SALISBURY NHS FOUNDATION TRUST
TRUST BOARD

MONDAY 8 JUNE 2015, 1.30PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
1.30pm	**1**	**APOLOGIES FOR ABSENCE** Ian Downie			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES**			
		Meetings held on 13 April and 11 May 2015			1
	4	**MATTERS ARISING**			
1.35pm	**5**	**CHIEF EXECUTIVE**			
		Chief Executive's Report	PH	SFT 3656	11
1.45pm	**6**	**STAFF**			
		1. Workforce Performance Report to include Safer Staffing and Skill Mix	AK/LW	SFT 3657	13
		2. Staff Survey	AK	SFT3658	41
		3. Voluntary Services Annual Report	AK	SFT3659	45
2.10 pm	**7**	**PATIENT CARE**			
		1. Quality Indicator Report to 30 April (Month 1)	CB/LW	SFT 3660	53
		2. Customer Care Report – Quarter 4	LW	SFT 3661	61
		3. Report of Director of Infection Prevention and Control	LW	SFT 3662	71
2.40 pm	**8.**	**PERFORMANCE AND PLANNING**			
		1. Finance & Performance Committee Minutes 30 March & 27 April 2015	NM	SFT 3663	147
		2. Finance and Contracting Report 30 April 2015 (Month 1)	MC	SFT 3664	155
		3. Progress against Targets and Performance Indicators to 30 April 2015	AH	SFT 3665	159
		4. Update on Strategic Planning	LA	-	
		5. Capital Development Report	LA	SFT 3666	165
		6. National In-Patient Survey Results	LW	SFT 3667	175
		7. Informatics Strategy Progress Report	LA	SFT 3668	203

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

1.	Minutes from Clinical Governance Committee 26 March 2015	LB	SFT 3669	219
2.	JBD Minutes Evidencing Presentation of Assurance Framework and Risk Register	PH	SFT 3670	227

3.50 pm **10** **ANY OTHER URGENT BUSINESS**

11 **QUESTIONS FROM THE PUBLIC**

12 **NEXT MEETING**

The next ordinary meeting will be held on Monday 3 August 2015, in the Board Room at Salisbury District Hospital starting at 1.30pm.

13 **CONFIDENTIAL ISSUES**

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

SALISBURY NHS FOUNDATION TRUST

Minutes of the meeting of Salisbury NHS Foundation Trust Board Held on Monday 13th April 2015

Board Members Present:	Dr N Marsden	Chairman
	Mr L Arnold	Acting Chief Operating Officer
	Dr C Blanshard	Medical Director
	Mr M Cassells	Director of Finance & Procurement
	Mr A Freemantle	Non-Executive Director
	Mr I Downie	Non-Executive Director
	Mr P Hill	Chief Executive
	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
	Revd Dame S Mullally	Non-Executive Director
	Ms L Wilkinson	Director of Nursing
In Attendance:	Mr P Butler	Communications Manager
	Mr D Seabrooke	Secretary to the Board
	Mr P Lefever	Wiltshire Health Watch
	Mrs J Sanders	Public Governor
	Mr J Carvell	Public Governor
	Dr B Robertson	Public Governor
	Mrs C Martindale	Lead Governor
	Mrs L Taylor	Public Governor
	Mr B Fisk	Staff Governor
	Cllr John Noeken	Appointed Governor
	Dr A Lack	Public Governor
	Mr R Polkinghorne	Appointed Governor West Hampshire CCG
	Mrs M Monnington	Appointed Governor
	Colonel J Denny	Military Governor
	Mr & Mrs Gould	Volunteers
Apologies:	Dr L Brown	Non Executive Director

2074/00 INTRODUCTION AND WELCOME **ACTION**

The Chairman welcomed Andy Hyett to his first meeting of the Trust Board following his appointment as Chief Operating Officer from 13 April 2015.

2075/00 DECLARATIONS OF INTEREST AND FIT AND PROPER/GOOD CHARACTER

Members of the Board were reminded that they have a duty to declare any impairments to be 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.

2076/00 MINUTES

The minutes of the meeting of the Board held on 2 February 2015 were

approved as a correct record subject to an amendment in 2062/00, the end of the second paragraph to refer to four departures rather than two.

The Board approved the minutes of the Joint Meeting with the Council of Governors held on 23 February 2015

2077/00 CHIEF EXECUTIVE'S REPORT - SFT 3637 – PRESENTED BY PH

The Board received the Chief Executive's Report.

PH highlighted the thanks he had given to the Trust's staff through his regular communications for their loyalty commitment and support during 2014/15. In particular, staff in A&E had met a testing challenge in meeting their operational targets.

It was noted that the Trust was working with Great Western Hospital and Royal United Hospitals Bath on a joint bid to create a new model for Adult Community Services across Wiltshire from July 2016. The Trusts were bidding through a competitive process organised by Wiltshire CCG and the process would continue through the remainder of 2015.

Congratulations were given to Christine White who had won the National Chief Scientific Officers 2015 award for Organisational Lead Scientist and Millie Mitchell and Jessica Norton, Trainee Clinical Scientists who were finalists in the Rising Star Life Sciences category. This prestigious award demonstrates how health care scientists at Salisbury were fully engaged in their work and were receiving recognition.

Also highlighted in the Chief Executive's Report was the Trust's staff success in the Wiltshire Public Health Awards, a recent Medicine for Members event, the commemoration of 60 years of the League of Friends and the formation of a clinical ethics committee.

The Board noted the Chief Executive's Report.

2078/00 STAFF

2078/01 Workforce Performance Report including Nurse Staffing SFT 3638 - Presented by AK & LW

The Board received the Workforce Performance Report and Safe Staffing Report for Month 11. This newly commissioned report gave details of Workforce numbers, quality health and compliance.

The following principal points from the narrative associated with the dashboard report were noted -

- Agency costs year to date were £7.1m compared to £5.2m in the same period in 2013/14.
- The Trust was £409,000 overspent on workforce costs.
- There was differing information about appraisal rates. 77% of staff had linked onto the SPIDA appraisal system (this did not mean that the remaining staff had not had an appraisal) and of those staff included on SPIDA 35.6% had a fully signed off appraisal registered. However 84% of staff reported via the Staff Survey that they have had an appraisal. It was noted that medical revalidation depended on being able to demonstrate compliance in this regard.
- Compliance with mandatory training varied between just over 50% for Information Governance and up to 80% for Safeguarding. It was

noted that compliance with the training requirements had to be maintained at intervals and that an employee not being up to date on this training did not raise immediate safety concerns.

It was noted that where temporary medical cover was required the matter was discussed by the Clinical Lead and Directorate Manager and this would often result in the Trust securing a locum from an agency, particularly for junior posts.

Senior medical cover was normally for short-term absences but there were some instances of longer term and where more tasks were carried out by middle grades or nurse specialists to make appropriate use of consultant capacity. The Trust continued to work with a specialist agency to reduce locum costs.

Responses to the Trust's recruitment advertising for nurses was variable both for Salisbury and other organisations. The Trust networked across the locality to learn about and try different solutions.

The Nurse Staffing Report indicated a registered nurse shift fill rate of 97.4% for February 2015 and a fill rate of 103.5% for nursing assistants. Red flags were described in the Hospice, clinical support and NICU areas for night shifts and for Radnor, NICU and Clinical Support in day shifts. The report described the mitigations in place for all Red and Amber rated areas.

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

2078/02 Staff Survey 2014 – SFT 3639 – Presented by AK

The Board received a report summarising the results of the Staff Survey conducted in autumn 2014 by the Picker Institute. The results had been reviewed by the Operational Management Board which was proposing to adopt focus groups to further explore the emerging themes with staff to develop action plans and effect change.

There were 29 key findings and in 20 of these the Trust was in the best or better than average category and average in a further four areas. It was not represented in the worst performing 20% but in the below average the theme of physical violence and also harassment, bullying or abuse from patients relatives or the public in the preceding twelve months was reported and physical violence and also harassment, bullying or abuse from staff was reported. Overall the Trust came out 6th or 137 hospitals taking part in the survey.

The Trust continued to support staff and emphasised that they should feel safe at work. It was noted that the Trust had recently launched a 24 hour on-site security service.

The number of staff reporting they were witnessing near misses on clinical incidents had reduced to an average level.

Conflict Avoidance training was available and the Trust took into account available advice on designing out violence and aggression where possible.

It was noted that the Executive Workforce Committee would continue to receive updates on the Staff Survey and that the Board would receive a further report on progress at the 7 December 2015 meeting.

2079/00 PATIENT CARE

2079/01 Quality Indicator Report to 28 February (Month 11) – SFT 3640 - Presented by CB and LW

The Board received the Quality Indicator Report. It was noted that mortality rates had been decreasing through to November 2014 and were within the expected range. The mortality reviews were continuing. A Never Event had been reported and two other Serious Incident Inquiries had been commissioned. It was noted that escalation bed capacity had been high during the period covered in the report.

The Clinical Governance Committee continued to review the Trust's performance on preventing C-Diff. This had reached 18 attributed cases in February and it was noted that there had been a further five cases in March all of which were subject to review. The nine cases in February and March had occurred in seven separate clinical areas. No further cases had been reported in April.

There had been ten falls resulting in moderate harm. These had occurred in seven different wards but were being reviewed for common themes. Many had arisen from work with patients on remobilisation. Commissioners were visiting the Trust to discuss whether any improvement in delivering single sex accommodation breaches was possible. The breaches the Trust experienced arose mainly from the Intensive Care Unit and were largely as a result of the Trust trying to avoid the transfer of patients in the middle of the night.

The Board noted the Quality Report.

2079/02 Customer Care Report – Quarter 3 – SFT 3641 – Presented by LW

The Board received the Customer Care Report. It was noted that complaints in the Medicine directorate were reducing and this was thought to be due to the work of a new Customer Care Facilitator dedicated to Medicine and it was thought that this practice could spread to the other Clinical Directorates. The Parliamentary and Health Service Ombudsman had closed three cases during the Quarter, of which one had been upheld.

SL reported on his regular dip-sampling of complaint files and emphasised the need to respond to the personal issues raised by the complainant at the end of the investigation process.

The Board noted the Customer Care Report.

2080/00 PERFORMANCE AND PLANNING

2080/01 Finance & Performance Committee Minutes 2 February & 23 February 2015 – SFT 3642 – Presented by NM

The Board received the Finance and Performance Committee Minutes and the Chairman highlighted the Trust's achievement on its CQUIN targets.

The Board noted the minutes of the Finance and Performance Committee from 2 and 23 February 2015.

2080/02 Finance and Contracting Report to 28 February 2015 – SFT 3643 – Presented by MC

The Board received the Finance and Contracting Report for Month 11 and it was noted that the Trust was £1.7m in deficit after 11 months of the financial year. The forecast outturn was subject to a range of factors but was thought to be up to £2m deficit, excluding charitable donations.

It was noted that Medicine and Clinical Support and Family Services directorates were challenged by their forecast outturns in relation to plan. The Trust had delivered a sizable savings plan in 2014/15 with a 14.5% shortfall. Work was underway to develop robust plans for 2015/16.

On 2015/16 contracts it was noted that Heads of Terms had been signed with Dorset CCG and good progress was being made with West Hampshire CCG. For specialist Commissioners discussions were continuing and it was noted that the Trust had requested a payment of £800,000 in support of the Genetics Services.

The Board noted the Finance and Contracting Report for Month 11.

2080/03 Progress against Targets and Performance Indicators to 28 February 2015 – SFT 3644 – presented by LA

The Board received the Targets and Indicators Report to February 2015.

It was noted that the Trust had achieved the A & E target in February 2015 and for Quarter 4. There was a planned breach agreed in advance with Monitor and commissioners in relation to the 18 Weeks (admitted) standard for February. It was noted that the rate of cancelled operations had reduced to 0.7%. Delayed Transfers of Care stood at just over 20. Delayed Transfers of Care caused by the hospital were confined to a very small number of incidences.

The Board noted the Performance Report.

2080/04 Update on Planning Process – Presented by LA

LA reported that the Trust had submitted the Operational Draft Plan to Monitor on 10 April and that the more detailed version was under development at present for submission by 14 May. This would be discussed by the Joint Board of Directors, the Governor's Strategy Group and approved at a meeting of the Trust Board on 11 May.

2080/05 Emergency Department Survey Results – SFT 3645 – Presented by LW

The Board received the Emergency Department Survey which was taken in May – September 2014. In three incidences in the 35 questions the Trust had the highest score nationally and scored favourably throughout the survey. An action plan brought forward by the A&E Department was attached. It was noted that the survey period had been a busy one for the A & E Department at Salisbury.

2080/06 Code of Governance Compliance Review – SFT 3646 – Presented by NM

The Board received a report setting out the Trust's arrangements for compliance with the code of Governance and reflecting the requirements for the Annual Report in this regard. Appended to the report were updates on Board statements required under the Code and a table of "Comply or Explain" responses that were required to be published.

The Board noted the Report.

2080/07 Financial Estimates 2015/16 – SFT 3647 – Presented by MC

The Board received the Financial Estimates for 2015/16. It was noted that the budget setting process for 2015/16 had been especially difficult in view of overspending and the 3.5% cut in the value of the Tariff. The Trust's planned income would not make sufficient allowance for costs pressures, inflation and the required contribution to the Clinical Negligence Scheme. There were indications from the Trust's own analysis that the national tariff would be worth 1% than had been originally indicated. The range of non-tariff prices had also been reduced. In determining which of the Tariff options to select the Board had been mindful of the availability of £3.5m of CQUIN payments.

A range of internal costs pressures such as IT, equipment, staffing were described. Savings in 2014/15 had been achieved but much of this was non-recurrent and would have to be factored into 2015/16 were this was the case. There was an intention nationally to reduce activity through the Better Care Fund and QUIP mechanisms which put at risk the Trust's position. There were greater mandatory penalties in the 2015/16 contract and the Trust could expect less resilience support in 2015 than in 2014/15.

The shortfall was £13.8m and with a savings target of £8m the Trust was planning for a £6m deficit for 2015/16.

In order to protect the Trust's cash position, a loan application had been submitted to the Foundation Trust Financing Facility and the outcome of this was awaited. The loan would be applied to some of the schemes in the Trust's Capital Programme, if granted. No resources had been identified at this stage to support the implementation of the Electronic Patient Records. If implemented the Electronic Patient Records system would deliver revenue savings.

The Board approved the estimates for 2015/16.

2081/00 PAPERS FOR NOTING OR APPROVAL

2081/01 Minutes from Clinical Governance Committee 29 January and February 2015 – SFT 3648 – Presented by SM

The Board received for information the confirmed minutes of the Clinical Governance Committee for 29 January and 26 February 2015.

2081/02 Draft Minutes from the Public Section of the Council of Governors meeting 16 February 2015 – SFT 3649 – presented by NM

The Board received for information the draft minutes of the Council of Governors meeting held on 16 February 2015.

2081/03 Draft Minutes of Audit Committee 22 January 2015 – SFT 3650 – Presented by PK

The Board received for information the draft minutes of the Audit Committee meeting held on 22 January 2015. It was noted that a change to the planned number of internal audit days had been discussed by the Committee.

2081/04 JBD minutes evidencing presentation of Assurance Framework and Risk Register – SFT – 3651 – Presented by PH

The Board received for information the update from the Joint Board of Directors.

2082/00 QUESTIONS FROM THE PUBLIC

In relation to a question about the seniority compared to other Trusts of the infection Control Team asked by Brian Fisk, LW confirmed that there was a variable position across different organisations. However she was satisfied that the level of resource devoted to Infection Control was adequate and this was kept under regular review by the Clinical Governance Committee. The Salisbury Team were very experienced and highly regarded..

In relation to a question about cancelled operations and the effect of this on patients LA commented that the Trust did not take any late cancellation of patient procedures lightly. The decisions were based on clinical need.

In relation to a question about caring for patients with co-morbidity LW explained that the Trust continued to carry out regular Skill Mix Reviews that checked staffing levels and skills in relation to patient need. The Trust was also implementing the Safer Care Bundle in support of this.

In relation to a question about violence and harassment among staff from Mary Monnington AK explained that the Trust had information from the survey split at directorate level but was using focus groups to look at the detail to gain a better understanding of the issue, where and when it was occurring.

Finally volunteer Mrs Gould commented that in her experience conducting real time feedback in the hospital she very seldom came across anyone who had a bad word to say about the care provided by the Trust.

2083/00 DATE OF NEXT MEETING

It was noted that the next public meeting of the Trust Board will be on Monday 8 June 2015, in the Board Room at Salisbury District Hospital starting at 1.30pm.

SALISBURY NHS FOUNDATION TRUST

Minutes of the special meeting of Salisbury NHS Foundation Trust Board Held on Monday 11th May 2015

Board Members Present:	Dr N Marsden	Chairman
	Dr C Blanshard	Medical Director
	Mr M Cassells	Director of Finance & Procurement
	Mr A Freemantle	Non-Executive Director
	Mr I Downie	Non-Executive Director
	Mr P Hill	Chief Executive
	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
	Revd Dame S Mullally	Non-Executive Director
	Dr L Brown	Non-Executive Director
Corporate Directors:	Mr L Arnold	Director of Corporate Development
	Mr M Ace	Associate Executive Director
In Attendance:	Mr D Seabrooke	Head of Corporate Governance
Apologies:	Ms L Wilkinson	Director of Nursing

1. DECLARATIONS OF INTEREST

No matters were declared in relation to the Annual Plan 2015/16.

2. APPROVAL OF THE TRUST'S OPERATIONAL PLAN 2015/16

The Board received a report and appendix setting out the final draft of the Annual Plan 2015/16 which was required to be submitted to Monitor by Thursday 14 May 2015.

The report indicated that it was believed that new five year strategies would be requested during 2015/16 with 2016/17 as year one. The Operational Plan and Financial forecasts included with the report were consistent with the policy intentions of the existing five year strategy submitted to Monitor in summer 2014. The Trust was recommitting to the aims of that earlier strategy.

The Operational Plan had been considered by the Joint Board of Directors and at two meetings of the Governor's Strategy Committee in addition to the Joint Board/Council Meeting held in February.

An early summary financial forecast had been submitted to Monitor and feedback had been received principally around resolving differences between the Trust's and CCG forecasts for finance and activity. It was noted that in recent weeks a greater alignment of activity forecasts had been achieved.

Within the financial return the Trust was required to make a response in relation to the Continuity of Service condition in the licence requiring it to

make a declaration for the year ahead.

It was highlighted in the strategy that the Trust was budgeting for a deficit of £6m in 2015/16. The budget gap was assessed at £14m and the remainder would be addressed by cost improvements of £8m which were in the course of being fully identified.

In relation to the Board declarations for sustainability and resilience for 2015/16 the Board considered that a clear statement should be made on the balance the Board plans to strike between a planned deficit and cost improvement and an acknowledgement of the Trust's responsibility to improve efficiency while avoiding adverse effects on patient care.

On this basis, the Board approved the Annual Plan for submission to Monitor.

CHIEF EXECUTIVE REPORT

MAIN ISSUES:

TRUST WINS NATIONAL AWARD

We have been named as one of the top hospitals in the country by leading national healthcare intelligence organisation, CHKS. This is an outstanding achievement and reflects the hard work and efforts of staff this year. The awards are based on over 20 key performance indicators from safety, clinical effectiveness and health outcomes to the efficiency of the organisation and overall patients' experience and quality of care. They show our patients what they can expect when considering which hospital to go to for treatment and highlight the value of our hospital and our staff to commissioners and regulators – all of whom can influence the future success of the Trust.

SALISBURY REMAINS IN THE BEST BAND IN CQC MONITORING SYSTEM

In 2013, the care Quality Commission (CQC) introduced a new inspection programme together with its intelligent monitoring system. This involves more than 150 different indicators to direct hospital inspection resources where it is most needed and prioritise future inspections. The CQC regularly publishes its ratings and in its latest publication, the Trust has remained in Band 6, which is the rating given to hospitals with the lowest risk. CQC inspections now involve a far more comprehensive assessment, with larger inspection teams, more time spent within individual Trusts and a wider engagement process for gathering views from the local community. It is anticipated that the Trust will receive a comprehensive inspection some time in 2015/2016. It is essential that we remain well prepared in both our ability to provide the access and level of input the CQC will require from us during an inspection and to ensure that we give a balanced view of the hospital and the services we provide for our patients. Senior staff meet monthly to plan for an inspection and ensure that the Trust is prepared for an inspection when it is announced.

ADULT COMMUNITY SERVICES UPDATE

Work is progressing on our joint bid with the Great Western Hospital and Royal United Hospitals to create a new model for adult community services across Wiltshire. Clinical engagement is taking place in key areas such as stroke and diabetes and, while there is significant competition to provide this service, we have been successful in reaching the next stage. We will now be one of three shortlisted candidates that will submit an outline proposal to Wiltshire Clinical Commissioning Group (CCG) on June 22, with completed proposals scheduled for submission in the autumn. The CCG will make a final decision by the end of the year with a view to letting the new five-year contract from July 2016.

ACCOUNTABLE OFFICER FOR EMERGENCY PLANNING

Chief executives of organisations commissioning or providing care on behalf of the NHS must identify an accountable emergency officer who has responsibility for ensuring the organisation complies with legal and policy requirements around Emergency Preparedness, Resilience and Response (EPRR). Chief Operating Officer, Andy Hyett, is now the accountable officer for the Trust, whose role will be to provide assurance to the Board that strategies, systems, training, policies and

procedures are in place to ensure an appropriate response from the Trust in the event of a major incident or civil contingency event.

HOSPITAL CHAPLAIN JOINS SALISBURY CATHEDRAL COLLEGE OF CANONS

Congratulations to Salisbury District Hospital Chaplaincy Team Leader, Kim Stephens, who has been chosen to join Salisbury Cathedral's College of Canons. The College of Canons provides feedback to the Cathedral on its activities and informs the policy decisions of its governing body. This is a prestigious role and a considerable achievement for Kim, who has been chosen for her valuable experience and her link with the NHS and this hospital, where she has been a chaplain for the last 13 years.

ELECTION OF TRUST GOVERNORS

Eighteen Governors have been elected to the Council of Governors following elections held in our public and staff constituencies. They join a further eight on the Council, who were either not due an election this year or are nominated Governors from other organisations. Our public and staff governors provide an essential link between the hospital and our members, feeding back information that can be used to help shape and plan our services for the benefit of our patients. The eight public constituencies are Salisbury City, South Wiltshire Rural, North Dorset, New Forest, Kennet, West Wiltshire, East Dorset and the Rest of England. In welcoming our new Governors I want to acknowledge the outstanding commitment and contribution to the membership that our outgoing Governors have made to the hospital and to local people who use our services. This includes John Carvell, Chris Wain, John Markwell and Carole Noonan who were part of the first Council of Governors elected in 2006, together with Mandy Cripps, Sarah Bealey, June Griffin, Lynda Viney and Brian Fisk – all of whom have served the hospital and our patients with distinction. A full list of our Council of Governors can be found on the Trust's website at: www.salisbury.co.uk.

NEW CONSULTANT APPOINTMENTS

A number of new Consultant appointments have been made in recent months, including two plastic surgeons, two anaesthetists and a consultant in sexual health. We have also appointed consultants in dermatology, cardiology and radiology (TBC). Over the coming weeks we are hoping to recruit to histopathology and gastroenterology, as well as a stroke physician and a consultant community geriatrician.

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 2015-6

Presented for: Information

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

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

Previous Committees: none previously (M1)

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

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

Strategic Aims

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

Values

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

1. Summary
This report describes the key workforce performance metrics for the Trust and the actions undertaken to address those metrics recorded as RED and AMBER, and how the Trust aims to 'Return to Green' at a high level. The report / appendices also provide a brief narrative across all of the presented metrics, with trend analysis for the GREEN rated items.

The report is summarised against four categories:

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

2. Performance

Please refer to the charts in the document for monthly data (April 2015) and trends over the previous five months (November 2014 – April 2015).

Workforce Numbers

2.2 Vacancies – Green / Amber

The overall vacancy rate is 7.5%. This equates to c 203 FTE. When variable staffing (use of temporary agency / bank staff) is included the vacancy rate is 3.1%.

The Nursing and Midwifery (NMW) vacancy rate is higher than the Trust average at 10.9%. NMW vacancies are partly mitigated by the use of variable staffing.

Updates and next steps

On-going recruitment for nursing staff includes international recruitment. The internal multi-disciplinary Recruitment and Retention Forum is beginning a work programme focused on the substantive workforce and will review issues including: improving retention, relocation, managing the market, under the banner of becoming an Employer of Choice.

2.3 Workforce Costs and Quality

Pay costs for M1 are £10.6m. Workforce costs showed an overspend of £337k against budget after 1 month of the financial year (see Figure 1 below).

The combined cost of the variable workforce (bank and agency), in April 2015, is £1.3 million.

- Year to date (M1) ***bank costs*** are £478k, compared to £506k for the same period in the previous year.
- Year to date (M1) ***agency costs*** are £858k. This is higher than in the previous year, of the same period, with costs of £478k.

Updates and next steps

The Trust is seeking to move to a position where the update of bank shifts is the major proportion of variable staffing where required, with agency usage at a minimum. Current actions taken to improve the cost of agency spend include:

- An updated protocol for the purchasing of agency nursing.
- A review with the agency, which supports the substantive medical post recruitment, and its effectiveness planned for Q1.
- The Nursing and Administration Bank has been active in Q4 leading to a number of new bank staff being appointed.
- On-going international nurse recruitment is planned during 2015-16 to reduce the vacancy rates

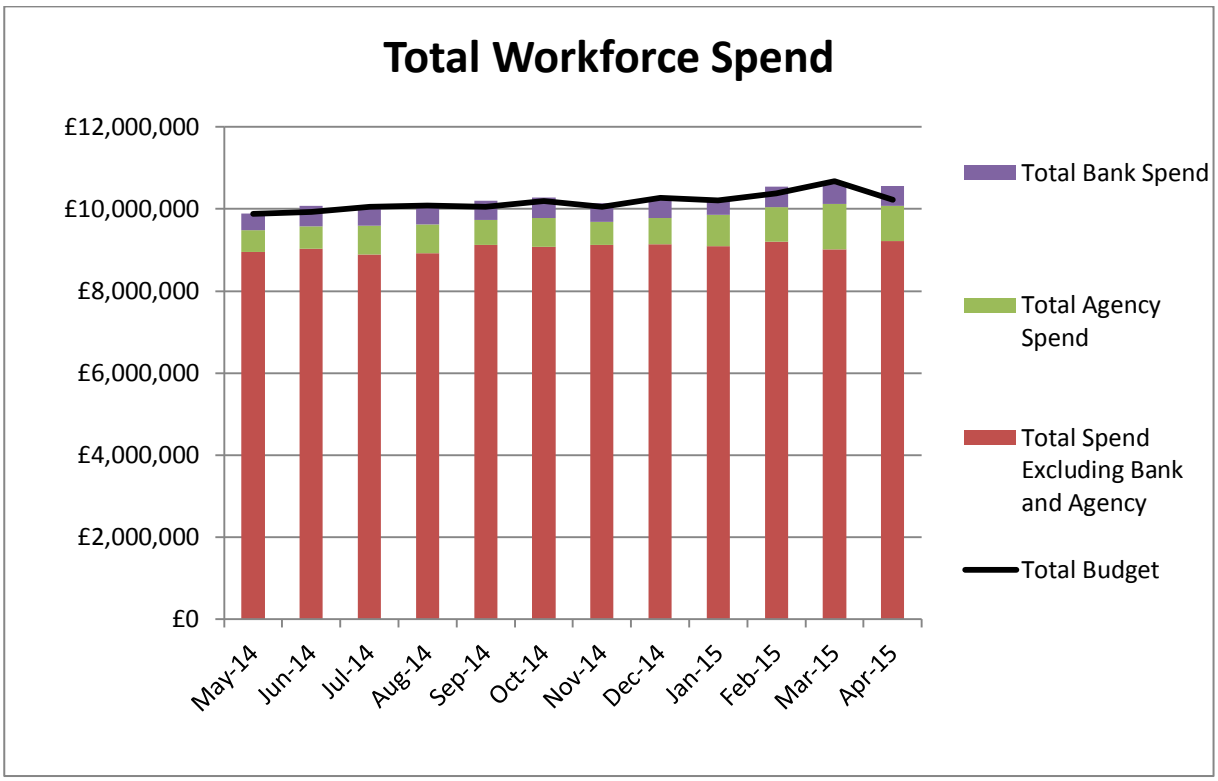


Figure 1

Workforce Quality

2.4 Efficiency of staff deployment - RED

The shift fill rates and shift fill hours for nursing has shown no improvement in the first month of the year (2015-16). The Trust is seeking to move to a position where the update of bank shifts is the major proportion of variable staffing where required, with agency usage at a minimum.

Return to Green

- An updated protocol for the purchasing of agency nursing has been developed and introduced.
- A review of nurse agencies has been undertaken with clear guidelines for ward managers.
- A review with the agency, which supports the substantive medical post recruitment, and its effectiveness planned for Q1.
- The Nursing and Administration Bank has been active in Q4 leading to a number of new bank staff being appointed.
- A review of bank incentives has led to a new payment system being introduced
- On-going international nurse recruitment is planned during 2015-16 to reduce the vacancy rates

2.5 Safer staffing

The expected ratio of 60:40 has remained largely stable since last month, with a slight increase of percentage qualified staff to 62%.

Appended to this report is the 'Safer Staffing NQB Report – April 2015' which provides a further analysis of the nursing staffing levels across the Trust including a full breakdown of the percentage of filled shifts (day and nights). The report also provides an assessment of Red and Amber areas and mitigations.

Workforce Health

2.6 Sickness absence – AMBER

In April the sickness absence rate showed a slight decrease to 3.2%.

Return to Green
Pop up physiotherapy clinics and access to psychological well-being sessions are available to staff to support a timely return to work.

Support for staff to be present and well at work is co-ordinated through the Staff Survey Steering Group and the Safer Staffing Steering Group.

2.7 Turnover – GREEN / AMBER

Trust turnover (which excludes medical staff on rotation) is 11%, against a target of 8.5%. A detailed breakdown of the 'Reasons for leaving' for 2014-15 is provided in Figure 2 below.

Figure 3 shows that in the final quarter of 2014-15 the number of starters across the entire Trust was greater than the number of leavers.

Nurse turnover and starters show a gap on previous months, with active recruitment campaigns aimed at UK and European nurses underway.

Nurse turnover is 8.6% which is lower than the trust average.

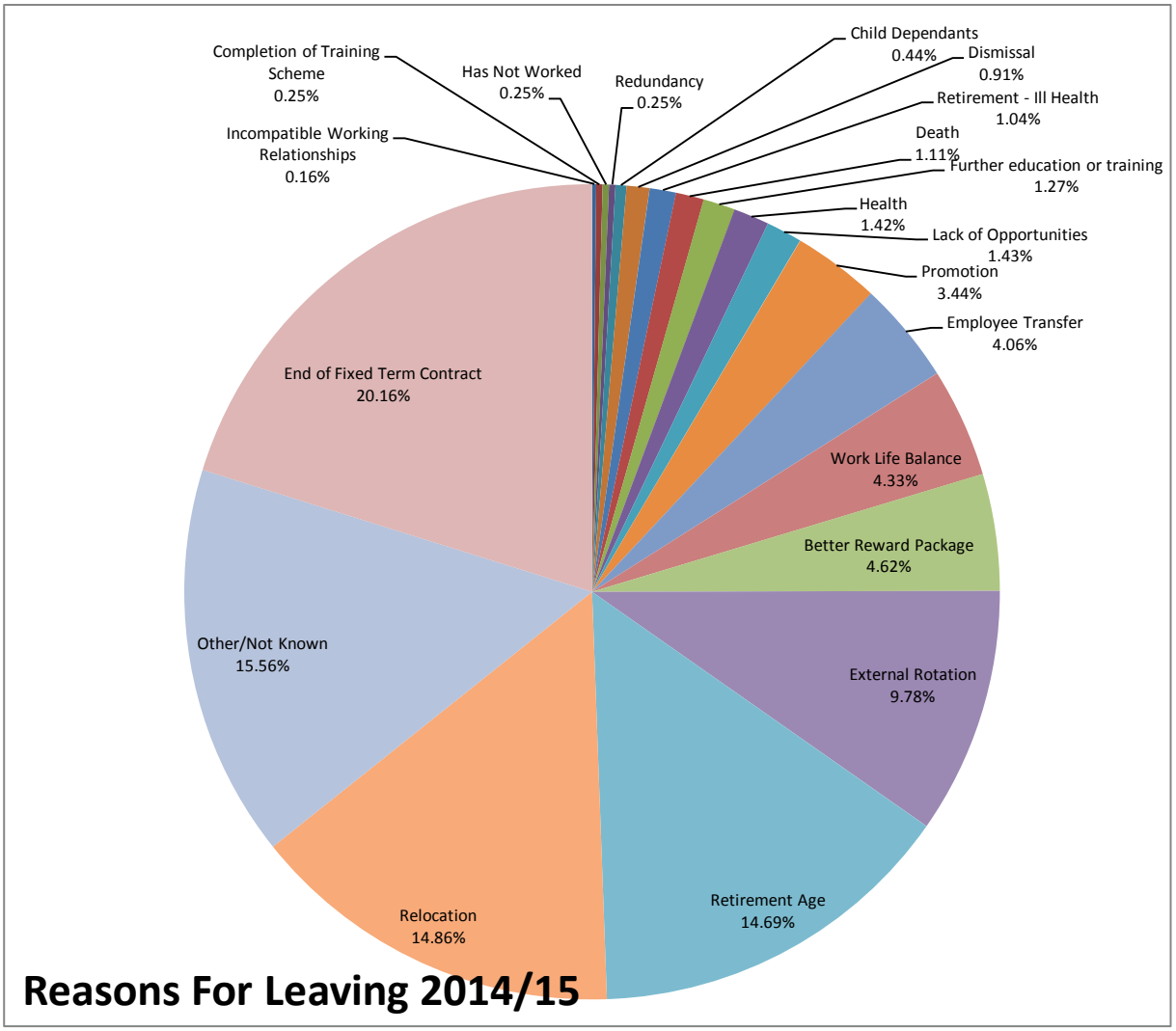

Completion of Training Scheme 0.25%
Has Not Worked 0.25%
Redundancy 0.25%
Child Dependants 0.44%
Dismissal 0.91%
Retirement - Ill Health 1.04%
Incompatible Working Relationships 0.16%
Death 1.11%
Further education or training 1.27%
Health 1.42%
Lack of Opportunities 1.43%
Promotion 3.44%
Employee Transfer 4.06%
End of Fixed Term Contract 20.16%
Work Life Balance 4.33%
Better Reward Package 4.62%
Other/Not Known 15.56%
External Rotation 9.78%
Relocation 14.86%
Retirement Age 14.69%
Reasons For Leaving 2014/15

Figure 2

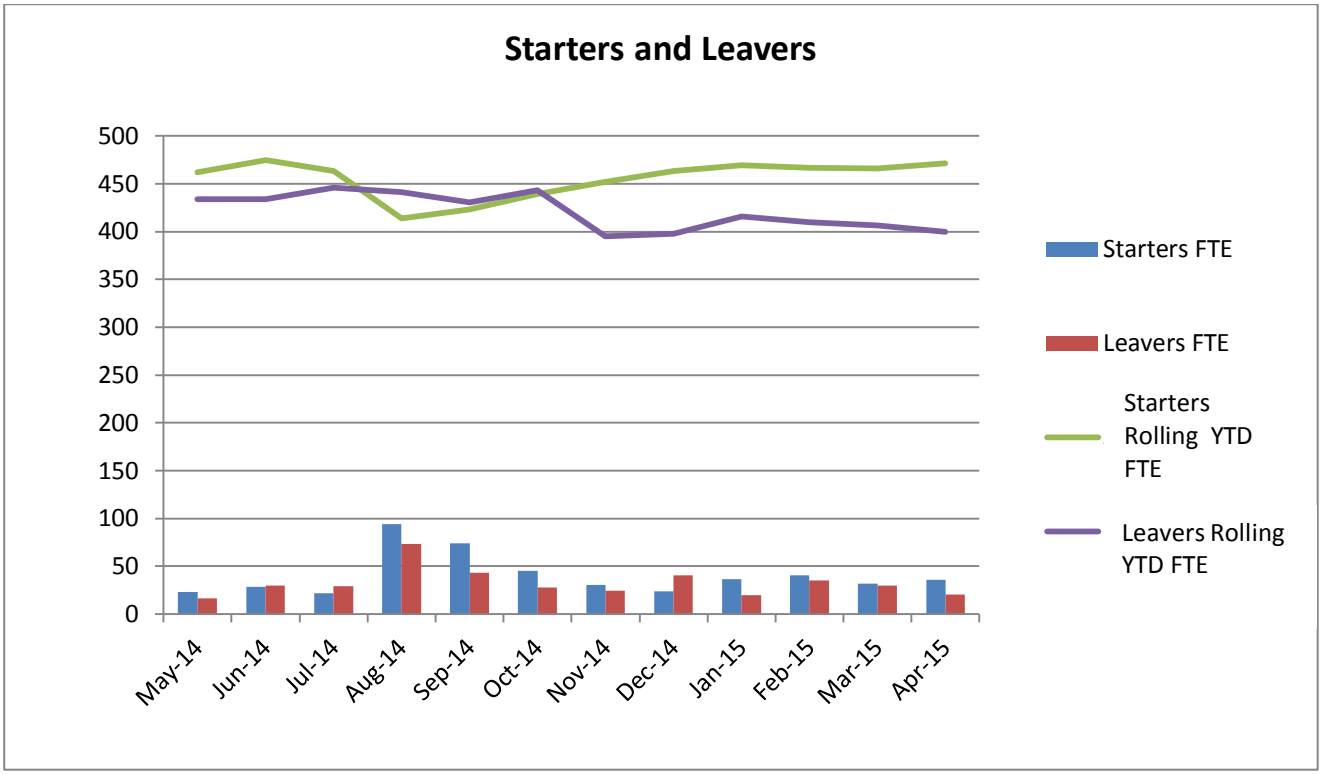


Figure 3

2.8 Friends and Family Test – GREEN

The trend data continues to place the Trust in a strong position in comparison to national data.

Workforce Compliance

2.9 Appraisal rates - RED

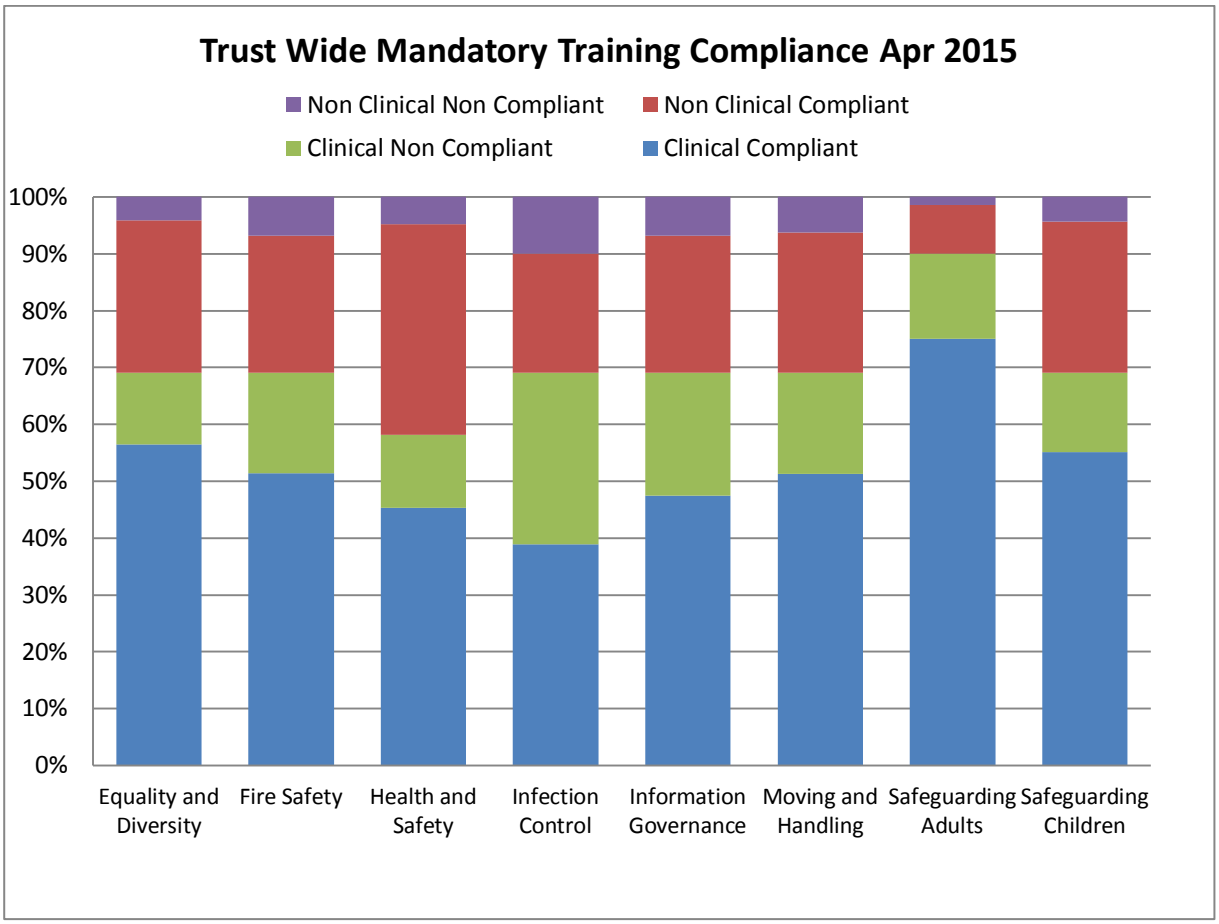
The percentage of Trust staff (non-medical including clinical and admin) that are recorded as having had an appraisal on the SpIda system that has been agreed, signed off and had a second sign-off by the 'grandparent' is 46%.

Return to green
A review of the Spida system has been undertaken and reported to Executive Workforce Committee. Further work includes assessing the customer experience of the system, and expediting the service development of the service.

Line managers have now received detailed records of appraisals completed and incomplete with names of staff members allowing for targeted support.

2.10 Statutory and Mandatory Training – AMBER/RED

Compliance with training is reported as amber at 76.7% and varies between each of the core topics.



