guideline development/review

Guidelines recently completed and approved:

- Plastic Surgery Antibiotic Policy (January 2016)
- Burns Antibiotic Policy (January 2016)
- Antibiotic Review/Stop Date & Indication Policy (March 2016)

The following guidelines are currently being reviewed:

- Cellulitis guidelines (April 2016)
- ENT guidelines (April 2016)

Guidelines under development:

- Antifungal guidelines

12. Decontamination

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

12.1 Progress against Decontamination Strategy

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

12.2 Activity to promote compliance with decontamination arrangements

- Decontamination Policy in place

- CJD Policy has been reviewed and in place

- Tray Tracking - go live for this system was cancelled twice in December due to the data base not having sufficient information to support the tasks and issues with set numbers. Due to failures to go live and insufficient support from the supplier the trust has terminated

the contract with Trisoft and is progressing with this work with Synergy under the joint venture.

- Instrumentation – 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 the main causes are storage and handling in user locations and transportation. The Sterilisation and Decontamination Unit (SDU) and the main theatre department are working collaboratively to provide a permanent solution. A capital bid was accepted to replace theatre racking and SDU trolleys. The installation of the racking took place August 2015. 88 orthopaedic trays identified as high risk have been containerised to prevent holes in wraps. A further 60 trays have been identified and the order has been placed to containerise these trays.

- New instrumentation is on site and theatre and SDU teams are working together to verify delivery and put into use.

- SDU Sterilisers – Synergy Health as part of the joint venture have conducted chamber tests on the SDU Sterilisers and have sourced two second hand sterilisers to put in to help maintain service levels for the next 12 months until the new build is completed.

- The SDU continues to process all flexi scopes used within the Trust including the additional weekend lists for the Endoscopy Department, evening lists in Ear Nose and Throat Outpatients department and lists in Obstetric & Gynaecology. This ensures all endoscope decontamination takes place in fully compliant washers and is in line with MDS DB2002 (05).

12.3 Decontamination Audit plan

Quarter 1 - Audits conducted in Spinal unit, Respiratory and Radiology. Action plans are in place and review Audits required

Quarter 2 - Audits conducted in the Emergency Department, Intensive Care Unit and Ear Nose and Throat Outpatients department. Action plans are in place and review audits are required. A review audit was conducted of the Spinal unit; good progress had been made against actions from previous audit.

Quarter 3- Audits conducted in Radnor, Maternity and Cardiac. Action plans are in place and review audits are required.

Quarter 4 - Audits conducted in Day Surgical Unit and Oncology. Action plans are in place and review audits are required.

12.4 Maintaining a fully complaint SDU

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. 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.

12.5 Market 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 commencing talks with the MOD about further continuation of this contract.
- The Wiltshire Community Health contract for its South Wiltshire Podiatry Tray Service continues and is 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. The tender for this contract goes live 15th April 2016 and the SDU is submitting a bid.
- SDU is currently in partnership with Synergy Health PLC to build new fully compliant purpose built unit on Trust site. There is a plan to increase external custom and expands the service.

12.6 The Decontamination Committee

The decontamination committee has oversight of the usage of equipment around the Trust such as bedpan washers, mortuary washing machine, endoscope washer-disinfector, cabinet washer disinfectors, and autoclaves in SDU and the pathology laboratory which ensure safe conditions are maintained.

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

12.7 Choice Framework Documents, (CFPP)

There is a plan to revert 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” to Health Technical Memorandums (HTMs). Consultation documents have been circulated and comments have been returned to the DH in January 2015. These changes are expected to take place at some point in 2016.

13. Education and Training Activities

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

At the request of the Trust Board the figures presented in Appendix 5 reflects the percentage of staff in each directorate who have completed a hand hygiene assessment during the relevant quarter. Appendix 6 identifies the figures for the IP&C computer based learning (CBL) modules completed via the intranet site during 2015/16.

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

14. Water Safety Management

This section provides assurance of the arrangements in place to appropriately manage the water safety in the Trust during 2015/16.

The safety of the water systems on site is monitored and managed in line with the Trust policy. This requires a temperature and flushing regime in the main areas with a supplementary Copper/Silver dosing system in the Spinal and Central area system. Clinical areas continue to be flushed by dedicated Estates staff. Two members of staff are engaged in providing a flushing service as part of their routine activities. Non-clinical and office areas are flushed and reported as such by the users (see section 4).

In light of lessons learnt in relation to water safety management at a neighbouring Trust, separate risk assessments (main Risk ref **1291**) have been raised for the key controls measures in respect of water safety, these are identified in the table below, and are reviewed at the quarterly water safety steering group (WSSG) meetings.

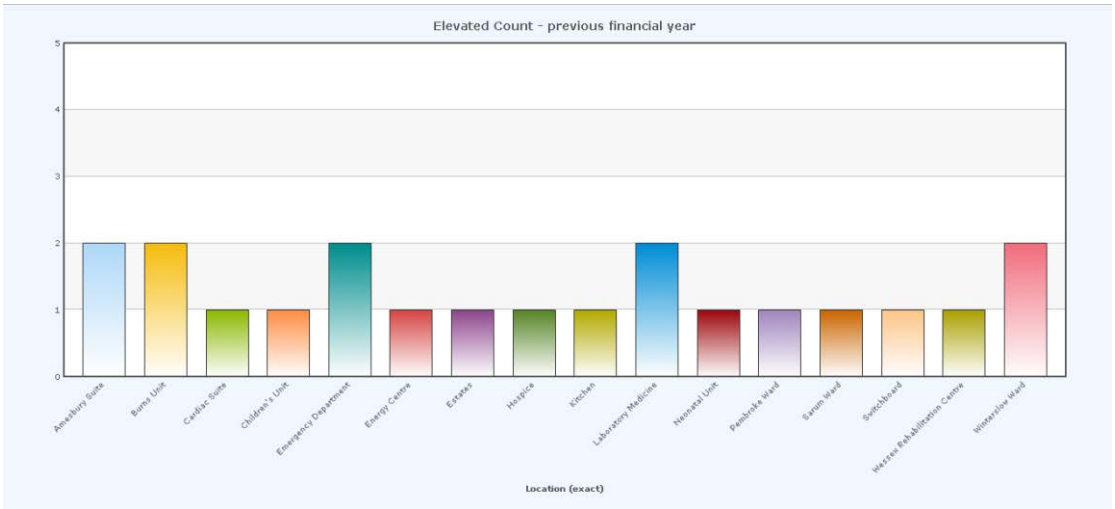
Table 16: List of current risks on risk register

	Risk	Risk Reference	Current Risk Score	Target Risk Score	Review Date
1	Water Safety – Flushing	4426	12	4	24-06-2016
2	Water Safety – TMV Maintenance	4427	12	4	24-06-2016
3	Water Safety – Tank & Calorifier Cleaning	4428	12	4	24-06-2016
4	Water Safety – Record keeping, dwgs etc.	4429	8	4	24-06-2016
5	Water Safety – Temperature control	4430	12	4	24-06-2016
6	Water Safety – System / Engineering RA	4431	12	4	22-04-2016
7	Water Safety – Routine sampling	4432	12	4	23-09-2016
8	Water Safety – Shower Head De-scales	4433	12	4	23-09-2016

14.1 Routine Sampling – Legionella

In July 2015 water sampling for Legionella contamination commenced on an annual basis. Since this date 230 separate outlets have been sampled. All live counts have been managed in line with Trust policy. When any result where the count has exceeded 1000 cfu/l is recorded a meeting is held to agree an action plan to mitigate risks to patients and staff. Table 17 below provides counts by ward area.

Table 17: Elevated counts by ward area



The information above has been produced from the incidents reported on Datix and shows the number and areas that have had evaluated counts (Legionella & Pseudomonas), some of these areas may have had numerous elevated counts linked to a single reported incident. The clinical areas that have had elevated counts are:

- Amesbury Suite
- Burns Unit
- Cardiac Cath Labs
- Children's Unit
- Emergency Dept
- Hopsice
- NICU
- Pembroke Ward
- Sarum Ward
- Winterslow Ward

Actions taken have included cleaning and disinfection of outlets, with temperature checking and increased flushing of the outlet. Action plans have been devised to further investigate issues identified which has included work to rebalance the water systems. ETS continue to work closely with the PFI staff.

14.2 Routine Sampling – Pseudomonas

The last round of routine testing was completed in January 16. During this six monthly testing period, 224 points were sampled in the augmented areas (NICU, Radnor, Pembroke, Burns and part of Avon Ward). All positive samples were recorded and managed in line with Trust policy.

14.3 Flushing

The flushing of clinical areas is on-going, 74% of the outlets were flushed in line with the Trust policy and the related technical guidance (HSG 274). There is however a degree of non-compliance with flushing in non-clinical areas. Department heads have been contacted in writing to remind them of their duty to ensure this is completed.

14.4 Copper / Silver

There have been no recorded issues in this reporting period. Regular maintenance continues on the Silver/Copper ionisation plant serving the Spinal and Central areas of the hospital supporting the overall management of Legionella.

14.5 Independent Advice

This service has been provided via a contract with Interserve until January 2016. Estates are currently working with procurement to appoint a new specialist Authorising Engineer for water safety and provide training for Estates 'in house' trade staff. In the interim, Estates have an external company to use for independent advice.

14.6 Drain Blockages

It is clear that the number and severity of blockages has reduced significantly, due to a number of factors:

- Raising staff and visitor awareness by producing an explanatory leaflet, and running awareness sessions on the wards and at induction for new staff
- Investment in some modifications to the drainage system in problem areas
- Changing the paper towels to a type that breaks down more easily in water
- During capital works, ensuring that all holes through the floor slabs (for pipes to pass through) are fully sealed beside the pipes to prevent any water flowing to the level below.

15. Cleaning Services

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

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

The Trust planned to undertake 50 internal PLACE assessments between September 2015 and March 2016 and achieved 49 out of the 50. An outstanding PLACE result was achieved by Clarendon Ward.

There was active engagement and good support from Governors, Volunteers and the local Health watch representatives to undertake the audits. Each ward produced their own action plans and reported progress via the Matrons monthly group. Focus is given to themes from the ward or department and learning that can be shared with other areas. The PLACE internal audits have produced evidence that supports capital bids and decorating programmes so funds are appropriately allocated.

The result of each assessment are submitted on the will be recorded within the PLACE lite tool linked to the Health and Social Care Information Centre. The PLACE lite plan for 2016/2017 will begin in June 2016 to undertake 50 internal PLACE lite assessments using the new criteria and PLACE paperwork.

15.2 National PLACE

The Trust participated in the National PLACE assessment on March 8th 2016. 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 provisional results reflect improvements have been made in most areas. The score for this trust and others will be published mid-August. The results from PLACE are analysed and key themes form the basis of improvement plans within the Trust.

Table 18 demonstrates the additional cleaning activity arising as a result of the internal PLACE audit findings, Housekeeping audits and the requirements linked to the patients' needs on the wards.

Table 18: Additional cleaning activity

Area of Focus	KPI	APR 2015	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR 2016
Departmental Data	Post Infection Cleans	373	417	416	367	385	457	400	414	374	384	395	530
	Enhanced cleaning hours	109.75	50.75	34.5	10.25	26	31.75	49.75	44.75	2.5	16.75	43.75	125.75
Cleaning	Total audits	117	99	96	115	94	95	113	96	109	96	93	109
	Passes	52	38	46	46	37	34	50	47	61	55	41	67
	Qualified Passes	65	61	50	69	57	61	63	49	48	41	52	42
	Fails	0	0	0	0	0	0	0	0	0	0	0	0

15.3 Terminal enhanced and double cleaning

Table 19 below illustrates the additional cleaning undertaken in clinical areas between April 2015 and March 2016, with figures for 2014/15 included for comparison.

Table 19: Terminal enhanced and doubles cleaning

Month/Year XX –Highest XX- Lowest	2014/15 Number of terminal cleans	2014/15 Enhanced cleaning hours	2014/15 Double cleans in hours	2015/16 Number of terminal cleans	2015/16 Enhanced cleaning hours	2015/16 Double cleans in hours
April	326	77.25	**35.75**	373	109.75	47
May	**287**	100.75	44.5	471	50.75	79
June	389	168.50	55	416	34.50	103.25
July	360	**200.75**	69	**367**	10.25	70.5
August	321	73.50	46.25	385	26	63.25
September	330	80.00	**93.25**	457	31.75	64.25
October	**393**	66.25	62.5	400	49.75	86
November	291	71.75	52.5	414	44.75	81.75
December	373	100.75	44	374	**2.5**	64
January	390	68.25	37.5	384	16.75	**115.50**
February	345	**60.50**	42.75	395	43.75	**45**
March	391	144	77.25	**530**	**125.75**	108.25
Year to Date total	**4196**	**1212.25**	**660.25**	**4966**	**546.25**	**927.75**
Totals for Year	**6068.50**			**6440**		

15.4 Deep clean programme/rapid response team

The deep clean and decorating programme started in April 2015 and is now reached its conclusion. 15 bays and 19 siderooms were unable to be completed because patients were unable to be relocated to achieve this. However, these areas will be prioritised should they become available and the deep clean and GLOSAIR 400 treatment will be undertaken.
The deep clean and decorating programme for 2016/2017 has been developed, circulated, approved and started in April 2016.

In addition to the deep clean programme, the demand on the GLOSAIR 400 room decontamination system remains high and reflects the robust measures in place to ensure appropriate infection control. Table 20 reflects the activity in 2015/16.

Table 20: GLOSAIR 400 room decontamination

2015/16 MONTH	APRIL	MAY	JUNE	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
GLOSAIRS (Not including Deep Clean Plan)	28	16	31	28	26	50	21	32	27	43	26	30
Total for 2015/2016	**358**											
2014/15 MONTH	**APRIL**	**MAY**	**JUNE**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
GLOSAIRS (Not including Deep Clean Plan)	27	25	30	29	34	40	50	22	17	23	21	29
Total	**347**											

15.5 Housekeeping resource

The Head of Facilities and Facilities General Manager have reviewed the capacity in the Housekeeping service to ensure the current cleaning resources can meet the demands on the service and ensure national cleaning standards and infection control needs are met. An options paper was submitted to the Executive Directors and discussions are continuing to establish how this can be progressed .Housekeeping service strive to work in a multi-disciplinary team way, communicates well and be responsive to the needs of our patients.

15.6 Improvement Work Projects

Housekeeping management team are continuing to review 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. An options paper is being drafted. An executive decision will then be required in relation to adopting BSI Standards.

Housekeeping General Manager is an active part of a Department of Health working group - Improve Cleaning Efficiency forming part of the Lord Carter Program. This ensures the Trust is considering the cost efficiency and effectiveness of our Housekeeping service.

A new training competency document has been developed and is currently being trialled with newly recruited housekeeping staff members. These competencies when achieved will support the quality of the cleaning being undertaken and ensure standards are high.