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

Return to Green

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

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

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

5. Supporting Information

The following documents are attached as appendices:

1. Metrics
2. Safer Staffing NQB Report – April 2015.

Alison Kingscott
Director of HR and OD
May 2015

Workforce Numbers

Staff In Post (SiP) numbers	*Target*	Apr-15	Trend	*Forecast Out Turn*	Dec-14	Jan-15	Feb-15	Mar-15
Total substantive Staff in Post (FTE)	= 95% of funded establishment (see vacancy rate RAG rating criteria below)	2,703		2,703	2754	2711	2698	2756
Establishment (FTE)	No target	2,923		2,923	2869	2872	2877	2883
Total substantive SiP - Nurses (FTE)	= 92% of funded establishment (see vacancy rate RAG rating criteria below)	1,089		1,089	1092	1072	1084	1093
Establishment - Nurses (FTE)	No target	1,223		1,223	1188	1197	1198	1204

Vacancies	*Target*	Apr-15	Trend	*Forecast Out Turn*	Dec-14	Jan-15	Feb-15	Mar-15
All Vacancies - excluding variable staffing (%)	<8% = green, 8% to 10% = amber, >10% = red	7.5%		7.5%	4.0%	5.6%	6.2%	4.4%
All Vacancies - including variable staffing (%)	<=4% = green, 5% to 6% = amber, >6% = red	3.1%		3.1%	-1.3%	0.7%	2.6%	-0.8%
Nursing Vacancies - excluding variable staffing (%)	<10% = green, 10% to 12% = amber, >12% = red	10.9%		10.9%	8.1%	10.4%	9.5%	9.2%
Nursing Vacancies - including variable staffing (%)	<=4% = green, 5% to 6% = amber, >6% = red	3.8%		3.8%	-0.4%	2.0%	3.8%	0.3%

Workforce Costs and Quality	*Target*	Apr-15	Trend	*Forecast Out Turn*	Dec-14	Jan-15	Feb-15	Mar-15
Total Workforce spend vs. plan (YTD % above/below plan)	Plan ±<1% = green, plan ±1 to 5% = amber, plan ±>5% = red	3.3%		3.3%	0.3%	0.3%	0.4%	0.3%
Variable Staffing spend as proportion of total workforce spend (YTD %)	Reduction	12.7%		12.7%	10.6%	10.9%	12.7%	15.1%
Bank Spend Total	Upward trend	£478,613		£5,548,432	437,792	348,914	501,239	483,522
Nursing Bank Spend	Upward trend	£330,402		£3,639,217	297,531	208,310	358,200	317,501
Medical Locum Bank Spend	Upward trend	£68,170		£1,013,473	73,609	83,220	62,982	86,954
Agency Spend Total	5 to 10% decrease = green, 0 to 5% decrease = amber, increase = red.	£858,254		£8,186,905	647,197	758,815	839,157	1,121,518
Nursing Agency Spend	5 to 10% decrease = green, 0 to 5% decrease = amber, increase = red.	£443,526		£3,430,259	278,392	337,758	390,831	546,900
Medical Agency Spend	5 to 10% decrease = green, 0 to 5% decrease = amber, increase = red.	£283,383		£3,237,812	259,219	291,401	349,872	384,050

Workforce Quality

Efficiency of Staff Deployment	*Target*	Apr-15	Trend	*Forecast Out Turn*	Dec-14	Jan-15	Feb-15	Mar-15
Bank Shift Fill Rate % - All Nursing	Increase = green, 0 to 5% decrease = amber, >5% decrease = red.	52.4%		52.4%	51.5%	56.4%	53.8%	52.8%
Bank Shift Fill Hours - All Nursing	Increase = green, 0 to 5% decrease = amber, >5% decrease = red.	13,854		13,854	11,753	13,116	12,876	15,695
Agency Shift Fill Rate % - All Nursing	Reducing	40.6%		40.6%	31.3%	28.9%	29.2%	37.6%
Agency Shift Fill Hours - All Nursing	Reducing	10,742		10,742	7,155	9,924	6,971	11,180

Safer Staffing	*Target*	Apr-15	Trend	*Forecast Out Turn*	Dec-14	Jan-15	Feb-15	Mar-15
Actual Staffing Levels - Nursing Assistants % of planned	No target	104.2%		104.2%	105.4%	104.2%	103.5%	105.3%
Actual Staffing Levels - Registered Nurses % of planned	No target	99.2%		99.2%	96.8%	98.6%	97.4%	97.3%
Actual Skill Mix % Qualified	No target	62.0%		62.0%	62.0%	61.0%	61.0%	61.0%

Workforce Health

Sickness Absence	*Target*	Apr-15	Trend	*Forecast Out Turn*	Nov-14	#####	Jan-15	Feb-15	Apr-15
Overall Sickness Absence Rate (12m rolling average %)	<=3.1% = green, 3.1% to 4% = amber, >4% = red (2.87% target).	3.2%		3.2%	3.3%	3.3%	3.3%	3.4%	3.2%
Short Term Sickness	No target	0.8%		0.8%	1.6%	1.8%	1.8%	1.5%	0.8%
Long Term Sickness	No target	1.5%		1.5%	2.0%	2.0%	1.9%	2.0%	1.5%
Average number of working days lost per FTE (in previous 12 months)	<=11.3 = green, 11.3 to 14.6 = amber, >14.6% = red	11.8		12.1%	11.9	12.2	12.0	12.3	11.8
Financial cost of sickness in last 12 months	<=3.1% = green, 3.1% to 4% = amber, >4% = red	£3,923,171		£3,923,171	3,947,388	#####	#######	4,068,474	3,923,171
% of Sickness Absence with no reason recorded	<=5% = green, 5% to 15% = amber, >15% = red	13.4%		13.4%	15.1%	10.0%	10.0%	14.7%	13.4%
Turnover	*Target*	Apr-15	Trend	*Forecast Out Turn*	Nov-14	#####	Jan-15	Feb-15	Apr-15
Staff Turnover rolling 12 months % (Excluding Rotational Medical Staff)	7-10% = green, 10% -12% = amber, >12% = red. (8.5% target)	11.0%		11.0%	10.9%	11.6%	11.5%	11.5%	11.0%
Registered Nurse Turnover rolling 12 months %	7-10% = green, 10% -12% = amber, >12% = red. (8.5% target)	8.6%		8.6%	8.0%	8.1%	7.9%	8.4%	8.6%
Starters % rolling 12 months (Excluding Rotational Medical Staff)	No target	14.0%		14.0%	13.0%	13.0%	13.2%	13.3%	14.0%
Registered Nurse Starters rolling 12 months	No target	6.9%		6.9%	6.8%	6.7%	6.8%	6.6%	6.9%
Staff Friends and Family Test	Target	Q2 2014/15	Trend	*Forecast Out Turn*	Q1 2014/15	Q2 2014/	Q4 2014/15		
% of Staff agreeing they would recommend the hospital as a place to receive treatment	Top 20% of Trusts Nationally	92.0%		92.4%	97.5%	92.0%	92.4%		
% of Staff agreeing they would recommend the hospital as a place to work	Top 20% of Trusts Nationally	81.3%		82.5%	83.8%	81.3%	82.5%		

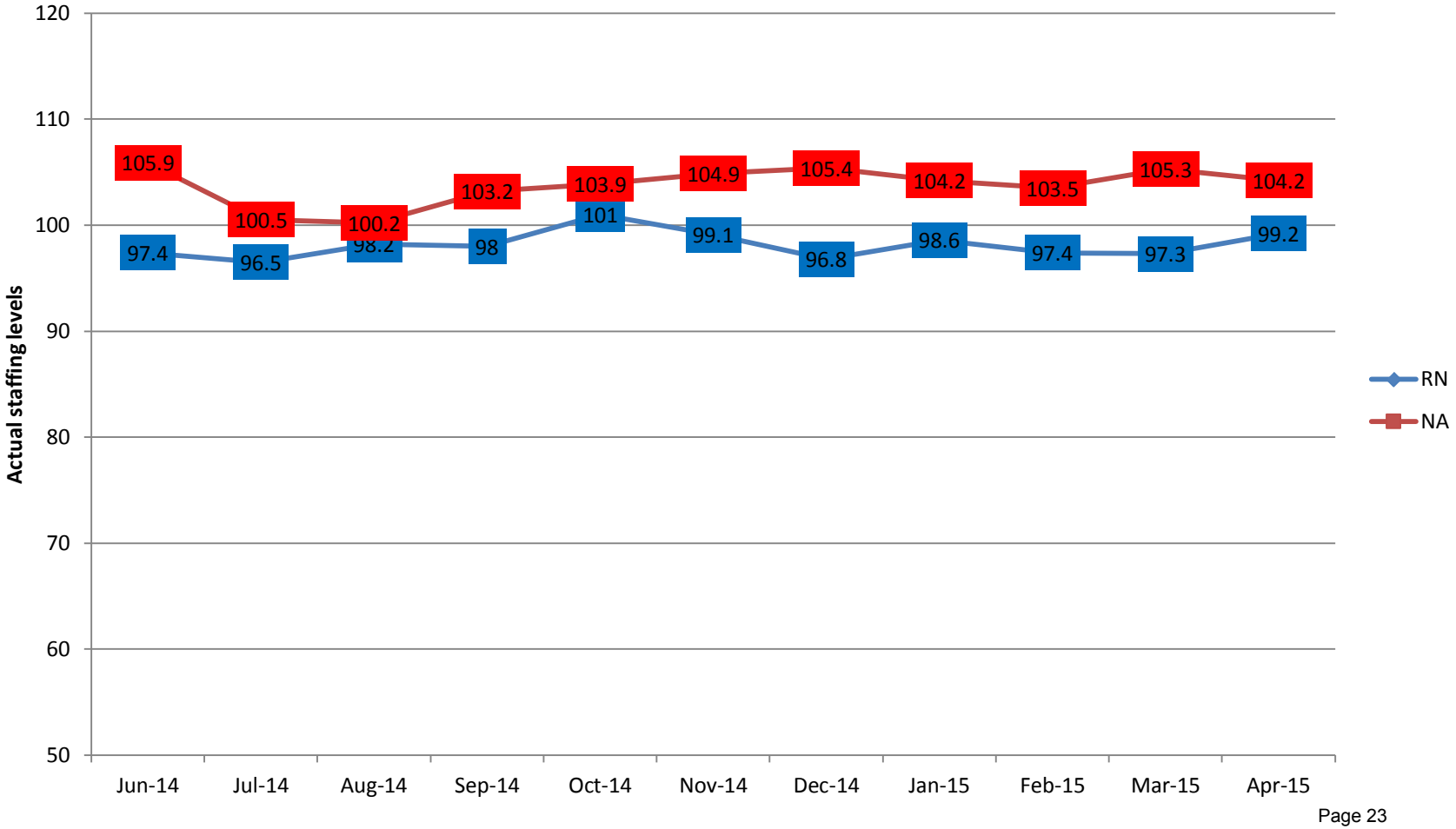
Workforce Compliance

Appraisal rates (excludes Medical Staff)	*Target*	Apr-15	Trend	*Forecast Out Turn*	Nov-14	#####	Jan-15	Feb-15	Apr-15
Appraisal rates for Non Medical Staff	>85% = green, 75% to 85% = amber, <75% = red	46.0%		46.0%	57.0%	55.0%	51.7%	53.1%	46.0%
Appraisal rates for Medical Staff	>85% = green, 75% to 85% = amber, <75% = red	94.0%		94.0%				87.0%	94.0%
Statutory and Mandatory Training - All Staff	*Target*	May-15	Trend	*Forecast Out Turn*	Dec-14	#####	Feb-15	Mar-15	May-15
Overall Statutory and Mandatory Training Compliance	>85% = green, 75% to 85% = amber, <75% = red	76.7%		76.7%	64.3%	70.0%	76.0%	78.4%	76.7%
Equality and Diversity	>85% = green, 75% to 85% = amber, <75% = red	83.3%		83.3%			74.8%	81.2%	83.3%
Fire Safety	>85% = green, 75% to 85% = amber, <75% = red	75.6%		75.6%			74.1%	72.2%	75.6%
Health and Safety Overview	>85% = green, 75% to 85% = amber, <75% = red	82.3%		82.3%			77.6%	83.5%	82.3%
Infection Prevention and Control (including hand hygiene)	>85% = green, 75% to 85% = amber, <75% = red	59.9%		59.9%			77.8%	82.3%	59.9%
Information Governance	>85% = green, 75% to 85% = amber, <75% = red	71.7%		71.7%				77.7%	71.7%
Moving and Handling	>85% = green, 75% to 85% = amber, <75% = red	76.0%		76.0%			68.3%	73.5%	76.0%
Safeguarding Adults	>85% = green, 75% to 85% = amber, <75% = red	83.5%		83.5%			80.6%	82.5%	83.5%
Safeguarding Children Level 1 and 2	>85% = green, 75% to 85% = amber, <75% = red	81.6%		81.6%			78.8%	74.5%	81.6%

Safe Staffing NQB Report - April 2015

Monthly Comparisons – Actual Staffing Levels

Registered Nurses			Nursing Assistants			Combined			Planned Skill Mix		Actual Skill Mix	
P	A	%	P	A	%	P	A	%				
58176.2	57683.4	99.2	33500	34920.8	104.2	91676.2	92604.2	101.0	63	37	62	38



Overview of Nurse Staffing Hours – March 2015

	RN	NA
Total Planned hours (day shift)	35580.5	22365.5
Total Actual hours (day shift)	34948.7	23312.1
Percentage	**98.2**	**104.2**
Total Planned hours (night shift)	22595.7	11134.5
Total Actual hours (night shift)	22734.7	11608.8
Percentage	**100.6**	**104.2**

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

Nursing Hours by Day Shifts

Row Labels	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**14850.8**	**15120.51**	**101.8%**	**10742.75**	**11778.67**	**109.6%**
Breamore Ward	1263.5	1330.5	105.3%	923	1150.5	124.6%
Durrington Ward	1003	1153.26	115.0%	802	1016	126.7%
Emergency Department	345	345	100.0%	345	345	100.0%
Farley Ward	1787.3	1805.5	101.0%	1420	1415	99.6%
Hospice	1015.5	1003.25	98.8%	626	583	93.1%
Pembroke Ward	898.5	932.5	103.8%	438.5	438.5	100.0%
Pitton Ward	1498	1515.5	101.2%	1082.5	1363.17	125.9%
Redlynch Ward	1510.5	1459	96.6%	1103	1148.5	104.1%
Tisbury Ward	1991.5	1880	94.4%	690.25	719.5	104.2%
Whiteparish Ward	1693	1743.5	103.0%	1028	1042.5	101.4%
Winterslow Suite	1845	1952.5	105.8%	2284.5	2557	111.9%
Surgery	**6556.5**	**6393.09**	**97.5%**	**2657.25**	**2432.76**	**91.6%**
Britford Ward	2199	2195.25	99.8%	1227.5	1168.26	95.2%
Downton Ward	1400.5	1391.51	99.4%	988.5	937.25	94.8%
Radnor	2957	2806.33	94.9%	441.25	327.25	74.2%
Clinical Support	**4587**	**4249**	**92.6%**	**1911**	**1213.5**	**63.5%**
Maternity	2572.5	2204.5	85.7%	1151	762.5	66.2%
NICU	1074	1072.5	99.9%	415	115	27.7%
Sarum Ward	940.5	972	103.3%	345	336	97.4%
Musculo-Skeletal	**9586.25**	**9186.08**	**95.8%**	**7054.47**	**7887.19**	**111.8%**
Amesbury Suite	1996.25	1915.68	96.0%	1490	1486.19	99.7%
Avon Ward	1432.45	1393.35	97.3%	1457.86	1815.61	124.5%
Burns Unit	1491.5	1487.76	99.7%	546.25	570.5	104.4%
Chilmark Suite	1492.25	1519.09	101.8%	1041	1287.81	123.7%
Laverstock Ward	1872.67	1758.92	93.9%	1048.17	1033.67	98.6%
Tamar Ward	1301.13	1111.28	85.4%	1471.19	1693.41	115.1%
Grand Total	**35580.55**	**34948.68**	**98.2%**	**22365.47**	**23312.12**	**104.2%**

Nursing Hours by Night Shifts

Row Labels	RN hours required	RN hours filled	% RN hours filled	CA hours required	CA hours filled	% CA hours filled
Medicine	**10125.67**	**10469.16**	**103.4%**	**5311**	**6274.25**	**118.1%**
Emergency Department	345	345	100.0%	345	345	100.0%
Farley Ward	1035	1090.58	105.4%	690	688.5	99.8%
Hospice	494	570	115.4%	481	359	74.6%
Pembroke Ward	690	690	100.0%	0	0	
Pitton Ward	1035	1091	105.4%	690	1009.25	146.3%
Redlynch Ward	1035	1023.5	98.9%	356.5	540	151.5%
Tisbury Ward	1379.17	1379	100.0%	345	345	100.0%
Whiteparish Ward	1375.5	1479.5	107.6%	345	345	100.0%
Winterslow Suite	1023.5	1015.5	99.2%	1035	1344.5	129.9%
Durrington Ward	678.5	718.5	105.9%	678.5	690	101.7%
Breamore Ward	1035	1066.58	103.1%	345	608	176.2%
Surgery	**4227**	**4149**	**98.2%**	**870**	**860.5**	**98.9%**
Britford Ward	890	930	104.5%	570	550.5	96.6%
Downton Ward	600	601	100.2%	300	310	103.3%
Radnor	2737	2618	95.7%	0	0	
Clinical Support	**4485**	**4155.5**	**92.7%**	**1426**	**931.5**	**65.3%**
Maternity	2415	2259	93.5%	1035	747.5	72.2%
NICU	1035	862.5	83.3%	345	126.5	36.7%
Sarum Ward	1035	1034	99.9%	46	57.5	125.0%
Musculo-Skeletal	**3758**	**3961**	**105.4%**	**3527.5**	**3542.5**	**100.4%**
Amesbury Suite	568	577.5	101.7%	855	845.5	98.9%
Avon Ward	600	760.5	126.8%	880	790	89.8%
Burns Unit	600	634.5	105.8%	300	310	103.3%
Chilmark Suite	570	570	100.0%	570	674.5	118.3%
Laverstock Ward	820	820	100.0%	322.5	332.5	103.1%
Tamar Ward	600	598.5	99.8%	600	590	98.3%
Grand Total	**22595.67**	**22734.66**	**100.6%**	**11134.5**	**11608.75**	**104.3%**

Overview of Areas with Red/Amber

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	**Radnor**	74.2		√	Day	Small numbers of NA's used to support the team. Not covered each shift which is not always clinically indicated but the data collection model used cannot reflect this flexibility as planned establishment has to be entered into the system as a standard daily amount.
Red	**Maternity**	66.2		√	Day	Small number of MA's used to support the team
Red	**NICU**	27.7		√	Day	Small number of MA's used to support the team.
Red	**NICU**	36.7		√	Night	Small number of MA's used, see supporting notes above
Red	**Hospice**	74.6		√	Night	Small number of NA's used and staffing flexed according to needs of patients, over 100% on RNs
Amber	**NICU**	83.3	√		Night	Reflects flexing of staff to demand
Amber	**Maternity**	72.2		√	Night	Small number of MAs used
Amber	**Maternity**	85.7	√		Day	Escalation protocol used and each shift assessed. 1:1 care in labour maintained, midwife to birth ratio 1:34
Amber	**Avon**	89.8	√		Night	High number of vacancies – each shift assessed by DSN
Amber	**Tamar**	85.4	√		Day	High number of vacancies – each shift assessed by DSN

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

Mitigation of Risk

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

- Specialist areas such as Radnor ICU and NICU flagging where staffing used flexibly according to patient numbers and acuity which cannot be reflected accurately on this tool. Each shift risk assessed for staffing needs by senior nurse and adjusted accordingly. Appropriate 1:1 or 1:2 ratios maintained on all shifts
- All shifts are assessed daily by Directorate Senior Nurses to ensure they are safe.
- NA remains over 100% - this is due to NA's being used on unfilled RN shifts and specials.

Actions taken to mitigate risk

- Patient acuity assessed for staffing levels by individual wards by nurse in charge
- Trust wide staffing levels assessed against patient acuity and staff moved across wards by Directorate Senior Nurses and Clinical Site Team as required
- Staffing levels reduced when beds empty/ procedure lists reduced whilst maintaining appropriate staffing ratios
- If all of the above measures have been taken there may be a requirement that staff on training days are brought back to work clinically as required and / or Sisters on supervisory shifts work clinically.
- Additional NAs rostered to support unfilled RN shifts
- CCOT team support wards where acuity of patients high

Trust Board June 2015

Title	Six Monthly Skill Mix Review Update – June 2015
Meeting Date	June 8th 2015
Sponsoring Executive	Lorna Wilkinson – Director of Nursing
Author	Denise Major – Acting Deputy Director of Nursing

1. Background

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

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

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

This report provides the Board with an update on the continuing national guidance being issued, a progress report on the 2015 skill mix review, and an evaluation of the investment allocated in 2014/15. The full results of the June 2015 skill mix review are being presented and discussed at the June Trust Board Seminar and it is recommended that the outcome of this is presented to the public Board in August.

During 2014/15 there was investment into nurse staffing as a result of the 2 skill mix reviews totalling £917 000.

- April 2014 - £800 000 to fund supervisory band 7 ward sisters, establish the minimum 1:8 ratio on day shifts, support 2 band 6 junior sister posts as a baseline on each ward
- October 2014 - £117 000 to fund extra staffing requirements identified on Durrington and Amesbury wards.

2. Guidance on Safer Staffing:

NICE has produced guidance for safe staffing levels and they continue to produce further guidance on this as set out below:

- Safe Staffing of Adult Wards in Acute Settings July 2014
- Safe Midwifery Staffing for Maternity Settings Feb 2015
- Safe Staffing for Accident and Emergency Settings – out in draft, final due in May 2015

3. General Wards:

3.1 NICE Safe Nurse Staffing of Adult Wards in Acute Settings:

A gap analysis was undertaken against this guidance when it was published with the Trust meeting virtually all of the standards as most were already evident within the NQB guidance. An action plan was developed and is currently being updated following implementation of the Safer Care Module and establishing a process for 'red flag' reporting.

3.2 Ratio of RNs to Patients:

NICE guidance acknowledges that there is no single nursing staff to patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs but work undertaken by the RCN and Safe Staffing Alliance demonstrated that a ratio of more than 1:8 was more likely to lead to poor patient outcomes. There is a recommendation that day shift ratios in general wards should not exceed 1:8. All wards at Salisbury FT are compliant with this ratio on day time shifts during the week but there are some wards (Redlynch and Pitton) who reduce this ratio at weekends.

Night shifts have a higher ratio of RN to patients and range from 1:5-1:16. These ratios reflect the patient case mix on these wards.

3.3 Ratio of RN to Nursing Assistant (NA)

The ratios of RN:NA are listed in appendix B. Not surprisingly this differs from ward to ward depending on case mix of patients. The wards range from 80:20 to 50:50, however there are 2 wards that fall below 50% RNs**;** Avon (46:54) and Tamar (45:55).

Both of these wards are within the Spinal Injuries Rehabilitation Unit and have a higher number of band 3 positions than other ward areas. The band 3 nursing assistants have specific competencies and have an important role in supporting patient care. This is exemplified by respiratory competencies where the band 3 can support a registered nurse with acute care needs. An increase in the number of band 3s however, has reduced the ratio of RN:NA.

In areas where we are developing the Band 4 roles (such as elderly care) this can have a negative impact on the ratio even where it adds to the continuity of ward staffing and enhancement of skills. It will be important in the future as this part of the workforce grows to explain where this may be impacting on this ratio.

3.4 Methodology of the Skill Mix Review:

All inpatient wards have been subject to a detailed skill mix review during April/May. The reviews were undertaken using a defined approach to ensure consistency for comparison and which included a range of information; triangulating the ward staffing levels against nurse sensitive indicators, NICE standards, quality indicator / outcome data, HR indicators, and financial information. Professional judgement was ensured as each review has been undertaken by the Directorate Senior Nurse and

Ward Sister with a DSN/Lead Nurse from outside the Directorate to add objectivity and provide initial challenge.

Trust bed capacity modelling and the proposed bed footprint are currently being reviewed by the Chief Operating Officer, Director of Nursing and Medical Director and this report will need to be considered in light of any changes.

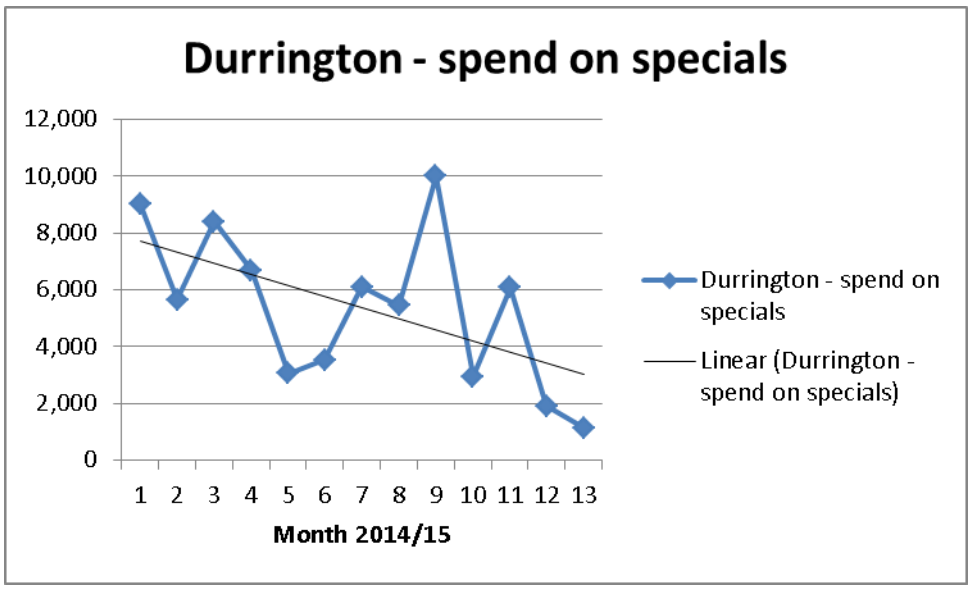
3.5 Findings:
The overall assessment is that the majority of wards have satisfactory staffing levels when vacancies are reduced, the hospital is running efficiently and bed capacity is matched to demand. However there is debate required as to where future investment may be made and this is being fully explored during the Board Seminar on June 8th 2015.

Initial analysis and findings of the skill mix reviews are included in Appendix B. The budgeted RN:Patient staffing ratio is demonstrated by shift alongside the RN:NA ratio. The Supervisory Ward Sister/Charge Nurse role is in addition to these ratios and with the two Junior Sisters, supports senior cover across 7 days.

All ward staffing levels are assessed daily by the nurse in charge and escalated to the Directorate Senior Nurses where it is felt the staffing levels do not match the acuity/dependency of the patients or where there are concerns around any shortfalls against planned levels. Night staffing levels have been included for review but it is nationally recognised that staffing levels are reduced at night time. Several wards utilise varied shift patterns such as twilights to maximise staffing to peaks in demand.

From the investment in 2014:

- the supervisory ward sister role continues to develop and a development programme was completed for the band 7 ward sisters this year, with ongoing action learning groups and a ward accreditation process to be developed as part of this concept. As previously reported some wards have not been able to fully introduce the role due to the number of registered nurse vacancies and the requirement for them to be counted within the establishment shift numbers.
- All wards now have two band 6 posts, this has been a positive development across the ward areas in succession planning for our future ward leaders and allowing us to flex into increased winter capacity using these band 6s to ensure consistent and strong leadership in our escalation areas. It has also allowed us to introduce senior clinical leadership cover across 7 days.
- Following the October 2014 mid-year review further investment was provided for two areas.
  - Amesbury Ward (elective orthopaedics) uplifted the late shift to include an additional registered nurse on the late which reduced the ratio from 1:11 to 1:8 at a busy time of the day when patients are returning from theatre and helping with the management of the workload moving into the night. This has improved safety and quality on the ward, a concerning theme from complaints on this ward was delays in care, and delays in obtaining pain relief. During Q4 the ward has received only one complaint.
  -Durrington Ward uplifted the night shift to include an additional nursing assistant due to the increasing requirement to provide 1:1 specialling to an increasing number of high risk patients. This has resulted in a reduction in the use of specials overnight, which has now been eliminated – the remaining spend below is on day shifts.



4. **<u>Maternity</u> –** Not previously included in the skill mix review

NICE Safe Midwifery Staffing for Maternity Settings
This is recently published guidance is being considered by the Head of Midwifery alongside the Birthrate Plus recommendations. Birthrate Plus is a validated tool used as a framework for workforce planning in maternity units. The Trust commissioned Birthrate Plus to carry out a review of maternity staffing requirements over a 3 month period Oct 2014 – Jan 15. The report was shared with the Trust in March 2015 and is forming the basis of the maternity staffing review in order to work towards a midwife to birth ratio of 1:32.

5. **<u>Emergency Department</u>** – Not previously included in the skill mix review

NICE Safe Staffing for Accident and Emergency Settings:
This guideline is currently in draft with an expected publication of May 2015. The Lead Nurse for Emergency Medicine has completed a gap analysis and based her skill mix review on the key recommendations as well as ECIST feedback.

6. **<u>Allocate E-Rostering and Safer Care Module</u>:**

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

E-rostering is now in place across all inpatient areas with Maternity the most recent department to 'go live'. Trust data available from the Allocate system is showing that the average headroom requirement is 22% which is 3% over and above the current headroom available of 19%. This impacts on the wards' ability to cover the shifts required, which then incur bank/agency costs, and so further review is a key recommendation of the June report.

During 2015/16 the Safer Staffing Steering Group are focussing on efficiency of rostering through the reporting and review of KPIs generated through the Allocate system.

SafeCare has been rolled out during Q4 2014/15 to all inpatient wards (except ITU, ED and Paediatrics) and analysis is only now becoming available for the early implementers. The commitment of ward leaders has been excellent and data is being entered for every shift onto the SafeCare module by all the wards. Data entries align with information taken directly from the rosters to provide evidence of either excess levels of staffing or staffing shortfalls and these can be extracted into a reporting format. All information needs to be treated with caution at this stage as the system develops as wards are only beginning to interpret the Shelford tool and at present no account is taken of other nursing tasks which is built into this tool (i.e. patient escorts from the ward, large burns/plastics dressings etc). This data will be reported through the Safer Staffing Steering Group.

7. Recruitment and Retention:

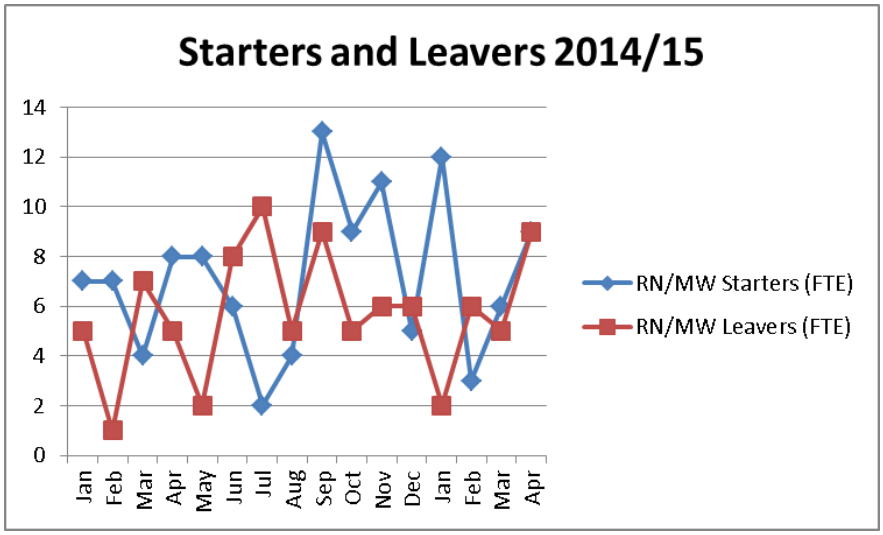
The high number of nursing vacancies within the Trust has continued and there are active recruitment programmes both within the UK and overseas. Unfortunately, despite these efforts some vacancies have still not been recruited to following the nursing uplifts agreed in 2014. There is an ongoing high usage of temporary nursing staff across the Trust with work ongoing to reduce this requirement as successful recruitment takes place.

A total of 32 newly qualified nurses started in the Trust from October 2015 – April 2015. Open days will continue for nursing, midwifery and AHP students who are starting year three of their training, in an attempt to showcase the opportunities and benefits in working for the Trust. Many are being recruited up to 10 months pre-qualification and this will be an opportunity to encourage applications for positions here. Applicants for current band 5 positions are predominantly from student nurses who will qualify in September 2015.

A total of 25 nurses have been recruited from Italy since December 2014 with a further 11 expected to start in June 2015 and 2 in September 2015.

The Trust has committed to supporting the development of clinical educator posts to support nursing staff in practice – this will include those on the preceptorship programme, overseas recruits, return to practice, and those working towards the Care Certificate.

The graph below shows the number of starters and leavers. Despite the turnover being relatively low our vacancy levels remain elevated, particularly in some areas (Farley, Winterslow, Amesbury and Spinal). It is imperative that we remain focussed on recruitment programmes. Competition against surrounding Trusts, an increasing number of staff choosing to work for agencies and an ageing workforce will continue to impact the existing vacancy rate. There will be no benefit felt from any national increase in the number of University training places for at least three years and attrition from nursing training as well as leavers in the first year are recognised problems nationally.



8. Actions for the Board

- To note that third skill mix review has been completed and is the basis for a full discussion at the June Trust Board Seminar
- Note the impact of previous investment in nursing skill mix during 2014/15
- Request that the full skill mix review paper is presented to the public Board in August 2015 following the June Trust Board Seminar
- Support the analysis work from the Allocate Roster Perform system and Safecare tool across the ward areas to inform future skill mix requirements
- Support the continuation of recruitment and retention activities as set out in section 7

Appendix A

NQB Expectations and Trust Status April 2015

Expectation	Progress	Action
Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery, and care staffing capacity and capability	• The Board receives a number of reports each month which provide information on quality and standards of patient care. Board agrees ward based staffing requirements through the 6 monthly skill mix review and is also informed through the monthly safer staffing reporting and quality indicators report.	
Processes are in place to enable establishments to be met on a shift to shift basis	• Daily staffing levels recorded on a shift by shift basis through allocate e-roster system. • Review of staffing at the twice daily bed meetings to identify any areas of risk and agree action required. This often involves moving staff around if there are gaps. • Ward level capture of 'red flags' as described in NICE guidance 2014.	
Evidence based tools are used to inform nursing, midwifery and care staffing capacity and capability	• During Q4 the allocate safer care module was rolled out which is based on the Safer Nursing Care Tool. This is an evidence based tool that enables nurses to assess patient acuity and dependency. This data will be measured continuously in order to inform future skill mix reviews. • Skill mix reviews do triangulate nurse sensitive indicator data and professional judgement alongside the above. • Allocate roster perform data and safer care module data to be reported into the Safer Staffing Steering Group by each Directorate. This group is chaired by the DoN. • NICE have recommended a ratio of one Registered Nurse (RN) to eight patients 1:8. This is not a mandated requirement and other factors need to be considered e.g. patient acuity and dependency, as well as support roles such as Assistant Practitioners. The 1:8 ratio is reviewed as part of the skill mix review • The Trust commissioned Birthrate Plus to carry out an extensive 3 months review of our midwifery staffing. This report was shared with in March 2015 – recommendations form part of the skill mix review paper. NICE guidance on maternity staffing was also published in February 2015 which will also form part of this review. • The Chief Nursing Officer for England has produced a document Safer Staffing: A Guide to Care Contact Time (Nov 2014) which strongly recommends that Trusts assess care contact time on their wards. It is important to note that there are no validated tools published for the process but suggestions given to using productive ward tools or a system of time and motion clocks. We have used some of this	Safer Care data to be used as the basis of future skill mix reviews. Directorate reporting into Safer staffing Steering Group Complete midwifery case and commence monthly reporting through Nursing, Midwifery, Therapy workforce steering group

	methodology to evaluate the pilot of a band 1 ward assistant in elderly care in showing how direct contact time can be increased through such role development. • The Director of Nursing is working through the Safer Staffing Steering Group on how direct contact time can be utilised within the Trust in a way which is meaningful.	Scope and plan how care contact time will be introduced.
Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns	• Raising Concerns Policy in place for many years • NMC revised code – information has been sent out to all staff and presentations delivered at NMF • NMC revalidation • Nursing and Midwifery and AHP Strategy due for launch June 2015 – very clear on responsibilities of nurses and midwives to put the interest of people in their care first.	Revalidation readiness Strategy launch
A multiprofessional approach is taken when setting nursing, midwifery and care staffing establishments	• Ward leaders are involved in the skill mix reviews and establishment setting • Roles beyond nursing are considered as part of this process e.g. band 1 ward support role on Winterslow, admin support for nursing staff on Britford • Key workforce groups are multi professional • Skill mix review papers are fully worked up with input from executive colleagues	
Nurses, Midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties	• Current headroom is set at 19% to cover sickness, leave and continuous professional development • Through Allocate e-rostering system this has been monitored over the last 6 months which is showing a need for 22% which is the national average allocated. • The impact of this is being explored further by the DoN • Ward leaders were made supervisory in 2014. This has released time for them in their management of the ward, monitoring of quality standards, and most importantly being visible clinical leaders working alongside staff and coordinating care. • A Roster Policy is in place which has been revised since the implementation of Allocate. E-rosters are monitored against the KPIs for managing annual leave etc through the Safer Staffing Steering Group. • Mandatory training and appraisal rates are monitored via the workforce report through the Directorate 3:3s, and has identified a need for improvement through 2015. • Clinical educator posts have been agreed which will allow greater supervision of staff in practice as part of the preceptorship programme, obtaining the Care Certificate, and the introduction of a Return to Practice course during 2015	Headroom to be revisited
Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every 6 months on the basis of a full nursing and midwifery skill mix	• Safer staffing report is presented to Board each month detailing down toward the planned versus actual nurse staffing • Full workforce report developed 2015 which covers all staff groups • A skill mix review is presented to the Board twice per year.	

review	• These are published on the Trust's website	
NHS Providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, dept on each shift	• Displayed on all wards • New information Boards being implemented May 2015	
Providers of NHS services take an active role in securing staff in line with their workforce requirements	• Recruitment plans in place and continuously reviewed. • Safer Staffing Steering Group oversees this work. • EU recruitment campaign running through 2015/16 • Recruitment and retention initiatives under constant review – includes rotational posts and return to practice • Close working with local universities and HEW	RTP scheme to be implemented Recruitment and Retention Plan 2015/16 to be developed

Appendix B

Six Monthly Skill Mix Review June 2015

Ward	RN: Patient Ratio (Early)	RN: Patient Ratio (Late)	RN: Patient Ratio (Night)	% RN : HCA (based on establishment)
Whiteparish	1:5 (1:6)	1:5 (1:6)	1:5.6 (lower with twilight)	72:28
Tisbury	1:4.5/2.5	1:45/2.5	1:5.75	75:25
Pitton	1:6.75(1:9)	1:6.75(1:9)	1:7.6	59:41
Redlynch	1:6.75(1:9)	1:6.75(1:9)	1:7.6	57:43
Farley	1:6	1:6	1:10	55:45
Durrington	1:7	1:7	1:10.5	55:45
Winterslow 40	1:8	1:8	1:13.3	49:51
Pembroke	1:5	1:5	1:5	81:19
Hospice	1:5	1:5	1:5	60:40
Amesbury	1:6.4	1:8	1:16	50: 50
Chilmark	1:6 (8)	1:8	1:12	55:45
Burns	1:6 (1:3 Paed)	1:6 (1:3 Paed)	1:8.5	80:20
Laverstock	1:5.2	1:8.6	1:8.6	66:34
Avon	1:4.25	1:5.6	1:10.5	46:54
Tamar	1:7	1:7	1:10.5	45:55
Britford	1.5.8	1:5.8	1:10	64:36
Downton	1:7	1:7	1:12	62:38
DSU ward	1:7	1:7	N/A	78:22
Sarum	1.8 (5)	1.8	1.5	73:27
ED				
Radnor	ICS Levels of care 1:1 or 1:2			

Numbers in brackets denotes weekends

Salisbury NHS Foundation Trust

SFT3658

Salisbury NHS Foundation Trust
Staff Survey 2014 Update on Progress

Presented for:	Information
Presented by:	Alison Kingscott, Director of Human Resources and Organisational Development
Author:	Victoria Downing-Burn, Deputy Director of HR (interim)
Previous Committees:	Sections presented to Executive Workforce Committee (May 2015).

Key points
The Trust Board is asked to consider this report and the actions taken to date to address the areas for improvement within the 2014 Staff Survey.

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

Strategic Aims

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

Values

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

1. Summary and background
This report provides a summary of the key actions taken to date in addressing a number of themes in the 2014 Staff Survey. It follows an initial report to the Trust Board on 13 April 2015 that provided a full summary of the results from the Survey.

It also provides a detailed assessment of the intended work programme focused on 'Acceptable Behaviour at Work', addressing bullying and harassment.

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

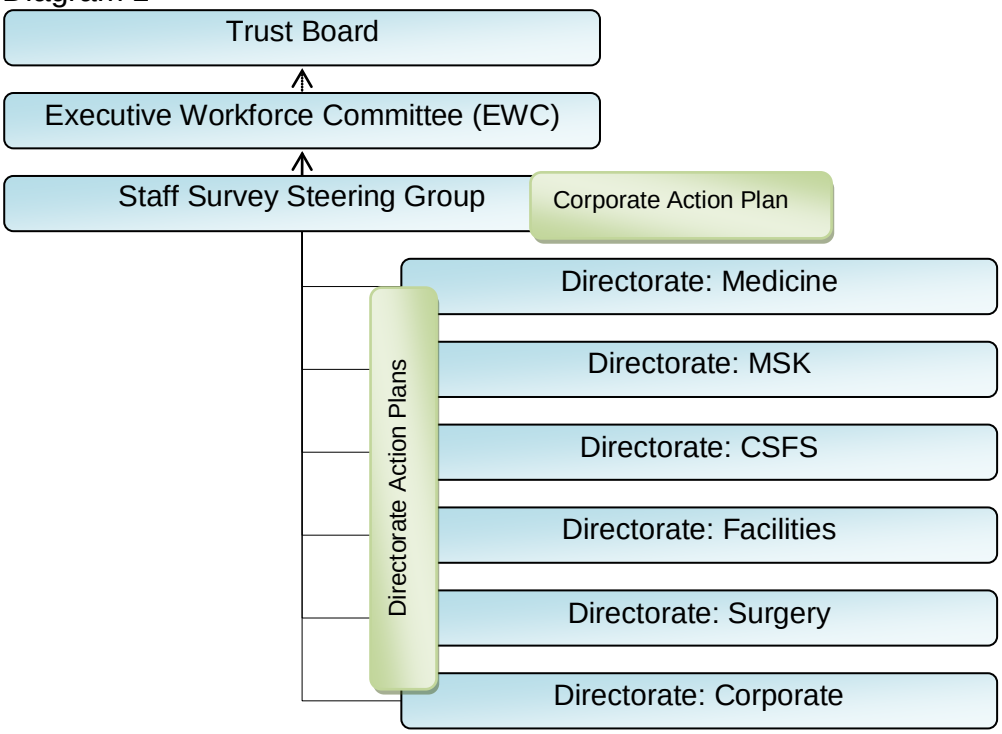
2. Programme of work, governance and monitoring

There were six key themes identified as areas for improvement from the 2014 survey, as presented to Board in April, and they are summarised below. These themes form the basis of the Corporate Action Plan (described in section 2.1-2.6), which will be monitored through the Executive Workforce Committee. Supporting the Corporate Action Plan are Directorate Action Plans.

The arrangements for monitoring the actions and improvements are described below in Diagram 1. These arrangements will provide clear accountability for improvement plans; the opportunity to share internal good practice, and to monitor progress. There are two levels of Action Plans: Corporate and Directorate.

The Deputy Director of HR chairs the Staff Survey Steering Group.

Diagram 1



Work programme

2.1 Percentage of staff experiencing discrimination at work in the last 12 months

- This is a category for the Trust where the results this year are statistically worse than in the previous year. Following an analysis of the respondents to the Survey a specifically targeted Listening into Action group is being arranged to understand more about the experiences of those reporting decimation. This work is being done with the support of the Trust Head of Equality and Diversity. Actions from the session will be added to the Corporate Action Plan and monitored through the EWC.

2.2 and 2.3 Percentage experiencing harassment, bullying or abuse from patients, relatives the public or staff in the last 12 months and Percentage experiencing physical violence from patients, relatives the public or staff in last 12 months.

- For staff, the Trust is providing more support in the form of a new role of Staff Support Advisor who will be skilled in offering guidance and support in achieving Acceptable Behaviours at Work, and consistent with the Trust values. The role will also support individual to report incidents of bullying. A nominations and selection process is underway. This role will complement the existing NED role.

- The Trust Bullying and Harassment Policy is under review with a stronger focus on Values and Behaviours under the heading of Acceptable Behaviour at Work, to provide a clear behavioural framework.

- Conflict resolution training is underway to cover non-clinical areas, and the complement the work already done in clinical areas.

- The adoption of the detailed, follow-up, questionnaire focused on bullying (already adopted in Facilities; Surgery; MSK (May 2015) and Maternity), is being adopted by the Medicine directorate. Actions will be included in Directorate Action Plans.

- We are seeking good practice benchmarks from other NHS Trusts to inform our plans, and learn from others.

- Managers will continue to use the Values and Behaviours framework through the appraisal process to shape behaviours and offer challenge and support.

- The Violence and Aggression Sub Group is progressing a number of work streams to support staff.

- The establishment of a Trust based 24/7 security service was launched in quarter one, 2015.

2.4 Percentage receiving job relevant training, learning or development in last 12 months

- Staff are reminded of the requirement to complete statutory and mandatory training through the appraisal process.
- The Trust Continuing Professional Development (CPD) Survey has recently been completed with a focus on bands 1-4. There has been good responses across all directorates with nursing, allied health professional and 'leadership' being key themes.

2.5 Percentage suffering work related stress

- The Violence and Aggression sub group operates to co-ordinate actions in reducing V&A, and to investigate through focus groups the issues experienced by staff.

- Staff access to counsellors and physiotherapy services through occupational health, including access to a Registered Mental Health Nurse (RMN).
- Significant number of health and wellbeing events to support staff including workshops on mindfulness, and managing stress run by Staff Counsellors.

2.6 Percentage appraised in the past 12 months

- The uptake of appraisals is 46% as reported in the Trust Board Workforce Report. Managers are required to use SpIda for all non-medical appraisals.
- Detailed reports providing compliance rates by Directorate and by staff name have been recently provided to managers for effective monitoring.
- A screensaver is currently active, as a reminder to all staff.
- The developments of the reporting options of the system are being reviewed, which will enable better access to detailed data.

Alison Kingscott
Director of HR & OD
May 2015

PAPER: SFT 3659

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 2014/2015.

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 2015, 717 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.

Applications. In the twelve months to 31st March 2015, 157 applicants applied to be a volunteer, 35 applicants who returned their form later changed their mind or were refused a placement due to either health checks or Disclosure & Barring checks. 79 new applicants started during the year and 43 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 – Brian Fisk completed his terms this year as the Volunteers governor.

Meet the…. Brian Fisk invited the volunteers to 'Meet The… Medical Director' (Christine Blanshard). Volunteers heard a little bit about Christine and her experience, where he sees the hospital heading in the future. Volunteers were given an opportunity to ask the Medical Director questions about our challenges.

Staff Awards. Volunteers are included in the annual Staff Awards. The winner can be either an individual or a team of volunteers. There were 8 nominations received and a judging panel of 3 decided on the winners. It is hard for the panel to make a decision they finally came up with one winner and two highly commended.

Arthur Kendrew was the overall winner. Arthur has been a volunteer for the past 9 years and retired from his post July 2014 due to his health. Arthur is a children's entertainer and visited the children's unit to brighten up their day. In many cases though it wasn't just the children he helped, very often it was the parents and other family member he cheered up and brought a small to many faces. Jane Daniel from the Palliative Care team received a Highly Commended for her support to bereaved relatives. Jane sits and listens to relatives, offer them support and comfort them in their time of grief. Highly Commended was also awarded to Mike Pointer. Mike helps with the Engage project which is run through the Clinical Psychology team. Mike although a volunteer will often help and support new volunteers to the project, he is very sensitive to the patients and their needs. Feedback from staff regarding his work with the patients has always been very positive.

National Association of Voluntary Service Managers (NAVSM). The Voluntary Services Manager (VSM) has attended 2 out of the 3 three regional meetings held in the Wessex area. These meetings provide an opportunity to network, share working practices as we are all affected by the same changes to services.

Work Experience. We provide placements to pupils aged 14 and 15 in non-clinical areas, with 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 92 students in over 30 locations around the Trust. 51 either changed their mind or were unsuccessful in securing a placement with us. We would like to say 'Thank You' to all the wards and departments who agree to take WEXP students.

Careers & Further Education Fairs. The VSM and Voluntary Services Assistant have 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 Tuesday 3rd June 2014 from 4.00pm – 6.00pm. Volunteers were also invited to our Christmas 'Mince and Mingle'. This gave the Trust a chance to say 'Thank you' to all the volunteers who attended and an opportunity for the volunteers to meet with other like minded people who help us.

Achievements

It has been a challenging year after the manager, Jo Jarvis, had been off for 11 weeks with both arms broken. However, a new Volunteering policy has been written and ratified, together with the Work Experience policy updated. New Volunteering and Work Experience leaflets have also been written. The website now includes a section for both volunteering and work experience and finally a uniform for volunteers is coming in to use from April 2015.

We have carried out a Service User audit to enable us to discover exactly what departments and wards require from their volunteers, this will help us to develop volunteer roles to ensure they are fulfilling and meaningful. Alongside this we have also carried out a volunteers audit to discover how they found their recruitment

process, their induction and also the support they receive once they are here. Again we hope this will lead us to improving the service all round.

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 website now operational we can promote volunteering and promote specific roles the hospital would like help with, it can be a challenge matching volunteers with specific roles, but this new method appears to be working well.

We plan to improve on the Induction of volunteers. We'd like to include the 10 core MaST and for subject matter experts give 10/15 minute talks on their topic. The objective is to enable the volunteer to be equipped with information that is meaningful and to give them the opportunities to ask questions to assist with their understanding.

A volunteer will be coming to help in the Voluntary Services Department to help with basic admin tasks and to also become a 'mentor' for the volunteers. She will be able to 'check in' with the new volunteers to ensure they are settling in well, and to answer any basic questions.

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 717.

To conclude, 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 2015

AUTHOR: Jo Jarvis
TITLE: Voluntary Services Manager

Salisbury NHS
NHS Foundation Trust

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 12 volunteers who are professional artists who give their time to offer patients the opportunity to 'have a go' at art in hospital.

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 2 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 37 volunteers who are able to offer comfort, prayers and other spiritual support to patients at their bedside.

Clinical Psychology

The Clinical Psychology department have 57 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.

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

Eight 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 39 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, 54 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 ensures they receive appropriate training specific to their needs.

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!

Information Technology (IT)

IT currently has 1 volunteer who was interested in this field and wanting to gain experience.

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 3 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 19 volunteers providing live and recorded programmes to our patients.

Recycling

A team of 25 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 32 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 have 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.

Royal Voluntary Service

Teams of dedicated members provide an afternoon service to both staff and patients with their trolley of 'goodies', to all wards. Their visits and chats are welcomed by all. The profits made from their sales are donated back to the hospital via the Stars Appeal.

Trust Board meeting **SFT 3660**

Quality indicator report – April 2015

Date: 19 May 2015

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

Executive Summary:

- 5 new serious incident inquiries.
- A decrease in the crude mortality rate in April 15. SHMI is 104 and SHMI adjusted for palliative care is 100 to September 2014 is as expected. HSMR increased to 101 in December 14 is as expected.
- An increase in the adverse event rate in January 15 as measured by the Global Trigger tool with a decline in February 15. Detail reported at the Clinical Risk Group.
- An increase in grade 2 pressure ulcers. Two grade 3 pressure ulcers.
- Safety Thermometer – 96% 'new harm free care'. A decrease to 92% of 'all harm free care' of patients admitted to hospital with a harm.
- There were 6 falls, 2 resulting in major harm (fractured hips requiring surgery), 4 resulting in moderate harm; 1 fractured impacted hip, 2 fractured wrists and 1 neck fracture all managed conservatively. RCAs undertaken and ongoing aggregated learning reported at the Falls Working Group.
- An improvement in patients arriving on the stroke unit within 4 hours. A reduction in patients spending 90% of their time on the stroke unit as three patients were transferred to other wards prior to discharge to provide capacity for new stroke patients.
- There was a decrease in high risk TIA referrals being seen within 24 hours. This affected 5 patients who were seen between 45 minutes and 6 hours over the target time.
- Escalation bed capacity increased in April. Ward moves of patients moved more than twice remains at a low level.
- There were 8 breaches affecting 46 patients in mixed sex accommodation mainly on AMU (44) and the remainder were 2 patients ready to be transferred out of Radnor who waited more than 12 hours. The Director of Nursing and Chief Operating Officer are undertaking daily reviews on AMU.
- Real time feedback was as expected. The Friends and Family test response rate for inpatients was at target but the ED response rate fell below target and the Maternity Services response rate remains well below target. Day cases and outpatient response rates remain variable. Overall, there was a 36.3% response rate for the staff FFT in 14/15 with over 90% of staff recommending the hospital as a place 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 2015

Supporting Information

Salisbury NHS
NHS Foundation Trust

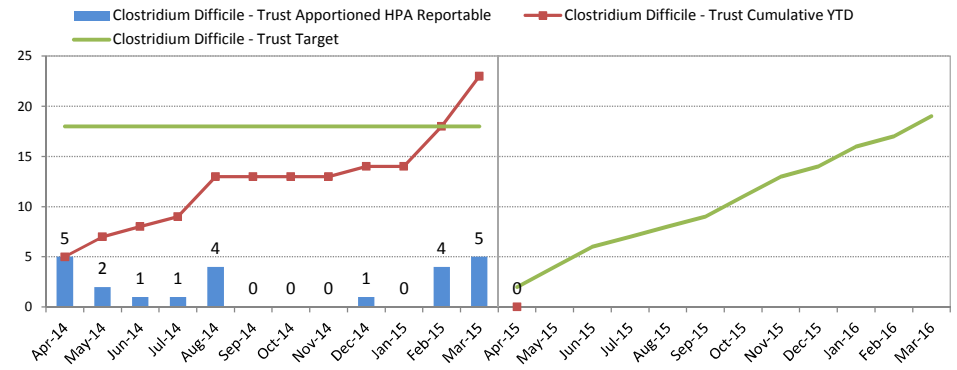
Trust Quality Indicators - April 2015

Quality Measures

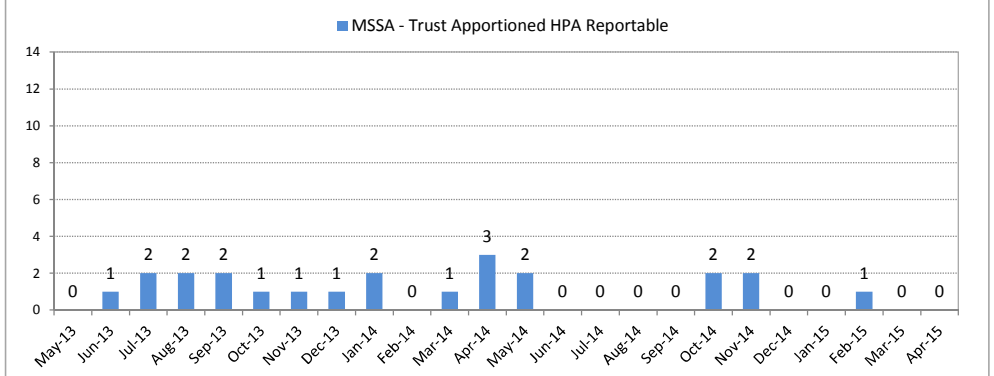
Infection Control	2014-15 YTD	2015-16 YTD
MRSA (Trust Apportioned)	1 (+1)	0

Trust Incidents	2014-15 YTD	2015-16 YTD
Never Events	2	0
Serious Incidents Requiring Investigation	30	5

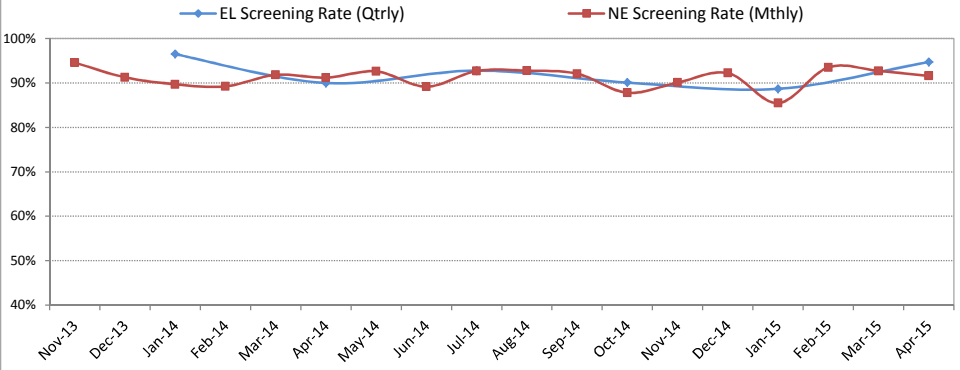
Clostridium Difficile - Trust Apportioned



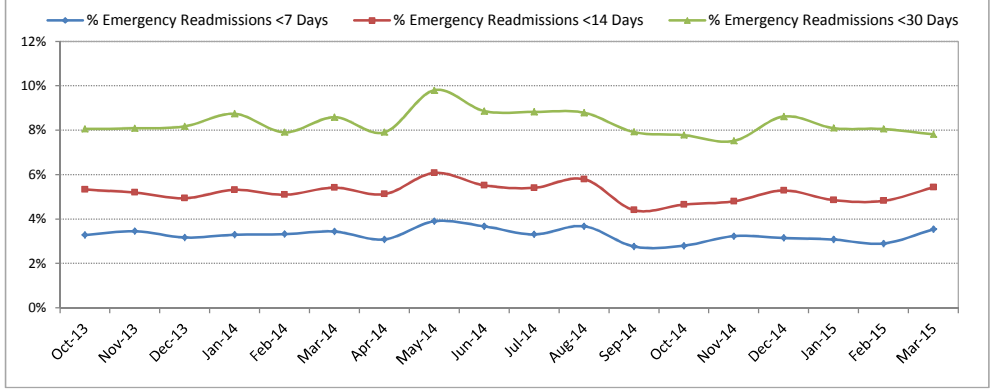
MSSA - Trust Apportioned



MRSA Screening



Emergency Readmissions within 7, 14 & 30 days of Discharge

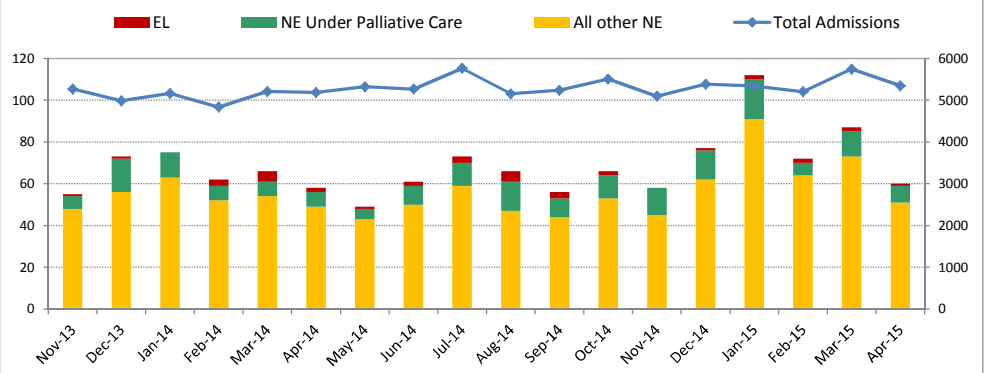


Salisbury NHS
NHS Foundation Trust

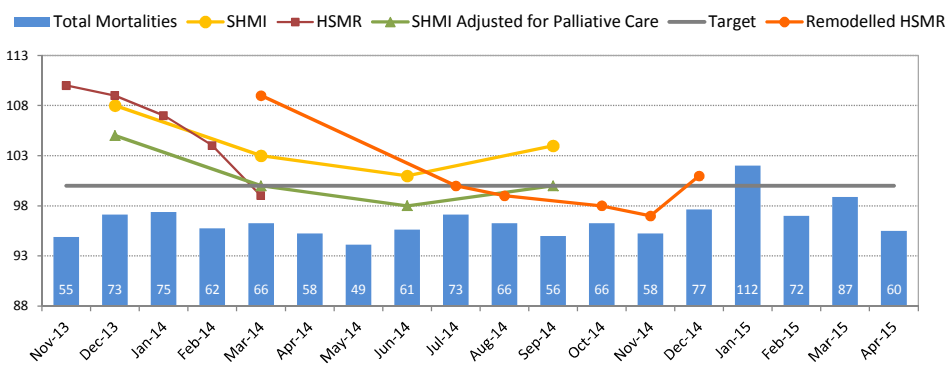
Trust Quality Indicators - April 2015

Quality Measures

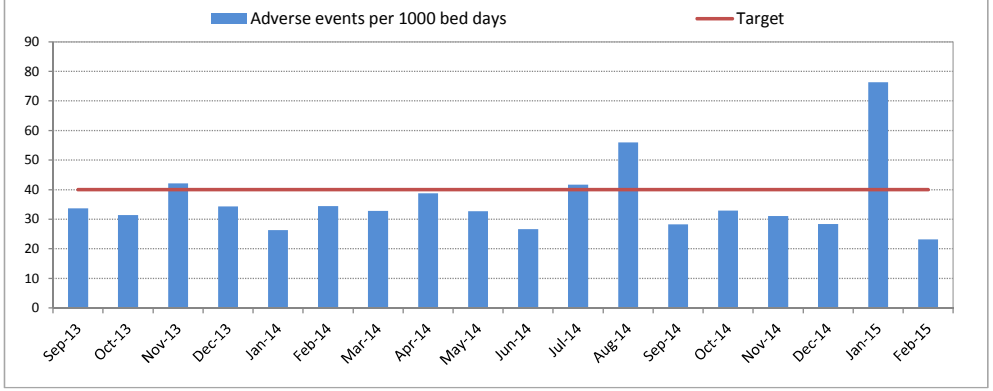
Hospital Mortalities



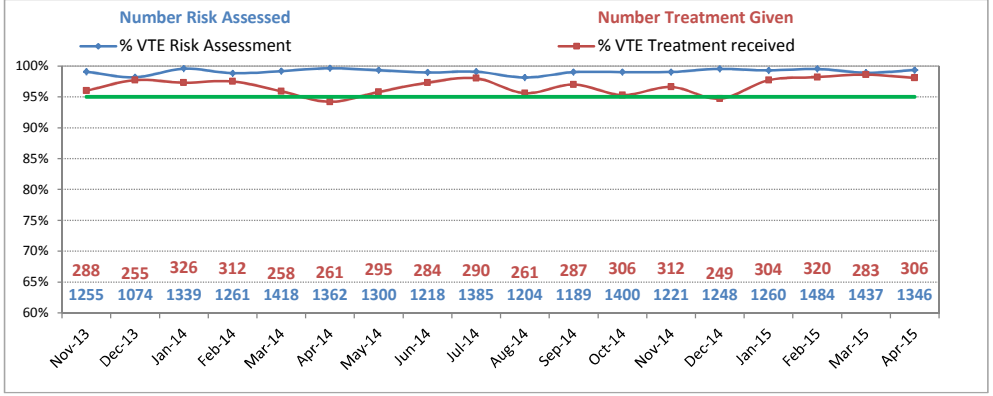
HSMR and SHMI



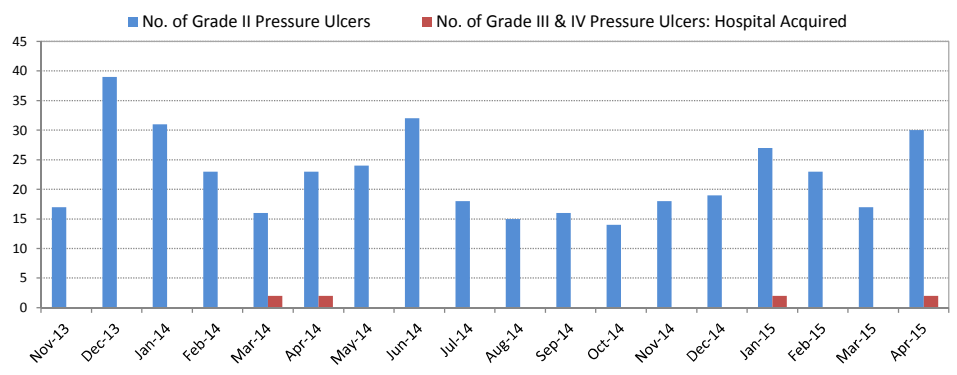
Global Trigger Tool



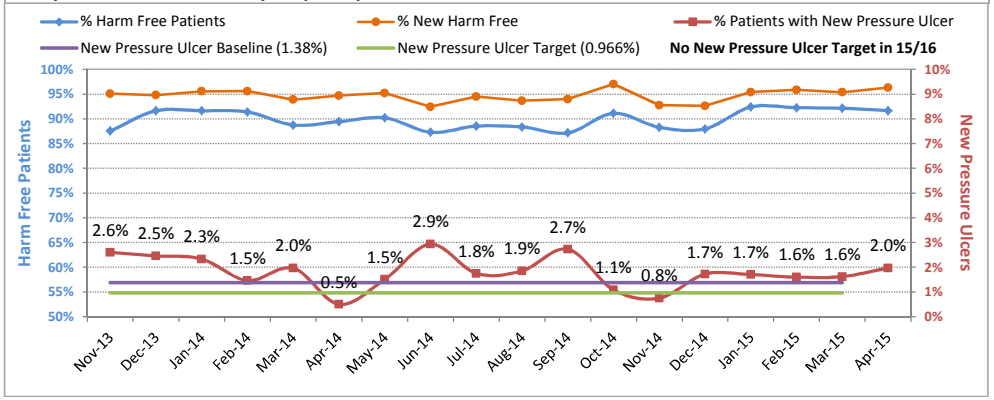
Venous Thrombous Embolism: Risk Assessment & Prophylaxis



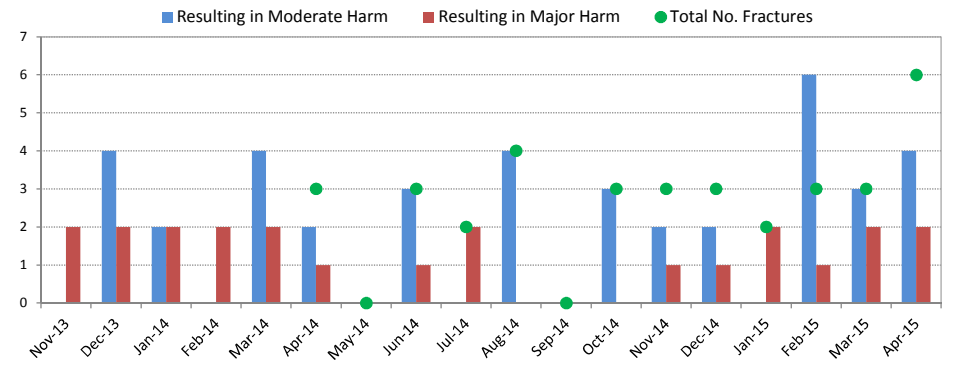
Pressure Ulcers - Total Number per Month



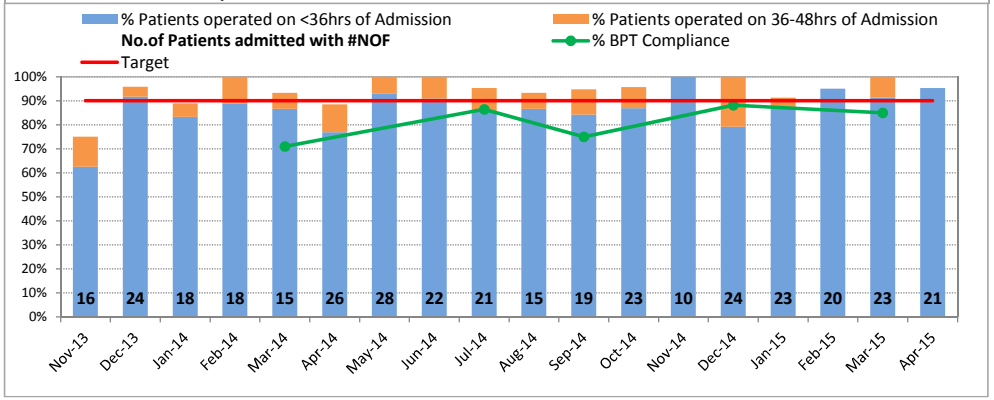
Safety Thermometer - One Day Snapshot per Month



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



Fracture Neck of Femur operated on within 36 hours

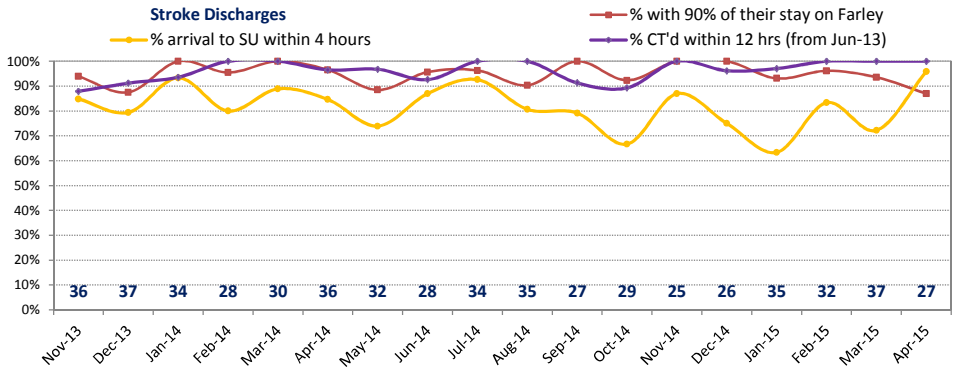


Salisbury NHS
NHS Foundation Trust

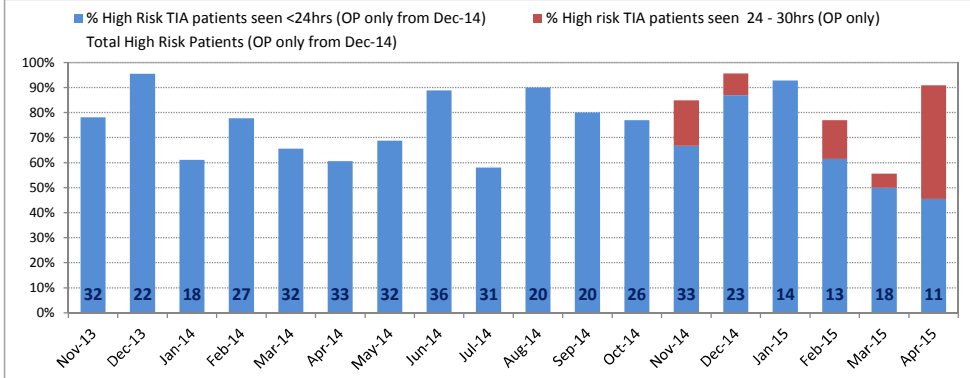
Trust Quality Indicators - April 2015

Quality Measures

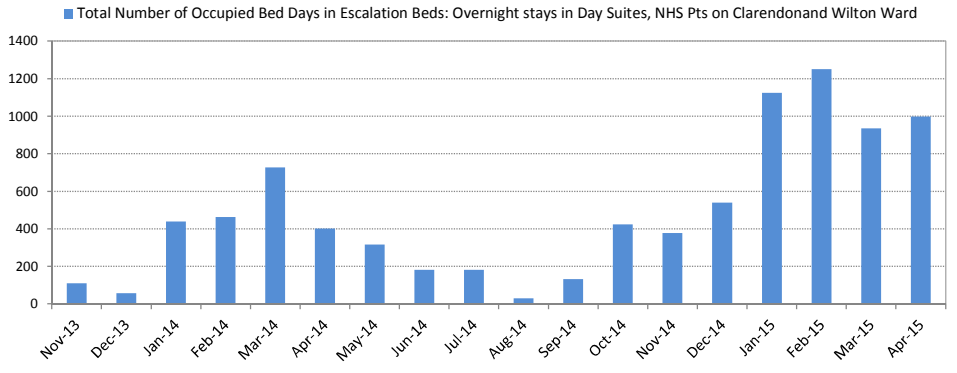
Stroke Care



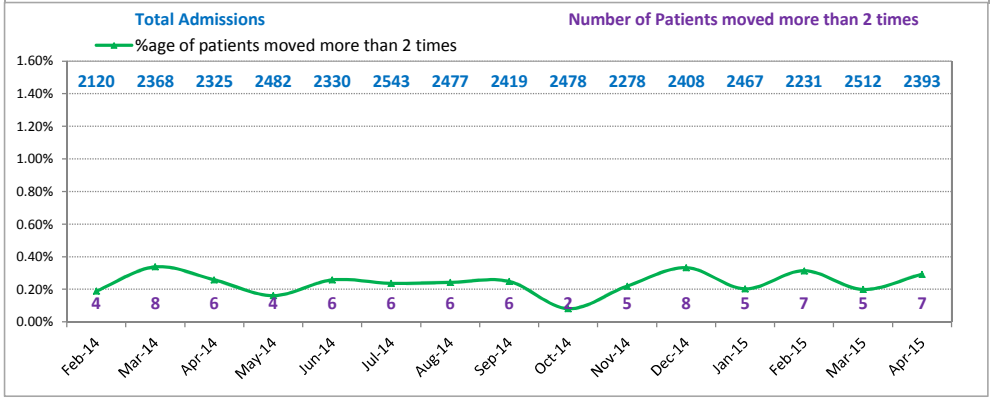
TIA Referrals



Escalation Bed Days

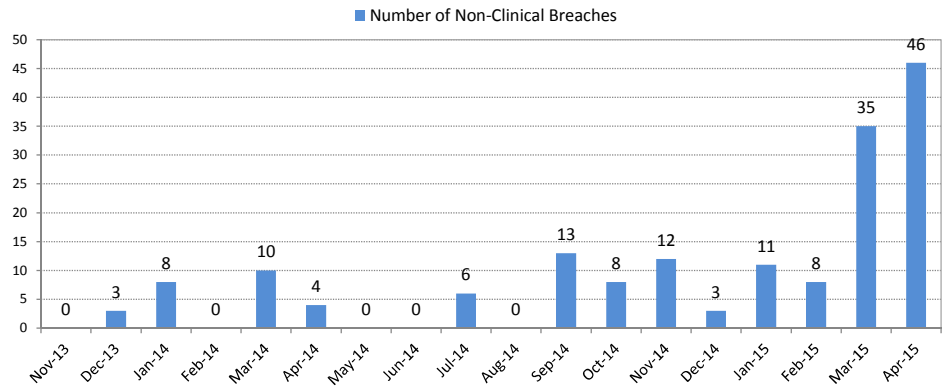


Patients moving multiple times during their Inpatient Stay

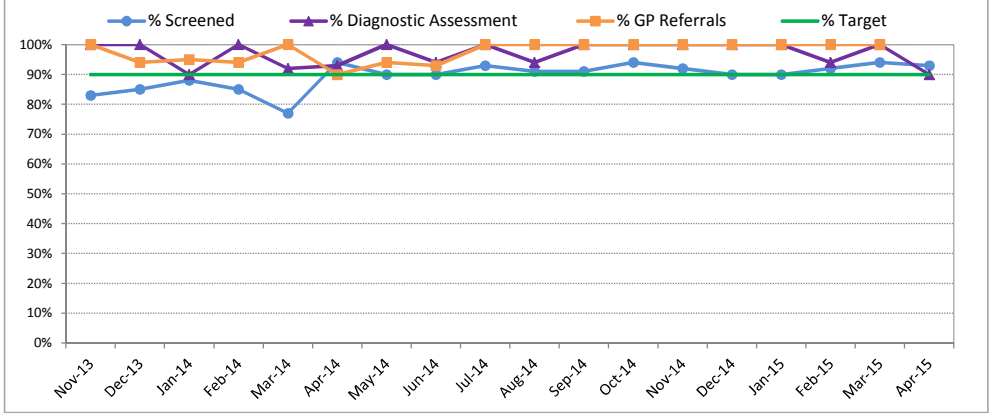


Please note, from Sep-14 escalation bed capactity is Winterslow 8 beds, Wilton 12 beds and DSU if it stays open at night. Breamore ward opened from 1st January 2015 with a further 27 escalation beds. From 1st April 2015 Wilton closed for escalation beds.

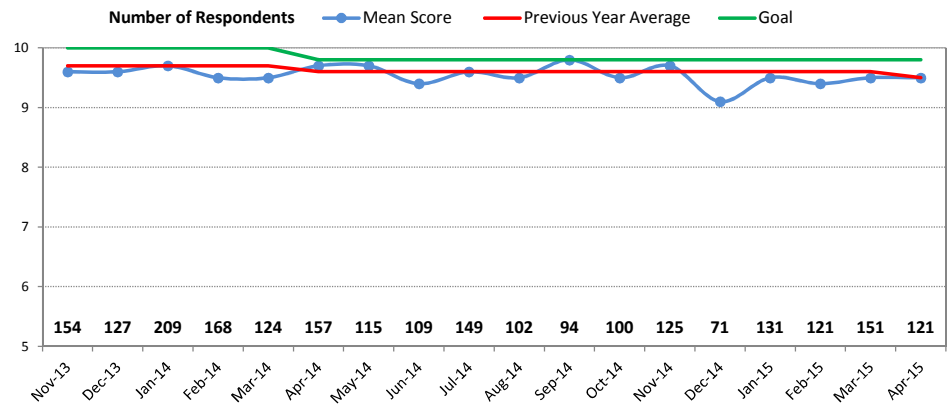
Delivering Same Sex Accommodation



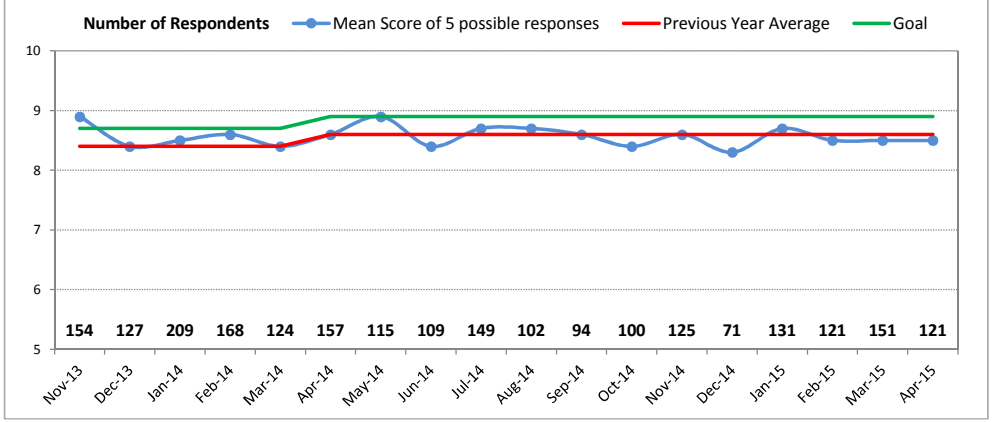
Dementia Audit of Patients Aged 75+



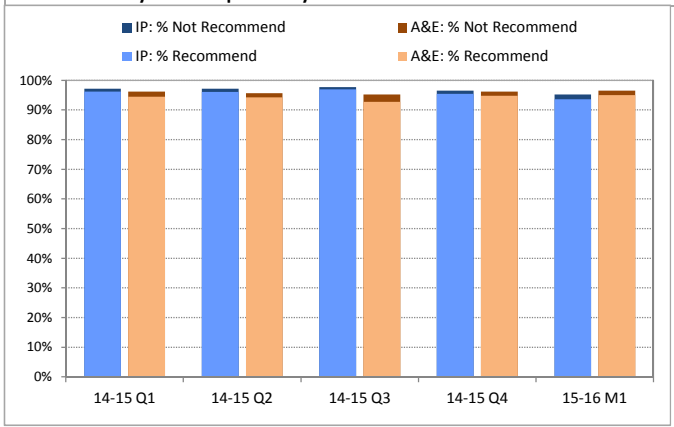
Real Time Feedback: Are you being treated with care and compassion?

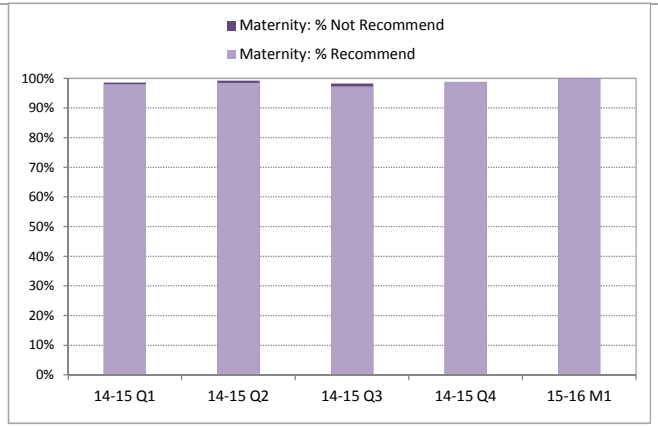


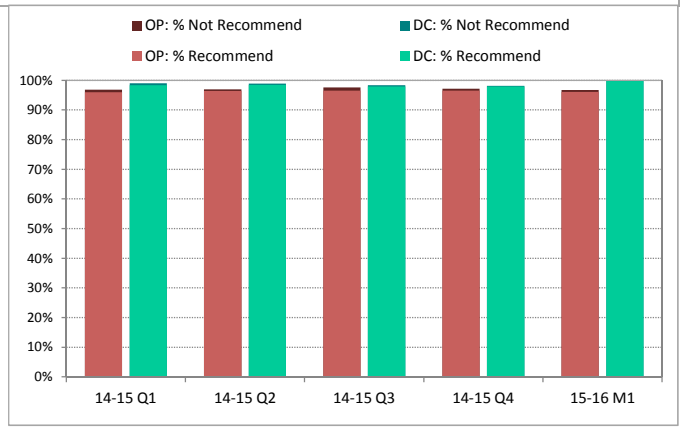
Real Time Feedback: Overall how would you rate the quality of care you received?



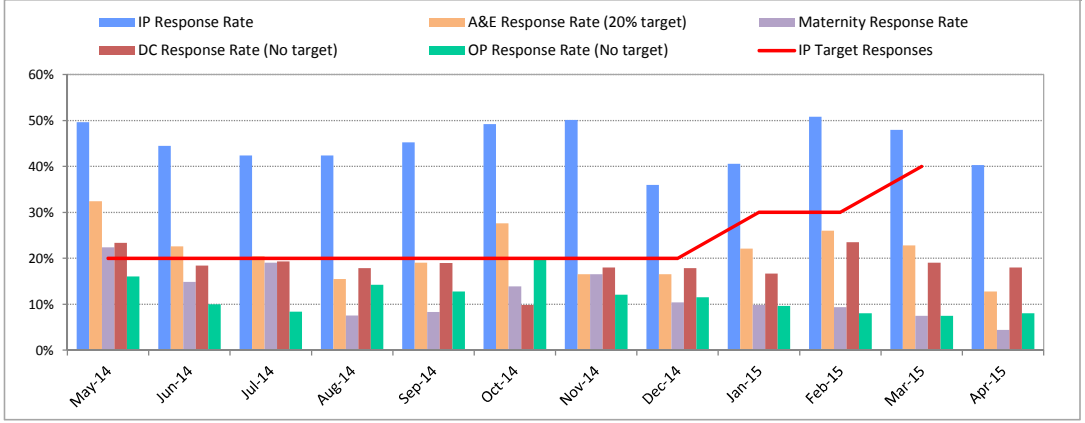
Friends & Family Test: Responses by Area



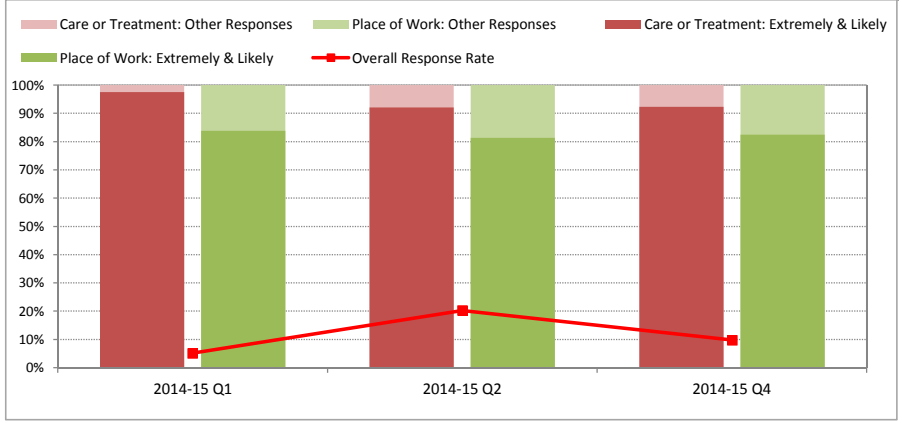




Friends & Family Test: Response Rates (%) by Area



Friends & Family Test: Staff (% Responses)



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

CUSTOMER CARE REPORT - Quarter 4 (1st January – 31st March 2015)

Date:

Report from: Hazel Hardyman, Head of Customer Care
Presented by: Lorna Wilkinson, Director of Nursing

Executive Summary:
The main issues from complaints are:

- Clinical treatment (31) - sub-themes were 10 unsatisfactory treatment across 10 different specialties, 8 delays in receiving treatment which has increased this quarter by 2, 6 correct diagnosis not made, 2 further complications, 2 inappropriate treatment, 1 treatment unavailable, 1 ward moves and 1 pain management. Obstetrics and Gynaecology received the highest number of complaints (4) about clinical treatment but there were no themes.
- Staff attitude (12) – 9 related to medical staff, 2 nursing staff and 1 therapist across 11 different areas. There were 10 complaints for the same period last year.
- Appointments (11) – sub-themes were 5 appointment date required (across 5 different specialties), 4 appointment system delays, 1 cancelled and 1 appointment procedures.

74 complaints were received in quarter 4. This compares to 76 complaints in quarter 3 (2014-15) and 75 complaints for the same period in the previous year.

Proposed Action:
To note the report.

Links to Assurance Framework/ Strategic Plan:
Improving Patient Experience
Patient Feedback – acting on complaints and compliments

Appendices:
None

Supporting Information
None

Customer Care Report - Quarter 4
1st January – 31st March 2015

PURPOSE OF PAPER:

- The purpose of the paper is to update the Board with an analysis of the Quarter 4 patient experience data.

1. COMPLAINTS

The main issues from complaints are:

- Clinical treatment (31) - sub-themes were 10 unsatisfactory treatment across 10 different specialties, 8 delays in receiving treatment which has increased this quarter by 2, 6 correct diagnosis not made, 2 further complications, 2 inappropriate treatment, 1 treatment unavailable, 1 ward moves and 1 pain management. Obstetrics and Gynaecology received the highest number of complaints (4) about clinical treatment but there were no themes.
- Staff attitude (12) – 9 related to medical staff, 2 nursing staff and 1 therapist across 11 different areas. There were 10 complaints for the same period last year.
- Appointments (11) – sub-themes were 5 appointment date required (across 5 different specialties), 4 appointment system delays, 1 cancelled and 1 appointment procedures.

Complaints numbers remain static. 74 complaints were received in quarter 4. This compares to 76 complaints in quarter 3 (2014-15) and 75 complaints for the same period in the previous year. A breakdown of numbers and themes according to Datix is below:

	CE	Clin Supp & Family Services	Medicine	Musculo-Skeletal	Surgery	Q4 total 2014 -15	Q4 total 2013 -14
Admission	0	0	1	1	2	4	1
Appointments	0	1	2	5	3	11	12
Attitude of staff	0	2	4	5	1	12	9
Call bells	0	0	1	0	0	1	0
Capacity issues	0	0	1	0	0	1	0
Clinical Treatment	0	9	10	5	7	31	26
Communication	0	1	2	3	0	6	7
Confidentiality	1	1	0	0	0	2	0
Delay	0	0	0	1	0	1	1
Dementia	0	0	0	0	0	0	1
Discharge arrangements	0	0	1	0	0	1	4
Facilities on site	0	0	0	0	0	0	2
Falls	0	0	0	0	0	0	1
Food	0	0	0	0	0	0	1
Hospital procedures	0	0	0	0	0	0	1
Infection control	0	0	0	0	0	0	1
Information	0	0	0	0	0	0	1
Invoicing	0	0	0	0	0	0	1
Nursing Care	0	0	1	1	0	2	0
Operation	0	0	1	0	0	1	2
Privacy and dignity	0	0	0	1	0	1	1
Waiting time	0	0	0	0	0	0	3
Totals:	1	14	24	22	13	**74**	**75**
Patient Activity		9645	26283	19268	16648		

In Quarter 4, the Trust treated 16,312 people as inpatients, day cases and regular day attendees. Another 10,086 were seen in the Emergency Department and 45,446 as outpatients. 74 complaints were received overall which is 0.1% of the number of patients treated, this percentage has remained unchanged. 710 compliments were received across the Trust in Q4, which represents 1.0% of the number of patients

treated. Those sent directly to the Chief Executive or Customer Care Department were acknowledged and shared with the staff/teams named.

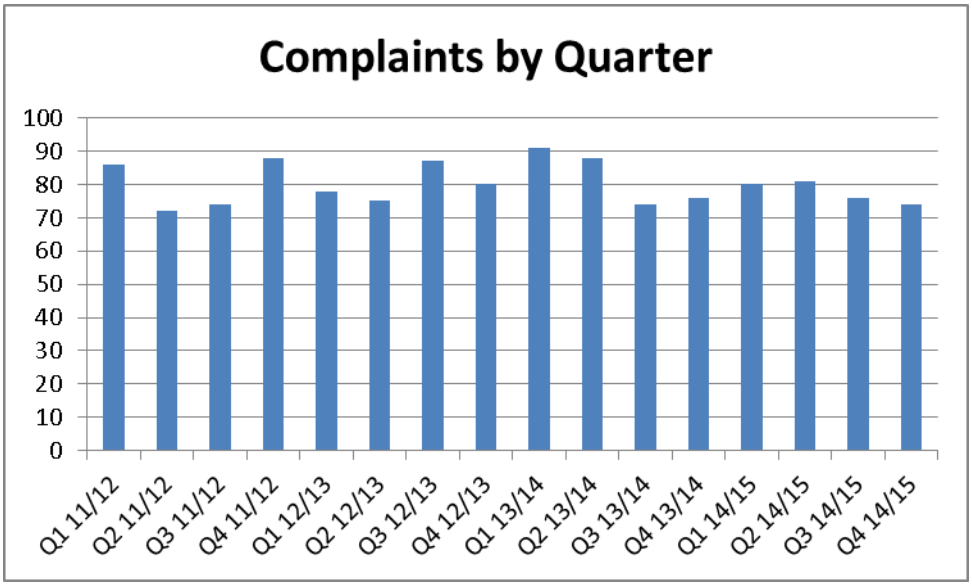
100% of complaints were acknowledged within three working days. 11 complaints were re-opened in Q4 compared to 14 in Q3. The overall number of enquiries, comments, concerns and complaints response times:

0-10 working days		11-25 working days		25+ working days	
433	76%	84	15%	49	9%

Reasons for some complaints taking more than 25 working days to respond to include: arranging meetings; local review; and awaiting comments from key members of staff. Directorate performance on response timescales is being managed by the Chief Operating Officer. The 25+ working day response timescale has improved in Q4 (9%) compared to Q3 (14.03%).

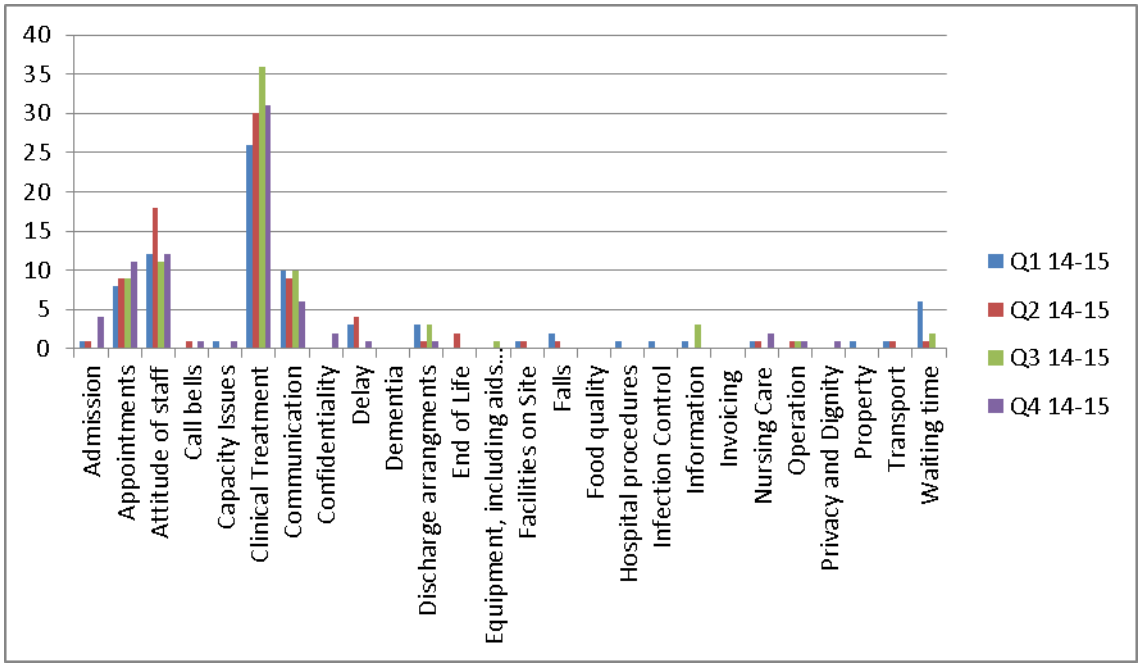
COMPLAINTS BY QUARTER

The following graph shows the trend in complaints received by quarter.



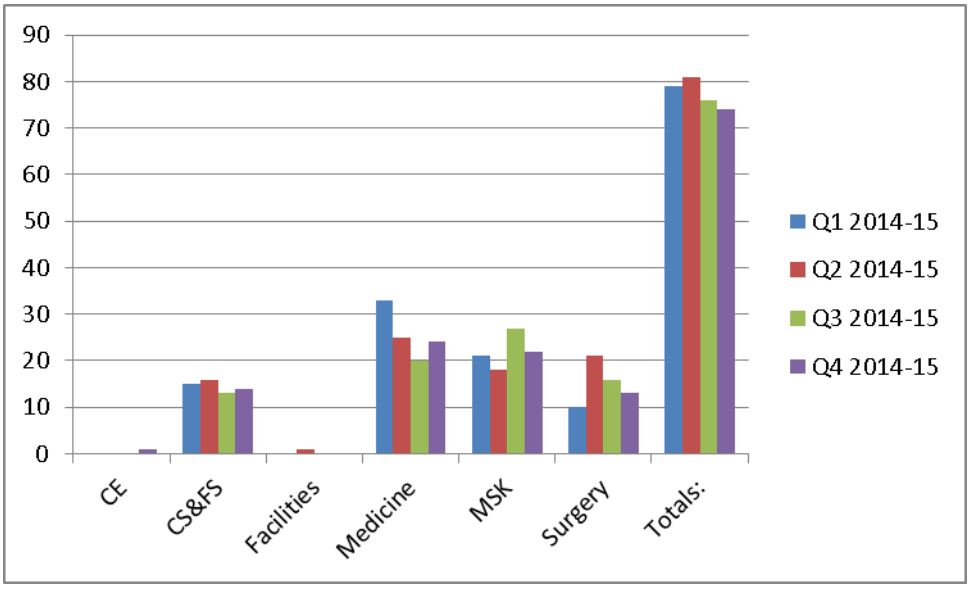
COMPLAINTS BY SUBJECT

The following graph shows the trend in complaints by subject over the last four quarters. Complaints about admission (4) have increased since Q3 (0). Three were cancelled/postponed/delayed and one there was no bed available. Clinical treatment (31) has decreased by 5 from Q3 and communication (6) has decreased by 4 from Q3.



COMPLAINTS BY DIRECTORATE

The following graph shows the number of complaints by directorate over the last four quarters.



CLINICAL SUPPORT AND FAMILY SERVICES

	Quarter 4 2013-14	Quarter 3 2014-15	Quarter 4 2014-15
Complaints	7	13	14
Concerns	13	7	17
Compliments	16	50	284
Re-opened complaints	0	1	1
% complaints responded to within 25 working days	42.5%	69%	71%

- Improving response timeliness.
- One complaint has been re-opened due to a dispute over an unpaid invoice.
- Radiology received 2 complaints regarding pain during procedure and staff attitude and 7 concerns were received, 2 appointments, 2 attitude of administrative staff, communication, equality and

diversity, and privacy and dignity. Meeting held with DSN and Radiology senior management team to review the complaints and concerns and actions agreed as set out below.

- Customer Care are beginning to receive concerns regarding on the day delays in GP walk-in service, established January 2015. This has been well received by patients and GPs. Patients can have an x-ray on the day. Unfortunately some concerns have arisen from this service as there is sometimes a wait if several patients arrive at one time. Area does not have a receptionist and again this has caused problems particularly if patients are not registered at the hospital. Patients do not have a letter and so cannot use self-check-in. A service evaluation is planned.

Themes and actions

Department/Ward	Topic	Actions
Radiology	Administrative delays	Administration processes streamlined. Dedicated person to take phone calls and resolve queries in a timely manner.
	Delays in receiving appointment	Electronic system replaced paper system resulting in more transparency and an easy to track patient journey and appointment facility.
	Attitude of reception staff and waits to check in at reception.	Self-check-in which has improved the wait to check in and is well used. Positive feedback from patients. Improved 'can I help attitude?' by staff.
	Perceived attitude of staff	Staff attitude addressed through appraisal and performance management process.
	GP Spinal X-ray on the day delays	Service evaluation will be undertaken to address this issue.

Compliments
In total 284 compliments have been received across the Directorate with the breakdown as: Maternity = 210, Child Health = 36, NICU = 17, Endoscopy = 10, Radiology = 6, Speech Therapy = 3, Orthotics = 1 an Sexual Health = 1

MEDICINE DIRECTORATE

	Quarter 4 2014	Quarter 3 2014/15	Quarter 4 2015
Complaints	28	20	24
Concerns	25	28	35
Compliments	25	136	168
Re-opened complaints	4	5	3
% complaints responded to within 25 working days	60%	60%	50%

- Complaints have increased in Quarter 4 and Directorate activity has remained high.
- Three complaints have been re-opened due to further questions being asked and not being happy with the response.
- The Directorate continue to try and address potential complaints at source to prevent it becoming a formal complaint with the assistance of the Customer Care Advisor.

- The Customer Care Advisor continues to take an active role with the Directorate, attending regular walkrounds and monthly DMT meetings to discuss ongoing complaints. New Directorate Administrator developing a system to track and manage complaints and will work with the newly appointed Assistant Directorate Manager on this project in order to improve timeliness.
- Meetings are offered to complainants initially.

Themes and actions

Department/Ward	Topic	Actions
Emergency Department	Attitude of reception staff Missed or delayed diagnosis	Customer Care training for admin staff in the Emergency Department is ongoing Continue to look at systems for reducing risks of missed diagnosis and learning from incidents shared.

Compliments
In total 168 compliments have been received across the Directorate with the breakdown as: Pembroke = 46, Emergency Department = 34, Hospice = 21, Durrington = 20, Winterslow = 18, Farley = 14, Whiteparish = 6, Redlynch = 4, Pitton = 2, Tisbury = 2, Breamore = 1.

MUSCULOSKELETAL DIRECTORATE

	Quarter 4 2013-14	Quarter 3 2014-15	Quarter 4 2014-15
Complaints	18	27	22
Concerns	22	16	33
Compliments	3	78	138
Re-opened complaints	3	3	6
% Complaints responded to within 25 working days	33%	46.5%	63.5%

- Improved timeliness of responses.
- Six complaints have been re-opened due to inaccuracies in the response, further questions, unhappy with the response and further questions from another relative following the response.
- Orthopaedics continues with the highest numbers, receiving 5 complaints and 18 concerns. Of these, 1 complaint and 6 concerns related to appointments.
- Dermatology received 2 concerns and 1 complaint regarding the attitude of staff.
- Amesbury Ward had no complaints and three concerns, which was down from 5 complaints and 1 concern in Q3.
- Plastic Surgery received 4 complaints in Q4 with 2 regarding poor communication.
- The Directorate are meeting with patients and carers where possible and attempting to resolve issues whilst patients are in attendance.

General actions
- Risk of delays and cancellations remains on the Directorate Risk Register – consultant appointments and outpatient transformation work linked to these actions.
- The DMT has been tasked with looking at ways in which to reduce the number of complaints overall, detail to be shared in next report.

Themes and actions

Department/Ward	Topic	Actions
Dermatology	Staff attitude	Addressed with the individual member of staff.
Spinal	Concerns regarding nursing care and pressure sore	Local review meeting has taken place and action regarding a named Plastic consultant for SIU has

	management.	already been put in place.
Orthopaedics	Waiting times/delays	Remains on Directorate Risk Register. Currently only one consultant who can provide certain operations. Appointments always expedited where possible with discussion and apology to patient.

Compliments
In total 138 compliments have been received across the Directorate with the breakdown as: Amesbury = 30, Laverstock = 23, Dermatology = 16, Tamar = 15, Chilmark = 15, Burns Unit = 11, Wessex Rehab = 8, Plastics = 8, Avon = 7, Orthopaedics = 3 and Rheumatology = 2.