16. Summary

This annual 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 2016/17 include:

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

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

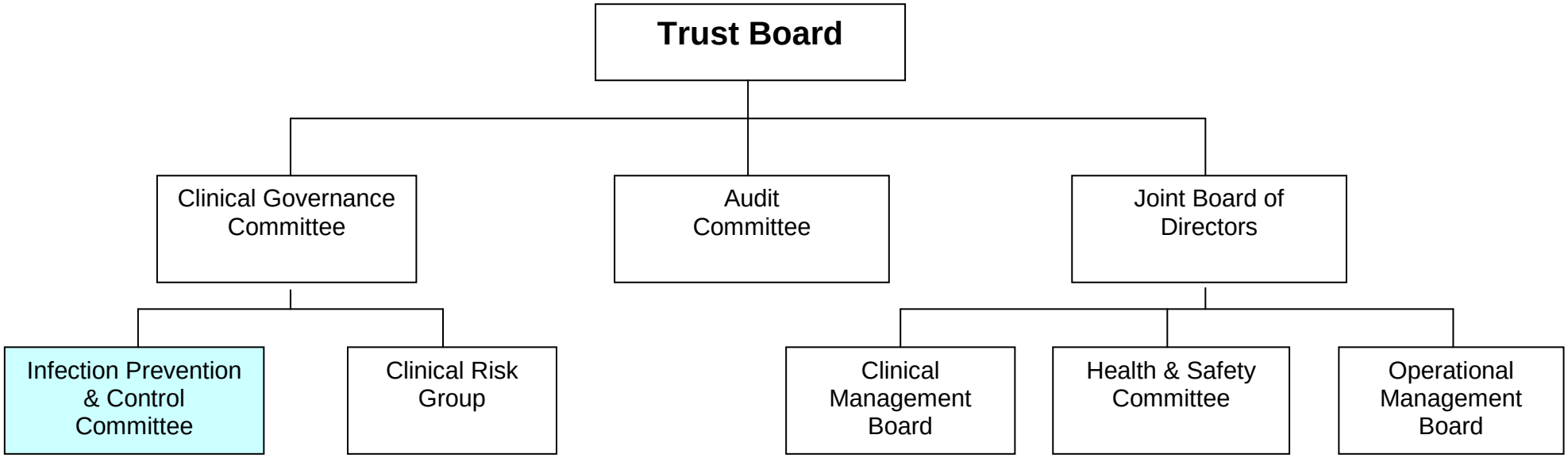
Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs.		
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

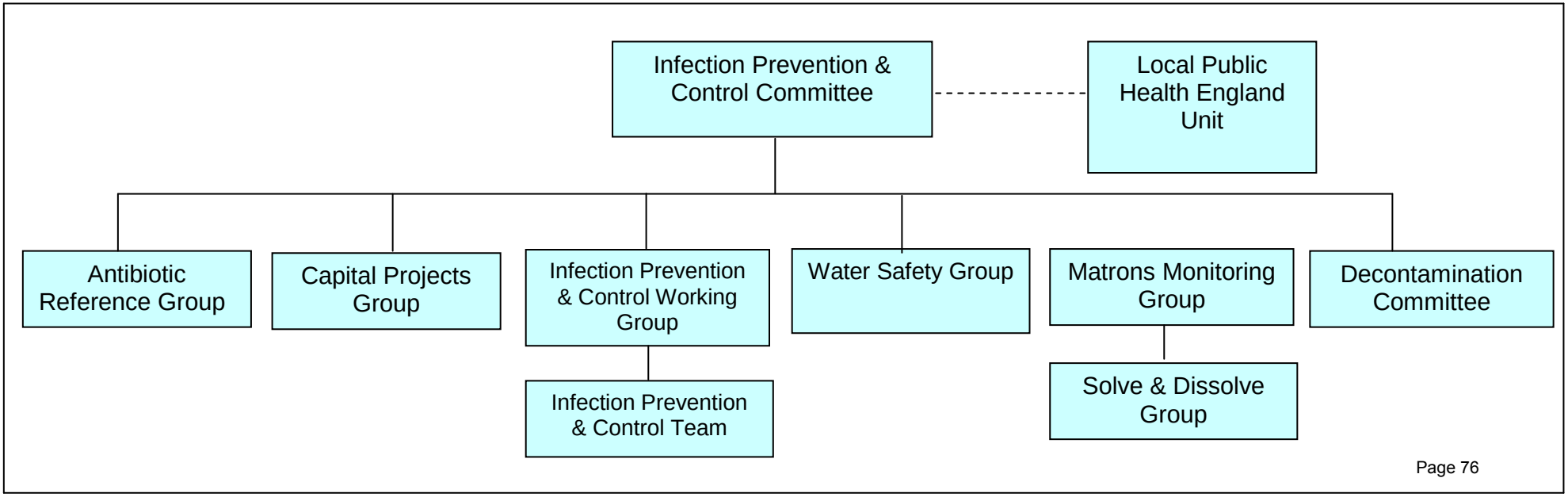
KEY INITIALS

DIPC	Lorna Wilkinson, Director of Infection Prevention & Control
DDIPC	Karen Littlewood, Deputy DIPC (July 2015 to April 2016)
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

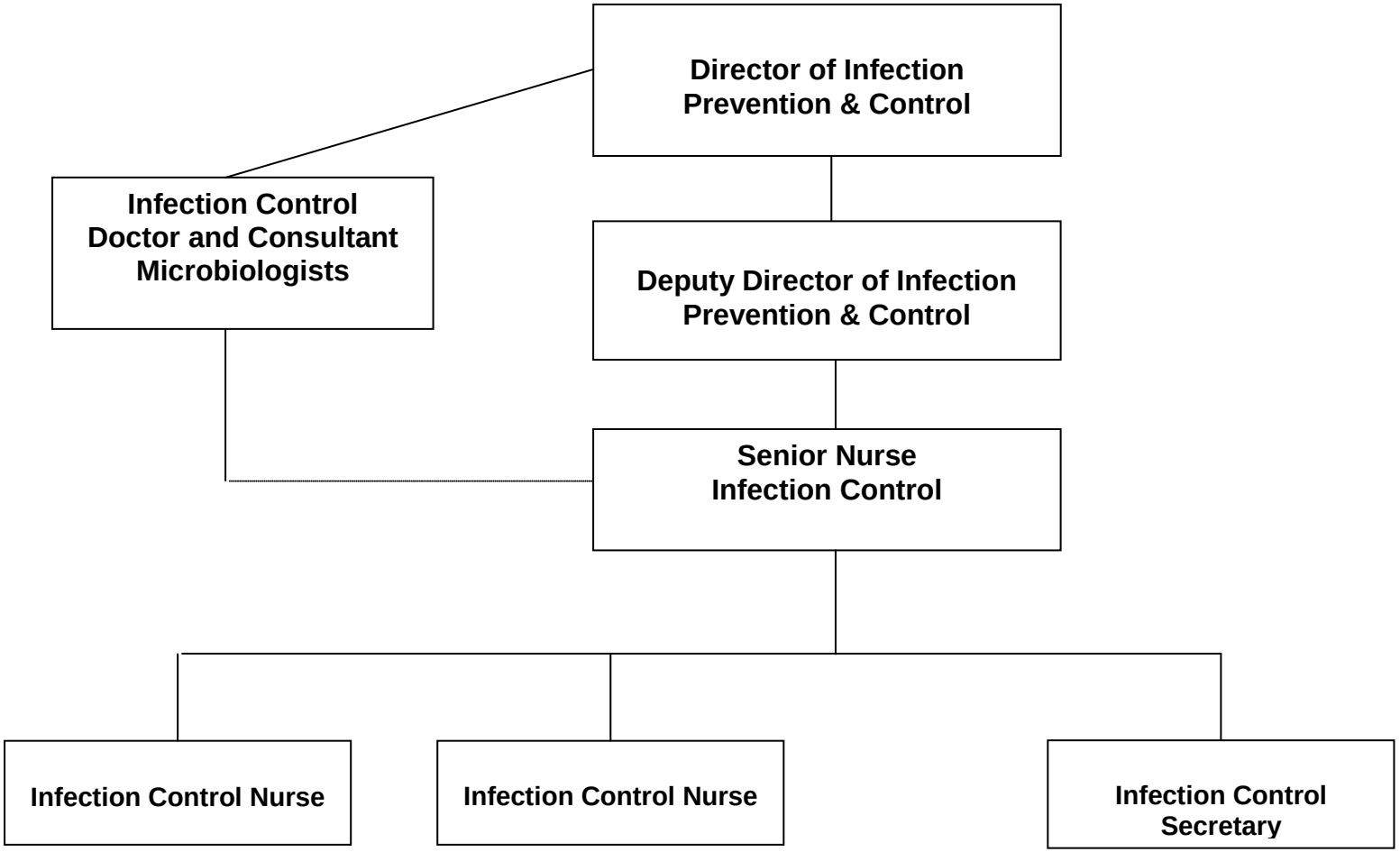
Appendix 2

Trust Reporting Structure





Infection Prevention & Control Team



Appendix 4

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.
4	High standards of hygiene in clinical practice.	Hand hygiene, including Isolation nursing and use of personal protective equipment (PPE).	• Priorities & timescales agreed with DIPC. • Plus, targeted audits.	Clinical Leaders/DSNs IPCT.

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

No	Aim	Audit	When by/How	Person(s) responsible/main author
6	Continued	Patient information leaflet - MRSA Contact Bay.	Review August 2016.	ICNs.
		Patient information leaflet - MRSA Screening.	Review July 2018.	ICNs.
		Outbreak Management Policy.	Under review 2016.	IPCT.
		Outbreak Management of Norovirus Policy.	Under review 2016.	IPCT.
		Patient information leaflet – Norovirus.	Review February 2019.	ICNs.
		Patient 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.	Review January 2018.	ICD.
		Patient information leaflets – CPE C3 – Colonised. C4 – Carrier. C5 – Contact.	Review August 2017.	ICNs.
		Peripheral Venous Cannulation Policy.	Under review 2016.	ICNs.
		Patient information leaflet – Having a 'drip' (peripheral venous cannula)	Review February 2019.	ICNs.
		Standard Precautions Policy.	Review November 2018.	ICNs.
		Surveillance Policy.	Review January 2019.	ICNs.
		Taking Blood Cultures Policy – Adults.	Review July 2017.	ICNs.
		Tuberculosis Infection Control Policy.	Review December 2017.	ICD.
		Ebola and other Viral Haemorrhagic Fevers Policy.	Review August 2017.	ICD.
		Management of VRE Policy.	Under development 2016.	ICD & Deputy ICD.
		Patient information leaflet – GRE.	Review September 2018.	ICNs.
		Patient information – Infection Control Advice to Patients	Review November 2018.	ICNs.
		Staff information - MERS-CoV	Review September 2018.	ICD.

Appendix 5

Reports accessed from the Managed Learning Environment (MLE), and outlines the directorate compliance rates for the Hand Hygiene Assessments completed for 2015/16

Quarter 1 (2015/16)

KEY:	0-79%	80-84%	85-100%

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%

Quarter 2 (2015/2016)

Directorate by Training Title

KEY:	0-79%	80-84%	85-100%

Report database last refreshed on 01/10/2015 at 04:56:40

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%

Report accessed from the Managed Learning Environment, and outlines the directorate compliance rates for Hand Hygiene Assessments (data accessed 01.10.15).

Quarter 3 (2015/2016)

Directorate by Training Date

KEY:	0-79%	80-84%	85-100%

Report database last refreshed on 06/01/2016 at 10.53

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Hand Hygiene Assessment 122014	Ambulatory Care (Direct)	0	2	2	0%
	Balance Sheet (Direct)	6	47	53	11%
	Capital (Directorate)	12	1	13	92%
	Clinical Support & Family Services (Direct)	544	381	925	59%
	Corporate Directorate (Direct)	314	118	432	73%
	Diagnostics Directorate (Direct)	0	1	1	0%
	Facilities Directorate (Direct)	266	108	374	71%
	Finance - Charitable Funds (Direct)	2	3	5	40%
	Medical Directorate (Direct)	4	2	6	67%
	Medicine Directorate (Direct)	384	270	654	59%
	Musculo-Skeletal (Direct)	271	209	480	56%
	Nursing Directorate (Direct)	0	4	4	0%
	Odstock Medical (Direct)	17	2	19	89%
	Quality Directorate (Direct)	217	288	505	43%
	Replica 3DM (Direct)	0	1	1	0%
	Surgery (Direct)	407	280	687	59%
	SW Hub (Direct)	0	4	4	0%
	Top (Direct)	0	1	1	0%
		12	89	101	12%
Hand Hygiene Assessment 122014		**2456**	**1811**	**4267**	58%

Report accessed from the Managed Learning Environment, and outlines the directorate compliance rates for Hand Hygiene Assessments (data accessed 06.01.16).

Quarter 4 (2015/2016)

Directorate by Training Title

KEY:	0-79%	80-84%	85-100%

Report database last refreshed on 12/04/2016 at 08.59

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Hand Hygiene Assessment 122014	Ambulatory Care (Direct)	0	1	1	**0%**
	Balance Sheet (Direct)	11	47	58	**19%**
	Capital (Directorate)	21	2	23	**91%**
	Clinical Support & Family Services (Direct)	551	350	901	**61%**
	Corporate Directorate (Direct)	335	100	435	**77%**
	Facilities Directorate (Direct)	281	82	363	**77%**
	Finance - Charitable Funds (Direct)	5		5	**100%**
	Medical Directorate (Direct)	3	6	9	**33%**
	Medicine Directorate (Direct)	383	251	634	**60%**
	Musculo-Skeletal (Direct)	292	183	475	**61%**
	Nursing Directorate (Direct)	0	1	1	**0%**
	Odstock Medical (Direct)	17	1	18	**94%**
	Quality Directorate (Direct)	221	277	498	**44%**
	Replica 3DM (Direct)	0	1	1	**0%**
	Surgery (Direct)	440	235	675	**65%**
	SW Hub (Direct)	0	3	3	**0%**
	Top (Direct)	0	1	1	**0%**
		4	88	92	**4%**
Hand Hygiene Assessment 122014		**2564**	**1629**	**4193**	**61%**

Report accessed from the Managed Learning Environment, and outlines the directorate compliance rates for Hand Hygiene Assessments (data accessed 12.04.16).

Appendix 6

Report accessed from the Managed Learning Environment (MLE), 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%

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%

Report accessed from the Managed Learning Environment, and outlines the directorate compliance rates for the Infection Control CBL Package for **Quarter 3 of 2015/16** (data accessed 6th January 2016)

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Infection Control 122014	Ambulatory Care (Direct)	0	2	2	0%
	Balance Sheet (Direct)	22	31	53	42%
	Capital (Directorate)	13		13	100%
	Clinical Support & Family Services (Direct)	740	185	925	80%
	Corporate Directorate (Direct)	324	108	432	75%
	Diagnostics Directorate (Direct)	0	1	1	0%
	Facilities Directorate (Direct)	328	46	374	88%
	Finance - Charitable Funds (Direct)	2	3	5	40%
	Medical Directorate (Direct)	4	2	6	67%
	Medicine Directorate (Direct)	516	138	654	79%
	Musculo-Skeletal (Direct)	388	92	480	81%
	Nursing Directorate (Direct)	0	4	4	0%
	Odstock Medical (Direct)	19		19	100%
	Quality Directorate (Direct)	407	98	505	81%
	Replica 3DM (Direct)	0	1	1	0%
	Surgery (Direct)	558	129	687	81%
	SW Hub (Direct)	0	4	4	0%
	Top (Direct)	0	1	1	0%
		8	93	101	8%
Infection Control 122014		**3329**	**938**	**4267**	78%

Report accessed from the Managed Learning Environment, and outlines the directorate compliance rates for the Infection Control CBL Package for **Quarter 4 of 2015/16** (data accessed 12th April 2016)

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Infection Control 122014	Ambulatory Care (Direct)	0	1	1	**0%**
	Balance Sheet (Direct)	26	32	58	**45%**
	Capital (Directorate)	22	1	23	**96%**
	Clinical Support & Family Services (Direct)	708	193	901	**79%**
	Corporate Directorate (Direct)	364	71	435	**84%**
	Facilities Directorate (Direct)	330	33	363	**91%**
	Finance - Charitable Funds (Direct)	4	1	5	**80%**
	Medical Directorate (Direct)	6	3	9	**67%**
	Medicine Directorate (Direct)	496	138	634	**78%**
	Musculo-Skeletal (Direct)	396	79	475	**83%**
	Nursing Directorate (Direct)	0	1	1	**0%**
	Odstock Medical (Direct)	18		18	**100%**
	Quality Directorate (Direct)	405	93	498	**81%**
	Replica 3DM (Direct)	0	1	1	**0%**
	Surgery (Direct)	541	134	675	**80%**
	SW Hub (Direct)	0	3	3	**0%**
	Top (Direct)	0	1	1	**0%**
		3	89	92	**3%**
Infection Control 122014		**3319**	**874**	**4193**	**79%**

TRUST BOARD

CQC ACTION PLAN AND PROGRESS

Date: 6 June 2016

Report from: David Seabrooke **Presented by: Lorna Wilkinson**

Executive Summary:
In December 2015 a planned CQC Inspection was undertaken at the Trust. Overall the Trust was rated as 'Requires Improvement' however many areas of outstanding practice were recognised, and a rating of good was given for care and effectiveness.

The report was published in April, immediately following the multi-agency Quality Summit. The Summit involved a range of regulators, service commissioners, and delivery partners.

Our focus as an organisation is to maintain the areas of outstanding practice while pursuing improvement actions in the areas that the CQC reflected in their final report.

This paper provides the Trust Board with information on how the improvement actions will be monitored to ensure that we are making progress in all of these areas.

Proposed Action:

- To agree the governance arrangements for oversight and monitoring progress of the CQC Improvement Plan

Links to Assurance Framework/ Strategic Plan:

- Links to Strategic Objective - Care
- BAF Risk 2.2 Failure to comply with internal and external expectations on quality of care

Appendices:

Supporting Information

A comprehensive Care Quality Commission inspection took place in the Trust during December 2015. Overall the Trust was rated as 'Requires Improvement', however many areas of outstanding practice were recognised, and a rating of good was given for care and effectiveness.

The Trust noted a range of positive findings from the inspection, including extremely positive feedback from patients and relatives, a positive culture in the Trust and staff had a strong sense of respect for each other and communicated well. Innovation and improvement were encouraged and rewarded; there was professionalism in emergency situations shown by staff.

Areas identified as outstanding practice included staff providing kind and compassionate care, support from consultants to junior colleagues, child bereavement facilities and sensitive support, use of nurse led pathways and the high availability of medical notes.

Our focus as an organisation is to maintain these areas of outstanding practice while pursuing actions in the areas that the CQC reflected in their final report as areas for improvement. The resulting action/improvement plan sets out exactly how we will do that.

The report was published in April, immediately following the multi-agency Quality Summit. The Summit involved a range of regulators, service commissioners, and delivery partners. The Trust is working with many of these agencies in support of its Sustainability & Transformation Plan (STP). The summit focused on some key themes: support in ensuring the right patients are accessing hospital services at the right time, timeliness of discharge out of the hospital with appropriate support, internal issues, and mental health liaison

These wider issues are being taken forward, arising from discussions held at the Quality Summit and through its stake in Wiltshire Health & Care, a new provider which assumes responsibility for adult community services in Wiltshire from July 2016.

Following publication of the report a series of internal focus groups were held with key teams from the core services to establish what measures needed to be taken internally to ensure improvement in the areas highlighted within the CQC report. These form the basis of the core service action plans.