SURGICAL DIRECTORATE

	Quarter 4 2014	Quarter 3 2014/15	Quarter 4 2015
Complaints	21	15	13
Concerns	19	22	22
Compliments	40	152	111
Re-opened complaints	3	5	1
% complaints responded to within 25 working days	70%	40%	92%

- Improved timeliness of responses.
- One complaint was re-opened.
- Three complaints were received for Ophthalmology and five concerns. The issues span consultant attitude, bookings and processes in clinic.
- There were three complaints for ENT, two regarding appointment bookings and one regarding attitude of consultant.
- Three issues were received regarding cancellations of theatre appointments, these were for separate departments with unrelated causes.
- 8 concerns were received regarding appointment bookings and letters of appointment across ENT and Ophthalmology.

Themes and actions

Department/ward	Theme	Action
Ophthalmology	Capacity issues, resulting in long waits.	Secondment of senior manager to the department for 4 weeks to review patient flow and pathways.
Central Booking	Cancellations and appointment booking issues. Some related to capacity and non availability of medical staff (particularly ophthalmology) leading to short notice cancellations.	Outpatient admin consultation paper written to design single trustwide process. Recruitment of substantive posts continues to be an issue.

Compliments
In total 111 compliments have been received across the Directorate with the breakdown as: Britford = 39, Downton = 20, Radnor = 18, Bowel Screening = 17, DSU = 6, General Surgery =4, ENT = 3, SAL = 2, Audiology = 1 and Theatres = 1.

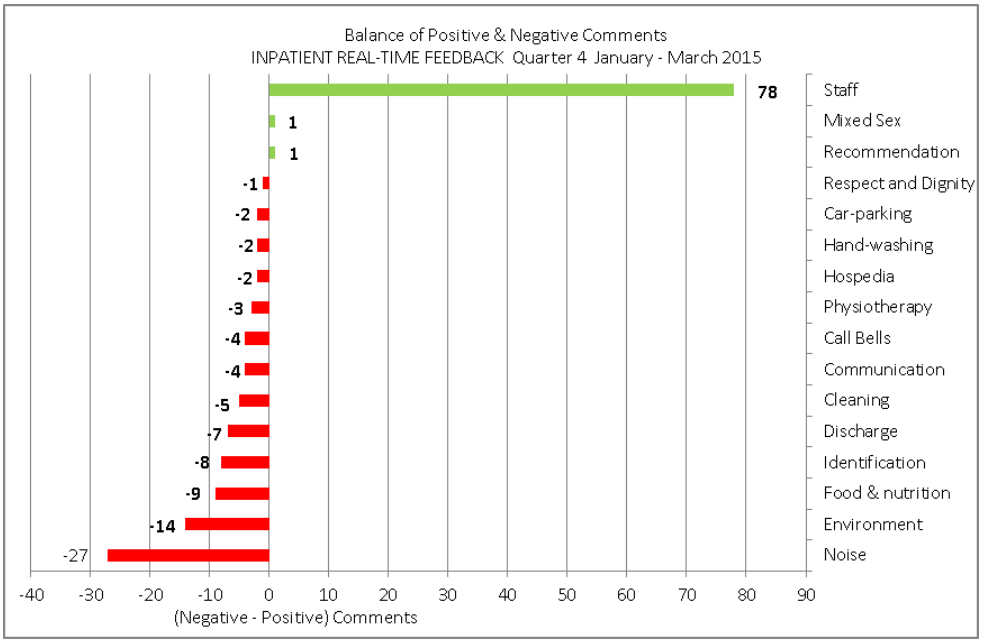
2. TRUSTWIDE FEEDBACK – INCLUDING REAL TIME FEEDBACK AND THE FRIENDS AND FAMILY TEST

The top negative themes from inpatient real time feedback, the Friends and Family Test and complaints are:

Feedback area	Theme	Actions
Complaints	Clinical treatment Staff attitude Appointments	• The two highest areas were Obstetrics and Gynaecology (4) and ED (3) with no particular theme. • No themes across a number of areas. • A review of paediatric occupational therapy waiting lists was undertaken. • DSU to ensure clinical requests/bookings/appointments are marked correctly across the surgical specialties e.g. urgent.
Inpatient RTF	Noise Environment Food and nutrition	• Work has been undertaken to reduce delivery lorries out of hours to help reduce noise levels. • Some bathrooms have been refurbished and wet rooms are suitable for wheelchair users. • A sub-group of the Food and Nutrition Group looked at the comments from April 2014 to March 2015 and further questions have been developed to gain more detailed feedback from April 2015.
FFT Maternity Emergency Department Inpatients	 Communication and waiting times Staff attitude and communication	• No adverse comments received for this area in Q4. • Actions taken as a result of negative feedback are not currently recorded.

INPATIENT REAL TIME FEEDBACK

A total of 403 inpatients were surveyed in the quarter. They made 184 positive and 157 negative comments. These have been categorised and the balance of positive to negative comments is shown in the graph below. The three main areas of concern were noise, environment (toilets and bathrooms; lack of weekend activities; bedding; lighting; temperature; bins; lack of pictures; lack of single room) and food and nutrition. All the survey results are reported back to the nurse in charge at the time and formally to the ward leader for action.



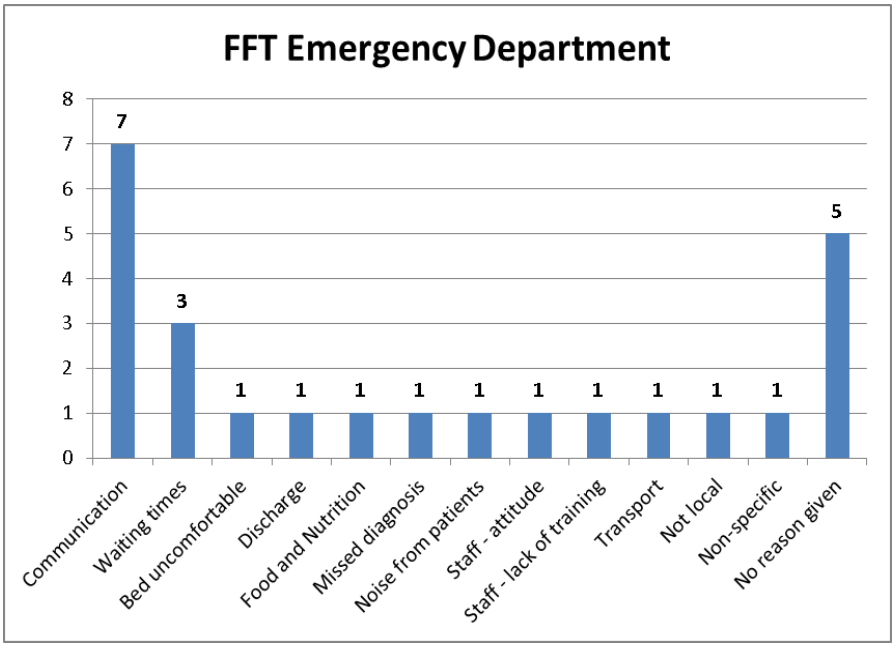
FRIENDS AND FAMILY TEST

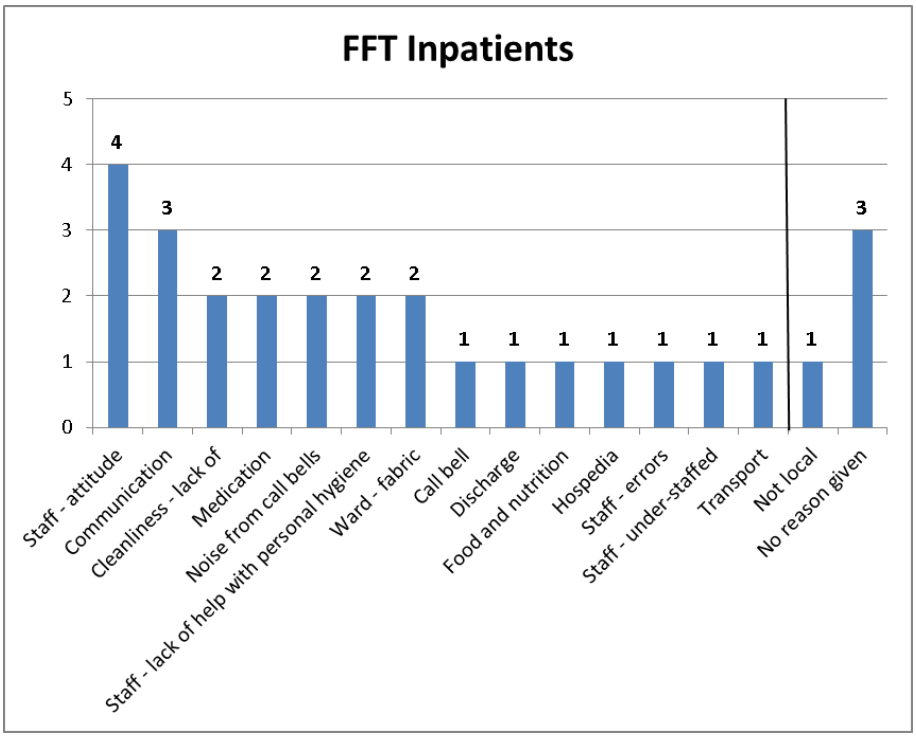
Responses for the period were as follows:

		Rating					
	Total Responses Received	**Extremely Likely**	**Likely**	**Unlikely**	**Extremely Unlikely**	***Rec**	***Not Rec**
Inpatients	1601	1243	285	11	6	95%	1%
Emergency Department	1512	1193	241	8	13	95%	1%
Maternity	179	163	14	0	0	99%	0%

* Shortfall from 100% = patient unsure.

Comments made by those patients who stated they would be unlikely or extremely unlikely to recommend the hospital have been categorised as set out in the graphs below. No adverse comments were received for Maternity during the reporting period.





3. PATIENT AND PUBLIC INVOLVEMENT

In Q4 there were five new project requests to the Patient and Public Involvement Group:

- Maternity – To improve the way in which Newborn examinations are carried out, ensuring that both parents have the opportunity to be present during the check. Awaiting approval.
- Upper Gastro-Intestinal Cancer Service – To gain a better understanding of the experiences of people using the Upper Gastro-Intestinal Cancer Service and how they feel at different stages of their care. This will help to improve the care given and the service offered in the future. Approved.
- Medical Photography – To gain an understanding of any improvements that can be made to the current service. Awaiting approval.
- Sexual Health – To establish what service users require in terms of clinic provision, location, opening times and access. Approved.
- Speech and Language Therapy – To establish whether patients with cleft palate treated by a single surgeon report any change in speech following orthognathic surgery. Approved.

4. PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

In Q4 there was one request for independent review. This case had originally been opened by the PHSO in November 2014. In February 2015, the PHSO asked the Trust to respond to the complainant's further concerns, which it did. In March 2015 the PHSO had a further request from the complainant to undertake an independent review.

Two cases were closed in Q4: Endoscopy concern not upheld. A Medicine complaint was partly upheld by the PHSO. The concerns raised were about clinical care and treatment. The PHSO found that much of the care provided was appropriate, however failings in some aspects of care provided were identified including: poor record keeping; earlier investigations and interventions.

Despite the identified failings the PHSO could not conclude that the patient outcome was a consequence of the identified failings in care. In terms of complaints handling the PHSO concluded positively on the Trust's processes. The responses were open and accountable and the Trust acted fairly. The PHSO stated "I have seen much to commend in their approach".

The Trust has provided the complainant with an open and honest acknowledgement of the failings identified in the PHSO report and an apology for the impact of these failings. The Trust also sent an action plan of the lessons learnt and details of what the Trust plans to do to avoid a recurrence of these failings and will keep the complainant updated.

The PHSO publish anonymous summaries of selected cases they investigate and include them on their website at http://www.ombudsman.org.uk/make-a-complaint/case-summaries. The names of the organisations will be published.

5. NHS CHOICES WEBSITE

In Q4 there were 16 comments posted on the NHS Choices website relating to 12 different areas. Of the 11 positive comments, one person said of Respiratory Medicine "A thank you isn't enough; I'm from up north and was very surprised at the efficiency, friendliness and warmth from such a busy yet well run hospital. Take a bow guys and galls you each deserve a medal as big as a dustbin lid". Of the 5 negative comments, one person said of Orthopaedics "I am not happy that valuable NHS money is being wasted by doing pre-ops when there is no actual date and the fact that the operation is going to be more than 3 months from the pre-op, means I will have to have another pre-op". All the feedback was shared with the departments.

AUTHOR: Hazel Hardyman
TITLE: Head of Customer Care
DATE: May 2015

Trust Board meeting **SFT 3662**

Director of Infection Prevention and Control (DIPC) – Annual Report 2014/15

Date: 8th June 2015

Report from: Fiona McCarthy – Lead Nurse Infection Prevention and Control

Presented by: Lorna Wilkinson – Director of Nursing and DIPC

Executive Summary:

The Director of Infection Prevention and Control (DIPC) Annual Report, together with the monthly Key Quality Indicator (KQI) Report, are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively and that the Trust remains registered with the Care Quality Commission (CQC), without conditions.

The purpose of this DIPC Report is to inform the Trust Board of the progress made against the 2014/15 Annual Action Plan to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

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 and Mandatory Surveillance
During quarters 1 and 2 of 2014/15, there were 2 separate outbreaks of Clostridium difficile identified within the medical directorate (2 patients and 3 patients respectively). During quarters 3 and 4 of 2014/15, the Trust experienced a period of increased incidence of Clostridium difficile during February and March 2015. There are no outbreaks of other organisms to report.

- **Clostridium difficile** – The Trust did exceed the challenging target set for 2014/15 of no more than 18 Trust apportioned reportable cases in reporting 23. 2 of these are currently subject to the appeals process and the Trust is awaiting the outcome of this review.
- **MRSA –** There have been 2 MRSA bacteraemia cases identified during 2014/15 and following investigations it was concluded that the cases were not linked with any other cases, and one was classed as a contaminant as opposed to a clinical bacteraemia.
- **MSSA –** during 2014/15, a total of 10 Trust apportioned cases were identified. From the incident investigations undertaken for each case, the presence of an indwelling device could be identified as a potential contributory factor for 3 of the cases, which were unrelated and could not be linked to any other cases. This is a reduction of 3 on the 13 cases reported in 2013/14

- **Influenza –** During quarter 4 (2014/15), there was an increase in the number of patients admitted to the Trust with 'flu-like' symptoms, or who later developed symptoms during their admission. The Trust responded well to this challenge with rapid triage and assessment, isolation where indicated and at source, and the provision of an evening flu swab testing service provided by the laboratory during this time. Additional guidance was produced by both the Consultant AMU Physician and Consultant Respiratory Physician (Influenza Lead), incorporating up to date PHE guidance issued in January 2015.
- **Carbapenemase producing enterobacteriaceae (CPE)** – Following the increase in the number of cases of CPE infection identified at other regional hospitals, advice continues to be provided by the ICNs in relation to the safe transfer of patients to the Trust from other countries or UK hospitals with a known higher prevalence of CPE. During quarter 4 (2014/15), there was a full and appropriate response to a possible case which turned out to be negative on testing by the reference laboratory.

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

Proposed Action:

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.

Links to Assurance Framework/ Strategic Plan:

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

BAF – 2.1

Appendices:

Supporting Information

Salisbury NHS
NHS Foundation Trust

Director of Infection Prevention & Control (DIPC)

Annual Report for 2014/15

Lorna Wilkinson
DIPC

May 2015
Version 3

Contents

Appendices

1. Introduction

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

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

The purpose of the DIPC Report is to inform the Trust Board of the progress made against the 2014/15 Annual Action Plan (Appendix 1), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The Action Plan focuses on 'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (December 2010), which identifies criteria to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible. This document includes references to other national strategy initiatives in infection control including –

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

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

2. Overview and Action Plan

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

3. Description of Infection Control Arrangements

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

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

4. DIPC Reports to the Board

The IPCC monitors the action plan on behalf of the Trust Board, which is achieved through the following actions:

- Agree an annual infection control programme and monitor its implementation.
- Oversee the implementation of infection control policies and procedures.
- Monitor and review the incidence of HCAI.
- Develop and review information regarding infection prevention and control.
- Monitor the activities of the IP&CT.
- Monitor the Trust's delivery of control of infection standards in various accreditation systems, and against CQC Regulations.
- Monitor the implementation of infection prevention and control education.
- Receive regular updates from the Antibiotic Reference Group (ARG).
- Receive regular updates from the IPCWG.
- Monitor compliance and formal reporting on Legionellosis and Pseudomonas water management, via the Water Safety Committee.
- Receive regular reports from the Decontamination Committee.

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

5. Budget Allocation for Infection Control

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

Staff

Nursing	£131K
Administrative	£20K

Support

Non staff	£3K

Training

Training budgets are held centrally in the Trust.

6. HCAI Management and Statistics

6.1 Management

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

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

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

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

During quarters 3 and 4 of 2014/15, the Trust experienced a period of increased incidence of Clostridium difficile during February and March 2015, as detailed below.

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

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

Norovirus
There were no declared outbreaks of Norovirus during 2014/15; however the Trust has experienced a continued level of diarrhoea and vomiting activity. This included patients who were admitted with symptoms of diarrhoea and/or vomiting and isolated in a sideroom from admission, and patients who were nursed in a bay environment and developed symptoms during their admission. The testing of inpatient stool samples identified 3 confirmed cases of Norovirus during quarters 3 and 4 of 2014/15.

Where patients developed symptoms after admission, the appropriate infection control measures were implemented, and environmental cleaning completed. The level of diarrhoea and vomiting activity necessitated the closure of 24 bays in wards across the medical, surgical and musculoskeletal directorates at different times, to ensure the safe management of patients and continued service provision.

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

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

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

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

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

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

- Following the identification of 3 patients with C.difficile (3 Trust apportioned cases, 1 case not reportable to PHE), who had been nursed in the only bay (4 bedded) on Pembroke Ward within the medical directorate, the bay was closed under isolation precautions from 28th May 2014. Immediate actions implemented included enhanced environmental cleaning and additional monitoring and audit of practices by ward staff. An outbreak of C.difficile was declared by the Trust on 3rd June 2014, which was initially reclassified by the CCG as a PII of C.difficile until ribotyping results were known. Ward and patient management was discussed at the Infection Control update meetings and separate review meetings were held with attendance by key personnel. Symptomatic patients were moved to sideroom facilities on the ward and the bay reopened on 5th June 2014 following the completion of deep cleaning and use of the GLOSAIR 400 room decontamination system. Following ribotyping results a formal outbreak was declared retrospectively. A SII was completed by the directorate with the involvement of the IP&CT, and was signed off by the Chief Executive.
- A PII of C.difficile was declared following the identification of 2 patients with C.difficile (2 Trust apportioned reportable cases), who had been nursed in separate areas on Redlynch Ward within the medical directorate. Immediate actions implemented included enhanced environmental cleaning and additional monitoring and audit of practices by ward staff. Ward and patient management was discussed at the Infection Control update meetings and separate review meetings were instigated with directorate representation. From ribotyping samples, results have indicated that these cases could not be linked. However, meetings continued to provide ongoing assurance for the management of patients on both Redlynch and Pitton Wards. A report was written by the directorate during quarter 3 (2014/15) regarding the events on Redlynch Ward, with identified learning outcomes.
- Positive stool samples were sent for ribotyping at the external Reference Laboratory, to establish epidemiological data and aid the Trust in further understanding the presentation of C.difficile. The Consultant Microbiologists facilitated this work, and the outcome of results included within a formal report presented to the CGC during quarter 2 (2014/15).
- A comprehensive action plan to reduce the incidence of C.difficile was implemented following a thorough review of practice in June 2014. This is discussed in detail in section 6.2.3 and is available in Appendix 11.

During quarters 3 and 4 of 2014/15, the Trust experienced a PII of C.difficile during February and March 2015, affecting the medical, musculoskeletal and surgical directorates.

- During February 2015, 4 Trust apportioned reportable C.difficile cases were identified for patients being nursed in separate areas (Farley, Durrington and Avon Wards and Winterslow Suite). Following the identification of these positive results, immediate actions implemented included isolation nursing, enhanced environmental cleaning and additional monitoring and audit of practices by ward staff.
- During March 2015, 5 Trust apportioned reportable C.difficile cases were identified for patients being nursed in separate areas (Britford, Durrington and Tamar Wards and Tisbury CCU). Following the identification of these positive results, immediate actions implemented included isolation nursing, enhanced environmental cleaning and additional monitoring and audit of practices by ward staff.
- Positive stool samples were sent for ribotyping at the external Reference Laboratory, to establish epidemiological data and aid the Trust in further understanding the presentation of C.difficile, and aid accurate reporting of the PII. The ICD led this work, and the full outcome of results is expected during quarter 1 (2015/16) and a formal report will be presented to the IPCC.
- Analysis of themes arising from the incident investigations have identified specific issues for these cases, which related to staff not always following the Trust algorithm for the

management of inpatients with diarrhoea. This included missed opportunities in obtaining samples, incorrect documentation, symptoms not being escalated for clinician review, and not isolating a patient in a sideroom facility when a stool sample was sent.

- As a result, during quarter 4 (2014/15), the ICNs created a Diarrhoea Pathway for the management of diarrhoea for all staff groups to use. This 2 page document supports the Trust algorithm for the management of inpatients with diarrhoea. The aim of the Diarrhoea Pathway is to aid staff with the assessment of patients, and includes several triggers to consider possible non infective causes for symptoms, and prompts for requesting a clinician review with the date and time of request. There is a section for clinicians to record the outcome, and confirmation of the required actions when an infective cause for symptoms is suspected. The document was originally trialled on a medical ward with plans for implementation across the medical directorate initially during quarter 1 (2015/16).

Vancomycin Resistant Enterococcus (VRE)

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

During 2014/15, cases of VRE have been identified from inpatient samples sent as part of routine clinical assessment, for patients nursed across the medical, surgical and musculoskeletal directorates. Cases of VRE have also been identified from samples taken in the community setting. Where inpatient cases were identified, required actions were agreed following discussion with a Consultant Microbiologist. These have included the completion of additional environmental and equipment cleaning, and where indicated screening of identified patient contacts, with the continuation of antibiotic stewardship.

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

Influenza

During quarter 4 (2014/15), there was an increase in the number of patients admitted to the Trust with ‘flu-like’ symptoms, or who later developed symptoms during their admission. The management was discussed as part of the Infection Control Update forum where it was recognised that there had been an increased demand to access sideroom facilities for the source isolation of these patients. The viability of establishing a bay for the cohort nursing of influenza positive patients was considered, and an acute medical ward was identified to be the most appropriate for this purpose. This was agreed with the medical directorate; however there has been no requirement to initiate the cohort bay facility.

Where there has been a high suspicion of influenza, patients have been isolated within sideroom facilities on admission, whereas when the suspicion has been considered to be low, patients have been managed within the bay setting. Following the confirmation of an influenza positive result,

identified patient contacts have been assessed by the clinicians for antiviral prophylaxis, as per PHE guidance issued in January 2015. A dedicated meeting was held during quarter 4 (2014/15), with the involvement of relevant personnel to agree the management of influenza contacts, including prophylaxis antiviral treatment. Additional guidance was produced by both the Consultant AMU Physician and Consultant Respiratory Physician (Influenza Lead), incorporating up to date PHE documents. As a result, there was an increased process of triaging patients admitted to Whiteparish AMU, isolating patients at source and the provision of an evening flu swab testing service provided by the Laboratory during this quarter.

Information was disseminated out to all appropriate emergency department and medical personnel to raise awareness of the increase in incidence in Influenza and advise on the management of suspected cases. Through clinical visits, the ICNs continued to provide support and guidance to staff groups within the ward teams in the ongoing management of identified patients, and included the wearing of PPE and respiratory protection.

The ICD has requested that in preparation for the forthcoming winter season 2015/16, an influenza preparedness meeting is arranged to take place during quarter 2 (2015/16).

6.2 Mandatory Surveillance

6.2.1 Surgical Site Infection Surveillance (SSIS)

The ICNs collect 'alert organism' and 'alert condition' surveillance data within the Trust. This data is used in the detection of outbreaks and monitoring of trends. In addition, the ICNs coordinate data collections for the national SSIS programme and within this there are various surgical procedures that are applicable to the Trust.

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

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

The Trust complies with this annual requirement to undertake SSIS, and the surveillance categories completed during 2014/15 are as follows:

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

- For quarter 2, a total of 103 procedures were recorded with 1 surgical site infection identified and classified as deep infection.
- For quarter 3, a total of 83 procedures were recorded with 1 surgical site infection identified and classified as deep infection.
- Therefore, the combined figures for quarters 2 and 3 recorded 186 knee replacement procedures, and the 2 surgical site infections identified gives an infection rate of 1.08%. These were unrelated cases with no practice concerns identified.

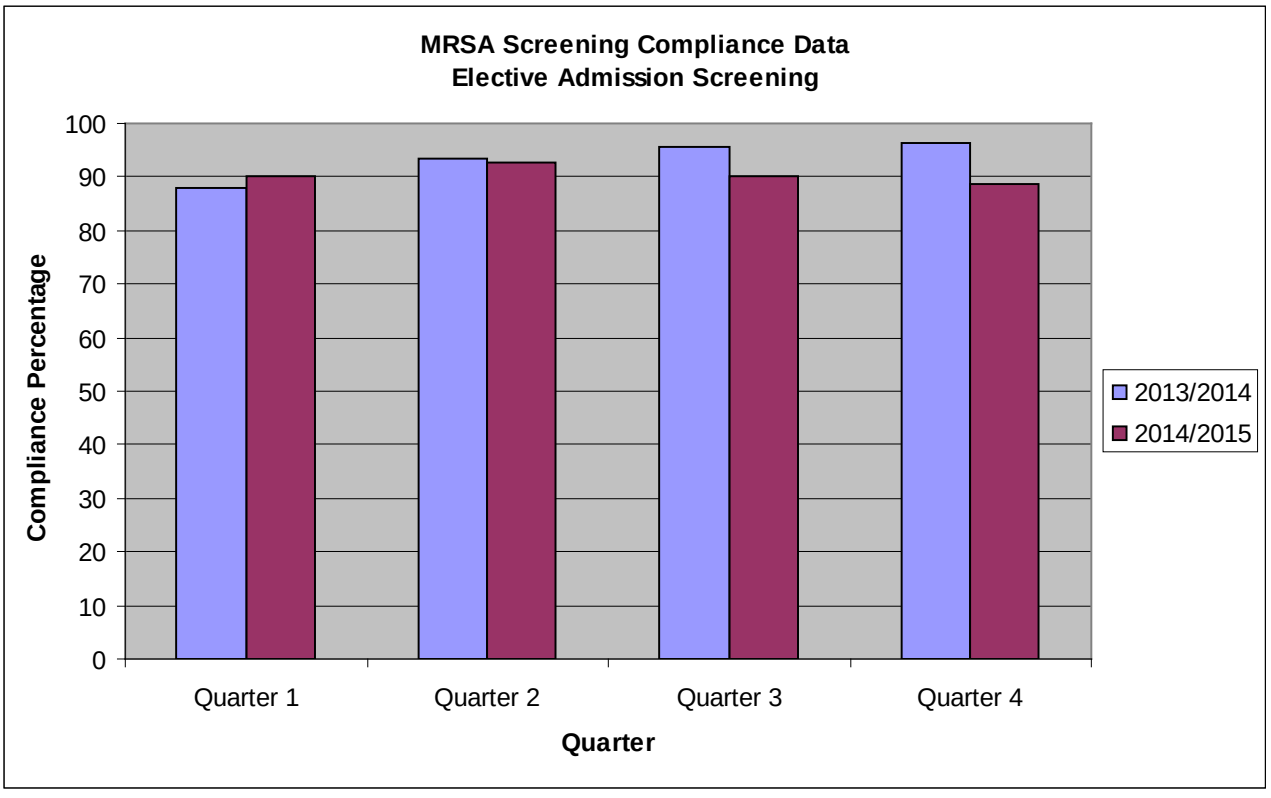
The ICNs produce a formal report outlining progress with SSIS each quarter, which is presented at the IPCC and disseminated to relevant Trust personnel.

6.2.2 Methicillin Resistant Staphylococcus aureus (MRSA)

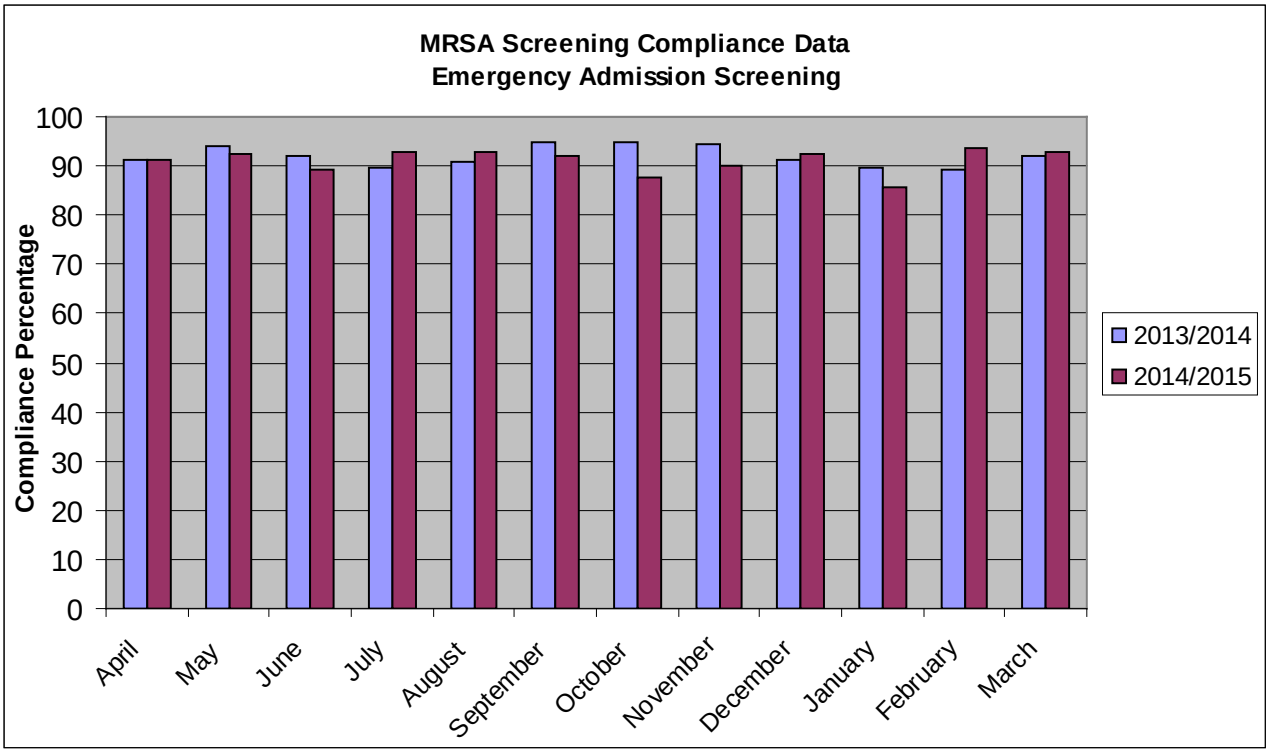
The Department of Health (DH) Mandatory MRSA Bacteraemia Surveillance scheme has been used to measure the effectiveness of infection prevention & control practices in all NHS Trusts. The rationale behind this scheme is that it is sometimes difficult to distinguish between colonisation and true infection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

The Trust continues to undertake MRSA screening for all elective and emergency admissions to ensure continued improvement with reducing infections. MRSA screening compliance rates are monitored by the DMTs and reported as a key quality performance indicator. The ICNs continue to be responsible for generating the monthly emergency admission screening MRSA audit, and the quarterly elective admission MRSA screening audit figures. The compliance rates and any identified missed screens are fedback to the DMTs for follow up actions with outcome reporting to the Matrons Monitoring Group (MMG).

Tables 1 and 2 relate to the overall compliance for both elective admission and emergency admission screening audit figures, for April 2014 to March 2015, with figures provided for April 2013 to March 2014 for comparison.



(Table 1)



(Table 2)

The Trust continues to report as per the requirements of PHE, with a weekly reporting format for mandatory surveillance onto the national HCAI Data Capture System. The Trust adheres to the classification of cases in accordance with the set definitions. This is applicable to MRSA bacteraemia cases and C.difficile cases, and is different to previous classification reporting formats. Results from this scheme are as given in the summary below, and cite the definitions of 'Trust apportioned' cases and 'non Trust apportioned' cases.

MRSA Bacteraemia Trust apportioned cases include patients who are –

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

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

Breakdown of total number of Trust cases recorded April 2014 – March 2015.
The figures in brackets show the number of cases recorded April 2013 – March 2014.

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

(Table 3)

1: The MRSA bacteraemia case identified from blood cultures during September 2014 was classed as a contaminant.
2: The unrelated MRSA bacteraemia cases identified from blood cultures during September and November 2013 were both classed as a contaminant.

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

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

For the non Trust apportioned cases identified in May (1 case), and December (2 cases) 2014, the PIR investigations were undertaken by the relevant CCG, with the cooperation of the Trust with this process.

Findings and key learning from the Trust apportioned PIR investigations:

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

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

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

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

The Trust have identified the requirement for further work in relation to reducing the incidence of contamination rates for the taking of blood cultures. An action plan has been created and agreed by the IPCWG for implementation Trust wide. Part of this work will include an annual audit of blood culture contamination rates, led by the ICD.

6.2.3 C.difficile

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

Monitoring and diagnostic C.difficile testing

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

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

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

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

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

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

Breakdown of reportable cases recorded for inpatients April 2014 – March 2015.
The figures in brackets show the number of reportable cases recorded April 2013 – March 2014.

	Quarter 1			**Quarter 2**			**Quarter 3**			**Quarter 4**			**Total**
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**6 (1)**	**2 (2)**	**1 (3)**	**2 (4)**	**5 (1)**	**0 (3)**	**0 (3)**	**1 (2)**	**2 (1)**	**1 (7)**	**4 (1)**	**5 (2)**	**29 (30)**
Non Trust apportioned cases	1 (0)	0 (0)	0 (0)	1 (2)	1 (1)	0 (2)	0 (1)	1 (0)	1 (1)	1 (1)	0 (0)	0 (1)	6 (9)
Trust apportioned cases	5 (1)	2 (2)	1 (3)	1 (2)	4 (0)	0 (1)	0 (2)	0 (2)	1 (0)	0 (6)	4 (1)	5 (1)	23 (21)

(Table 4)

Breakdown of total number of reportable Trust C.difficile cases recorded April 2014 – March 2015. The figures in brackets show the number of reportable cases recorded April 2013 – March 2014.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Inpatients	**6 (1)**	**2 (2)**	**1 (3)**	**2 (4)**	**5 (1)**	**0 (3)**	**0 (3)**	**1 (2)**	**2 (1)**	**1 (7)**	**4 (1)**	**5 (2)**	**29 (30)**
Community Hospitals	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (1)	0 (0)	0 (0)	0 (0)	0 (0)	0 (1)
General Practitioners (GPs)	3 (2)	0 (0)	3 (1)	1 (1)	1 (1)	3 (1)	3 (1)	2 (0)	1 (0)	1 (1)	0 (1)	0 (1)	18 (10)
Residential/Nursing Home	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)
Other (e.g. Coroner, Private Hospital, Day Attender, A&E, Outpatient)	0 (0)	0 (1)	0 (1)	0 (0)	1 (1)	0 (0)	0 (0)	0 (2)	1 (1)	0 (0)	0 (0)	0 (0)	2 (6)
Total	**9 (3)**	**2 (3)**	**4 (5)**	**3 (5)**	**7 (3)**	**3 (4)**	**3 (4)**	**3 (5)**	**4 (2)**	**2 (8)**	**4 (2)**	**5 (3)**	**49 (47)**

(Table 5)

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

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

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

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

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

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

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

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

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

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

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

During quarters 3 and 4 (2014/15), 5 of the Trust apportioned reportable C.difficile cases were identified for submission to the Appeals Process with the relevant CCG. To date, 3 of the appeals have not been upheld and the 2 remaining are awaiting panel. If successful these cases will be reclassified as not attributable to the Trust. When received, the outcome of these appeals will be fedback to the appropriate groups and committees by the DIPC.

6.2.4 Methicillin Sensitive Staphylococcus aureus (MSSA)

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

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

MSSA Bacteraemias figures recorded for blood cultures from inpatients, and blood cultures taken in outpatient areas and the Emergency Department, from April 2014 – March 2015. The figures in brackets show the number of cases recorded from April 2013 – March 2014.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**4 (1[3])**	**3 (1)**	**5 (3)**	**2 (5)**	**3 (3)**	**2 (6[3])**	**3[1] (1)**	**3 (4[4])**	**4[2] (4)**	**2 (4)**	**3 (1[5])**	**3 (3)**	**37 (36)**
Non Trust apportioned cases	1 (1)	1 (1)	5 (2)	2 (3)	3 (1)	2 (4)	1 (0)	1 (3)	4 (3)	2 (2)	2 (1)	3 (2)	27 (23)
Trust apportioned cases	3 (0)	2 (0)	0 (1)	0 (2)	0 (2)	0 (2)	2 (1)	2 (1)	0 (1)	0 (2)	1 (0)	0 (1)	10 (13)

(Table 6)

1: 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.
2: 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.
3: During April and September 2013, additional MSSA bacteraemia cases were identified from blood cultures taken from attendees at the Salisbury Dialysis Unit.
4: During November 2013, an additional MSSA bacteraemia case identified from blood cultures taken from a patient who attended the Emergency Department only, and not admitted to the Trust (patient was admitted to Newhall Hospital).
5: During February 2014, an additional MSSA bacteraemia case was identified from blood cultures taken from a patient who attended the Pembroke Assessment Room as outpatient only and not admitted to the Trust.

During 2014/15, there were 10 Trust apportioned cases identified. The ICNs undertake an infection control incident investigation for Trust apportioned inpatient cases, in conjunction with staff from the clinical area concerned. It is important to emphasise the need for continued monitoring of invasive devices by staff, adherence to the relevant Trust policies relating to the taking of blood cultures and skin disinfection/decontamination and maintaining the required care documentation.

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

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

Updates on progress on identified actions are monitored by the Directorate Senior Nurses (DSNs).

6.2.5 Escherichia coli (E.coli)

The Trust continues to input data in accordance with current guidance from the DH and the PHE. Currently, there is no national guidance for data definition of E.coli bacteraemia cases for targets to be set. From 1st April 2012, the Trust has applied the definition criteria used for MRSA bacteraemia

cases to the E.coli bacteraemia cases recorded within the Trust. This allows the cases to be classified as either 'Trust apportioned' or 'non Trust apportioned'.

E.coli Bacteraemias figures recorded for blood cultures from inpatients, and blood cultures taken in outpatient areas and the Emergency Department, from April 2014 – March 2015. The figures in brackets show the total number of cases recorded from April 2013 – March 2014.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**13 (2)**	**3 (9)**	**7 (4)**	**9 (7)**	**14 (3)**	**9 (4)**	**7 (4)**	**6 (7[1])**	**7 (5)**	**10 (9)**	**3 (4)**	**5 (6)**	**93 (64)**
Non Trust apportioned cases	9 (2)	3 (8)	5 (4)	7 (5)	10 (2)	5 (3)	5 (3)	5 (7)	6 (3)	8 (9)	1 (3)	5 (5)	69 (54)
Trust apportioned cases	4 (0)	0 (1)	2 (0)	2 (2)	4 (1)	4 (1)	2 (1)	1 (0)	1 (2)	2 (0)	2 (1)	0 (1)	24 (10)

(Table 7)

1: During November 2013, additional E.coli bacteraemia case identified from blood cultures taken from a patient who attended the Emergency Department only, and not admitted to the Trust.

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

Of the 24 Trust apportioned cases identified during 2014/15, 10 were determined as likely HCAI related, 7 cases as possibly HCAI related, for 2 cases it was unknown if it was HCAI related, and the final 5 cases were determined as not HCAI related. The classification of whether the bacteraemias are HCAI related is completed by the Microbiologist, based on the information obtained from the relevant clinicians. This data is entered onto the HCAI Data Capture site by the ICNs. Where concern is highlighted by the Microbiologist for an individual case, further investigation is undertaken. For these Trust apportioned cases, no further follow up was identified.

6.2.6 Carbapenemase producing enterobacteriaceae (CPE)

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

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

trigger CPE screening, they are isolated appropriately within side room facilities, and provided with the relevant patient information.

During quarter 4 (2014/15), a patient on Radnor Ward was identified to be likely CPE positive from routine investigations. The patient was isolated in a sideroom facility on the ward and staff advised regarding the requirement to wear enhanced personal protective equipment (PPE) when undertaking close personal care, namely the wearing of long sleeved water repellent gowns. Patient contacts were identified for enhanced screening for CPE, and a multidisciplinary meeting was arranged for the beginning of quarter 1 (2015/16). No contacts were found to be CPE positive from the enhanced screening exercise, and following further testing at the reference laboratory, the final investigative results for the index case were negative.

7. Hand Hygiene

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

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

The Trust target for hand hygiene compliance rates is 100%, with formal reporting by the directorates of measures implemented to improve any lower compliance. This target is reflected in the clinical leaders and DSNs personal objectives, with ongoing work required by the DMTs to sustain improvements. Part of this has involved the ICNs continuing to train and update the Infection Control Link Professionals (ICLPs) to undertake hand hygiene assessments for staff in their own areas. This is a successful and useful method to further raise the profile of hand hygiene behaviour and compliance with BBE. It also provides an alternative opportunity for staff to complete their annual mandatory hand hygiene assessment. The directorates are encouraged to share successes within individual areas at the MMG meetings.

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

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

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

During 2014/15, the ICNs have continued to facilitate the completion of hand hygiene audits across selected clinical areas by an external auditor, the Healthcare Manager for GOJO Industries. The external auditor utilised the World Health Organisation (WHO) hand hygiene audit tool, and assessed the hand hygiene practices of all staff groups against the '5 moments for hand hygiene'. For quarters 1 and 2 (2014/15), the overall compliance rate from external auditing was 71%. An improvement has been achieved over quarters 3 and 4 (2014/15), with an overall compliance rate of 78.83%. The identified non compliance continues to be predominantly missed opportunity number 5, which related to contact with patient surroundings. The results were fedback to the

relevant Clinical Leaders and DSNs with actions identified, and additional education and support provided for staff groups.

The requirement to complete an annual hand hygiene assessment is indicated on each staff member's Learning Plan on the Managed Learning Environment (MLE). During 2014/15, the ICNs have undertaken hand hygiene assessment 'drop-in' sessions for departments/staff to attend. The sessions continue to promote effective hand care and skin health for both clinical and non clinical staff. If an attendee identifies concerns regarding their skin health, the ICNs direct them to Occupational Health for further advice/involvement. The total number of hand hygiene assessments completed during 2014/15 is 3018 assessments, compared to 2769 for the same period in 2013/14 (Appendix 5 – This includes the total number of hand hygiene assessments recorded by the ICNs and ICLPs, and staff members may complete more than 1 assessment during the year. At the IPCC in October 2014, it was requested that the figures presented in Appendix 5 also includes the number of hand hygiene assessments recorded on the MLE. This was requested from the Education Department, however has not been available for the ICNs to access).

All completed hand hygiene assessments are entered onto the MLE by the ICNs. This is achieved by creating a 'workshop' on the MLE and then uploading onto the workshop the name of every staff member who completed a hand hygiene assessment on the date concerned. The MLE system then automatically updates the staff members' individual learning plans, and resets the electronic reminder facility. Unfortunately it continues to be identified that the automatic update of learning plans and reset of the reminder facility is not always happening. The Education Department have investigated with the external company MLE supplier, and currently when a staff member for whom this applies contacts the ICNs, their learning plans are initially accessed individually (by the ICNs) and amended. This remained an ongoing issue through quarters 3 and 4 (2014/15), with continued system issues. Therefore it has been agreed that the Education Department will action any individual staff issues.

The ICNs have continued to review hand hygiene posters and signage across the Trust site, and utilised educational resources from the National Patient Safety Agency (NPSA). The dissemination of the '5 moments for hand hygiene at the point of care' initiative remains a key focus for education. The opportunity to emphasise the importance of hand hygiene for patients, relatives and visitors, has been enhanced by the installation of a new notice board sited along the main corridor on Level 4. This facility has also allowed for the provision of health promotion messages, including food hygiene and safety.

During 2014/15, the refurbishment of the alcohol hand rub gel stations sited outside the inpatient and outpatient clinical areas was completed. New hand hygiene signage was developed by the ICNs to complement this work, with the replacement of gel dispensers in the public areas with automated gel dispensers to further promote hand decontamination opportunities for patients, visitors and staff members.

8. Audit

In line with the requirements of the Health and Social Care Act 2008, a programme of infection prevention and control audits is illustrated in the annual audit programme (Appendix 6). The programme ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust.

The ICNs have been involved with the following audit work during 2014/15, including the follow up and outcomes from auditing against infection control policies:

- Commode Cleanliness – update on completed reaudits
    - Commode cleanliness audits continue to be facilitated by the DSNs with results fedback via the Infection Control Update meetings and the directorates report findings and outcomes via their existing forums/meetings.

- Handling and Disposal of Linen in the Clinical Areas
    - The report for the reaudit completed during 2013/14 was presented to the IPCC in July 2014. The reaudit included the inpatient areas and all outpatient areas where patient linen was in use, and assessed the management of clean linen and the clean linen store, and observed the practice of staff in the clinical areas. Across the directorates the reaudit identified similar themes compared to the findings from the previous audits. These included dust in clean linen cupboards, inappropriate items stored in the clean linen cupboards, and used linen bags more than two thirds full. Staff were not always observed to wear disposable plastic aprons when handling clean linen and/or used linen. The relevant clinical areas implemented actions to resolve the identified issues at the time of the audit. Continued vigilance in these areas has been requested through MMG.
- BBE policy and Uniform and Workwear guidance
    - Reaudit was completed during quarter 3 (2014/15), with data collection undertaken by the ICLPs and Clinical Leaders across the clinical inpatient and outpatient areas for clinical staff wearing a uniform. A total of 374 observations of staff members were recorded across the directorates.
    - Achieved 100% compliance with no sleeve or garment being worn below the elbow.
    - Achieved 96.8% compliance with wearing no wrist watch or wrist jewellery, where 12 staff were identified to be non compliant.
    - In addition, the other main theme of non compliance related to jewellery, with 70 staff found to be wearing earrings that did not adhere to the uniform policy.
    - In response to feedback from previous audits, the ICNs undertook additional data collection of clinicians not wearing a uniform, to audit solely against the BBE requirements. 117 observations were recorded, with 100% compliance achieved with no sleeve or garment being worn below the elbow, and 100% compliance achieved with no nail varnish or false nails being worn. Achieved 99.15% compliance for both wearing no wrist watch or wrist jewellery, and wearing no ring with stones. For both cases, 1 staff member was identified to be non compliant.
    - A further breakdown of the results for clinical staff wearing a uniform were provided for each directorate. The aim of providing this information was to enable the directorates to further target and improve their compliance levels.
    - The findings from the reaudit will be utilised in line with current evidence based research and best practice guidance within the revision of the Trust BBE and uniform policies and workwear guidance. The report was approved by the IPCWG during quarter 4 (2014/15), and is for presentation to the IPCC in quarter 1 (2015/16).
- Observation of Practice Audits
    - The ICNs have undertaken additional observational audits of staff practices within clinical areas, as part of the Trust C.difficile Prevention Action Plan. Results are fedback at the time of the audit to the nurse in charge, and where non compliance has been identified this has been addressed with the individual staff member and fedback separately to the relevant Clinical Leader.
    - The DSNs were also tasked by the interim DIPC to undertake similar observational audit work, with reporting via the Infection Control Update meetings.
    - Improvements in practice have also been achieved following the implementation of colour coding the use of plastic disposable aprons in the inpatient clinical areas.

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

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

8.1 Innovations

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

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

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

During quarter 2 (2014/15), an alternative decontamination wipe was trialled on Redlynch and Pitton Wards. This was a sporicidal product in the form of a single wipe (activated by water), to be used for the decontamination of patient commodes only. The trial was extended to other clinical inpatient areas within the medical and surgical directorates during quarter 3 (2014/15). Evaluation forms were completed by the ward teams, and the final outcome will be presented to the IPCWG during quarter 1 (2015/16).

The ICNs and a Consultant Microbiologist have been involved with the review of an alternative disinfection product that the Housekeeping Department have selected for trial within the Trust. Two inpatient clinical areas have been identified for the trial, which will complement existing environmental decontamination processes. This work will be led by the Housekeeping Department, with plans to commence the trial during quarter 1 (2015/16).

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

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

Overview

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

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

Key work areas 2014/15 include:

9.1 Guideline development/review

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

- Antibiotic quick reference guidance
- Burns and Plastics guidelines
- General adult surgical guidelines

Guidelines recently completed and approved:

- Paediatric antibiotic policy
- Abdominal Sepsis
- Endocarditis (Prophylaxis and Treatment)
- Work plan for 2015/16

Guidelines under development:

- Antifungal guidelines

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

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

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

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

9.2 Audit

Regular Antimicrobial Stewardship Audits

The rolling programme of antibiotic stewardship audit is ongoing, and is now a locally agreed CQUINN target for the Trust. We continue to audit one ward every fortnight, to provide a snapshot of antimicrobial prescribing practice within the Trust.

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

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

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

The information is entered onto a spreadsheet designed for our use by one of the Consultant Microbiologist. The spreadsheet yields a percentage performance score for the ward in question, and is fedback as follows:

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

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

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

If results show that an area is not meeting the expected standard of antimicrobial stewardship, i.e. scores less than 80%, an action plan is formulated which usually involves discussion with the lead clinician, presentation by the antimicrobial team at clinical governance sessions and review of antimicrobial guidelines in that area. It is planned that each ward is audited every six months to ensure that improvements are being maintained.

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

Recent audit results
For each quarter of 2014/15, the target of auditing an average of 2 wards per month has been met. Results and discussions are included within the quarterly CQUIN report. In summary, performance in these audits has been steadily improving:

CQUIN Average Quarterly Score

Quarter	1 (April – June)	2 (July – Sept)	3 (Oct – Dec)	4 (Jan – March)
Average percentage	81.3%	96.7%	93.6%	91.9%

Point prevalence audit
The regional Annual Antibiotic Point Prevalence Audit was conducted in February 2015. This data provides a snapshot of antibiotic usage and prescribing practices within the Trust, and allows for a comparison with other Trusts in the southwest region and past results. Overall final results will be published in April 2015.

Last year's results from February 2014, showed an improvement in the documentation of the indication. This may be attributed to the introduction of a new prescription chart within the Trust. Course length/review date however had not improved (69.2% compliance versus 71.9% for the previous year 2013). Following these results, the prescription chart has since been modified. The audit showed that antibiotic stewardship at the Trust compares favourably to other Trusts in the southwest region, and shows a steady improvement in practice against standards.

9.3 Additional information

C.difficile
Work this year to date includes:

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

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

Consultant Microbiologist Ward Round
In August 2013 a weekly ward round by a senior pharmacist and a Consultant Microbiologist was initiated. The aim was to review any high risk or complex patients to ensure they are receiving optimal antibiotic treatment.

It was found to be a very useful initiative but the service has suffered from a lack of availability of Consultant Microbiologist time and as such has in recent months been at best sporadic. We hope in the future that Microbiologist cover may be fully available for this service. This staffing issue has been escalated through the correct Infection Control and Microbiology channels. This service is currently on hold, pending resolution of the issues raised above.

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

The following drug usage reports are provided to the ARG every six months:
- Cephalosporins, Ciprofloxacin, Clindamycin and Co-amoxiclav
- Ceftazidime, Cefalexin and Cefaclor
- Daptomycin, Vancomycin, Teicoplanin and Linezolid
- Imipenem, Meropenem, Ertapenem and Tazocin
- Clindamycin, Clarithromycin and Doxycyline.

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

European Antibiotic Awareness Day
As part of the European Antibiotic Awareness Day on 18th November 2014, a campaign is planned to raise awareness of the need to use antibiotics responsibly, introducing a range of actions including:
- Advertising the European Antibiotic Awareness Day and key antibiotic messages throughout the hospital. Utilizing public notice boards, infection control notice boards, the pharmacy dispensary patient waiting area, and other education and training notice boards.
- Broadcast e-mail and Cascade brief to all Trust staff.
- Screensaver – detailing the principles of the 'Start Smart Then Focus' initiative

10. Education and Training Activities

It is widely recognised that ongoing education activity in infection control is required in order to improve health care worker compliance with infection prevention and control practices. The ICNs undertake a number of induction and educational updates to a wide range of key staff within the Trust. The ICNs keep attendance data from these sessions and supports the Trust in its delivery of mandatory education for all staff. Appendix 7 identifies the figures for the IP&C Computer Based Learning (CBL) modules completed via the intranet site during 2014/15. At the Trust Board meeting held in December 2014, it was requested that the figures presented in Appendix 7 also reflects the percentage of staff in each directorate who have completed the CBL package on the MLE during the relevant quarter. This has been investigated with the Education Department, however this information is not currently available to the ICNs.

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

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

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

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

Training documentation was devised as part of the Trust Ebola preparedness work to accompany the dedicated PPE training undertaken by the ICNs for the management of patients with suspected/confirmed Ebola. A high level of intensive sessions were held for Emergency Department staff, with additional PPE training sessions completed for other key groups, namely maternity staff, paediatric consultants, and the clinical volunteers group.

Opportunities continue to be provided for clinical staff to shadow the ICNs, by both new starters to the Trust, newly promoted (Band 6 and 7) and established staff members, including ICLPs. This aids improved understanding of infection control within an individual clinical area, reinforcing staff responsibilities in relation to infection control within their role, and the strategic impact across the Trust.

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

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

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

11. Water Safety Management *(information for this section has been provided by George Atkinson, Person Responsible for Water for quarters 1 and 2 of 2014/15, and by Neville Edwards, Interim head of Estate for quarters 3 and 4 of 2014/15)*

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

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

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

The Trust Water Safety Group (WSG) has been active during 2014/15 in response to the management and response of events involving the water systems on site. The WSG is formed of technical and non-technical staff who can recommend, change and enforce issues relating to water safety across the Trust. The WSG includes representatives from all of the high risk areas identified in the policy, and Interserve (the Trust's independent advisor), will be attending future meetings, the next of which is set for 18th May 2015.

In line with the policy requirements the Trust has carried out the recommended routine monitoring for Legionella and Pseudomonas during the last 12 months. The results of these are summarised below.

11.1 Legionella Monitoring

Quarters 1 and 2 of 2014/15

The annual Legionella sampling commenced in July 2014, 269 separate outlets were sampled. Between July and September 2014, 25 points were reported as positive and were the subject of investigative work to clear the outlets. The Trust had 14 positive results under review, 6 of these were less than 100 colony forming units/l (cfu/l) and whilst they were regarded as satisfactory by the test Laboratory and HSE L8, they are beyond the permissible range as detailed in the current Trust policy. The 8 other results (indicated * in the table below) were less than 1000 cfu/l and are investigated by the WSG members as required. The results were discussed further at the WSG meeting in November 2014 and actions identified.

Description	Room No	Asset	At 2nd Oct 2014
Labour ward Birth pool	82-21 Rm 7	Shower	20
Whiteparish Bay 4	4.1.38	WHB mixed	40
Block 65 Old Breamore	RM 15 Sluice	Sluice tap hot	20
Block 77 NICU Prep room	Rm 77.11	WHB cold tap	440*
Vascular	3.12.63	Cold tap	600*
Ortho O/P	3.0.17	Sink cold tap	40
Ortho O/P	3.0.18 utility room	WHB cold tap	80
Ortho O/P	3.0.08 plaster room	WHB cold tap	600*
Ortho O/P	3.0.08 plaster room	Sink cold tap	480*
Ortho O/P	3.0.13	WHB cold tap	240*
ED resuscitation	Resus room Paed sink	WHB mixed	80
ED Disabled W/C	3.1.25	WHB mixed	160*
ED Majors	3.1.13	WHB mixed	200*
ED minors	3.1.52	WHB mixed	760*

Quarters 3 and 4 of 2014/15
Between October 2014 and April 2015, 70 points have been reported as positive and have been the subject of investigative work to clear the outlets. The Trust currently has 14 positive results under review, 10 of these were over 20 but less than 100 colony forming units/l (cfu/l) and whilst they are regarded as satisfactory by the test Laboratory and HSE L8, they are beyond the permissible range as detailed in the current Trust policy. 3 other results were between 100 and 1000* cfu/l and were investigated by the WSG members as required.

Description	Room No	Asset	At 27th April 2015
Tisbury	4.1.22	Shower	80
Ortho O/P (GJ 103)	3.0.08 plaster room	Sink cold	20
Ortho O/P (GJ 153)	3.0.08 plaster room	WHB cold	20
ED Resus	3.1	WHB mixed	80
POAU (Block 81)	81.2	Hot tap	20
Durrington Ward	2.2.20	WHB hot	20
Ortho O/P	3.0.07	WHB cold	420*
Durrington Ward	2.2.18	WHB mixed	40
Durrington Ward	2.2.21	WHB hot	20
Winterslow	2.10.80	Shower	20
Winterslow	2.10.79	WHB mixed	100
Winterslow	2.01.77	WHB mixed	1000*
Plastics	3.10.35	WHB mixed	150
Winterslow	2.10.80	WHB mixed	200*

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

Office and support areas (non clinical) are required in line with the amended water safety policy to self manage the flushing regime and report this to ETS. Flushing of the systems is currently recorded centrally by ETS staff and an electronic data system is under development by the Trust IT department to capture this directly from the areas.

Several emergency review meetings, as noted in the Water Safety policy, have taken place in the Trust following elevated sample results. The actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of e-mail communications as events occur, and as regular reports to the WSG and IPCC. The meetings are attended by the Consultant Microbiologist, the responsible person (Water), Senior ICN and the manager of the Area concerned (as a minimum), as an action plan is agreed to address the issues causing the problem. The majority of problems have been linked to lack of usage, where practices have changed temporarily causing potential stagnation in the supply. Measures taken include more intensive flushing regimes and disinfection of the local water systems and fittings. The frequency of testing is increased until 3 clear counts have been noted.

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

Quarters 1 and 2 of 2014/15
The Trust has commenced with the routine sampling of outlets in April 2014. 258 points were sampled and 17 outlets were identified as positive. All were reviewed with the department leads, infection control and cleaning staff. The outlets were cleaned, replaced as required and retested. Following the appropriate remedial actions there are no current outlets with positive results.

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

Description	Sample ref	Room No	Asset	First Count	Action Summary	Last Count
NICU Kitchen	GJ 61	77.5	Sink mixed	1	Resample	0-(3rd)
NICU	GJ 66	77.7	WHB mixed	110	Resample	0-(3rd)
Avon ward	GJ 72	Rm 69	Shower	>100	Resample	0-(2nd)
Avon ward	GJ 75	Rm 106	Shower	1	Resample	0-(1st)
Avon ward	GJ 77	Rm 67	WHB mixed	5	Resample	0-(1st)
Avon ward	GJ 81	Rm 110	Shower	>100	Resample	0-(4th)
Avon ward	GJ 82	Rm 111	Male WC WHB	10	Resample	0-(2nd)
Avon ward	GJ 85	Rm 66	Adj WHB mixed	4	Resample	0-(1st)
Avon ward	GJ 86	Rm 66	WHB mixed	7	Resample	0-(3rd)
Sarum Rm 5 En-suite	GJ 116	4.6.12	Shower	2	Shower head and hose removed, resampled	0-(2nd)
Sarum Staff WC	GJ 146	4.5.16	WHB	22	Shower head and hose removed, resampled	0-(4th)
Sarum Parents	GJ 150	4.5.11	Shower	>100	Shower head and hose removed, resampled	0-(2nd)
Burns W/C	GJ 160	4.11.06	WHB	33	Resample	0-(4th)
Burns Rm 2 En-suite	GJ 166	4.11.21	WHB	51	Resample	0-(2nd)
Burns Rm 9 En-suite	GJ 186	4.11.38	Shower	>100	Resample	0-(2nd)
Burns HD En-suite	GJ 224	4.11.28	Shower	51	Shower head and hose removed, resampled	0-(3rd)
Sarum Assess	GJ 227	4.6.42	WHB	9	Resample	0-(3rd)

Quarters 3 and 4 of 2014/15

The Trust has commenced with the routine sampling of outlets in February 2015. 137 points were sampled and 5 outlets were identified as positive. All were reviewed with the department leads, infection control and cleaning staff. The outlets were cleaned, replaced as required and retested. Following the appropriate remedial actions there are no current outlets with positive results.

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

Description	Sample ref	Room No	Asset	First Count	Action Summary	Last Count
Pembroke	GJ 13	2.10.21	Sink mixed	60	Resample	0-(4th)
Burns	GJ 100	4.11.53	WHB mixed	27	Resample	0-(2nd)
NICU	GJ 117	77.21	Cold tap	70	Resample	0-(1st)
NICU	GJ 123	77.18	WHB cold	1	Resample	0-(1st)
NICU	GJ 124	77.17	Shower	123	Resample	0-(2nd)

11.3 Events

The Trust are continuing to support PHE undertaking a joint research project with the Health & Safety Executive. The project is looking at the effectiveness of Legionella testing, and continues to

collect samples from different types of water systems over the 12 month period, until Autumn 2015. The water samples from Salisbury District Hospital (approx. 20 samples on a monthly basis – to be advised by Consultant Microbiologist) are being analysed for Legionella by traditional plate culture and rapid polymerase chain reaction (PCR) to give results within 24 hours. The results from the research project will be analysed to help understand interpretation of the results and to determine whether PCR results can be used in a meaningful way to understand microbial risk in relation to the action limits currently set by culture results in L8. There will be no cost to the Trust for being part of this study. The PHE lead or a colleague, will attend the WSG meetings to discuss the results and outcomes of the Legionella testing project to date with the WSG members. However, PHE have been unable to attend recent meetings.

11.4 Independent advice

A meeting was held on 28th October 2014 with Interserve, who have purchased the water safety arm from Initial Rentokil. Ongoing support arrangements and the delivery of training to water staff involved in the maintenance and monitoring of the water system safety has been agreed.

Interserve continues to provide independent technical support to the Trust with regard to water management. A training day was organised in January 2015 for all Responsible Persons and Deputies, which resulted in the attendees being awarded a City and Guilds standard certificate for the Control of Legionella in Water Systems.

Interserve presented the findings of their Risk Assessment and Management Scheme Review on 7th April 2015, and whilst it was noted that significant progress has been made, further work is required on the following:

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

The contract with Interserve runs until November 2015.

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

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

Personal protective equipment (PPE)

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

The Health and Safety Manager, Infection Control Senior Nurse and Decontamination Lead met to review progress in September 2014, and findings were that all clinical directorates have a nominated trained person to conduct fit testing. However, during quarter 3 of 2014/15, it was identified that cascade training of colleagues had not been completed. In April 2015, further

training was conducted by an external company (3M) and these trainers will now cascade train colleagues, new starters and medical staff.

Further PPE has been obtained as part of the Trust's Ebola preparedness work. This includes disposable overshoes, coverall suits with hoods, longer cuff gloves (two colours) and extra long face visors. Stock of held within the Emergency Department (ED), with replenishment stock available from SDU.

Progress against Decontamination Strategy
The Decontamination Strategy remains in place with aspects of key objectives reviewed at each meeting. Risk assessments are monitored and updated where necessary. The Trust Decontamination policy is up to date and has been approved by the IPCC and is ready for ratification by the CMB.

12.1 Ensure fully compliant decontamination practice – ongoing Trust-wide
Tray tracking
Tray tracking via the Sentinel System has been delayed due to information technology (IT) issues. No progress has been seen from the company and the SDU is now identifying alternative suppliers.

As a result of the lack of progress from the current Tracking system provider the Decontamination Lead created a risk assessment for the tracking of reusable medical devices to patient records. The Capital Bid for a replacement tracking system to include Endoscopy and patient records tracking was submitted to the Capital Controls Group. This bid was approved with a number of providers being identified as capable of meeting the specification. The provider has since been approved and implementation is underway. The first stage is to replace the SDU tracking system and the second stage is to roll this out in the Main Theatres Department (MTD) and Day Surgery Unit (DSU) alongside the TMan system. This will enable tray tracking to Theatre locations and patients. The third stage is to implement electronic tracking and traceability for flexible Endoscopes.

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

- Bbraun project is replacing high risk instruments which were found to be faulty. Good progress has been made with Main Theatre Department and Bbraun. Bbraun Project Manager has taken a proactive role and working with Anaesthetic lead to achieve results.
- SDU are working with Main Theatres to remove unnecessary consumable products from trays. This has improved the turnaround time for trays and released £39K from the SDU budget. Theatres now purchase presterile products for use in operating rooms; this has reduced wastage in Theatres and is considered best practice when compared to the previous method. As a result of this the SDU has then been able to change the packing process in the inspection, assembly and packing area which has been a further improvement of tray turnaround.
- New detergent has been supplied for the bedpan washers. The Decontamination Lead and Estates Operations Officer arranged commissioning tests to use the same product in use on the SDU washer disinfectors. This will provide greater cleaning efficacy (evidenced in two medical papers with the SDU and PHE), and produced 63% cost reduction compared to the previous brand.
- High risk instruments are currently being replaced and MDMC are investigating ways to generate income from old/non compliant devices. Ophthalmic instruments have been identified as high risk due to age and corrosion; these are being replaced as priority through the instrument replacement project. Inventory audits continue to take place to confirm capital requirements.

Guidance documents
MHRA guidance for healthcare and social organisations has been reviewed by the Decontamination Committee and the Trust practices are compliant. BSG guidance for the GI endoscopy was amended and discussed at the IPCWG and Endoscopy Unit, current processes in place were found to be compliant. A new European Standard for Controlled environment storage cabinets for processed thermo liable Endoscopes (EN16442:2015) has been released. The Decontamination Lead and Authorised Person for Decontamination are currently reviewing the Trust compliance with this standard.

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

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

The SDU continues to process all flexi scopes used within the Trust, including the additional weekend lists for the Endoscopy Department, evening lists in Ear Nose and Throat (ENT) outpatient department and lists in the Obstetrics and Gynaecology service.

During 2014, there were issues of delays in processing flexi scopes due to additional demand, automatic endoscope reprocessing (AER) failures, and SDU staffing levels. Endoscopy increased demand in quarter 3 and 4 of 2014/15, by conducting additional evening lists.

A Capital Bid was approved for the SDU to supply a vacuum packed flexible scope option using hydrogen peroxide. This enables lesser used scopes to be stored for up to 35 days, saving staff time and more cost effective, as currently these scopes have to be reprocessed through SDU every 3 days whether used or not. This will also increase the life cycle of the devices as it will reduce wear and tear.

12.3 Maintain a fully compliant SDU until at least 2017

The SDU continues to maintain its compliance and accreditation to the latest European Standards in Sterile Services. The yearly review and audit of the SDU quality system, by the external auditor (the Notified Body) was undertaken in October 2014. A low number of Non Conformities were found and SDU has completed the Transfer of notified body services from SGS to BSI. This was achieved via conducting an additional successful Transfer Audit provided by BSI. The SDU received the BSI certification 27th March 2015, and a full vigilance audit is planned for June 2015.

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

The first stage of the SDU washer disinfector replacement project is complete. Two new washer disinfectors have been installed in SDU providing greater capacity and cleaning efficacy. The second stage is to install a further two machines. The capital bid for this has been approved and discussions are being held over the future location for SDU.

12.4 Marketing the SDU services to increase the external customer base

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

- The SDU continues with the Ministry of Defence (MOD) Army, Royal Marines and Navy contracts until May 2015, with MOD retaining the right to extend by a further two years.
- The Wiltshire Community Health Services contract for its South Wiltshire Podiatry Tray Service continues to progress but continues to be under review.

- The SDU continues to expand its decontamination contract with an external independent healthcare provider BMI. This contract is progressing and the fourth BMI hospital which was mobilised in November 2014. Discussions are currently underway to provide a flexible endoscope service as an additional contract with BMI.
- The SDU is currently tendering for the Dorset Podiatry contract which would see sterile services delivered to over 70 sites in Dorset.

12.5 Additional work of the Decontamination Committee

The sections listed below detail standard agenda items:

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

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

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

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

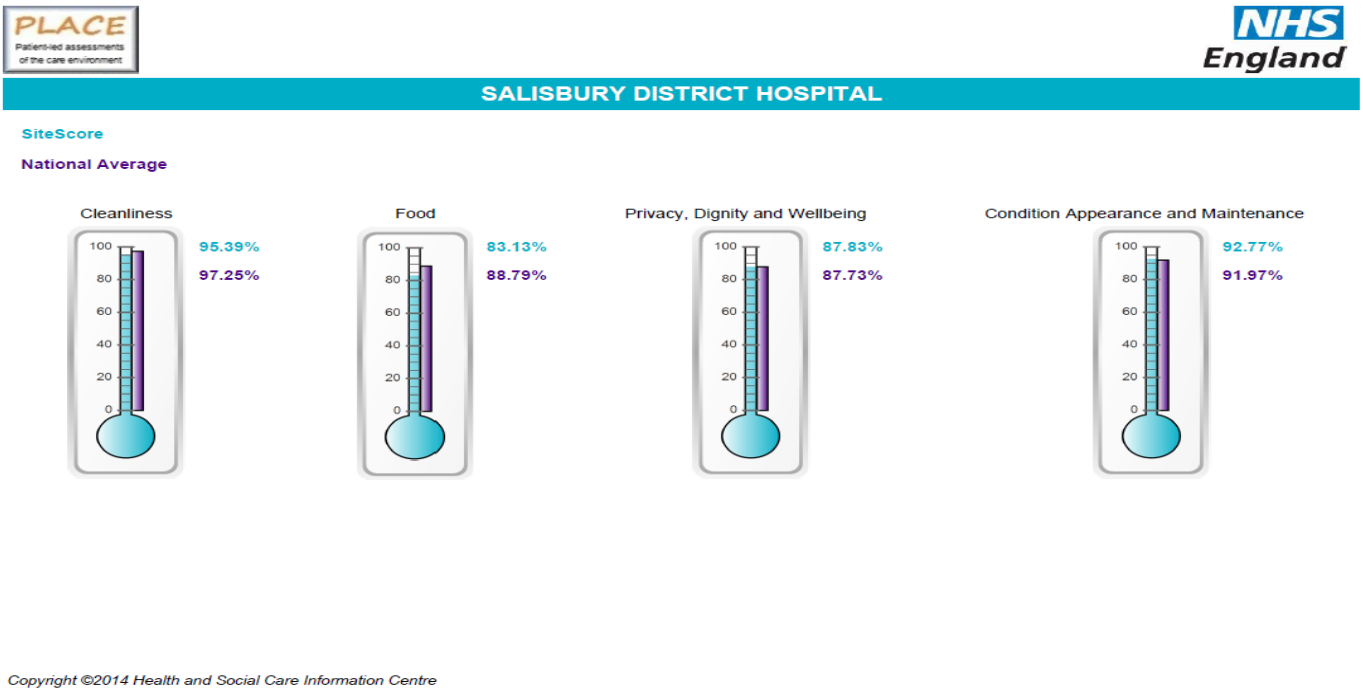
Patient led assessment of the care environment (PLACE) internal audits

A total of 40 internal PLACE assessments have been undertaken during 2014/15 (3 were held between July to September 2014, and 37 were held between October 2014 to March 2015). These continue to receive good support from Governors and Volunteers and our local Healthwatch representatives. An action plan is produced and progress reported and monitored through the monthly MMG meetings. Focus is given to themes from the ward or department and learning that can be shared with other areas. The new PLACE audits are also helping inform and drive the capital bids and decorating programmes. The Health and Social Care Information Centre have published a tool called 'PLACE lite' for Trusts, to use in their own audit systems, based on the annual programme, and this system is being utilised. Results will be reported annually using this tool at the MMG meetings.

National PLACE

The Trust participated in the National PLACE assessment in 2014/15. The assessment was conducted over two days on May 9th and 12th 2014, with 12 members of the public participating plus Trust staff. The teams visited 10 wards, tasted food on 3 wards and assessed 25% of the public spaces. The results were submitted to the Health and Social Care Information Centre on May 13th 2014. The results, shown below, were published nationally on August 27th 2014. A detailed Trust action plan was produced for Cleanliness and Food. Cleanliness is monitored through the IPCWG and MMG (Appendix 9), and food is monitored by the Food and Nutrition Group.

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



The Trust plans to participate in the National PLACE assessment again for 2015/16. The assessment will be conducted over 1 day during April 2015. A total of 10 wards and the emergency Department will be visited and 4 food assessments undertaken. In addition, 2 outpatient areas as well as external spaces and communal areas will be included within the PLACE criteria. Results will be published nationally in August 2015.

Cleaning Data
Quarters 1 and 2 of 2014/15

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

Quarters 3 and 4 of 2014/15

Area of Focus	Key performance indicator	Oct – 14	Nov – 14	Dec – 14	Jan – 15	Feb - 15	Mar - 15
Departmental Data	Post Infection cleans	393	291	373	390	345	391
	Enhanced cleaning hours	66	72	101	68	61	144
Cleaning	Total audits	116	98	116	97	99	99
	Passes	51	42	53	53	43	51

	Qualified Passes	64	54	62	44	56	48
	Fails	1	2	1	0	0	0

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

Terminal, enhanced and double cleaning

The tables below illustrates the additional cleaning undertaken in clinical areas between April 2014 to March 2015.

	Number of terminal cleans 2013/14	Enhanced cleaning hours 2013/14	Number of terminal cleans 2014/15	Enhanced cleaning hours 2014/15	Double cleans in hours 2014/15
April	270	181	326	77.25	35.75
May	234	166.5	287	100.75	44.5
June	260	73	389	168.5	55
July	319	127.5	360	200.75	69
August	243	134.25	321	73.5	46.25
September	223	85.25	330	80	93.25
October	254	135.50	393	66.25	62.50
November	235	128.25	291	71.75	52.50
December	228	81.25	373	100.75	44
January	275	172.5	390	68	37.5
February	305	167	345	61	42.75
March	381	136.5	391	144	77.25
Year to date total	**3227**	**1588.5**	**4196**	**1212.5**	**660.25**

Deep clean programme/rapid response team

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

For 2015/16, the Deep Clean programme has been redesigned to include decorating, maintenance and any key issues raised during internal PLACE audits in 2014/15. The programme is due to start in April 2015 on Durrington Ward. A copy of the programme is available from the Housekeeping Department.

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

Housekeeping resource

The Head of Facilities is reviewing the level of cleaning resources and funding that is available to meet current demands in order to meet national cleaning standards and infection control needs. A paper was presented to Executive Directors during 2014/15 and is currently being developed further.

14. Summary

This annual Report has provided the Trust Board with evidence of the measures in place to work towards improving infection prevention and control practices across the Trust. The report provides

assurance with regard to registration without conditions with the CQC standard for ‘Cleanliness and infection control’, Outcome 8 (Regulation 12).

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

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

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

Appendix 1

Infection Prevention & Control – Annual Action Plan 2014/15

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

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

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

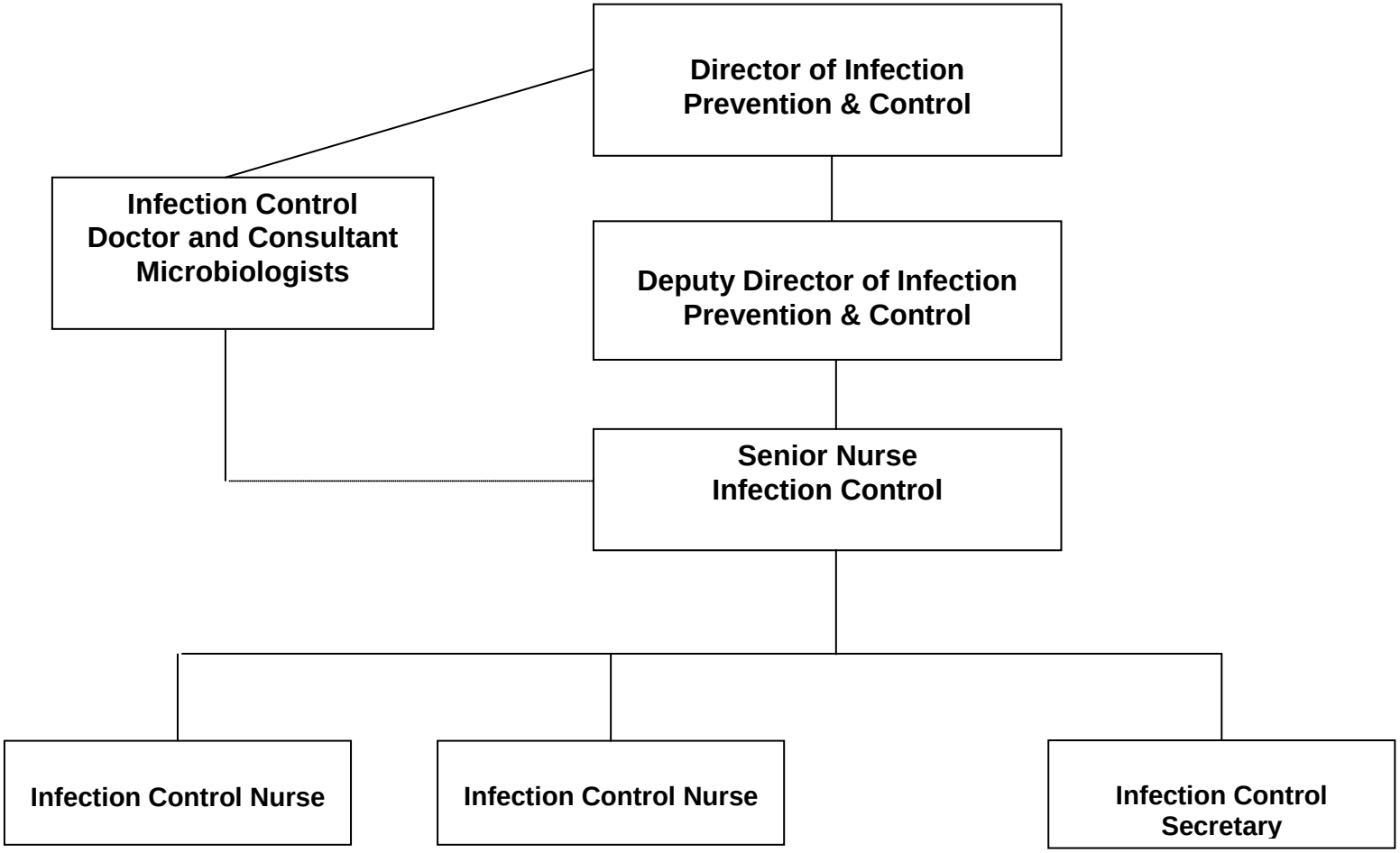
Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	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	MC	In place
Antimicrobial prescribing	JH/SH/ET	In place
Mandatory reporting HCAIs to the HPA	JH	In place
Control of infections with specific alert organisms; MRSA and C. difficile	IP&CT	In place
Additional policies:		
Transmissible Spongiform Encephalitis (TSE)	JH	In place
Glycopeptide Resistant Enterococcus (GRE)	JH	Included in
Acinetobacter species	JH	Isolation
Viral Haemorrhagic fever (VHF)	JH	Policy
Prevention of spread of Carbapenem resistant organisms	JH	In place
Diarrhoeal infections	JH	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	SK/JD	In place
Infection control measures for ventilated patients	MF	In place
Tuberculosis	JH	In place
Legionellosis risk management policy and procedures, including pseudomonas	GA/NE	In place
Strategic Cleaning Plan & Operational Policy	MC	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	GA/NE	In place
Waste Management Policy	PJ	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	PW/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

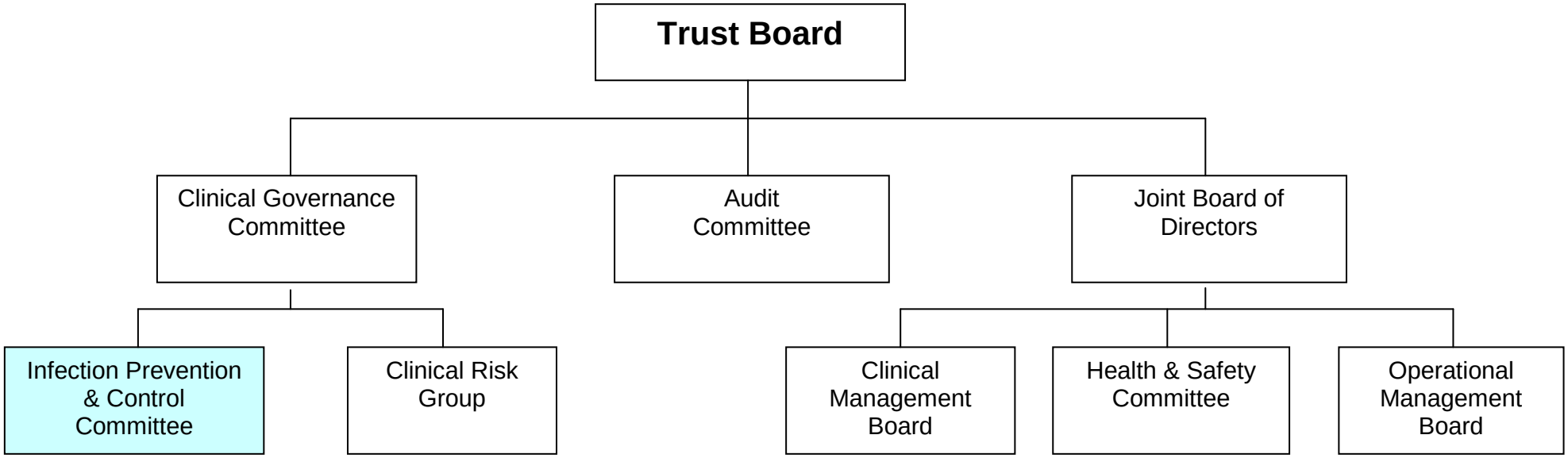
DIPC	Lorna Wilkinson, Director of Infection Prevention & Control (from August 2014)
DDIPC	Fiona Hyett, Deputy DIPC & Interim DIPC (March – July 2014)
PW	Peter Wells, Trust Decontamination Lead and SDU Manager (until June 2014)
RW	Robert Warburton (from Autumn 2014)
JH	Julian Hemming, Consultant Microbiologist & Infection Control Doctor
SC	Stephen Cotterill, Consultant Microbiologist
PR	Paul Russell, Consultant Microbiologist
IR	Ian Robinson, Head of Facilities
GA	George Atkinson, General Manager, Facilities (until January 2015)
NE	Neville Edwards (from January 2015)
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
SK	Shirley Kinsey, Neonatal and Postnatal Services Manager (until Autumn 2014)
JD	Jacqui Dalley (from January 2015)
MF	Maria Ford, Nurse Consultant in Critical Care
PJ	Paul Jackson, Energy and Waste Manager, Facilities
AK	Alison Kingscott, Director of Human Resources
MC	Maggie Cherry, Facilities Matron
ET	Emma Taylor, Principal Pharmacist

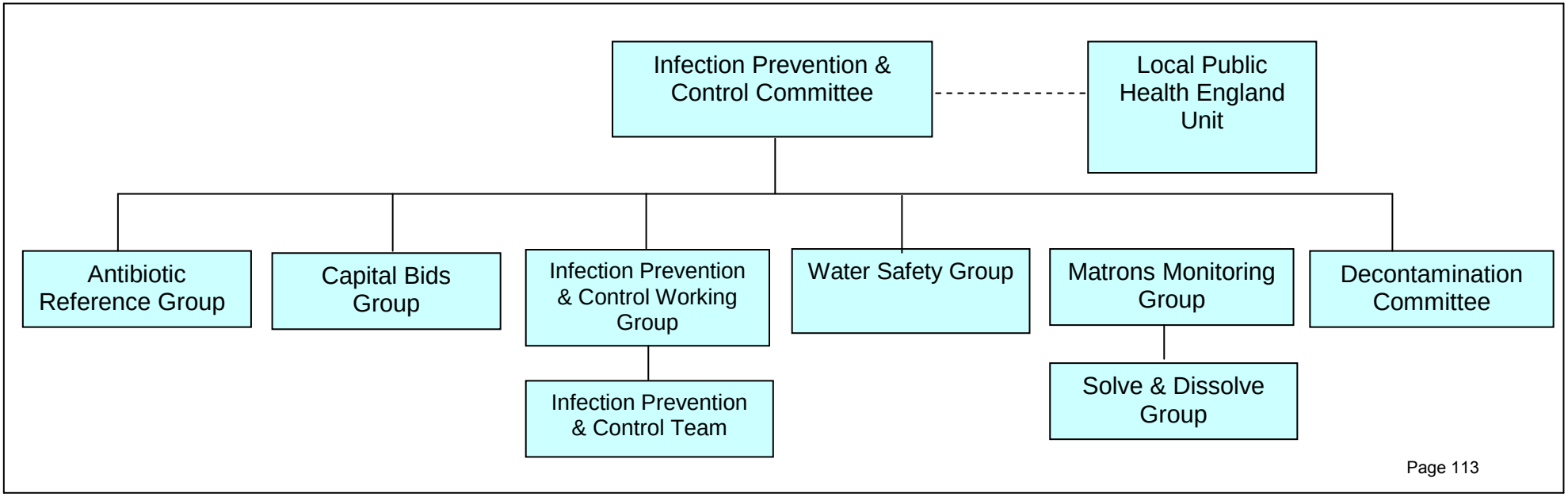
Infection Prevention & Control Team



Appendix 3

Trust Reporting Structure





Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Clinical Support & Family Services (April to September 2014)

	Mean April %	Mean May %	Mean June %	Mean July %	Mean August %	Mean September %
Sarum Ward	x	85.00%	95%	95%	80%	100%
Labour Suite (inc DAU)	90.48%	90.91%	100%	100%	84.21%	100%
Beatrice Post Natal	100%	95.62%	100%	100%	100%	100%
Neonatal Unit (NNU)	100%	100%	100%	100%	100%	100%
Gynae Clinic	100%	100%	100%	100%	100%	100%
Sexual Health	100%	100%	100%	100%	100%	100%
Salisbury Fertility Centre	100%	100%	100%	100%	100%	100%
Radiology Department	100%	x	100%	x	82.35%	x
Endoscopy Department	100%	100%	100%	100%	100%	100%

Clinical Support & Family Services (October 2014 to March 2015)

	Mean October %	Mean November %	Mean December %	Mean January %	Mean February %	Mean March %
Sarum Ward	100%	100%	94.44%	100%	X	100%
Children's Outpatient Department (OPD)	Monthly audits undertaken from January 2015			40%	X	100%
Labour Suite (inc DAU)	100%	100%	X	90.48%	94.74%	100%
Beatrice Post Natal	100%	100%	X	100%	92.86%	X
Neonatal Unit (NNU)	100%	100%	100%	100%	100%	100%
Gynae Clinic	100%	100%	100%	100%	100%	100%
Sexual Health	95%	93.75%	100%	100%	100%	100%
Salisbury Fertility Centre	100%	100%	100%	100%	100%	100%
Radiology Department	95%	X	88.88%	95.45%	100%	90%
Endoscopy Department	100%	100%	100%	100%	100%	100%

X = depicts audit not completed by the clinical area

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Medicine (April to September 2014)

	Mean April %	Mean May %	Mean June %	Mean July %	Mean August %	Mean September %
Whiteparish AMU	100%	95%	90%	80.95%	82.61%	78.13%
Tisbury CCU	90%	90.91%	80%	77.77%	75%	86.63%
Pitton Ward	100%	100%	X	100%	96%	89.66%
Redlynch Ward	100%	94.44%	100%	78.26%	100%	93.57%
Farley Ward	94.74%	87.50%	100%	88.89%	100%	100%
Winterslow Suite	100%	95%	70%	94.74%	95%	96.43%
Pembroke Ward	100%	100%	100%	100%	100%	95.00%
Pembroke Suite	100%	100%	99.78%	100%	100%	100%
Durrington Ward	100%	100%	100%	100%	100%	100%
Hospice	100%	100%	100%	100%	100%	100%
Emergency Department*	47.40%	72%	73.91%	52%	60%	45.99%
Dermatology Department	100%	100%	100%	87.50%	Moved to Musculoskeletal Directorate	
Cardiac Suite	100%	95%	100%	95%	100%	100%
Nunton Discharge Lounge	100%	100%	100%	100%	100%	100%
Breamore/Wilton Ward	100%	100%	Closed	100%	Closed	Closed

X = depicts audit not completed by the clinical area

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

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Medicine (October 2014 to March 2015)

	Mean October %	Mean November %	Mean December %	Mean January %	Mean February %	Mean March %
Whiteparish AMU	66.66%	100%	X	88.89%	90%	100%
Tisbury Ward CCU	80.95%	73.33%	57.9%	83.33%	75%	100%
Pitton Ward	93.54%	83.33%	91.66%	69.23%	76.47%	88.24%
Redlynch Ward	95.65%	85.7%	X	100%	89.47%	97.5%
Farley Ward	100%	95%	100%	100%	100%	100%
Winterslow Suite	94.73%	95%	X	90%	100%	90%
Durrington Ward	100%	55%	X	100%	80%	90%
Pembroke Ward	96.87%	100%	100%	100%	100%	100%
Pembroke Suite	100%	100%	100%	100%	100%	100%
Hospice	92.85%	100%	90.90%	100%	100%	95%
Emergency Department*	25%	65.22%	X	65%	63.64%	64.29%
Cardiac Suite	100%	100%	100%	95%	100%	100%
Nunton Unit	100%	100%	X	100%	100%	100%
Wilton/Breamore Ward	100%	Closed	100%	100%	100%	100%

X = depicts audit not completed by the clinical area

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

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Musculoskeletal (April to September 2014)

	Mean April %	Mean May%	Mean June %	Mean July %	Mean August %	Mean September %
Amesbury Suite	93.1%	X	X	X	92.6%	100%
Chilmark Suite	64.65%	55%	77.27%	85%	90.48%	90%
Laverstock Ward	80%	81.81%	X	X	100%	53.13%
Burns Unit	85%	95.24%	95%	X	90%	90%
Avon Ward	81.82%	90%	86.36%	X	95%	100%
Tamar Ward	100%	90%	95%	95%	90%	X
Spinal OPD	73.33%	100%	100%	X	80%	61.54%
Orthopaedic OPD	100%	100%	96.88%	100%	93.75	100%
Plastics OPD	X	100%	100%	100%	100%	86.36%
Oral Surgery OPD	100%	100%	100%	100%	100%	100%
Rheumatology	X	100%	100%	X	100%	100%
Wessex Laser Centre	100%	100%	100%	100%	100%	94.44%
Burns & Plastics Therapy	X	100%	X	X	85.7%	X
Dermatology Department	N/A	N/A	N/A	N/A	100%	X

X = depicts audit not completed by the clinical area

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Musculoskeletal (October 2014 to March 2015)

	Mean October %	Mean November %	Mean December %	Mean January %	Mean February %	Mean March %
Amesbury Suite	X	100%	87.5%	84.38%	100%	100%
Chilmark Suite	80%	95%	94.74%	100%	95%	95%
Laverstock Ward	X	75%	100%	X	63.16%	39.70%
Burns Unit	85%	95%	90%	90%	95%	94.74%
Avon Ward	X	100%	100%	100%	95%	95%
Tamar Ward	84.37%	95%	90%	90%	100%	100%
Spinal OPD	100%	66.66%	71.43%	85.71%	55.56%	X
Orthopaedic OPD	84.37%	93.75%	96.88%	X	84.38%	75%
Plastics OPD	X	94.45%	95.24%	X	X	91.30%
Oral Surgery OPD	100%	100%	100%	100%	100%	100%
Rheumatology	X	100%	100%	100%	100%	X
Wessex Laser Centre	100%	100%	93.33%	78.57%	100%	90%
Burns & Plastics Therapy	100%	85.2%	93.75	100%	92.31%	X
Dermatology Department	100%	100%	X	100%	100%	100%

X = depicts audit not completed by the clinical area

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables – Surgery (April to September 2014)

	Mean April %	Mean May %	Mean June %	Mean July %	Mean August %	Mean September %
Britford Ward	100%	78.26%	77.78%	100%	100%	83.33%
Downton Ward	91.3%	70%	73.91%	82%	90%	80%
Radnor Ward	100%	100%	88.89%	X	100%	90.1%
Vascular & Diabetic OPD	100%	X	100%	X	100%	100%
Medical & Surgical OPD	100%	100%	100%	100%	100%	100%
ENT Department	100%	76.90%	91.67%	86.96%	100%	100%
Ophthalmology	100%	100%	100%	100%	100%	100%
Main Theatres & Recovery	100%	100%	100%	100%	88%	93.75%
Surgical Admissions Lounge	100%	100%	100%	100%	100%	100%
Day Surgery Unit	100%	100%	85%	90%	85.71%	95.83%
Pre-op Assessment Unit	X	X	X	100%	100%	100%
Clarendon Suite	100%	90%	Closed	88%	Closed	100%

Surgery (October 2014 to March 2015)

	Mean October %	Mean November %	Mean December %	Mean January %	Mean February %	Mean March %
Britford Ward	87.23%	77.5%	96.15%	77.78%	100%	100%
Downton Ward	91.30%	100%	95.45%	90.48%	87.5%	87.5%
Radnor Ward	95%	95%	87.5%	X	X	95%
Vascular & Diabetic OPD	100%	100%	100%	100%	100%	100%
Medical & Surgical OPD	100%	100%	100%	100%	100%	100%
ENT Department	100%	100%	95.83%	100%	100%	100%
Ophthalmology	100%	100%	90.91%	X	X	100%
Main Theatres & Recovery	100%	100%	X	100%	80%	100%
Surgical Admissions Lounge	100%	100%	100%	100%	100%	100%
Day Surgery Unit	100%	85.71%	X	X	94.12%	88.24%
Pre-op Assessment Unit	X	100%	100%	X	100%	100%
Clarendon Suite	Closed	100%	Closed	Closed	Closed	76.92%

X = depicts audit not completed by the clinical area

Appendix 5

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

Directorate	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Chief Executive	32 (19)	28 (20)	47 (44)	20 (49)	**127** (132)
Clinical Support and Family Services	156 (102)	178 (83)	211 (193)	104 (146)	**649** (524)
Consultants/Doctors/Medical students	37 (24)	93 (58)	52 (55)	19 (48)	**201** (185)
Contractors/Other	11 (24)	2 (0)	0 (3)	1 (29)	**14** (56)
Facilities	90 (149)	103 (67)	104 (97)	35 (39)	**332** (352)
Finance and Procurement	11 (30)	33 (13)	19 (16)	13 (23)	**76** (82)
Human Resources	15 (9)	16 (24)	48 (87)	29 (26)	**108** (146)
Medicine	108 (96)	150 (62)	114 (135)	44 (72)	**416** (365)
Musculo-Skeletal	118 (74)	149 (68)	45 (92)	67 (72)	**379** (306)
Quality	61 (27)	40 (20)	46 (70)	53 (24)	**200** (141)
Students/Work Experience	4 (4)	5 (6)	5 (6)	54 (0)	**68** (16)
Surgery	109 (56)	134 (76)	122 (219)	65 (69)	**430** (420)
Wiltshire Council	0 (21)	1 (10)	16 (7)	1 (6)	**18** (44)
Total	**752** (635)	**932** (507)	**829** (1024)	**505** (603)	**3018** (2769)

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

Appendix 6

Infection Prevention & Control Annual Audit Programme 2014/15

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 IP&CT, including key personnel from affected areas.
2	Reduction of infection risk from the use of catheters, tubes, cannulae, instruments & other devices.	Patient Safety Stream Work – implementation of care bundles e.g. central line & peripheral vascular devices.	5 year programme (ended October 2014).	Facilitated by ICNs, including Clinical Leaders/DSNs and educational support from key staff.
		Saving Lives: High Impact Interventions (HII)'	• Priorities & timescales agreed with DIPC. • Plus, targeted audits.	Clinical Leaders/DSNs assisted by ICNs. IP&CT.
3	Reduce the reservoirs of infection.	Environmental & equipment cleanliness	• Priorities & timescales agreed with DIPC. • Plus, targeted audits.	Clinical Leaders/DSNs assisted by ICNs. IP&CT.
		In house Patient Led Assessment of the Care Environment (PLACE) visits.	Programme led by Facilities Directorate.	Facilities Matron/ Housekeeping Manager with the involvement of DMTs.