Structure of the action plan and monitoring arrangements

The aim of the action/improvement plan is to improve quality, address the findings of the report and thereby move the judgements of Requires Improvement to Good via a re-inspection. A Trust-wide plan captures cross departmental issues that are further developed and detailed as necessary by the nine core areas of service that were inspected. This results in an action plan consisting of 10 chapters.

Departmental Management Teams are responsible, through their clinical leads, for the delivery of the relevant core service chapters:

Clinical Directorate	**Core Areas**
Musculo-skeletal (MSK)	Spinal, Surgery (part)
Surgery	Surgery, Critical Care, Outpatients
Children & Family Support	Children & Young People, Maternity & Gynae, Diagnostics
Medicine	Medical Care, Urgent & Emergency Care, End of Life Care

The Trust Board is responsible for the continued delivery of high quality care. The Chief Executive is the Accountable Officer and the Director of Nursing is the Senior Responsible Officer.

The delivery of this action plan will be monitored and managed via the following routes:

- At the monthly Directorate Performance Reviews – where each Directorate Management Teams will be held to account on delivery of their core service plans.
- Oversight of the action plan as a whole and delivery of the trust-wide actions through a dedicated CQC Steering Group, chaired by the Director of Nursing.
- Board oversight of progress is through the Clinical Governance Committee (CGC).
- Both the Clinical Governance Committee and the Joint Board of Directors also have a programme of core area presentations, starting in May to enable them to hear direct from the services on progress with their improvement plans.

Response to Warning Notice

As part of the CQC inspection process the Trust received a Warning Notice related to the length of time spinal patients were waiting for routine outpatient reviews and video urodynamic studies. As well as being included in the Trust action plan, the Musculoskeletal Directorate in conjunction with the executive team have agreed an underpinning and very detailed response to solve this issue. Progress is being monitored by the executives through a further layer of fortnightly reporting.

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance and Performance Committee
Held on 21 March 2016

Present:	Dr N Marsden	Chairman
	Dr L Brown	Non-Executive Director
	Mr I Downie	Non-Executive Director
	Mr P Hill	Chief Executive
	Mr M Cassells	Director of Finance and Procurement
	Mr A Hyett	Chief Operating Officer
	Mr L Arnold	Director of Corporate Development
In Attendance:	Mr P Kemp	Non-Executive Director
	Mr D Seabrooke	Head of Corporate Governance
	Miss L Wilkinson (for item 3)	Director of Nursing
	Mr R Webb (for items 4 & 5)	Associate Director of Procurement Commercial Services
	Mr S Dennis (for item 5)	Procurement Manager
	Mr N Wilkinson (for item 4)	

Apologies

1. FINANCE AND PERFORMANCE COMMITTEE MINUTES – 29 FEBRUARY 2016

The minutes of the meeting held on 29 February 2016 were agreed as a correct record.

2. MATTERS ARISING

There were no matters arising.

3. CQUIN

The Committee received the CQUIN Report informing it of progress in Month 11 and setting out Quarter 4 schemes considered to be at risk. It was noted that an escalation meeting was being arranged in relation to CQUIN 7 as over £600,000 was at risk and the Commissioner's position in relation to Quarters 2 and 3 was considered unacceptable.

On CQUIN 8 there was a small risk in relation to Quarter 4 performance.

It was noted that the CQUINs for 2016/17 had recently been published.

4. MY TRUSTY

The Chairman welcomed Neil Wilkinson who had been working with the Trust in support of the My Trusty brand during 2016. Mr Wilkinson summarised the work he had carried out so far and his suggested next steps.

He considered the product itself to be of good quality and was selling at a reasonable retail price. The positioning and packaging could be improved and the NHS heritage was considered to be a key selling point. The Trust would need to build and see through a marketing plan to work

with a major retailer in the longer term for the product to realise its full potential. He described the costs associated with updating the packs and putting together a professional trade presentation.

The Trust would need to be clear with national NHS Leadership about the appropriate use of the NHS brand in this connection.

It was noted that the entry point for the product with a major retailer would be February 2017 and that planning for this would need to be put in place for June 2016.

The Chairman thanked Mr Wilkinson for his work so far and his presentation.

It was agreed that the work being carried out by Mr Wilkinson should be supported and should be progress through the remainder of 2016.

5. BED STACKER – COMMERCIAL PROPOSAL

The Committee received a report setting out proposals to produce and market a mechanical system that would improve the efficiency of hospital bed storage arrangements making it quicker to deploy these and to reduce the amount of floor space required for this. There did not appear to be a system available in the UK that did this.

A range of options to take the new product forward with an engineering partner were set out in the report and the preferred approach was to form a jointly owned company with the engineering partner. This was considered to provide entry to the NHS market for the engineering partner, as there was considerable interest in the idea if it could be shown to work in practice.

It was agreed that work on this project should continue and that a recommendation to the Board to authorise the formation of a joint venture company be made.

6. FINANCE REPORT TO 29 FEBRUARY (MONTH 11)

The Committee received the month 11 Finance Report. It was noted that the Trust had experienced a difficult Month 11 as income had fallen short of activity. There had been considerable spend on supplies during the month. Nursing and medical agency spend was reducing but there was more to do on this.

The Committee noted the Finance Report.

7. SERVICE LINE REPORTING – UPDATE

There were no new matters to report.

8. TRANSFORMATION AND COST IMPROVEMENT

The Committee received the Transformation and Cost Improvement Report. It was noted that £6.3m of savings for 2016/17 were now planned. About two thirds of the savings target for 2016/17 had been identified and quality impact assessments were underway. Improvement to theatres would be the principal scheme. The implementation of

Electronic Patient Record was reflected in all the CIP plans.

The Committee noted the report.

9. REVENUE ESTIMATES 2016/17

The Committee received the Base Estimates 2016/17 report explaining the base estimates to enable budgets to be set for the 2016/17 year in accordance with the Trust's standing orders.

It was noted that in order to receive sustainability and transformation funding of £6.3m through the year the Trust was required to deliver an income and expenditure control total surplus of £1.8m which would require savings totalling £9.5m (4.5%) This was considered to be a significant risk.

Changes to the Tariff made more cash available, thought to be £2.2m. The assumption was that the laundry and other subsidiary companies would be neutral in the estimates.

The committee recommended that the estimates be approved.

10 REPLICA 3D UPDATE

There were no matters to report this month.

11 OPERATIONAL PERFORMANCE MONTH 11

The Committee received the Operational Performance Report and it was noted that in February Cancer Targets had been delivered but there was concern about new referral pathways apparently being introduced by the Cancer Network which appeared to remove key elements of the decision making by GPs. There was better engagement with GPs on ensuring patients were ready to attend hospital when referred on a two week cancer pathway.

The 18 Weeks Incompletes RTT Target had been delivered at Trust level.

On the Emergency Department 4 Hour Target the Trust was running below 95% currently. Data from ED was validated each day.

The Committee noted the report.

12. DATE OF NEXT MEETING

Monday 25 April 2016 at 9.30 am.

SALISBURY NHS FOUNDATION TRUST

Notes of the Finance & Performance Committee
Held on 25 April 2016

Present	Dr L Brown	Non-Executive Director (Acting Chairman)
	Mr P Hill	Chief Executive
	Mr M Cassells	Director of Finance and Procurement
	Mr A Hyett	Chief Operating Officer
	Mr L Arnold	Director of Corporate Development
In Attendance:	Mr P Kemp	Non-Executive Director
	Mr D Seabrooke	Head of Corporate Governance
	Mrs C Gorzanski (for item 3)	Head of Clinical Effectiveness
	Miss F Hill (for item 4)	Head of Risk Management
	Mrs K Stovin-Bradford (for item 10)	Business Relations Manager
Apologies	Dr N Marsden	Chairman
	Mr I Downie	Non-Executive Director

It was noted that this meeting was inquorate and therefore any actions would require ratification.

1. FINANCE AND PERFORMANCE COMMITTEE MINUTES – 21 MARCH 2016

The minutes of the meeting held on 21 March 2016 were agreed by those present as a correct record.

2. MATTERS ARISING

There were no matters arising.

3. CQUIN

The Committee received the CQUIN Report detailing the 2015/16 end of year position and information about the 2016/17 schemes. Claire Gorzanski attended for this item.

It was noted that Wiltshire CCG were paying in full for CQUINs at £2.53m. £634,000 had not been received in respect of ambulatory care but it was considered that the actions the Trust had undertaken at the beginning of the year had been delivered. The Trust had missed its quarter 4 target for Emergency Department coding meaning a loss of £6,400.

CQUINs for Specialised Commissioning and West Hampshire were 100% paid.

Clinical teams had done well in meeting these targets successfully.

For 2016/17 Wiltshire were proposing a 1% reduction in the use of antibiotics in support of antibiotic resistance and stewardship. West Hampshire were seeking local CQUINs for Ambulatory Care and Excess Bed Days which it was not considered would be acceptable. Specialised commissioning were seeking improvements to adult Critical Care, Timely Discharge and the Spinal Cord Injury Outreach Team. It was noted some financial investment maybe required to get the 2016/17 schemes started.

4. ASSURANCE FRAMEWORK/RISK REGISTER – QUARTERLY REVIEW

The Committee received the finance extract of the Assurance Framework and of the Risk Register. It was noted that there had been no change in the Assurance Framework in terms of gaps in control or positive assurances since the January 2016 update.

The report detailed the movement of the top risks on the corporate risk register.

Fenella Hill undertook to review Risk 3928 to ensure the changes to the risk score were accurate. FH

5. FINANCE REPORT TO 31 MARCH

The Committee received the paper outlining the consolidated draft financial position for the period ending 31 March 2016. MC reported that the Trust had met its 2015/16 target. EBITDA was significantly less than plan due to agency costs for nurses and doctors and the performance of cost improvement programmes.

In a review of asset values an asset impairment of £463,000 had arisen in 2015/16. There had been a contribution from Salisbury Trading Limited. Capital spend had come in less than planned and this was being discussed with IT from where the shortfall was understood to originate.

2015/16 outturns had been agreed with commissioners. Arrangements with West Hampshire CCG would be closer in practice to Payment by Results. A £150,000 collar had been agreed with Dorset CCG. Projected activity under the Wiltshire contract was 3% less for 2016/17.

It was also noted that discussions around the building project associated with the Sterile Services Joint Venture would continue to be discussed. It was suggested that representatives of the company be invited to a future meeting of the Committee. MC

The report was noted.

6. TRANSFORMATION AND COST IMPROVEMENT

The Committee received the PMO Transformation report. It was noted that £6.5m of savings had been delivered in 2015/16. The Programme Management Office had continued to improve the governance of cost savings schemes.

The Save 7 scheme was progressing well in the Trust. For 2016/17, 74% of the agreed savings target had been identified so far.

The Transformation Report was noted

7. REPLICA 3D UPDATE

MC reported that shareholder letters as previously discussed had been issued. New equipment had been commissioned by the company which was improving the profitability of the models produced.

8. OPERATIONAL PERFORMANCE REPORT

AH circulated copies of the Month 12 Operational Performance Report which had been subject to verification of some of the indicators. The Month 11 Workforce Report was received for information. The Trust had not delivered the Emergency Department Four Hour Standard in 2015/16. Performance had been 94.8%. It was noted that the Trust had been under considerable pressure up to the middle of April. A number of divert requests had been received from other providers in the area. There were reported to be over 40 Delayed Transfers of Care and over 100 patients were currently assessed as Green to Go.

The Cancer targets had been delivered. The Referral to Treatment targets had been delivered although there were backlogs in Orthopaedics and Ophthalmology. The Trust planned to continue to deliver the Referral to Treatment target each month except for April which took account of the junior doctors strike action.

Current trajectories for Cancer targets where for quarterly and yearly delivery and for ED delivery over 95% in quarters 1 and 2 and slightly below in quarters 3 and 4. The position however continued to be discussed with NHS Improvement.

The Operational Performance Report was noted.

9. MONITOR QUARTER 4 RETURN 2015/16

Reflecting the discussion of the month 12 performance, the Committee received the quarter 4 return for NHS Improvement. This indicated that the Trust had not met the ED Target in Quarter 4 of 2015/16 which would be a consecutive breach as the Trust did not deliver in quarter 3. Under the Risk Assurance Framework the Trust would need to deliver the ED target in quarters 1, 2 and 3 to avoid being seen as a governance concern by NHS Improvement.

The returns for licence compliance and the corporate governance statements were presented but were deferred to the 31 May meeting of the Committee for approval.

10 GP REFERRALS/MARKETING INTELLIGENCE

The Committee received the market share update April 2016. Kate Stovin-Bradford attended for this item. It was noted that the Trust's market share from its principal core practices had increased slightly between 2014 and 2015. The Trust continued to work towards achieving 55% of market share from these GP practices. An improved dashboard from Doctor Foster was presented that detailed market share across a range of elective specialities and the movement in these. Information was also split across the 38 core practices. Details were given on elective share across the Trust and its competitors on key providers. Reports of meetings with individual GP surgeries were provided.

The report was noted.

12. DATE OF NEXT MEETING

Tuesday 31 May 2016 at 9.30 am.

TRUST BOARD

FINANCE & CONTRACTING REPORT TO 30th April 2016

1. Introduction

This paper summarises the Trust's consolidated financial position for the first month of the 2016-17 financial year. The ability to fully scrutinise the position has been affected by staff having to also undertake work on: the annual accounts, annual plan, contract negotiations, and processing of the new year's budgets. Accordingly there is further work to be done to drill down into the figures. The figures at this stage need to be treated with some caution.

The Group Income & Expenditure (I&E) position for April was a deficit of £382k, a favourable variance against plan of £224k. This is because the savings target is phased towards the year's end. The Plan includes the STF funding in the months when it is paid however it should be accrued for; hence it is shown as a separate item.

Summary of Key Financial Information	Plan £000s	Actual £000s	Var £000s	Var %
Income	16,836	16,811	-25	-0.1%
Expenditure	16,766	16,549	-217	-1.3%
EBITDA	**70**	**262**	**192**	**274.3%**
Finance and Depreciation Costs	1,201	1,169	-32	-2.7%
I+E Surplus /(Deficit) excl donated income & STF	**-1,131**	**-907**	**224**	**19.8%**
Donated Asset Income Adjustment	0	0	**0**	
Sustainability & Transformation Fund	525	525	**0**	
I+E Surplus /(Deficit)	**-606**	**-382**	**224**	**37.0%**

2. Sales

NHS activity revenue for the month of April 2016-17 was £14,601k which was circa £151k above the plan. Resilience funding from Wiltshire CCG has been included in this position although no formal agreement has yet been signed. It is expected that £960k will be received from this source during the year. The additional activity above plan can be mainly attributed to non-elective activity.

Contract Activity Performance 2015/16 (AQpril 2016)	Actual 2014-15	Actual 2015-16	Plan 2015-16	Year on Year Variance	Plan Variance
Elective inpatients	468	420	458	-48	-38
Elective PSDs/day attenders	1,795	1,784	1,919	-11	-135
Regular Day Attenders	584	765	709	181	56
Non Elective Inpatient	2,144	2,297	2,204	153	93
Outpatient initial attendances	5,239	5,412	5,239	173	173
Outpatient follow-up attendances	8,939	9,297	8,939	358	358
Outpatient procedures	2,822	2,941	2,822	119	119
A&E attendances	3,758	3,692	3,751	-66	-59

- Elective spells were down by 38 against plan and year on year comparison by 48, with notable reductions against Trauma & Orthopaedics and Plastics. This is concerning given it is more profitable work.

- Day Cases were down by 135 against plan and year on year comparison down by 11. The under-performance in Gastroenterology can be attributed to the non-recurrent additional work that was carried out in April 2015 to clear the patient backlog relating to the bowel cancer awareness scheme.
- Non-Elective activity has over-performed by 93 spells against plan with activity up against A&E and General Medicine. Over-performance was 153 spells higher than activity for the same time period in 2015-16.
- Overall Outpatient attendances were up by 650 against plan
- A&E activity was down against plan by 66 attendances and was also below April activity 2015-16 by 59 attendances. Patients continue to choose to present at ED for some relatively minor concerns. Wiltshire CCG has confirmed the Salisbury Walk-in centre contract has been extended until the end of 2016-17.

Other income was behind plan by £205k due lower than expected non-NHS clinical income.

3. Cost of Sales including indirect costs

The total expenditure for all Directorates in Month 1 was £14,303k, resulting in an adverse variance of £184k. The position is summarised below:

Directorates	Plan	Actual	Var
	£000s	£000s	£000s
Medicine	3,453	3,567	-114
Musculo Skeletal	2,406	2,375	31
Surgery	2,870	2,982	-112
CSFS	3,158	3,215	-57
Facilities	285	258	27
Corporate	1,947	1,906	41
TOTAL	**14,119**	**14,303**	**-184**

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

The main drivers of the overall Directorate's adverse variance are:-
- Non delivery of target savings.
- The cost of agency staff to cover vacancies.

4. Cost Improvement Plan

The total cost improvement savings target for the year is £9.5m which includes revenue Income Generation (IG) schemes of £1.7m (net profit). At this stage Directorates & Corporate Services have been allocated a target of £6.5m with the balance of £3m earmarked for strategic and Lord Carter initiatives as yet to be identified. The unidentified savings of £3m is back loaded into the last three months of the year. Therefore the plan is for a significant surplus to be delivered in the last quarter of the financial year in order to achieve the Sustainability and Transformation control total annual surplus of £1.8m.