No	Aim	Audit	When by/How	Person(s) responsible/main author
4	High standards of hygiene in clinical practice.	Hand hygiene, including Isolation nursing and use of personal protective equipment (PPE).	• Priorities & timescales agreed with DIPC. • Plus, targeted audits.	Clinical Leaders/DSNs assisted by ICNs. IP&CT.
5	Prudent use of antibiotics.	Antibiotic prescribing & usage.	Action Plan agreed & monitored by the Antibiotic Reference Group (ARG).	Chief Pharmacist & Interim Antimicrobial Pharmacist.
6	Management & organisation – • Policy, guideline & information development & review programme (review dates according to ICID or SDH intranet site).	Pt information leaflet - Acinetobacter.	Review January 2018.	ICNs.
		Microbiology Alerts Policy.	Review September 2015.	Stephen Cotterill.
		Aseptic technique.	Review October 2015.	ICNs.
		Central Line	Under Review 2015.	Sarah Clark.
		Clostridium difficile Policy.	Review May 2017.	ICD.
		Pt information leaflet - C.difficile.	Review February 2017.	ICNs.
		Contractors/Procurement information leaflet – infection prevention in hospital.	Under Review 2015.	ICNs.
		Creutzfeldt Jacob Disease (CJD) Policy.	Review February 2016.	Decontamination Lead & ICD.
		Decontamination Policy.	Under Review 2015.	Decontamination Lead.
		Pt information leaflet - ESBL.	Review May 2017.	ICNs.
		Glove Usage Policy & Chart.	Under Review 2015.	ICNs.
		Pt information leaflet - Group A Strep (GAS).	Under Review 2015.	ICNs.
		Staff information leaflet - Hand Hygiene.	Under Review 2015.	ICNs.
		Infection Control Policy.	Review February 2016.	ICNs.
		Infection Prevention & Control Practice in the Operating Department.	Review September 2017.	Lucinda Pluck.
		Inpatients with diarrhoea algorithm.	Review September 2015.	ICNs.
		Isolation Policy (including diarrhoeal infections & other alert organisms).	Review June 2017.	ICD.
		Hand Hygiene Policy.	Under Review 2015.	ICNs.
		Pt information leaflet - Invasive GAS Disease.	Under Review 2015.	ICNs.

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

Appendix 7

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

Directorate	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Clinical Support and Family Services	84 (100)	108 (90)	97 (93)	124 (104)	**413** (387)
Facilities	40 (84)	70 (66)	60 (40)	51 (28)	**221** (218)
Medicine	72 (94)	92 (99)	71 (61)	61 (95)	**296** (349)
Musculoskeletal	46 (65)	44 (55)	52 (50)	61 (47)	**203** (217)
Quality	61 (41)	92 (62)	51 (42)	67 (40)	**271** (185)
Surgery	56 (89)	90 (84)	63 (85)	49 (85)	**258** (343)
Corporate	34 (45)	54 (43)	36 (66)	54 (55)	**178** (209)
Doctors	22 (12)	53 (48)	34 (38)	34 (35)	**143** (133)
Wiltshire Council	0 (0)	5 (0)	2 (2)	3 (0)	**10** (2)
Other Groups	17 (12)	8 (10)	10 (15)	7 (10)	**42** (47)
Total	**432** (542)	**616** (557)	**476** (492)	**511** (499)	**2035** (2090)

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

Corporate Directorate

Hand Hygiene Assessment

Course Status (en)	No of Users
Complete	333
NotStarted	108
Total:	441

Infection Prevention and Control (e-Learning)

Course Status (en)	No of Users
Complete	377
Incomplete	7
NotStarted	57
Total:	441

Clinical Support & Family Services Directorate

Hand Hygiene Assessment

Course Status (en)	No of Users
Complete	540
NotStarted	311
Total:	851

Infection Prevention and Control (e-Learning)

Course Status (en)	No of Users
Complete	697
Incomplete	11
NotStarted	143
Total:	851

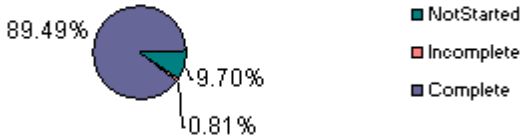
Facilities Directorate

Hand Hygiene Assessment

Course Status (en)	No of Users
Complete	289
NotStarted	82
Total:	371

Infection Prevention and Control (e-Learning)

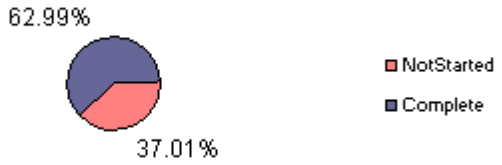
Course Status (en)	No of Users
Complete	332
Incomplete	3
NotStarted	36
Total:	371



Medical Directorate

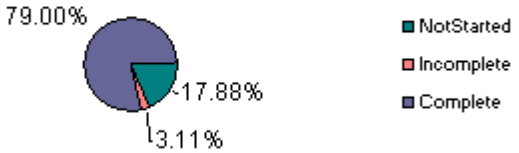
Hand Hygiene Assessment

Course Status (en)	No of Users
Complete	405
NotStarted	238
Total:	643



Infection Prevention and Control (e-Learning)

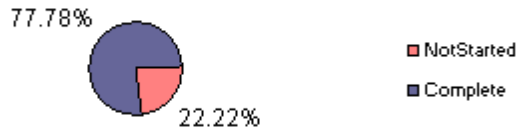
Course Status (en)	No of Users
Complete	508
Incomplete	20
NotStarted	115
Total:	643



Musculoskeletal Directorate

Hand Hygiene Assessment

Course Status (en)	No of Users
Complete	371
NotStarted	106
Total:	477



Infection Prevention and Control (e-Learning)

Course Status (en)	No of Users
Complete	397
Incomplete	9
NotStarted	71
Total:	477

Quality Directorate

Hand Hygiene Assessment

Course Status (en)	No of Users
Complete	246
NotStarted	232
Total:	478

Infection Prevention and Control (e-Learning)

Course Status (en)	No of Users
Complete	381
Incomplete	16
NotStarted	81
Total:	478

Surgery Directorate

Hand Hygiene Assessment

Course Status (en)	No of Users
Complete	384
NotStarted	264
Total:	648

Infection Prevention and Control (e-Learning)

Course Status (en)	No of Users
Complete	550
Incomplete	14
NotStarted	84
Total:	648

Appendix 8

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

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

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

Appendix 8

Topics covered at the ICLP monthly meetings during quarters 3 and 4 of 2014/15 have included the following:

- Notification of the MRSA bacteraemia case identified during September 2014 for a patient on a ward in the medical directorate, outlining the Post Infection Review process and the identified learning outcomes.
- Notification of the 2 non Trust apportioned MRSA bacteraemia cases identified during December 2014, with confirmation that these were unrelated cases and that the Post Infection Reviews were undertaken by the relevant CCG. It was emphasised that the management of the patients remained the same as for any patient when a MRSA positive result is identified.
- Explanation and educational support regarding the alternative MRSA nasal decolonisation medication prescribed across the Trust in response to the national supply issues of the usual product.
- Explanation of the classification and timeframes for Trust and non Trust apportioned cases for both C.difficile and MRSA bacteraemias.
- C.difficile (discussed at each meeting during the quarter):
    - Reporting the number of inpatient cases identified each month since April 2014, and reinforcing the Trust target of no more than 18 cases for 2014/15. Notification of the increased number of Trust apportioned reportable C.difficile cases identified from February 2015.
    - Discussion of the 'Critical Friend' review undertaken by the local Clinical Commissioning Groups (CCGs).
    - Update with progress on the completion of actions detailed in the Trust C.difficile Prevention Action Plan.
    - Discussion of the sporicidal wipes trial commenced for the decontamination of commodes on Pitton and Redlynch Wards.
    - Feedback regarding the Trust review of personal protective equipment (PPE), including the different coloured disposable plastic apron trial extended to other inpatient areas.
    - Sharing and discussion of the learning identified from completed incident investigations, highlighting positive practices and areas for further improvement.
    - Emphasising the safe management of patients, the requirement for prompt diagnosis to ensure appropriate treatment is implemented, and the importance of documentation within patient healthcare records.
- Ebola Preparedness:
    - Notification of the Trust position and preparedness meetings chaired by the DIPC, and attended by key staff groups and personnel.
    - Explanation that the established Trust policy for 'Ebola and other Viral Haemorrhagic Fever (VHF) guidance' could be accessed via a link on the front page of the Trust intranet. Discussion of the Ebola information and patient management advice already disseminated within the Trust to the Clinical Leads and Directorate Teams, with confirmation that the Trust policy had been updated to reflect PHE guidance and the current assessment algorithm.
    - Feedback from the look back exercises completed in response to the low probability cases managed in the Emergency Department, outlining what had gone well and the further work carried forward into the preparedness meetings. For the second suspected case the look back exercise identified that the Trust Ebola plan had worked well.
    - Relaying the request for volunteers from the directorates of those clinical staff willing to undergo the required training and be contacted to provide care on the admission of a suspected case.

    - Discussion of the PPE requirements for the management of suspected/confirmed cases, with the explanation that this involves being 'fit tested' for a respirator mask (e.g. Full Face Protection Level 3 mask), and also a separate PPE training session.
    - The ICLPs were reminded that each directorate had staff trained to undertake 'fit testing' of other staff members for a respirator mask, and that staff were required to undergo 'fit testing' in order to care for a suspected/confirmed Ebola case.
    - The PPE training was explained in detail with a practical demonstration. This included the putting on, or 'donning', of the PPE; the removal of potentially contaminated PPE with an 'undresser'; and the 'lone undressing' procedures. Update on the revised PPE available in the Trust, a new style of all-in-one suits and gloves with longer cuffs and being supplied in 2 colours to more easily identify a break in glove integrity.
    - Discussion following the cases reported in the media of healthcare workers repatriated into the UK following needle stick injuries.
    - Information produced by the PHE and guidance generated by the Trust was made available at the meetings for the ICLPs, to aid the cascade of information to colleagues, with additional website links.
- Confirmation of the management of patients with suspected or confirmed influenza, in response to a high level of suspected and confirmed influenza cases admitted to the Trust. This included screening, isolation implications and PPE requirements, communication between teams and the advised prophylaxis antiviral treatment for identified contacts of positive cases.
- Reaudit of the BBE and uniform compliance across inpatient and outpatient areas. Explanation of the audit process, with data collection in the areas by the ICLPs and/or Clinical Leaders of clinical staff who wear a uniform. Data collection by the ICNs of clinical staff not wearing a uniform as part of their role, e.g. clinicians.
- Discussion of the level of diarrhoea and vomiting activity, the increased number of patients admitted with symptoms, and that the level of activity had resulted in the closure of bays and one ward at different times. Communication of the high level of diarrhoea and vomiting cases reported in the region, including at residential and nursing homes and at other local Trusts.
- NICE guidance 49 – surgical site infection surveillance. Discussion of the NICE document and the actions and baseline assessment undertaken. The ICLPs were tasked to review the relevant patient information and pathways utilised within their areas, with emphasis placed upon ensuring accurate documentation within patient healthcare records.
- Overview and update with decontamination processes, covering:
    - The decontamination of equipment in accordance with current Trust policy, and staff responsibilities for decontamination.
    - Reinforcing the decontamination methods and products in use to decontaminate equipment within clinical areas.
    - Highlighting the health and safety implications and the requirement for appropriate use of PPE by staff.
    - Requirement for formal risk assessment where it is identified that Trust procedures for decontamination can't be followed.
- Presentation by a Consultant Microbiologist (Antimicrobial Lead) – Helping me, helping you, helping the patient – Your Role in Infection Control. A copy of the presentation was distributed with the meeting minutes for the ICLPs to cascade to colleagues in their areas/departments.
- Hand hygiene audits – continued education and support made available to the ICLPs, and notification that an external auditor had been on site to undertake additional hand hygiene audits.
- Discussion regarding the number of sewage leaks and blocked pipes experienced across the Trust over a weekend period in January 2015. Feedback from the completed investigation, and that the leaks were attributed to the flushing of dry patient wipes into toilet facilities. Actions were identified for the ICLPs to cascade to colleagues, areas/departments and ensure that the wipes were not available in patient and staff toilets/bathrooms.
- Infection control quiz.

- Responding and advising on specific clinical related issues, in addition to the various concerns identified by the ICLPs.
- Feedback of the ongoing issue with the MLE not always recording the most up to date information for completed hand hygiene assessments, and reassurance that the issue had been raised via the Education Department to the external MLE supplier.
- Reminder for the ICLPs to undertake refresher training with the ICNs, to enable continued use of the UV light box to undertake hand hygiene assessments in their areas/departments.
- Reminders for the different ‘drop-in’ education sessions facilitated by the ICNs.

Appendix 9

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

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

Appendix 10

Additional information relating to Trust activity with alert organisms

- **Acinetobacter baumannii**

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

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

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

- **Carbapenem Producing Enterobacteriaceae (CPE)**

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

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

Please refer to page 16 of main report.

- **Chickenpox (Varicella Zoster)**

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

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

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

- **Escherichia coli**

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

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

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

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

During 2014/15, there have been 3 cases of iGAS identified for inpatients which were not linked. For each case identified, patients are managed according to the Trust Isolation policy, with treatment advised by a Microbiologist, with the involvement of the local PHE. This is to enable the required follow up of any identified household contacts in the community.

- **Pertussis (‘whooping cough’)**

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

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

- **Respiratory Syncytial Virus (RSV)**

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

There were no declared outbreaks of RSV during 2014/15.

- **Tuberculosis (TB)**

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

During 2014/15, inpatients admitted with or identified during admission to have suspected pulmonary TB were isolated under respiratory precautions in sideroom facilities.

During quarters 3 and 4 of 2014/15, there were 3 patients identified to have pulmonary TB. Two of these patients were inpatients within the medical directorate and the remaining patient was identified post discharge. All patients were managed appropriately during their care episode. These cases were fully investigated and found to be unrelated. The ICNs worked closely with the Respiratory and OH Departments to ensure the follow up of any identified patient or staff contacts.

- **Vancomycin Resistant Enterococcus (VRE)**

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

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

- **Viral Gastro-enteritis**

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

There were no declared outbreaks of Norovirus during 2014/15.

The Trust has a Norovirus Major Outbreak Plan Policy in place, which provides additional information and guidance on Salisbury NHS Foundation Trust’s operational response to a major outbreak of Norovirus. The aims and objectives of this document are to ensure a procedure is in place to deal with the command and control of Norovirus issues that might affect the operational running of the Trust. This policy identifies appropriate areas for isolation nursing and the management of patients presenting with symptoms of viral gastro-enteritis direct from the community, and helps minimise disruption to the Trust, whilst continuing to operate effectively

without the need to cancel elective admissions. The Trust did **not** need to utilise this policy during 2014/15.

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

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

Appendix 11

Clostridium difficile Prevention Action Plan – created 7th July 2014 (updated 31.03.15)

	Recommendations	Actions & steps	Person(s)/Lead Responsible	When by & progress update/completion
Policies and Procedures:				
1.	Review the current *C.difficile* infection (CDI) policy and procedures (including Diarrhoeal Algorithm), to include the prevention, early suspicion and detection of the disease.	The policy should include the following: • Initial management of suspected potentially infectious diarrhoea using the 'SIGHT' mnemonic protocol *(as per recommendation within the current national guidelines on Clostridium difficile infection: How to deal with the problem, 2009).* • Latest guidance on prudent antimicrobial prescribing and use of proton pump inhibitors (*as per 'Updated guidance on the management and treatment of Clostridium difficile infection, 2013'*). • Management of recovered CDI patients with evidence of risk assessment documented in healthcare records (not being routinely removed from sideroom facilities). • Environmental decontamination requirements. Key policy changes to be included within: • Trust and local area/ward inductions • *C.difficile* prevention workshops • Updates provided by Infection Control Link Professionals (ICLPs).	**JH/PR/SH/ET/FM**	**March 2015 – completed:** Review of the medical aspect of the policy required. **November 2014** – **completed:** ET has provided the latest evidence which will be included within the policy.

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

Cont:	Recommendations	Actions & steps	Person(s)/Lead Responsible	When by & progress update/completion
Antimicrobial Prescribing				
3.	Ensure actions taken as a result of completing two antibiotic stewardship audits per clinical area/ward per month are fedback to the relevant staff in a timely manner (links to CQUIN requirements).	• Use of the antimicrobial pharmacist and consultant microbiologist (or allocating ward/speciality level auditing as a Junior Doctor project, e.g. HiMP). • Working with Prescribers to ensure antibiotic therapy prescribed where clinically appropriate and stopped in a timely manner i.e based on clinical review.	**SH/ET/JH/PR/SC** **ET/Doctor identified by Christine Blanshard**	**Ongoing – Update:** CQUINNs completed (as per requirements) with audit results available from ET. Additional information: ET to report back following contact with Pharmacy Clinical Commissioning Group Lead. Christine Blanshard to report back following contact with local LMC chair regarding support for reduction in inappropriate prescribing of antibiotics in the community by GPs. **January 2015 – Update:** No progress. PR to identify clinician champion for antibiotic stewardship.
4.	Review of antimicrobial prescribing polices to ensure following best practice.	• Establish why using and compare policies with other NHS Trusts.	**SH/ET/PR**	**September 2014 – completed:** Evidence available from ET.
Assurance				
5.	**Epidemiology:** • Establish further profiling of CDI cases.	• Mapping of ribotypes against speciality and risk factors and understanding the time to onset of cases. • Consider access to CDRNE Enhanced Fingerprinting Service and undertake further epidemiological analysis on cases. • Trust's involvement within national project for DNA analysis of ribotyping profiling with Enhanced Fingerprinting Service.	**JH** **JH** **SC**	**Ongoing – Update:** Ribotyping profiling report for SDH completed. Presented at Clinical Governance Committee 25.09.14. **August 2014 – Update:** SC in communication with Bristol Reference Laboratory. **Action closed February 2015.** **January 2015 –** commenced June/July 2014. **Action closed February 2015.**
6.	**Audit:** • Independent domestic/environmental cleaning audits to be undertaken to include areas of the clinical environment/ward that are not accessible to patients, e.g. dirty utility rooms and clean preparation areas/utility rooms.	• Independent audits of cleaning performed by Directorate Senior Nurses (DSNs) with Housekeeping Manager (and consider peer auditing), e.g. use of 'Confidence in Caring' forms to support PLACE audits.	**DSNs/AU**	**Immediate & ongoing – Update:** Clinical leaders liaising with Housekeeping Supervisors; completion of 'Confidence in Caring' audits by DSNs; exception reporting at 9.45am meetings held three times a week.

Cont:	Recommendations	Actions & steps	Person(s)/Lead Responsible	When by & progress update/completion
	• Improved compliance with adherence to infection control practice policies.	• DSNs, ICNs and Infection Control Link Professionals (ICLPs) to undertake periodic objective checks of care bundles and audit within the clinical areas, with audit outcomes and actions required to be fedback in real time to the relevant forums and committees. • DSN representation at Infection Prevention & Control Working Group (IPCWG) meeting.	**DSNs/ICNs/ICLPs** **DSN**	**Immediate & ongoing – Update:** Weekly walkrounds of clinical areas by Deputy DIPC and Senior ICN commenced August 2014. Exception reporting at meeting held three times a week (Infection Control and Housekeeping in attendance). **Commenced June 2014 – Update:** DSN's for medicine and surgery in attendance from quarter 2 (2014/15).
7.	**Clinical Review:** • Strengthen the multidisciplinary *C.difficile* round team membership. • Investigate enabling ward staff with the decision making process for the management of patients with symptoms of diarrhoea (Type 5 – 7 stools).	• Inclusion of gastroenterologist and dietician within the team to ensure robust team review of *C.difficile* patients. • Consider use of electronic observations system to trigger Type 5 – 7 stools, e.g. Patients Observational Electronic Tool (POET).	**JH** **Ward Leaders/Infection Prevention & Control Team (IPCT)**	**November 2014 – Update:** JH has e-mailed Sam Vyas (copy in DIPC) and to recommend dietician involvement. **February 2015** gastroenterologist to be accessed as required. **Trust Project – Update:** Meetings have started, with DIPC involvement.
Clinical practice, Cleaning and the Environment				
8.	**Clinical practice:** • Reinforcement to all clinical staff the importance of consistent compliance with standard infection control precautions, e.g. appropriate use of personal protective equipment (PPE).	• DSNs to undertake reviews of practices and audits of environmental and equipment cleanliness. • IPCT to work alongside staff to educate regarding key areas within infection prevention and control practices. • Trial of coloured disposable aprons within the clinical setting to minimise wearing of contaminated PPE in different areas. • Alcohol hand rub gel dispenser available at patient's bedside (end of bed).	**DSNs** **IPCT** **Tisbury CCU & Whiteparish AMU Clinical Leaders** **Ward Leaders**	**Immediate & ongoing – Update:** Completion of 'Confidence in Caring' audits by DSNs. **Immediate & ongoing** **January 2015 – Update:** Trial completed in August. Other areas included Pitton, Redlynch, Durrington and Farley Wards. Implementation continues. 'Spot checks' of practices by ICNs and clinical leaders. Formal feedback to Matrons Monitoring Group. For Trust 'roll out'. **January 2015 – Update:** Required information e-mailed to clinical leads for action. Implementation completed.

Cont:	Recommendations	Actions & steps	Person(s)/Lead Responsible	When by & progress update/completion
9.	**Patient Care Equipment and Environmental Decontamination:** • Review of cleaning agent and consider the implementation of a single stage cleaning regime. • Consider undertaking routine cleaning using a chlorine-releasing agent. • Terminal cleaning of infectious siderooms is available throughout the day (into the late evening). • Ensure all sideroom facilities vacated by a *C.difficile* patient are decontaminated using hydrogen peroxide, e.g. GLOSAIR 400 room decontamination system.	• Investigate other NHS Trusts cleaning policies and what chemicals/products in use and provide recommendations to IPCWG. • Submission of capital bids for additional cleaning monies for resources, if required. • Inclusion within the SDH Trust policies (including Operational Policy for Use of Hydrogen Peroxide GLOSAIR 400).	**MC** **MC** **MC**	**September 2014 – completed:** Final decision made by the IPCWG members. **January 2015 – Update:** paper submitted to Operational Management Board (OMB) and Executive Directors. Capital bid submitted for use of microfibre (floor cleaning system). No outcome to date. **February 2015 – completed:** To be an appendix to Strategic Cleaning Policy and approval at Infection Prevention & Control Committee in January 2015. **Additional information/update:** Pitton, Redlynch, Durrington and Farley Wards have trialled sporicidal wipes for commode decontamination. Evaluation of the product to be reviewed by the IPCWG.
10.	**Education and Training:** • Review current methods of learning (including MLE) for infection prevention and control and consider reinstating 'face to face' learning for infection prevention issues specific to CDI. • Ensure 'SIGHT' mnemonic protocol is covered in induction with updates (as required) throughout 2014/15, including sampling processes for staff.	• Ensure current methods provide what is required in relation to management of CDI. • Establish how many staff have received education/training on the Trust Diarrhoeal Algorithm.	**IPCT** **IPCT**	**January 2015 – Update:** Review of Junior Doctors Handbook/teaching sessions by JH/PR. **September 2014 – Update:** as of July 2014, included within update workshops and scheduled educational sessions.

Person(s) responsible:

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

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance and Performance Committee
Held on 30 March 2015

Present:	Dr N Marsden	Chairman
	Mr L Arnold	Acting Chief Operating Officer
	Mr P Hill	Chief Executive
	Mr I Downie	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
	Dr L Brown	Non-Executive Director
Apologies:	Rev S Mullally	Non-Executive Director
	Mr A Freemantle	Non-Executive Director
In Attendance:	Mr P Kemp	Non-Executive Director
	Mr M Collis	Deputy Director of Finance
	Mrs M Cripps	Directorate Manager (Surgery)
	Mr M Ace	Associate Executive Director
	Mr D Seabrooke	Head of Corporate Governance
	Mrs C Gorzanski	Head of Clinical Effectiveness (for item 3)

1. MINUTES – 23 FEBRUARY 2015

The minutes of the meeting held on 23 February 2015 were accepted as a correct record.

2. FINANCE REPORT TO 28 FEBRUARY (MONTH 11)

The Committee received the Finance and Contracting Report.

It was noted that the Trust was showing a deficit year to date of £1.7m and cost improvement plans were behind the phased plan by £1m. Agency spend was higher and the Trust continued to feel the effects of treating non elective patients.

The report included forecasts for the year end with details of the assumptions being made.

On activity it was noted that outpatient follow-ups continued to reduce but that spend on healthcare assistants and nurses was up. A £1m more than last year had been spent on employing doctors.

On contracts it was noted that heads of terms had been agreed with Dorset CCG.

With regards to controlling nursing agency costs the Trust had piloted an incentive for a limited range of difficult to fill shifts. In addition overseas recruitment for both doctors and nurses was being pursued.

The committee welcomed the approach to the financial forecasts and asked that this be developed to include more commentary.

The Committee the noted the Month 11 Finance Report.

3. CQUIN MONTH 11 REPORT

The Committee received the report on CQUIN and Clare Gorzanski, Head of Clinical Effectiveness attended for this item. It was noted that the position on Wiltshire and Dorset CQUINs was Green and there was one Amber in relation to Time for Initial Consultation where the Trust was underperforming slightly on the West Hampshire CQUIN. The Trust was on target for the specialist CQUINs.

Guidance for national 2015/16 CQUINs had recently been issued and would be taken into account in the negotiations with Wiltshire and West Hampshire in relation to their CQUIN requirement.

The Committee noted the CQUIN Report.

4. REVENUE ESTIMATES 2015/16

The summary of the revenue estimates for 2015 was circulated. It was noted that the Source and Application of Funds statement remained a work in progress as a number of variables were still changeable at this stage. The effect of the 2015/16 Tariff was still being examined and there was reason to believe that it would in practice deliver £1m less than originally indicated.

Since the report had been circulated the final National Contract documentation had been received and this included a number of non-discretionary elements for CCGs around provider penalties.

The Trust had made Monitor made aware by of its forecast outturn position for 2015/16. The Annual Report would also require a declaration by the Board about the 2015/16 financial position and going concern.

There had been good engagement within the Trust in relation to the budget setting process including the review of potential cost pressures. The analysis had allowed for the national pay award for Agenda for Change and Medical staff and followed national assumptions in relation to drugs costs. However nothing was included in relation to Seven Day Working, Electronic Patient Records or Electronic Discharge.

It was noted that the Board would be asked to give final approval for the estimates at the 13 April meeting.

The Committee noted the report.

5. TRANSFORMATION AND COST IMPROVEMENT

The report of the Programme Management Office was circulated at the meeting. The year-end forecast was for £1.7m against a savings target of £2.9m. The great majority of savings achieved were in the non-pay workstream. The Trust continued to strengthen the governance arrangements around cost improvements schemes including the “Return To Green” approach in relation to projects that were off track. Plans had been developed for savings of up to £5m for 2015/16 based on a series of smaller schemes. The need for continuing engagement throughout the hospital on this vital theme was emphasised.

The Committee noted the report.

6. OPERATIONAL PERFORMANCE – MONTH 11

The Committee received copies of the Performance Report for Month 11.

The Trust was within target at the end of February for C-Diff but further cases had been declared in March that now took the Trust over the annual trajectory. The underperformance in relation to 18 Weeks Admitted RTT was as a result of a planned initiative carried out earlier in the year. There had been good performance in A&E in relation to the Four Hour Target and it was thought that the Quarter Four and annual performance would recover to 95%.

There were 28 Delayed Transfers of Care at the end of February mainly relating to Wiltshire.

The Committee noted the report.

7. DATE OF NEXT MEETING

Monday 27 April 2015 at 9.30 am in the Boardroom.

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance and Performance Committee
Held on 27 April 2015

Present:	Dr N Marsden	Chairman
	Mr L Arnold	Director of Corporate Development
	Mr I Downie	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
	Dr L Brown	Non-Executive Director
	Rev S Mullally	Non-Executive Director
	Mr A Freemantle	Non-Executive Director
	Mr A Hyett	Chief Operating Officer
Apologies:	Mr P Hill	Chief Executive
In Attendance:	Mr P Kemp	Non-Executive Director
	Mrs F Hill	Head of Risk Management (items 3 & 4)
	Mr M Ace	Associate Executive Director
	Mr D Seabrooke	Head of Corporate Governance
	Mrs C Gorzanski	Head of Clinical Effectiveness (for item 3)

1. MINUTES – 30 MARCH 2015

The minutes of the meeting held on 30 March 2015 were accepted as a correct record but it was noted that Andrew Freemantle had attended the meeting.

2. CQUIN REPORT

The Committee received the CQUIN Report giving the summary of the 2014/15 schemes and proposals for 2015/16. The Trust had achieved its CQUIN schemes in full for all commissioners in 2014/15 with a value of £3.64m.

The Committee recorded its thanks for all staff concerned in achieving this.

CQUINs for Wiltshire, Dorset and associates for 2015/2016 included Sepsis screening, acute kidney injury, dementia and delirium (staff training). The Trust was working with other providers on negotiating improvements to ambulatory care to reduce A&E admissions. It was felt the other parts of the health and social care system needed to be working fully effectively before this CQUIN as proposed could be agreed.

For West Hants CCG representing the SHIP Group work on out-patient reform (reducing face to face follow ups) would continue but the Trust was negotiating on reducing Delayed Transfers of Care to ensure that this reflected areas that were within the Trust's control.

There had been a good meeting with specialised commissioners and a range of four CQUINs described in the report had been agreed.

It was noted that contract discussions with Wiltshire were continuing and the future CQUINs would need to be agreed as part of this.

The Committee noted the end of year achievement for 2014/15 CQUIN and prospects for the 2015/16 CQUINs.

It was agreed that the two days of Band 5 support for the Dementia CQUIN should continue for a further year.

3. ASSURANCE FRAMEWORK/RISK REGISTER – QUARTERLY REVIEW

The Committee received a report and extract from the Assurance Framework.

A gap in control for Risk 4.2 (failure to secure income) was noted in relation to the commissioner contract negotiations, and that negotiations were ongoing.

In relation to 4.3 (failure to contain expenditure within budgets and achieve agreed efficiency savings) gaps in control were noted in relation to the forward planning of cost improvement programmes, the scale of the 2015/16 CIP requirement and the system of forecasting capabilities and system needs.

It was noted that CIP schemes were RAG rated and Amber and Red schemes were reviewed by the Programme Steering Group and then reported to the Finance and Performance Committee.

The assurance framework did not specify how planned improvements to forecasting would be achieved. Not all of the £8m saving requirement for 2015/16 had identified schemes against it.

It was suggested that the process for devising and monitoring cost improvement plans may need to be reviewed as the Trust entered into a deficit position to ensure that the right information was coming through to enable schemes to be supported appropriately at the right levels.

An extreme risk (3501) had been registered from the MSK directorate in relation to its CIP plans and Fenella Hill would be discussing this with the team to identify remedial actions.

4. ANNUAL GOVERNANCE STATEMENT

The Committee received a copy of the Draft Annual Governance Statement for inclusion in the Annual Report 2015/16. It was suggested that the role of the Programme Management Office (paragraph 3 on page 6 of the AGS) should be reworded to describe an enabling and facilitating role for the Programme Management Office.

The final Annual Governance Statement would be reviewed by the Audit Committee as part of the Annual Plan approval process.

5. FINANCE REPORT TO 31 MARCH (MONTH 12)

The Committee received the Finance and Contracting Report. It was noted that the draft accounts for 2014/15 had been submitted and would reviewed by the auditors. An acceptable year end settlement with Wiltshire CCG had been arrived at. Concern was expressed about the

nursing agency spend and it was suggested that additional information about the actions being taken in this regard should be brought to the Committee.

The Chairman would consider how the strands of performance, workforce and financial information should be brought together and discussed in a timely way.

It was suggested that the way in which demand for nurse recruitment could be forecast needed to be set out in a forward strategy that reflected the Trust's Service Strategy.

MC highlighted the range of major work streams currently being addressed by the executive including the Community Services Bid, Pathology Project with Poole and Bournemouth, Genomics with University Hospitals Southampton and University of Southampton, work on commercial income streams including the My Trusty brand and the ongoing leadership of cost improvement programmes.

MC highlighted the progress with contract negotiations, which were progressing well with Dorset, West Hampshire and with specialist commissioners. Difficulty continued to be experienced with Wiltshire and MC was emphasising that the Trust should continue to be paid for the activity it delivered under the contract. A firm but collaborative approach would continue to be adopted.

The Board noted the Finance and Contracting Report.

6. MONITOR Q4 RETURN AND ANNUAL PLAN RETURNS

The Committee received a report from the Head of Corporate Governance setting out the draft Quarter 4 declaration to Monitor. It was noted that the Trust had not met the C-Diff target in Q4 and that final figures in relation to 62 Day Cancer Waits would be confirmed before the return was submitted.

The Committee was reminded of the Quarterly declaration to the effect that a continuity of Service Risk Rating of at least 3 would be maintained over the coming twelve months and it was agreed that this should be affirmed for Quarter 4 but kept under regular review during 2015/16. The Committee was also given a reminder of the requirements of Monitor in relation to in-year exception reports.

The Trust was also required to submit annual declarations in connection with the Annual Plan in relation to licence compliance AHSCs and Governor training. A draft Corporate Governance Statement was also set out for submission to Monitor.

The Committee agreed the submission of the Quarter 4 return to Monitor, the Statement of Compliance with the licence and the Corporate Governance Statement.

7. GP REFERRALS/MARKET INTELLIGENCE

The Committee received the GP Referrals Report giving rolling twelve month averages across a range of GP practices. There had been increased referrals from outside Wiltshire and from central Salisbury.

It was noted also that the next stage of the Community Services procurement had been announced and that a “essay question” on the delivery of the service had been agreed by the three partners and would be circulated to Board Members for information.

8 TRANSFORMATION/COST IMPROVEMENT

The Committee received the update from the Programme Management Office and it was noted that the Red rated schemes, Outpatient productivity, patient flow, theatre productivity, orthopaedics and diagnostics would be reviewed by the Programme Steering Group. The report indicated that 79% of planned savings had been achieved at the year end and of these 43.25% were recurring and 56.75% non-recurring.

It was also noted that the Electronic Patient Record initiative was progressing. This would require loan finance and would be brought to the Committee with a statement on benefits realisation.

9 OPERATIONAL PERFORMANCE MONTH 12

The Committee received and noted the Operational Performance Report for Month 12.

10 DATE OF NEXT MEETING

Monday 18 May 2015 at 9.30am

Trust Board

FINANCE & CONTRACTING REPORT TO 30th April 2015

1. Introduction

This paper summarises the SFT Group consolidated financial position for the first month of the 2015/16 financial year. The ability to fully scrutinise the position for the first month has been affected by staff having to also undertake work on: the annual accounts, annual plan, contract negotiations, and processing new year budgets. The figures need to be treated with some caution.

The Group Income & Expenditure (I&E) position for April (see Appendix 1) was a deficit of £1,101k which results in an adverse variance against the Plan submitted to Monitor on 14th May of £193k.

The main reasons for the adverse variance were:

- High expenditure on agency
- Income being much lower than expected (subject to review)
- Excessive 'resilience' spend
- CIPs being less than planned

Summary of Key Financial Information	April 2015			
	Plan £000s	Actual £000s	Var £000s	Var %
Income	16,090	15,685	-405	-2.5%
Expenditure	15,721	15,524	197	1.3%
EBITDA	**369**	**161**	**-208**	**-56.4%**
Finance Costs	1,277	1,273	4	0.3%
I+E Surplus /(Deficit) excl donated asset incom	**-908**	**-1,112**	**-204**	
Donated Asset Income Adjustment	0	11	**11**	
I+E position including donated asset income	**-908**	**-1,101**	**-193**	

2. Sales

NHS activity revenue was £13,403k which is circa £500k less than the plan. Some anticipated resilience funding from Wiltshire CCG has been applied.

Contract Activity performance 2015/16 (April 2015)	Actual 2014-15	Actual 2015-16	Trust Plan 2015-16	Year on Year Variance 2015-16	Trust Plan Variance 2015-16
Elective inpatients	459	539	505	80	34
Elective DC Only	1,758	1,791	1,933	33	-142
Regular Day Attenders	604	582	568	-22	14
Non-Elective Activity	2,091	2,147	2,042	56	105
O/Pt initial attendances	5,351	5,320	5,511	-31	-191
O/Pt follow-up attendances	9,792	8,933	9,323	-859	-390
Outpatient procedures	2,925	2,538	2,931	-387	-393
A&E attendances	3,565	3,757	3,601	192	156

Income is less than expected for drugs, non-elective work (including Burns, Spinal and Critical Care) and outpatients. Income from other clinical activities and other operating

income were circa £100k over plan. The plan figures allow for the effect of the bank holidays.

The substantial reduction in out-patient procedures compared with the same period in 2014/15 needs to be fully understood as this has driven the income reduction together with other out-patient work. It is also possible with the recent need for escalation beds that additional patients are in the system but won't be counted financially until discharge.

We are evaluating whether there has been any unexpected impact of the new tariff and we will check systems to ensure all income generating activity is being properly recorded and accrued for.

3. Cost of Sales including indirect costs

The total expenditure for all Directorates in Month 1 was £13,936k, resulting in an adverse variance of 635k. The position is summarised below:

Directorates	April 2015		
	Plan	Actual	Var
	£000s	£000s	£000s
Medicine	3,222	3,470	-248
Musculo Skeletal	2,310	2,372	-62
Surgery	2,773	2,930	-157
CSFS	2,902	2,981	-79
Facilities	309	308	1
Corporate	1,785	1,875	-90
TOTAL	**13,301**	**13,936**	**-635**

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.

Nursing pressures in Medicine accounted for £120k of the variance in the directorate, and medical staff a further £61k. The major cause is the continued operation of escalation beds.

The variance in MSK related mainly to savings not achieved (£40k) and an overspend in Spinal (£22k), due to nursing costs.

The variance in CSFS is mainly due to a shortfall on savings, most of which relates to unidentified schemes.

Nursing budgets were £187k over-spent in month, with agency spend at £443k which is much higher than average in 2014/15. It looks as though hourly rates have grown substantially suggesting our 'neutral vendor' is channelling higher cost agency staff to us. This is being investigated.

Variances due to savings affected all directorates except facilities and medical.

4. Cost Improvement Plan

The total cost improvement savings target for the year is £8.0m which includes revenue Income Generation (IG) schemes of £2.1m. There is no evidence that the income generation schemes have taken effect as yet.

The Trust achieved savings and IG schemes in month of £204k against a plan target of £481k an adverse variance of £277k.

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. 2015/16 Contracts

At the time of writing the Trust has not yet reached agreement with Wiltshire CCG our main commissioner from whom we get just under half our income. In 2014/15 the Trust undertook clinical activity above Wiltshire CCG's plans. Broadly speaking the Trust has included the same activity levels in the 2015/16 plan plus growth estimates based on a 3 year average less a £1m net financial impact of QIPP proposals for 2015/16. The Trust's financial proposal also includes growth in drugs and rectification of under-funded non-PbR block contracts.

The Trust continues to work with partners to pursue the aims of the Better Care Fund (BCF) and is engaged in a number of local initiatives consistent with providing care to patients as close to their normal residence as possible. As such, we are looking to work across the local health system on projects to reduce the average length of stay of patients and avoidable admission to hospital. There has been a significant problem with the levels of Delayed Transfers of Care (DToCs) in 2014/15 but it is expected that these will reduce as a consequence of the BCF.

The Trust has reached contractual agreement with Dorset and West Hampshire CCGs and NHSE for specialised services.

6. Risks

The Trust's key financial risks for 2015/16 can be summarised as follows:

- Deliver the CIP target of £8m; this is the greatest financial challenge;
- Contractual challenges from CCGs;
- Meet contractual obligations and avoid penalties;
- Delivery of CQUIN targets to achieve full CQUIN payments;
- 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.

7. Conclusions

The Group reported position for April was a deficit of £1,101k giving an adverse variance of £193k against plan.

8. Recommendation

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

Malcolm Cassells
Director of Finance and Procurement
29 May 2015

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	12,665	12,345	-320	12,665	12,345	-320
High cost drugs income	1,252	1,058	-194	1,252	1,058	-194
Other Clinical Income	433	608	175	433	608	175
Research & Development & Education	554	514	-40	554	514	-40
Other (Excluding Donated Asset income)	1,186	1,160	-26	1,186	1,160	-26
TOTAL INCOME	**16,090**	**15,685**	**-405**	**16,090**	**15,685**	**-405**
Operating Expenditure						
Pay - In post	9,883	9,877	6	9,883	9,877	6
Pay- Agency	705	891	-186	705	891	-186
Drugs	1,490	1,334	156	1,490	1,334	156
Clinical Supplies	1,496	1,623	-127	1,496	1,623	-127
Non-Clinical Supplies	758	701	57	758	701	57
Other (incl PFI unitary charge)	1,389	1,098	291	1,389	1,098	291
TOTAL EXPENDITURE	**15,721**	**15,524**	**197**	**15,721**	**15,524**	**197**
EBITDA (Earnings Before Interest, Tax, Depreciation & Amortisation)	**369**	**161**	**-208**	**369**	**161**	**-208**
Financing Costs	1,277	1,273	4	1,277	1,273	4
SURPLUS / (DEFICIT) excluding DONATED ASSET INCOME	**(908)**	**-1,112**	**-204**	**(908)**	**-1,112**	**-204**
Donated Asset Income	0	11	11	**0**	11	11
SURPLUS / (DEFICIT)	**(908)**	**-1,101**	**193**	**(908)**	**-1,101**	**-193**

Trust Board meeting **SFT 3665**

MONTH 1 OPERATIONAL PERFORMANCE REPORT

Date: 8 June 2015

Report from: Andy Hyett, Chief Operating Officer

Presented by: Andy Hyett, Chief Operating Officer

Executive Summary:
The trust delivered all Infection Control, Referral to Treatment, Emergency Department and 7 out 8 cancer standards in April.

Proposed Action:

To note the report

Links to Assurance Framework/ Strategic Plan:

Choice – To deliver key 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 2015

AGENDA ITEM
TRUST PERFORMANCE REPORT TO END OF APRIL 2015

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

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

MONITOR

Emergency Pathway

In addition to delivering the 4 hour standard for April, the standard has also been delivered for May and as of 1st June performance is above 95% for the quarter.

RTT

All RTT standards were delivered in April at Trust level. Whilst the admitted standard was not met in General Surgery, Orthopaedics and Oral Surgery this was due to the treatment of patients waiting over 18 weeks and therefore a positive action.

Cancer

The trust failed to deliver the Symptomatic Breast Cancer - two week wait standard in April. The service saw an increase in referrals however performance in May is improved. The Cancer Board will be meeting on 10th June when progress against the action plan and capacity / demand for all sites will be reviewed.

The MSK directorate is currently reviewing dermatology capacity ahead of a predicted seasonal peak in demand.

PATIENT CHOICE

Diagnostic

The trust failed the diagnostic standard of 6 weeks from referral to procedure with 210 patients waiting longer than the standard in April. All patients whose pathway breached were waiting for endoscopy. The service has seen a significant increase in referral's - 2013/14 8.5% increase on previous year and 2014/15 8.6% increase on previous year. There was a sharp increase in referrals in Q4; January 692, February 776, March 959. Referrals have decreased in Q1 (April 594, May 630) however will be monitored closely going forward.

Capacity has been increased and there is a trajectory to clear the waiting list to less than 6 weeks by Q2.

Endoscopy Diagnostic Standard Performance

	00 < 02 Weeks	02 < 04 Weeks	04 < 05 Weeks	05 < 06 Weeks	6 + Weeks
Colonoscopy	73	54	36	50	84
Flexi sigmoidoscopy	68	17	17	22	14
Cystoscopy	37	5	2	0	0
Gastroscopy	127	72	55	55	112

Cancelled Operations rebooked within 28 days

This performance relates to one patient who required a specific type of bed. The patient has now been booked at a mutually agreeable date.

PARTNERSHIP WORKING

Delayed transfers of care (DTOC) – the number of DTOCs has dropped slightly following the winter period. The trust is engaging with CCG and community partners to improve discharge pathways.

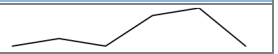
ACTION REQUIRED BY THE BOARD: To note the Trust's performance.

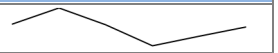
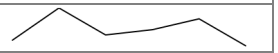
AUTHOR: Andy Hyett
TITLE: CHIEF OPERATING OFFICER

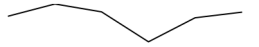
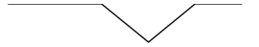
Trust Board Performance Report - April 2015

Salisbury NHS
NHS Foundation Trust

Monitor Assurance

Metric Name	Indicative Monthly Volume	Target Source	Ceiling	Apr-15	YTD	Benchmark	Trend
Infection control – Clostridium difficile	5,800 discharges	Contract	18 cases (deminimis volume 12)	0	0		
Infection control - MRSA	5,800 discharges	Contract	0 cases (deminimis volume 6) *	0	0		

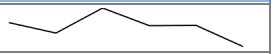
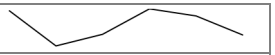
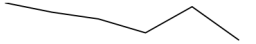
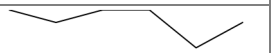
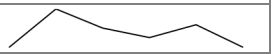
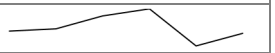
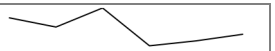
Metric Name	Indicative Monthly Volume	Target Source	Target	Apr-15	Quarter 1 to date	Benchmark	Trend
Patients treated within 18 weeks requiring admission	1,000 patients	Contract	90% treated within 18 weeks	91.7%	91.7%	92%	
Patients treated within 18 weeks not requiring admission	3,500 patients	Contract	95% treated within 18 weeks	98.4%	98.4%	97%	
Proportion of patients waiting less that 18 weeks for first treatment	10,300 patients	Contract	92% still waiting within 18 weeks	97.2%	N/A	95%	
Zero tolerance RTT waits > 52 weeks		Contract	Zero	0	0		

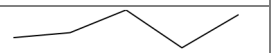
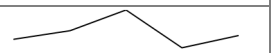
Metric Name	Indicative Monthly Volume	Target Source	Target	Apr-15	YTD	Benchmark	Trend
All Cancer two week waits	450 patients	Contract	93% patients within 2 weeks	93.1%	93.1%	95.4%	
Symptomatic Breast Cancer - two week waits	85 patients	Contract	93% patients within 2 weeks	92.4%	92.4%		
31 day wait standard	110 patients	Contract	96% patients within 31 days	100.0%	100.0%	97.9%	
31 day subsequent treatment : Surgery	20 patients	Contract	94% patients within 31 days	100.0%	100.0%		
31 day subsequent treatment : Drug	20 patients	Contract	98% patients within 31 days	100.0%	100.0%		
62 day wait standard	50 patients	Contract	85% patients within 62 days	92.1%	92.1%	87.0%	
62 day screening patients	4 patients	Contract	90% patients within 62 days	100.0%	100.0%		
62 day patients waiting first definitive treatment after Consultant upgrade	3 patients	Contract	85% patients within 62 days	100% (Jan-15)	100% (to Jan-15)		

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

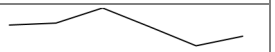
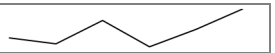
Quarterly Governance risk rate	Green: No evident concerns

Patient Choice

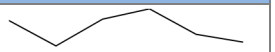
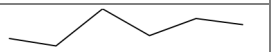
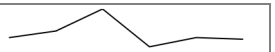
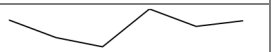
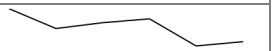
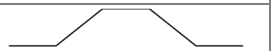
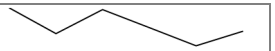
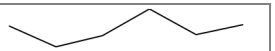
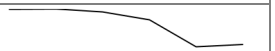
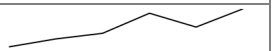
Metric Name	Indicative Monthly Volume	Target source	Target	Apr-15	YTD	Benchmark	Trend
Patients waiting less than 4 weeks for diagnostics	1,800 patients	Trust	98% of Diagnostic Waiting List <= 4 weeks	73.7%	73.7%	81%	
Patients waiting less than 6 weeks for diagnostics	1,800 patients	Contract	100% of Diagnostic Waiting list < 6 weeks	95.1%	95.13%	99%	
Friends and Family - % patients with feedback	1,400 discharges	Contract	15% patients offer feedback by end of Q1, 20% or more by end of Q4	40.3%	40.3%	N/A	
Friends and Family - % likely to recommend Hospital	1,400 discharges			93.6%	93.6%	N/A	
A&E Clinical Target 1 - Effectiveness of Care - unplanned reattendance rate	3,600 patients	Contract	<5% ED attendances to have unplanned return	2.6%	2.6%	7.2%	
A&E Clinical Target 2 - Left without being seen	3,600 patients	Contract	<5% patients to leave ED without being seen by clinician	1.2%	1.2%	2.7%	
A&E Clinical Target 3 - 95th Percentile time in A&E	3,600 patients	Contract	95th percentile ED wait to be less than 4 hours	03:58	03:58	04:11	
A&E Clinical Target 4 - Time to initial assessment	3,600 patients	Contract	95th percentile ED time to initial assessment < 15 minutes	00:07	00:07	benchmark data not fit for purpose	
A&E Clinical Target 5 - Time to treatment	3,600 patients	Contract	Median time to treatment in ED < 60 minutes	46	46	benchmark data not fit for purpose	
Ambulance Handover Breaches	970 arrivals by ambulance	Contract	Patients waiting > 20 minutes for Ambulance Handover	0	0		
Trolley Waits in A&E		Contract	Patients waiting > 12 hours on a trolley	0	0		
GUM % Offered appt within 48 hours	340 patients	Contract	100% patients offered appt within 48 hours initial referral	100%	100%	100%	
GUM % Accepted appt within 48 hours	340 patients	Contract	80% patients seen within 48 hours initial referral	81.5%	81.5%	89%	
Cancelled operations on the day of surgery	2,100 elective admissions (incl. daycase)	Trust	< 0.7% elective patients cancelled	0.87%	0.87%	0.77%	
Cancelled operations rebooked within 28 days	20 cancellations per month	Contract	100% patients rebooked within 28 days of cancelled surgery	94.4%	94.4%	96%	

Metric Name	Indicative Monthly Volume	Target source	Target	Dec-14	2014-15	Benchmark	Trend
Market Share: NHS Wiltshire - Elective		Strategy		30.3%	29.6%		
Market Share: NHS Wiltshire - Non-Elective		Strategy		36.6%	36.2%		
Market Share: Core Practices - Elective **		Strategy	Increase market share from 52% to 55% over 5 years	53.7%	53.1%		
Market Share: Core Practices - Non-Elective **		Strategy		64.0%	63.9%		

Partnership working

Metric Name	Indicative Monthly Volume	Target source	Target	Apr-15	YTD	Benchmark	Trend
Delayed Transfers of Care - NHS				14	N/A		
Delayed Transfers of Care - Social Services			4 DTOCs based on 3 Wilts SS delays and ~1 other	6	N/A		
Outpatient Follow Up rates	15,000 attendances	Contract	Aspire for Follow up -New Rate <=1:1.6	1.59	1.59		

Value and Effectiveness

Metric Name	Indicative Monthly Volume	Target source	Target	Apr-15	YTD	Benchmark	Trend
Elective Medical Length of Stay	40 Medical G&A overnight stays	Trust	3.48 days	3.3	3.3	Benchmark data not fit for purpose	
Non-Elective Medical Length of Stay	900 Medical G&A overnight stays	Trust	7.78 days	8.1	8.1	15.7	
Elective Surgical Length of Stay	480 Surgical G&A overnight stays	Trust	2.19 days	2.2	2.2	3.5	
Non-Elective Surgical Length of Stay	750 Surgical G&A overnight stays	Trust	3.15 days	3.5	3.5	3.0	
Hip replacements discharged within 5 days	25 patients	Trust	60% patients discharged within 5 days	70.6%	70.6%		
Knee replacements discharged within 5 days	24 patients	Trust	60% patients discharged within 5 days	73.7%	73.7%		
Coding - % coded within 1 week of discharge	5,800 discharges	Trust		47.7%	47.7%		
Coding - % coded within 5 days of month end	5,800 discharges	Trust		86.2%	86.2%		
NHS no. coverage	230,000 patients	Contract	95% of patients with activity in last 3 years to have validated NHS no.	98.2%	98.2%		
1st Outpatient DNA rate	5,500 appointments	Contract	No more than 7.5% patients to not attend 1st outpatient appointment	5.7%	5.7%	7.0%	
Elective Theatre Utilisation - Main Theatres	530 cases	Trust	Data recently obtained from new theatre system, no target set at this point	96.5%	96.5%		
Elective Theatre Utilisation - Day Surgery	860 cases	Trust	Data recently obtained from new theatre system, no target set at this point	80.7%	80.7%		
Non-elective Theatre Utilisation - Main Theatres	370 cases	Trust	Data recently obtained from new theatre system, no target set at this point	48.1%	48.1%		
Daycase Rates for selected procedures	350 patients	Trust	80% of selected elective surgical cases to be treated as daycase	82.3%	82.3%	81.2%	
Continuity of Service Risk Rating (CoSRR)	4. No compliance issues						

Cells with black dotted outlines indicate provisional data

*Please note: MRSA is no longer monitored by Monitor

PAPER:SFT 3666

CAPITAL DEVELOPMENT REPORT
FOR THE PERIOD JANUARY TO MAY 2015

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 2014).

MAIN ISSUES:

Springs main entrance redevelopment

This project will see the creation of a new main entrance lobby and walkway at the current Springs Entrance in SDH North. Planning permission (Reference 15/03349/FUL) has been submitted and decision is expected by 15th June 2015. Tender specifications are being drawn up and are due to be sent out end of May. Work on site is now expected to start on site in late summer 2015 with completion expected early Spring 2016.

Breast Care Unit

The User project team is well established and the outline plan of the new Breast Care Unit has been approved and signed off. Detailed design work is now underway and building work is expected to start late autumn 2015.

Further Improvements to Phase 1 Wards

Following the success of the recent refurbished Pitton and Redlynch wards, plans for further improvements to the Phase 1 wards in SDH North will see the next ward to undergo refurbishment starting in late summer and to be complete by mid-December. The opportunity is being taken as part of the deep clean programme to carry out small scale, but effective, improvements to the wards.

Maternity Unit

At its private meeting on 19th January, the Trust Board approved in principle that preliminary planning work should begin on the development of an expanded maternity unit. The final business case for this scheme is still being developed informed by the service review underway in obstetrics and gynaecology. In the meantime more detailed design work has begun to ensure that the expanded facilities are available for when the local military population is due to expand in 2018.

IT Schemes

Single Sign On (SSO)

SSO was rolled out to inpatient wards and 2 outpatient areas during 2014. However, the outpatient roll out was delayed due to the range of programmes that clinic staff need to access. The IT Department have been working closely with the IT Clinical Lead on an SSO

build that will meet clinician's requirements. This work has resulted in a number of 'published applications' being built within the SSO environment ie: Internet, Outlook, Word, Excel, as well as a number of links to frequently used web pages.

IT staff have also been working closely with the clinicians in Whiteparish Ward to create a prototype version of the inpatient SSO build which provides users with access to their internet and Outlook accounts as well as the usual SSO applications.

Progress has been hampered due to staff being involved in troubleshooting ongoing network issues affecting the whole Trust

Patient Observation and Escalation Tool (POET)

The first phase of this development is almost complete. An initial proof of concept was undertaken in December 2014 on Laverstock Ward. A small number of aesthetic changes were made as a result of this. A more formal pilot then started on Laverstock Ward in February 2015. The aim of the pilot was to focus on showing that connectivity was sufficient, integration with other trust systems (IPM/BATS/Consultant List) worked effectively and that the solution was clinically safe to use. Having resolved some connectivity issues the project team started a second pilot on the 11th May. The objective of this pilot is to ensure that disaster recovery processes work effectively if the system becomes unavailable and to enable the pilot ward to stop using the paper charts. The next pilot area will be Britford Ward and the Surgical Assessment Unit. The aim of this pilot will be to more robustly assess the clinical process elements of the POET solution. We will then commence with a Trustwide roll-out.

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.

The system includes the ability to record data, flag patients according to different risk criteria and link to systems which will assist with other Trust priorities, e.g. infection control and the sepsis six.

Electronic Discharge Summaries

The Trust is producing 60% of discharge summaries electronically (main inpatient wards) and sending the output electronically into 50 GP Practices/Branch Practices. This percentage must be substantially increased during 2015 and a group looking at how to increase the amount of digital communication with primary care will take the lead on this.

Electronic Patient Record (EPR)

Procurement work for EPR is currently on track. Responses to the ITT were received from 5 bidder organisations and the scoring of these responses has now been completed. There has been good clinical engagement so far with 39 clinical staff having been involved in one way or another, including, mapping current processes, reviewing ITT responses, attending site visits and attending demonstrations of the various offerings.

The Outline Business Case (OBC) has been taken to ISSG with plans for this to be taken to a Trust Board Meeting in the summer. The current focus is on two main pieces of work;

completion of the remaining parts of the scoring to enable identification of the preferred bidder and the Full Benefits Case.

Blood Tracking

Project to allow tracking of blood from "vein to vein". 100 % Traceability is a regulatory requirement under the Blood Safety and Quality regulations (2005).

Blood Tracking phase 2 is the bedside administration of Blood Transfusions. The software supplier (Msoft) is configuring their software to meet our requirements and testing will begin shortly.

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 2014/2015 (Appendix A to C inclusive)

Laurence Arnold
Director of Corporate Development

APPENDIX A

Other significant schemes in the Approved Capital Programme for 2015/16

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.	March 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	October 2015	£180K
Main Theatres Laminar Flow system (7070C0) This scheme will see Theatre 5 converted into a laminar flow facility.	August 2015	£185k
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 ongoing to Nurses stations.	November 2015	£190k
Road repairs and Pedestrian crossings (7020C0) Repairs to the roads on site and upgrading the pedestrian crossings to current standards	March 2016	£120K
Accommodation upgrade (7011C0) Refurbishment of the kitchens and bathrooms in staff accommodation	March 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.	March 2016	£188k (this year)
Nurse Call System upgrade (7202C0) Project to replace ageing nurse call systems through out wards in the main SDH north building and maternity wards. 2nd year of 2. £75k slipped to 15-16 to link with refurbishment requirements	March 2015	£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	March 2016	£66k

APPENDIX B

Information Technology schemes	Completion date	Budget cost incl VAT
PACS/RIS (7943C0) Main project now complete. Planned upgrades were undertaken in January and February. Another RIS) upgrade is planned for end May. Work on XDS (Cross Data Sharing) is proceeding with end to end testing planned for June with a potential go live of October.	October 2015	
Order Comms and Results Reporting (7942C0) About to go live with Radiology requesting to GP's in May/June 2015. A major upgrade of the Review system will take place though the summer 2015.	June 2015	£100k
Genetics Software Upgrade Upgrading the SFT site to Windows 7 has meant that much of the software in Genetics will not run. This is to upgrade the software to run on Windows 7	October 2015	£101K
Maintenance Renewal This is the replacement of the existing 5 year contracts which covers the Trust IT infrastructure including networks, storage and virtual hardware blades. Renewals due from June 15 to February 16	June 15 to February 16	£650K
Microsoft Licensing There is a license gap between licenses we hold and those highlighted by an independent software auditor. This is mainly in area of SQL.	June 2015	£500K
OpenEyes This is an open source product from Moorfields Hospital where we have installed the Cataract Module. Discussions are in place to determine the future direction.	Not known at present	£153K
Paperless Real-time Patient Status. 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.	June 2016	£560K

Information Technology schemes	Completion date	Budget cost incl VAT
Replace 6509x3 network hubs Replacement of 3 of the core network switches.	January 2016	£350K
Telecomms Voice Over IP Movement of some non clinical areas off the main telephone frame which reaches end of life in 2018	February 2016	£167,000
Wireless Expansion and Coverage The rollout of POET and the need for mobile working under the new EPR means that the existing Wireless network needs to be increased in capacity and made more robust	March 2016	£122K

APPENDIX C

Medical Devices schemes	Completion date	Budget cost incl VAT
Bed Replacement programme (7131C0) The bed replacement programme is now entering the third year. So far, 222 beds have been replaced. A further 101 beds will be purchased in 2015/16.	Years 2 and 3 of a 4 year programme	£150k (2014/15) £204k (2015/16)
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.	June 2015	TBC
Endoscopy stack and scopes (7132C0) Owing to the introduction of the Bowel Scope project it was necessary to purchase an additional stack and 8 new slim colonoscopes. They were delivered and commissioned in February in time for the scheme to start in March 2015.	February 2015	£162k
Ultrasound machine – EPU (7147C0) The purchase of a replacement ultrasound machine was brought forward from the 2015/16 capital programme owing to the current machine becoming unreliable for the Early Pregnancy Unit. The machine was delivered and became operational in March.	March 2015	£70k
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. Site visits are planned for May when a tender award can be made.	June 2015	£110k
Review of Theatre Instruments (7122C0) The Trust commissioned an external review of instrumentation. All trays have been reviewed and procedure specific cards agreed by the Theatre staff which has formed the basis for the specification.	December 2016	£300k (2014/15) £500k (2015/16)
Vascular unit ultrasound machine (7125C0) The machine has been received and is in use.	March 2015	£90k
Clinical Radiology 2x ultrasound machines (7124C0) The replacement machines for Ante-Natal clinic and Room 1 have	March 2015	£160k

Medical Devices schemes	Completion date	Budget cost incl VAT
been delivered and are in use.		
Fluoroscopy x-ray machine replacement (7114C0) The machine used for interventional radiology is being replaced owing to it's age and increasing failure rate. The new machine will enable more procedures to be undertaken and provide improved radiation protection for both the patient and the operator.	July 2015	£384k
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.	October 2015	£99k
Bariatric (heavier patient) equipment (7150C0) Capital funding has been invested in an additional bariatric bed and mattress system, a gantry hoist with two slings and a hoverjack to enable staff to manage patients in a more dignified and appropriate way.	April 2015	£31k

NATIONAL INPATIENT SURVEY 2014
ANALYSIS OF CQC BENCHMARK REPORT AND LOCAL ACTION PLANS

PURPOSE:

To provide the Board with an analysis of the Care Quality Commission's benchmark report on the National Inpatient Survey 2014 and the actions to be taken by the Trust.

MAIN ISSUES:

1.0 Introduction

Salisbury NHS Foundation Trust participated in the twelfth national inpatient survey between October 2014 and January 2015. Questionnaires were sent to 850 randomly selected patients who had spent at least one night at Salisbury District Hospital during the month of July 2014. The Trust achieved a response rate of 63% which was 3% above target and 16% higher than the national average.

2.0 The Benchmark Report

Each year the Care Quality Commission (CQC) produces a report for each acute Trust in England showing the results weighted against other Trusts. Weighting is applied in three specific areas:-

a) a high percentage of responses from older people who tend to report more positive experiences than younger respondents;
b) a high percentage of women respondents who tend to report less positive experiences than men;
c) a high percentage of respondents from emergency admissions who tend to be more negative than those respondents who had a planned admission.

A scoring system is used which marks each question out of a maximum of 10 points.

In the report, the word 'better' or 'worse' is displayed if a Trust's score is significantly better or worse than most other Trusts, as shown in Example 1 below.

Example 1

The tables at the back of the report show SFT's score compared to the lowest and highest score across all Trusts, and the number of SFT respondents for that question. The tables also indicate with an arrow whether a Trust's score is significantly up or down on the previous year, as shown in Example 2 below.

Example 2

Q48	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	9.3	8.2	9.6	282	8.9	↑

The CQC expects Trusts to use the report to understand their own performance and to identify areas for improvement.

3.0 Analysis of the Benchmark Report

The survey contained 60 core questions which could be analysed. Other questions (known as filters) instructed respondents to skip certain questions or sections that did not apply to them.

The results are grouped into eleven sections and Trusts are scored for their overall performance in each section. SFT scored 'about the same' as all other Trusts in all sections:

- The Emergency/A&E Department
- Waiting list and planned admissions
- Waiting to get to a bed on a ward
- The hospital and ward
- Doctors
- Nurses
- Care and treatment
- Operations and procedures
- Leaving hospital
- Overall views of care and services
- Overall experience

SFT scored 'about the same' as all other Trusts for 59 of the individual questions and 'worse' for one question:

- Did you ever share a sleeping area with patients of the opposite sex?

When compared with its own 2013 benchmark results, SFT scored significantly higher for one question:

- Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?

The Trust scored significantly lower for two questions:

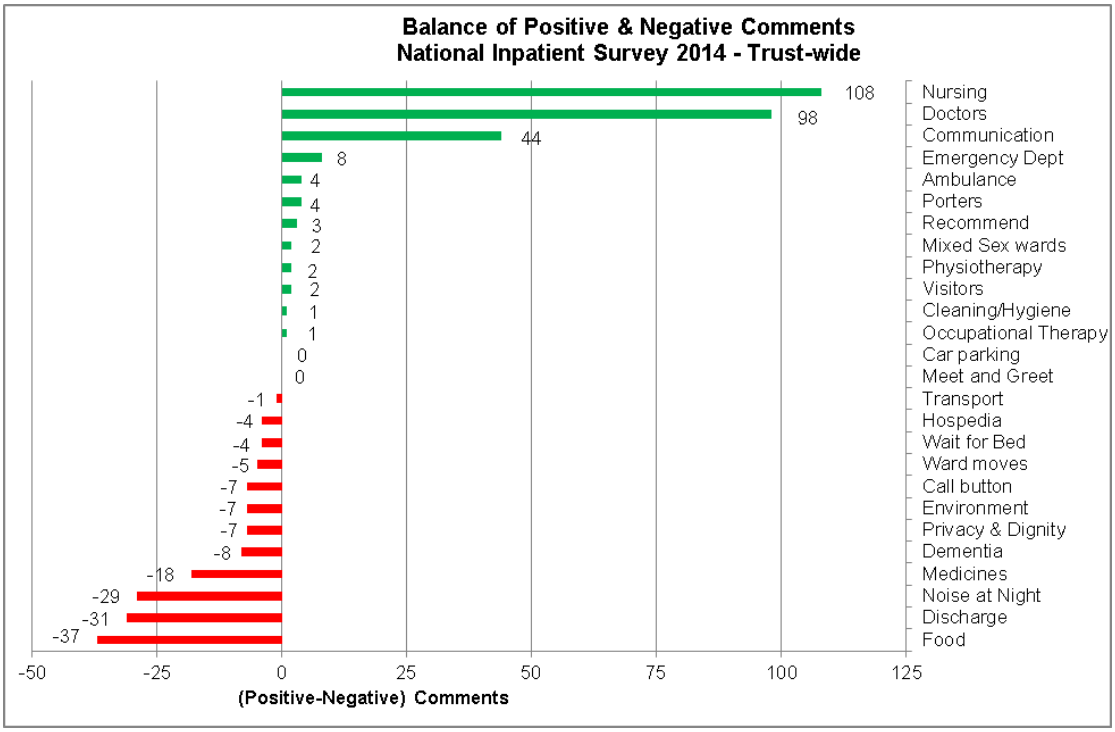
- Did you ever share a sleeping area with patients of the opposite sex?
- Did nurses talk in front of you as if you were not there?

4.0 Comparisons with Demographic Characteristics

The split between male and female respondents was 44% male and 56% female, compared with 47%/53% nationally. Age group, religion and sexual orientation responses were in line with national figures. SFT's ethnicity responses for the White group were slightly higher than nationally (96% compared with 89%); responses from other ethnic groups were 3% compared with 11% nationally.

5.0 Local Results Analysis and The Next Steps

In addition to the standard questions, patients were invited to make comments about anything which they felt was particularly good about their care or things that they felt could be improved. A total of 290 comments were received regarding things that were good about the patients' stay and 239 comments on things that could be improved. These have been categorised and analysed to show the areas where further attention is required, as indicated in the graph below:



The Patient Experience Analysis Group met in February 2015 to look at the results in conjunction with themes arising from incidents, concerns and complaints. The questionnaires for real-time feedback 2015/16 have been adjusted to reflect concerns raised and to gather more detailed information where required.

An overarching Trust action plan is being developed to cover the key theme areas such as food and single sex. This is returning to the Clinical Management Board in July 2015.

The Food and Nutrition Group has recently carried out work to try to identify the reasons why negative comments have been received, particularly via real-time feedback (RTF). In many cases, patients had not stipulated exactly what the problem was so the RTF questionnaire for 2015/16 has been adapted to include a question asking patients' views on what could be done to improve in this area.

Regarding patients sharing a sleeping area with patients of the opposite sex, the main areas of concerns are on Radnor ward and Whiteparish Acute Medical Unit (AMU). Our Commissioners have been invited into the Trust to review the issues on Radnor since the unit was refurbished, and AMU. Daily reviews of any breaches or capacity issues on AMU are being led by the Chief Operating Officer and Director of Nursing, with the clinical teams. A longer term piece of work is looking at a proposal to relocate the AMU into a larger footprint, to be considered by the Executive Directors.

The results have been further analysed down to ward level and ward leads have considered these along with any ward issues from incidents, concerns and complaints. Action plans have been drawn up (see Appendices A – R) which are being monitored by the Directorate Senior Nurses through the Nursing and Midwifery Forum.

ACTION REQUIRED BY THE BOARD:

Board members are invited to endorse this approach and note the contents of this report.

ATTACHMENTS AVAILABLE TO VIEW ON WEBSITE:

Appendix A	Amesbury Suite	Appendix J	Laverstock Ward
Appendix B	Avon Ward	Appendix K	Pembroke Ward
Appendix C	Britford Ward	Appendix L	Pitton Ward
Appendix D	Burns Unit	Appendix M	Redlynch Ward
Appendix E	Chilmark Suite	Appendix N	SSEU
Appendix F	Downton Ward	Appendix O	Tamar Ward
Appendix G	DSU Escalation	Appendix P	Tisbury Ward
Appendix H	Durrington Ward	Appendix Q	Whiteparish AMU
Appendix I	Farley Ward	Appendix R	Winterslow Ward

AUTHOR: Lorna Wilkinson

TITLE: Director of Nursing

Issue	Action plan	Lead	Monitoring
Some patients felt they waited too long for call bells to be answered.	• Continue to feedback call bell waiting times to staff through ward based audit of times. Currently answering 95% of bells within 5 minutes.	CH	• Call Bell Audits, Friends and Family Feedback, RTF
Patients sometimes feel that they do not have someone to discuss their worries and fears with.	• 'Sister's Surgery' implemented whereby certain times of the week are set aside for patients to request time to discuss concerns, fears or worries. This is also available for their friends and carers.	CH	• Call Bell Audits, Friends and Family Feedback, RTF
	• Use a proportion of supervisory time to spend introducing myself to staff and raising the profile of the ward sisters to the patients and their relatives.	CH	
	• Utilise the psychology teams to their full potential in identifying which patients would benefit from a visit.	CH & teams	
Lengthy times waiting for a bed to become available on the ward.	• Work with other departments and engage in project work looking at speeding up the discharge process and having earlier discharges to make beds available for post op patients.	CH, team and project groups	Outcome of project work Patient feedback
	• Use medical staff induction time to share vision that TTOs/ EDS are completed in a timely fashion.	CH & junior doctors	
	• Work with pharmacy to improve timeliness of TTOs being completed.		
	• Attempt to reduce reliance on transport (due to 4 hour window issue).	CH & ward pharmacist	
		CH	

Action Plan for National Inpatients 2014 Survey Results
Avon Ward

Problem	Action Plan
Communication: Staff to patients each shift/ day	Discussed at Team Meetings, and in Spinal Action Plan, to introduce self to patient and agree their care plan for the shift.
Communication: Patient & partners not prepared for home care delivery adequately	Patients to attend all in-patient teaching sessions, in preparation for discharge. To attend Goal Planning Meetings to prepare for discharge. Named Nurse to review discharge care plan with patient & relatives. Relatives to attend Goal Planning Meetings, plus relatives teaching days, if possible.
Bank/Agency staff: Concern about lack of spinal knowledge, and leading nursing teams within a specialty ward	All bank/agency staff re given an induction orientation to the ward, prior to starting their shift. All bank/agency staff are allocated regular spinal staff to work with, plus overseen by the Nurse-in-Charge. Complaints about care are reported to the staff manager.
Safe staffing: Patients are concerned at the poor skill mix/ staffing	Skill mix reviews are held 6 monthly with senior managers; all shifts are assessed using SafeCare on the electronic roster, and this is monitored by managers. Staff encouraged to report using Datix for all shifts they have concerns about, and escalate problems to managers. Beds have been closed to improve the ward safety margins.
Staff competency: Patients are concerned that staff are safe and competent	All staff being task checked for competency, at present, and this will inform the teaching plan for routine skills. Staff able to book time to complete their mandatory Managed Learning on-line. Senior staff are supervising care delivery, and assessing competency in skill and tasks, using the Trust competency framework
Environment: Patients have concerns that the facilities in ward do not meet their needs, or requirements	PLACE audits completed, and improvements identified – now awaiting funding for completion. Monthly audits completed to identify routine problems eg: cleaning, equipment.
Staff attitudes & behaviours: Ward users have commented that their experience of staff has not been acceptable	This is an integral part of new Trust performance review, and expectations have been published for staff around attitudes & behaviour the Trust expects in practice. Poor behaviours are tackled at source, and all RTF is discussed at Team Meetings.

Charge Nurse Dominic Holbourne
Avon Ward
Spinal Centre
April 21st 2015

Issue	Action plan	Lead	Monitoring
Communication and information giving to patients that are being discharged is not always timely and adequate. Patients and carers not always aware of what care they will need when they go home.	• Ensure patients and their carers are given as much notice as possible re potential discharge date • Ensure, if applicable, that any further health or social care service, physio or community nurse needs are discussed with the patient/family/carer prior to discharge and that the patient it aware of what they will need and what is going to be arranged. • Ensure nurse discharging patients asks if they understand all the information and if they have any questions. • Ensure nurse discharging patient informs patient who to contact if they are worried about their condition or treatment after they have left hospital • Ensure all patients are given the friends and family test questionnaire on discharge to enable feedback.	CH-J	All areas should show improvement via the Friends and Family test, Real time feedback results as well as complaints and compliments. This can be undertaken on a monthly basis Ward leader as part of supervisory role will monitor and audit.
Issue	**Action plan**	**Lead**	**Monitoring**
Lack of privacy and dignity in SAU when examining patients (mainly of a O&G nature) or speaking in a confidential place	• Ensure doctors and nurses try and maintain dignity by drawing round curtains during any procedure in SAU and ask for a nurse chaperone who can ensure the curtain stays shut • Ensure Britford Ward has correct provisions post ward refurb • Use ward sisters office or office on Breamore Ward for any sensitive conversations with patient or family as no area on ward is suitable – sisters office key is left on CD keys so is always accessible should this be required.	CH-J	Ward lead as part of supervisory role to monitor O&G doctors encouraged to bring patients back to the day assessment unit or O&G OPD if required rather than SAU where the set up is not ideal

Issue	Action plan	Lead	Monitoring
Not enough nurses on duty or with enough knowledge	• Recruit up to establishment (now achieved) in order to get consistency in staff- thus reduce agency/bank nurses • Ward leader to continue tailor made study days to ensure all staff are given training on areas there may be gaps in knowledge (commenced and proving extremely beneficial) • Skill mix review with DSN and DDON to discuss staffing levels and acuity	CH-J	Ward leader/finance and DSN to discuss monthly staffing levels and any potential recruitment needed Ward leader to identify potential knowledge gaps and arrange suitable training for staff – all staff to receive at least one tailor made study day per year. Staff encouraged to complete a Datix for any nursing red flag issues to highlight shortfall for monitoring purposes. Ward lead meets monthly with risk manager to discuss issues where these will be identified

Issue	Action plan	Lead	Monitoring
Ensuring a safe and timely discharge for all patients on the Burns Unit. Issues reported include: -Delays -Lack of information -Lack of communication	1. Aim to do EDS the day before discharge so there are no delays with obtaining TTOs. Pharmacist is then able to spend time explaining medications to patient prior to discharge. 2. Review of patient information leaflets (those given on discharge) as part of Scar Management Service review. 3 Purchase additional leaflet display rack to enable leaflets to be readily available to patients and relatives. 4. Involve patients in decisions about discharge. Invite patients to attend MDT meeting. 5. Ensure patients have the correct contact numbers in case advice needed after discharge.	Nursing staff lead by A Johnson, E Brown and S Rainbow Ward pharmacist Scar SIG E Brown A Johnson and R East (OT) All ward staff	Friends and Family test, Real time feedback results as well as complaints and compliments. This can be undertaken on a monthly basis.

Issue	Action plan	Lead	Monitoring
Communication and information giving to patients that are being discharged is not always timely and adequate. Patients and carers not always aware of what care they will need when they go home. The aim of the actions is to improve the knowledge of the patient of what to expect on discharge.	• Ensure patients and their carers are given as much notice as possible re potential discharge date. • Ensure, if applicable, that any further health or social care service, physio or community nurse needs are discussed with the patient/family/carer prior to discharge and that the patient is aware of what they will need and what is going to be arranged. • Ensure nurse discharging patient asks if they understand all the information and if they have any questions (all patients to be given the discharge checklist sheet that they need to complete and return to nurse to confirm understanding of information given). • Ensure nurse discharging patient informs patient who to contact if they are worried about their condition or treatment after they have left hospital (give discharge information sheet which has these details). • Ensure all patients are given the Friends and Family Test questionnaire on discharge to enable feedback. • Ensure all patients are given a copy of their electronic discharge forms. • All relevant patients to be given relevant information from the physiotherapy and occupational therapy teams.	Clare Wood Gill Hibberd (physio) Catherine Whitmarsh (OT)	All areas should show improvement via the Friends and Family test, Real time feedback results as well as complaints and compliments. This can be undertaken on a monthly basis Audit discharge check lists given out to patients for the month of May 2015.

Issue	Action plan	Lead	Monitoring
Communication between all grades of staff that work in clinical areas of the Trust with carers, patients and relatives. Poor communication is the cause of people raising concerns and complaints, and not understanding what is planned for their care and discharge.	• Set up “sister clinics” as part of supervisory role to aid in communication with patients and relatives. • Ensure regular senior nurse / ward co-ordinator contact with all patients to reinforce plan of care and discharge and answer any outstanding questions. • Ensure increased use of patient information leaflets. Develop discharge patient information leaflet. • Ensure the opportunity for family meetings is offered to all appropriate patients. • Ensure all grades and disciplines of staff communicate at a level appropriate to the person they are talking to. • Ensure the patient/relative/carer has the opportunity for questions. • Ensure the patient/relative/carer is asked if they understand what they have been told. This applies to all grades of staff working with the patients. • Ensure all medication is fully explained. • Ensure that discharge arrangements are explained fully and that all carers and relatives are fully informed in a timely manner. • Ensure all patients being discharged receive a copy of their discharge information. • Ensure that all grades and disciplines of staff are constantly reminded of the need for clear and consistent information giving to all patients and their carers/relatives/partners. • Ensure that patients and relatives are aware of who to contact if they experience problems following discharge	Senior sister and ward team.	All areas should show improvement via the Friends and Family Test and Real-Time feedback results, as well as complaints and compliments. This can be undertaken on a monthly basis.

Issue	Action plan	Lead	Monitoring
Medications are not fully explained during inpatient stay and on discharge	• Ensure all ward staff, pharmacy and medical teams engage in informing patients and their relatives about medications both as an inpatient and following discharge. • Ensure staff are aware of the need to fully explain patients' medication to them prior to discharge and ensure that they understand this explanation. • Ensure staff fully explain potential side effects and complications from said medication. • Ensure patients are informed of how to take medication and are shown the EDS. • Provide any appropriate patients with medicines information cards or blister packs.		RTF National Inpatient survey Customer care feedback Blue cards Thank you letters
Standard of Cleanliness and clutter on ward	• All staff to be vigilant regarding ward cleanliness – staff to ensure compliance with cleaning task list. • Ensure staff engage in de-cluttering ward area on a daily basis • Ensure ALL staff take responsibility for notifying housekeeping of any cleaning concerns		• Cleaning task list • Monthly environmental audits • PLACE audits • Confidence in caring

Issue	Action plan	Lead	Monitoring
Patients bothered by noise at night by hospital staff	• Ensure all staff who work on ward and visit ward during the night are aware of the requirement to keep noise to a minimum • Ear plugs to be offered to all patients • Manage patient expectations regarding noise by informing them that some noise is unavoidable due to the requirement to provide 24 hour care to patients – inpatient leaflet recently updated to contain this information	Senior sister	• Spot checks at night to review noise levels • Sharing negative comments regarding noise in real time with ward staff to raise awareness of patient perceived issue
Communication between all grades of staff that work in clinical areas of the Trust with carers, patients and relatives. Poor communication is the cause of people raising concerns and complaints, and not understanding what is planned for their care and discharge.	• Ensure all grades and disciplines of staff communicate at a level appropriate to the person they are talking to. • Ensure the patient/relative/carer has the opportunity for questions at all times throughout their stay • Ensure the patient/relative/carer is asked if they understand what they have been told. This applies to all grades of staff working with the patients. • Ensure all medication is fully explained prior to discharge particularly when dispensing TTOs • Ensure that discharge arrangements are explained fully and that all carers and relatives are fully informed in a timely manner. • Ensure all patients being discharged receive a copy of their discharge information. • Ensure that all grades and disciplines of staff are constantly reminded of the need for clear and consistent information giving to all patients and their carers/relatives/partners.	Senior sister Gill Hambridge (ward pharmacist) and senior sister	• All areas should show improvement via the Friends and Family Test and Real-Time feedback results, as well as complaints and compliments. This can be undertaken on a monthly basis. • Monthly ward rounds undertaken by ward lead and DSN to speak to patients and alleviate any issues at an early stage so we can react and update them before they are discharged. • Ward pharmacists to be more actively involved in trying to improve communication when dispensing TTO'S. • EDS is now in use and nursing staff when signing off the copy need to ensure that a copy is sent electronically to the GP. Ward clerks will ensure every EDS in the notes has had a copy sent. • Documentation audits undertaken internally by link nurses and ward leaders and issues arising dealt with at the time • Implementation of supervisory role will allow ward leads time to communicate to all patients each day.

APPENDIX G

Action Plan for National Inpatients 2014 Survey Results
Day Surgery Unit - Escalation

Action	Person responsible	Start date	Planned completed date
♦ DSU opened in escalation due to bed pressures in the Trust has resulted in patients commenting on various areas that need to improve. These include: Pharmacy, Food, Staffing levels and Communication. There is an existing management plan in place when DSU is opened and these items are included in this.	♦ Bernie Dunn / DMT Surgery	01/12/12	Ongoing
♦ Communication concerns relating to where patients are going after surgery. To be discussed with theatre management team to make sure staff keep relatives informed of the location of patients and to keep hospital PIMS system up to date.	♦ Bernie Dunn / Jenny Evans	30/04/15	30/05/15
♦ Pharmacy cover is provided on an ad hoc basis when DSU is opened in escalation.	♦ Bernie Dunn / Jan Jarman	01/1/14	Ongoing

The data provided from the inpatient survey, Friends and Family Test and real-time feedback have assisted in providing the input for this action plan.

SPECIFIC PROBLEM	OBJECTIVES	MEASURES	ASSIGNED TO	TIMESCALE
Information relayed to patients and their families is often misunderstood, or not given in a timely manner, with little time for patients/carers to ask questions.	For patients and carers to receive direct and true information in a timely manner. For staff to have the confidence in talking to patients and carers.	Results from real time feedback and in-patient survey. No complaints regarding mis-communication. Safety brief will in-corporate any relatives/carers that wish to speak to Dr/Sister on that day. VB will do a ward round every afternoon during visiting time. Poster regarding how to speak to Dr/sister and when we are available for this.	VB	To be reviewed every 3 months commencing end of July 2015.
Nurses station noise/noise at night.	For noise at night to be kept to a minimum to promote rest.	Soft closing bins were placed in the ward Feb 2015. Staff to wear quite shoes. Sluice door to remain closed at all times. Call bells to be at lowest level for night time. Investigation commenced as to whether the nurses station can be removed and office area to be further away from the clinical area which may have an impact on condensed noise at the nurses station	VB/Steve Long/Estates	September 2015

SPECIFIC PROBLEM	OBJECTIVES	MEASURES	ASSIGNED TO	TIMESCALE
Food is sometimes cold and un-appetising. Not enough menu choices.	At mealtimes patients will be ready and prepared to eat. Patients will have assistance with their menu choices. The fundamentals of protected mealtimes will be re-introduced. Snacks and wholesome drinks will be available throughout the day. Carers will be encouraged to bring in extras/assist with mealtimes as necessary for the patient.	Separate action plan to be produced.	VB/3 NA's and 1 RN (to be decided).	Action plan team to be allocated by end of May 2015 with nutrition teaching month to be July.
Call bells are sometimes not answered in a timely manner	For call bells to be answered within 8minutes at any time of the day.	Call bell audits to commence and actioned accordingly. Staff allocation to continue.	1 RN and 1 NA yet to be allocated	Allocated by 5/5/2015. Audits to commence June 2015.

APPENDIX I

Action Plan for National Inpatients 2014 Survey Results
Farley Ward

Issue	Action plan	Lead	Monitoring (All Issues)
Poor quality tea/coffee that is available to patients.	• Ensure drink rounds are completed in a timely manner, • All grades of staff be involved with serving and feeding drinks. • Senior sister to investigate costings of new tea coffee making facilities for patients	Senior sister	Through monthly feedback via friends and family and RTF. Regular staff meetings and feedback sessions. All staff aware of complaints and compliments received. Recruitment in progress as staffing below expected at present. The Supervisory role of the Senior sister having more visable presence on ward, and being more readily available to answer concerns.
Answering of call bells	• Ensure all call bells are answered in an acceptable time frame, by all members of staff.	Senior Sister	
medicine rounds	• Liasie with all staff the importance of structure over medicine rounds and completed as soon as possible.	Senior Sister	
Interpersonal skills	• Ensure all levels of staff communicate effectively with patients with care and compassion. Yearly appraisals conducted appropriately and constructive feedback given	Senior Sister	
Environmental Noise and staff shortages.	• Ensure all staff are aware of the level of noise on the ward and the importance of quiet time, and patients needs for rest, 24hours a day.	Senior Sister	

APPENDIX J

Action Plan for National Inpatients 2014 Survey Results
Laverstock Ward

Concern	**Background**	**Analysis of some communication with patients re: trauma surgery at ward level.**	**Action to smarten and standardise information.**
Communication	Pts report that surgical plans change often.	1. Consultants do not write in the Notes. 2. Ward rounds are led by many plastic registrars, which lacks continuity. 3. Plans for surgical procedures change depending on clinical competence. 4. Professional opinion is conveyed to patient as well as clinical facts.	1. Multidisciplinary meeting to raise concerns. 2. Set standards. 3. Identify training needs for information giving. 4. Source research into information giving. 5. Document findings. 6. Consider change of practise to improve communication. 7. Review current written information.

Issue	Action plan	Lead	Monitoring
Patients unaware of discharge plan and had inadequate information on discharge.	1. All patients to be included in their care planning and to have all their plans explained fully. 2. Morning whiteboard meetings to be fed back to the patient by the multidisciplinary team 3. Ward rounds by the consultant/doctors are to include the patient, (and their family if available). To ensure that the patient fully understands any discussions that were had, and that they have the opportunity to ask any questions and are able to have a discussion with the doctor. 4. To ensure that all medicines are explained fully and checked with the patient, (Family), by the discharging nurse. 5. To complete chemotherapy information checklist on discharge. 6. That the discharge plan is clearly explained by the discharging nurse and the patient /family have all the relevant contact phone numbers on discharge in case of an emergency. 7. Ensure that all staff are always aware of patient involvement privacy and dignity	Nurse in charge/Ward sister Nurse in charge Nurse in charge/Ward sister Discharging nurse/Ward sister Nurse giving the chemotherapy/Ward sister Nurse in charge Ward sister	RTF, Friends and Family response cards Complaints/compliments To discuss at the safety brief Patients diary Check list for information giving filed in the notes regarding explanation and information regarding their chemotherapy treatments. All discharge summaries are printed one is given to the patient/representative on discharge, one is faxed to the relevant GP then filed in the discharge folder originals are filed in the patient's notes. Review in 2 months

Issue	Action plan	Lead	Monitoring
Noise At Night from Hospital Staff	1. To improve staff awareness of the need for reduced noise at night to enable patients to have good quality sleep. 2. Lights off and patients settled by 23.00hrs 3. Staff to ensure that noise is kept to a minimum 4. Appropriate doors kept shut at night 5. Telephones to be put on quiet ring 6. Prompt response from staff to call bells and alarms 7. Ensure all staff are aware and comply with the noise at night standard which was agreed in June 2012	Ward sisters, to be achieved by June 2015	RTF Friends and Family Complaints Noise at night standard

APPENDIX L

Action Plan for National Inpatients 2014 Survey Results
Pitton Ward

Areas to improve	Plan	Resources required
1. Communication and information regarding diagnosis and treatment	- Nurse in charge/ band 7 to walk round once a day to discuss and questions relating to care. - Hand out appropriate leaflets for patients to have written info.	- ICID leaflets, British lung foundation leaflets - Display space
2. Clear ward leadership	- NIC to be visible whilst on shift – wearing yellow badge, name displayed on allocation board. - Permanent band 7 in post. - Allocated band 7 supervisory time to be spent with junior band5 team to enhance leadership and management skills.	- Band 7 post filled. - Band 7 time.
3. Communication to manage discharge expectations.	- All staff to highlight to patient at earliest possible time day of discharge. - On day of discharge explain to patient, wait for discharge summary and pharmacy checks, potential use of discharge lounge.	

APPENDIX M

Action Plan for National Inpatients 2014 Survey Results
Redlynch Ward

ISSUE	ACTION
Call bell time answer time is longer overnight.	• There is only one HCA on a night shift so we will ensure that all staff realise it is everyone's responsibility to answer the bells • Make sure staff communicate together on the night to formulate a plan to ensure all patients' needs are met in a timely manner. • Skill mix review has identified that only 1 HCA on nights is an issue with regards to patient care and will be sent to the Board to discuss.
Nursing staff are not good at introducing themselves to patients	• Ensure all staff are communicating appropriately to their patients and saying who they are. • If patients are unable to understand who they are due to cognition or acute illness, then to ensure that the relative of the patient is aware when they come in.

APPENDIX N

Action Plan for National Inpatients 2014 Survey Results
Short-Stay Emergency Unit

COMPLAINT	ACTION	COMPLETION
Lack of hot drinks.	• Hot drinks to be offered at 10.00; 15.00 and 21.00 as well as at meal times.	In place
Noise at nights	• Access doors to main corridor locked down at 22.00 with access by ID badge only. • Side rooms used as appropriate for clinical condition for patients that are noisy.	In place
Information re complaints	• Customer care complaints leaflets to be displayed by SSEU • Local resolution posters displayed in SSEU and ED with name, contact number and email address of lead nurse encouraging patients to make contact of any concerns.	June 2015
Lack hand gel	• Hand gel available in all cubicles in SSEU • Sink now fitted in main area in SSEU	In place
Medications	• Dedicated pharmacist for SSEU to attend daily, advise patients on side effects, methods of administration and general instructions.	Spring 2016
Help at meal times	• Help needed identified in patients care plan. • Encourage relatives to attend at meal times to help • Use of volunteers	In place
NB There are no patient phone/ TV's on SSEU [2 complaints were with regards to this]		

APPENDIX O

Action Plan for National Inpatients 2014 Survey Results
Tamar Ward

ISSUE	ACTION	DATE FOR COMPLETION
Noise at night	• Behaviour Policy implemented to repatriate the patients concerned. • Staff wear soft soled shoes. • Call bells are lowered at night. • Noise highlighted at ward meetings.	Complete and ongoing
Poor food (NB: No specific reason was given. Also, patient may be referring to another ward they stayed on]	New menus are being introduced in the hospital. Real-time feedback questionnaire adapted for 2015/16 to ask how food service may be improved.	31 March 2016
Concern raised about unsafe staffing, especially on the late shifts.	• Increased staffing on the late to 5 from 4. We aim to have 3 trained but have not always been successful in this but have managed to have an extra NA often Spinal trained. This has made a huge difference to both the patients and staff, resulting in more responsive prompt care and less tired staff when we have been busy with increased dependent patients. Increased staffing has resulted in more prompt answering of buzzers. • On an early at weekends we have 8 staff on the early rather than 7. • We have also used more Bank / agency nurses to achieve staffing levels. • To reduce Agency and gain more permanent staff we have, in the last few months, successfully recruited 4 new NA's and 3 new trained nurses; 2 Italian nurses in the last April intake. Unfortunately the first Italian nurse is leaving us to return home. • A new bank nurse has expressed an interest in working on the unit. If the nurse is appropriately trained, this will increase our pool of expert trained staff to draw on. • Advertisements are out at the moment for trained nurses. Interviews will be held this month for a Band 6 and Band 5s.	Complete and ongoing Complete and ongoing Complete and ongoing Complete and ongoing 31 May 2015 31 May 2015

APPENDIX P

Action Plan for National Inpatients 2014 Survey Results
Tisbury Ward / Coronary Care Unit

COMPLAINT	ACTION	COMPLETION
Some cleaners are worse than others	• Has been identified when our permanent cleaner was on leave and the ward was being covered with temporary cleaning staff. Issue raised with Maggie Cherry, regular cleaner now back on ward.	In place
Have been waiting for a bed in Southampton for 10 weeks	• 2 of our sisters attended a meeting with Southampton to discuss the whiteboard and how we can improve transfers • Ensure patients are getting timely investigations as part of referral i.e. Spirometry – ward nurses now being taught this to speed up process. • We have arranged for SGH whiteboard case manager to come to SDH for training of Whiteboard for nursing staff to ensure actions are completed to speed up the acceptance of referral.	Sept 2015
I have been waiting to go to Southampton for 3 weeks	• As above	As above
Tea was not hot enough	• Ensure tea trolley is plugged in at all times	In place

APPENDIX Q

Action Plan for National Inpatients 2014 Survey Results
Whiteparish AMU

COMPLAINT	ACTION	COMPLETION
Discharge	1. Highlight potential discharges early to the nurse in charge. 2. Book transport the day before discharge where possible to minimise wait times. 3. Encourage medical teams to write TTO's at the earliest opportunity (potential discharges also) and to communicate with pharmacy. 4. Nursing staff advised to sign off TTO's when completed by the pharmacist. 5. Medical teams encouraged to give all patients an EDD so discharge planning can happen sooner.	1. In place via the safety brief 2. Ongoing 3. Ongoing 4. Nursing staff encouraged to do so at handover. 5. Ongoing
Noise at night	1. Trial the use of the ambulatory bay to admit patients overnight and then transfer the bays. 2. Communicate to staff appropriate noise levels at night. 3. Communicate to patients on admission to AMU that there may be noise at times due to the nature of an admissions unit that runs 24/7.	1. Will aim to start a trial of this in May. 2. Ongoing 3. Ongoing
Wait for a bed	1. This is an ongoing issue. There are plans being discussed to improve flow for beds. ? the use of the Farley ward space as AMU. 2. Early communication between nurse in charge and site manager to identify any problems that may cause a delay in getting a patient to a bed. 3. Medical wards to come to Whiteparish and identify a patient from the unit that can be transferred at the earliest opportunity. 4. Early identification of patients that can outlie when it has been highlighted from the bed meeting that medical capacity could be an issue. 5. Communicate any possible delays to the patient.	1. Ongoing 2. In place 3. In place 4. In place 5. Ongoing

ISSUE	OBJECTIVES	BY WHEN	BY WHOM	COMPLETED BY
Noise at night from staff - Staff unable to find each other so shouting out - Reduce staff noise at night	Reduce level of staff noise 1. Staff to be informed not to shout for other members of the team. 2. For all staff to look for each other in bays/SR's instead of shouting. 3. Senior nurses to remind all staff to keep noise to a minimum at night.	 ASAP Commenced Commenced	 All staff All staff Senior and Junior sisters	 On-going On-going On-going
Call bells - Variable times answering bells	1. To complete a monthly call bell audit (over 3 day). 2. To identify key areas/problem times from audit and create action plan from results. 3. To create a checklist (e.g. intentional rounding) for all staff to reduce the amount of call bells. Clare to liaise with DDoN. 4. NIC to ensure call bells are answered promptly, highlight staff to answer bells. 5. To have a call bell monitor over meal times – to have a badge to highlight who this is.	Monthly Monthly March 2015 On-going On-going	Louise Henderson Louise Henderson Clare Winter All senior staff Sue Burwell – badge. Clare Winter/ Louise Henderson	On-going On-going On-going On-going
Food temperature cold	1. To ensure that regular checks are done by Kitchens to ensure food is arriving hot. 2. To ensure that staff are ready to serve out meals as soon as they arrive. 3. To speak to Sandy Woodbridge and Jo Jarvis regarding more volunteers at meal times to ensure meals are handed out promptly so not getting cold.	March 2015 March 2015 March 2015 – on-going	Kitchens NIC to ensure ready Louise Henderson	

Salisbury NHS
NHS Foundation Trust

Informatics Strategy Update (May 2015)

Purpose of report

This report is intended to give a summary of progress made on the work-stream themes of the Informatics Strategy 2011 - 2016, since its last update in March 2014.