The Trust achieved savings and IG schemes in month of £250k against a plan target of £399k an adverse variance of £149k.

Clinical Directorates & Corporate Services continue to work on developing schemes and finalising the deliverability of key project milestones and the monthly phasing of savings. However, further work is required to identify sizable change projects that will release significant savings.

5. Statement of Financial Position

Overall the working capital position (current asset less liabilities) was better than plan by £620k mainly due to a higher than expected cash balance.

6. Capital Expenditure

Expenditure was £601k which was ahead of plan by £261k.

7. NHS Commissioner Contracts

Wiltshire CCG has agreed a contract baseline of £91.9m for 2016-17. The contract is being finalised. The CCG will continue to raise challenges in relation to the Interventions Not Normally Funded (INNF) policies and no prior approval agreement will result in no payment for the procedure. The CCG will be looking to audit the Criteria Based Assessment treatments to ensure full compliance with their policies.

The Trust has agreed a contract baseline with Dorset CCG to the value of £19.3m and Heads of Agreement has been signed. The contract carries a £150k 'cap and collar' arrangement, after which reasonable marginal rates will apply.

The Trust has signed a Heads of Agreement with West Hampshire CCG and the baseline value is £15.5m. The contract does not have any cap or collar arrangements but reasonable marginal rates will apply once the contract over-performs by £400k (the value of QIPP).

The Trust has agreed a financial baseline with Specialised Services to the value £27.3m which is lower that their contractual out-turn and they have been advised that their contract is likely to over-perform early in the financial year. They have acknowledged this issue. The Trust is still awaiting a response on the quality schedule, their proposed QIPP and CQUIN schemes. Additional funding of between £750k and £1m is being sought for the Spinal Unit given the comments in the CQC report and there are indications that this service is significantly underfunded compared with other Spinal Units.

NHS England is expecting all providers to carry out another impact assessment of the specialised services information rules in preparation for their application in 2017-18. This will be a significant piece of work which will need to be completed by the end of June 2016.

All commissioners are looking to implement sizeable QIPP schemes for 2016-17. The Trust has been very clear in its contract negotiations, that QIPP schemes should deliver real cash savings for both parties. Commissioners have agreed that they will take full responsibility for any non-delivery of QIPP schemes based on demand management.

The way ambulance breaches are counted has been changed with the clock starting when the Ambulance team log onto their hand over system (CAD) and this has led to a significant rise in potential Ambulance hand over breaches. The ED department continue to validate the breaches and in April 51 breaches were validated.

8. Risks

The Trust's key financial risks for 2016/17 can be summarised as follows:

- Deliver the CIP target of £9.5m; this is the greatest financial challenge;
- Deliver performance trajectories to secure Sustainability & Transformation funding;
- 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.

9. Other Financial Issues

SDU/SSL – Progress is being made:

- the Shareholder Agreement should be signed within the next two weeks and Articles agreed
- new Board will commence in June (SFT reps – David Taylor and Ron Burrows)
- loan agreements are being finalised
- tenders being issued for 5.3m units per annum facility
- planning application will be submitted when design and build tenders are evaluated
- specification of service for interim arrangements being finalised
- interim arrangements such as license to occupy being finalised
- TUPE consultation finished and pension and payroll arrangements are in hand
- Contracts for services to SSL by SFT and our partner are being finalised
- lease of the land to SSL is underway
- transfer of equipment being finalised

NHSLA/CNST – As a part of a national consultation on the criteria to be used for the funding of clinical negligence costs a full response has been made which emphasises the need for: equity, transparency, flexibility, caps on increases, and benchmarking of performance. As we now spend £6.973m in 2016-17 on the scheme we await the outcome with interest.

LOAN TO FUND EPR – An application has now been made to the ITFF for £6m in order to fund the costs of implementing the EPR system.

10. Conclusions

The Group reported position for April was a deficit of £382k giving a favourable variance of £224k against plan.

11. Recommendation

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

Malcolm Cassells
Director of Finance and Procurement
31 May 2016

Appendix 1 - SUMMARY STATEMENT OF COMPREHENSIVE INCOME

	In month			YTD (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Operating Income						
NHS Clinical Income	13,182	13,362	180	13,182	13,362	180
High cost drugs income	1,268	1,239	(29)	1,268	1,239	(29)
Other Clinical Income	650	457	(193)	650	457	(193)
Research & Development & Education	520	534	14	520	534	14
Other (Excluding Donated Asset income)	1,216	1,219	3	1,216	1,219	3
TOTAL INCOME	**16,836**	**16,811**	**(25)**	**16,836**	**16,811**	**(25)**
Operating Expenditure						
Pay - In post (includes bank & locums)	10,630	10,627	3	10,630	10,627	3
Pay- Agency	539	536	3	539	536	3
Drugs	1,579	1,503	76	1,579	1,503	76
Clinical Supplies & purchase of healthcare	1,881	1,875	6	1,881	1,875	6
Non-Clinical Supplies	560	498	62	560	498	62
Other (incl PFI unitary charge)	1,577	1,510	67	1,577	1,510	67
TOTAL EXPENDITURE	**16,766**	**16,549**	**217**	**16,766**	**16,549**	**217**
EBITDA (Earnings Before Interest, Tax, Depreciation & Amortisation)	**70**	**262**	**192**	**70**	**262**	**192**
Financing Costs	1,201	1,169	32	1,201	1,169	32
SURPLUS / (DEFICIT) excluding donated income & STF	**-1,131**	**-907**	**224**	**-1,131**	**-907**	**224**
Donated Asset Income	0	0	0	0	0	0
Sustainability & Traansformation Fund	525	525	0	525	525	0
SURPLUS / (DEFICIT)	**-606**	**-382**	**224**	**-606**	**-382**	**224**

Appendix 2 - CAPITAL EXPENDITURE

Project Name / Category	Approved Plan 16/17 £000s	Agreed Changes 2016/17 £000s	Slippage to 2017/18 £000s	Revised Plan 2016/17 £000s	YTD spend £000s	Anticipated Under/(Over) spent on Projects £000s
Bariatric Bed	11,140	0	0	11,140	0	
Clinical Radiology 2 x Ultrasound	17,700	0	0	17,700	0	
Orthodontics & Oral Surgery Cone Beam CT Scanner	110,000	0	0	110,000	0	
Breast Unit enabling	10,194	0	0	10,194	0	
CT Scanner Building and Enabling	9,013	0	0	9,013	0	
Laverstock Ward (Decant Ward Project)	354,720	0	0	354,720	0	
Maternity development	354,712	0	0	354,712	3,850	
Radnor Ward Development	12,594	0	0	12,594	0	
SAU Refurb (Decant Ward Project)	88,147	0	0	88,147	11,327	
SDU Development	30,338	0	0	30,338	2,596	
Springs entrance development	1,228,718	-1,228,718	0	0	0	
Ward changes - Dementia Patient Care	1,457	0	0	1,457	0	
Accommodation Boilers (Wylye House & Victoria Drive)	80,000	0	0	80,000	0	
Accommodation H&S Work	40,000	0	0	40,000	0	
Accommodation replacement of kitchens and bathrooms	46,850	0	0	46,850	2,772	
Accommodation Roof Repairs (Compton & Langley)	60,000	0	0	60,000	0	
AHU replacement yr 4 (2016/17) of 7	170,596	0	0	170,596	0	
Asbestos management	17,776	0	0	17,776	0	
Avon and Bourne Boiler Replacement	52,000	5,983	0	57,983	0	
BMS upgrade	44,023	0	0	44,023	0	
Car park 8 machinery replacement	10,071	0	0	10,071	0	
Catering Changing Area	19,000			19,000	0	
Catering Dishwasher	49,066	0	0	49,066	0	
Catheter Suite - Rebalance of Heating System	6,048	0	0	6,048	0	
Central booking relocation - block 79 (Wilton ward)	101,439	0	0	101,439	0	
DSU Roof Repairs	5,822	0	0	5,822	0	
DSU Salto	13,668	0	0	13,668	0	
Ductwork & Fire Damper Cleaning Whole Site	129,483	0	0	129,483	0	
Electricity at Work Regulations Compliance	84,239	0	0	84,239	1,185	
Estates health and safety	4,725	0	0	4,725	0	
Fertility Centre Upgrade	15,000	0	0	15,000	0	
Fire compartmentation SDH north - remedial works	18,271	0	0	18,271	0	
Fire Door Compliance	40,000	0	0	40,000	0	
Flooring Replacement	40,534	0	0	40,534	0	
General laboratory replacement autoclave and Motuary Disinfector	54,075	0	0	54,075	0	
Genetics Coolong	36,000	0	0	36,000	0	
Hospice and Finance Fire Alarms	45,295	0	0	45,295	0	
Level 4 Bedspace Power Sockets	41,610	0	0	41,610	0	
Llfts overhaul - year 3 (2014/15) of 3	40,488	0	0	40,488	2,192	
Main boiler burners	5,549	0	0	5,549	0	
Main Entrance L3 Upgrade	5,807	0	0	5,807	0	
Maternity Obstetric Theatre Refurbishment	1,030	0	0	1,030	0	
Maternity Post Natal Upgrade	6,437	0	0	6,437	0	
Mattress Laundering	2,521	0	0	2,521	0	
Medical Gas Hoses 2nd year of 2 (2015/16)	147,000	0	0	147,000	0	
MSK Notes Preparation	6,500	0	0	6,500	0	
Nurse Call System Upgrade - SDH North & Maternity - 2nd year of 2	123,167	0	0	123,167	0	
OHSS replacement windows	5,270	0	0	5,270	1,891	
Old GUM Clinic Demolition	10,449	0	0	10,449	0	
Pathology - air tube upgrade	4,119	0	0	4,119	0	
Pathology - conversion of computer room to office	12,000	0	0	12,000	0	
Pathology Reception	6,370	0	0	6,370	0	
Pharmacy Cold Room	10,000	0	0	10,000	0	
Powered Door Curtains Level 2	30,000	0	0	30,000	0	
Productive Operating Theatres	18,542	0	0	18,542	0	
Public & Staff WCs L5,L4,L3	53,357	0	0	53,357	97	
Public Spaces Fund	12,441	0	0	12,441	0	
Roads and paving repairs	214,259	0	0	214,259	0	
SDH North Drain Survey	4,999	0	0	4,999	0	
Server Rooms - Air Conditioning	16,890	0	0	16,890	0	
Shower Cubicle Drainage Improvements	17,693	0	0	17,693	4,269	
Site Signage	7,517	0	0	7,517	0	
Spinal Boiler Replacement & Associated Pipework	5,983	-5,983	0	0	0	
Spinal treatment centre refurbishment	16,306	0	0	16,306	4,548	
Spinal Unit Doors and Locks	4,282	0	0	4,282	0	
Springs servery upgrade - floor and freezers only	75,000	0	0	75,000	0	
Taps & IPS panels - sitewide	48,056	0	0	48,056	665	
Water Safety	42,000			42,000	0	
Water tanks access - main tanks only	30,000	0	0	30,000	0	
Alternative to Microsoft products - review	75,000	0	0	75,000	0	
Blades	193,000			193,000	0	
Blood Tracking Phases 1 - 3	185,945	0	0	185,945	32,541	
BMS Network Upgrade	987	0	0	987	0	
Brocade Switch Replacement	5,004	0	0	5,004	0	
CALS	200,000			200,000	0	
Catering Cash Register Replacement	4,400	0	0	4,400	460	
Citrix Support	102,276	0	-68,184	34,092	0	
Community Midwifery system trial	29,244	0	0	29,244	0	
Connectivity Upgrade for Warminster & Shaftesbury	19,023	0	0	19,023	0	
EEG Neurophysiology Review Software	5,000	0	0	5,000	0	
Electronic Letters	14,617	0	0	14,617	0	
EPMA	405	0	0	405	0	

Appendix 2 - CAPITAL EXPENDITURE

Project Name / Category	Approved Plan 16/17	Agreed Changes 2016/17	Slippage to 2017/18	Revised Plan 2016/17	YTD spend	Anticipated Under/(Over) spent on Projects
EPR Lines	11,000	11,000	0	22,000	0	
EPR Supplier Costs	-183,774	5,179,900	0	4,996,126	312,382	
Estates - Oracle software interface	24,000	0	0	24,000	0	
Genetics - software upgrade	7,836	0	0	7,836	0	
Genetics High Spec Analysis Equipment & Software	29,405	0	0	29,405	0	
Histopathology Hardware	10,773	0	0	10,773	0	
IBD register	8,951	0	0	8,951	0	
Inhouse development team - applications, databases and Dashboards (subject to bus case)	101,465	0	0	101,465	8,208	
Maintenance renewal - estimate	38,034	0	0	38,034	0	
Mobile Computing	8,772	0	0	8,772	48	
Mortuary module	52,000	0	0	52,000	0	
Network Unsupportable	24,000	0	0	24,000	0	
Network Upgrade Consultancy	129,774	0	0	129,774	0	
Ophthalmology System	140,926	0	0	140,926	0	
Order Comms (includes System Admin Bid & Sexual Health Bid)	15,265	0	0	15,265	0	
PACS	116,873	-54,000	0	62,873	0	
PACS ED Machines	0	54,000	0	54,000	0	
Palliative Care EPR	39,437	0	0	39,437	0	
PAS 2016 Replacement - Consultancy Costs	780	0	0	780	0	
Radiology - OrderComms	36,117	0	0	36,117	0	
Replace 6509x3 network hubs	67,479	0	0	67,479	2,841	
Reporting System	3,570	0	0	3,570	0	
Results System in GP Practices 'Review' System	10,079	0	0	10,079	0	
SAN Storage	210,000	0		210,000	0	
SBAR Cardiology DICOM Migration	45,100	0		45,100	0	
SBAR for PAS	2,476	0	0	2,476	2,501	
SBAR re NACS Update to ED Symphony	7,500	0	0	7,500	0	
SBAR re UPS Replacement (formerly UPS Replacement - Room based for Computer Rooms)	21,150	0	0	21,150	0	
Telecomms Voice Over IP - invest to save (non clinical areas - subject to a telephony strategy)	189,543	0	0	189,543	14,029	
Telepath enhancements	3,505	0	0	3,505	0	
Telepath to CSCLims (Phase 3 / Year 4 of 4 2016/17)	150,000	0	0	150,000	0	
TMG-UAG	15,000			15,000	0	
UPS Replacement Programme	34,132	0	0	34,132	0	
Whiteboards	208,320	0	0	208,320	72,015	
XML for Pathology COSD Submission	11,900	0	0	11,900	0	
ANC Ultrasound (GROW Programme)	80,000	0	0	80,000	0	
Bariatric Bed (2016/17 bfwd)	346	-346	0	0	0	
BED replacement programme - 4th (2016/17) yr of 4	58,996	0	0	58,996	0	
DSU Camera Stack	98,000	0	0	98,000	0	
DSU Ophthalmic Microscope	120,000	0	0	120,000	0	
General x-ray machine - Westbury - radiology	99,000	0	0	99,000	0	
Genetics DNA Extractor	77,000	0	0	77,000	0	
Grouped Items 2016/17	100,000	0	0	100,000	0	
Maternity Theatre Equipment	26,014	0	0	26,014	0	
Medical Equipment <£50k 14/15	26,400	0	0	26,400	0	
Medical Equipment <£50k 15/16	11,635	0	0	11,635	0	
Medical Equipment <£50k 16/17	231,780	0	0	231,780	0	
Radiology Lead Aprons	30,000	0	-20,000	10,000	0	
Radiology Room 11 Ultrasouind Replacement	80,000	0	0	80,000	0	
Radiology Room 2 Replacement	228,000	0	0	228,000	0	
Refrigerated Centrifuge	444	-444	0	0	0	
Rigid hysteroscopes x 4 plus stack	3,561	0	0	3,561	0	
Ringwood Ophthalmology Equipment	50,000	0	0	50,000	0	
Scopes	32,153	0	0	32,153	0	
Spinal Hoists	37,574	0	0	37,574	0	
Static and Pressure Relieving Mattresses	22,209	0	0	22,209	0	
Theatre Instrumentation Replacement Programme	773,355	0	0	773,355	117,342	
Thermometery Data Loggers	12,958	0	0	12,958	0	
VAC Terapy Machines	3,600	0	0	3,600	3,600	
Videoscopes x2 - main theatres	50,000	0	0	50,000	0	
Bed Stacking	36,494	0	0	36,494	0	
Car Park Machinery	37,000	0	0	37,000	0	
Catering Boiling Pan	15,000	0	0	15,000	0	
Cold Servery Counters	70,000	0	0	70,000	0	
Demand Response Generator Conversion	178,920	0	0	178,920	0	
Efficiency schemes	222,170	-109,000	0	113,170	0	
Finance systems	90,000	0	0	90,000	0	
LED Lighting	30,737	0	0	30,737	0	
Outpatient Kiosks	65,953	0	0	65,953	0	
Phhotovoltaic's / Solarthermal PV	17,683	0	0	17,683	0	
Procurement Tug 2015/16	2,050	0	0	2,050	0	
Project costs	25,529	0	0	25,529	0	
Scan4Safety (GS1)	0	109,000	0	109,000	0	
Security	40,000	0	0	40,000	0	
Telecoms Trunk Lines	8,280	0	0	8,280	0	
Theatres Storage and Trolleys	2,580	0	0	2,580	0	
Ward Waste Bins	60,643	0	0	60,643	0	
Trust Totals	**10,020,710**	**3,961,392**	**-88,184**	**13,893,919**	**601,357**	**0**

Trust Board meeting

SFT 3778

MONTH 1 OPERATIONAL PERFORMANCE REPORT

Date: 30th May 2016

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

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

Executive Summary:

Operational pressures resulted in the trust failing to deliver the referral to treatment standard and ED standard for Month 1. Infection control and diagnostic standards were met.

Emergency Pathway

The trust failed to deliver the ED standard in Month 1, with 90.5% of all patients being admitted or discharged within 4 hours. This was however ahead of the performance trajectory that the trust had reported to NHS England.

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 in addition to high numbers of attendances.

A number of actions have been introduced including operational standards in ED and across the trust. The patient flow action plan has been reviewed and additional ED specific actions have been added.

Delayed transfers of care have increased and at the time of writing this report there are 48 patients whose transfer of care is delayed.

RTT

Due to the effect of the Junior Doctors strike action and the subsequent cancelation of activity the trust board were made aware of the risk in delivering the RTT incomplete standard in April and May. Whilst the trust failed to deliver the standard in April reporting 91.1% against a standard of 92% this was ahead of the trajectory of 90.49%.

Diagnostic

The trust is continuing to work to decrease diagnostic waiting times further. Whilst referrals increased in Q4 the work done to decrease waiting times last year created capacity to manage this increase in demand.

Cancelled Operations

Unfortunately elective procedures have 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

We are currently still validating April figures. The main contributor to our breaches has been the Head and Neck pathways. We have been working hard with the H&N team to improve the lymphoma pathway to avoid late transfers to haematology. As a result, the team have instigated weekly MDT meetings from June instead of fortnightly. This will bring about more timely decision making and speed up the pathway. The other breaches are due to complex pathways involving multiply diagnostic tests or where patients require relevant medical treatment prior to commencing their cancer treatment.

Improvements in pathways for breast and urology referrals are resulting in improved performance despite the large volumes of referrals.

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 – April 2016

Salisbury Hospital NHS Foundation Trust Board Report April 2016

		Reporting Month		Rolling 12 months	
Metric Name	**Ceiling / Standard**	**Apr-16**	**Patients Affected in Apr-16**	**Months Compliant**	**Trend**
Referral to Treatment Incomplete Performance	92%	91.1%	1195	11 out of 12	
Referral to Treatment Incomplete Specialty Compliance	16 of 16 areas	12 of 16			
Zero tolerance RTT waits > 52 weeks	100%	100%	0	12 out of 12	
A&E - Time in A&E department	95%	90.5%	351	5 out of 12	
12 Hour Trolley Waits	100%	100%	0	12 out of 12	
Patients waiting less than 6 weeks for diagnostics	100%	99.37%	24	0 out of 12	
Diagnostic Test Compliance	14 of 14 areas	11 of 14			
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	10 out of 12	
Mixed Sex Accommodation Breaches	0	0	0%	2 out of 12	
Infection control – Clostridium difficile	19	2	2	12 out of 12	
Infection control - MRSA*	0	0	0	12 out of 12	
Metric Name	**Ceiling**	**Apr-16**	**Patients Affected in Apr-16**	**Months Compliant**	**Trend**
All Cancer two week waits	93%	93.9%	35	11 out of 12	
Symptomatic Breast Cancer - two week waits	93%	93.6%	10	11 out of 12	
31 day wait standard	96%	97.6%	3	12 out of 12	
31 day subsequent treatment : Surgery	94%	100.0%	0	12 out of 12	
31 day subsequent treatment : Drug	98%	100.0%	0	11 out of 12	
62 day wait standard	85%	79.7%	13	10 out of 12	
62 day screening patients	90%	96.9%	1	12 out of 12	
62 day patients waiting first definitive treatment after Consultant upgrade	85%			8 out of 11	
Cancer 104 Day Waits**	0	1	1		

Cells with black dotted outlines indicate provisional data

*Please note: MRSA is no longer monitored by Monitor

**This excludes patients transferred to another Provider and now exceed 104 days

Major Projects Report

Date: May 2016

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

Executive Summary:

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

- **IT/technology (EPR and GS1) and the adaptive impact on the organisation**
- **a joint ventures to improve the responsiveness and efficiency of sterilisation services, and**
- **another joint venture with two other acute organisations to improve the quality of adult community services and they interact with both primary care and acute care services.**

Proposed Action:
To note the report.

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

Appendices:

Supporting Information

Introduction

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

- Electronic Patient Record
- The GS1 initiative
- Wiltshire Health and Care management of community services
- Joint venture to provide a sterilisation and disinfectant unit (SDU)
- Organisational development impact – a report will go to Executive Workforce Committee on 31st May

Summary

Salisbury NHS Foundation Trust

Project	Lead	Status	Workstreams	Summary
EPR	LA	Stable at Amber	4 x green 5x amber 2 x red	Contract signed. First set of data loaded, second trial underway. **Go live due weekend of 28/10 – currently on track.** Detailed planning underway – SOPs complete and configuration underway. Increasing communication around the organisation. Emerging issue with pathology testing – checkpoint at next ISSG (13/6)
Scan for Safety	MC (LW)	Stable at Green	4 x green	Recruitment progressing well. Working with other Trusts to collaborate and share learning.
Wiltshire Health & Care	LA AK (board)	Stable at Green	8 x green 1 x amber	Chair recruitment underway. Contract negotiations with CCG. Draft annual plan written. **New contract begins 1st July – on track**
SDU	MC	Declining at Green	3 x green	Positive engagement with Synergy. Initial consultation with SDU staff now ended. Subject to commercials and confirmation of service specification staff transfer will proceed in next few months with Synergy providing the service – from July.

Salisbury NHS Foundation Trust

Electronic Patient Record (EPR)

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

Workstream	Status	Trend	Actions
Infrastructure	Amber	Stable	Infrastructure roll out continues. Positive feedback to new hardware. Examining input devices with clinical staff
Configuration	Amber	Declining	Preparing for trial load 2 validation. Significant workload from letter creation.
Integration	Amber	Stable	Additional resource started 9/4 and making good progress
Data migration	Green	Stable	Trial load 2 underway.
Data warehouse	Red	Stable	Good progress with creation of data warehouse, but failed to recruit to key post – contractor brought in.

Salisbury NHS
NHS Foundation Trust

Electronic Patient Record (EPR)

Workstream	Status	Trend	Actions
Business change	Green	Stable	Complete final standard operating procedures
Benefits	Green	Stable	Completion of interim 'Benefits Review'
Role based access	Amber	Improving	Smart card issue has begun
Training	Green	Stable	Developing training materials and detailed plan
Requests & Results	Red	Declining	Catalogue testing underway with additional senior resource. Sample ID issuing challenge. Checkpoint on go-live required – ISSG on 13/6
Validation	Amber	New	Testing manager appointed – and supporting staff. Testing trial load 2

Scan for Safety v2

Salisbury NHS Foundation Trust

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

Workstream	Status	Trend	Actions
Global location numbering	Green	Stable	Single GLN location in place. Space registry now in place being populated with Estates linking with EPR as part of Lorenzo implementation
Catalogue management	Green	Stable	Catalogue management tool in place. Inventory management strategy with roll out plan to be signed off by end May. Detailed process mapping currently underway major processes mapped by Mid May
Patient identification	Green	Stable	Working with EPR and other demo site to identify points for identification usage Detailed process mapping currently underway major processes mapped by Mid May
Purchase to pay/Inventory	Green	Stable	Producing Inventory Strategy and Updated purchase to pay policy by end May

SFT, together with RUH Bath and GWH Swindon Trusts, has successfully tendered to be the provider of adult community services across Wiltshire. A limited liability joint venture will be established to enable the three organisations to manage the services and to aid the integration of services across acute and community settings.

Workstream	Status	Trend	Actions
Planning	Green	Declining	Contract negotiations progressing, albeit slowly. Draft annual plan. Plans for 6 key projects being developed.
Corporate governance & Monitor	Green	Stable	Progress on Member's Agreement. Setting up Board arrangements. Monitor confirmed transaction not significant and minor comments on MA. Chairman recruitment underway.
Clinical governance	Green	Stable	Agreed WH&C set up as separate organisation with own reporting systems. Second draft of CG approach received. Review of risk register.
Communications	Green	Stable	Engagement events, within acutes, with GPs and ICHD directorate. Branding complete. Website being developed.

Workstream	Status	Trend	Actions
HR	Amber	Declining	Progress on Chair recruitment, advert for CD extended. Additional HR resource coming on board.
Finance and supply chain	Green	Declining	Additional resource and substantive appointment now made. Good progress on finance structure. Provider to provider contract review underway.
Estates	Green	Stable	Review estates occupancy to inform recharging complete. GWH to be landlord.
IM&T	Green	Declining	NHS mail set up, but delay on agreement for transferring staff email'
Equipment	Green	Stable	Asset and maintenance contract review underway

SDU Joint Venture

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

Workstream	Status	Trend	Actions
Commercial	Green	Declining	JV agreement due to complete in June Followed by x2 SLAs – interim agreement and one following opening of new facility. Work on land and services lease underway (June complete)
Workforce	Green	Stable	Consultation with staff completed and went well. Transfer of staff – aiming for 1st July subject to commercials.
Facility design	Green	Stable	Plans being prepared for submission to planners. Space being freed up ready for expected build start in early autumn, with demolition potentially starting in late summer.

Capital Development Report

Date: May 2016

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

Executive Summary:

The Capital Development Report describes the improvements that have been made in the last four months to the Estate, across buildings, information technology, medical equipment and infrastructure.

Ongoing improvements have continued on phase 1 areas –work has completed on the Surgical Assessment Unit which became operational in April. Building work has started on the breast unit which will complete in October. The second phase of the Laverstock upgrade is due to begin in early June.

The EPR project is a major focus for 2016 and work is underway testing the Trust's data in the current PAS and how it will transfer over to Lorenzo and in designing the configuration for how Lorenzo will support the Trust's clinical and administrative processes. This is involving substantial amount of staff time to review, amend or refine those processes.

Further upgrades to two home-grown digital systems managing patient observations and discharge summaries is extending the range of clinical data recorded and transmitted electronically.

Proposed Action:
To note the report.

Links to Assurance Framework/ Strategic Plan:
Choice – "Delivering an estates strategy which ensures patient care is provided from the highest possible quality accommodation and which makes optimal use of the Trust's estate"

Appendices:

Supporting Information

PAPER: SFT 3779

CAPITAL DEVELOPMENT REPORT
FOR THE PERIOD JANUARY TO APRIL 2016

PURPOSE:

The purpose of this paper is to update the Board on developments with some of the more significant capital schemes on the Salisbury District Hospital site since the date of the last report (December 2015).

BUILDING SCHEMES:

Breast Care Unit
The building contractor has now been appointed and building work has started. The building work is expected to be completed in October with the new Breast Unit being fully operational by first week of November 2016.

Further Improvements to Phase 1 Wards
The refurbishment of the Surgical Assessment Unit is now completed and the service moved into their new accommodation late April 2016.

The second phase of the refurbishment of Laverstock Ward will start in early June. Building work will take four months to complete.

Maternity Unit
Planning application has been submitted, planning reference number 16/02951/FUL, target date for decision 18th July 2016. The design project teams, which include recent mothers, are currently finalising the tender documents. The Trust will go out to tender in early 2017, subject to Board approval.

IT SCHEMES:

Electronic Patient Record (EPR)
The EPR project has continued to maintain progress and remains on track for the initial phase of implementation at the end of October 2016. The initial phase of delivery in October will include core EPR functionality (patient administration processes), implementation in the Emergency Department, the inclusion of some clinical documentation (and processes) and potentially Order Communications (ordering of tests). The later phases in 2017 will see the deployment of Theatre, Maternity and EPMA (electronic prescribing of medicines) modules. The delivery of each of these modular elements will enable the retirement of the corresponding existing system.

The primary focus of the project over the first part of 2016 has been the definition and agreement of the business process that the trust will move to with the implementation of

Lorenzo. Through late spring and early summer the focus will turn to the configuration (build) and testing of these processes.

Communication activity through departmental presentations, system and hardware demonstrations, regular newsletters, a video featuring key messages from the trust Executive team are also underway and will continue to increase over coming months, as will the issuing of Smart Cards (the means of access to the Lorenzo system).

The project is a major focus for the trust across 2016 and 2017 and is a significant pull on resources across Informatics and across the Trust, these demands will increase over the coming months as we move through testing, training and into implementation.

Single Sign On (SSO)
Vergence has been upgraded to V6. SSO has been re-built on a platform that will make it 'Lorenzo' ready (x64bit).

Ward template signed off and now being rolled out to wards on refurbished PC's and Laptops that are 'Lorenzo' ready. Once wards receive the new SSO build, users will no longer need to use HAS. Instead they will access clinical applications via bridges/links (PACS, Review, HAL, POET, TheatreMan, Refer-a-Patient etc) and non-clinical applications (Word, Excel, Outlook etc) via Published Applications.

Theatre/DSU Template has been built and currently being tested within the IT Team, it will then go through UAT by Theatre & DSU staff with a view to rolling out by the end of June 2016.

Electronic Whiteboards
This project focusses on the implementation of an electronic whiteboard solution in order to improve patient flow and discharge planning. Funding for this project is from the Nurse Technology Fund.

We are currently in the pre-implementation phase. Work is being undertaken on setting up the system and integrating it with iPM and our internally developed solutions (Consultant Lists, POET, HANT). Training and system demonstrations are being delivered across all ward areas and key clinical departments. We have a current planned go live date of the 7th June. Implementation will be across all wards, with the initial focus being on Admission Transfer and Discharge, and replication of the current physical whiteboards.

Patient Observation and Escalation Tool (POET)
The project is now well into the implementation phase. It is currently live on Laverstock, Britford, Downton and Farley wards. Training is in progress on Winterslow with a view to going live shortly. Future developments will include a link to Review (which is currently in test) and inclusion of the Fluid Balance Chart.
This initial solution focuses on the recording of patient observations and assessments and the creation of a track and trigger score. An automated escalation function will be developed in phase 2 of the project.

Electronic Discharge Summaries
A number of developments are in the process of being undertaken to fix bugs, improve functionality and to assist the Trust in meeting current CQUIN targets. Changes include:

Ordering of Drugs - Improvements to the way drugs are ordered from Dispensary
Deceased Patients - no longer requires input from a Pharmacist
AKI Changes – to meet the current CQUIN targets users are required to select a 'Primary Cause' of the AKI.
Blood Products/Blood Transfusion – Doctors will need to select if a patient has been given any blood products
Follow Up Booking Notification – a web page has been developed to allow appointment booking staff to view follow up appointment requests for patients post discharge.
Incomplete EDS Report - A report that will allow certain users to view EDS's that have been started but not completed for patients who have been discharged.

Blood Tracking – Phase 2
The project will enable the tracking of blood from donor to transfusion or disposal using Bloodhound software and Mio handheld devices. 100 % Traceability is a regulatory requirement under the Blood Safety and Quality regulations (2005).

A new blood issue room has been built and equipped with new issue fridges and a platelet agitator all controlled by Bloodhound. The Bloodhound software has been installed within the Trust's environment and on a Trust mobile (MIO) device and testing discovered a number of significant issues. A new version of the software has been received which resolves those issues.

Phase 3 of the project – Bedside sampling and Order Comms integration is now to be aligned to plans for Salisbury's new EPR.