Context

The Informatics Strategy 2011 – 2016 sets a Vision for Informatics at Salisbury Foundation Trust (SFT) and describes the approach that the department will take to deliver that Vision. The strategy sets out forty themes intended to enable the organisation to deliver the overarching vision and strategy for the Trust.

1. **Picture Archive and Communication System (PACS) and Reporting Information System (RIS) re-procurement.**

Our PACS/RIS system was procured and developed as part of a consortium involving SFT, Southampton, Isle of Wight, Portsmouth & Southern Health.

Update:.

Major upgrades occurred to RIS in January 2015 and PACS in February 2015.

We have also utilised the vendor neutral archive (VNA) storage available in the PACs hosted datacentre to store medical photography images and are currently looking at storing Cardiology images into PACS to complete a patient imaging health record.

SFT is now working toward the introduction of the cross data sharing (XDS) system so that any search on the SFT system will automatically return results available from the other partners. XDS testing with all suppliers and SWASH Trusts is planned for the end of June at Southampton. The expected Go-live date, pending successful testing, is the end of October (This timeframe is dependent on the availability of Suppliers resources and the workload at the other Trusts in SWASH). We are also working towards connecting to other domains including Bournemouth, Poole and Dorchester as well as Surrey and Sussex and more locally Bath and Bristol. This project however involves the other Trusts buying in to the service (e.g. making a financial commitment) and a commitment of resources for both SFT and the other Trusts involved.

2. **Clinicians View (CV) Stage 1 (Datasets).**

We now have 23 databases in CV feeding clinically agreed data sets in real time. The remainder of the databases will be added as CV is expanded.

Update: *An initial tranche of datasets has been provided through CV however the addition of further datasets will be determined by the choice of Electronic Patient Record (EPR) provider as we expect this functionality to be contained in this new system. A review of this workstream will take place once the successful EPR bidder is known.*

3. **CV Stage 2 (Click through).**

In this stage a minimum of 5 host clinical systems will be linked to CV to allow the user to access them without logging into the host system or finding the patient again and this functionality will be made available to all users of CV.

Update: *This project became known as Single Sign On (SSO) and was rolled out with fast user switching functionality across all wards during summer 2014. This system allows clinicians to swipe their ID badge, type their password and gain access quickly to specific applications without having to retype username and passwords for each system they access. SSO currently has 9 bridges allowing fast access into EDS Adult, EDS Paeds, Review, Clinicians View, Employee online, Historical Results, Teletracking, Bighand, Consultant Lists & Storefront,*

SSO and fast user switching is planned to be further rolled to Outpatients and Emergency department beginning at the end of June 2015. We will also update the versions of SSO in currently in use in Day Surgery and Main Theatres.

A solution to enable letters, created in the upgraded version of BigHand, to be automatically filed in Windip (the document management system) is currently being tested. Clinic letters in WinDip is scheduled to be Live by June 2015. Once live, the BigHand upgrade will be rolled out Trustwide. A project plan for roll-out is currently being developed but is likely to be delivered in conjunction with the SSO project. The combination of the BigHand upgrade, SSO in outpatients and access to both the BigHand letters and historical clinic attendance letters via Windip, could enable clinicians to operate a paperless clinic.

4. **CV Stage 3 (Electronic Document Management (EDM).**

The commercial EDM system, WinDip, will be seamlessly integrated into CV to provide the facility to store, retrieve, search and arrange clinical objects (for example, transcribed clinic letters, medical photography, outputs from some medical devices (e.g. ECG machines) and scanned paper records). This will be made available to all users of CV.

Update: *The Windip project is required to allow staff access to legacy data scanned from paper based records to be accessed as we progress further to a full EPR.*

All historical clinical letters have been migrated from iPM into the test WinDip. We plan to transfer these letters to the Live environment at the end July 2015. From this point forward the BigHand (letter dictation system) will automatically store all of its output into the WinDip document management system.

5. **Networked Medical Devices.**

This project will systematically ensure that all medical devices with information processing capabilities are networked, store their images and reports on network storage and provide a summary of their content to CV as appropriate. This may be via the PACS system if appropriate or using an alternative arrangement. This is happening as new systems are installed (e.g. Blood Glucose) and existing systems are replaced (e.g. Spacelabs replacing existing bedside monitoring kit)

Update: *The Blood glucose (BG) system has now been upgraded and data is being fed from the device into the BG server via a network connection. As Spacelabs devices are installed to replace existing products they are being connected to the Trust network by default.*

6. **CV Stage 4 (Patient Access).**

In this stage patients, carers and other professionals will be able to access and update (either directly or via a medical device in the home) CV. CV will be developed so that it can be embedded into the clinical systems of primary care and other healthcare partners, with appropriate security controls.

Update: *This work will be reviewed once the successful EPR bidder is known.*

7. **Digitise medical records.**

As we progress with an integrated Electronic Patient Record (EPR) system records will be created in a digital format. Historical paper based information will need to be digitised and made available to complement those records already created digitally.

Update: *A pilot involving the scanning of 500 patient records has been completed. An independent supplier provided a strategy for digitising paper records however this workstream is likely to be incorporated as part of the Electronic Patient Record (EPR) project.*

8. **Electronic Discharge Summaries (EDS).**

This project will achieve the full implementation of electronic discharge summaries (including To Take Out (TTO) prescribing) sent directly to GP practices systems electronically. The contents of the EDS will be available on CV.

Update: *EDS is being used across all main Inpatient wards. Further development will be required before rolling out to Day Surgery and Hospice.*

Currently 40 GP Practices are receiving electronic discharge summaries directly into their clinical systems. This project is being reviewed following the recent contract requirements to send 100% of EDS's electronically by October 2015.

9. Access to primary/community information.

In the first instance read only access to the Wiltshire clinical system (SystemOne from TPP and the national Summary Care Record will be provided to clinical staff at SFT using a proprietary viewing system for each data source (Phase 1), in the longer term datasets will be imported from the local community, primary care and Social Service systems into CV (Phase 2). Read only access to TPP has been set up for specific areas in the Trust. Permission is being sought to extend this access to all clinical areas. The national Summary Care Record still does not exist in the South of England we are unable to progress this. TPP are engaging with other GP Systems suppliers to share information and we are examining whether it will be possible to electronically transfer information (with the patient's permission) into the Trust Information Systems.

Update: *Access to TPP is now live and available in the Emergency Department (ED) and the Medical Assessment Unit (MAU). It is also used by the Pharmacists. A GP lead is helping with the training of clinical staff in the use of this system. The continuation of the rollout of access to the TPP system will require robust data sharing agreements to support information Governance requirements.*

10. Electronic Transmission of Clinic Letters.

Letters that are currently generated via IPM will be created in BigHand (SFT's digital dictation system). This will enable the creation of an electronic workflow by department so that letters can be approved electronically. Once approved, where possible these letters will then be transferred directly into GP clinical systems. For GP's that are not able to receive letters in this way, they will have the opportunity to receive them by email via NHS.net or by paper via Synertec, the company we currently use to outsource our batch printing requirements.

Update: *A new version of BigHand is currently in test and will be released when testing is complete. We have successfully piloted the process of creating electronic letters in clinic using the colorectal department as a lead and we are in the process of developing the rollout plan to extend the facility to other departments.*

11. Electronic Requesting by GPs for Diagnostic Tests.

A new pathology web browser will be launched which will enable GPs to access test results for their patients that were initiated by SFT clinicians during the patient's care at the Trust. The current roll out of electronic requests for pathology tests from GPs will continue until full implementation.

Update: *The upgrade to allow GP's to electronically request Radiology tests is in final testing. The work to allow GP's to view and access all test results for their patients, (both pathology and radiology tests requested by them or SFT clinicians) is currently delayed as we resolve SQL licensing cost issues.*

12. Order Communications/Results Reporting (OCS/RR).

Review (the electronic viewing of results) has been installed. Paper results reporting to GP Surgeries has been switched off and the number of results in SFT being printed has greatly reduced. This will reduce to zero as the electronic patient record is developed. Electronic Requesting (tQuest) of Pathology and Radiology results has been rolled out.

Update: *The rollout of requesting in outpatients for pathology and radiology test was completed by the end of March 2014.*

A follow on project to include a fix for histopathology requesting, requesting in sexual health and an upgrade to Review (results reporting) will take place when the supplier makes the necessary upgrades available. Currently the supplier is predicting availability of these fixes within the next 4 to 5 months however historically they been delayed a number of times. This workstream will be reviewed when the successful bidder for EPR is known.

13. Theatre Management System (TMS).

SFT has implemented the TMS to enable real time recording of patient activity and theatre utilisation and support the productive theatre project. Tray Tracking is planned to be delivered in 2015.

Update: ***"****Tray tracking" provides an audit trail of the sterilised trays of surgical equipment used within the Theatres. It allows the identification and reconciliation of specific trays used on individual patients during their operations providing safer operating environments for patients.*

The operation notes facility is installed but is in limited use. This is due to the fact that only a generic template is available for use however clinicians want a template per speciality. This would require a substantial amount of resource commitment from both project team members, clinicians and the supplier however it is being reviewed as part of the Theatre Management stream within the trusts Transformation Programme.

14. Clinical Datasets.

Formerly a product called Excelicare was used as a forms framework to capture data that was previously only held on paper or based in unsustainable databases. This product has ceased to be

used in the Trust and the data is currently being converted into databases created by the in house software development team. This will provide a clinical documentation facility for all clinical staff to collect structured, coded data at the point of care.

Update: *Currently some databases formerly provided through Excelicare have been replaced by the introduction of the Somerset Cancer Database application whilst other such as Baby Hips, Urology, Orthodontics and Resus database are shortly to be released on the new platform.*

15. Enhanced Patient and Bed Tracking.

Building on the successful implementation of the Bed Availability Tracking System (BATS) the next phases of the project will improve patient flow through the inpatient settings of the Trust and support length of stay reduction. This has been expanded to include electronic whiteboards so that updating either a Whiteboard or BATS or Consultant Lists or iPM will automatically update the other systems for specific information. A project to record electronically the blood in the Blood Fridge is nearing completion. The next phase, tracking of blood from vein to vein is scheduled to complete towards the end of 2013. The final phase, printing of blood sample labels at the bed site is planned for 2014/15.

Update: *The outputs required of the Whiteboards project is now being absorbed into the work being undertaken as part of the Patient Pathways Project within the Trusts Transformation Programme. BATS functionality will be taken over by a future release of POET (Patient Observation Escalation Tool)*

The Trust has been successful in gaining funding from NHS England for an Electronic Whiteboards Project. This workstream may be influenced by the choice of EPR provider. Work is taking place to complete the loop between iPM, BATS, Consultant Lists and POET i.e. if you update one of these systems then the others are automatically.

The project to electronically record the blood in the Blood Fridge is now complete.

16. Electronic Prescribing and Medication Administration (EPMA).

This project will manage the purchase and implementation of a system to achieve electronic transmission of prescription information from a prescriber to the pharmacy, integrate to the current electronic dispensing process and achieve paperless administration of drugs. SFT has formed a consortium with 3 other Trusts to jointly procure jointly a system. A significant part of the funding will come from the Government. Final Government approval was received in mid May 2013. The next stage is to plan the procurement and implementation.

Update: *SFT has withdrawn from this collaborative as each of the bidders in the EPR tender has an EPMA module within their systems.*

17. Patient Monitoring.

The intention is to build or procure a system to enable electronic capture of patient vital signs (e.g. temperature, pulse, and respiratory) at the point of care and the automatic calculation of an Early Warning Score for patient deterioration. It will also incorporate clinical decision making information and the ability for nursing assessments to be collected electronically. National funding is to be sought to undertake an in-house development.

Update: *NHS England funding was secured and the decision made to develop a system in-house. External design assistance was procured to ensure the look and feel of the system was consistent with modern off the shelf products. The system is now in use (pending some tweaks) on Laverstock ward and is receiving excellent feedback from staff using it.*

18. Promoting the trust website.

The vast majority of the survey respondents have not used the trust website or were unaware of it. This suggests that there should be more communications to promote the trusts presence on the web. The latest data shows increasing "hits" to the website and this promotional work should continue. Feedback about the Trust website has resulted in some development work to redesign the website to reflect today's needs – this will go live in late summer 2013.

Update: *The Website continues to expand with more departments requesting their own dedicated sites. These departments include Maternity, Diabetic Eye screening, Spinal, Volunteers, Audiology, Dermatology and Plastics*

19. Email letters to patients.

Patients responded very positively to receiving clinical letters, appointment letters and test results via email. However, a significant minority would have issues with this so the choice of paper letters should be preserved. The deployment of electronic check in facilities with outpatients will assist with the collection of patient email addresses.

Update: *"Email letters to patients" is now part of the BigHand clinical letter project. Electronic kiosk based check-in facilities have now been deployed in certain areas of the Trust.*

20. Patient held medical devices.

A project will be established to explore the use of patient held medical devices that are capable of sending electronic information to care organisations. SFT will review the lessons of the national Whole System Demonstrators (WSD) on this subject before proceeding. A trip to review a national early adopter will take place in late summer.

Update: *There has been no progress on this workstream.*

21. System replacement.

We will continue to assess and replace aging and out of date infrastructure and clinical systems as they go end of life. Focus for the near future is to concentrate on systems that could benefit from replacement as part of the introduction of a new integrated Electronic Patient Record system.

Update: *Many core infrastructure systems that were going end of life have been replaced. The system that control access to the network (Active Directory) and the core email systems have been upgraded within the last year.*

Funding was obtained from NHS England for the OpenEyes Open source Opthamology system from Moorfields Hospital. During last year the Cataract module was installed and discussions are taking place regarding next steps for the deployment of further modules.

22. Selling Software.

Whilst originally the trust sought a commercial partner to help support SFT selling existing software this proved unsuccessful. Localised instances of selling particular in house developed. Non clinical systems have proved promising.

Update: *We continue to attempt to sell our products to other Trusts and have received interest in selling our Freedom of Information (FOI) system and also interest in selling the source code for our SpiDa appraisal management system. We are also drawing up plans to provide an FOI and data protection advice service to NHS organisations, public sector organisations and businesses and this should go live in summer 2015.*

23. Secondary Thin Client Environment.

The original thin client environment HAS was based on a technology platform that has since become end of life by the manufacturer. We had planned to replace the environment with the latest version of the thin client platform called XenApp

Update: *We do now have a XenApp environment and works are underway to utilise thin client technology in slightly different way. The advancement of standard desktop facilities has meant that we are now able to provide and manage desktop applications in a manner that staff are accustomed to using in their home environments. We will switch to a new desktop environment as we roll out system throughout the next 12 months.*

24. Patient and public questionnaires.

The Trust needs to support the increased use of online questionnaires by developing the current system or replacing it with an alternative that feeds the Data Warehouse and hence enables effective reporting. In line with Government initiative, the Trust has developed the ability for

patients and relatives to give structured feedback using the Friends and Family questionnaire. Findings from these questionnaires will be published on the Trust website.

Update: *The Friends and Family questionnaire and results are live on the external website. This test can also be completed from within the SFT Smartphone application which is available through the iTunes and GooglePlay stores.*

25. Public access to wi-fi.

The Trust has a commitment to provide patients and the public access to the internet and emails whilst visiting or staying at the hospital.

Update: *During 2014- 15, the Trust tested a guest wifi service on some wards by providing access to Wiltshire Council's free online service. Testing failed to comply with contractual restrictions contained within our bedside entertainment system supplier's contract and, as a result, the Trust was unable to implement this wifi service. The provision of this service has been tendered again with external providers and we are entering the final stages of the procurement process for this service.*

26. Reporting Services.

The recently launched reporting service of dashboards and cubes framework will be further embedded to improve the Trust's consumption of information. This framework will be capable of adaptation to any of the requirements generated by the agendas shown above. During 2012/13 the Dashboards for Performance, Human Resources and Quality were launched. During 2013/14 these will be refined further. Further dashboards and tools will be developed aimed specifically to support the work of the Directorates in providing safe, effective and efficient services.

Update: *During the 2014-15 Qlikview was trialled by the Trust, with dashboards for A&E, Emergency Readmissions and Clinical coding produced. The software demonstrated a potential use case for the Trust, but the format of the dashboards produced was not well received. The quoted cost of the software was also considered high, and next steps are to investigate if these costs can be reduced, before pulling together a business case for consideration at the Trust.*

27. Forecasting/modelling/benchmarking.

The analysis team will develop a forecasting/modelling and benchmarking capability to proactively alert senior stakeholders to unexpected variation in activity, process and outcome measures and provide a scenario testing service to enable users to simulate the outcome of alternatives courses of action. During 2012/13 modelling work was completed demonstrating bed requirements. Also a piece of simulation work demonstrating the flow of Orthopaedic patients through Main Theatres was completed. During 2013/14 these pieces of work will be developed further, to provide more comprehensive planning information that can subsequently be monitored against.

Update: *During 2014, a bed modelling tool was developed that allows users to state the predicted growth / decrease for their service, define an expected reduction in length of stay and then, using that data, predict on a week by week basis the number of beds that would be required to deliver that service. Similar tools are also being developed for outpatient services and A&E.*

28. Outcome measures.

In collaboration with the Quality Directorate Information Services will lead on the creation and embedding of outcome measures into existing and new information systems, and then reported on, to support the Trust achieving an outcome focus to its Quality Accounts. During 2012/13 the Information Services department developed a range of metrics that were successfully used as part of the ongoing reporting to support CQUINs, and inform the Quality Account. During 2013/14 these indicators will be expanded in line with service developments and the CQUIN framework.

Update: *During 2014 Information Services developed data collection and reporting tools for the Safer Staffing reporting framework, which compares the number of staff required to run a ward safely with the number of staff on shift, thereby enabling the Trust to demonstrate our ability to deliver safe care for patients in line with national guidelines.*

29. Supporting Choice.

The analysis team will participate in all national and regional initiatives to support patients making choices based on a set of assured information that describes the availability and quality of the Trusts services.

Update: *During 2014-15, the operational managers have been supported by Information Services ensuring that waiting list information is delivered in a timely manner, to support the booking process. The reporting and monitoring of recent DH funded waiting list initiatives was also undertaken by Information Services, who acted as liaison between the operational managers, the finance department and monitor.*

Other initiatives supported by Information services include the monthly Friends and Family surveys, and the quarterly Friends and Family staff survey.

30. Real time notification.

Users will receive more proactive notification (as near real time as possible) when their work breaches DQ standards so it can be resolved at source, during the operational process.

Update**:** *The Data Quality Notification (DQN) system is a notification system which highlights Data Quality issues to users and guides them to resolve them. Increasingly the DQNs are also used to provide an alert system to key users that additional information is needed to support a specific pathway, thus making the DQN more of a proactive tool. In the last year the total number of DQNs*

raised was 86,500 and the total closed was 84,700, representing a 98% completion rate by users. In the last year there were also approximately 7000 calls to the DQ Helpdesk, averaging 26 calls a day.

31. Process improvement.

Using the analysis produced by the data Quality team, the Informatics training team will support operational departments in defining their processes to support 'right first time' data collection and ensure appropriate training and support is in place.

Update: *The structures for Right First Time and the Data Quality Improvement Group are now fully established and work is ongoing to support training assessments and process improvements.*

Over the last year DQIG work has generally fallen into the following categories:

- *Maximising income from Trust activity: ensuring activity is properly recorded and coded on IPM. Ensuring Best Practice Tariffs are applied and evaluated. Advice given to GPs from a Letter request is now recorded on IPM though currently not charged to GPs. Accurate recording of private patients, specifically patients to go private part way through their treatment.*
- *Support for RTT recording: updating of outcome forms and production of pathway specific outcome forms from IPM to help clinicians complete the forms accurately.*
- *Move the registration and updating of patient demographics in ED from Symphony to IPM, thus being able to utilise standard Trust processes for registration and updating. To become mandatory where a receptionist is available once Symphony upgrade completed (upgrade took place on 3rd March 2015)*
- *Improvements in management of patients through individual pathways by improving booking processes in specialty areas*
- *DQ Notice Advice to ensure ongoing improvements in data input is made.*

40 issues raised to the Group have been resolved over the last year and 60 issues remain open illustrating the ongoing requirement of DQ Improvement support.

32. Innovative skill building.

The training department will continue to implement innovative/blended training solutions that respond to the needs of customers - including e-learning, floor walking and peripatetic training support (solving work based problems).

Update: *Projects which have been implemented in the last year across the Trust have included Single Sign On which has dramatically reduced the time taken for staff to access clinical applications on the ward and the introduction of kiosks to selected clinic areas to support patients booking into appointments. The Team are also involved in a programme to improve the MSOffice skills of staff*

which will be ongoing as MSOffice 2010 and the new Trust Desktop is rolled out across the Trust in the coming months. The Team continue to use e-learning, floor walking and peripatetic support as well as traditional classroom training to support staff. The team have moved to a new ELearning authoring package in the last year which offers further flexibility in being able to support a greater variety of devices.

33. Thin client upgrade.

The original thin client environment, HAS, was based on a technology platform that has since become end of life by the manufacturer. We had planned to replace the environment with the latest version of the thin client platform called XenApp

Update: *We do now have a XenApp environment and works are underway to utilise thin client technology in slightly different way. The advancement of standard desktop facilities has meant that we are now able to provide and manage desktop applications in a manner that staff are more accustomed to using in their home environments. Each departmental area is being reviewed and the best application delivery tool (or mixture of tools) for that area is then implemented.*

We will switch to a new desktop environment as we roll out system throughout the next 12 months.

34. Storage, back up and archive strategy.

Our existing storage area network (SAN) offers opportunities to improve the speed of backup and restoration by applying a tiered storage model – so that older data is consuming less expensive disk space.

Update: *We plan to replace the current backup software with a product called ArcServe that will allow us to stop "snapshotting" SQL servers and give us more granularity when restores are required, e.g. snapshotting requires an entire server to be restored where we often require single databases or files. The SQL works are planned to be complete by end May 2015 and rest by end July 2015.*

35. Review of key infrastructure applications.

There will be a proactive review of all the key applications that support the SFT core IT infrastructure to ensure the supplier's roadmap for this application is known, particularly if they plan to end support of the product in the next 12 months.

Update: *Last year we installed a product called Dell Kace that allows us better monitoring, distribution and control of applications. We continue to monitor major vendor roadmaps and are undergoing planned upgrades such as the conversion of desktop operating system from XP to Windows 7.*

36. Mobile Devices.

As ward based use of electronic data develops the demand for bedside computing will grow. The latest advances in mobile computing and lessons learnt from leading NHS Trusts will be studied to ensure SFT invests wisely in this complex area.

Update: *Many wards have been issued with laptops on wheels allowing staff to access information at the bedside. Also as part of POET project, NHS England funding has been secured to provide tablet and hand held devices for clinical staff.*

37. Operating Level Agreements.

With the implementation of the new service desk will come the opportunity to agree operating levels with Trust departments which can be measured, reported on and subject to escalation if necessary.

Update: *A service level agreement has been put in place for the services supplied to Genetics team. As new applications and systems are installed the service catalogue for that system will reflect the expected service levels. Also a service level agreement has been implemented for services supplied to the laundry service now they have been split as a separate organisation from the Trust*

38. IG Assurance.

A mature governance system has been implemented and is regularly reviewed that ensures all critical assets are owned, administered effectively and the full range of assurance activities are completed. New regulations come into force throughout 2015 and the requirements will be advised to the Trust and applied as necessary. New regulations are expected from the European Union Data protection directives (expected in July 2015), Cyber security standards and the Cabinet Office Duty of Candour standards all of which will have an impact on the IG team and the Trust as a whole.

Update: *As part of the work to comply with the IG Toolkit an InfoPath form for completion by Information Asset Owners and Information Asset Administrators has been released. This process is now fully in place and a database of the relevant information is maintained. Works for this year indicate that we are once again likely to achieve our annual IG compliance. We are however seeing a 100% annual increase in Freedom of Information requests which is creating substantial resource demands on the team.*

39. Corporate Records Management.

The Corporate Records will be audited and procedures agreed with the appropriate departments to ensure the organisational memory is preserved effectively.

Update: *Regular audits are now carried out including audits of management boards and committees. The security and efficiency of records usage has been significantly improved as a result of increased*

use of digital information over paper based records. The corporate records management board has now been subsumed into the Electronic Patient Record (EPR) board.

40. Informatics capacity management.

The transformation team will implement a new structure for projects based on the Prince2 methodology ensuring consistency of delivery across projects which will lead to a more controlled demand on technical resources.

Update: *The Request For Change (RFC) process is now soundly embedded into the culture of Informatics and new RFC's are reviewed at the weekly Informatics Senior Managers meetings. Where there are priority clashes, these are escalated to the monthly IPG (Informatics Priority Group) meetings and if necessary to the bi-monthly ISSG (Information Systems Strategy Group) meetings. A critical path for the Informatics programme has been created and is maintained. This critical path has been matched against the corporate strategy and lists the prioritised major projects and their dependencies.*

Where we are we heading.

As we enter the forthcoming year the Informatics Department will focus on supporting the Trust to deliver its business goals and corporate vision by focussing on the delivery of the following main programmes of work over the forthcoming year.

These main themes will include :-

- EPR – The selection and commencement of Phase 1 of the implementation project (Patient Administration System module) of the electronic patient record system
- WinDip – The document management system that will be a repository for required legacy letters and other paper based data as well as offering storage for data that enters the Trust in a paper format.
- OrderComms – will focus on giving GP's access to test requesting facilities and results. A number of further enhancements are due following specific SFT requests to the vendor.
- EDS – The expansion of the electronic discharge to encompass more specialist departments in the Trust.
- POET (Patient Observation and Escalation Tracking system) – The system will continue to be rolled out across ward areas.
- Blood Tracking – Phase 2 will see the delivery of the bedside administration of blood transfusions whilst phase 3 will focus on bedside sampling

Successful Project work for Transformation Team – January 2014 to February 2015

1. Allocate implementation – roll-out to wards completed in 9 weeks plus later upgrades
2. Allocate move to the Cloud
3. Allocate – access to EOL from home
4. Allocate – Safe Care rollout across wards but needed to have enough Windows 7 PC's available for this to work
5. Maternity upgrade to v1.5
6. Maternity server move from actual to virtual
7. Maternity upgrade to the PDS service – failed but successful roll-back to existing system
8. Maternity upgrade to the PDS service which was successful
9. Maternity NBBS – New-born Bloods spot failsafe solution
10. PACS data migration to VNA server on wheels and transfer to data centres
11. PACS upgrade to v16.1 – failed but successful roll-back to existing system
12. CRIS upgrade to vR1e
13. PACS upgrade to v16.2 – successful
14. Move of Medical photography images into PACS
15. Urodynamic printout into PACS for ease of use
16. Ward watcher implementation – Intensive care audit data for national reporting
17. Roll-out of Radiology Order Comms across the Trust
18. T'Quest for GP's upgrade
19. Fountain Way access to Review
20. Site acceptance for Order Comms for sign off
21. T'Quest for GP's implemented at 4 more surgeries
22. Blood Tracking Phase 1 - Blood tracking electronic fridge and stock control
23. Microsoft Patch to improve Order Comms system stability
24. SpIda implementation and enhancements
25. SSO roll-out to in-patient wards
26. Clarendon suite refurbishment
27. Medical records scanning pilot and strategy
28. EDS roll-out to the majority of in-patient wards
29. Electronic transmission of EDS to 40 GP surgeries
30. Successful evaluation of mobile devices
31. Implementation of Datix Web – 2nd time round
32. Jayex
33. EHNA pilot
34. MDMS move data back to UK
35. EPMA – BA and business case data to be used as part of EPR project
36. Project management of AD upgrade, Edge security and Exchange 2010
37. BAU work for all projects is ongoing e.g. 139 BAU Issues relating to T'Quest & Review (internal & Primary Care) investigated and resolved, day to day PACS related issues and CRIS DQ – unable to quantify but considerable

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 26th March 2015, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – LYDIA BROWN

Present:

Dr Lydia Brown (Chair), Christine Blanshard, Paul Kemp, Steve Long, Peter Hill, Fiona Hyett, Sally Tomlin, Angela Clarke, Jan Sanders, Sarah Mullally, Mark Stabb.

In attendance:

	Item
Kate Williams	Minute taker
Carmen Carroll, Vanessa Bridgeman, Claire Walters, Gill Hibberd, Ian Harvey	CGC0304
Gill Sheppard	CGC0309 & CGC0314

Apologies:

Claire Gorzanski, Hazel Hardyman, Lorna Wilkinson, Laurence Arnold, Denise Major.

Not in attendance, apologies not received:

Hollie Foreman

CGC0302 – Minutes of the meeting held on 26th February 2015

The following amendments were made to the last set of minutes:-

- The addition of Sarah Mullally to the list of those present

The minutes of the last meeting were then agreed as an accurate record.

Post meeting note – amendments completed and final minutes circulated.

CGC3203 – Matters Arising/Action Tracker

There were no matters arising due this month.

CGC0208 on the Action Tracker was noted as completed.

STRATEGY

CGC0304 – Core Service presentation – Medicine with a focus on care of the elderly. Carmen Carroll, Vanessa Bridgeman, Claire Walters, Gill Hibberd.

CC delivered a Powerpoint presentation on Medicine with a focus on care of the elderly.

CC highlighted the following points:-

- The main issue is the service redesign :
  - Implications in terms of how the service runs
  - Impact on the safety and effectiveness of the service
- The aim of the redesign is to achieve streamlined wards and a seamless flow in and out of the hospital
- Being able to provide timely and efficient hospital care for elderly people, with a particular focus on extremely elderly people in the last three years of life
- Being able to maximise the wellbeing and functional independence of elderly patients
- There has been a surge in elderly people having falls which is a major cause of hospital admissions

- The need to plan for the future – there is an increasing demand across the board for these services

CC discussed the challenges regarding the provision of services both now and in the future.

Staffing issues are currently being addressed with the recruitment of agency staff.

Winterslow Ward has developed a system whereby Band 4 staff are developed, there is recruitment from overseas and of trainees and they are block booking agency staff to assist in the continuity of care.

It was noted that training and development of staff is being progressed and encouraged and that there is a need for a good skill mix on the wards.

It was noted that there should be flexible options for the elderly to have support in the community following hospital care and that to assist in this there needs to be improved links between the hospital and community care teams.

Durrington Ward - would like to provide the Rapid Discharge Process for community geriatric care.

Winterslow Ward currently fulfils acute and community care and would consider active transfers with Durrington Ward.

Areas considered to be at risk are the Dementia Rounds and particularly the Parkinson's Disease Service which would have a major impact as we rely heavily on this service.

The provision of services for the elderly has been significantly improved but overall it was felt that both the work force and costs are stretched.

SM asked for more information regarding the service redesign

CC discussed the Rapid Access Clinics, Durrington acute care and the aim to improve turnover with an aim for 4-6 daily admissions which would be an increase on the current 2-5 daily admissions. Part of this would be due to improved bed management and community care which affect transfer of patients and turnarounds. Advertisements have been placed to obtain community help.

SL asked if there needs to be clear decisions made about where the services need to be in the next 5-10 years

CC discussed current projections indicating a large increase in the elderly population in 2020 / 2030 which is a nationwide issue. We are constrained by resources.

It was suggested that providing job offers to people to be applicable on condition of future qualification could assist in recruiting people to this area. CC discussed the need to recruit both now and in the future.

FHy commented that there needs to be an alternative to fill the gaps when senior personnel leave. IH is looking into this.

SM questioned whether there is a forum regarding ethical decisions in elderly care particularly with regard to the offering of treatments and discussions regarding quality of life. FHy referred to the Ethics Committee at which all teams are encouraged to discuss these questions and others such as pain management. AC stated that any decisions about an elderly person's care and treatment would also have to be taken at an individual level.

LB thanked CC, VB, CW, JH and IH for their report and presentation.

CGC0305 – Patient Story

This item was cancelled as the patient withdrew consent for this to be brought before the committee.

CGC0306 – Raising Concerns Policy Update, Christine Blanshard

The Raising Concerns 'Whistleblowing' Policy was reviewed and extensively rewritten during 2013 to align it to procedures followed in practice by staff, and to take account of national requirements to allow staff to feel able to raise concerns without fear of repercussions.

Two concerns have been raised since the last report. Both related to staffing issues and have been resolved satisfactorily.
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CB discussed concerns regarding staffing levels and these had been resolved. An Action Plan has been created to deal with additional issues. This is being dealt with on an ongoing basis - not all actions have been completed and work on the items in the action plan will need to continue into next year. There will be additional actions as time progresses, with staff responses being considered. The policy will be reviewed in August 2016.

PK asked if we would be able to show progress in June 2015 and whether the staff responses are anonymous as the Francis Report had demonstrated the importance of anonymity in such matters.

CB was able to confirm that work is in progress to allow for the option of online reporting and that this topic would be brought back before the CGC with a further response and action plan.

CGC0307 – Dementia Strategy End of Year Report, Carmen Carroll

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

1. Use the experience of people with dementia and their carers to prioritise service improvements based on the results of the Trust dementia quality indicators
2. Celebrate success – the dementia training programme, outpatient standards, ENGAGE and "Elevate" projects have all been commended as positive practice on www.dementiapartnerships.org.uk and the Trust has used the DH grant to create a caring environment for older people
3. Improve compliance with the dementia screening and carer support CQUINs targets
4. Establish a dementia pathway and ways of identifying people with dementia to maintain dignity and to deliver care promptly and safely
5. Undertake a local Charter Mark Audit.
6. Participation in the development of the Wiltshire wide Dementia Strategy.
7. A successful education programme.

CC discussed the valuable partnerships the service has with Care Support Wiltshire, the Alzheimer's Society and Dementia UK.

Historically, complaints in this area have centred around a lack of information and a lack of support for families.

CQUIN – there is a preliminary agreement for the development of a Carer Café in Springs Restaurant which will need posters and advertising. It is suggested that this takes place once per week and will be manned by volunteers from the Alzheimer's Society and Care Support Wiltshire.

Care Support Wiltshire are keen to work with the Trust, train more carers and come into the hospital to reach more people in this area.

There are currently two support workers who support carers of people who are in hospital and efforts are being made to improve referrals with the Alzheimer's Society being a key link.

Dr Ghosh – a neurologist and dementia expert who deals with medically complex patients may set up a 'memory' service.

We have been developing a research project re: ELEVATE with Southampton Hospital which is very positive for the Trust. ELEVATE was very well received when presented to the public and provided good publicity.

CB stated that she would like to see data regarding the positive aspects of ELEVATE.

<u>Discussion on the Core Service Presentation</u>.

SL stated that the high standards we have on our wards need to be extended in cost effective ways to improve patient experience elsewhere.

LB said that it was a very important part of hospital care which is being recognised externally for its good work.

A discussion took place regarding the recruitment of new clinicians and what steps are being taken to make the Trust attractive as employers. CB stated that changes have been made for recent advertisements for staff and we are waiting to see how many people that attracts.

SM asked if we could recruit an experienced clinician who would then be able to shape resources.

PH stated that it would be very desirable to recruit a clinician to provide leadership skills in this area.

PK said that he would have liked something more tangible in terms of how we are progressing and CB responded that the main concern is that although long term plans are in place, more needs to be done to deal with matters arising in the short-term.

CGC0308 – End of Life Care Biannual Report (tabled for information only), Christine Blanshard

This was tabled for information only because an End of Life Care presentation was given by the HPCT at the CGC meeting in February 2015.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC00309 – ED Survey 2014 – CQC Benchmark report & Local Action Plans, Gill Sheppard

GS discussed the participation of Salisbury NHS Foundation Trust (SFT) in the fifth national Accident and Emergency Department survey between May and September 2014.

SFT scored 'better' than most other Trusts in five of the eight overall sections and were close to being the highest scoring Trust. It was 'about the same' for the remaining three sections.
SFT was 'better' in 16 of the 35 individual questions; three of which were the highest scoring Trust. It was 'about the same' for the remaining 19 questions.
SFT scored significantly higher for patients being able to get help from a member of the medical or nursing staff if they needed attention. It scored significantly lower for patients feeling threatened by other patients or visitors. This is being addressed through the action plan
SFT had a higher response rate than the national average and was in line with the national picture for demographic characteristics.
The Emergency Department has carefully considered the results of the 2014 survey and has drawn up an action plan of areas where improvements can be made.

PK questioned why the four points on the action plan were not already being done and asked what improvements could be made.

FHy stated that not all of the information is made available so that issues can be addressed.

SL noted that the Trust has made large improvements in this area which was agreed in general.

CGC0310 – Q3 Complaints Report, Fiona Hyett

The main issues from complaints were :

- Clinical treatment.
- Staff attitude.
- Communication.
- Appointments

At the CMB CB asked all directorates to come back with an action plan on how they are going to improve direct communications with patients.

CGC0310A – Q3 Complaints Dip Sampling Report, Steve Long

SL reported to the CGC the results of NED dip sampling of complaints made during quarter 3.

SL noted that a complaint could be a single issue or a number of complaints over a length of time and discussed the impact of this on patients and their relatives.

The main concern is that responses tend to be clinical rather than emotional. Patients were unhappy to receive long letters of explanation, often containing complex medical terminology. It would be better to provide more personal contact with telephone conversations and meetings. Some meetings do take place but there needs to be more consistency in the responses. Lorna Wilkinson has made changes and we need to continue to have conversations to meet the emotional needs of patients and their relatives.

SL stated that we need to consistently provide the same response to patients and their relatives.

SM felt that efforts should be made to improve letters to patients so that it meets both legal requirements and emotional needs.

Action: Update on progress to the CGC in July 2015 SL

ASSURING CLINICAL EFFECTIVENESS

CGC0311 – Quality Indicator Report (for information), Christine Blanshard

• 6 cases of C Difficile which means the Trust has breached the target by 2. These are being investigated.
• 1 MSSA bacteraemia - not line related.
• 3 new serious incident inquiries.
• 1 never event.
• A decrease in the crude mortality rate. SHMI is 101 and SHMI adjusted for palliative care is 98 to June 2014. HSMR is 97 to November 14 which is as expected.
• A decrease in grade 2 pressure ulcers.
• Safety Thermometer - 96% 'new harm free care'. 92% 'all harm free care' which indicates a proportion of patients are admitted to hospital with a harm.
• Ten falls, all resulting in moderate harm; 3 fractures managed conservatively, 3 soft tissue injuries, 3 aggravated old injuries requiring medical intervention and 1 head injury. The falls happened across 7 different wards.
• An improvement in the percentage of fractured hip patients operated on within 36hrs.
• Escalation bed capacity increased**.** There were 8 non-clinical same sex accommodation breaches. Ward moves of patients moved more than twice remains at a low level.
• An increase in patients arriving on the stroke unit within 4 hours and sustained performance of patients spending 90% of their time on the stroke unit and receiving a CT scan within 12 hours. There was a decrease in high risk TIA referrals being seen within 24 hours.
• Real time feedback was as expected. The Friends and Family test response rate for inpatients and ED was achieved. The Maternity Services response rate remains below target. Day cases and outpatient response rates remain variable.

FHy reported that there were three cases of C Difficile on Durrington Ward prompting a deep clean and a reminder being made to all staff of the action plan. Our target for next year is 19.

CGC0312 – Draft Quality Account, Christine Blanshard

The Trust is mandated to provide a Quality Account for the public each year. The purpose is to inform them about progress made in improving the quality of care in 14/15 and improvement plans for 15/16

Overall, the Trust has made good progress in improving the quality of care in 14/15 but there is still work to do.

Five quality priorities have been selected for 15/16 following a wide consultation. The five priorities are:

- Priority 1 Strive to keep patients safe from avoidable harm
- Priority 2 Ensure patients have a positive experience of care
- Priority 3 Actively work with our community partners and patients to prevent ill health
- Priority 4 Provide patients with high quality care seven days a week
- Priority 5 Provide co-ordinated care across the whole health community.

CB invited the committee to contact Claire Gorzanski to suggest improvements.

Last year priorities remained the same as we needed to make more progress. As good progress has been made the priorities for this year have now been changed with a different emphasis including the seven day week agenda.

PK asked if we have removed items where progress has been made.

CB confirmed that this was the case but that we are constrained by what has to be included and reported.

Feedback is that our Quality Account reads better than most.

CGC0313 – Internal Audit Programme, Christine Blanshard

CB informed the Committee of the progress of the internal audit programme from June 2014 to January 2015.

- In 2014/15 two audits had outstanding actions. Of the 8 recommendations, 6 have been completed and two partially completed.

Of the two partially completed actions, one will be finished in June 2015, and the other will be finished in April 2015.

CGC0314 – External Enquiries and External Agency Visits Biannual Report (inc. National Conference Enquiries, External Visits and National Reviews and National Clinical Audit Update), Christine Blanshard, Gill Sheppard

GS provided the Committee with an update on reports received and action taken in respect of these four areas of activity.

- National Reviews. No new reports were published within the reporting period. Actions from six reports published in preceding reporting periods are progressing satisfactorily.
- National Confidential Enquiries. One report was published within the reporting period. The Trust is compliant with 17 recommendations and partially compliant with the remaining one. The report and self-assessment will be presented to the Clinical Management Board in March 2015. Work on recommendations from six reports published in the preceding periods is progressing. There has been some delay in the production of a Neonatal / Critical Care Transfer Policy in respect of the report “Are We There Yet?” which reviewed organisational and clinical aspects of children’s surgery.
- External Visits. Eight visits took place within the reporting period. Actions are being taken to address areas of non compliance. Actions from four visits in preceding reporting periods are progressing satisfactorily.
- National Clinical Audits. Twenty-one reports were published within the reporting period. Actions in all areas are being monitored by the Clinical Management Board. Actions from eleven reports published in previous reporting areas are progressing satisfactorily.

ST reported that concerns were noted on audit regarding the logging of results of environmental monitoring and that trends needed to be monitored more carefully. This has now been achieved.

PK asked about dates for completion in respect of the external audit of the Fertility Centre.

GS responded that the work had been done and we were waiting for the outcome of the Licencing Panel to be able to give dates.

CGC03115 – Major Issues Report, Christine Blanshard

CB informed the Committee about important clinical governance events affecting safety, effectiveness and the patient experience that have occurred since the end of November 2014 both within the Trust and externally, covering the following:

- Safer Staffing: A Guide to Care Contact Time
- Themes and lessons learnt from NHS investigations in matters relating to Jimmy Savile .
- DH launched a consultation on updating the NHS Constitution
- The Report of the Morecambe Bay Investigation
- Freedom to Speak Up
- PHSO report “My expectations for raising concerns and complaints”.
- Complaints and Raising Concerns from the Health Select Committee
- SFT announce a joint tender for adult community service bid in 2016
- Staff survey results 2014
- Charge to Trusts for accessing Skills for Health e-learning from 1/4/15.
- Visits from two national Patient Safety Leads from NHSE
- Expansion and refurbishment of Radnor

CB drew attention to the particular importance of the Morecambe Bay Report.

Based on the reports of experiences of mothers in labour who have been transferred to theatre for an emergency c-section and their concerns regarding privacy, this is something that no longer occurs within the hospital.

FHy stated that work would be done around the Guide to Care Contact time.

A discussion took place regarding the labour intensity of inputting data and joining up across the patch..

The committee were informed that a new statement by a former patient had been received as a result of our hospital’s part of the publication concerning the Jimmy Savile enquiry. The former patient recollects that they were asked to show Jimmy Savile around on a visit to the hospital. This new statement is now being followed up.

ASSURING SAFETY

CGC0316 – Risk Report Card Q3, Fenella Hill

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

- 1010 incidents reported over the quarter
- No incidents categorised as catastrophic
- 2 incidents categorised as major*
- 2 major incidents due to fractures within the quarter
- No Never Events reported within the quarter
- 1 new Clinical Review commissioned within the quarter
- No new Non-clinical Reviews commissioned within the quarter
- 6 new Serious Incident Inquiries commissioned within the quarter (1 removed in agreement with CCG following receipt of results)
- No new Local Reviews commissioned within the quarter

*Initial grading and subject to change following review.

FH confirmed that we are almost paperless in terms of reporting.

PK questioned the list of events and a full explanation was provided by FH and CB.

CGC0317 – Assurance Framework, Fenella Hill

FH presented the Clinical Governance Committee with the Assurance Framework for review and updating

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

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

An outcome of the Care Quality Commission is the assessment and monitoring of the quality of service provision

The Committee was asked to review each of the principal risks and in doing so assure themselves that all possible steps are being taken to manage and control each risk.

A discussion took place regarding the C Difficile target breach and the new larger target set for next year. Work also needs to be done regarding the two 'never events' which have now been reported.

CGC0318 – Q3 Safeguarding Adults Report (deferred from February), Fiona Hyett

FHy led the discussion regarding The Care Act which comes into force in April 2015. There will be key changes with more focus on agencies such as hospitals or the police to become involved. The implication is that safeguarding enquiries will increase, leading to additional workloads.

It was reported that Rebecca and Jo have enjoyed additional responsibilities in this area and we are looking forward to the return of Gill Cobham.

The committee agreed that progress was being made.

PAPERS FOR NOTING

CGC0319, Clinical Risk Group Minutes (Feb 2014)	Noted
CGC0320, CMB Minutes (Feb 2015)	Noted
CGC0321, Children's Quality & Safety Board (Dec 2014)	Noted

CGC0322, ANY OTHER BUSINESS

The NEDs were asked about difficulties in receiving and opening documents electronically prior to the CGC meeting and it was agreed that a meeting needs to be arranged with IT to resolve this issue.

LB asked for suggestions for Board Meeting topics and both SM and SL proposed Elderly Care and recruitment.

FHy stated that she would now be taking planned personal leave and the CGC members gave their thanks to her for her contributions.

NEXT MEETING

2015 dates will be Thursdays, 10am-12pm in the Boardroom 28th May, 25th June, 23rd July, 24th September, 22nd October, 26th November. No meetings in April, August or December.

JOINT BOARD OF DIRECTORS (JBD) MINUTES FROM 15 APRIL 2015 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 Committee, Clinical Governance Committee and the Joint Board of Directors (JBD).

JBD – 15 April 2015

ASSURANCE FRAMEWORK REVIEW AND UPDATE
It was noted in relation to Risk 2.4 Robust Governance Processes that the Board had received an update on the review by Thames Valley and Wessex Leadership Academy and an action planning meeting would take place in June. The new Workforce Report would mitigate the issues raised in Risk 3.1 and 2 but there were no plans to give a direct report to the Board from the Executive Workforce Committee. Newly identified assurances were noted in relation to the CQC banding, ED performance in Quarter 4 and the new Access Policy. Peter Hill requested that the risk identified from Genetics in the Risk Register be reviewed. It was agreed that Executive Directors would each review their areas of the Risk Register. The result would be reported to Trust Board in June.

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