ACTION REQUIRED BY THE BOARD:

To note the progress of the Trust's significant capital schemes.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

Other significant schemes in the Approved Capital Programme for 2015/2016 (Appendix A to C inclusive)

Laurence Arnold
Director of Corporate Development

APPENDIX A

Other significant schemes in the Approved Capital Programme for 2016/76

Building and Works schemes	Completion date	Budget cost incl VAT
Efficiency schemes (7703C0) Funding available to support efficiency projects with rapid payback revenue savings. Funding ring-fenced for in-year bids. *Work ongoing as bids approved approx. £20K left – Ian R managing this*	2016	£160k
Demand Response Generator Conversion (7717C0) This scheme will allow the Trust to generate electricity at peak times during the winter months to reduce high demand charges *Project shelved until full details of the proposed Photo-Voltaic project are clarified, as this scheme will be less cost-effective,.*	2016/17	£180K
Spinal Treatment Centre refurbishment (7049C0) Replacement of single glazed windows with double glazed units along with range of smaller refurbishment items prioritised in the 2014/15 programme. *Works scheduled for 2015/16 completed in December 2015* *Some 'snagging' works to be actioned May / June 2016*	June 2016	£190k
Road repairs and Pedestrian crossings (7020C0) Repairs to the roads on site and upgrading the pedestrian crossings to current standards	October 2016	£120K
Accommodation upgrade (7011C0) Refurbishment of the kitchens and bathrooms in staff accommodation	August 2016	£150K

Rolling work programmes (multi year projects)

Building and Works schemes	Completion date	Budget cost incl VAT
Air Handling Units (7041C0) This is the third year of a 7 year (£2m) programme to replace the 50 specialist ventilation systems supporting SDU, Pharmacy, ED/SSEU, Pathology, Spinal X ray and all the Theatres.	March 2020	£352k this year
Ductwork and fire damper cleaning (7093C0) Across whole SDH site, ventilation ductwork and fire dampers will be cleaned out to comply with fire and health and safety legislation. 3rd year of 3.	June 2016	£188k (this year)
Nurse Call System upgrade (7202C0) Project to replace ageing nurse call systems throughout wards in the main SDH north building and maternity wards. 2nd year of 2. £75k slipped to 15-16 to link with refurbishment requirements *Work undertaken during ward refurbishments*	2016/17	£133k (this year)
Lift Refurbishment Programme (7056C0) A programme to upgrade all the lifts in Phase 1 building. Year 3 of 3. Lifts 3 & 4 completed work in progress on lifts 1 & 2	August 2016	£66k

APPENDIX B

Information Technology schemes	Completion date	Budget cost incl VAT
PACS/RIS (7943C0) Following the system issues experienced in December 2015 the full remedial work has now been completed but this took much longer than expected by the Trust and the Suppliers, but is now complete. Following further issues since then, Andy Hyett wrote to the Managing Director of SECTRA explaining our frustration and disappointment in the failure of service we have been experiencing. In May we have had further issues with retrieving images and pre-fetching of images for Outpatient appointments which we have worked closely with all the suppliers involved and have succeeded with fixing some and are currently working on plans to improve pre-fetching as a whole. The development work for XDS is continuing and we are nearing the completion of alpha testing and we will be working with all the suppliers in June for end to end testing and for the start of beta testing. We are hoping to be using this in the LIVE environment at the end of the Summer.	July 2016	
Order Comms and Results Reporting (7942C0) Electronic requesting of Radiology exams by GPs is now LIVE and has been very successful. We reached our first 1000 requests before Christmas and now 90% of GP practices using Laboratory requesting are now using Radiology requesting. There has been a significant rise in requests since the new year, and there are currently only 3 GP practices left to roll out to. GPs access to Review (electronic access to reports) is progressing well.	April 2016	£100k
SAN Storage (7907CO) Equipment ordered and on target for summer '16 installation..	Summer 2016	£210K
Ophthalmology EPR A procurement to provide a full Ophthalmology EPR for all specialties was run from the 23/11/2015 with a closing date of 08/01/2016. 3 vendors submitted proposals with Medisoft being awarded preferred status. A pre-contract meeting with Medisoft is due to take place on the 4th May hosted by procurement.	September 2016	£141K
Telecoms Voice Over IP (7948CO) A number of pilots – Main Switch board, Radnor, EPR project team are now underway. (Project to move some non-clinical areas off the main telephone frame which reaches end of life in 2018). 220 additional extensions identified for move over to VOIP platforms. Procurement of SpliceComm interface underway, this allows the use of generic	July 2016	£189,000

Information Technology schemes	Completion date	Budget cost incl VAT
VOIP phones instead of branded devices future proofing the investment in the handsets and minimising ongoing license costs. Rollout begins in June.		
SPiDA SpIda 2 has been in LIVE service since 1st February 2016. This delivered a new version of SpIda that separated each of the functionalities and included Nurse Re-validation. There have been several patch releases to fix issues as they have risen and currently we are still fixing data issues from the migration. A new compliancy report has been released giving managers direct access to information on progress with appraisal at an individual staff member level. A new Admin page will be phased in over the next couple of weeks to assist HR in dealing with the issues as they are raised e.g. closing records, dealing with data errors etc. The final outstanding piece of work is to create the compliancy report at Line Managers level.	February 2016	

APPENDIX C

Medical Devices schemes	Completion date	Budget cost
Capital schemes		
Bed Replacement programme (7131C0) The bed replacement programme is progressing. 403 of the replacement beds have now been ordered. The remaining beds are due to be ordered this year, however owing to limited availability of capital funding, the scheme will extend to a 5th year.	Year 4 of a 5 year programme	£150k (2014/15) £204k (2015/16) £120k (2016/17)
Review of Theatre Instruments (7122C0) The Trust commissioned an external review of instrumentation. Both the urgent and the Urology instrumentation have now been delivered and are being put into circulation. Plastics trays are being replaced. The next speciality to be replaced will be Laparoscopic / General Surgery.	Rolling programme	£300k (2014/15) £500k (2015/16) £500k (2016/17)
Overhead hoists for the Spinal Unit (7112C0) 13 overhead hoists and 1 mobile hoist have been replaced in the Spinal Unit, covering both Avon and Tamar wards. The hoists were 10 years old and failing regularly. Owing to their high usage and the increasing manual handling risk, they were replaced as a matter of urgency.	February 2016	£70k
Radiology Room 11 ultrasound replacement (7160C0) The existing machine was used for scanning patients including pregnant ladies. The machine was 6 years old, high use and the image quality was starting to deteriorate.	July 2016	£80k
Scopes (7126C0) The scopes used in Endoscopy were originally replaced as part of a tendering process in 2008. A rolling replacement programme was implemented and the scopes which were becoming obsolete in 2015 and those additional scopes needed for the increased demand and the introduction of the bowelscope programme were replaced / purchased. The project was undertaken in 2 phases.	October 2015 February 2016	£259k £263k

Medical Devices schemes	Completion date	Budget cost
Ophthalmic microscope for DSU (7166C0) The existing microscope is 15 years old. It is used mainly for cataract surgery and treats between 1300-1500 patients each year. £4.5k was spent on parts in the last 2 years to maintain the service. The new microscope will be future proofed to enable intraoperative OCT, robotics and laser cataract surgery to be undertaken. It will also be wifi enabled.	October 2016	£120k
Camera stack for DSU (7165C0) This stack will replace a broken 8-year old stack from DSU Theatre F. It will be wifi enabled and connect to PACS. A stack is currently being moved between Main Theatres and DSU.	September 2016	£98k
General x-ray machine – Westbury (7115C0) The machine currently installed at the White Horse Medical Centre in Westbury is coming to the end of its life. Owing to the increased activity and newly implemented walk-in service, a new machine will be purchased to accommodate the patients using this facility. Site visits have been undertaken and a specification drafted to consider the future needs. Clinical evaluations have been undertaken and preferences tabled. **See flooding in Radiology below**	June 2016	£99k
<u>Other projects</u>		
Flooding in the Radiology department A leak has caused damage to equipment in the Radiology department. An insurance claim has been submitted for the replacement of both a mammography machine and a general x-ray machine for room 2. The Trust has received the outcome: • Mammo machine has been repaired and is operational • Room 2 is to be replaced The Room 2 machine and the Westbury machine are similar specifications therefore a double tendering exercise has been undertaken and concluded.	June 2016	£15k £228k
Portable ultrasound machine for GROW (7162C0) SFT have signed up to the "Sign up to Safety" DH led initiative. One element of this initiative is the GROW programme, avoiding preventable harm in maternity, its aim is to detect foetal growth restriction using the Growth Assessment Protocol (GAP) tool. SFT submitted a bid for DH capital funding for a portable ultrasound	March 2016	£30k

Medical Devices schemes	Completion date	Budget cost
to implement this programme fully. The bid was successful. This portable ultrasound will be used in Tidworth and Shaftesbury.		
<u>Donated Assets</u>		
Orthodontics and Oral Surgery Cone Beam CT Scanner (7127C0) The scanner produces images which are used to aid diagnosis and treatment planning of orthodontic and orthognathic cases. The costs are being finalised including the necessary enabling works.	March 2016	£110k

SALISBURY NHS FOUNDATION TRUST
Minutes of the Audit Committee
Held on: 14 March 2016

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

In Attendance: Mr J Oldroyd (KPMG)
Mr J Brown (KPMG)
Mr D Seabrooke (Head of Corporate Governance)
Mr M Cassells (Director of Finance and Procurement)
Mr A Morley (Local Counter Fraud Specialist)
Mr M Stabb (TIAA)
Ms Susan Lees (IT Training Manager for item 5)

Apologies:

ACTION

1. MINUTES – 12 OCTOBER 2015

The minutes of the meeting held on 12 October 2015 were accepted as a correct record.

2. MATTERS ARISING

The Committee received a report from the Director of Human Resources and Organisational Development setting out the Trust's position on disclosure and barring checks in relation to employees in post before 2002, those that had changed roles within the Trust since 2002 and those recruited into the Trust since 2002. It identified the costs associated with conducting retrospective checks in relation to employees who had never had a disclosure and barring check and also Porters. The report also identified the cost of a rolling 3 year programme of DBS checks.

The report was noted.

3. EXTERNAL AUDIT UPDATE

The Committee received the March 2016 Progress Report which identified initial work undertaken in support of the 2015/16 year end process. Changes to the rules around financial procurement, the Trust's local estates evaluation and the Sterile Services joint venture were highlighted. Initial work had started around the audit of the performance indicators featured in the Quality Account was underway. It was understood that Monitor were likely to implement the revised reporting framework for the 'Limited Assurance' report on those performance indicators.

In the technical update the introduction from 1 February 2016 of caps on agency uplifts for clinical and non-clinical staff, changes to the Monitor Well Led Framework, latest developments of the 2015/16 Annual Reports requirements, sustainability and transformation plans and the Care Quality Commission's assessment of value for money to be rolled out in January 2017 for acute trusts.

It was noted that falls had been chosen as a local indicator in the Quality Account. The Trust would be discussing its response to the Monitor Well Led Framework and the requirement for independent external review.

The Committee noted the External Audit Report.

4. INTERNAL AUDIT

The Committee received the Summary Internal Audit Progress Report including the Audit Plan 2016/17 for approval.

It was noted that of the four 2015/16 scheduled audits, still to commence, three were starting in March. There had been no limited assurance reports so far.

In relation to data quality the implementation of a Data Quality Assurance Framework was highlighted and ongoing training for staff who managed waiting lists. There were minor issues that were being resolved around the reporting of these indicators. In relation to the management of falls and pressures ulcers, improved falls management was being developed and would be cascaded by the Director of Nursing. On safer recruitment it was noted that identity and background checks would be carried out at interview stage rather than at induction stage. On the Bed Management Policy the implementation of electronic whiteboards was noted.

The Committee requested a written update for circulation in relation to progress with putting in place authorised engineers within the Estates Department. It was noted that authorised engineers had been appointed for lifts, ventilation, working at height and confined spaces. An authorised person for ventilation work had completed the necessary training but there would be no local appointment of authorised persons for lifts, working at height and confined spaces and there would be a risk assessment in relation to these. Work would continue to secure a management response in relation to patient property.

Counter Fraud

The Committee noted the Counter Fraud caseload set out in the report and specific work undertaken in relation to rostering, pre-employment checks by temporary staffing agencies and the use of Single Tender Action Forms within the Trust. The review of rostering in Radiology and Pathology had not identified any significant issues. The Trust was working with one of the principal staffing agencies to ensure that pre-employment checks were completed appropriately. There would be a further report at a future meeting of the Committee. **DS**

It was agreed that the Director of Finance would write out to staff to remind them to use scratch cards appropriately. **MC**

The review of Single Tender Actions had not identified any fraudulent activity but there was concern that only about half of the sample were considered to be justified when scrutinised. Work would continue to improve compliance with this exemption safeguard.

2016/17 Audit Plan

The Committee approved the 2016/17 Internal Audit Plan totalling 310 work days.

5. DATA QUALITY UPDATE

Susan Lees attended for this item and the Committee received a report summarising the current position on data quality highlighted by recent audits and actions underway to improve the position. A Data Quality Assurance Framework was being introduced focussing on Referral to Treatment, Emergency Department and Cancer Waits being overseen by a data quality group. Staff training on the Access Policy would be taking place and training on the Lorenzo EPR would be taking place during the summer in readiness for the October 2016 roll out of EPR.

It was noted that the Data Quality Framework was in early stages and there was concern about the reliance being placed on enhanced capabilities and processes associated with the implementation of Lorenzo and the new Data Warehouse, which itself was in the process of being designed.

6. HALF YEAR REVIEW OF THE ASSURANCE FRAMEWORK

The Committee received the report from the Head of Risk Management setting out the Committee's biennial review of the work of the assuring committees over the preceding quarter. It was noted that the Board had considered the Assurance Framework in detail at its September workshop and the results had been consolidated into the Assurance Framework and approved at the December 2015 meeting. With the introduction of the Datix system it was considered that the timings of the Board Annual Review of the Assurance Framework could be changed in future years.

The Committee noted that the Clinical Governance Committee had highlighted gaps around safeguarding and suitable remedial actions and that the Joint Board of Directors had identified a gap around ensuring learning from complaints across the trust and remedial actions undertaken by Customer Care. The reports from the Finance and Performance Committee highlighted the high risks on the Risk Register with no action plans and it was noted that updates to these instances were being requested. The Committee shared this concern as it was not considered that risk ratings could meaningfully be reduced without documented actions.

7. REVIEW OF LOSSES AND COMPENSATION REGISTER

The Chairman signed the latest Losses and Compensation Register.

8. ANY OTHER BUSINESS

It was noted that the five year contract with KPMG as external auditors was due to expire on 31 March 2017 and that in the second half of 2016 members of the Committee would work with the Council of Governors towards selecting a provider from 1 April 2017.

9. SCHEDULE OF COMMITTEE MEETINGS 2017

The Committee would continue to meet close to the financial year end and at the time the Annual Report required to be signed off and would set its meetings at even intervals in the second half of 2017.

10. DATE OF NEXT MEETING

The next meeting of the Audit Committee will be on Friday 20 May 2016 at 10 am.

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 25th February 2016, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair) - Non-Executive Director
Peter Hill - Chief Executive Officer
Dr Christine Blanshard - Medical Director
Claire Gorzanski - Head of Clinical Effectiveness
Lorna Wilkinson - Director of Nursing
Karen Littlewood - Deputy Director of Nursing
Hazel Hardyman - Head of Customer Care
Dr Angela Clarke - SpR
Steve Long - Non-executive Director
Ian Downie - Non-executive Director

In attendance:

Kate Williams	Minute taker
Jan Sanders	Governor
Dr Pippa Baker – Consultant in Palliative Medicine	CGC021604
Sarah Hennell – Senior Nurse Manager, Hospice	CGC021604
Hannah McClean – End of Life Care Facilitator	CGC021605
Stef Scott – Head of Research & Development	CGC021611 & CGC021612

CGC021601 Apologies:

Andy Hyett - Chief Operating Officer
Mark Stabb – Head of TIAA

Not in attendance, apologies not received:

Hollie Foreman – Staff Nurse

CGC021602 – Minutes of the meeting held on 28th January 2016

PH asked that the Minutes of the Clinical Governance Committee be made more concise and more action orientated. The minutes of 28.01.16 to be amended to reflect this. **KW (Action complete)**

CGC021603 – Matters Arising / Action Tracker

Two items : the Spinal Unit Leadership Update, and the National Children's Inpatient and Day Care Survey 2014 – Update on Local Action Plans are on the Agenda from the Action Tracker. One other item will now be presented at the JBD and the remaining items to be heard at future Clinical Governance Committee meetings as per the dates agreed.

CGC021603A – Matters Arising – Spinal Unit update – Improvement Notice Update – Christine Blanshard

An action plan will be produced by 24th March. CB, AH and LW are all meeting regularly with the team.

STRATEGY

CGC021604 – Core Service presentation – End of Life Care – Dr Pippa Baker / Sarah Hennell

PB gave a presentation which highlighted achievements and challenges within End of Life Care.

End of Life Care in SFT was inspected by CQC and the report is awaited. The new End of Life CNS team have made significant progress since starting in June/July 2015 with the roll out of the Personalised Care Framework (PCF), extensive education programme, leadership of the rapid discharge home to die process and many other projects. The team is working at capacity and the lead nurse is due to go on maternity leave with ongoing challenges at securing cover. This in conjunction with a depleted hospital palliative care team (HPCT) leaves the Trust at risk with regard to standards of end of life care. The long-term security of the specialist palliative care CNS 7 day working project has been extended to March 2017 and the chaplaincy team is struggling to cope with the increased demand that the EoLC Team and PCF generate. There remains a problem locally with the national drive for an effective electronic palliative care co-ordination system (EPaCCS) as ADASTRA no longer exists but its replacement with an end of life component of TPP/System 1 is not in use within the community and SFT. Salisbury Hospice Charity have agreed funding of a Hospice @ Home 3 year pilot which will commence on 01/04/16.

LB thanked PB and SH for their presentation.

CGC021605 – Hot Topic – Rapid Discharge Home to Die – Hannah McClean

HM presented the achievements and challenges relating to Rapid Discharge Home to Die :

Significant progress has been made since the RDHTD working group was reformed in July 2015. Data, although limited, is now being collected, areas for improvement identified and action taken to address these. RDHTD do occur, are appropriate and the processes in place enable successful discharges within the 24hr time frame. Numbers are small but this is partly due to the clinical condition and prior home set up of the relevant patients. A significantly larger number of patients who have a life expectancy of weeks rather than days are successfully discharged for EOLC in the community. The biggest barrier to facilitating RDHTD and discharges for EOLC is a lack of 24hr care provision in the community, particularly for patients who do not have complex health or palliative care needs.

It was agreed that F1's and F2's need training in what is necessary for fast track applications.

LB thanked HM for her presentation.

CGC021606 – Nursing, Midwifery and AHP Update – Lorna Wilkinson

This item was deferred to May 2016.

CGC021607 – Junior Doctor feedback (verbal) – Angela Clarke

AC reported that she was initially approached by Dr Page to be a member of the committee and has found it very interesting. AC was able to contribute more to discussions on medicine, than surgery and was reassured to see that challenges on the Spinal Unit were revisited at each meeting. AC suggested that it would be helpful if she could feedback relevant information to her colleagues but that this is not currently possible during clinical hours. She further suggested that it would be useful to encourage the junior nurse to attend more meetings.

LB thanked AC for her valuable contributions and wished her well in her forthcoming maternity leave.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC021607A – National Children & Young People's Survey 2014 Update on Local Action Plans – Christine Blanshard

This item was noted by the Committee.

ASSURING CLINICAL EFFECTIVENESS

CGC021608 – Quality Indicator including DSSA – Tabled only – Christine Blanshard

LW reported that there are increased system wide pressures at this time of year, there were 8 flu patients in the previous week and there had been 4 patients with C Difficile in February.

CGC021609 – Internal Audit programme – Christine Blanshard

- In May 2015 KPMG undertook an audit of the indicators in the Quality Report. There were 7 recommendations, 5 have been fully completed and the other 2 are not completed with a plan to do so by March 2016.

- TIAA undertook an audit of the management of falls and pressure ulcers in October 2015 and made 11 recommendations. Of the 6 recommendations that were due for completion by February 2016, 4 have been completed and 2 partially completed with review dates extended to March & April 16.

- An audit of the review of safeguarding children recruitment practices was undertaken in December 2015. 5 recommendations were made and are due for completion by 31 March 2016.

- A review of the bed management policy was undertaken in January 2016. Of the 4 recommendations, 2 have been completed and the other 2 remain work in progress with review dates extended to March 16.

- An assurance review of data quality was completed in January 2016. Of the 6 recommendations due by the end of February 2016, 5 have been completed 1 remains work in progress with a plan to complete by the end of March 2016.

The committee noted the report.

CGC021610 – Major Issues Report – Christine Blanshard

LW reported that the Sepsis team won an award at the Wessex AHSN event which has been a boost.

CB noted that SFT's data was included within the Lord Carter report.

The EPR is on track to be delivered and implemented. GS1 funding has been received, work has begun and will go hand in hand with EPR. LW will investigate dates for completion.

A small number of operations / outpatients appointments were cancelled due to the strikes. 3 more strikes have been announced for 9th March, 6th and 26th April. Each will be for 48 hours and emergency cover will be in place.

The National Staff Survey 2015 demonstrated exceptionally good results.

CGC021611 – Q3 Research and Development Report – information only – Stef Scott

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. The Trust makes 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.
SS reported that there has been a great success as the team have been developing a non-invasive test for Down's Syndrome which has been accepted by UK National Screening and which will be rolled out nationally.

CGC012612 – Income distribution from commercial research policy update – Stef Scott

'Income Distribution from Commercial Research Income Policy' version 1.0 was approved by CMB and ratified by CGC in June 2014. The policy meets the requirement for the Trust, as a research active NHS Organisation, to have a clear policy for the distribution of income derived from NIHR Clinical Research Network Industry studies.

The revisions to the policy relate to:

- Distribution of pharmacy overheads; and
- Payment of income into Charitable Trust funds

SS asked that it be ratified that once NHS costs had been reimbursed, that any profits could be paid into trust funds to be reinvested going forwards.

The committee asked that the percentage of overheads be agreed and that subsequently this matter should go to the Finance committee. Subject to the information requested, the policy is approved. **SS**

CGC021613 – Dr Foster report and Mortality Reviews – Christine Blanshard

- SHMI is 109 and 104 when adjusted for palliative care and is as expected to June 2015. HSMR is 109 to October 15 and is higher than expected. Deaths in low risk diagnosis groups are as expected.

- Deaths by day of admission are as expected on weekdays and Sundays, but higher than expected for non-elective patients admitted on a Saturday. The mortality working group will look at a sample of non-elective admissions to ascertain if any deaths were avoidable and for any learning points.

- Care Quality Tracker - for the period November 2014 to October 2015 our overall risk is 4 which is lower than the national median and there is one elevated risk and two risks.

- Quality investigator – 4 diagnosis groups and 2 procedural groups have a relative risk of over 100. An assessment of avoidability and learning points are given where these groups have been investigated.

- NHS England – Mortality Governance Guide and self-assessment on avoidable mortality. SFT reported an avoidable mortality rate of 0.91% to NHSE in January 16. Plans are set out to strengthen mortality governance.

CB reported that there was 1 elevated risk in musculo-skeletal which is being investigated. Pathological fractures may be as a result of coding issues. Learning points are being looked at in relation to urethral catheterisation – currently the procedural codes are problematic as they suggest a link between urethral catheterisation and death which may not be the case. SFT will be publishing on avoidable mortality rate. Work will be completed to strengthen mortality governance.

CGC021614 – Annual HTA report – Christine Blanshard

The annual report is a requirement of holding an HTA licence and complies with the standards laid down by the licensing body.

SFT holds 2 licences:

1. Stem Cell Licence number 11102 was inspected in October 2015 and found SFT had met all the standards. The licence continues.

2. Post mortem examination Licence number 12047. This continues to be licenced.

ASSURING SAFETY

CGC021615 - Q3 Sign Up to Safety Programme Report – Lorna Wilkinson

Quarter 3 progress on the 4 workstreams were reported on:

LW reported that this is a work in progress. Katrina Glaister has been working with IT to capture and enter data. Continuing to work on reducing harm peri-operatively. The GROW programme is proving successful in intervening at an earlier point when babies are not growing as expected.

CGC021616 – Safeguarding Children Q3 – Karen Littlewood

Angela Conway is the new named nurse for Safeguarding Children.

KL reported that we are mapping against standards in our schedule. Maternity results are good and training is under way to provide the correct levels of training for other members of the workforce, to be completed by March 2017.

PAPERS FOR NOTING

CGC021617	Clinical Management Board meeting minutes (January 2016)	Noted
CGC021618	Information Governance Group meeting minutes (October 2015)	Noted
CGC021619	Clinical Risk Group meeting minutes (December 2015)	Noted

CGC1123 - ANY OTHER BUSINESS

There were no additional items.

NEXT MEETING

2016 dates will be Thursdays, 10am-12pm in the Boardroom – 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
CLINICAL GOVERNANCE COMMITTEE
Thursday 24th March 2016, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair) - Non-Executive Director
Peter Hill - Chief Executive Officer
Dr Christine Blanshard - Medical Director
Lorna Wilkinson - Director of Nursing
Karen Littlewood - Deputy Director of Nursing
Steve Long - Non-executive Director
Ian Downie - Non-executive Director

In attendance:

Kate Williams	Minute taker
Jan Sanders	Governor
Dr Diran Padiachy – Consultant, Elderly Care	CGC031604
Louise Henderson – Sister, Winterslow	CGC031604
Vanessa Bridgeman – Sister, Durrington	CGC031604
Katrina Glaister – Clinical Effectiveness Facilitator	CGC031605
Sandy Woodbridge – Learning Facilitator	CGC031606
Louise Williams – Staff Nurse, Redlynch	CGC031606
Sarah Hennell – Senior Nurse Manager, Palliative Care	CGC031607
Gill Sheppard – Clinical Governance Administrator	CGC031609, CGC031610, CGC031617 & CGC031618
Fenella Hill – Head of Risk Management	CGC031619

CGC031601 Apologies:

Claire Gorzanski – Head of Clinical Effectiveness
Hazel Hardyman – Head of Customer Care
Mark Stabb – Head of TIAA
Hollie Foreman – Staff Nurse, Laverstock

CGC031602 – Minutes of the meeting held on 25th February 2016

The committee asked for more time to consider these. To be considered at the next CGC meeting in May.

CGC031603 – Matters Arising / Action Tracker

Action tracker update dates to be given to LB / KW by the lead involved, or completion date where appropriate.

LW noted that the incorrect action had been attributed to her and that this would require amendment. **KW (Action completed)**

CGC031603A – Matters Arising – Amended Minutes of the meeting held on 28th January 2016

The amended minutes were approved by the committee.

STRATEGY

CGC031604 – Core Service presentation – Medicine with a focus on care of the elderly – Diran Padiachy, Louise Henderson, Vanessa Bridgeman

DP gave a presentation which highlighted achievements and challenges within the Department of Elderly Medicine.

There is a strong Clinical Governance Structure, with minuted monthly meetings and weekly departmental meetings. Mortality data received through DATIX is reviewed. There has been good performance in several key indicators. There has been a lot of work in conjunction with Infection Control, both Durrington and Winterslow Wards have a high level of cleanliness. Feedback from staff, and Friends and Family is good. Any complaints received are considered and actions taken where necessary. There is ongoing development of staff regarding dementia, close supervision is made of patients with dementia and it has proved useful to use the 'This is me' document. The Carers Cafe is valuable for sharing experiences and gaining information. 84% of staff on both wards have completed the e-learning regarding DoLS. Salisbury has a high level of patients over the age of 90 compared to other Trusts. Previously there were difficulties in capturing data but this has now been resolved. Previous problems in recording patient weights have been much improved by increased teaching and training.

Although falls are commonly reported, very few give rise to significant harm and many are unavoidable. Efforts are being made to reduce these. Weekly audits are taking place regarding the recording and monitoring of urinary catheters. A challenge for the department is the recruitment and retention of nursing staff. There is a low sickness rate amongst staff on both wards and there is ongoing recruitment from other countries. Efforts are being made to reduce the length of stay on the wards, better integration with community services is needed. Delays in transfers of care extends the bed days.

A discussion took place at which the good leadership of the team was acknowledged and it was noted that additional consultants would be beneficial in expanding the service. The role of therapists, which had not been included within the report, was noted as established and working well. The Carer's Café is being underutilised and there is a plan to extend this onto the wards. Future plans for the service are to be able to get assessments completed in other wards and increased community care.

LB thanked PD, LH and VB for their presentation.

CGC031605 – Patient Story – Katrina Glaister

KG presented the patient story in video format in which the patient's relative relayed her experiences at SFT following her father's diagnosis of Alzheimer's. She spoke about bed moves to Whiteparish, then Durrington Wards, and that she felt she needed to be present to ensure that her father received the attention that he needed. KG confirmed that this story was approximately 18 months old and therefore practices and procedures had evolved since then.

The committee discussed the importance of triage in such cases to avoid unnecessary bed moves. KG will interview some Board members about patient stories and how they are presented and will feedback at the September 2016 meeting.

KG

ASSURING A QUALITY PATIENT EXPERIENCE

CGC031606 – Dementia Strategy End of Year Report – Sandy Woodbridge

SW gave a presentation which highlighted achievements and challenges for Dementia care.

The focus for SFT in the last year has been to:-

1. Improve services available to carers throughout the trust by:
    - Implementing the weekly Carer Café in Springs.
    - Advertising Carer Support Wiltshire widely.
    - Open dementia related training to local care homes.
2. Identify gaps in local service provision by completing and working on Dept of Health Self-Assessment Framework.

3. Recognise confusion is often a symptom of delirium – improve recognition, treatment, prevention and follow-up of patients with delirium.
4. Support wards with dementia care by re-instating weekly dementia rounds.
5. Allow means of "confusion follow-up" – instigated a monthly "confusion clinic" supported by mental health team.
6. Develop a focussed workplan for year, with a means of measuring progress built into dementia steering group meetings.
7. Continue work on Education - focussing on Dementia champions and widening our educational sphere including liaison with EOL and local care homes.

There have been improvements to the Carer's Café which now takes place every week and there is now to be an outreach to the carers on the wards. Delirium referrals are being made to the Confusion Clinic. A national audit of notes and questionnaires for staff is taking place. The benefits of reinstating the dementia ward rounds are that pressure is removed from staff and carers. Data in support of this is being collected. The committee noted that it would like to see measurable improvements in dementia care.

Action: The next time the dementia care report is presented at CGC (October 2016) measures should be included in the report. **SW**

CGC031607 – End of Life End of Year Report – Sarah Hennell

SH gave a presentation which highlighted achievements and challenges for End of Life Care.

End of Life Care in SFT was inspected by CQC and we await the final report. Preliminary feedback recognises the significant amount of change and improvements that have occurred over the last year and noted areas requiring improvement which were in the main areas that are recognised in this report. The new End of Life CNS team have made significant progress since starting in June/July 2015 with the roll out of the Personalised Care Framework (PCF), extensive education programme, leadership of the rapid discharge home to die process and many other projects. The lead EOL CNS (Band 7) is due to go on maternity leave and cover is with a band 5 (to develop to Band 6), the hospital palliative care team (HPCT) is also depleted. The long-term security of the specialist palliative care CNS 7 day working project has been extended to March 2017 and the chaplaincy team is struggling to cope with the increased demand that the EoLC Team and PCF has uncovered. There remains a problem locally with the national drive for an effective electronic palliative care co-ordination system (EPaCCS) as ADASTRA no longer exists but its replacement with an end of life component of TPP/System 1 is not in use in the community and within SFT. Salisbury Hospice Charity have agreed funding of a Hospice @ Home 3 year pilot which will commence on 01/04/16.

The committee noted the report.

CGC031608 – Maternity Survey 2015 – CQC Benchmark Report and Local Action Plans – Lorna Wilkinson

SFT participated in the fourth national Maternity Services survey. Questionnaires were sent to 300 mothers who had given birth during January and February 2015. The Trust achieved a 58% response rate compared with the national average of 41%.

The committee discussed the results and the action plan. It was noted that Fiona Coker has links with Dorchester Hospital and the suggestion was made to link up and find out more in areas they have excelled in.

CGC031609 – Friends and Family six-monthly update – Gill Sheppard

Gill Sheppard presented the Friends and Family six-monthly update report.

<u>Patients</u>

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

The overall score for SFT continues to be high with an average 96% of respondents recommending SDH as a place to receive care and treatment.

Response rates and scores for individual wards and departments are set out in tables within the paper.

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

Staff

Staff FFT was run locally in quarters 1, 2 and 4. Information for quarter 3 was gathered via the national staff survey.

In the 2015 national staff survey Salisbury was in the top 20% of Trusts for key finding "Staff recommendation of the Trust as a place to work or receive treatment".

The Next Steps

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

The Head of Customer Care is currently leading workshops with the wards to look at all issues raised through national surveys, real-time feedback, FFT, complaints and concerns, in order to identity key areas where action is required.

The committee discussed the varied response rate ward – ward. GS stated that staff were continually encouraged to obtain feedback.

CGC031610 – Real-Time Feedback Annual Report – Gill Sheppard

GS presented the Real-Time Feedback Annual Report.

Adult Inpatients

- 2,247 inpatients were interviewed.
- Results are consistently high for pain management; cleanliness of bathrooms/toilets; floors, hand hygiene, patients being treated with care and compassion and overall quality of care.
- Questions were added in April 2015 to ascertain if patients found any difference between weekday and weekend in six areas. The average scores to date are care (8.3), food (9.4), help with food (9.6), call bells (9.1), noise (8.6) and activities (7.7).
- 1,328 positive and 1,169 negative comments were received.
- Action is being taken to address the three areas of main concern – noise, weekend staffing and environment.

Spinal Inpatients

- 152 spinal inpatients were interviewed.
- Avon ward achieved good results for patients knowing which nurse was looking after them, confidence in the doctor, pain management, hand hygiene and patients receiving help with their meals.
- Tamar ward achieved good results for patients having confidence in the doctor and patients receiving help with their meals.
- A new question was added in April 2015 asking whether a member of the therapy team had explained the purpose of the therapy session. Both wards have scored poorly to date. It is felt this is due to the wording of the question as informal questioning of patients on this issue has produced positive responses. The question will be reviewed and re-worded.
- Weekday v weekend scores are care (Avon 8.0 / Tamar 7.3), food (Avon 9.1 / Tamar 8.8), help with food (Avon 8.6 / Tamar 8.1), call bells (Avon 8.9 / Tamar 8.7), noise (Avon 8.1 / Tamar 8.0) and activities (Avon 5.6 / Tamar 4.5).
- 79 positive and 131 negatives comments were received.
- Action is being taken to address the four areas of main concern – weekend, communication, noise and environment.

Maternity

- 162 new mothers were interviewed.
- Good results were achieved for mothers feeling they were treated with kindness and understanding, cleanliness of labour ward and cleanliness of post-natal ward.
- 34 positive and 26 negative comments were received.
- Action has been taken to address all areas of concern as detailed in the report.

Paediatrics

- 202 adults and 68 children were interviewed.
- Good results were achieved from children for nurses providing understandable information, ward feeling safe and secure and being treated with kindness and understanding.
- Good results were achieved from adults for nurses providing understandable information, overall quality of care, ward feeling safe and secure and being made to feel welcome.
- 41 positive and 51 negative comments were received.
- Action has been taken to address the two main areas of concern – food and nutrition from Facilities and staffing levels at weekends.

LW noted that the workshops should be very valuable in bringing all the learning together. Leaflets are currently available for patients regarding aftercare.

The committee noted the report.

CGC031611 – Q3 Complaints report – Lorna Wilkinson

LW presented the Q3 Complaints report.

66 complaints were received in quarter 3 compared to 59 complaints in quarter 2 and 75 complaints for the same period in the previous year.

The main issues from complaints are:

- Clinical treatment (22), the same as Q2 - sub-themes were 10 unsatisfactory treatment across10 different areas, 8 correct diagnosis not made, and 1 each for night care, surgery unsuccessful, further complications and inappropriate treatment. Of these, the Emergency Department received 6 complaints about clinical treatment with 3 relating to missed fractures, which were picked up on review of the x-ray. Orthopaedics had 4 complaints relating to clinical treatment with no themes.
- Appointments (15), 8 more than Q2 (7) – sub-themes were 6 appointment delays, 3 appointment cancelled, and 2 each for appointment date required, unsatisfactory outcome and appointment system procedures, across 8 different specialties.
- Staff attitude (13), 4 more than Q2 (9) – 6 related to medical staff, 6 nursing staff, and 1 administrative across 11 different areas.

These findings also reflect the main issues arising from concerns.

There were no new requests for independent review to the Parliamentary and Health Service Ombudsman.

A total of 418 inpatients were surveyed in the quarter. They made 241 positive and 254 negative comments with the main negative issues being:

- level of service at weekends
- noise
- food and nutrition on the wards

The main areas of concern from the Friends and Family Test were:

- waiting times
- communication
- check-in system

There were 6 new requests to undertake Patient and Public Involvement projects.

NHS Choices received 21 comments in Q3 with 16 positive, 3 negative (2 communication and 1 care) and 2 mixed.

The committee noted the report.

CGC031612 – Q3 Complaints Dip Sampling report – Steve Long

SL presented the Complaints Dip Sampling report.

The dip sampling exercise for this quarter focused on complaints about staff members attitude. Examination of these complaints suggests that greater attention needs to be given to the reasons for the complaint and greater attention to what action should be taken to ensure lessons are learnt and improvements made. Additionally it is suggested that a more personal response in addition to a

letter would improve the successful resolution of a complaint of this nature.

The committee discussed the need to create a file note concerning investigations being taken. There are communication issues and some complaints could be resolved by a phone call – staff should be supported to do this.

The committee noted the report.

CGC031613 – Learning Disabilities End of Year report – Lorna Wilkinson

This item was deferred to May 2016. **GC**

ASSURING CLINICAL EFFECTIVENESS

CGC031614 – Quality Indicator including DSSA – Tabled only – Christine Blanshard

CB presented the Quality Indicator report.

- 1 MSSA bacteraemia. RCA being undertaken.
- 4 cases of Trust apportioned C Difficile in February. Investigations in progress and samples sent for ribotyping.
- 2 new serious incident inquiries commissioned in month.
- A reduction in the crude mortality rate. SHMI is 109 and is as expected to September 2015. HSMR is 110 to November 15 and is higher than expected. The Trust is preparing to strengthen mortality governance in line with recent NHSE guidance.
- An increase in grade 2 pressure ulcers in February but year on year decrease evident. Pressure ulcer share and learn meetings continue.
- Safety Thermometer- a slight decrease to 96% of 'new harm free care'.
- One fall resulting in a wrist fracture treated with a plaster cast. January figures corrected one fall resulting in a hip fracture requiring surgery. Delay in reporting and SII commissioned in March 16.
- A reduction in patients with a fractured hip operated on within 36 hours of admission. Note: February data incomplete until later in the month.
- In February, good performance was sustained in stroke patients receiving a CT scan within 12 hours. There was a reduction in patients spending 90% of their time on the stroke unit. 3 stroke patients were transferred to other wards to make way for new stroke patients. There was an improvement in patients reaching the stroke unit within 4 hours. SSNAP audit was Grade C at the end of 03.
- High risk TIA patients seen within 24 hours decreased significantly. One related to a referral made via e-mail from a consultant, two were due to misdirected GP referrals. One case was delayed due to consultant leave and in the other the patient was seen in an afternoon clinic but treatment was not completed until after 24 hours.
- Escalation bed capacity increased in February and there was a reduction in the number of multiple patient ward moves. Planned escalation ward open for a three month period.
- In February there were no non-clinical mixed sex accommodation breaches.
- Real time feedback from patients about whether they were treated with care and compassion and rating the quality of the care received remained consistent. FFT inpatient response rates were sustained but ED declined from the previous month. Maternity Services and day case response rates improved. Outpatient response rates remain at a low level. Improvements are reported in the quarterly Customer Care report as 'You said, we did'.

LW reported Norovirus had affected Farley and Pitton wards, the situation was now resolved. C-difficile level is at 14 for the year. CB reported that there is a great deal of Influenza A in the community and patients are being admitted with it. It is a challenging month. One never event was reported this week and is subject to a full investigation.

The committee noted the report.

CGC031615 – Draft Quality Account – Christine Blanshard

CB presented the Draft Quality Account.

- Overall, the Trust has made good progress in improving the quality of care in 15/16 but there is still work to do.
- Five quality priorities have been selected for 16/17 following a wide consultation. The five priorities are:
- Priority 1 Continue to keep patients safe from avoidable harm.
- Priority 2 Ensure patients have an outstanding experience of care
- Priority 3 Actively work with our community partners, patients and carers to prevent ill health and manage long term conditions
- Priority 4 Provide patients with high quality care seven days a week
- Priority 5 Provide co-ordinated care across the whole health and care community.
- The draft quality account has been sent to the Readership panel and their suggested amendments will be considered for inclusion in the text.
- KPMG will complete a review of the account and audit two mandated indicators – 1) The ED 4 hour wait 2) RTT incomplete pathways and one indicator selected by the governors which is the number of patients who fall resulting in a fracture or serious harm.

The committee discussed the re-basing of levels. CB reported that specialist services were involved and more would be added into this report. Any comments to be fed back to CGz.

CGC031616 – National Clinical Audit Update – Christine Blanshard

CB presented the National Clinical Audit Update.

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

Actions from 20 reports published in previous reporting areas are progressing satisfactorily.

The committee noted that the explanations for non-compliance are clearly stated and recommended that more detail be recorded for actions taken.

The committee noted the report.

CGC031617 – External Enquiries and External Agency visits Biannual Report – Gill Sheppard

GS presented the External Enquiries and External Agency visits Biannual Report.

<u>National Reviews</u>

Three reports were published between August 2015 and January 2016. Action plans have been developed as appropriate.

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

<u>National Confidential Enquiries</u>

Four reports were published between August 2015 and January 2016. Three of the reports relate to

Maternity and are fully compliant. Of the 18 recommendations relevant to SFT in the fourth report (Sepsis), 13 are fully compliant and 5 are partially compliant.

The Trust is partially compliant with 16 recommendations from five reports in the previous reporting period.

External Visits

A total of 13 visits and inspections took place between August 2015 and January 2016. Action plans have been developed where necessary.

Actions from 2 visits which took place in previous reporting periods are still outstanding but work is progressing.

The committee noted the report.

CGC031618 – Raising Concerns Annual Report April 2015 – March 2016 – Gill Sheppard

GS presented the Raising Concerns Annual Report.

Two concerns have been raised between 1 April 2015 and 31 March 2016. One has been satisfactorily resolved and the other is currently being addressed.

Three new roles have been developed to meet national recommendations:-

- Independent National Officer (ICO) appointed by the Care Quality Commission
- Freedom to Speak Up Guardian, a voluntary role undertaken by one of the Trust's governors.
- Dignity at Work Ambassadors, 15 members of staff who undertake the role on a voluntary basis.

The Policy was due for review in August 2015 but the deadline was extended to April 2016 in order to capture all new national recommendations. National guidance regarding training for individual roles is still awaited.

The online raising concerns staff survey was repeated in the summer of 2015. The results showed a marked improvement in awareness and use of the Policy. The national staff survey results showed SFT scored favourably against all other Trusts for staff being able to report incidents and staff feeling secure to raise concerns about unsafe clinical practices.

The committee noted that Isobel McLellan is now the Trust's Freedom to Speak Up Guardian.

The committee noted the report.

ASSURING SAFETY

CGC031619 – Assurance Framework and Risk Register – Fenella Hill

FH presented the Assurance Framework and Risk Register.

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

Gap in Control: Increased spinal outpatient waiting times (includes annual reviews and (VUD) – (CQC).
Remedial action: Full action plan to be agreed to resolve issue
Use of PTL to be introduced
Risk review of those on the lists

Newly Identified Positive Assurances

Risk 2.1 (Compliance with infection prevention practice and policy)

- Q1, Q2 and Q3 HCAI data report from SW shows SFT in best performing quartile for rates of MRSA/MSSA/C.Diff/Ecoli

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

- Downward trend in Q3/4 of MSA breaches

5. Risk Register

A summary of all 15+ risks that are on the Trust Risk Register was given to the committee to provide an oversight of extreme risks, followed by the detail of those that are new and those that have increased in score since the risk register was last presented.

The committee discussed the scoring of new risks and the level at which corporate risk should be flagged for the Trust Risk Register

The committee noted the report.

PAPERS FOR NOTING

CGC031620	Clinical Management Board meeting minutes (February 2016)	Noted
CGC031621	Information Governance Group meeting minutes (February 2016)	Noted
CGC031622	Clinical Risk Group meeting minutes (January 2016)	Noted
CGC031623	Children and Young People's Quality and Safety Board (December 2015)	Meeting cancelled

CGC031624 - ANY OTHER BUSINESS

There were no additional items.

NEXT MEETING

2016 dates will be Thursdays, 10am-12pm in the Boardroom – 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 Council of Governors Meeting – Part 1
At Salisbury District Hospital
Held on Monday 16 May 2016

Present:	Nick Marsden (Chairman)		
Governors Present:	Ross Britton Mary Clunie Shaun Fountain Lucinda Herklots Raymond Jack Alastair Lack (Lead Governor) Jenny Lisle Colette Martindale John Mangan Rob Polkinghorne John Parker Jan Sanders Lynn Taylor Christine White Sharan White Jonathan Wright	**Apologies:**	Beth Robertson Michael Mounde Chris Horwood

In Attendance:
Lydia Brown (Non-Executive Director)
Paul Kemp (Non-Executive Director)
Andy Hyett (Chief Operating Officer (for item 5)
Malcolm Cassells (Deputy Chief Executive)
Lorna Wilkinson (Director of Nursing) (for item 7)
Sue Mortlock (for item 2)
David Seabrooke (Head of Corporate Governance)

ACTION

1. CHAIRMAN'S UPDATE

The Chairman welcomed Mary Clunie to her first meeting following her election as a public governor for Rest of England earlier in the year.

2. BOARD DEVELOPMENT PRESENTATION

The Chairman welcomed Sue Mortlock who had been working alongside the Trust and Thames Valley and Wessex Leadership Academy over the past 18 months to support the Board in ensuring it is fully effective individually and collectively. She described established methodologies for evaluating this and a range of factors an effective board should be focused on. She described the strengths identified through the work and areas for consideration.

3. MINUTES - 22 FEBRUARY AND 29 FEBRUARY 2016

The minutes of from the Public meeting held on 22 February and the joint meeting with the Board of Directors on 29 February 2016, were approved as correct record.

4. MATTERS ARISING

There were no matters arising.

5. TRUST PERFORMANCE TO 31 MARCH 2016

The Council received the Performance Report and it was noted that the 18 Weeks Stroke RTT and Cancer Targets had been delivered throughout 2015/16. The Finance and Performance Committee reviewed these metrics every month in detail. Performance on diagnostic waits had improved through the year. A&E had not delivered the Four Hour Target in the year as a whole, recording an outturn of 94.8%. Breaches were due to lack of an early assessment by the specialty and bed availability.

In relation to the challenges that had arisen in the year, governors joined the Chairman in saying 'well done' to Andy Hyett and the team.

6. FINANCE REPORT – MONTH 12

The Council received the Finance Report. It was noted that the Trust had met its target of a £5.5m deficit which had arisen largely due to cuts in the value of the tariff. Donated assets were required to be consolidated into the outturn and this had improved the Trust's reported position. Income had been less than planned and agency spend on nurses and doctors had been higher than planned. There had however been some additional income achieved. A re-assessment of assets had changed some of the depreciation charges by lengthening asset life in some instances.

Through the year activity was down on electives and these had been partly squeezed by non-elective activity. Capital spend had been constrained through the year.

It was noted that the Sterilisation and Decontamination Unit Joint Venture was nearing a conclusion.

In relation to governors questions the following points were noted –

- Finance costs included a Treasury charge of 3.5% on assets and also PFI payments.
- Trusts had been put under unusual pressure to stretch the boundaries of financial accounting by Monitor/NHS Improvement.
- The Trust had accepted a control total from NHS Improvement for 2016/17 which allowed access to a £6.3m payment from the Sustainability and Transformation Fund. The Trust was required to achieve a surplus of £1.8m which gave it savings target in 2016/17 of £9.5m. The settlement had been accepted with a range of caveats because to do otherwise would have made problems with cash highly likely. It was also noted that the Trust was seeking loans in support of its cash positon and based on the Electronic Patient Record acquisition.

7. CUSTOMER CARE REPORT – QUARTER 3

The Council received the Customer Care Report for October, November and December 2015. Complaints had reduced slightly and the top three categories remained aspects of clinical treatment and appointments. Staff attitude was a factor in some complaints.

On infection control/cleanliness there had been no MRSA cases in 2015/16 and there had been 15 attributed C-Diff cases against a ceiling of 19. Lorna Wilkinson recorded her thanks to the staff for this achievement.

The targets for 2016/17 for MRSA and C-Diff were unchanged. There had been norovirus activity earlier on in 2016/17. A CQUIN was in place to encourage better antibiotic stewardship. The Trust's flu vaccination rate was below 47% and work would continue to raise this.

The Chairman thanked Andy Hyett, Malcolm Cassells and Lorna Wilkinson for their attendance.

8. LEAD GOVERNOR PROCESS

The Council received details of an amendment to the section of the constitution dealing with the appointment of the lead governor. This had been the subject of email consultation with governors and described a revised process in which it was expected that a new deputy lead governor would progress to become lead governor for two years with a further period of one year as deputy lead governor, subject always to their continuing on the Council of Governors and to an annual vote of approval by the Council for each change or appointment.

The Council approved the change to the Council's standing orders.

The Council approved the reappointment of Alastair Lack as Lead Governor for a second year to run from 1 June 2016 to 31 May 2017 and under the new procedure it would be expected he would continue as Deputy Lead Governor from 1 June 2017 for a further year.

As discussed at an earlier meeting of the Council Collette Martindale would be standing down as Deputy Lead Governor from 31 May 2016 and nominations for a successor had been sought. Raymond Jack was the only nomination and accordingly was appointed a Deputy Lead Governor from 1 June 2016 and with the expectation under the new procedure that he would become Lead Governor from 1 June 2017.

9. QUALITY ACCOUNT 2015/16

The Council received the Draft Quality Account 2015/16 which would form part of the Annual Report from the Trust. A revised statement from the Council of Governors was circulated separately and was approved to form part of the Quality Account.

10. FEEDBACK FROM NHS PROVIDERS GOVERNANCE FOCUS CONFERENCE – 20 APRIL 2016

The Council received the report from Raymond Jack on his attendance at this conference together with slides presented by NHS Providers on the current strategic context in the NHS.

11. COMMITTEES AND WORKING GROUPS REPORTS

The Council received the minutes of the Strategy Committee held on 25 April 2016.

It was agreed that the Terms of Reference for the Strategy Committee would be amended to make either the deputy of lead Governor the Chair of the Committee.

Reports from the Food and Nutrition Steering Group and Patient Food Forum were noted. The Chairman undertook to circulate a note regarding progress with the introduction of contactless payments in the Trust's restaurants.

The Council received the report of the Governor and Volunteer Working Group that had made a comparison of hospital web sites against a range of criteria. It was noted that management was responding positively to the findings of the group. An update would be provided in relation to the two web pages concerning the Trust held by NHS Choices.

12. DATES OF COUNCIL OF GOVERNORS MEETINGS IN 2016

The Council received the note detailing the remaining scheduled Council meetings, informal meetings with the Chairman and Non-Executive Directors, Development Sessions, AGM (26 September), Medicine for Members (24 May) and scheduled meetings of the Trust Board.

It was also noted that the Wiltshire CCG were holding a meeting of the governing body at City Hall, Salisbury on 22 November from 10 am to 12 pm, which governors could attend as observers.

PAPER - SFT 3784

JOINT BOARD OF DIRECTORS (JBD) MINUTES FROM 20 APRIL 2016 RE: QUARTERLY REVIEW OF ASSURANCE FRAMEWORK AND RISK REGISTER

PURPOSE

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

MAIN ISSUES

Each year the Trust Board reviews and approves the Assurance Framework and associated Risk Registers.

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

JBD – 20 April 2016

ASSURANCE FRAMEWORK REVIEW AND UPDATE
There were newly identified gaps in control in relation to the access policy and a lack of a cyclical review process for essential services. Gaps under workforce were compliance rates in mandatory training and the vacancy gap in nursing staff. Remedial actions were set out in each instance. The revised Access Policy would come forward in May, reflecting national policy changes and there would be a need to advise and educate GPs about how the Trust would be working under the new process.

ATTACHMENTS AVAILABLE TO VIEW ON WEBSITE

none

ACTION REQUIRED BY THE BOARD

The Board is asked to note the minute extract from JBD

Nick Marsden
Chairman